**A meeting of the Finance and Performance Committee will be held on Wednesday, 1st May 2019 at 9:30am to 1.00pm in the Executive Meeting Room, Headquarters, St Cadoc's**

# AGENDA

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| **1** | **Preliminary Matters** | | | |
| **9:30** | 1.1 | **Apologies for Absence**<br>To receive apologies for absence | Verbal | Chair |
| | 1.2 | **Declarations of Interest**<br>To receive declarations of interest | Verbal | Chair |
| | 1.3 | **Minutes of the Finance and Performance Committee – 21st February 2019** | Attachment | Chair |
| | 1.4 | **Action Log** | Attachment | Chair |
| | 1.5 | **Matters Arising from the Previous Meeting** | Verbal | Chair |
| **2** | **Items for Assurance:** | | | |
| **09:45** | 2.1 | **RTT 2018/19 and 2019/20 Delivery Plan** | Attachment | Director of Operations |
| **10:15** | 2.2 | **Workforce Performance Report:**<br>• **Performance/People Plan Update**<br>• **Recruitment and Retention Progress Update**<br>• **Welsh Language Update** | Attachment | Director of Workforce and OD |
| **11:00** | 2.3 | **Finance Performance Report** | Attachment | Director of Finance and Performance |
| **11:20** | 2.4 | **Integrated Performance Report** | Attachment | Assistant Director of Performance & Information |
| **11:40** | 2.5 | **Strategic Areas of Efficiency:**<br>• **Bed Utilisation** | Attachment | Director of Operations/Senior Planning & Service Development Manager |
| **12:00** | 2.6 | **Value Based Healthcare and the impact on delivery of services** | Attachment | Director of Finance and Procurement |
| **12:30** | 2.7 | **Committee Risk Register** | Attachment | Chair |
| **3** | **Final Matters** | | | |
| | 3.1 | **Items for Board Consideration** | | All |
| | 3.2 | **Risks for Board Consideration** | | All |
| | 3.3 | **Date of the Next Meeting**<br>Thursday, 4th July 2019 at 09:30 in the Executive Meeting Room, Headquarters, St Cadoc's | | Chair |

Finance and Performance Committee
1st May 2019
Agenda Item: 1.3

# Aneurin Bevan University Health Board

## Minutes of the Finance and Performance Committee held on Thursday 21 February 2019 in Conference Rooms 1 and 2, Headquarters St Cadoc's Hospital, Caerleon

**Present:**

| | | |
|---|---|---|
| Shelley Bosson | - | Chair, Independent Member (Community) |
| Catherine Brown | - | Independent Member (Finance) |
| Frances Taylor | - | Independent Member (Community) |

**In Attendance:**

| | | |
|---|---|---|
| Judith Paget | - | Chief Executive |
| Peter Carr | - | Director of Therapies and Health Sciences |
| Claire Birchall | - | Director of Operations |
| Geraint Evans | - | Director of Workforce and OD |
| Nick Wood | - | Director of Primary Care, Community and Mental Health |
| Dr Stephen Edwards | - | Assistant Medical Director |
| Rob Holcombe | - | Assistant Director of Finance |
| Mark Ross | - | Assistant Director of Finance (observing) |
| Lloyd Bishop | - | Assistance Director of Performance and Information |
| Kath Smith | - | Interim Associate Director of Operations |
| Gabrielle Smith | - | Performance Audit Lead, Wales Audit Office (observing) |
| James Quance | - | Internal Audit (observing) |
| Rona Button | - | Corporate Services Manager (Secretariat) |

**Apologies:**

| | | |
|---|---|---|
| Cllr Richard Clark | - | Independent Member (Local Government) |
| Dr Paul Buss | - | Medical Director |
| Glyn Jones | - | Director of Finance |
| Nicola Prygodzicz | - | Director of Planning, Digital and IT |
| Martine Price | - | Director of Nursing |
| Dr Sarah Aitken | - | Director of Public Health |
| Richard Bevan | - | Board Secretary |
| Debra Wood-Lawson | - | Chief of Staff |

**FPC 2102/01 Apologies for Absence**

The Chair welcomed members and observers to the meeting and apologies for absence were noted.

**FPC 2102/02 Declarations of Interest**

There were no declarations of interest to be recorded.

**FPC 2102/03 Minutes of the Last Meeting – 18 October 2018**

The Chair expressed her disappointment that items which had been agreed to be added to the agenda at the agenda setting meeting had subsequently been removed. Therefore it was agreed that the Bed Utilisation paper would be added to the agenda for May's meeting. **ACTION: Claire Birchall, Nicola Prygodzicz and Secretariat**

The Chair also requested that in future, if items were removed from the agenda after being agreed, she should be contacted with an explanation. **ACTION: Secretariat**

The Minutes were agreed as a true and accurate record.

In respect of the patient satisfaction matrix, the Chair asked for further information in order to be assured that the objectives contained in the IMTP were on track, as it was not possible to determine this because the data had not been provided. Judith Paget agreed to feed this back to Glyn Jones. **ACTION: Judith Paget**

**FPC 2102/04 Action Log**

The actions were noted and it was acknowledged that all actions were either on the agenda or scheduled for a future meeting.

**FPC 2102/05 Strategic Change Plans (SCPs):**

- **SCP3 – Management of Major Health Conditions**

Peter Carr presented the paper and provided some background on SCPs, advising the Committee that an Executive Lead was assigned to each SCP, and local delivery plans had been developed which aligned to national priorities set out by each national implementation group. Information was collated and sent to Welsh Government.

SCP 3 focused on the delivery of systematic and proactive management of major health conditions in order to:

- improve health outcomes
- reduce inappropriate use of hospital services

- have a significant impact on reducing health inequalities

The key performance measures provided in the report were outlined in the National Outcomes and Performance Framework as set by Welsh Government.

Cancer and stroke services were highlighted for discussion, with the focus being on their objectives and whether or not these had been met. It was noted that although the urgent suspected 62 day cancer treatment times had improved in December 2018, the 91.3% compliance remained outside the 95% target and IMTP profile. However, there had been an increase in the number of referrals received each month from 1,700 in 2017 to over 2,000 in 2018, and over 2,100 in January 2019 alone. This increase had seen a knock-on rise in the number of patients being treated for cancer.

Winter pressures remained a challenge for the Stroke Service, and there had been a deterioration in compliance performance, particularly the 4 hours bundle, including initial swallow screen.

In order to demonstrate the benefits, the major health condition groups would need to draw on patient outcomes and experiences, local audits and peer reviews.

General progress against the key milestones regarding the management of major health conditions was discussed, together with the areas of highest concern, and the risks and mitigating actions taken.

Further information was requested regarding Advanced Care Plans (ACPs) and their value for money, and this would be added to the forward work programme to be discussed at a future meeting. **ACTION: Stephen Edwards/Secretariat**

The Committee was reasonably assured by the report and requested to have further assurance the next time SCP 3 was discussed at the committee meeting. Peter Carr agreed that this would include a demonstration of the benefit trackers employed. **ACTION: Peter Carr**

- **SCP 4 – Mental Health and LD**

Nick Wood updated the Committee and advised that progress had been made on all five priorities in the SCP. A delivery framework and evaluation tracker had been developed to ensure that the capabilities achieved through the Mental Health and LD Plan delivered the anticipated outcomes and benefits.

The Committee questioned the purpose of the SCPs being discussed at the Finance and Performance Committee meeting when they did not contain any financial information which clearly defined how the actions/activities being reported were progressing against milestones in the IMTP. As financial quantification was required in the reports, it was agreed that the Chair (of the Committee) would speak to the Chief Executive outside of the meeting for clarification. **ACTION: Shelley Bosson and Judith Paget**

The Twyn Glas facility was discussed and it was agreed that the Third Sector should be included to establish if there was a better service available for this cohort of patients. This would be picked up by the Mental Health Team. **ACTION: Nick Wood**

Following a discussion regarding the report, it was noted that much of the information had been reported to the Board and to the Mental Health Committee. It was agreed that the Committee's requirements for reporting should be reviewed to seek to avoid duplication of business. However, this may result in changes to the terms of reference for each committee, and this was something that the Chief Executive would address with the Board Secretary as part of the review of committees which was currently underway. It was felt that the way the report had been written did not close the loop from a finance and performance perspective. **ACTION: Judith Paget and Richard Bevan**

Nick Wood advised that some benchmarking information was new so it would be possible to begin collecting information, and it was reported that there had been some issues in establishing benchmarking within Mental Health. It should also be noted that not all benefits would result in direct cash benefits.

**FPC 2102/06 Workforce Performance/People Plan Update**

Geraint Evans updated the Committee with the key messages from the 2018 update report. It was noted that sickness had increased during the winter months, although this was the same across Wales. The current figure equated to 684 Whole Time Equivalent (WTE) staff away from work each day. There had also been a corresponding increase in long term sickness absence (over 28 days). 30% of bank and agency staffing was being used to cover sickness.

The figure reported for PADR compliance would increase to 78% once all the information was uploaded onto the ESR system.

The Committee asked for a letter of thanks to be sent to Gareth Hughes, Divisional Director of Facilities, regarding his team's PADR compliance (87.68%), and Judith Paget agreed to do this. **ACTION: Judith Paget**

It was reported that recruitment rates had improved, although the Committee would like to see the length of time from a vacancy being requested by the manager to the unconditional offer reduce from over 60 days. Suspension rates needed to improve and the Team was currently looking at a new approach to disciplinary proceedings, which included the use of dedicated Investigating Officers. In terms of numbers leaving the organisation, the Committee asked if it was known where people were going, as this would be useful information, together with lowering the numbers who left for "unknown reasons". Additionally, details were requested on the how many people returned after retirement.

Following the staff survey, an action plan was being developed to address the issues and this would be reported back to the Committee at a future meeting. However, it was noted that there were no dignity at work or bullying and harassment concerns within the survey data. **ACTION: Geraint Evans/ Secretariat**

A paper was also requested on employee engagement and how the Health Board was addressing this. **ACTION: Geraint Evans**

Rates for job planning had seen an improvement and Dr Stephen Edwards advised the Committee that particular groups of consultants were being closely monitored by the service.

The Committee asked how good the Health Board was at talking about mental health issues, and Geraint Evans advised that the Health Board was as good as, if not better than, other Health Boards in discussing these issues, although it was still necessary to do more.

**FPC 2102/07 Month 10 Finance Performance Report**

Rob Holcombe provided the Committee with the Month 10 finance report and advised that the Health Board was £440,000 overspent, although the position had improved by £130,000 on the previous month. One of the areas that had helped improve this position was Continuing Health Care (CHC) following the settlement of retrospective claims. The plan and forecast assumed that the £3.1 million performance funding was

retained, and it required the Health Board to deliver reduced elective waiting times. Discussions were ongoing with Welsh Government to retain the funding providing the target of treating patients over 36 weeks by 31 March 2019 was met, although the Committee remained concerned should any funding have to be returned. The specific risks regarding funding were the Trauma and Orthopaedic, and Ophthalmology services, but the Chief Executive advised the Committee that the Executive Team had ongoing confidence in the organisation's ability to break even.

Although the organisation was well into the winter period, there had not been the expected levels of spend, and £4m had been received from Welsh Government towards winter funding. It was advised that the Health Board would need to utilise all of its revenue reserves, however the expectation was that financial balance would be achieved by year end. At worst, there would be a £2m overspend.

The Committee was concerned about the potential balance at the end of the financial year, as well as about efficiency and benchmarking, as there was no way of the organisation assessing itself against a benchmark. The Committee again reiterated that they would like to see a greater focus on value for money. The Committee also requested a better way of being able to monitor the Health Board's progress from a financial point of view. In addition, the Committee would like further information on efficiencies, and reserves, risks and opportunities. Rob Holcombe advised that this information could be built into the report and he would look at amending the report for future meetings. **ACTION: Rob Holcombe**

The Chair of the Committee asked for further information in relation to the governance and finance arrangements for the Regional Partnership Board, in order that the Committee could receive assurance on the governance and decision making in terms of the Health Board's financial position. Rob Holcombe advised that there was a process for this which was audited. Judith Paget agreed to speak to Phil Robson, Chair of the Regional Partnership Board, regarding assurance and his requirements for the Board. **ACTION: Judith Paget**

It was agreed that the financial controls paper should be put on the agenda for the Audit Committee. **ACTION: Secretariat**

**FPC 2102/08 Performance Report**

Lloyd Bishop updated the Committee with the Performance Report and the key areas were highlighted. There had been an improvement against the national performance measures in a number of areas, including mental health and cancer access. It was also noted that the Health Board was well ahead of the target for staff flu vaccines.

The Committee would like to have seen the age split for those waiting over 12 hours in A&E departments, and how long in excess of 12 hours those individuals had to wait. Outpatient follow ups were also a concern, but Claire Birchall explained that ongoing work was taking place and action plans were being developed to address these. It was anticipated that at the end of the year there would be between 17,000 and 18,000 such patients, although extra funding had been received for very specific initiatives.

The way the Health Board had to complete the dashboard did not provide an accurate reflection of the current position, because it was no longer possible to use an amber colour to denote an "almost there" category. Instead, only red and green could be used, because either the target had been met or it had not.

Lloyd explained to the Committee how the dashboard was fed, from the Health Board's systems (including DATIX and WPAS) via the Data Warehouse and the appropriate committees and assurance groups, to the dashboard itself. Detailed dashboards were also being developed, with Falls and Healthcare Acquired Infection information ready to be uploaded. Various gatekeeping measures would be installed to ensure quality of the data, and it was anticipated that this would be the Committee's summary sheet in the future.

Patient satisfaction data was currently being collected via PREMS (Patient Reported Experience Measures) on Ward C4E at the Royal Gwent Hospital, and this would be rolled out to other wards in the future. An increased focus was required around pressure ulcers and the document was a work in progress.

The Chair noted the current performance and recognised the efforts being made by staff. The Committee looked forward to patient experience information being included in the future and noted the development of performance dashboards for each of the Health Board's sub-committees.

**FPC 2102/09 Strategic Areas of Efficiency:**

- **Theatre Productivity**

  Claire Birchall and Glenys Mansfield provided a report to update the Committee on theatres' productivity and it was reported that four of the six work streams were well described and developed. The Health Board was using the new Omnicell system which was an autonomous solution for procuring and controlling theatre supplies, by inputting the expected stock levels and, as these were used, replenishing automatically to the agreed levels via the Oracle system. However, the implementation of the contract had been a challenge due to operational issues over the last nine months and included issues such as software problems which Omnicell had to resolve, and the radio-frequency identification (RFID) system not going live until later this year. The organisation was continuing to engage with Omnicell on their delivery of the contract.

  Ysbyty Ystrad Fawr, Royal Gwent, Nevill Hall and St Woolos Hospitals had gone live on the system between May and September 2018, with minimal disruption to the service, although the final aspect of the rollout to the RGH would not take place until March 2019. It was anticipated that savings would be made from staff time in due course, and these could increase, as Omnicell was more than just a drug control system, and it was the Health Board's intention to use its functions more fully, with one of the main benefits being a closed loop stock control system. This would ensure correct stock levels to mitigate any safety concerns regarding patient procedures and cancellations. However, financial savings would not become apparent until at least the next financial year. The Committee was disappointed that the potential financial savings, as well as staff time and other resources, had not been included in the report, even if they were indicative at this stage.

  The Committee asked whether or not it was advisable for the Health Board to have been the first to implement a new system, rather than learning from the implementation of other organisations, and it would necessary to evaluate clinical user satisfaction. The Committee requested a financial summary on the system to include the benefits realisation, and it was agreed that this would be brought to the committee meeting in October 2019. **ACTION: Claire Birchall/Secretariat**

**FPC 2102/10 WAST Amber Review**

Kath Smith provided the Committee with a presentation on the Health Board's response following the WAST Amber Review. An amber call category was defined as patients with serious conditions which were not immediately life threatening, but were nonetheless urgent and might need treatment and care at the scene or rapid transfer to a healthcare facility. However, it was noted that the prioritisation of calls was complex, with a range of different responses depending on the patient's condition.

Graphs within the presentation illustrated the response times to Amber 1 and Amber 2 calls, together with statistics on the number of incidents logged and the number of lost hours during hospital handover. The three recommendations within the review were:

- To improve and simplify the availability of alternative services.
- To ensure that lost hours for ambulances outside hospitals reduced.
- To reduce the longest waits for patients in the community.

A number of actions had been put in place to address the recommendations, including the promotion of Minor Injury Units, working with WAST to reduce the number of falls transported to hospital, relaunching the Escalation policy, maximising the use of trolleys in the Minors area of the ED in RGH, and increasing the staffing establishments in EDs and MAUs to allow ambulance crews to transfer patients to the Health Board's care. It was noted that regular conversations took place with WAST colleagues to ensure that maximum efficiency was maintained.

Judith Paget advised that from a strategic perspective, the Health Board had three main actions to implement which would assist in the future:

- Do whatever was possible to reduce conveyance rates by increasing the numbers of advanced paramedics.
- Increase the numbers of hear and treat staff in the clinical desk through increased investment.
- Increased availability of emergency ambulances in the Gwent area, and it was advised that the number of vehicles and paramedics had increased.

The Committee asked how much of the problem was not related to the differences between the EDs at RGH and NHH, as crews at NHH were able to transfer patients from ambulances into the ED much more quickly than in the RGH. It was reported that there were differences in the physical environments of all hospital EDs, and it was most important to keep patients safe. To that end, plans had been put in place to improve the triage process.

The Committee received the report.

**FPC 2102/11 Strategic Areas of Efficiency:**

- **Premium Workforce Costs and Usage**
  Geraint Evans updated the Committee on the costs and usage, and advised that, generally, the workforce wanted flexible working, and it was therefore important to keep skilled staff within the organisation, whilst maintaining the necessary services. An 18 point plan had been developed and was being actioned on nurse retention, which was monitored at the monthly Nurse Workforce Group meeting.

  The paper informed the Committee on agency usage for nursing and midwifery registered staff which remained high due to the increase in vacancies. To the end of Month 10 in the 2018/19 financial year, the average use of agency staff was 81 WTE per month, and it was noted that an increase in agency use was part of the winter staffing plan.

  Premium payments for medical staffing were under review and a paper in relation to Waiting List Initiatives, Backfill and out of hours payments was to be considered by the Executive Team.

**FPC 2102/12 Medical Locum and Agency Cap Compliance Update**

Dr Stephen Edwards provided the Committee with a summary of the premium workforce work for medical and dental staff used.

Locum and agency use had increased during December 2018, including below and above capped rates. The agency usage had been a mix of senior and junior medical staff, and 71% of locum and agency medical usage was due to vacancies, as some areas were proving difficult to recruit into, and the usage was necessary to maintain patient safety and provide care. All requests to breach the capped rate were escalated and agreed by the Executive Team for this purpose. Any learning for the

organisation centred on the drive for substantive recruitment, and a summary of each Division's progress was outlined.

In the Welsh Health Circular (WHC/2017/042 – Addressing the Impact of NHS Wales Medical and Dental Agency and Locum Deployment in Wales, 23 October 2017) there was an expectation that there should be a 35% reduction in agency only expenditure by November 2018, from the baseline period of 1 November 2016-31 October 2017 (£7.508m). However, the actual spend had been £7.525m (£0.025m more than in the baseline period). The Committee questioned the consequences of not meeting the targets, and it was reported that the Health Board was in a better position than some organisations, although any consequences were unknown.

Agencies were still unwilling to work with the organisation and encourage doctors to adhere to the capped rates, and Procurement had advised that the rates for some specialties were above the cap, with little recourse to address this. In addition, it had proved difficult to attract doctors to travel to Nevill Hall Hospital, with some requesting accommodation and expenses. To date, these had not been paid, however this did not mean that a breach would not be necessary in the future.

There was also an issue in the application of waiting list initiative (WLI) rates, where non-contractual backfill was being used and attracting WLI rates, even though the cover should have been a locum at ad hoc locum rates. The Health Board was working to reduce these rates, and it was hoped that there would be an All Wales approach to defining this which would reduce the inflated WLI rated down to the level of the cap.

In conclusion, there was an ongoing need to use medical locum and agency staff, mainly to cover vacancies, and work continued to reduce the number of agency hours, although this remained challenging in the current recruitment climate.

The Committee noted the report.

**FPC 2102/13 Committee Risk Register**

The Committee received the Risk Register. The Committee discussed that there were three risks which it was felt would be better suited to the Quality and Patient Safety Committee. Judith Paget advised that the Corporate Risk Register was being reviewed to ensure that risks were appropriately assigned. It was also queried why Risk 1 (Failure to achieve financial balance at end of 2018/19) had reduced and it was recorded

that it had been reduced in line with the financial position. The Committee was surprised with this action and thought that the financials and efficiencies should be considered separately regarding value for money. **ACTION: Glyn Jones**

**FPC 2102/14 Items for Board Consideration**

The following item was to be brought to the attention of the Board:

- Further information was required on efficiencies regarding finance, although it was acknowledged that this was a work in progress.

**FPC 2102/15 Risks for Board Consideration**

There were no risks to be brought to the attention of the Board.

**FPC 2102/16 Date of the Next Meeting**

The next meeting was due to take place on Wednesday 1 May 2019 at 9.30am in the Executive Meeting Room, Headquarters, St Cadoc's Hospital, Caerleon.

**Finance and Performance Committee**
**21 February 2019**
**Action Sheet**

**Agreed Actions**

| Minute Reference | Agreed Action | Lead | Progress/Completed |
|---|---|---|---|
| **FPC 2102/03** | **Minutes of the Last Meeting – 18 October 2018:** Bed Utilisation paper to be added to the agenda for May's meeting. | **Claire Birchall/ Nicola Prygodzicz/ Secretariat** | Item on May Committee agenda. |
| | If items were removed from the agenda following the agenda setting meeting, the Chair of the Committee should be advised. | **Secretariat** | Action noted for future. |
| | Feedback to be provided to Glyn Jones that the patient satisfaction matrix did not provide assurance that the objectives were on track due to a lack of data provided, and further information was required. | **Judith Paget** | Completed. |
| **FPC 2102/05** | **Strategic Change Plans (SCPs): SCP3 – Management of Major Health Conditions:** Further information regarding Advanced Care Plans (ACPs) and their value for money to be discussed at a future meeting. | **Stephen Edwards/ Secretariat** | Added to the Committee forward work programme for July 2019. |

| Minute Reference | Agreed Action | Lead | Progress/Completed |
|---|---|---|---|
| | Further assurance required the next time SCP 3 discussed at the Committee to include a demonstration of the benefit trackers employed. | **Peter Carr** | Added to the Committee forward work programme for February 2020 (date to be confirmed). |
| | **SCP 4 – Mental Health and LD:** The purpose of SCPs being discussed at the Committee meeting to be addressed outside of the meeting. | **Shelley Bosson/ Judith Paget** | This will be covered through the Committee Review work and when determining the forward work programme. |
| | The Third Sector to be included in discussions to establish if there was a better service available for the patients currently residing in the Twyn Glas facility. | **Nick Wood** | Completed as part of the Third Sector Commissioning Strategy by the Mental Health and Learning Disabilities Division. |
| | The Committee's requirements in terms of reporting to be discussed to avoid duplication with other committees. | **Judith Paget/ Richard Bevan** | This is being covered through the Committee Review work which will be reported to the May meeting of the Board. |
| **FPC 2102/06** | **Workforce Performance/People Plan Update:** Letter of thanks to be sent to Gareth Hughes, Divisional Director of Facilities to commend him on his Team's PADR compliance. | **Judith Paget** | Complete. Email sent to Gareth Hughes by Judith Paget on 25 February and acknowledged by Gareth Hughes on 27 February. |

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Finance and Performance Committee
1st May 2019
Agenda Item: 1.4

| Minute Reference | Agreed Action | Lead | Progress/Completed |
|---|---|---|---|
| | Action plan following the staff survey to be put on the agenda for a future meeting. | **Geraint Evans/ Secretariat** | Added to the Committee forward work programme for October 2019. |
| | Paper on employee engagement and how the organisation is addressing this to be put on the agenda for a future meeting. | **Geraint Evans/ Secretariat** | Added to the Committee forward work programme for July 2019. |
| **FPC 2102/07** | **Month 10 Finance Performance Report:** Information on efficiencies, and reserves, risks and opportunities, to be added to future finance reports. | **Glyn Jones/ Rob Holcombe** | M12 – agenda item for May Committee. |
| | The Chief Executive to speak to Phil Robson, Chair of the Regional Partnership Board, regarding assurance and his requirements for the Board in relation to governance and finance arrangements. | **Judith Paget** | This is being covered through the Committee Review work which will be reported to the May meeting of the Board. |
| | Financial controls paper to be put on the agenda for the Audit Committee. | **Secretariat** | Item transferred to the Audit Committee. |
| **FPC 2102/09** | **Strategic Areas of Efficiency: Theatre Productivity:** Financial summary on the Omnicell system, to include the benefits | **Claire Birchall/ Secretariat** | Added to the Committee forward work programme for October 2019. |

| Minute Reference | Agreed Action | Lead | Progress/Completed |
|---|---|---|---|
| | realisation, to be put on the agenda for October's meeting. | | |
| **FPC 2102/13** | **Committee Risk Register:** Risk register to be reviewed to ensure risks were appropriately apportioned. Financials and efficiencies to be considered separately regarding value for money. | **Glyn Jones** | Board risk register updated to reflect separate risk on VFM (March Board). |

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| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol<br>Aneurin Bevan<br>University Health Board | Finance and Performance Committee<br>1st May 2019<br>Agenda Item: 2.1 |

# Aneurin Bevan University Health Board

## Referral to Treatment Times (RTT) 2018/19 and 2019/20


### Executive Summary

To provide an update to the Finance and Performance Committee on the updating of the Health Board Referral to Treatment Time delivery plans in light of the 2018/19 outturn.

The Health Board has delivered significant improvements in elective access in recent years and, as set out in the Integrated Medium Term Plan, has eliminated 36 week waits in all areas with the exception of Orthopaedics and Ophthalmology.

The paper describes the detailed work undertaken in assessing demand and capacity for this coming year and the development of specialty specific plans. In addition inefficiency and improvement plans along with risks and limitations are detailed. The original demand and capacity plan was designed to deliver zero 36 weeks by the end of March 2021. However, there have been recent discussions with Welsh Government to clear the 2018/19 patients waiting over 36 weeks by the end of quarter 1 2019/20, with the revised target of month on month delivery of zero thereafter. This plan presents a significant challenge to a number of specialties who will need to bring their outpatient wait forward, and has a resulting impact on diagnostics. The delivery of the zero monthly plans is still being worked through.

The Finance and Performance Committee is asked to:

- Note the delivery of the 2018/19 outturn.
- Note the progress in the finalisation of demand and capacity plans and the approach taken.
- Note that the residual breach patients for Orthopaedics which will be accommodated in April and May 2019.
- Note that the residual breach patients for Ophthalmology will be included in the outsourcing figures for 2019/20, but will be accommodated in April.
- Note the remaining demand and capacity gap within the 2019/20 Orthopaedic plan.
- Note the risks and limitations of the modelling and meeting a zero month on month position, and the approach to mitigate this risk.
- Note the assessments undertaken on work to date for delivering the plan which includes a plan to reduce outpatient waiting times below 26 weeks for some specialties.
- Note the ongoing work to deliver a monthly zero position.
- Note the current status of the plan which is undergoing further scrutiny by the Executive Team.

| **The Finance and Performance Committee is asked to:** (please tick as appropriate) | | | |
|---|---|---|---|
| Approve the Report | | | |
| Discuss and Provide Views | | | ✓ |
| Receive the Report for Assurance/Compliance | | | ✓ |
| Note the Report for Information Only | | | |
| **Executive Sponsor:** Claire Birchall, Executive Director of Operations | | | |
| **Report Author:** Ian Jenkins, Assistant General Manager, Surgical Services | | | |
| **Report Received consideration and supported by :** | | | |
| **Executive Team** | | **Committee of the Board [Finance and Performance]** | ✓ |
| **Date of the Report: 23 April 2019** | | | |
| **Supplementary Papers Attached: None** | | | |

## Purpose of the Report

To provide an update to the Finance and Performance Committee on 2018/19 RTT outturn, and progress with the 2019/20 Referral to Treatment Time delivery plans, including the requirements to deliver the outstanding demand and capacity gap.

## Background and Context

The Divisions have made significant improvements in elective access since March 2016, with the number of patients breaching the 36 week target falling from more than **2,600** at this time to **812** at the end of March 2018. The Divisions had been on track to eliminate 36 week waits by the end of March 2019 but despite unprecedented treatment activity in Orthopaedics, the Directorate unfortunately had 81 patients breaching the target. Additionally due to the inability of planned outsourcing to be delivered, Ophthalmology had a further 37 patients breaching the target. The resultant outturn was 118 which is a significant reduction on the previous year but above the initial Integrated Medium Term Plan 2018/19 aim of eliminating 36 week waits.

Radiology 8 week breaches have reduced from numbers in excess of **500** during quarter 2 to a zero position for March 2019. This has been delivered due to additional locum capacity being sourced for USS, along with 16 additional days of mobile MRI scanner being provided.

The Health Board secured funding from Welsh Government of £3.1m to deliver zero 36 week patients waiting at the end of March 2019, and have confirmed that there will be no financial claw back if these patients are accommodated by the end of Quarter 1. All of these patients have been booked before the end of Quarter 1.

*NB two late administrative errors have been identified and means that one general surgery patient waiting >36 week and one >52 week orthopaedic patient.*

## Assessment and Conclusion

The Divisions have begun to address plans for the delivery of RTT in 2019/20, based on the backlog from 2018/19 and the usual demand and capacity approach to modelling for 2019/20.

**Demand**

Derived demand is utilised for the purposes of demand and capacity planning which is calculated by measuring the change in a waiting list over a 12 month period then adding the activity for the same period. The period utilised for the modelling was August 2017 to July 2018. In previous years the total demand was then applied evenly to each of the months of the year. However in this year's modelling demand and capacity was profiled over the year to give a more realistic variation of demand and capacity.

Diagnostic imaging however, has yet to undertake profiled modelling. This variation can be significant in some specialties and diagnostic modalities.

Total outpatient demand has reduced by 5% from last year with the most significant reductions in General Surgery, Dermatology, Maxillo-Facial and Orthopaedics. This reduction has been actively influenced by demand reduction plans and backlog demand which has reduced significantly from last year after extensive progress has been made in reducing outpatient waiting times.

Demand reduction plans are being implemented in ENT, Maxillo-Facial, Orthopaedics and Rheumatology which aim to collectively reduce outpatient demand by 1,222 in year with greater reductions in future years. In addition to these plans, outpatient backlogs have been eliminated in ENT, Maxillo-Facial and Orthopaedics which have contributed to reducing the total outpatient demand. Recurring demand has reduced, but at the much lower rate of 1% which equates to approximately 742 fewer than last year.

Conversely total treatment demand has increased despite a considerably lower treatment backlog of 118 compared with the 812 of the previous year. Total treatment demand has increased by 4% which equates to 1,103 additional treatments. These figures take into account planned demand reductions schemes which aim to reduce demand primarily in Maxillo-Facial and to a lesser degree in Orthopaedics. In addition to these plans the yearend outturn was significantly lower than the 2017/18 outturn of 812.

Diagnostic imaging demand has increased across all modalities apart from plain films, due to their contribution to the early diagnosis of cancers. Plain films have seen a decrease in demand due to the increased use of CT to provide a swifter diagnosis. The greatest rises sit within MR and Nuclear Medicine with increases in demand of 24% and 23% respectively, with CT and general Ultrasound seeing rises of 7% and 8%. Such high increases will require prudent and effective management of demand/capacity plans to ensure that sufficient capacity can be created. It should be noted that this cannot necessarily be delivered from internal resource alone.

Similarly to outpatient demand, the above measures mask a different picture in recurrent demand which has increased by 8% (2,371 treatments) driven primarily by General Surgery and Orthopaedics. These two specialties make up more than 80% of the increase with General Surgery up 13% (613 treatments) and Orthopaedics, up 18% (1,330 treatments). Whilst marginal decreases are expected in ENT and Ophthalmology all other specialties are expected to increase.

## Demand Management Schemes

The below table details the forecasted impact of identified demand management schemes, some of which will only have a part year affect in 2019/20 and will be dependent on the timing of recruitment.

| Specialty | Scheme | Outpatient | Treatment |
|---|---|---|---|
| Ear, Nose & Throat | GP Pathways | 240 | |
| | GP Email Advise Line | 48 | |
| Maxillo-Facial | Implementation of Referral Criteria | 199 | 199 |
| Ophthalmology | Diabetic Retinopathy Referral Refinement | 59 | |
| | Cataract Referral Refinement | 30 | |
| | Paediatric Pathway Review | 120 | |
| Rheumatology | Inappropriate Referral Review | 338 | |
| T&O | Shoulder/Hip/Knee Triage | 397 | 20 |
| | **Total** | **1,431** | **219** |

These new schemes will work in conjunction with existing schemes which include GP advice processes across a range of specialties, the spinal triage, Wet Muscular Degeneration (AMD), Varicose Vein pathway, Prostate Specific Antigen (PSA) surveillance and see on symptom pathways.

## Capacity

Capacity is determined utilising a team effectiveness template separated for outpatient and treatments. The average capacity per week for new outpatients and treatments is calculated by consultant using clinic templates and average completed procedures for the previous rolling 12 months. The weekly average is then multiplied by the number of expected weeks in a standard year which is 42 for most consultants, allowing for annual and study/professional leave.

In some specialties consultants dedicate some weeks to supporting emergency services such as trauma. Where consultants have such commitments in their job plans the 42 week figure is reduced as appropriate. Additionally, for those specialties which are planned at the subspecialty level the consultant is used as a proxy to determine the subspecialty's demand and capacity. Work is ongoing in multiple Directorates most notably Ophthalmology and Orthopaedics to have the subspecialty of each pathway included in primary systems, as using consultant as a proxy is not sufficiently robust for service planning and delivery.

This method has been in place for several years and Directorates are accustomed and experienced with the method which is easy to understand. However, there are limitations and variances in service delivery which are not easily representable in this format, including:

- Clinic templates/theatre slots, fluctuate dependent on junior doctor and advanced nursing/physio support which can significantly impact on actual capacity. This is difficult to represent as junior doctors not only rotate throughout the year they and other advanced roles also have leave which cannot be factored into the modelling.

- Capacity switching, is often necessary to manage demand across a Directorate which will also be required to accommodate cancer and emergency patients who would fall outside of RTT, along with balancing follow up demand.
- Theatre capacity, is assumed to be equal when in reality capacity varies between high and low acuity, General Anaesthetic and Local Anaesthetic, inpatient or daycase.
- The method to calculate total capacity over a period can significantly be impacted by the fall of bank holidays for individual consultants which can have a disproportionate impact in smaller teams.
- Follow up, capacity is not modelled as part of the process due to the inability of the primary systems to determine demand. This is heavily influenced by the number of new outpatients delivered along with the number of treatments and the impact of year on year activity changes is never modelled through to follow up.
- Diagnostic Imaging capacity is derived at modality level and based the hours per day a service runs and an average length of time per examination. Examination timeframes are split into 15 minutes (CT), 30 minute (MR) and an average number of scans per session (USS), however it is recognised that the length of time for examinations is variable dependant in the complexity which can significantly impact on efficiency levels forecasted. Models also require time to be carved out to accommodate emergency activity from within overall sessions available.

In previous years the total capacity was divided equally across each month of the year, however this year the Directorates have attempted to profile capacity more accurately by reducing capacity in months where higher levels of leave are expected. Whilst this has previously been factored into the Directorates' weekly delivery plans it is the first time this method has been used for demand and capacity planning.

**Demand and Capacity Gaps 2019/20**

The below tables summarise the demand and capacity plans by specialty and stage displaying any capacity gaps after recurring capacity and inefficiency and improvement plans have been applied. Solutions for any capacity gaps are listed below which are required for all specialties with the exception of ENT. The table does include the expected impact of demand management plans but this is limited to part year effect in some cases and will increase in following years.

**Outpatient Demand and Capacity Summary**

| Measure | Dermatology | ENT | Maxillo-Facial | General Surgery | Ophthalmology | Rheumatology | Orthopaedics | Urology | Gastroenterology | Gynaecology |
|---|---|---|---|---|---|---|---|---|---|---|
| Recurring Demand | 9,629 | 9,794 | 3,987 | 15,133 | 10,085 | 2,846 | 14,848 | 6,933 | 7,677 | 8,028 |
| Backlog | 433 | 0 | 0 | 0 | 1,173 | 0 | 0 | 261 | 598 | 0 |
| Demand Reduction | 0 | 288 | 199 | 0 | 0 | 338 | 397 | 0 | 2,070 | 0 |
| Total Demand | 10,062 | 9,506 | 3,788 | 15,133 | 11,258 | 2,508 | 14,451 | 7,194 | 6,205 | 8,028 |
| Recurring Capacity | 9,879 | 11,102 | 3,780 | 15,116 | 10,608 | 2,570 | 10,182 | 6,823 | 6,153 | 10,416 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Inefficiencies | 988 | 1,055 | 533 | 1,578 | 1,231 | 177 | 815 | 791 | 0 | 1,354 |
| Efficiencies | 239 | 48 | 215 | 384 | 300 | 115 | 0 | 656 | 0 | 0 |
| Sustainability | 91% | 106% | 91% | 92% | 86% | 100% | 65% | 93% | 99% | 113% |
| **Remaining Gap** | **932** | **(589)** | **326** | **1,211** | **1,581** | **0** | **5,084** | **506** | **52** | **(1,034)** |
| Backfill | 0 | 0 | 326 | 2,402 | 112 | 0 | 0 | 0 | 0 | 0 |
| WLI | 932 | 0 | 0 | 608 | 240 | 0 | 5,084 | 510 | 0 | 0 |
| Other | 0 | 0 | 0 | 0 | 148 | 0 | 0 | 0 | 0 | 0 |
| Outsource | 0 | 0 | 0 | 0 | 1,081 | 0 | 0 | 0 | 0 | 0 |
| **Gap/(Surplus)** | **0** | **(589)** | **0** | **(1,799)** | **0** | **0** | **0** | **(4)** | **52** | **(1,034)** |

The table above shows the gaps associated with the modelling, and plans assessed to date to deliver. In ENT, the surplus will be used to pull the outpatient wait back towards 20-22 weeks without further investment. The significant surplus in General Surgery relates to reduced Breast Services demand and is a subspecialty issue. The solutions for the other outpatient gaps are centred around backfill and Waiting List Initiative (WLI) activity. Where possible, sustainable appointments are being secured which will support care activity and backfill. In Ophthalmology, an outsourcing solution has already been agreed to provide a longer term solution to the existing significant service gaps whilst the Ophthalmology Sustainabilty plan is developed, which will include exploring regional solutions.

**Treatment Demand and Capacity Summary**

| Measure | Dermatology | ENT | Maxillo-Facial | General Surgery | Ophthalmology | T&O | Urology | Gastroenterology | Gynaecology |
|---|---|---|---|---|---|---|---|---|---|
| Recurring Demand | 1,529 | 1,899 | 2,831 | 5,218 | 4,278 | 8,592 | 5,967 | 15,984 | 3,180 |
| Backlog | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,179 | 0 |
| Demand Reduction | 0 | 0 | 199 | 0 | 0 | 20 | 0 | 1,373 | 0 |
| Total Demand | 1,529 | 1,899 | 2,632 | 5,218 | 4,278 | 8,572 | 5,967 | 15,790 | 3,180 |
| Recurring Capacity | 1,501 | 2,290 | 2,940 | 5,905 | 4,065 | 6,492 | 6,302 | 10,739 | 2,886 |
| Inefficiencies | 134 | 490 | 535 | 1,424 | 557 | 973 | 939 | 0 | 0 |
| Efficiencies | 24 | 159 | 228 | 458 | 342 | 230 | 364 | 0 | 0 |
| Sustainability | 91% | 103% | 100% | 95% | 90% | 67% | 96% | 68% | 91% |
| **Remaining Gap** | **138** | **(60)** | **(1)** | **279** | **428** | **2,823** | **240** | **5,051** | **294** |
| Backfill | 0 | 0 | 0 | 323 | 0 | 1,914 | 216 | 2,858 | 210 |
| WLI | 138 | 0 | 0 | 0 | 72 | 390 | 144 | 1,951 | 100 |
| Mobile Theatre | 0 | 0 | 0 | 192 | 0 | 280 | 0 | 0 | 0 |
| Outsource | 0 | 0 | 0 | 0 | 364 | 0 | 0 | 0 | 0 |
| **Gap/(Surplus)** | **0** | **(60)** | **(1)** | **(236)** | **(8)** | **239** | **(120)** | **242** | **(16)** |

The gaps in treatment demand and capacity are across all specialties, with the exception ENT and Maxilo-Facial. Again, where possible sustainable approaches are being described as part of the plan, including e.g. the appointment of an additional Upper Gastrointestinal (GI) surgeon, a Consultant Urologist, a Bowel Function Nurse. There are however, high numbers of WLIs within the plan to deal with significant treatment gaps where we cannot

currently secure a sustainable solution. Constraints in theatre capacity have led to the mobile theatre being secured for the first 6 months of the year for both Orthopaedics and General Surgery. It should also be noted that presently, there remains an outstanding gap in the Orthopaedic plan of 239 (2019/20) and 83 (2018/9) backlog (322 treatments), which is currently being worked through.

**Diagnostic Imaging Demand & Capacity Summary**

| Measure | MR | CT | US Gen | US Obs | NM | Plain Film | Reporting | Comments |
|---|---|---|---|---|---|---|---|---|
| Recurrent demand | 28,280 | 49,701 | 52,326 | 26,866 | 3,528 | 264,110 | | |
| Growth | 1,414 | 3,976 | 2,616 | 269 | 346 | 0 | | |
| **TOTAL Demand** | **29,694** | **53,677** | **54,942** | **27,135** | **3,874** | **264,110** | **298,627** | |
| Recurring Capacity | 22,637 | 49,338 | 39,389 | 16,464 | 3,493 | 264,110 | 222,340 | |
| Inefficienceis | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Efficiencies | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Efficiencies determined for 2018/19 yet to materialise so further work to be progressed |
| **Remaining Gap** | **7,057** | **4,339** | **15,554** | **10,671** | **381** | **0** | **76,287** | |
| Additional hours/overtime | 1,794 | 4,320 | 9,544 | 6,274 | 381 | | 64,513 | Mix of WLIs and overtime/additional hours |
| Out of hours scanning | 1,027 | | | | | | | Additional weekend/evening work planned |
| Mobile MR | 4,236 | | | | | | | Increase from 16 to 30 weeks of Mobile MR plus SLA with Cwn Taf |
| Outsourcing Other | 0 | | | | | | 11,774 | RRO |
| Locums | | | 6,048 | 4,180 | | | | Locum sonographers and Radiologists |
| **Gap/Surplus** | **0** | **19** | **(38)** | **217** | **0** | **0** | **0** | |

There are significant gaps across all modalities with the exception of Plain Film. The impact of bringing forward outpatient waits will have an impact on diagnostic capacity and is still being worked through. The solutions include additional hours through overtime and WLIs, and securing a mobile MRI scanner for 30 weeks.

**Sustaining Zero Month on Month**

The revised expectation in the IMTP is to achieve the delivery of the 2018/19 backlog (118) by end of quarter 1 and maintain zero 36 weeks thereafter. The importance of reducing outpatient waiting times is crucial to maintaining a zero position month on month. Reducing the 26 weeks waiting for the first outpatient appointment requires services to squeeze multiple appointments which could include first outpatient, diagnostic, follow up, fitness for surgery assessment, pre assessment (PAC) and admission in the remaining 10 weeks. Waiting times can be further impacted by RTT rules in particular patient choice which requires a minimum of two dates to be offered to patients at least two weeks in the future for each appointment.

Whilst all specialties will struggle to meet zero month on month, the summer and Christmas months pose the greatest risk. Analysis prepared by corporate information demonstrates that for the waiting times to achieve zero month on month consistently by Directorate, waiting times would need to be at or below 20 weeks coming in the financial year to provide sufficient tolerance for specialties to consistently meet zero month on month. Further analysis is required to determine how waiting times can be balanced in a sustainable manner to enable consistent zero breachers.

The Divisions are therefore undertaking non recurrrent additional outpatient activity to reduce outpatient waiting times where possible in year. Reduced outpatient waiting times will reduce overall waiting times and potentially reduce the reliance on additionally funded

treatment sessions. Due to the pressure on some Directorate's existing plans, reducing the outpatient wait to this level will not be possible, but they will work towards it.

The Directorates listed in the below table would find it a significant challenge to reduce outpatient waiting times further in 2019/20. There are specialty specific reasons in each case however most have remaining 26 week wait backlogs to address in year. Whilst Maxillo-Facial and Rheumatology will not have 26 week backlogs, vacancies in both Directorates with recruitment challenges have contributed to making their existing plan higher risk then other Directorates. However the situation will be frequently monitored and should opportunity arise in year the waiting time targets will be reviewed.

| Specialty | 26+ | 22 -25 | 20-21 |
|---|---|---|---|
| Dermatology | 433 | 295 | 203 |
| Maxillo-Facial | 0 | 343 | 109 |
| Rheumatology | 0 | 123 | 63 |
| Urology | 261 | 291 | 136 |
| Ophthalmology | 1084 | 477 | 247 |
| Gynaecology | 88 | 184 | 159 |

For these specialties, there are potential risks for holding zero and these need further modelling and delivery profiles which is being led by Corporate Information colleagues. Short term measures to address potential breaches would still be required above and beyond what is considered to date in this plan.

The potential gain in year and for subsequent years of reducing the outpatient waiting times in these specialties would be hugely beneficial in progressing toward maintaining a zero month on month position as a sustainable solution going forward.

**Delivery of the Plans**

Plans to deliver the gap and associated costs are still being assessed through a weekly challenge process at Executive Team. The plan is being assessed in terms of efficiency, deliverability, cost and impact with a weekly update of the plan coming back to ET for scrutiny on a weekly basis.

A final version of the plan for approval will be presented to the Executive Team on 29 April where approval of costs and solutions will be requested and hopefully secured so that key appointments and activity can be secured.

In the interim the Divisions are continuing to deliver 2018/19 schemes in an attempt to maintain zero. There will be some risks for certain specialties where we know there are significant gaps, e.g. General Surgery will have a gap of approximately 30 treatments in June. Non recurrent solutions will be continued in these specialties to minimise the impact. In Ophthalmology we expect there to be a gap of circa 130 patients each month until outsourcing is secured. For Orthopaedics, we anticipate an ongoing issue with between 80 and 160 patients breaching the target each month until the backlog is cleared and the outpatient waiting time reduces. This is not in line with the IMTP trajectory, and recovery and sustainability plans continue to be developed and delivered to address this.

| **Recommendation** |
|---|
| The Finance and Performance Committee is asked to:<br>▪ Note the progress in the finalisation of demand and capacity plans and the approach taken.<br>▪ Note the approach being taken to approve the robustness and efficiency of the Divisional plans through Executive scrutiny.<br>▪ Note the risks and limitations of the modelling and meeting a zero month on month position, and the approach to mitigate this risk.<br>▪ Note the current risk to the IMTP profile. |

| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The report highlights key risks for target delivery. |
| ***Financial Assessment, including Value for Money*** | The delivery of key performance targets and risk management is a key part of the Health Board's service and financial plans. |
| ***Quality, Safety and Patient Experience Assessment*** | There are no adverse implications for QPS. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | There are no implications for Equality and Diversity impact. |
| **Health and Care Standards** | Supports the delivery of the relevant standards |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | This paper provides a progress report on delivery of the key operational targets |
| **The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working** | An implementation programme, specific to ABUHB has been established to support the long term sustainable change needed to achieve the Ambitions of the Act. The programme, will support the Health Board to adopt the five ways of working and self-assessment tool has been developed, and working with corporate divisions through a phased approach sets our ambition statements for each of the five ways of working specific to the Division and the action plan required to achieve the ambitions. |
| **Glossary of New Terms** | New terms are outlined in the paper. |
| **Public Interest** | This paper is written for the public domain. |

Finance and Performance Committee
1st May 2019
Agenda Item:2.2

2.2

# Aneurin Bevan University Health Board

## Workforce Performance Update
## March 2019

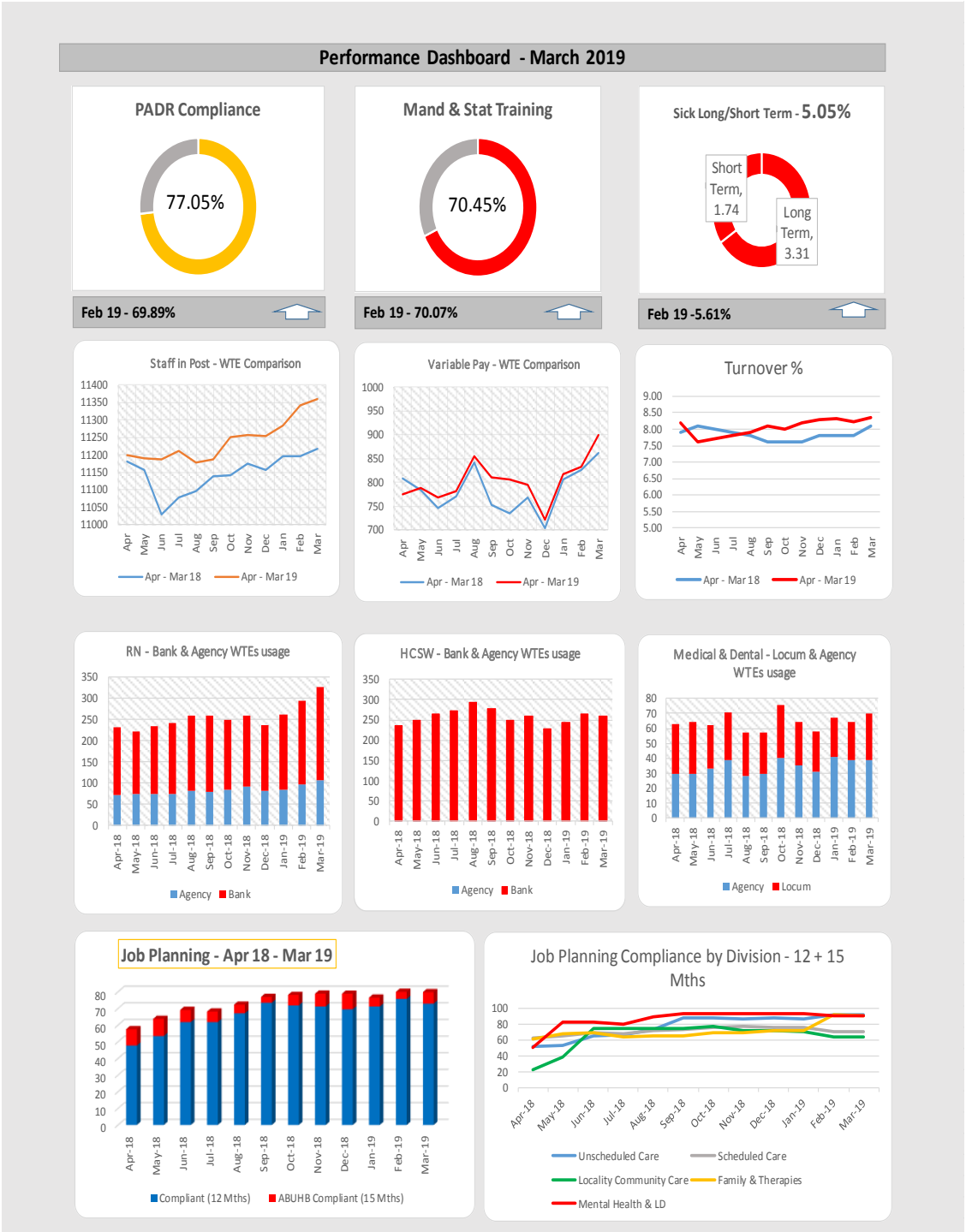
| **Executive Summary** |
|---|
| This report provides an update on key workforce activity including the Month 12 update on workforce performance. It also provides an overview of recruitment and retention activity and the work undertaken to date to implement the Welsh Language standards across the Health Board. |

| **The Finance and Performance Committee is asked to:** (please tick as appropriate) | | | |
|---|---|---|---|
| Approve the Report | | | |
| Discuss and Provide Views | | | ✓ |
| Receive the Report for Assurance/Compliance | | | |
| Note the Report for Information Only | | | |
| **Executive Sponsor:** Geraint Evans – Workforce & OD Director | | | |
| **Report Author:** Julie Chappelle, Sue Ball, Sarah Simmonds, Assistant Workforce & OD Directors; Kate Davies, Head of Workforce E-Systems | | | |
| **Report Received consideration and supported by :** | | | |
| **Executive Team** | | **Committee of the Board** | |
| **Date of the Report:** 24 April 2019 | | | |
| **Supplementary Papers Attached:** | | | |

# WORKFORCE UPDATE

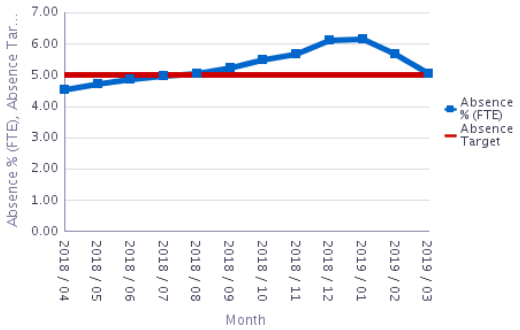
## SECTION 1 - WORKFORCE PERFORMANCE - MONTH 12 2019/2020

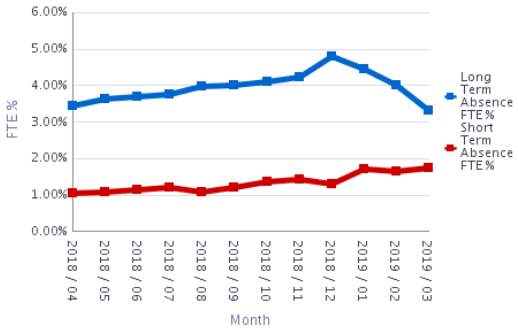
### PERFORMANCE DASHBOARD



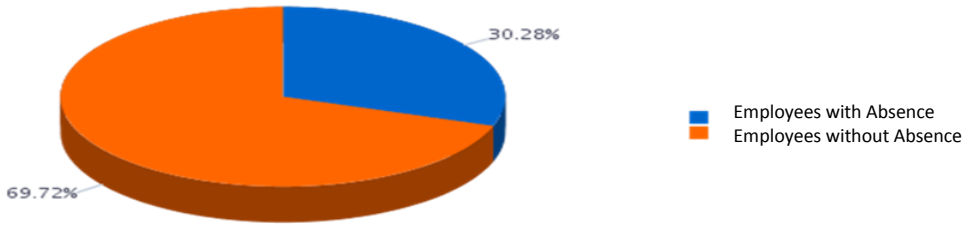
## SICKNESS ABSENCE

Sickness absence in March 2019 was 5.05%, which is 0.56% lower than February 2019 (5.61%). The 12 month rolling sickness is 5.29%. The Health Board target remains at 5%. Long term sickness has decreased this month by 0.73%.




Whilst sickness absence has been high over the winter period, 69.72% of staff have not had any sickness absence. Of the 30.28% that have had sickness absence it is mainly due to long term sickness.




*Sickness Absence Reasons*

In the last 12 months, 28.43% of sickness absence is due to Anxiety/Stress/Depression/Other psychiatric illnesses. Outlined in the table below are the Top 10 reasons for sickness absence.

| Absence Reason | % |
|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | **28.43** |
| S12 Other musculoskeletal problems | **11.35** |
| S25 Gastrointestinal problems | **7.66** |
| S28 Injury, fracture | **7.19** |
| S98 Other known causes - not elsewhere classified | **6.74** |
| S11 Back Problems | **6.51** |
| S13 Cold, Cough, Flu - Influenza | **5.49** |
| S26 Genitourinary & gynaecological disorders | **4.18** |
| S15 Chest & respiratory problems | **3.31** |
| S19 Heart, cardiac & circulatory problems | **3.22** |

*Sickness Absence Reasons by Age Profile*

Outlined below are the top 10 reasons by age profile.

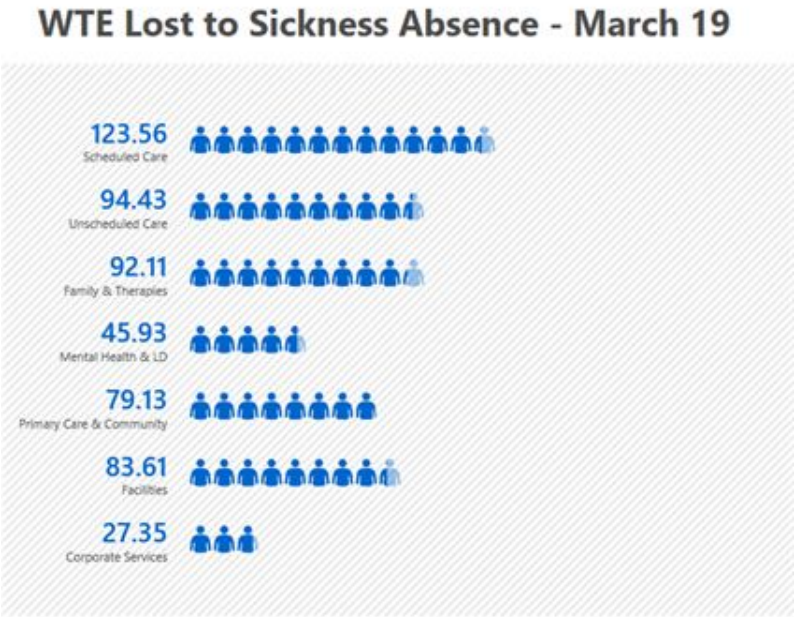
| Sickness Absence Reason | <=20 Years | 21-25 | 26-30 | 31-35 | 36-40 | 41-45 | 46-50 | 51-55 | 56-60 | 61-65 | 66-70 | >=71 Years |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| S10 Anxiety/stress/depression/other psychiatric illnesses | 0.19% | 3.23% | 8.73% | 11.30% | 10.76% | 11.83% | 16.13% | 16.88% | 12.79% | 6.54% | 1.40% | 0.21% |
| S12 Other musculoskeletal problems | 0.06% | 1.82% | 6.90% | 4.88% | 6.84% | 9.21% | 15.34% | 21.04% | 17.25% | 11.83% | 4.63% | 0.18% |
| S25 Gastrointestinal problems | 0.68% | 6.20% | 12.82% | 10.01% | 11.67% | 9.24% | 13.33% | 18.74% | 11.35% | 4.29% | 1.33% | 0.34% |
| S28 Injury, fracture | 0.06% | 1.28% | 9.32% | 10.13% | 7.22% | 7.84% | 16.00% | 22.13% | 15.69% | 6.94% | 3.31% | 0.07% |
| S98 Other known causes - not elsewhere classified | 0.23% | 3.60% | 6.56% | 6.44% | 6.48% | 9.75% | 16.57% | 20.62% | 18.26% | 8.36% | 0.59% | 2.55% |
| S11 Back Problems | 0.10% | 1.56% | 7.41% | 4.55% | 14.67% | 10.35% | 16.10% | 20.72% | 16.11% | 6.92% | 0.80% | 0.71% |
| S13 Cold, Cough, Flu - Influenza | 0.24% | 3.33% | 6.90% | 7.87% | 12.61% | 9.37% | 18.81% | 19.03% | 15.21% | 5.74% | 0.66% | 0.23% |
| S26 Genitourinary & gynaecological disorders | 0.68% | 3.76% | 7.49% | 10.45% | 12.10% | 11.44% | 20.17% | 16.64% | 11.99% | 5.27% | 0.01% | |
| S15 Chest & respiratory problems | 0.11% | 0.79% | 3.91% | 6.06% | 6.27% | 10.67% | 14.46% | 20.34% | 18.58% | 17.18% | 1.57% | 0.05% |
| S19 Heart, cardiac & circulatory problems | | 1.06% | 0.29% | 2.54% | 3.99% | 13.35% | 10.39% | 30.33% | 20.31% | 15.62% | 1.01% | 1.12% |

51-55 year olds have the highest % of sickness within 9 out of the 10 reasons.

*Division sickness absence profile*

| Division | Sickness % | Short Term % | Long Term % | Rolling Year % | Sick Target % | Avg Days Lost Per employee |
|---|---|---|---|---|---|---|
| Scheduled Care | 5.01 | 1.68 | 3.33 | 4.97 | 4.48 | 18.05 |
| Unscheduled Care | 5.97 | 1.8 | 4.17 | 5.32 | 4.96 | 19.95 |
| Family & Therapies | 4.57 | 1.78 | 2.79 | 4.67 | 4.77 | 17.41 |
| Mental Health & LD | 3.93 | 1.45 | 2.48 | 5.65 | 5.59 | 21.13 |
| Locality Primary Care | 5.12 | 1.65 | 3.47 | 5.86 | 4.69 | 20.84 |
| Facilities | 7.39 | 2.46 | 4.93 | 6.31 | 5.57 | 23.01 |
| Corporate Services | 2.83 | 1.14 | 1.69 | 3.98 | ------ | ------ |
| CHC | 6.37 | 2.67 | 3.7 | 7.23 | 6.8 | 26.04 |

The average days lost per employee due to sickness absence within the Health Board is 19.32 days, the average in the NHS Wales and England is 15 days per person. Scheduled Care (18.05) and Family & Therapies (17.41) are lower than the Health Board average which is 19.32 days, all other divisions are higher.




In March 2019, 573.74 WTE were lost to sickness absence. In winter (December 2018 to March 2019) an average of 670 WTE were lost every day.

Actions to improve Sickness Absence include a continued focus on managing hot spot areas, specifically for registered nurses and HCSWs. This has supported a reduction in HCSWs sickness absence from 9.6% to 8.17% over the winter period.

The new Managing Attendance at Work Policy has been launched:

- 314 managers have been trained on the new policy and a training programme is in place being delivered in partnership with TU colleagues.
- A number of roadshows have taken place across various hopsital sites within the Health Board to advise staff of the changes as well as updating them on the impact of the pay progression linked to the 2018/19 pay award.
- Workforce & OD have also joined Unison roadshows to deliver messages in partnership.
- On-going coaching for managers to support them in managing absence is being provided.
- Maintain the focus on hot spot areas for nursing and healthcare support workers.

Actions to target Well-Being and encourage attendance and an early return to work include:

- Launch of the Employee Experience Framework.
- Additional medical resources in Occupational Health over the winter period has led to a reduction in waiting times by 3 weeks.

- Task and finish group has been set up focusing on wellbeing at work focusing primarily on reducing staff fatigue. The membership of the group includes representatives from Trade Unions, Consultants, OD, Occupational Health, Medical Education and Facilities. A fatigue and facilities matrix has been developed to highlight 8 identified factors relating to fatigue.
- A poster has been developed to include all support services available to staff within the Health Board. These support services can be accessed via codes on the poster for those staff who do not have access to the intranet.
- Apppointment of additional counsellors to support staff during the winter period.
- Sickness questionnaires have been sent to staff who are/have been absent from work. This is to establish if appropriate support was offered before and during their period of absence. This gives the Health Board an opportunity to look at how things could have been done differently. This is currently being collated and once themes have been identified the HR team will focus on a targeted approach.

## PERSONAL APPRAISAL DEVELOPMENT REVIEW (PADR)

The current PADR organisational compliance is 77.05%, an increase compared to February 2019 (69.89%).

| Division | Reviews Completed % |
|---|---|
| Corporate Services | 70.21 |
| Continuing Health & Funded Nursing Care | 85.49 |
| Facilities Division | 88.20 |
| Family & Therapies Division | 82.45 |
| Locality Primary Care | 78.51 |
| Mental Health & LD | 74.19 |
| Scheduled Care | 67.11 |
| Unscheduled Care | 78.17 |
| **Total** | 77.05 |

4 out of the 17 Divisions and Corporate departments have reached the required 85%, Continuing Health & Funded Nursing Care, Facilities Division ABCi and Chief Executive/Non Executive (included in the corporate figure in the above table).

All nurses have now gone through the revalidation process and it has been agreed that the revalidation date will be the PADR date. 1,000 nurses PADR have been updated in ESR, increasing PADR compliance to 77%.

## STAFF IN POST / TURNOVER PATTERNS

Over the last 12 months staff in post has increased by 143 WTE, however two staff groups have decreased Nursing & Midwifery Registered (-42 WTE) and HCSW (-22 WTE). The biggest increase is within Admin & Clerical (+99 WTE). Over the last quarter, staff in post has increased by 106 WTE, 0.94%.

| | Staff In Post - WTE | | | | | | | Turnover % | |
|---|---|---|---|---|---|---|---|---|---|
| Staff Group | Mar-18 | Jun-18 | Sep-18 | Dec-18 | Mar-19 | +/- | % | Turnover % | All Wales Turnover % |
| Add Prof Scientific and Technic | 336 | 335 | 345 | 372 | 398 | 62 | 18 | 5.88 | 6.80 |
| Additional Clinical Services | 2297 | 2277 | 2237 | 2230 | 2275 | -22 | -1 | 8.39 | 9.70 |
| Administrative and Clerical | 2090 | 2115 | 2125 | 2150 | 2189 | 99 | 5 | 7.77 | 7.50 |
| Allied Health Professionals | 712 | 715 | 730 | 722 | 730 | 18 | 3 | 10.16 | 7.50 |
| Estates and Ancillary | 1084 | 1087 | 1072 | 1068 | 1077 | -7 | -1 | 6.49 | 7.80 |
| Healthcare Scientists | 221 | 216 | 226 | 223 | 221 | 0 | 0 | 12.04 | 6.80 |
| Medical and Dental | 966 | 965 | 982 | 1004 | 996 | 30 | 3 | 7.00 | 9.20 |
| Nursing and Midwifery Registered | 3509 | 3472 | 3461 | 3479 | 3467 | -42 | -1 | 9.10 | 7.60 |
| Students | 3 | 5 | 6 | 7 | 8 | 5 | 167 | 0.00 | 0.00 |
| ABUHB | 11218 | 11187 | 11186 | 11255 | 11361 | 143 | 1 | 8.34 | 6.80 |

The turnover rate for the Health Board is 8.34%, but varies across the staff groups. The three highest groups are Healthcare Scientists 12.04% (All Wales 6.80%), Allied Health Professionals 10.16% (All Wales 7.50%) and Nursing and Midwifery Registered 9.10% (All Wales 7.60%).

55% of the turnover is unplanned, this category of turnover is voluntary and requires only one month's notice which is a shorter period than the recruitment process which can take up to three months. This potentially means bank and/or agency are required to cover during this period.

There are numerous ways the Health Board can measure turnover which include the Employee Stability Index and the Workforce Survival Curve.

*Employee Stability Index*

The employee stability index is an alternative way to look at turnover. It measures the stability of the workforce over a 12 month period. The employee stability index is 90.26%, this figure shows that 9.74% (1,016) of the staff that were employed 12 months ago within the Health Board have now left. The recommended percentages within industry are between 75% to 85%. (75% and below would mean losing too many trained people and up to 85% is enough to enable healthy turnover).

Outlined in the table overleaf is the staff in post and employee stability index by Division:

| Staff Group | Mar-18 | Jun-18 | Sep-18 | Dec-18 | Mar-19 | +/- | % | Employee Stability Index % |
|---|---|---|---|---|---|---|---|---|
| Corporate | 646 | 950 | 919 | 943 | 966 | 320 | 50 | 81.27 |
| CHC | 286 | 288 | 284 | 289 | 308 | 22 | 8 | 92.16 |
| Facilities | 1132 | 1141 | 1128 | 1124 | 1131 | -1 | 0 | 92.53 |
| Family & Therapies | 2003 | 1974 | 1986 | 2013 | 2015 | 12 | 1 | 89.35 |
| Locality Primary Care | 1521 | 1529 | 1515 | 1523 | 1546 | 25 | 2 | 87.80 |
| MH & LD | 1168 | 1170 | 1163 | 1152 | 1169 | 1 | 0 | 85.88 |
| Scheduled Care | 2905 | 2592 | 2604 | 2623 | 2644 | -261 | -9 | 88.59 |
| Unscheduled Care | 1557 | 1543 | 1588 | 1587 | 1582 | 25 | 2 | 86.62 |
| ABUHB | 11218 | 11187 | 11187 | 11255 | 11361 | 143 | 1 | 90.26 |

**NB: Employee Stability Index shows the % still employed compared to 12 months ago**

*Workforce Survival Curve*

The survival curve can be extremely helpful in understanding the nature of employee turnover, for example it will indicate if a high number of new starters are leaving the organisation within a short period of time.

Outlined below is the Survival Curve, it maps the number of leavers plotted against the months they worked. The graph peaks at 3 months or less, 53 individuals left within 3 months of service. 152 individuals have left within 12 months of service.


In order to support retention, a range of additional ideas are being considered that we can implement quickly to understand why people are leaving and to ask staff what ideas they have that would make a difference to their decision to stay. These include enhancing exit surveys which now include an option for leavers to share contact details to allow us to stay in touch with Health Board news, vacancies and recruitment events, retire and return workshops and focus groups.

In the last 12 months 826.67 WTE have left the Health Board.

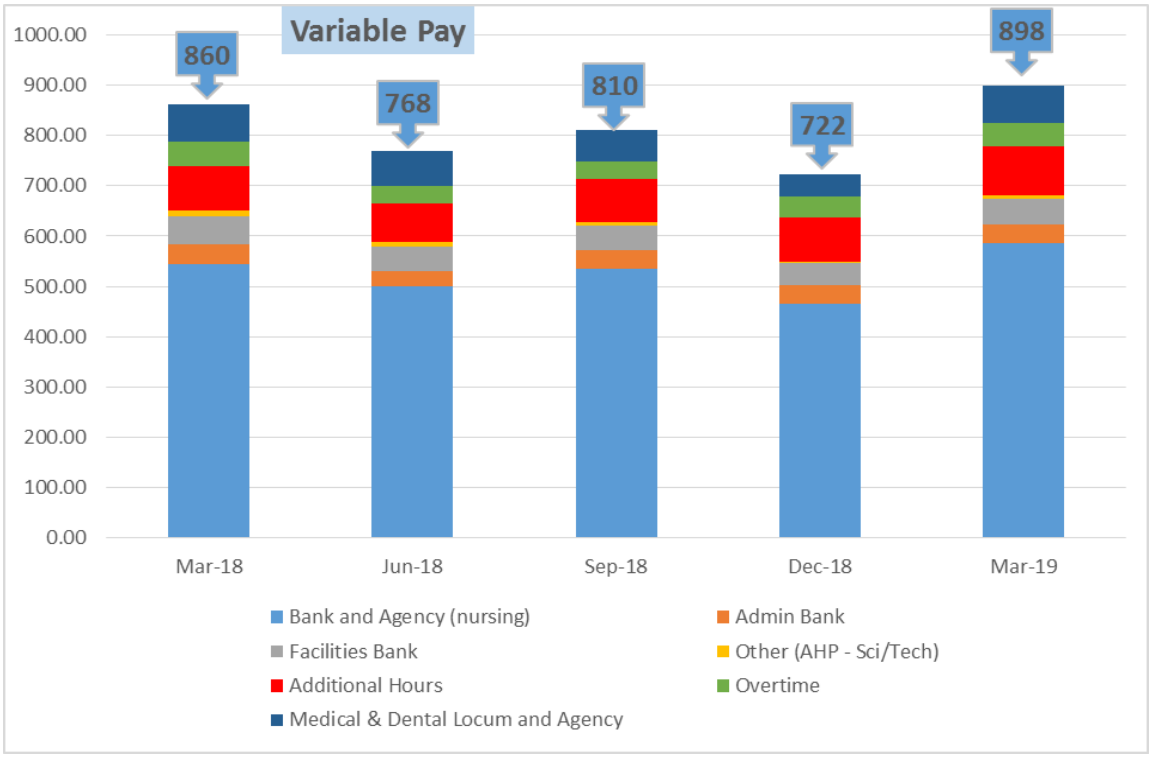
| Reasons for Leaving | WTE | % |
|---|---|---|
| Non Voluntary Registration | 32.32 | 3.91 |
| Voluntary Registration | 455.58 | 55.11 |
| Mutually Agreed Registration | 21.98 | 2.66 |
| Retirements | 316.79 | 38.32 |
| **Total** | **826.67** | **100%** |

## VARIABLE PAY

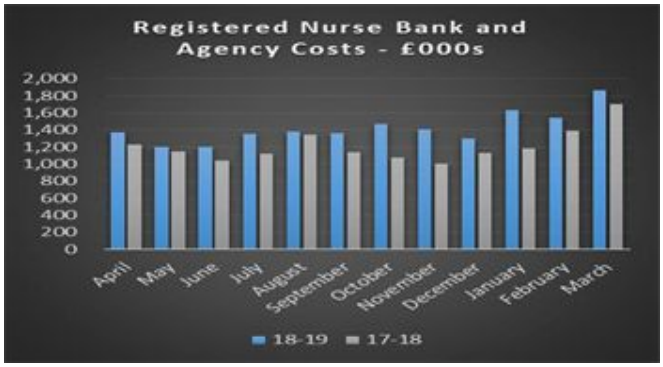
Throughout the year, the Health Board is reliant on additional hours used through, bank, agency, overtime and other variable pay elements to delivery services, cover sickness, maternity and other variables.

In March 2019, 898 WTE was used on variable pay, the usage is higher because of the winter period. The Health Board relies on variable pay to cover additional capacity beds, specialling, increased sickness, rota gaps and keeping services safe.

Outlined overleaf is the usage broken down into variable pay categories.



Further analysis into the costs / usage is outlined below:




***Registered Nursing Bank and Agency*** - In 2017/18, £14.499m was spent on registered nurse bank & agency usage and increased to £17.085m in 2018/19. An average of £1.423m per month, equivalent to 255 WTE.

Average usage / costs per month

| | Average Usage | Average Costs | Average Hourly Costs |
|---|---|---|---|
| Bank | 172 | £809,500 | £29.17 |
| Agency | 83 | £614,250 | £45.89 |

*Costs include on costs*

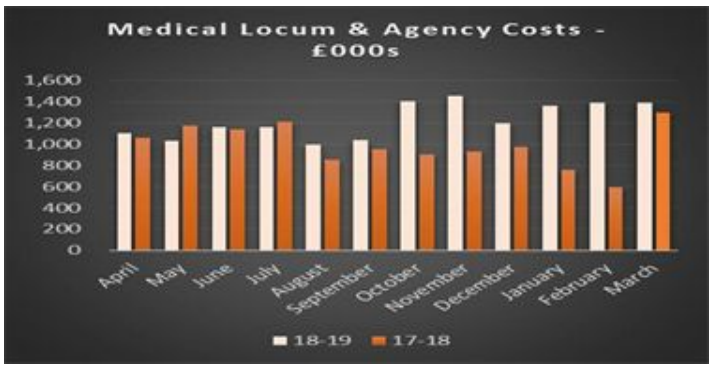
The graph shows below the impact of the winter period an upward trend from January to March 2019.


***HCSW Bank and Agency*** - In 17/18, £8.110m was spent on HCSW bank usage and increased to £8.136m in 2018/19. An average of £677,961 per month providing an average of 257 WTE.

Average usage / costs per month

| | Average Usage | Average Costs | Average Hourly Costs |
|---|---|---|---|
| Bank | 257 | £674,000 | £14.77 |

*Costs include on costs*




***Medical Locum and Agency*** - In 2017/18, £11.840m was spent on Medical locum and agency and increased to £14.676m in 2018/19. An average of £1.223m, providing an average of 64 WTE.

Average usage / costs per month

| | Average Usage | Average Costs | Average Hourly Costs |
|---|---|---|---|
| Locum & Agency | 64 | £1,223,000 | £119 |

*Costs include on costs*

The locum and agency spend for 2018/19 is £2.83m higher than the previous year. Since October 2018 costs have increased consistently throughout the winter period. The reasons for cover are gaps in rotas arising from recruitment shortages and to ensure our services are safe.

## INTEGRATED SCORECARD

The integrated workforce dashboard is circulated on a monthly basis to the Executive Team and all relevant departments. The data is published on the 15th of each month, with the aim of bringing the data in line, or as close as possible, to financial reporting dates.

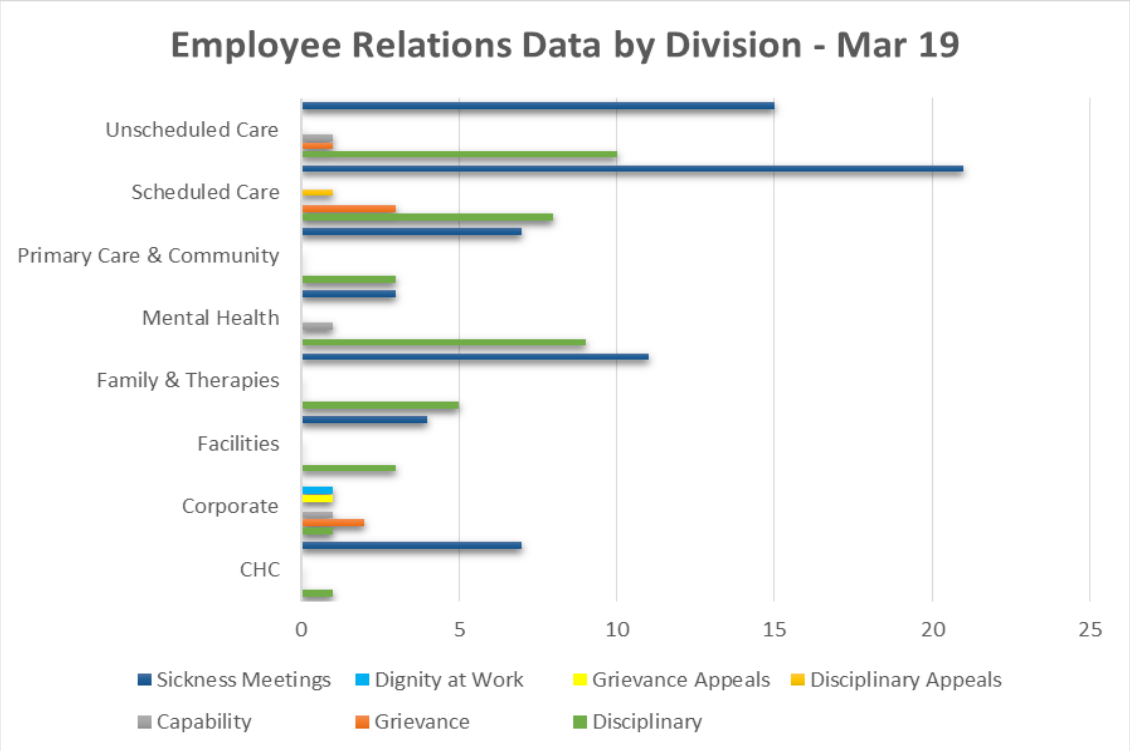
Outlined below is a high level analysis of the dashboard over the last 4 quarters:

| ABUHB Key Performance Indicators - Comparison | Compared to Dec 18 | Mar-19 | Dec-18 | Sep-18 | Jun-18 | Mar-18 |
|---|---|---|---|---|---|---|
| Sickness Absence - In Month % | ↓ | 5.05% | 6.01% | 5.20% | 4.89% | 5.15% |
| Overall Sickness Absence - 12 Month Rolling Year | ↓ | 5.25% | 5.29% | 5.25% | 5.22% | 5.30% |
| Short Term Sickness | ↓ | 1.74% | 1.81% | 1.21% | 1.09% | 1.58% |
| Long Term Sickness | ↓ | 3.31% | 4.20% | 3.99% | 3.80% | 3.57% |
| *Financial cost of sickness in last 12 months* | ↑ | £18,479,376 | £ 18,170,728 | £ 17,698,858 | £ 17,177,038 | £ 17,513,674 |
| Staff in Post | ↑ | 11361.24 | 11255.31 | 11186.17 | 11173.31 | 11218.26 |
| | ↑ | 14334 | 14157 | 14033 | 13953 | 14012 |
| PADR | ↑ | 77.05% | 72.06% | 71.01% | 73.68% | 72.65% |
| Overtime / Additional Hours | ↑ | 144.22 | 129.62 | 119.63 | 111.81 | 140.35 |
| Bank Usage - Nursing and Midwifery | ↑ | 185.62 | 154.88 | 177.75 | 159.89 | 206.96 |
| Bank Usage - HCSW | ↓ | 216.57 | 227.11 | 276.59 | 265.07 | 264.48 |
| Bank Usage - Other Staff Groups | ↑ | 87.81 | 84.76 | 93.09 | 87.85 | 105.11 |
| Bank Spend - All Staff Groups | ↑ | £2,026,301 | £ 1,560,199 | £ 1,638,837 | £ 1,518,335 | £ 2,211,705 |
| Agency usage WTE's - Nursing & Midwifery | ↑ | 96.98 | 83.29 | 80.82 | 74.65 | 72.62 |
| Agency usage WTE's - HCSW | ↑ | 0.14 | 0.00 | 0.05 | 0.10 | 0.42 |
| Agency Spend - All Staff Groups | ↑ | £1,197,353 | £ 824,457 | £ 864,005 | £ 766,500 | £ 979,483 |
| Medical Locum Spend | ↓ | £230,815 | £ 239,033 | £ 202,240 | £ 193,005 | £ 460,256 |
| Medical Agency Spend | ↑ | £1,077,968 | £ 781,472 | £ 652,103 | £ 743,247 | £ 835,951 |
| Turnover | ↑ | 8.34% | 8.30% | 8.09% | 7.69% | 8.08% |
| Statutory and Mandatory Training | ↑ | 70.45% | 69.60% | 67.94% | 64.50% | 45.38% |
| Job Planning Compliance - Consultants | ↑ | 80% | 79% | 77% | 69% | 55% |
| T18 - Time from Vacancy Requested by manager to unconditional offer 71 days | ↓ | 60.70% | 63.80% | 41.70% | 51.60% | 14.20% |

## EMPLOYEE RELATIONS

A summary of employee relations activity as at end of March 2019 is tabled below:

| Disciplinary | Grievance | Suspensions | Dignity at Work |
|---|---|---|---|
| 40 | 6 | 10 | 1 |
| Last month 56 | Last Month 15 | Last month 10 | Last Month 1 |
| **Disciplinary Appeals** | **Grievance Appeals** | **Capability** | **Sickness Meetings** |
| 1 | 1 | 3 | 68 |
| Last month 2 | Last month 0 | Last month 1 | Last month 70 |



Outlined below is the employee relations data trends over the last year.

| Month | Disciplinary | Grievance | Capability | Disciplinary Appeals | Grievance Appeals | Dignity at Work | Sickness Meetings |
|---|---|---|---|---|---|---|---|
| Apr-18 | 49 | 2 | 7 | 1 | 2 | 0 | 68 |
| May-18 | 59 | 4 | 7 | 1 | 2 | 0 | 66 |
| Jun-18 | 59 | 4 | 6 | 1 | 1 | 4 | 52 |
| Jul-18 | 68 | 12 | 9 | 3 | 3 | 5 | 40 |
| Aug-18 | 55 | 16 | 6 | 1 | 1 | 3 | 50 |
| Sep-18 | 77 | 18 | 6 | 1 | 2 | 0 | 18 |
| Oct-18 | 43 | 9 | 2 | 1 | 1 | 0 | 51 |
| Nov-18 | 47 | 10 | 2 | 1 | 1 | 0 | 5 |
| Dec-18 | 37 | 15 | 3 | 2 | 2 | 1 | 39 |
| Jan-19 | 41 | 8 | 3 | 1 | 2 | 1 | 78 |
| Feb-19 | 56 | 15 | 1 | 2 | 0 | 1 | 70 |
| Mar-19 | 40 | 6 | 3 | 1 | 1 | 1 | 68 |

A process has been developed and agreed with Trade Union colleagues to support reducing the timeframe for disciplinary investigations and entire process. This includes appointing Independent Investigation Officers and a case management tool to provide a project management approach to meeting key milestones.

## SUSPENSIONS

A focused approach to assessing appropriateness of suspensions is now in place. This includes fortnightly reviews to identify any change in circumstances and any opportunities to return to work in some capacity.

The table below indicates the number of employees suspended as at March 2019, 70% have been over 4 months.

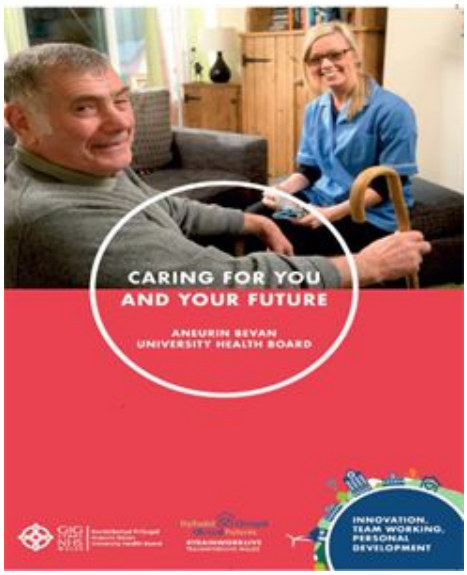
| **Timescale** | **No. Of Employees** |
|---|---|
| 0-3 Months | 1 |
| 3-6 Months | 3 |
| 6 Months+ | 6 |
| **Total Number of Suspensions** | **10** |
| Total Number over 4 Months | 8 |

The trend for suspensions over the last 12 months is outlined below:

| Month | 0-3 Mths | 3-6 Mths | 6 Mths Plus | Total | Over 4 Mths | % over 4 Mths |
|---|---|---|---|---|---|---|
| Apr-18 | 1 | 3 | 3 | 7 | 5 | 71.43 |
| May-18 | 3 | 1 | 4 | 8 | 5 | 62.50 |
| Jun-18 | 2 | 0 | 5 | 7 | 5 | 71.43 |
| Jul-18 | 2 | 0 | 5 | 7 | 5 | 71.43 |
| Aug-18 | 3 | 0 | 3 | 6 | 3 | 50.00 |
| Sep-18 | 2 | 4 | 0 | 6 | 3 | 50.00 |
| Oct-18 | 3 | 3 | 1 | 7 | 4 | 57.14 |
| Nov-18 | 2 | 1 | 4 | 7 | 5 | 71.43 |
| Dec-18 | 3 | 1 | 6 | 10 | 7 | 70.00 |
| Jan-19 | 1 | 1 | 7 | 9 | 8 | 88.89 |
| Feb-19 | 2 | 1 | 7 | 10 | 7 | 70.00 |
| Mar-19 | 2 | 3 | 5 | 10 | 4 | 40.00 |

## SECTION 2 - RECRUITMENT AND RETENTION

Workforce & OD have been working with an external recruitment advertising company to develop recruitment branding materials. In consultation and collaboration with employees, the "Caring for You and Your Future" materials have been developed.




The intention is to improve our ability to recruit by sharpening our image in the recruitment market and supporting this with materials that look professional, interesting and attractive. An inclusive approach was adopted by running a number of focus groups involving a wide variety of staff including doctors and Clinical Futures champions. Photography of our employees across a range of job roles has been used to develop recruitment webpages which will direct potential applicants to Health Board vacancies, career events and open days, information regarding the region as well as information on early careers, work experience and volunteering, and support for veterans. It will also include a link to the Primary Care vacancies in the region. The webpages will be available in the Welsh Language and launched early in May 2019.

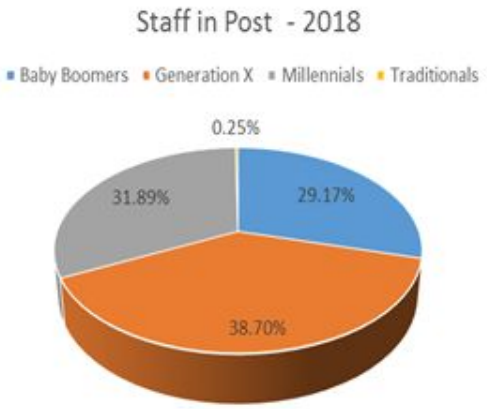

The recruitment branding will be supported by a range of materials and merchandise including social media banners and a bespoke recruitment video as well as traditional materials. These are in development and will be used through all recruitment campaigns by end of quarter 1 2019/2020.

The recruitment branding images and materials will be used to support the challenges over the next 12 months and beyond, including:

**Focus on Flexible Working**

An internal workshop has been held to consider the recruitment and retention challenges presented by different generational groups.

As a result:




- The Flexible Working Policy is being revised.
- A toolkit for agile and flexible working is being developed.
- Further workshops will be held with managers, Trade Union colleagues and nursing to scope out how we change recruitment and retentions practices to offer flexible working taking account of generational expectations. The first of the workshops will be run on the 25 April 2019.
- Expected outputs:
  - Increase awareness of differences in generational expectations and demands.
  - Challenge traditional thinking about job and rota design.
  - Inform re-design of job descriptions and adverts.

**Apprenticeship Programmes**

We continue to offer a wide range of education programmes available to upskill our current workforce through level 2-5 apprenticeship qualifications. This includes a new apprenticeship scheme for support staff employed by Facilities who wished to switch careers to HCSWs. There are currently 10 employees undertaking this route.

We are developing options to offer and deliver new apprenticeship opportunities to provide a route to employment with the Health Board. We are working with divisions to convert existing roles or creating new roles for apprenticeship programmes for a number of professions/job roles. This includes:

- Engaging with divisional management to identify appropriate roles/numbers of apprenticeships
- Working with apprenticeship training providers to use their knowledge of aligning different levels of apprenticeship qualifications to apprenticeship job descriptions.
- Plan to advertise first opportunities agreed with divisions at end of academic year 2019.

**Challenges of Recruitment and Retention aligned to the Clinical Futures Programme**

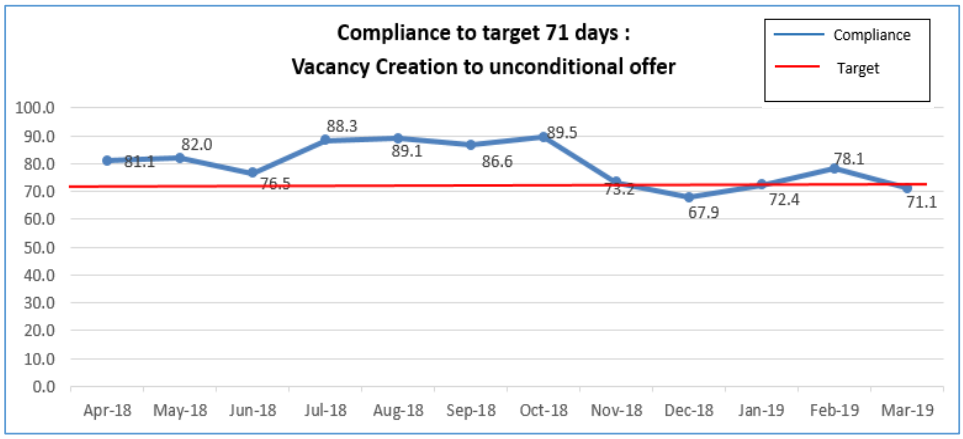
Recruitment and retention is one of the principal risks to the delivery of the Clinical Futures programme. Our ability to recruit appropriately trained and skilled staff will directly impact on our ability to deliver new service models.

A recruitment plan, taking account of the requirements for training periods, staff engagement and any required redeployment of skills, is currently being developed as part of the Clinical Futures Workforce & OD implementation plan. This will inform recruitment and retention activity up to April 2021.

The plan will be informed by workshops with divisional managers and medical colleagues to ensure views are considered before final plans are prepared. There are two workshops arranged for 09 May and 13 June 2019.

It is recognised that where recruitment is required for hard to fill posts or is required in large numbers (e.g. radiographers), a fresh approach will be required. The Workforce & OD team will support redesigning job roles, advertising externally and will work with divisions to test the recruitment market as early as possible. This has already proved successful in key areas such as recruitment of Clinical Fellows and Physicians Associates. However, where this is not successful, alternative plans will need to be developed.

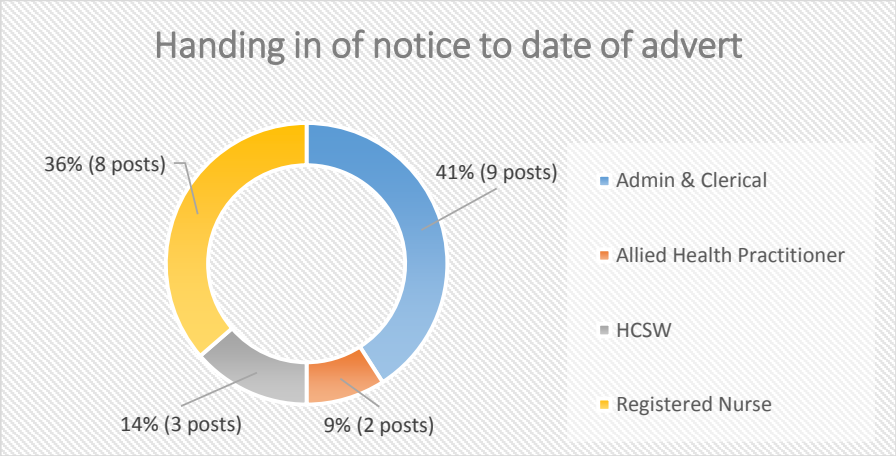
**RECRUITMENT PROCESS KPI PERFORMANCE**



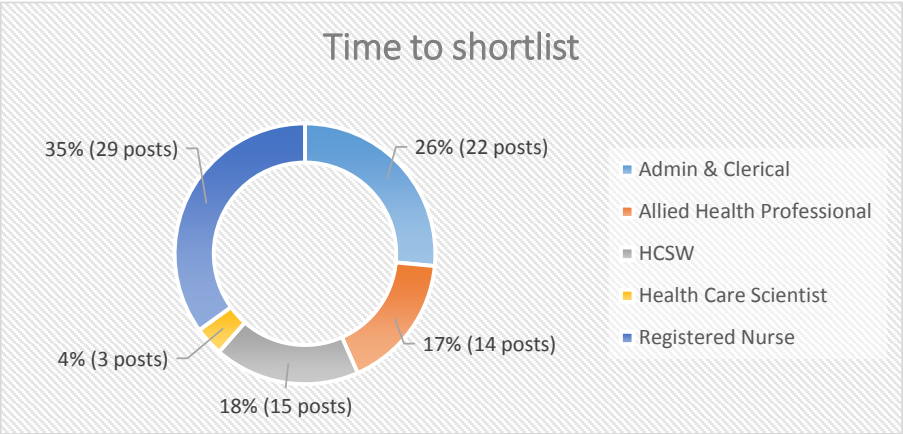
Performance against the recruitment timeline target 71 days – from the time a vacancy requested to be advertised by a manager to unconditional offer, has improved over recent months, from an average of 81.1 days in April 18 to 71.1 days in March 2019. This has been due to an increase in focus on managing and cleansing the TRAC system.

Focus on improving the target will continue in discussion with divisions. This will include continuing to seek support from divisions to cleanse the TRAC system as it is recognised that some vacancies are not "closed" on the system although the appointed person may have already commenced their employment. Workforce & OD will continue to challenge divisions by highlighting repeated breaches and demonstrating the impact of delayed recruitment on service delivery for clinical posts. In addition, we will be requesting from Shared Services in order to reduce these timelines.

The timeline requiring improvement is most notably the "notice to authorisation start date", i.e. the time from when resignation is accepted to the time the post is authorised to be advertised. This is consistently outside of the 5 day target (41 days Feb 2019). Some of this delay may be due to tactically holding vacancies. Although the graph below shows there are a number of clinical posts outside of compliance.




"Time to shortlist" is also consistently out of compliance with the 3 day target, regularly at 6 days or above. Improving timeframes for these two sections of the process will have a direct impact on improving the overall target.




It is recognised that nurse managers may not have the time to allocate to shortlisting due to service pressures. Workforce & OD are working with Divisions to identify administrative support to cleanse the data and are also currently recruiting a Band 4 Recruitment Co-ordinator who will focus on progression of nursing vacancies in the TRAC system as part of their role.

| | | |
|---|---|---|
| **Medical**<br>  <br>Current Medical Vacancies 139 wte, including 35 consultants and 22 speciality doctors. | **2018/2019**<br>• Developed a suite of medical recruitment KPIs and tested with some division. These will be shared with all divisions to identify opportunities to improve the process and work more collaboratively with divisions.<br>• Targeted focus on emergency medicine vacancies which reduced vacancies from 4 to 1. This was developed by reviewing advertising literature, planning recruitment timelines to coincide with known deanery timelines, e.g. when doctors can decide to leave training and gain employment as a Clinical Fellow.<br>• First doctor recruited from the Train, Work, Live campaign has started work following the BMJ Fair in London in October 2018. A case study will be developed to promote opportunities in Wales.<br>• Recruitment of 9 Physician Associates. | **2019/2020 +**<br>• Launch reviewed specialism specific recruitment literature, commencing in MH & LD.<br>• Agreed annualised subscription with the BMJ to enable us to advertise all medical posts on their website, develop an employer hub, adverts to target those hard to fill posts.<br>• Pilot medicine rotation roles @ NHH 2 months study/ 2 months working giving 2wte from 4 doctors.<br>• Develop bespoke Primary Care materials<br>• Develop a foundation career day, mandatory element training, to engage with all F2 to share career options in HB.<br>• Scoping out mirroring English CAPE psychiatry overseas scheme.<br>• Recruit additional 12wte Physician Associates across a range of specialities. |
| **Registered Nursing**<br>  <br>The current WTE vacancies are 388wte RN / RMN. | **2018/2019**<br>• Attended universities and holding local drop in sessions to share our opportunities with students and showcase our nurse career paths with student streamlining (28wte appointed).<br>• RN continuous recruitment wheel (23wte appointed).<br>• Bank Registered Nurses converted to substantive. (5wte appointed).<br>• Site specific recruitment events supported for NHH and border regions with limited success.<br>• Facilitated retention events for nursing staff to support those who may be considering leaving the profession.<br>• 21 HCSWs in training to become RNs through our flexible routes. | **2019/2020 +**<br>• 12 month registered nursing campaign has been agreed with divisions to include radio, journal and social media advertising to promote career opportunities. Focusing on creating bespoke events in local and border areas as well as attending and national opportunities. Recruitment from each event will be reviewed and evaluated.<br>• Continue with recruitment wheel, national programmes; Student Stream-lining, including liaison with universities and return to practice campaigns.<br>• Flexible route RN training numbers tbc summer 2019. |

| | | |
|---|---|---|
| **Overseas**<br>  | **2018/2019**<br>• BAPIO medical recruitment, New Delhi-14 doctors being offered posts. 11 accepted currently going through on boarding.<br>• The Overseas Trained Nurse pathway: 5 nurses now working as Band 5s and further 10 at Band 4 OSCE stage and 17 to sit their English exams between June and September 2019. Anticipated to start as Registered Nurses 4 months following successful completion of English Language exam.<br>A further 28 continue at assessment stage. | **2019/2020 +**<br>• Working with nursing colleagues to consider options 2 options to recruit from overseas for nurses with relevant overseas qualifications to register with NMC.<br>• In discussions at All Wales level to participate in BAPIO recruitment for 2020 for MTIs.<br>• Consideration on All Wales level to undertake joint recruitment campaigns overseas for doctors and registered nurses. |
| **Internal Recruitment**<br>  <br>(These activities are supported by the internal Health Board Team and do not rely on shared services resources.) | **2018/2019**<br>• Conversion of 100 workers from bank to substantive staff. (All staff groups).<br>• 319 individuals recruited across a variety of staff groups including 73 registered nursing and midwifery roles, 14 ODPs, and theatre practitioners (14), 77 HCSW and 83 admin and clerical.<br>• As part of the winter plan the resource bank have contacted all RNs that had not worked over a 12 month period and re-engaged 61 registered nurses and recruited 259 to the bank. The hours worked by these new starters/re-engaged provided 31wte over March 2019.<br>• Facilitated HCSW recruitment day, 37 recruited due to commence end of May 2019.<br>• Developed a pathway for internal career pathway to HCSW. This allowed our staff working in admin or facilities areas to switch careers. | **2019/2020 +**<br>• Continue with recruitment wheels- established programme of activity in place<br>• Publicise timeline of resource bank recruitment opportunities for RNs, HCSWs and admin and clerical to ensure clarity of when applications can be submitted.<br>• Develop and launch apprenticeship scheme.<br>• Develop and launch agile working framework.<br>• Develop flexible working options. |

| Flexible Workforce Recruitment and Retention (Bank and Agency) | 2018/2019 | 2019/2010+ |
|---|---|---|
|  | • Average weekly timesheets processed outside winter is 1444, rising during winter to 1705 peaking at 2300 last week of March.<br>• Agency block bookings secured 59.0wte.<br>• Processing up to 115wte agency workers per week.<br>• Removed paper pay slips for bank workers 1500 per week reducing postal costs.<br>• 5,500 personal files transferred electronic.<br>• E-invoicing implemented giving a leaner process.<br>• Progress CWS (284), Pump (27) & Vital Pac training for Bank and Agency workers to ensure they can continue to work. | • Removal of all paper timesheets and pilot drop down to payroll.<br>• Engagement and progression of All Wales Bank.<br>• Bank workers progression to 100% on statutory & mandatory training.<br>• Agency worker access to Employee on Line booking system to view and book shifts.<br>• Work with divisional management to move regular workers onto flexible employment contracts.<br>• Undertake lessons learned from winter period to plan for next winter. |

## SECTION 3 – WELSH LANGUAGE STANDARDS UPDATE

### Background

Language legislation requiring public bodies in Wales to plan their services so that they are available in Welsh have existed since the 1993 Welsh Language Act. This has now been superseded by the Welsh Language Measure (Wales) 2011 and Welsh Language Standards (Standards).

The Standards are designed to support Welsh speakers enforceable rights to use the Welsh language. These cover the areas of service delivery; policy making; operational standards; promotion of the Welsh language and record keeping. The Health Board's compliance notice which includes timescales for delivery ranging from 6 months to 2 years requires us to implement 121 Standards. These 'go live' on 30 May 2019. The Standards place a statutory requirement on the Health Board to ensure that the Welsh language is treated no less favourably than the English language. They also require the Health Board to promote and facilitate the use of the Welsh language throughout the organisation.

The Compliance Notice with details of each of the Standards can be accessed via the link to the website of the Welsh Language Commissioner below:

http://www.comisiynyddygymraeg.cymru/English/ReportsGuides/Publications/Pages/PublicationDetails.aspx?PublicationId=0e62e3dd-6788-4fda-802e-7a35cf9bd639&StandardsSearch=true

The Standards also contain specific duties which include:

- Publicising the standards and the way in which the organisation intends to comply
- Record keeping
- Publishing arrangements for overseeing, promoting and facilitating the use of Welsh
- Publishing a complaints procedure
- Producing an annual report on compliance with standards
- Providing information to the Welsh Language Commissioner

The Executive Team and the Board have supported a range of measures and additional investment that have continued to drive both the cultural change and practical actions required to effectively deliver the Standards. Nevertheless, some of the imposition dates placed on the Health Board are extremely challenging, particularly given the low numbers of Welsh speakers currently available within our workforce.

## Work in progress and approach

The Health Board has a Strategic Welsh Language Group who provide advice and assurance to the Board in regard to the discharge of its functions and the meeting of its responsibilities in line with the requirements of the Welsh Language Standards. The Group is chaired by the Director of Workforce and OD and has Executive and senior divisional representation from across the Health Board.

The approach to the implementation of the Standards recommended by the Strategic Group is the establishment of **'Implementation Task and Finish Groups'** who provide leadership, commitment and operational support to Welsh language service provision.

The Standards fall into natural groupings so each Task and Finish Group is responsible for a set of Standards and is led by a 'subject matter expert' with support from the Welsh Language Unit (Figure1).

**Figure 1**

| Task and Finish Group | Service Lead |
|---|---|
| Applications (Apps) | To be agreed (initial meeting with Nicola Prygodzicz) |
| Communications, Website Standards, Intranet & Social Media | Karen Newman |
| Correspondence Standards | Cynthia Henderson |
| ESR Competencies | Ruth Evans |
| Patient information Standards | Rhian Lewis |
| Telephony Standards | To be agreed (initial meeting with Cindy Rogers) |
| Informatics Directorate Group | Richard Howells |

Each group is required in the first instance to identify those Standards where we require an extension to the imposition date and to set out the rationale and evidence for any extension. This will enable us to follow the formal process required by the Welsh Language Commissioner for challenging any Standards in advance of the imposition dates. The deadline for the majority of the Standards is 30th May 2019. Each of these Task and Finish groups will develop a detailed action and implementation plan with identified responsibilities and timescales.

## Priorities and current action

The Strategic Welsh Language Group have agreed a programme of work and a project plan to implement the Standards.

**Short term actions undertaken**

- Continue with a renewed focus on 'getting the basics right'.
  - All staff to answer the phone bilingually
  - All staff to have bilingual e-mail signatures
  - All out of office replies to be fully bilingual
- A Welsh language staff survey has been undertaken to gain a baseline understanding of knowledge of the standards and the descriptors within ESR of Welsh language skills.
- A Welsh language translator/communications officer who will be based within the Corporate Communications Team is out to advert. The initial priorities for this role will be to:
  - Translate website and intranet so that both have Welsh language home pages by 30 May 2019 with all work on both interfaces being fully compliant with the Standards from there on.
  - Review how best to translate the carousel.
  - Progress the translation of Nye's news.
  - Progress the translation of social media.
  - Progress the translation of the Clinical Futures newsletter.
- An all Wales Workforce and OD Welsh language standards group has been established to look at 'Once for Wales' solutions; mainly in relation to Workforce policies, contracts etc.
- Maintain the established opportunities for raising awareness of Welsh language requirements in line with the Standards.
- The lease on the Welsh Language Centre of Excellence; 'Canolfan Y Degwm' based in the heart of the Monmouthshire community has been extended for a further year. We are currently developing specific evaluation criteria to enable a full evaluation of impact for both staff and patients by January 2020.
- Establishment of the Implementation Task and Finish groups who will initially review and provide evidence for an extension of Standards imposition dates.
- Develop a job description for the new role of Welsh Language Tutor and advertise appropriately.
- One to one Standards meetings with Executive Directors.

**Medium Term Priorities**

- Implement the Standards communication and engagement strategy to further raise employee awareness and involvement.

- Review the arrangements for using a number of translation providers to ensure appropriate and timely translation.
- Delivery of the ongoing work programme identified by the Implementation Task and Finish groups.
- Contribute to the scoping exercise in relation to the potential of an NHS Wales solution for Welsh Language translation.
- Appoint a Welsh Language Tutor to increase the competence and confidence of staff to develop and use Welsh language skills within the workplace. This will be achieved through providing Welsh language tuition locally in wards and departments. The initial priorities would be to:
  - Work within clinical areas to support Welsh language development.
  - Work with staff to increase the numbers who have recorded their Welsh language competencies on ESR.
  - Provide formal Welsh language courses across Health Board sites.
  - Support the establishment of informal 'developing Welsh language confidence' group.

**Longer Term priorities**

- A three year rolling programme of work to translate 'patients leaflets' in collaboration with the 'ABUHB Patient Information Unit' commenced on 01 January 2019.
- The Informatics Directorate Group have identified a project team to identify a realistic programme of work to support compliance with the Standards in relation to bilingual correspondence to patients. They are scheduled to report progress at the next Welsh Language Strategic Group.

**Enforcement for failure to comply with the Standards**

The Welsh Language Commissioner is responsible for regulating the implementation of the Standards and as such has published a Regulatory Framework and Enforcement Policy.

If the Welsh Language Commissioner having undertaken a statutory investigation into a suspected failure to comply with a Standard, finds the case is proved a number actions can be taken which may include the following:

- No further action required.
- Preparation of an action plan for the purpose of preventing the continuation or repetition of a failure to comply.

- The requirement to take specific steps for the purpose of preventing the continuation or repetition of a failure to comply.
- The Commissioner publicising the failure to comply.
- A requirement to publicise the failure to comply and a civil penalty imposed.

When the Commissioner decides to impose a civil penalty, the maximum penalty could be up to £5,000 per infringement. It should be noted, however, that Welsh Ministers may, by order, substitute a different amount for this maximum penalty. A Welsh Language Tribunal has been established by the Welsh Language (Wales) Measure 2011 to deal with requests for appeals and applications for reviews of the Commissioner's decisions.

**Risks**

Failure to deliver the Welsh Language Standards presents 3 main risks:

- Patients will not get the Welsh medium service they need and as such their experience and outcomes may be compromised.
- The reputation of the Health Board will be damaged which could reduce public and staff confidence.
- We may receive substantial financial penalties from the Welsh Language Commissioner if a failure to deliver on a Standard is proved.

**Next Steps**

The Executive and senior divisional management teams will continue to provide the leadership, commitment and support required to drive the implementation of the Standards. An extraordinary meeting of the Welsh Language Strategic group will take place in May to provide assurance to the Board that the formal process for challenging the imposition dates for implementing the Standards is on track to meet the 30th May deadline. In addition the actions identified by the Implementation Task and Finish groups will be reviewed to ensure satisfactory progress.

2.3

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Finance Performance Committee
1st May 2019
Agenda Item: 2.3

**Aneurin Bevan University Health Board**

# Finance Performance Report – Month 12 (March) 2018/19

## Executive Summary

This report sets out the following:

- The achievement of financial performance targets for the 2018/19 financial year against the statutory revenue and capital resource limits (subject to audit),
- The Health Board's cash position and compliance with the public sector payment policy, and
- Actions required to sustain financial balance going forward.
- Addendum Report covering: Underlying Financial Performance, Value for Money Assessment, Efficiency Delivery & Improvement.

Performance against the key financial targets is summarised in Table 1.

**Table 1: Performance against key financial targets 2018/19**

| Target | Unit | Current Month | Year to date |
|---|---|---|---|
| **Revenue financial target**<br>**Deficit / (Surplus)**<br>To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. | £'000 | (356) | (235) |
| **Capital financial target**<br>To ensure net Capital Spend does not exceed the Capital Resource Limit | £'000 | 26,271 | 141,019 |
| **Public Sector Payment Policy**<br>To pay a minimum of 95% of all non NHS creditors within 30 days of receipt of goods / invoice | % | 94.8% | 95.1% |
| **Cash balances**<br>Cash balance held by the Health Board to not exceed 5% of monthly cash draw down from WG | £'000 | n/a | 960 |

**Recommendations:**

The Committee is asked to note:

- The financial performance for the 2018/19 financial year,
- Achievement of the Health Board's statutory financial duty position, pending review and approval of the annual accounts and financial statements, by the Health Board's external auditors, and
- Note the actions required to sustain financial balance going forward.
- Note the Addendum information.

**Revenue Performance**

The 2018/19 financial out turn is a surplus of £235k. Subject to external audit review, the Health Board will have achieved its statutory revenue financial duty, summarised below.

| **ABUHB** | **2016/17** £000 | **2017/18** £000 | **2018/19** £000 | **Total 3 year rolling** £000 |
|---|---|---|---|---|
| **Reported Year-end Financial position (surplus)** | **(49)** | **(246)** | **(235)** | **(530)** |

The 2018/19 financial performance has been delivered through a range of recurrent savings and one-off measures across the organisation. This includes slippage on national spend programmes (c£1m) as well as receiving non-recurrent funding to support plans to deliver improved elective waiting times and deliver services during the winter period (c£7m in total).

**Funding and savings**

The Health Board's financial savings plan delivery in 2018/19 is £19.9m which is slightly higher than the IMTP target of £19.8m. There was a significant increase in savings delivery in March due to a number of drug rebates claimed for acute services. **Appendix 2** summarises the current breakdown of delivery of savings plans.

The £3.1m performance funding was conditional on delivering explicit waiting times performance targets by 31st March 2019. The Health Board did not meet the RTT > 36 week target at the end of the 2018/19 financial year, with 112 patient breaches. However, Welsh Government have agreed that ABUHB can retain the 2018/19 funding, on the basis that targets are met by the 30th June 2019 (including no patient waiting over 36 weeks).

The Health Board received c£4m funding to help deliver services over the winter period.

**Expenditure**

Financial performance against each of the delegated budget areas is set out in **Appendix 1**, with further analysis of pay and non-pay spend in **Appendices 3 and 4**. The material variances, include:

- Growth in mental health/learning disability CHC packages remains significant.
- Workforce costs remain above budgeted levels due to on-going use of agency and savings plans not being delivered. Variable pay (e.g. agency, locums, bank, and overtime) is £4.6m higher than last year (+9%). This contributes significantly to the underlying deficit in the Health Board.
- Medical workforce costs – the medical agency spend reduction target of 35% is not being achieved, with spend of c. £1m in-month. Medical agency spend is £2.1m higher than last year and medical locum spend is £0.6m higher. The main reasons for increased spend are delivery of performance targets, vacancies and sustaining services and rotas over more than one site.
- Nursing costs – spend on registered nurse agency is £1.5m higher than last year and bank staff spend is £1.0m higher. This is linked to sickness, vacancies, enhanced care and delivering winter plans through extra bed capacity.
- Orthopaedic elective activity – spend is higher than planned (c£1.1m), due to additional treatments being undertaken linked to RTT performance. The 2018/19 position is 720 cases ahead of plan, of which 218 were major/complex cases. There remains a backlog of 80 cases waiting longer than 36 weeks, which will be part of the 2019/20 Quarter 1 plan. 2018/19 activity for the year is 8,732 cases – significantly higher than the original plan of 7,881 cases and is reflected in the financial risk for quarter 1 in 2019/20.
- In addition there is a backlog of 31 cases within the ophthalmology specialty which will need to be treated in Q1 2019/20.
- Services over the winter period were funded in line with the Plan agreed by the Board. The level of flexible payments and other pay incentives was below forecast for the winter period. Plans are in place for some additional bed capacity and related staff incentives to continue during April/Easter period.
- Prescribing costs (both volume and price) increased in March compared to February however remain lower than the overall 2018/19 forecast.
- A number of one-off drug rebates (c. £1.0m) were received in March for hospital dispensed drugs, which were either new or significantly above forecast levels. As a result, this improved the financial out turn position.
- Reduced CHC (adult complex care) spend and patient numbers were broadly offset by retrospective claim settlements higher than the provisions.
- Slippage and increased savings occurred on a number of spending plans relating to national schemes and programmes – including the national 111 programme and NHS Wales Shared Services.

**Actions required to sustain financial balance**

- The Health Board reported as part of 2019/20 IMTP, and through the Welsh Government monthly monitoring returns, an £11.4m underlying deficit. The focus through the IMTP and individual Divisional plans will be on translating the efficiency opportunities identified into efficiencies, to reduce the underlying deficit throughout the 2019/20 financial year and contribute to recurrent financial balance.
- During Q1 there will be an increased focus through the Health Board's executive and divisional arrangements to implement improved efficiency – cash releasing and productivity – to support this.

**Capital performance**

The Capital Programme was approved by the Board in March 2018. The current resource limit is c. £141m with expenditure of £141m, resulting in a small underspend of £41k.
The Health Board has managed spend across a number of discretionary projects to ensure that the Health Board continues to operate within its capital funding for the financial year.

The Health Board will have achieved its statutory financial duty for 2018/19 and 3 year target, with a summary shown below. The year-end financial position is subject to external audit review.

| ABUHB | 2016/17 £000 | 2017/18 £000 | 2018/19 £000 | Total 3 year rolling £000 |
|---|---|---|---|---|
| **Reported Year end Capital position (surplus)** | **(42)** | **(78)** | **(41)** | **(161)** |

- **Cash position**

The Health Board has managed within its cash allocation and also held a cash balance of no more than 5% of its monthly cash draw down (best practice/notional target). The Health Board held a £1.0m cash balance at the end of March 2019, which is within the 5% level.

- **Public Sector Payment Policy (PSPP)**

The Health Board has not achieved the target to pay 95% of the number of Non-NHS creditors within 30 days during March (94.8%), although the target has been achieved in terms of invoice value (98.7%).

On a cumulative basis the Health Board has achieved the target, with 95.1% of invoices paid within 30 days.

**Recommendations:**

**The Committee is asked to note:**

- The financial performance for the 2018/19 financial year,
- Achievement of the Health Board's statutory financial duty position, pending review and approval of the annual accounts and financial statements, by the Health Board's external auditors, and
- Note the focus on actions to sustain financial balance going forward.
- Note the Addendum Information.

| **The Finance and Performance Committee is asked to:** (please tick as appropriate) | |
|---|---|
| Approve the Report | √ |
| Discuss and Provide Views | √ |
| Receive the Report for Assurance/Compliance | √ |
| Note the Report for Information Only | |

| | | | |
|---|---|---|---|
| **Executive Sponsor:** Glyn Jones, Director of Finance & Performance | | | |
| **Report Author:** Rob Holcombe, Assistant Finance Director | | | |
| **Report Received consideration and supported by :** | | | |
| **Executive Team** | | **Committee of the Board** [Finance & Performance] | |
| **Date of the Report:** 15th April 2019 | | | |
| **Supplementary Papers Attached:**<br>**Appendices 1-4**<br>**Addendum – Underlying Position, Value for Money Assessment, Efficiency Review** | | | |

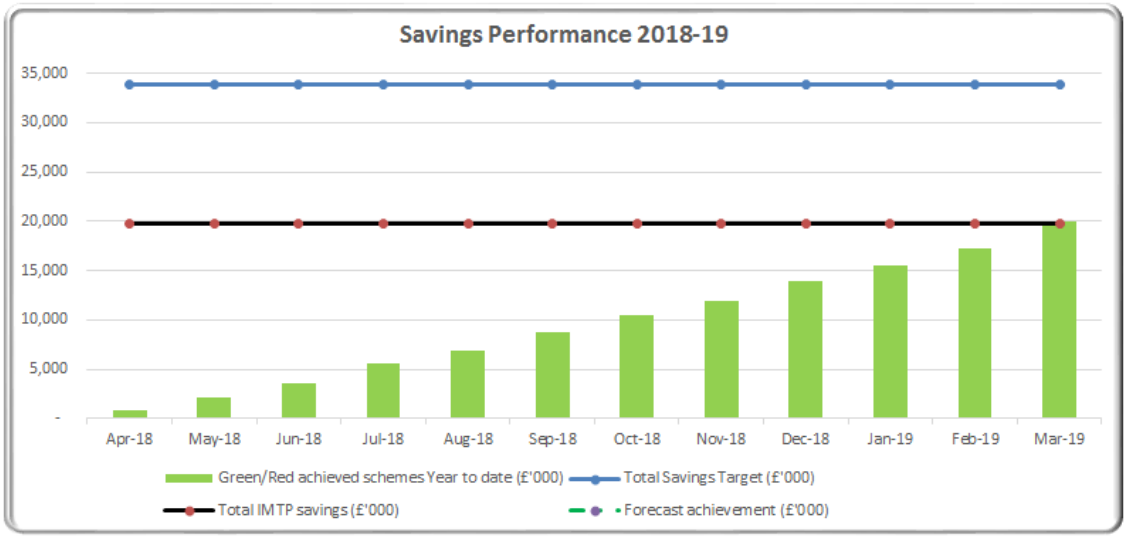
| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | Risks of delivering a balanced financial position are detailed within this paper. |
| ***Financial Assessment*** | This paper provides details of the 2018/19 financial position of the Health Board which is still subject to external audit review. |
| ***Quality, Safety and Patient Experience Assessment*** | This paper links to AQF target 9 – to operate within available resources and maintain financial balance. This paper provides a financial assessment of the Health Board's delivery of its IMTP priorities and opportunities to improve efficiency and effectiveness. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | Not Applicable |
| **Health and Care Standards** | This paper links to Standard for Health services One – Governance and Assurance. |

| | |
|---|---|
| **Link to Integrated Medium Term Plan/Corporate Objectives** | This paper provides details of the financial position that supports the Health Board's 3 year plan. The Health Board has a statutory requirement to achieve financial balance over a rolling 3 year period. |
| **The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working** | The Health Board Financial Plan has been developed on the basis of the approved IMTP, which includes an assessment of how the plan complies with the Act. |
| **Glossary of Terms** | A4C – Agenda for Change<br>A&E – Accident & Emergency<br>AQF – Annual Quality Framework<br>AWCP – All Wales Capital Programme<br>CAMHS – Child and Adolescent Mental Health Services<br>CCG – Clinical Commissioning Group<br>CHC – Continuing Health Care<br>COTE – Care Of The Elderly<br>CRL – Capital Resource Limit<br>DNA – Did Not Attend<br>DOSA – Day Of Surgery Admission<br>EASC – Emergency Ambulance Services Committee<br>GMS – General Medical Services<br>GP – General Practitioner<br>GWICES – Gwent Wide Integrated Community Equipment Service<br>HCSW – Health Care Support Worker<br>HIV - Human Immunodeficiency Virus<br>IMTP – Integrated Medium Term (3-year) Plan<br>LoS – Length of Stay<br>LTA – Long Term Agreement<br>NCN – Neighbourhood Care Network<br>NHS – National Health Service<br>NWSSP – NHS Wales Shared Services Partnership<br>PICU – Psychiatric Intensive Care Unit<br>PSPP – Public Sector Payment Policy<br>RRL – Revenue Resource Limit<br>RTT – Referral To Treatment (access target for elective treatment)<br>SCP – Service Change Plan (reference IMTP)<br>TCS – Transforming Cancer Services (Velindre NHS Trust programme)<br>UHB/HB – University Health Board/Health Board<br>VAT – Value Added Tax<br>WLIMS – Welsh Laboratory Information Management System<br>WHSSC – Welsh Health Specialised Services Committee |

## Appendix 1 Draft Revenue Financial Performance (Month 12 – 2018/19)

| Month 12 - March 2019 | Full Year Budget £000s | YTD M12 Reported Variance £000s | YTD M11 Reported Variance £000s | Trend compared to last month (February 2019) (F = Favourable, A = Adverse) |
|---|---|---|---|---|
| **Operational Divisions:-** | | | | |
| Primary Care and Community | 245,980 | (3,098) | (3,189) | A |
| Prescribing | 95,082 | (2,003) | (1,497) | F |
| Community CHC & FNC | 63,874 | (3,815) | (3,278) | F |
| Mental Health | 88,498 | 751 | 875 | F |
| Scheduled Care | 191,077 | 11,683 | 10,815 | A |
| Unscheduled Care | 102,532 | 7,354 | 7,393 | F |
| Family & Therapies | 101,878 | 102 | 36 | A |
| Estates and Facilities | 60,225 | (2) | 31 | F |
| Director of Operations | 40 | (293) | (349) | A |
| Primary Care and Mental Health | 1,034 | (287) | (61) | F |
| **Operational Divisions** | **950,220** | **10,392** | **10,777** | |
| | | | | |
| **Corporate Divisions** | **64,369** | **(3,769)** | **(3,212)** | **F** |
| | | | | |
| **Specialist Services** | **136,079** | **668** | **(729)** | **A** |
| | | | | |
| **External Contracts** | **63,991** | **(1,112)** | **(1,630)** | **A** |
| | | | | |
| **Capital Charges** | **23,429** | **(9)** | **(0)** | **F** |
| | | | | |
| **Total Delegated Position** | **1,238,089** | **6,170** | **5,206** | **A** |
| | | | | |
| **Centrally Held Reserves** | **6,405** | **(6,405)** | **(5,126)** | **F** |
| | | | | |
| **Total Reported Position** | **1,244,494** | **(235)** | **79** | **F** |

## Appendix 2: Savings Delivery 2018/19

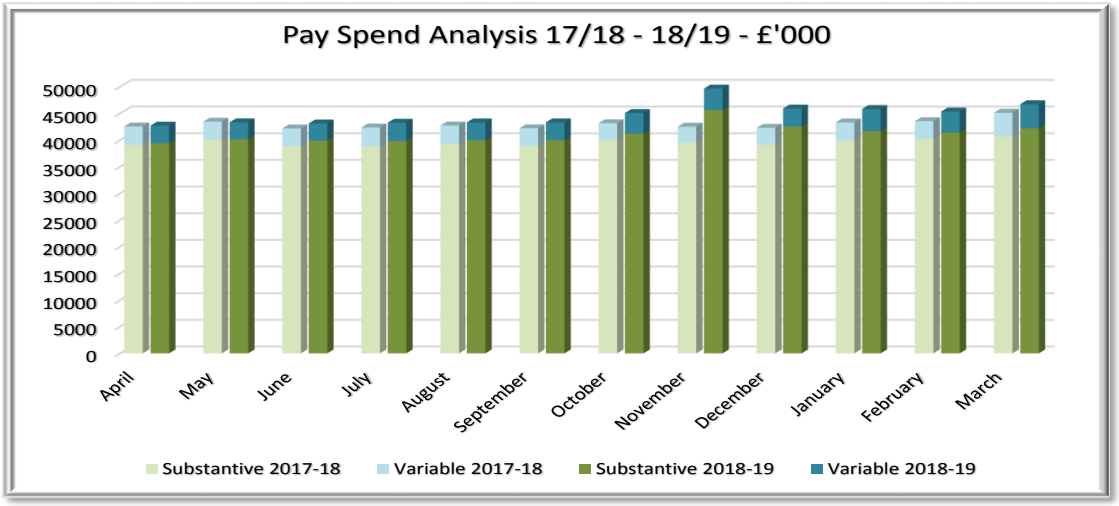


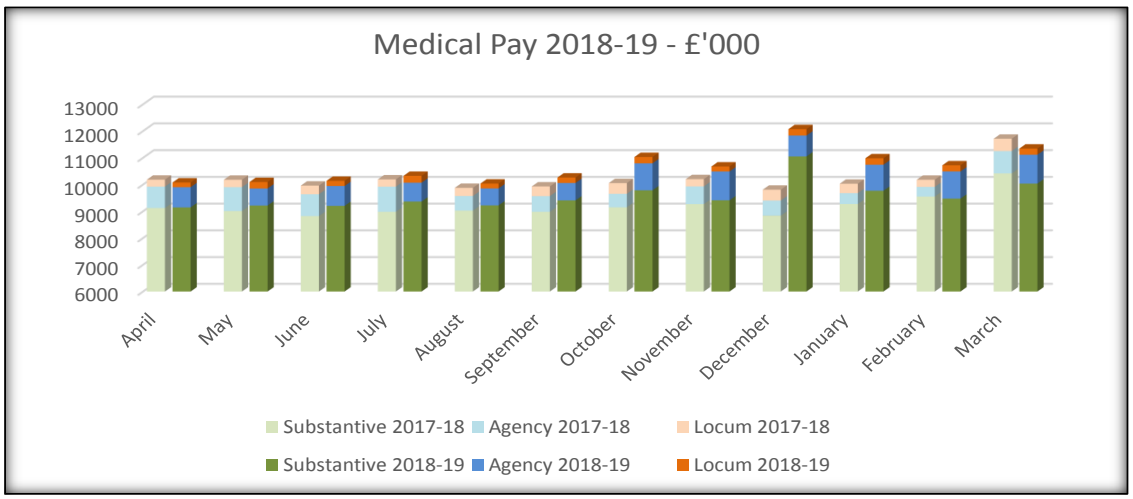

| Division | Initial 2018-19 IMTP Savings Target (£'000) | Green savings achieved (£'000) | Red forecast savings achieved (£'000) | Total forecast savings achieved (£'000) | Variance (£'000) |
|---|---|---|---|---|---|
| Primary Care and Networks | 5,967 | 5,528 | | 5,528 | 439 |
| Community CHC & FNC | 749 | 1,052 | | 1,052 | (303) |
| Mental Health | 3,372 | 3,576 | 21 | 3,597 | (225) |
| Scheduled Care | 2,891 | 4,113 | 10 | 4,123 | (1,232) |
| Unscheduled Care | 3,178 | 2,247 | 206 | 2,453 | 725 |
| Family & Therapies | 964 | 508 | | 508 | 456 |
| Estates and Facilities | 664 | 482 | | 482 | 182 |
| Chief Operating Officer | 0 | 0 | | 0 | 0 |
| **Total Operational** | **17,785** | **17,507** | **237** | **17,744** | **41** |
| Corporate | 786 | 1,030 | 0 | 1,030 | (244) |
| **Total Corporate** | **786** | **1,030** | **0** | **1,030** | **(244)** |
| Medical Director | 111 | 111 | 0 | 111 | 0 |
| Litigation | 94 | 94 | 0 | 94 | 0 |
| **Total Medical Director / Litigation** | **205** | **205** | **0** | **205** | **0** |
| WHSSC | 627 | 569 | 0 | 569 | 58 |
| EASC | | 0 | 0 | 0 | 0 |
| **Total Specialist Services** | **627** | **569** | **0** | **569** | **58** |
| Commissioning | 362 | 359 | 0 | 359 | 3 |
| **Total External Contracts** | **362** | **359** | **0** | **359** | **3** |
| | | | | 0 | 0 |
| **Total Reported Position** | **19,765** | **19,670** | **237** | **19,907** | **(142)** |

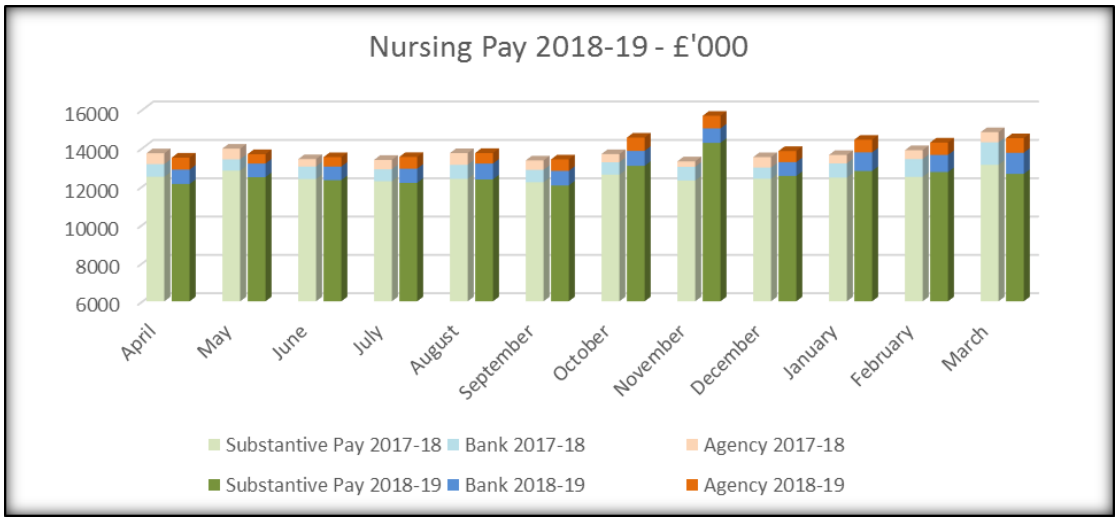
**Appendix 3: Pay spend analysis (2018/19)**

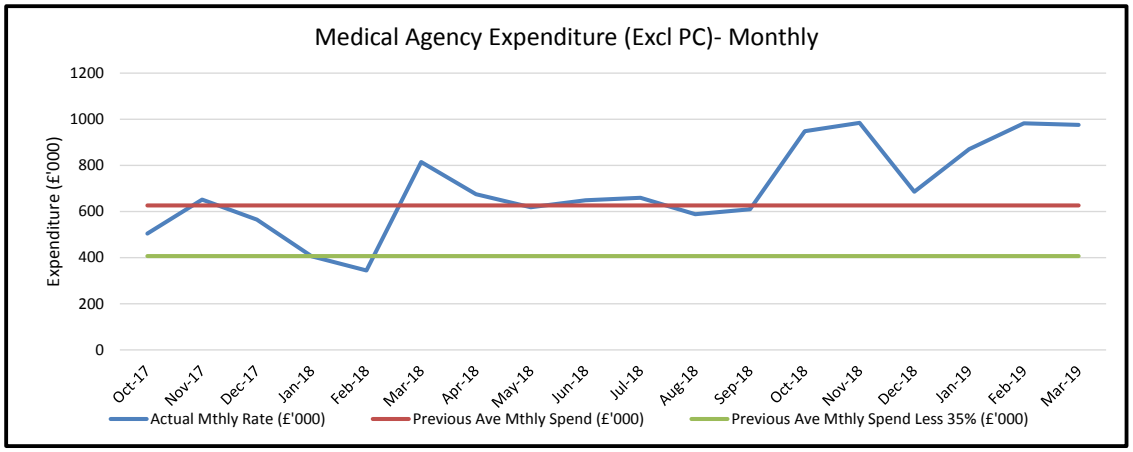
**(November – includes A4C pay award arrears)**

**(December – includes Medical pay award arrears)**



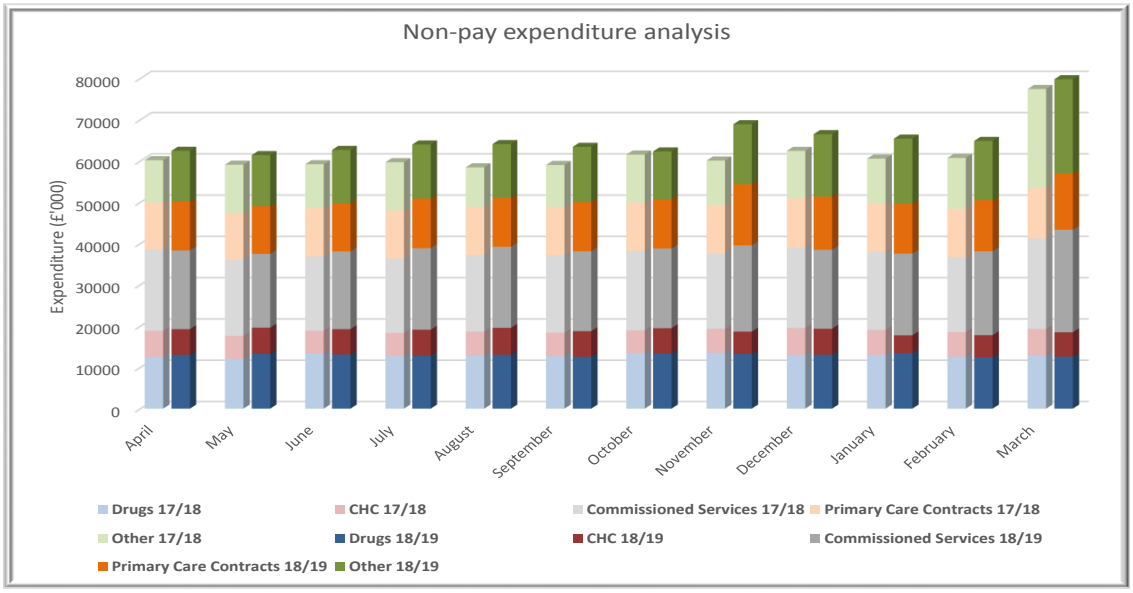



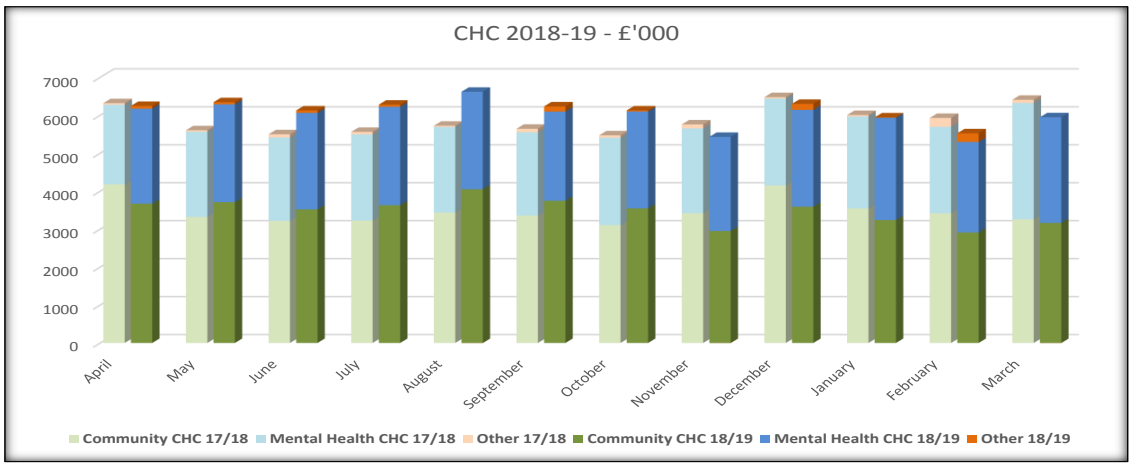


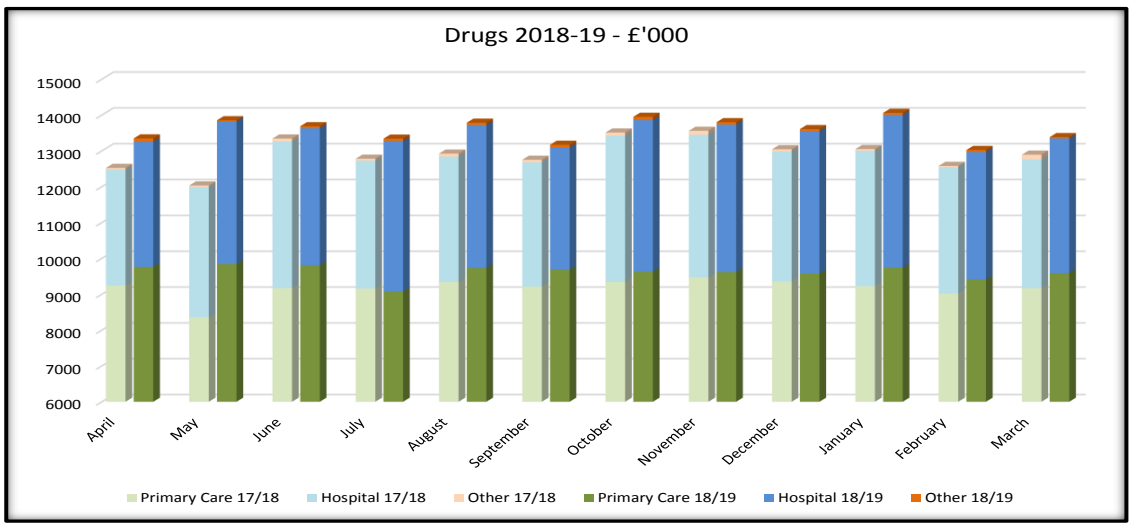

In March, medical agency (excluding managed practices) spend was at an equivalent level to February. It remains significantly above the agency spend reduction 35% target. The key cost drivers to the expenditure remain as follows below:-

- Ophthalmology – long-term sickness and vacancy cover for 7wte.
- Orthopaedics and other Scheduled Care – RTT performance delivery actions and cover for 9 agency posts in Orthopaedics.
- Paediatrics/Obstetrics & Gynaecology: increasing costs of sustaining existing rotas across sites.
- Emergency Department / COTE - issues sustaining rotas across multiple sites as well as covering vacancies. In March the use of additional shifts to support services and improve performance over the winter period resulted in continued high expenditure levels.
- Across specialities above and all other Unscheduled Care specialities costs have increased as part of the various additional winter initiatives.
- Radiology – specific expenditure in over the last quarter to achieve RTT performance targets.
- Occupational Health – covering vacant posts
- Primary Care – GP Out of Hours (managed practice additional costs excluded)

## Appendix 4: Non-pay spend analysis 2018/19



# Addendum
## Finance Performance Committee

This addendum will cover the following areas for which the Finance Performance Committee have requested further details:

- Underlying Financial Performance
- Value for Money assessment
- Efficiency Delivery & Improvement

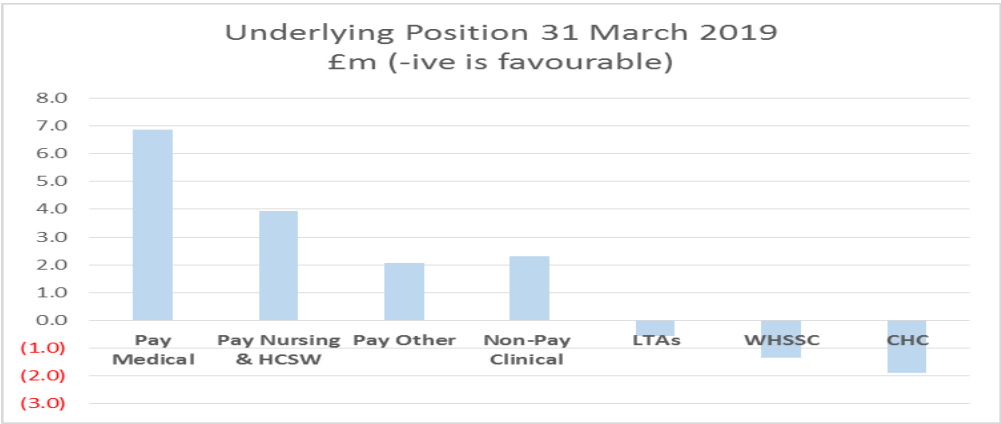
### 1. Underlying Financial Position 31st March 2019

The Health Board formally established a forecast underlying financial position, for the first time as part of the 2018/19 IMTP process and financial plan. The estimated underlying position for 2018/19 was a £19.7m deficit. During 2018/19 the closing underlying deficit has been updated to reflect the movements during the year.

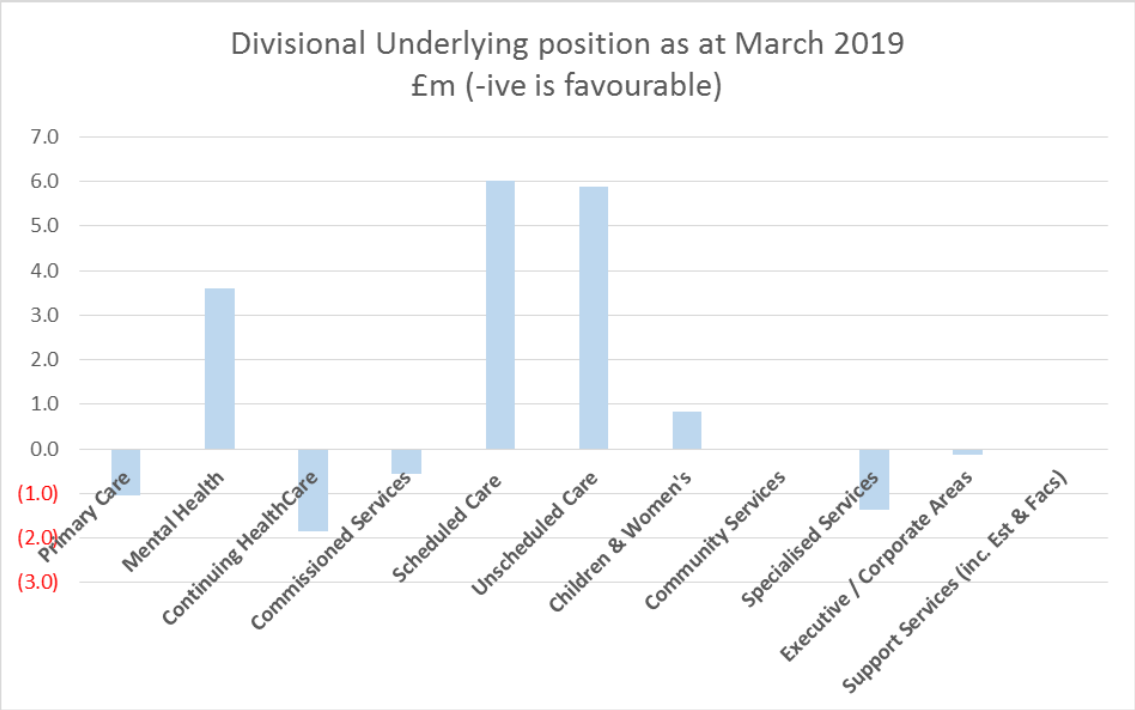
As at the 31st March 2019, the reported underlying position is a deficit of £11.4m. Key movements to this improved position are:

- Non recurring CHC savings being revised to recurrent savings of £1.1m,
- Full year effect of recurrent savings for medicines management and CHC improved by £3.6m,
- New Cost pressures lower than expected predominantly prescribing improvement of £1m,
- Other factors including RTT and winter pressures spending improvement of £6.2m, offset by brokerage b/f of £4.8m from 2017/18 and used to support the position, resulting in a net improvement of £1.4m.

**Spend Type analysis** - The table below indicates that the key pressure areas remain Medical & Dental, Nursing (both registered and unregistered) as well as radiology/pharmacy posts as part of professional & technical staffing. These pressures are predominantly vacancy, sickness and RTT driven but also due to enhanced care requirements.



**Divisional analysis** - The table below indicates that whilst the key pressures remain in Scheduled and Unscheduled Care, there is underlying pressure related to Mental Health CHC shown within Mental Health, this is off-set in part due to an underlying benefit with adult complex care CHC.




The forecast underlying position identified at a high level in the IMTP for 2019/20 is £7.9m, this forecast identifies underlying pressures, at an improved level in Scheduled Care, Unscheduled Care, Mental Health and Families divisions.

## 2. Value for Money Assessment

In order to establish an overall assessment of the value for money of resource utilisation within ABUHB, it was considered that the most appropriate information available would be national costing returns.

Recently, (April 16th) the 2017/18 national costing returns have been published, along with programme budgeting returns.

National costing returns provide a whole organisation comparison of costs compared with activity delivered for each health board. It is worth noting that the activity denominator for community returns is 1 (due to data capture inconsistencies, therefore represents the cost alone when compared).

Key Messages:

**Relative efficiency:**

- In 2017/8, AB's relative cost position has slipped from **2nd to 3rd** when ranked against other HBs in Wales.

| | 2017/8 | | | 2016/17 | | 2015/6 | |
|---|---|---|---|---|---|---|---|
| | Quantum | Variance to All Wales Average | Ranking | Variance to All Wales Average | Ranking | Variance to All Wales Average | Ranking |
| | £m | £m | | £m | | £m | |
| Abertawe Bro Morganwwg UHB | 1,143 | -40 | 2 | -50 | 1 | -43 | 1 |
| **Aneurin Bevan UHB** | **1,106** | **-33** | **3** | **-33** | **2** | **-32** | **2** |
| Betsi Cadwaladar UHB | 1,341 | 52 | 6 | 42 | 6 | 32 | 6 |
| Cardiff & Vale UHB | 1,040 | -41 | 1 | -21 | 3 | -26 | 3 |
| Cwm Taf UHB | 591 | 1 | 5 | -13 | 4 | 8 | 4 |
| Hywel Dda UHB | 739 | 36 | 7 | 53 | 7 | 40 | 7 |
| Powys THB | 224 | 23 | 8 | 22 | 5 | 21 | 5 |
| **TOTAL** | **6,184** | **0** | | **0** | | **0** | |

**VFM 2017/18 data:**

- In comparison with other **Welsh Health Boards**, the OVERALL AB costed activity as Finished Consultant Episodes (**FCE**) has remained at **£33m less** than the same activity costed at the All Wales average. (consistent with 2016/7)
- To test for consistency, the AB costed activity when using costed **spells** (admission to discharge potentially multiple FCS's) show AB's costs are **£21m less** expensive than the All Wales Average for acute spells.
- Further comparison of the AB spell activity cost with the average cost of a selected **English Peer Group** show AB activity as **£38m less** expensive than the English Peer Group for **acute** service spells.
- Analysis of performance comparatives were consistent across all of the benchmarks used:
    - Opportunities exist most notably in elective Orthopaedics and Ophthalmology

**Cost base movement:**

- In line with the strategic direction of travel for ABUHB Clinical Futures plans:
    - Decrease in the cost base of admitted patient care
    - Increase in the cost base of Community, and
    - Decrease in the cost base of Outpatients since 2015/6

***Please refer to Addendum appendix A for the full analysis.***

## 3. Efficiency Delivery & Improvement

The efficiency and savings agenda going forward will focus on 4 key areas driving costs:

- Beds
- Theatres
- Workforce
- Estates

***Please refer to Addendum appendix B for full details of example schemes***, additional examples will be reported in future committee reports.

**Beds**

From several versions and sources of benchmarking, including the original and latest assessments for the Clinical Futures strategy, there is an opportunity of circa 200 beds to be saved – this is subject to a separate paper for FPC so won't be repeated here.

Projects that have successfully delivered savings include:

**Mental Health – Older Adult Service restructuring**

In April 2018/19 St Pierre ward in Chepstow was closed, with a gross saving of around **£900k**. Executives approved reinvestment of most of the funding to Community services, with a net **£200k** recurring saving. Beds were reduced overall by **5** in Older Adult Mental health services.

**Learning Disabilities – Residential Services Review**

During 2018/19 the Learning Disabilities Directorate have restructured services, with 4 of the residences being closed, another due to close in May 2019, and one being kept for longer term complex cases. Many of the patients have transferred to Local Authority responsibility, with funding required for their packages transferring under section 28a agreements.
Financially, this has resulted in part year savings of **£204k** in 2018/19, which are assessed to rise to **£810k** for a full year for 2019/20, these resources have been utilised to support the sustainability of other mental health and LD services. From a patient perspective, it should be noted that high levels of satisfaction have been reported by patients and carers with the revised services, with patients having more independence and leading fuller lives.

**Theatres**

Several significant opportunities exist in terms of theatre utilisation and throughput – this is subject to a whole project focussed on delivering

theatre efficiencies, which will report separately. Key opportunities exist for orthopaedics and ophthalmology.
Projects that have successfully delivered savings include:

**Ophthalmology - Cataracts Efficiency Improvement**
By reviewing patient pathways and treatment inefficiencies, the gain expected in ABUHB in 2019/20 is a reduction of inefficiency rates from 14% to 5% for Ophthalmology DNA and CNA's.
There will be financial gains associated with the increased planned throughput per operating session, **from 4 to 6**, avoiding the additional costs of RTT waiting list initiatives to the approximate value of **£114k**.

**Workforce**
The drive to reduce premium rate variable staffing solutions has been and continues to be a driving focus. Medical agency spend caps are not being achieved and workforce pressures are driving up spend. Several workforce schemes are being progressed including the pilot medical bank and innovative skill mix roles.

Projects that have successfully delivered savings include:

**Doctor Dr. text remind Value Driven Project**
By introducing DNA improvement schemes such as Doctor Dr, the HBs overarching DNA rate has improved to 6.74% in 2018. This compares favourably with the rest of Wales, and has saved an estimated **£156k** in additional clinics required since 2016.

This has not resulted in releasable savings but has undoubtedly made a more efficient and patient focussed service, avoiding costs of additional sessions and workforce costs.

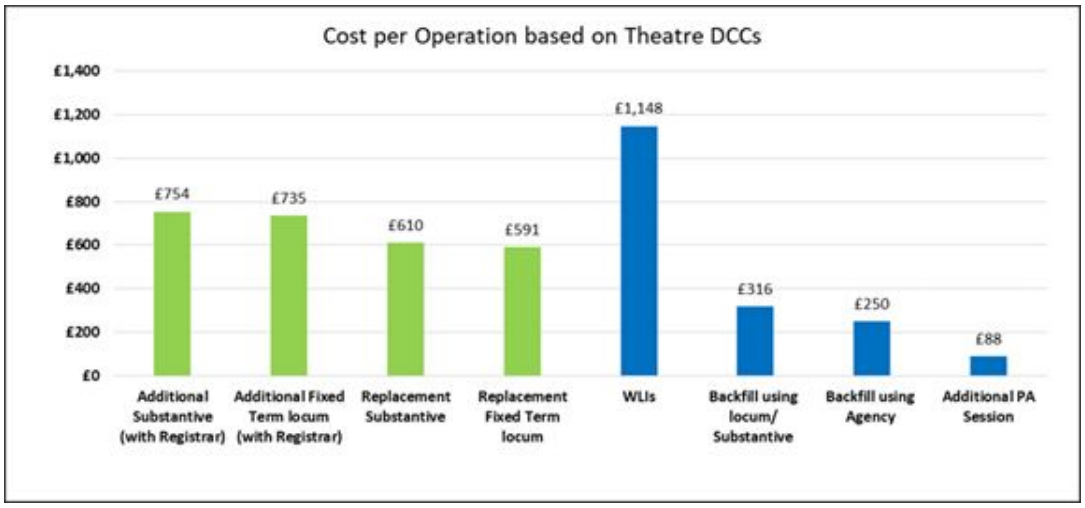
The aim is to reduce DNA rates to less than 6%, as set out above, which would save an additional **£242k** per annum.

| | | DNA Clinics Avoided | | | | | |
|---|---|---|---|---|---|---|---|
| CHKS DNA data | | 2016 | 2017 | 2018 | Total DNA Clinics avoided | Total Additional Clinics avoided since 2016/7 | Total Additional Clinics avoided if reduce to 6% |
| | | Rate | Rate | Rate | | £000s | £000s |
| OPA DNAs FU | ABUHB | 7.12% | 6.15% | 6.51% | 207 | | |
| | Rest of Wales | 8.03% | 7.87% | 7.41% | | | |
| OPA DNAs NEW | ABUHB | 7.13% | 6.78% | 6.97% | 33 | | |
| | Rest of Wales | 9.65% | 9.54% | 8.98% | | | |
| **TOTAL** | | | | | **240** | **156** | **242** |

Supporting Tools developed include:

**Nursing 'Visualise' System**
Nurse Staffing Act Visualise data capture used to inform and improve efficient ward rostering.

**Consultant solution VFM ready reckoner**
A model has been developed to present the best vfm solution for RTT and other additional activity requirements, depending on the specialty conditions and circumstances prevalent at the time of recruitment. The graph below illustrates the 'ready reckoner' cost per treatment comparisons for orthopaedics.




**Estates**
The Health Board Estates Strategy identifies the following profile for ABUHB currently:

Based on the recently completed Six Facet Survey and 2017/18 financial information the following is an overview of the totality of the existing directly owned estate:

- Total floor area of - 292,609 m2
- Total Operating cost - £56 million per annum
- Cost per metre **- £192** (Carter Median £331)
- Underused Estate - 29,000 m2 (10%) of the Estate is underused
- Empty Estate - 8,778 m2 (3%) is empty
- Maintenance Costs - £4 million per annum (£14 per m2, exc. staff costs)

This would infer that the 29,000 m2 of under-utilised estate is worth an opportunity of £5.6m, or for every 1% or 2,900 m2, there is an efficiency opportunity of £0.5m.

The efficiency opportunities for estate operated by ABUHB will be progressed via the implementation of the Estates Strategy.

**Efficiency Opportunities and Pipeline**
An executive process is being developed to promote and progress the drive for efficiency improvements to support sustainability. This will complement and be informed by ABUHB and external advisory information.

The intention is to expand the opportunities compendium and focus delivery through the Executive Board. Financial mechanisms will be used to support the monitoring and delivery for reporting purposes and capture the positive work taken forward.

The Committee will receive regular updates on progress.
***Please refer to Addendum appendix C for details.***

## Addendum Appendix A

### 1. Costing Benchmarking – How ABUHB compares to Peer Groups

Annual costing returns based on patient level costs are produced by Welsh HBs in line with central guidance. The basic counting unit for calculation in admitted care data is the finished consultant episode (FCE). This is the total time a patient spends under the care of an individual consultant, until the patient is referred on or discharged. These are consolidated centrally and comparative information is produced to indicate above or below average spend by activity type, or specialty and HRG (health resource group).

Patient level costing (PLC) uses electronic patient level data to match activities and associated costs to patient episodes. The resources used by patients can then be used to build the patient profile of actual costs. It can highlight variation for similar groups of patients and act as a catalyst for driving change and improvement by focusing on clinical variation and help in improving value for money and reducing costs.

The Welsh Average Specialty Costing Return summarises average specialty costs incurred by an organisation for inpatients, day cases, regular day/night attenders, new, follow-up and pre-operative outpatient attendances, total outpatient procedures, day care and community services. Primary Care and Other Healthcare expenditure is also included. All Wales average costs are calculated at HRG level for admitted patient care, at specialty level for outpatients and service level for community services. A HB's actual costs are then compared to these All Wales averages with the variances summarised to provide an indicator of comparative performance. For example, if ABUHB's care activity is £33m lower than the All Wales average (see Table 1 below), then AB costs are £33m less than the same activity costed at the All Wales average. Consideration of the consistency and completeness of both the underpinning activity and clinical coding (used to group activity into HRGs) is key to interpreting this comparative information.

### 2. 1 Costing returns 2017/8 Data – benchmarking comparisons across Welsh Health Boards

<u>All Wales Costing Returns</u>

It can be seen from Table 1 below that AB was ranked 2nd in 2016/17 but this ranking has slipped to 3rd in Wales in 2017/18 due to costing improvements made by C&V, moving C&V from 3rd to 1st position. However, ABUHB costs remain £33m less than the same activity

costed at the All Wales average in 2017/18, as was the case in 2016/17.

**Table 1:**

| | 2017/8 | | | 2016/17 | | 2015/6 | |
|---|---|---|---|---|---|---|---|
| | Quantum | Variance to All Wales Average | Ranking | Variance to All Wales Average | Ranking | Variance to All Wales Average | Ranking |
| | £m | £m | | £m | | £m | |
| Abertawe Bro Morganwwg UHB | 1,143 | -40 | 2 | -50 | 1 | -43 | 1 |
| **Aneurin Bevan UHB** | **1,106** | **-33** | **3** | **-33** | **2** | **-32** | **2** |
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| Powys THB | 224 | 23 | 8 | 22 | 5 | 21 | 5 |
| **TOTAL** | **6,184** | **0** | | **0** | | **0** | |

It can be seen that the cost bases of all other HBs have deteriorated over this period, with the exception of C&V which has improved to take it to first place.

The high level view of AB's cost base does mask the movements in cost base at the disaggregated levels. Table 2 below sets out these movements by patient group:

**Table 2:**

| | Admitted Patient Care | | | | Ouptatient | | | | Other/Community/Emergency dept | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 17/18 | 16/17 | 15/16 | Variance 16/17 to 17/18 | 17/18 | 16/17 | 15/16 | Variance 16/17 to 17/18 | 17/18 | 16/17 | 15/16 | Variance 16/17 to 17/18 |
| | £m | £m | £m | £m | £m | £m | £m | £m | £m | £m | £m | £m |
| ABUHB Total | **-50** | -49 | -38 | -1 | **4** | 4 | 5 | 0 | **13** | 13 | 1 | 0 |

Table 2 above shows that in 2017/18, in comparison with the All Wales Average:

i. Admitted Patient Care costs £50m **less** than the All Wales average.
ii. Out Patients cost £4m **more,** and
iii. Other/ Community /ED cost £13m **more**.

In comparison with other HB's Welsh average costed activity comparisons, this infers that this increase in community costs and decrease in inpatient costs are in line with the ABUHB strategic intentions.

The HB's performance should also be viewed in relation to the performance of other HB's, and also at Divisional level. The highlighted areas in Table 3 below displays the improved ranking of AB compared to the other HB's:

**Table 3:**

| | Variance to All Wales Average £m 2017/18 |
|---|---|
| | £m |
| Medicine | 1 |
| Surgical | 3 |
| Women and Children | 2 |
| Community | 6 |
| Accident & Emergency | 4 |
| Other | 5 |
| Continuing Care | 8 |
| Mental Health & Learning Dis | 6 |

Of note, the Medicine specialties have been ranked 1st, for each of the last 3 financial years.

Worsening areas notably are:

i. Surgical services decline of £6m from 2016/7. Further scrutiny of the movement variance to the All Wales average revealed this was related almost solely to orthopaedics.
ii. CHC unfavourable movement from 2016/17 of £8m, and
iii. Mental Health fall in ranking against other HBs in 2017/8. It should be noted that action has been taken by the division during 2018/9.

These issues will be further assessed later in the report.

<u>Albatross Costing System – Wales comparisons</u>

To give more consistency and assurance when comparing across HBs, a further piece of analysis was undertaken using the Albatross system to focus on spells rather than Finished Consultant Episodes (FCEs). A Hospital Provider **Spell** is a method of counting using continuous periods of care; for example, a patient that is brought into hospital as an emergency, has an operation before being transferred to a ward, has started a Hospital Provider Spell. It finishes when the patients stay has ended.

For this method of activity counting, AB was shown to be £21m less expensive than the All Wales average for acute spells. This is set out in Table 4 below:

**Table 4:**

| Sample of Significant Cost Differences - All Wales Average for Acute spells | | 2017/18 Spell cost Difference c/w All Wales Ave |
|---|---|---|
| | | £m |
| Treatment of mental Health by non Mental | Non Elect | -1.7 |
| Cardiac Disorders | Non Elect | -2.8 |
| Digestive system procedures and Disorders | Non Elect | -2.9 |
| Obstetric Medicine | Non Elect | -3 |
| Nervous system Procedures and Disorders | Non Elect | -3.4 |
| Respiratory system procedures and Disorders | Non Elect | -4.4 |
| Ungrouped | Non Elect | 17.6 |
| Ungrouped | Elective | -4.5 |
| Orthopaedic Non Trauma Procedures | Elective | 1.8 |
| Eyes and Periorbita Procedures and Disorders | Elective | 0.4 |
| **Overall Total** | | **-20.6** |

Non Elective procedures - Favourable comparisons were revealed for Cardiac disorder, digestive system, Obstetric medicine, nervous system and respiratory system. However, uncoded non-elective shows a £17.6m adverse comparative position that warrants further review.

Elective Procedures - In the Elective analysis there were specialties exposed to be above the average costs. E.g. Elective Orthopaedic and eyes services. Noting also that uncoded elective is favourable.

2. 2 **Albatross Costing System 2017/8 Data – benchmarking comparisons across the UK:**

- To ensure consistency of analysis and to understand AB's vfm position and relative efficiency ranking when compared more extensively to peers in England, the Albatross system was used to compare to an English peer group, selected on the basis of costing quality and similar demographics.
- Albatross is a patient cost benchmarking system that facilitates comparison of more than 90 NHS organisations in England and Wales. It helps to identify any potential efficiencies. It only covers acute hospitals and does not include data relating to Community, Critical Care overheads and Mental Health/Learning Disabilities. The data includes inpatient and day cases only.
- The notable outliers, both above and below average costs, are identified in Table 5 below:

**Table 5:**

| Sample of Significant Cost Differences - Albatross Costing System using Acute Spells | | 2017/18 Spell cost Difference to Peer Group Ave |
|---|---|---|
| | | £m |
| Digestive system procedures and Disorders | Non Elect | -2 |
| Obstetric Medicine | Non Elect | -9 |
| Nervous system Procedures and Disorders | Non Elect | -1 |
| Orthopaedic Non Trauma Procedures | Elective | 3 |
| Digestive system procedures and Disorders | Elective | 1 |
| Eyes and Periorbita Procedures and Disorders | Elective | 1 |
| **Overall Total** | | **-38** |

- Overall, there is some consistency with the spell analysis in Wales;
  - Elective Orthopaedic (non trauma procedures) is highlighted as more expensive, as are Elective Eyes.
  - Obstetrics (Non elective) appears to compare extremely well, being £9m less expensive than the Peer Group,
  - Non elective Digestive system and nervous system also appear to be consistent with the positive Welsh spells analysis; but note that elective digestive system is adverse.

**Summary Conclusion: VFM and Relative Efficiency**

- **VFM – In 2017/8 the OVERALL AB costed activity as FCEs has remained at £33m less than the same activity costed at the All Wales average. This is consistent with 2016/7.**
- **VFM – In 2017/8, to test for consistency of analysis, the AB costed activity was also costed as SPELLs, as an alternative to FCE's. Results show AB's costs are £21m less expensive than the All Wales Average for acute spells.**
- **VFM – In 2017/8, for a further comparison the AB spell activity was costed at an average cost of a selected English Peer Group. Results show AB activity as £38m less expensive than the English Peer Group for acute service spells.**
- **Analysis of performances were consistent across all of the benchmarking comparisons:**

    - **Opportunities exist – elective Orthopaedics and Ophthalmology**
- **Relative efficiency – In 2017/8, AB's relative position has slipped from 2nd to 3rd when ranked against other HBs in Wales.**
- **Relative efficiency – Ranking**
    - **Medicine consistently ranked 1st each year**
    - **Women and Children improved ranking from 2nd to 3rd**
    - **A&E and Community improved rankings**
    - **Surgical and MH had a fall in ranking against other HBs**
- **Relative Efficiency – Cost base. In line with the strategic direction of travel for ABUHB Clinical Futures plans:**
    - **Decrease in the cost base of admitted patient care**
    - **Increase in the cost base of Community, and**
    - **Decrease in the cost base of Outpatients since 2015/6**

## Addendum Appendix B

**Examples of Efficiency and VFM schemes in ABUHB**:

1. Beds - Mental Health and Learning Disabilities
   Older Adult Services Restructuring
   The National Benchmarking information for 2016/17 and 2017/18 showed that there were more Older Adult Mental Health beds in ABUHB than in most other areas.

   The Division went through a long consultation process, to reduce and consolidate the number and location of beds in ABUHB, which culminated in St Pierre Ward in Chepstow being closed, some bed increases in other ward areas, and a reinvestment programme agreed in community services.

   **In April 2018/19 St Pierre ward in Chepstow was closed, with a gross saving of around £900k. Executives approved reinvestment of most of the funding to Community services, with a net £200k recurring saving. Beds were reduced overall by 5 in Older Adult Mental health services**.

   Beds - Learning Disabilities - Residential Services review
   In the 1980s and 1990s Learning Disability service users from Llanfrechfa Grange were re-housed into social care, but there were some service users who were assessed as requiring Continuing Health Care, and this resulted in the Health Board having 6 community residences of 26 beds in total, with an annual cost of £3.6m as at 2017/18.

   Over the last few years it has been recognised that these residences are not the most appropriate environment for many of the patients, and also that the services provided through health in this way, are more expensive than some other options. Over the last year, the Learning Disability Directorate in the Health Board have been working with the Local Authority, to find an appropriate, person centred solution for individuals currently living in health board residential provision.

   During 2018/19 the Learning Disabilities Directorate have restructured services, with 4 of the residences being closed, another due to close in May 2019, and one being kept for longer term complex cases. Many of the patients have transferred to Local Authority responsibility, with funding required for their packages transferring under section 28a agreements.

**Financially, this has resulted in part year savings of £204k in 2018/19, which are assessed to rise to £810k for a full year for 2019/20. From a patient perspective, it should be noted that high levels of satisfaction have been reported by patients and carers with the revised services, with patients having more independence and leading fuller lives.**

2. Theatre - Cataracts

Visual impairment affects 4% of the population. Cataracts represent the greatest demand (>50%) on ophthalmology services with around 6,000 referrals and 3,000 day surgery cataract operations per year. Approximately 70% of patients referred for surgery have the operation. This means up to 30% could be better served in an alternative pathway.

Demand for cataract services is rising. Services need to be efficient to cope with demand and to ensure optimal service to patients. Actions taken were:

- A national costing exercise took place to understand the variation in cataract patient pathways across Wales.
- Patient Reported Outcome Measures (PROMs) data was collected from patients before and after cataract surgery.
- This information, combined with clinical outcomes and costing data, showed that some patients might be better served by an alternative pathway – improving their experience and outcomes, while saving time and money.
- Using a Time-Driven Activity Based Costing (TDABC) approach, the cataract patient pathway was mapped and the cost of each pathway step calculated. The approach was then used in the rest of Wales to allow comparison of variation in the pathways across Wales. Clinicians led an outcome measure collection and analysis process to drive service changes and improve patient outcomes. This outcome data will be used to triage and direct patient care.

Key findings:

- The 17 pathways in Wales demonstrated 40% variation in direct costs.
- By reviewing patient pathways and treatment inefficiencies, the gain expected in ABUHB in 2019/20 is a reduction of inefficiency rates from 14% to 5% for Ophthalmology.
- There will also be financial gains associated with the increased planned throughput per operating session, from 4 to 6, avoiding the additional costs of RTT waiting list initiatives to the approximate value of £114k.
- The data shows that a cohort of patients do not benefit from their surgery i.e. they do not report any improvement in their vision. In future, patients like these might be better served through an

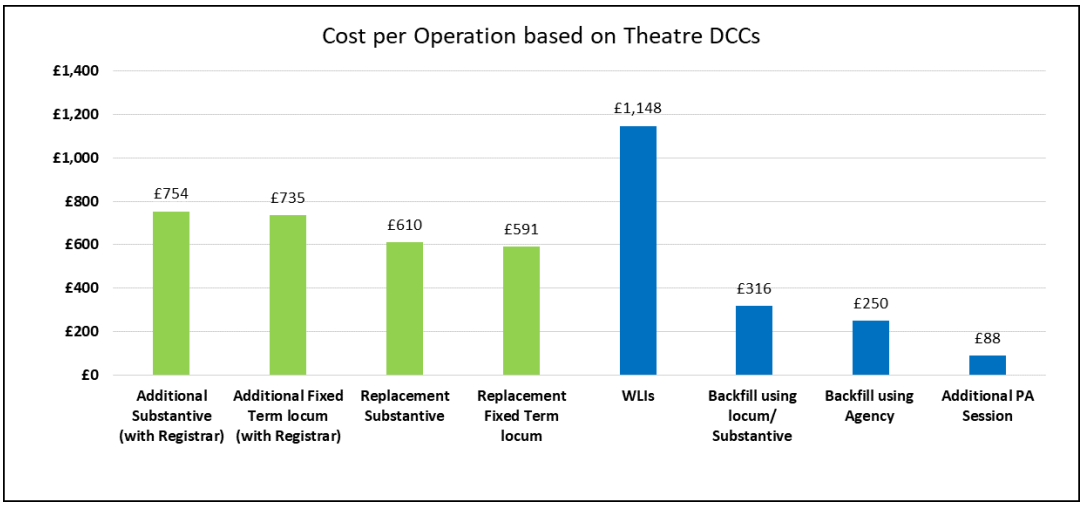
alternative pathway that starts with a consultant ophthalmology appointment.

- The long term aims and outcomes are expected to be:
  - Exploring how PROMs data can be used to triage patients to ensure they are treated in the most appropriate way.
  - Pre-operative PROMs data could allow the service to simplify the number of steps in the patient pathway – improving patient convenience and reducing unnecessary contacts with services.
  - Any future gains in efficiency and productivity will reduce the financial pressures associated with delivery of additional RTT activity.

3. Workforce - Nurse Staffing Act Visualise data capture
   Using the national NSA data system, Visualise, which captures a daily snap shot of the acute ward staff numbers, patient acuity and patient flow, the PHW senior nurse/programme manager for the NSA programme is working closely with the ABUHB Senior nurses to build a databank. Regular meetings are held to assess, analyse and understand the ward data and the impact messages. The aim will be to develop a picture of a 'typical' level of ward acuity and staffing requirements. In the future, once a sufficient amount of data is available, it could be used to inform and improve efficient ward rostering, the core and additional support required and also ward bed numbers. This work will be supported by the FDU/DoFs Efficiency Framework Group with a national benchmarking agenda.

4. Workforce -Consultant 'VFM ready reckoner'
   A model has been developed to present the best vfm solution for RTT and other additional activity requirements, depending on the specialty conditions and circumstances prevalent at the time of recruitment. The graphs below illustrates the 'ready reckoner' for a specialty that has the following assumptions:
   - All current vacancies are filled
   - Theatre and bed capacity is available
   - WLI sessions are assumed to be 2 session days and performed at the weekend

- Registrar would also deliver OP capacity and increase throughput in job planned Consultant clinics




The graph presents the relative cost of each workforce solution based on a 'treatment', there will also be the outpatient gain in activity where more permanent roles are employed. This indicates All substantive additional sessions (PAs) should be the first step, however if all consultants currently work 12 sessions then this option would not be available etc.

5. <u>Value - Doctor Dr</u>
   The overall Health Board DNA rate stood at 7.13% in 2016, which meant that cumulatively, an entire clinic was wasted approximately every 9 sessions. This includes Consultant, nursing, admin staff time and idle equipment. These sessions are then re-provided through additional clinics, backfill, and overbooking. Additional sessions are expensive, costing in the region of £650 per clinic (consultant, nursing, admin). Overbooking clinics runs the risk of clinics running late, and potentially cancelling patients. Each DNA incurs additional clerical time to remove, rebook the additional clinics and re-provide slots but also places additional pressure on staffing, including delays to patients on the lists.

By introducing DNA improvement schemes such as Doctor Dr, the HBs overarching DNA rate has improved to 6.74% in 2018. This compares favourably with the rest of Wales, and has saved an estimated £156k in additional clinics required since 2016. See **Table 6 below**:

| | | DNA Clinics Avoided | | | | | |
|---|---|---|---|---|---|---|---|
| CHKS DNA data | | 2016 | 2017 | 2018 | Total DNA Clinics avoided | Total Additional Clinics avoided since 2016/7 | Total Additional Clinics avoided if reduce to 6% |
| | | Rate | Rate | Rate | | £000s | £000s |
| OPA DNAs FU | ABUHB | 7.12% | 6.15% | 6.51% | 207 | | |
| | Rest of Wales | 8.03% | 7.87% | 7.41% | | | |
| OPA DNAs NEW | ABUHB | 7.13% | 6.78% | 6.97% | 33 | | |
| | Rest of Wales | 9.65% | 9.54% | 8.98% | | | |
| **TOTAL** | | | | | **240** | **156** | **242** |

This has not resulted in releasable savings but has undoubtedly made a more efficient and patient focussed service, avoiding costs of additional sessions and workforce costs.
The aim is to reduce DNA rates to less than 6%, as set out above, which would save an additional £242k per annum.

## Addendum Appendix C

1. **A Compendium of Future Opportunities Identified**

1. 1 Local Compendium

As in the previous two financial years, and in order to support the IMTP development, a comprehensive evidence based review is being undertaken of all available benchmark performance information, and will be brought together into one holistic opportunities framework. In ABUHB we refer to this databank as the Opportunities Compendium.

The Performance information collated as part of this costed assessment includes:

- *Beds and OP* - CHKS performance indicators across a range of productivity and efficiency indicators. Performance improvement is considered against Welsh organisations, CHKS top 40 ,and the top rated 'Outstanding' Foundation Trusts
- *Theatre utilisation*
- *Workforce –* avoiding premium cost variable pay solutions
- *Estates and Facilities Benchmarking*
- *NHS Wales Efficiency Group* – additional opportunities identified
- *NHS Benchmarking Network*

In recognition of this increased delivery expectation from WG in relation to the productivity and efficiency agenda, the ABUHB Opportunities Compendium will be updated on a quarterly basis for significant updates from the wide horizon scanning exercises.

1. 2 NHS Wales Efficiency Group Programme & Finance Delivery Unit (FDU) examining benchmark opportunities and publishing through the 'Efficiency Framework Tool'.

1. 3 Directors of Finance have also established an Efficiency Framework Group to support this agenda. Recent focus has been on Corporate Benchmarking, HSDU and facilities.

2. F**uture Opportunities to be developed by ABUHB – ABUHB Work Programme for 2019/20**

As stated above, the ABUHB Opportunities Compendium is currently being updated. It will be framed based on the main areas of focus for 2019/20, being:

- Beds,
- Theatres
- Workforce, and
- Estates.

Importantly it will also take into account the local impact on ABUHB of significant recent publications, including:

- CHKS – Focus on efficiency 2017/8, February 2019 - Welsh Government
- The Welsh Average Specialty Costing Return, March 2019
- Wales Planned Care 2018 Benchmarking Report, March 2019 – Welsh Government
- Estates and Facilities Performance Management Benchmarking, March 2019 – Shared Services
- Efficiency, Healthcare Value and improvement Group, current programme for HBs to engage with and report back on, include:
    - On the Ground Educator Programme Lymphedema
    - CHKS Productivity and Efficiency Improvement
    - Estates and Facilities Benchmarking
    - Postponed Procedures
    - All Wales Catering system Review
    - Lung Cancer outcome Dashboard

In response to the local and national productivity and efficiency agenda, ABUHB is improving local models and data capture systems to facilitate performance management and internal/external reporting.

Examples of AB areas of existing opportunity, identified through local benchmarking and being progressed are described below:

<u>Beds - Bed utilisation using CHKS ALOS</u>

Initial bed modelling for Clinical Futures in December 2012, suggested that a reduction of 230 beds was achievable across the hospital system in Gwent, based on improved and agreed performance levels, and also a step down system of care centred around the proposed Specialist and Critical Care Centre. The analysis was informed by peer benchmarks, and agreed with Directorates. It was based on occupancy rates of 85% (emergency) and 90% (elective), but did not include growth beyond those levels.

A more recent exercise undertaken, utilising the Opportunities Compendium described earlier, (CHKS and other benchmarking information), has highlighted key areas of opportunity amounting to approximately 192 beds, with an associated savings of approximately £9.5m. In addition. There is also an additional 86 beds which have previously been considered 'SCCC dependent' i.e., opportunities of economies of scale.

A full paper is presented separately to the Financial Performance Committee.

Theatres

A separate paper is being presented on theatre utilisation, however, as mentioned earlier it is also worth noting that the AB Opportunities Compendium will bring all evidence of opportunities into one databank, for common themes and significant outliers to be identified. For example the Compendium will cross reference and triangulate outputs from the Albatross costing evidence with the CHKS benchmarking exercises, and local intelligence e.g. the Clinical Cost Variation Group or theatre utilisation outputs, for instance.

An example of where this has indicated a significant area of opportunity for further investigation is Orthopaedics (Elective Non Trauma). The opportunities Compendium previously identified a theatre opportunity for T&O in excess of 500 operations, and this triangulates with the findings of the Albatross and CHKS exercises which also point to Orthopaedics being cost and LOS outliers, in particular for Very Major Knee procedures.

2.4

Finance and Performance Committee
1st May 2019
Agenda Item: 2.4

# Aneurin Bevan University Health Board

## Integrated Performance Report

### Executive Summary

To provide an update on the current performance of the Health Board at the end of months 11/12 of 2018/19, where available, in delivering key performance measures as set out in the performance dashboard and outlined in the National Outcomes and Performance Framework.

In terms of the National Performance measures there has been progress in the following key areas:

**Mental health access:**

- Sustained performance throughout the last quarter above the 80% target for Primary Care Mental Health Measures for both assessment and intervention.
- Sustained performance of the CAMHS measure of 80% with 93.7% of patients waiting less than 28 days at the end of March 19.
- Sustained performance for the CAMHS Neurodevelopmental pathway with 82.9% in March 19 against the 80% target.
- Sustained performance in the percentage compliance of valid care treatment plans completed with 90.3% in March against the target of 90%.

**Cancer access:**

- The national 98% target of 98% was achieved for the NUSC 31 day pathway in March with 98.2% achievement. This is an improvement on the February position of 97.5%

**Unscheduled Care access:**

- Ambulance response times within eight minutes to Category Red Calls sustained performance above the 65% target with 73.8% in March. This is the 3rd consecutive month that performance has improved despite increased pressures during the winter period.

**Elective treatment access:**

- The number of RTT 36 week breach patients decreased in March 19 with 112 compared to 469 in February. The 112 at the end of March is a significant achievement even though the Health Board had been expected to deliver zero patients waiting over 36 weeks by the end of March. Given the number of bed cancellations, due to emergency pressures during the last month, it was anticipated it would be difficult to treat all patients waiting beyond 36 weeks, 112 however represents the lowest number of patients waiting over 36 weeks the Health Board has reported since September 2012. The last quarter has been challenging with continued emergency pressures and whilst Ophthalmology had expected to deliver

the zero target, one of the outsourcing providers was unable to deliver on the expected numbers.

- RTT 26 week compliance in March increased to 92%. Whilst this is still slightly below the IMTP profile of 92.5% this is a significant improvement and the highest compliance since March 2013.

**Primary care out-of-hours:**

- There has been an improvement in performance in Out of Hours (OOH) with 72% of very urgent patients seen within 60 minutes in March 2019 compared to 65% in February 2019 and 12% higher than the same period last year. Compliance against the routine calls advised within 60 minutes also improved from 69% in February to 73% in March 19.

**Diagnostic access:**

- The 8 week diagnostic target was achieved at the end of March 19 with zero patients breaching 8 weeks. This is an improvement on the February position (13) and compared to the same period last year, March 18 (2). The March 19 position represents the lowest performance since April 2010.

**Therapies:**

- The 14 week therapy target was achieved at the end of March with zero patients breaching 14 weeks. The zero achievement in March represents 4 of the past 5 months of reporting in which this target has been achieved.

**Outpatient Follow-up access:**

- The number of outpatient appointments overdue their follow-up target date decreased in March with 15,433 compared to 18,065 in February. Whilst this is above the IMTP improvement profile of 10,000 for the yearend, the March position is a significant improvement and represents a decrease of 5982 patients since the end of December 18 (21,415). Profiles to reduce delayed follow up appointments in some key areas have not been realised mainly due to the challenge of achieving RTT targets in December 2018 and March 2019 and the continued focus on RTT. Profiles for 19/20 have been produced and services are producing key actions that will ensure a continued reduction in the number of delayed appointments. These will continue to be monitored at the monthly Delayed Follow up Group chaired by the Associate Director of Integration and Innovation. This remains an important priority for the Health Board.

**Stroke care:**

- Following the significant improvements in February's performance March has unfortunately seen a slight downturn in a number of the key measures. Whilst performance in March has maintained the 100% of eligible patients being thrombolysed for the tenth successive month there has been a deterioration in the numbers patient's thrombolysed within 45 minutes from 71.40% in February to 21.40% in March. Performance in the number of patients who received a CT scan within 12 hours was maintained above the national aspirational target of 95% in February with 100% and in March with 96.20%. Internal targets for stroke measures have been agreed by the service and are being implemented. With effect from April, Welsh Government has confirmed that there will be changes to the monthly Quality

Improvement Measures (QIMs) which will be used to monitor stroke performance at the regular performance meetings. The new measures go beyond the first 72 hours of a patients care in hospital, having been developed to cover the entire stroke pathway. As with the current measures, there is no compliance target and Welsh Government will expect continuous performance improvement from health boards, which will be reviewed at Quality and Delivery meetings. Organisations will be benchmarked against the SSNAP audit average for each indicator. The impact of the data collection requirements will need to be evaluated by the service.

**Prevention:**

- Uptake of flu vaccination has increased across all measures with health care workers, with direct patient contact at the end of March achieving the 60% target. This represents a significant achievement as the target has risen from less than 50% last January to 60% this January. The uptake for those over 65 years, compliance is 69.60%, which is slightly above the Wales average of 68.3%. The Primary Care Influenza Vaccination Group focussed on low uptake areas in primary care and to provide access to providers to encourage use of practice level data to drive improvement.

**Serious Incidents:**

- The number of serious incidents reviewed and assured, on a timely basis, increased in March to 66% compared to 56% in February. This improvement has been due in part to key staff returning from sick leave, along with an action plan being implemented by the Putting Things Right Team. Divisions have agreed improvement trajectories, in line with the agreed action plan, which should enable sustained improvement in this area.

**Outpatient attendance:**

- An improved level of Did Not Attend (DNA) rates for both new and follow up outpatients in March compared to February.

While there have been positive indicators, there remain significant challenges to improve areas where performance is below expected levels, including:

**Unscheduled Care/Winter Plans:**

- Unscheduled Care continues to be a key area of concern. The 4 hour A&E target performance has increased slightly in March 19 with 78.5% compared to 76.6% in February. This remains below the national target and outside of the IMTP profile of 90% in March. The trend of ever increasing numbers of attendances at the Health Board's A&E departments has continued with a higher number of attendances in January, February and March than previous corresponding months for the past 8 years.
- A deterioration in March with 558 ambulance handovers over 60 minutes compared to 519 in February and a deterioration on the position in the same period last year, March 18 (537). This remains outside of the IMTP profile.
- The 12 hour A&E target improved in March 19 with 561 patients compared to 619 in February 19. Whilst this remains below the IMTP target it is an improvement on the same period last year (752 – March 18). The Health Board implemented a range of services and increased focus, through its winter service plans, to provide safe care

and improve access during the winter period. Evaluation of these plans will be important in determining what has been effective and what further improvements need to be made.

**Cancer Access:**

- Urgent Suspected 62 day cancer treatment times continued to deteriorate in March with 87.3% compared to 91.30% in February 19. This remains outside of the target of 95% and the IMTP profile. The decrease in performance is partly attributed to treating a fewer number of total patients in February and March for the 62 day pathway. The backlog, although fairly small, has impacted on performance. Referrals for cancer overall remain above 2,000 per month. The sustained increase is being factored into the demand and capacity plans for the Single Cancer Pathway which are currently being developed.

**DToC:**

- March performance for Delayed Transfers of Care (DToCs) for mental health patients deteriorated to 7 patients being delayed. Delayed Transfers of Care for non-mental health patients rose from 69 in February to 95 in March. Whilst the mental health DToC position is within the IMTP profile of 8 for March, both measures have deteriorated from the same period last year. The main reasons for delay are due to community care arrangements and patient family issues.

**Critical Care DToC:**

- March performance for Critical Care DToC has deteriorated in March for both Royal Gwent and Nevill Hall sites. This deterioration is primarily due to the pressures outside of critical care meaning that there are often no suitable general beds to transfer critical care patients to when it is appropriate to do so.

**Safe and effective care:**

- HCAI performance deteriorated in March across all measures. In confirmed c difficile cases there were 28 cases per 100k in against a target of ≤25 cases per 100k and an increase on last month from 22.1. There was little change to staph aureus infections with 26.04 which is still above the national target of ≤19 cases per 100k. Both of these measures are an improvement on the same period last year. The number of e coli cases increased from 66.6 in February to 86.1 in March which is outside of the target of ≤61 cases per 100k

**Primary Care out of hours:**

- There has been a deterioration in OOH in March in unfilled hours for medical staff with 18% of GP shifts unfilled (654 hours), the highest since September 2018 and 24% of nurse shifts unfilled (697 hours), the highest since recording in 2016. This was partly due to nurse sickness throughout March and annual leave.

**Clinical Coding:**

- Clinical coding completeness performance decreased from 82.50% in December to 76.9% in January. This is below the target of 95% and a review of clinical coding capacity in relation to rising levels of activity will be undertaken to fully understand and address the issues in this area.

**Handling of Concerns and Complaints:**

- The timely handling of concerns and complaints within 30 days improved slightly in March with 38% compared to 32% in February. This is lower than for the same period last year (March 18, 59.3%). The Putting Things Right team are working with operational divisions to secure improvements in the way in which complaints are dealt with in the organisation and compliance with the targets. Improvement actions identified in this area require cross-organisational working which is recognised in the action plan which has been developed.

**Workforce:**

- Sickness absence improved in February to 5.61% and again in March to 5.05%, five of the eight divisions across the Health Board are now achieving the 5% target. However, overall this is still outside of the IMTP profile of 5%. PADR compliance improved in March with 77.05% compared to 69.89% in February, two of the eight divisions are achieving the 85% compliance target.

This provides a summary of the actions being undertaken to deliver and/or improve performance against the range of organisational and national targets.

| **The Committee is asked to:** (please tick as appropriate) | |
|---|---|
| Approve the Report | |
| Discuss and Provide Views | ✓ |
| Receive the Report for Assurance/Compliance | ✓ |
| Note the Report for Information Only | |
| **Executive Sponsor:** Glyn Jones**,** Director of Finance & Performance | |
| **Report Author:** Lloyd Bishop, Assistant Director of Performance and Information<br>Sue Shepherd, Head of Performance and Compliance | |
| **Report Received consideration and supported by :** | |

| **Executive Team** | | **Committee of the Board [Committee Name]** | **Finance & Performance Committee** |
|---|---|---|---|

| **Date of the Report: 18 April 2019** |
|---|
| **Supplementary Papers Attached:** Dashboard attached which now includes additional measures of therapy appointments seen within 14 weeks, readmission rates and cancellations due to no bed being available. |

| **Purpose of the Report** |
|---|
| This report provides a high level overview of performance at the end of months 11/12 against the Integrated Medium Term Plan (IMTP) with a focus on delivery against key national targets included in the performance dashboard. |

| **Recommendation** |
|---|
| The Committee is asked to:<br>• Note the current Health Board performance and trends against the national performance measures and targets. |

| Supporting Assessment and Additional Information | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The report highlights key risks for target delivery. |
| ***Financial Assessment*** | The delivery of key performance targets and risk management is a key part of the Health Board's service and financial plans. |
| ***Quality, Safety and Patient Experience Assessment*** | There are no adverse implications for QPS. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | There are no implications for Equality and Diversity impact. |
| **Health and Care Standards** | This proposal supports the delivery of Standards 1, 6 and 22. |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | This paper provides a progress report on delivery of the key operational targets |
| **The Well-being of Future Generations (Wales) Act 2015 –<br>5 ways of working** | An implementation programme, specific to ABUHB has been established to support the long term sustainable change needed to achieve the ambitions of the Act. The programme, will support the Health Board to adopt the five ways of working and self-assessment tool has been developed, and working with corporate divisions through a phased approach sets our ambition statements for each of the five ways of working specific to the Division and the action plan required to achieve the ambitions. |
| **Glossary of New Terms** | Terms are explained in the paper |

# Integrated Performance Dashboard

**March 2019**

| Domain | Sub Domain | Measure | Report Period | Current Performance | Previous Performance | In Month Trend | National Target | IMTP Target | IMTP Status | Performance Trend (13 Months) | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TIMELY CARE | RTT | Patients waiting less than 26 weeks for treatment | March | 92.00% | 91.80% | ↑ | 95% | 92.5% | ● | | 90.30% | 90.10% | 89.80% | 90.80% | 91.00% | 89.30% | 88.90% | 90.00% | 91.10% | 90.39% | 90.30% | 91.80% | 92.00% |
| | | Patients waiting more than 36 weeks for treatment | March | 112 | 469 | ↑ | 0 | 0 | ● | | 812 | 986 | 1090 | 848 | 910 | 1159 | 1067 | 1214 | 769 | 249 | 336 | 469 | 112 |
| | | Patients waiting more than 8 weeks for a specified diagnostic | March | 0 | 13 | ↑ | 0 | 0 | ● | | 2 | 320 | 279 | 502 | 417 | 663 | 407 | 283 | 71 | 4 | 60 | 13 | 0 |
| | | Patients waiting more than 14 weeks for a therapy appointment | March | 0 | 0 | ↑ | 0 | | | | 0 | 13 | 15 | 3 | 31 | 9 | 13 | 5 | 0 | 0 | 0 | 3 | 0 |
| | FUNB | Patients not booked for follow-up and delayed past their target date | March | 15433 | 18065 | ↑ | reduce | 10000 | ● | | 17587 | 18120 | 18513 | 18768 | 19857 | 20550 | 20567 | 19562 | 20012 | 21415 | 19603 | 18065 | 15433 |
| | STROKE | % stroke patients directly admitted to acute stroke unit ≤4 hours | March | 52.60% | 61.70% | ↓ | 12m | 85.0% | ● | | 25.60% | 42.50% | 64.80% | 61.70% | 42.90% | 51.50% | 37.50% | 41.80% | 63.30% | 39.70% | 41.20% | 61.70% | 52.60% |
| | | % of eligible stroke patients thrombolysed | March | 100% | 100% | ↑ | 100.0% | 100.0% | ● | | 100.00% | 92.60% | 85.70% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100% | 100.00% | 100% | 100% | 100% |
| | | % stroke patients thrombolysed ≤45 minutes | March | 21.40% | 71.40% | ↓ | 100.0% | 30.0% | ● | | 12.50% | 25% | 37.50% | 20% | 16.70% | 0.00% | 50.00% | 0.00% | 28.60% | 28.60% | 16.70% | 71.40% | 21.40% |
| | | % stroke patients who receive a CT scan ≤12 hours | March | 96.20% | 100% | ↓ | 95.0% | 98.8% | ● | | 97.60% | 97.50% | 98.60% | 100% | 98.40% | 97.10% | 98.20% | 100.00% | 98.30% | 97.10% | 98.50% | 100% | 96.20% |
| | ED | Category A ambulance response times within 8 minutes. | March | 73.80% | 71.00% | ↑ | 65.0% | 65.0% | ● | | 65.30% | 74.10% | 76.30% | 74.90% | 78.80% | 71% | 76% | 75% | 73.30% | 72.1% | 67.20% | 71% | 73.80% |
| | | Number of ambulance handovers over one hour | March | 558 | 519 | ↑ | 0 | 50 | ● | | 537 | 373 | 239 | 178 | 293 | 357 | 461 | 432 | 363 | 495 | 689 | 519 | 558 |
| | | % patients waiting < 4 hrs in A&E figures inc. YAB & YYF | March | 78.50% | 76.60% | ↑ | 95.0% | 90.0% | ● | | 75.30% | 79.80% | 79.60% | 82.50% | 78.80% | 78.50% | 78.60% | 78.40% | 78.30% | 74.8% | 76.20% | 76.60% | 78.50% |
| | | Number patients waiting > 12 hrs in ABUHB A&E departments | March | 561 | 619 | ↑ | 0 | 0 | ● | | 752 | 545 | 331 | 246 | 349 | 389 | 450 | 374 | 437 | 470 | 692 | 619 | 561 |
| | CRITICAL CARE | Critical care delayed transfers of care (4 hrs) days lost - nhh | March | 46 | 24 | ↓ | 12m | - | | | | 18 | 24 | 15 | 16 | 34 | 43 | 42 | 32 | 28 | 14 | 24 | 46 |
| | | Critical care delayed transfers of care (4 hrs) days lost - rgh | March | 118 | 86 | ↓ | 12m | - | | | | 53 | 28 | 60 | 82 | 72 | 68 | 70 | 62 | 35 | 53 | 86 | 118 |
| | CANCER | Delivery of the 31 day cancer standards for non-usc route | March | 98.20% | 97.50% | ↑ | 98.0% | 98.0% | ● | | 99% | 99% | 98% | 97% | 96.30% | 96.30% | 99.20% | 96.40% | 96.30% | 97.70% | 99.49% | 97.50% | 98.20% |
| | | Delivery of the 62 day cancer standards for usc route | March | 87% | 91% | ↓ | 95.0% | 92.5% | ● | | 92% | 91% | 80% | 87.0% | 82.50% | 82.20% | 85.50% | 89.90% | 86.20% | 91.30% | 88% | 91.30% | 87.30% |
| | MENTAL HEALTH | Assessment by LPMHSS within 28 days of referral. | March | 80.5% | 86.0% | ↓ | 80.0% | 80.0% | ● | | 88.9% | 84.70% | 91.50% | 86.80% | 87.70% | 83.20% | 82.90% | 91% | 84.50% | 84.0% | 88.7% | 86% | 80.50% |
| | | Interventions ≤ 28 days following assessment by LPMHSS. | March | 83.70% | 82.0% | ↑ | 80.0% | 80.0% | ● | | 88.5% | 83.90% | 80.80% | 85.20% | 82.70% | 81.20% | 80.90% | 82.30% | 82.50% | 80.4% | 83.40% | 82% | 83.70% |
| | | CTP Compliance | March | 90.30% | 90.1% | ↑ | 90.0% | 90.0% | ● | | 90.9% | 90.10% | 90.90% | 91.20% | 87.40% | 90.90% | 90.80% | 90.60% | 90.60% | 90.2% | 91.10% | 90.10% | 90.30% |
| | CAMHS | 4+ Weeks Waiting List | March | 93.50% | 88.0% | ↑ | 80.0% | | | | 85.2% | 81.40% | 83.30% | 87.70% | 94.30% | 89% | 95.60% | 96% | 98% | 97.0% | 94.40% | 88% | 93.50% |
| | | Neurodevelopmental (iSCAN) Waiting List | March | 82.90% | 84.9% | ↓ | 80.0% | | | | 88.0% | 86.80% | 83.30% | 81.10% | 81.00% | 72.40% | 67.40% | 67.10% | 80.60% | 86.5% | 84.8% | 84.90% | 82.90% |
| | Primary Care | Urgent Calls Returned in 20 mins | March | 80% | 81.0% | ↓ | 98.0% | 90.0% | ● | | 89% | 89% | 89% | 88% | 84% | 88% | 87% | 88.0% | 80% | 80% | 76% | 81% | 80% |
| | | Very Urgent Seen within 1 hour | March | 72% | 65.0% | ↑ | 90.0% | 77.5% | ● | | 60% | 74% | 78% | 76% | 64% | 67% | 75% | 69.0% | 86% | 65% | 79% | 65% | 72% |
| | | Routine calls advised in 60 minutes | March | 73% | 69.0% | ↑ | 98.0% | | | | | 83% | 84% | 80% | 76% | 86% | 83% | 79% | 81% | 74.10% | 70% | 69% | 73% |
| EFFECTIVE CARE | DTOCS | Number of dtocs for people all ages - mh | March | 7 | 6 | ↓ | 12m | 8 | ● | | 3 | 4 | 2 | 2 | 4 | 3 | 3 | 7 | 3 | 3 | 3 | 6 | 7 |
| | | DTOC's per 10,000 for people all ages - mh | March | 0.12 | 0.10 | ↓ | 12m | 0.16 | ● | | 0.05 | 0.08 | 0.03 | 0.03 | 0.07 | 0.05 | 0.05 | 0.12 | 0.05 | 0.05 | 0.05 | 0.1 | 0.12 |
| | | Number of dtocs for people >75years non-mh | March | 95 | 69 | ↓ | reduce | 73 | ● | | 87 | 89 | 73 | 60 | 54 | 61 | 73 | 86 | 97 | 65 | 74 | 69 | 95 |
| | | DTOC's per 10,000 for people >75years non-mh | March | 18.2 | 12.51 | ↓ | reduce | 14.15 | ● | | 17.6 | 17.9 | 14.8 | 12.1 | 10.9 | 12 | 13.8 | 17.50 | 18.6 | 12.40 | 12.63 | 12.51 | 18.2 |
| | CODING | % valid principle diagnosis code ≤ 1 month after episode end date | January | 76.9% | 82.5% | ↓ | 95% | 80.00% | ● | | 83% | 88.80% | 87% | 88.50% | 86.30% | 76.10% | 87.60% | 84.70% | 69.10% | 82.50% | 76.90% | | |
| STAYING HEALTHY | INFLUENZA | Uptake of influenza vaccination among 65 years and over (seasonal) | March | 69.60% | 67.10% | ↑ | 75% | 70% | ● | | 69.80% | | | | | | | 39.70% | 61.80% | 67.10% | 69.50% | 69.50% | 69.50% |
| | | Uptake of influenza vaccination among under 65's in risk group (seasonal) | March | 46.80% | 46.60% | ↑ | 75% | 55% | ● | | 50.80% | | | | | | | 21.10% | 38.30% | 42.50% | 46.60% | 46.60% | 46.80% |
| | | Uptake of influenza vaccination among health care workers with direct pt contact | March | 60.50% | 60.00% | ↑ | 60% | 45% | ● | | 58.00% | | | | | | | 34% | 50% | 56% | 60% | 60.50% | 60.50% |
| | CHILDHOOD IMMUNISATION | % of children who received 3 doses of the '6 in 1' vaccine by age 1 | Q3 | 95.90% | 95.80% | ↑ | 95% | 95% | ● | | 96.20% | | | 96.20% | | | 95.80% | | | 95.90% | | | |
| | | % of children who received 2 doses of the MMR vaccine by age 5 | Q3 | 91.90% | 90.30% | ↑ | 95% | 91.50% | ● | | 89.60% | | | 89.70% | | | 90.30% | | | 91.90% | | | |
| | SMOKING CESSATION | Smokers making quit attempt (full year extrapolation) | Q3 | 0.8% (2.44%) | 0.80% | ↑ | 5% (1.25% per qtr) | 0.9% (2.8%) | ● | | 3.50% | | | 0.84% | | | 0.8%(1.64%) | | | 0.8%(2.44%) | | | |
| | | Smokers who are CO validated as quit at 4 weeks | Q3 | 41.20% | 43.00% | ↑ | 40% | 40% | ● | | 40% | | | 45% | | | 43% | | | 41.20% | | | |
| DIGNIFIED CARE | PAP | Manifesto commitment for procedures cancelled > once | February | 34.50% | 36.96% | ↓ | 100% | 31.25% | ● | | 27.30% | 26.30% | 31.30% | 37.20% | 37.10% | 25% | 22.70% | 29.20% | 40.35% | 37.21% | 36.96% | 34.50% | |
| | COMP | Timely (30 day) handling of concerns and complaints | March | 38.0% | 32.0% | ↓ | 75% | 60% | ● | | 59.3% | 59.0% | 50.0% | 58.0% | 41% | 36% | 53% | 47% | 52% | 41% | 30% | 32% | 38% |
| STAFF AND RESOURCES | DNAS | Patients who dna - new opa - specific specialties | March | 5.90% | 6.70% | ↓ | reduce | 5.50% | ● | | 7.10% | 6.20% | 6.30% | 6.20% | 6.60% | 6.40% | 6.4% | 6.60% | 6.20% | 6.70% | 6.80% | 6.70% | 5.90% |
| | | Patients who dna - follow-up opa - specific specialties | March | 6.40% | 6.90% | ↑ | reduce | 6.20% | ● | | 7.50% | 6.80% | 7.30% | 6.50% | 6.80% | 6.50% | 6.8% | 7.60% | 6.60% | 6.90% | 6.80% | 6.90% | 6.40% |
| | W&OD | % PADR / medical appraisal in the previous 12 months | March | 77.05% | 69.89% | ↑ | 85% | 80.00% | ● | | 72.65% | 72.96% | 73.90% | 73.68% | 72.29% | 72.20% | 71.01% | 71.35% | 71.66% | 72.06% | 72.31% | 69.89% | 77.05% |
| | | Monthly % hours lost due to sickness absence | March | 5.05% | 5.61% | ↑ | 5% | 5% | ● | | 5.15% | 4.54% | 4.78% | 4.89% | 4.97% | 4.92% | 5.20% | 5.37% | 5.56% | 6.01% | 6.13% | 5.61% | 5.05% |
| SAFE CARE | HCAIS | Cases of e coli per 100k population (rolling 12m) | March | 86.14 | 66.65 | ↓ | ≤ 61 per | 55.6 | ● | | 54.42 | 76.5 | 78.6 | 74.98 | 64.5 | 98.77 | 77.1 | 56.4 | 87.48 | 32.25 | 62.1 | 66.65 | 86.14 |
| | | Cases of staph aureus per 100k pop (rolling 12m) | March | 26.04 | 26.62 | ↓ | ≤ 19 per | 17.0 | ● | | 32.25 | 26.4 | 34.3 | 20.83 | 32.25 | 16.13 | 27.08 | 38.3 | 27.08 | 28.22 | 14.02 | 26.62 | 26.04 |
| | | Clostridium difficile cases per 100k pop (rolling 12m) | March | 28.05 | 22.18 | ↓ | ≤ 25 per | 22.7 | ● | | 28.22 | 33.7 | 30.2 | 24.99 | 24.19 | 24.19 | 31.24 | 20.16 | 37.49 | 34.27 | 24.04 | 22.18 | 28.05 |
| | INCIDENTS | Patient safety solutions wales alerts and notices not assured on time | March | 4 | 4 | ↑ | 0 | 0 | ● | | 2 | 0 | 0 | 0 | 1 | 3 | 3 | 4 | 3 | 5 | 4 | 4 | 4 |
| | | % serious incidents assured on time | March | 66.0% | 56.0% | ↑ | 90% | 60.0% | ● | | 33.00% | 47.00% | 64.00% | 52% | 55% | 68% | 53% | 50% | 50% | 29% | 29% | 56% | 66% |
| | | Never events | March | 0 | 0 | ↑ | 0 | 0 | ● | | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| Efficiency & Productivity | Theatre | Theatre Utilisation (RGH) | March | 85.50% | 83.60% | ↑ | - | 85% | ● | | 106.3% | 80.2% | 85.0% | 85.4% | 84.5% | 86.0% | 81.5% | 85.2% | 87.9% | 80.0% | 82.20% | 83.6% | 85.50% |
| | | Theatre Utilisation (NHH) | March | 90.60% | 85.70% | ↑ | - | 85% | ● | | 86.4% | 91.8% | 90.9% | 88.5% | 89.7% | 87.8% | 88.2% | 86.6% | 88.4% | 90.4% | 85.10% | 85.7% | 90.60% |
| | Average LoS | Elective Surgical AvLoS (RGH) | March | 2.3 | 2.8 | ↑ | - | Improve | | | 3.0 | 2.9 | 3.0 | 2.7 | 2.7 | 2.5 | 2.7 | 2.5 | 2.5 | 2.8 | 2.5 | 2.8 | 2.3 |
| | | Elective Surgical AvLoS (NHH) | March | 2.8 | 3.3 | ↑ | - | Improve | | | 4.3 | 4.1 | 4.1 | 4.1 | 4.1 | 4.1 | 4.1 | 3.7 | 3.5 | 4.2 | 3.1 | 3.3 | 2.8 |
| | | Emergency Medical AvLoS (RGH) | March | 7.3 | 7.2 | ↓ | - | Improve | | | 8.0 | 8.0 | 7.7 | 7.1 | 7.0 | 6.5 | 7.0 | 6.9 | 7.4 | 6.8 | 8.4 | 7.2 | 7.3 |
| | | Emergency Medical AvLoS (NHH) | March | 7.3 | 7.2 | ↓ | - | Improve | | | 8.1 | 7.8 | 7.3 | 6.1 | 6.0 | 5.9 | 6.3 | 7.1 | 6.7 | 6.9 | 7.4 | 7.2 | 7.3 |
| | Readmissions | Readmission Rate Within 28 Days (CHKS) | February | 6.30% | 6.70% | ↑ | - | Improve | | | 11.2% | 11.2% | 10.8% | 10.8% | 10.8% | 10.6% | 11.4% | 10.4% | 10.3% | 9.8% | 6.7% | 6.3% | |
| | Cancellations | Elective Procedures Cancelled Due to No Bed | March | 107 | 94 | ↓ | - | Improve | | | 565 | 161 | 61 | 38 | 95 | 55 | 172 | 163 | 103 | 54 | 125 | 94 | 107 |

Trend Key

Achieving rating target and improved against previous reported position
Achieving rating target but deteriorated against previous reported position
Not achieving rating target but improved against previous reported position
Not achieving rating target and deteriorated against previous reported position

**Note, measures in blue font are provisional at this stage**

# Aneurin Bevan University Health Board

## Bed Plan Report

| **Executive Summary** |
|---|
| To update the Committee on progress with performance improvements/opportunities to reduce beds e.g. length of stay, readmissions, etc. and describe current operational plans to reconfigure the bed base, with required reductions, in preparation for Grange University Hospital (GUH). The report will also provide assurance on the progress with the delivery of efficiencies to include risks and issues. The report focusses on:<br><br>1. Planning - current bed base, and changes/assumptions towards GUH.<br>2. Performance – opportunities for greater efficiency presented within benchmarking information.<br>3. Operational - what divisions are doing from an operational perspective to deliver on both of the above, whilst maintaining a clear focus on quality, safety and patient experience.<br><br>Recommendation:<br><br>That the Finance and Performance Committee:<br>1. Note the contents of the report and assurances around improvement.<br>2. Note the issues that present risks to delivery.<br>3. Advise on any further actions that should be undertaken or explored to improve delivery of assurance. |

| **The Finance and Performance Committee is asked to:** (please tick as appropriate) | |
|---|---|
| Approve the Report | ✓ |
| Discuss and Provide Views | ✓ |
| Receive the Report for Assurance/Compliance | |
| Note the Report for Information Only | |

**Executive Sponsor:**
Nicola Prygodzicz, Director of Planning, Digital and IT
Claire Birchall, Director of Operations

**Report Author:** Alex Crawford, Senior Planning and Service Development Manager

**Report Received consideration and supported by :**

| **Executive Team** | | **Committee of the Board [Committee Name]** | |
|---|---|---|---|

**Date of the Report: 24th April 2019**

**Supplementary Papers Attached:**
**Appendix 1 – Grange University Hospital (GUH) Dependent Beds**
**Appendix 2 – Performance Comparisons - Bed day Opportunities showing ABUHB Average Length of Stay in 2018**
**Appendix 3 – Clinical Futures Modelling: Summary (20190**

## Background and Context

Initial modelling for Clinical Futures in December 2012, suggested that a reduction of 230 beds was achievable across the hospital system in Gwent, based on improved and agreed performance levels and a step down system of care centred around the proposed Specialist and Critical Care Centre. The analysis was informed by peer benchmarks, and agreed with Directorates. It was based on occupancy rates of 85% (emergency) and 90% (elective), but did not include growth beyond those levels.

Subsequent scrutiny for the Specialist Critical Care Centre ('SCCC') Full Business Case (FBC) in 2015 identified potential for a 259 bed reduction against a baseline of 1531 beds, thereby giving assurance to achieving the initial 230 bed reduction. This work included a provision for growth of an estimated 20 beds per year which was netted against an increase in occupancy from 85% to 90% for emergency and other performance improvements; took account of the impact of new clinical models and interventions; and reconciled the numbers to updated benchmarking data.

Of the opportunities identified, 86 beds were considered 'SCCC dependent' (appendix 1). The latter element (only) of the proposed bed reduction programme was included as a costed saving of £2.924m within the FBC (against an overall net recurring revenue cost of £744k for the entire FBC). In terms of profile the FBC shows those savings being realised immediately when the 'SCCC' opens as the majority are achieved through centralisation.

**Current status and assumptions towards GUH**

ABCi undertook a review of the planning assumptions in 2018, using Simulation software to model the impact of the 230 bed reductions required. It was concluded that the reduction was achievable. However, without significant changes in the flow of patients through the system, including the transformation required in primary care and availability of social care capacity, there would be a detrimental impact on secondary care performance (illustrated by a projected 4 hour and 12 hour performance outcome).

Since 2015 there have been factors influencing the ability to change bed configuration and bed numbers, including:

- Whilst investment has been made in areas such as EFU and Acute Care Physicians to manage assessments and ambulatory care to manage out demand through medical assessment there has been a year on year growth of surgical assessments converting to admissions.
- Our ability to discharge patients in a timely fashion is compromised by lack of capacity in social care, inability to deliver model ward processes and staffing (medical and nursing) in secondary care.

An audit of beds as at November 2018 showed bed numbers are almost the same as the 2015 IMTP baseline at 1532 total but within the overall number there has been some Divisional variance:

- Unscheduled care beds have increased by 39;
- Scheduled care bed numbers are the same as the 2015 IMTP baseline;
- Primary and community beds have reduced by 17;
- Family and therapies reduced by 20 beds
    - Gynaecology beds have reduced by 16, theoretically reaching their 2021 target. This was achieved by converting the beds to medicine rather than performance improvement.

It should also be noted that there are strong seasonal peaks in bed in use. Business Intelligence showed 1593 beds open in February 2019 to address winter pressures.

Assumptions towards GUH opening have not changed significantly, however the focus of the Clinical Futures Programme is on the 86 beds that are GUH dependent. The remaining 144 beds are to be reduced through IMTP service changes, productivity and efficiency.

Current lengths of stay (LoS) per specialty, based on 2018 Performance Comparisons, can be seen in summary in Appendix 2. As a Health Board we focussed on LoS during the winter period to enable the extra bed capacity required, but in the context that workforce might not be available to staff additional beds. Furthermore, in order to achieve GUH and IMTP bed reductions, without changing occupancy assumptions, length of stay reduction is critical. Whilst the overall (admitted) lengths of stay across the Health Board appear to be in a good position (Table 1), the performance comparisons against top performing hospitals in appendix 2 are key to understanding where the Health Board has further opportunities over the next 2 years.

**Table 1**

| source = CHKS | | 2016 | 2017 | 2018 | trend is improving | better than wales |
|---|---|---|---|---|---|---|
| ALOS | abuhb | 3.54 | 3.27 | 3.21 | ✓ | ✓ |
| | rest of wales | 4.32 | 4.25 | 4.13 | | |
| ALOS excluding zero los | abuhb | 7.71 | 7.32 | 7.27 | ✓ | ✓ |
| | rest of wales | 9.03 | 8.96 | 8.90 | | |

In 2017 focussed cross cutting work on organisational capacity included changes to MAU, flow and the model ward processes in RGH and NHH particularly. This yielded performance improvements in 4 hour and 12 hours over the summer of 2017, and allowed RGH to eliminate the use of corridors in ED as recommended by Health Inspectorate Wales. It also supported the switch of bed capacity between gynaecology and medicine noted above. However, the Complex Discharge Review by NHS Wales Delivery Unit in 2018 has highlighted continuing difficulties in discharge processes, and Model Wards have been difficult to sustain within the current staffing context.

Despite this, there have been some small but tangible improvements in the latter part of the financial year through a challenging winter, notably:

- **Elderly Frail Unit** expansion – latest phase of expansion has reduced ward LOS for EFU and COTE patients admitted to floor 4 of RGH to 6days (as at 1st April 2019)*. The target opportunity is to reduce this to 5 days with the introduction of ambulatory care on D4W which was opened in March 2019.
- **Surgical assessment** capacity and hot clinics – trialled over winter there has been a reduction in assessment lengths of stay and increase in assessed out rates. This is early days and a full evaluation of this model has been built into Service Change Plan 5 in the IMTP, to track continued progress in 2019.
- Receiving unit for **GP expected patients** providing an appropriate environment for GP referred orthopaedic patients was established taking pressure off ED for that cohort of patients and this will support developments along the fractured Neck of Femur pathway.
  *median ward LOS based on 13 monthly data points

Whilst the Health Board is generally good at assessing patients out (around 60% of assessments are assessed out), there has been an increase in 7 day, 14 day, 28 day and 30 day readmissions, in the context of increasing admissions and this compares unfavourably against the rest of Wales as can be seen in Table 2 below. There had been improvements in the conveyance rates of nursing home residents as a result of the support provided to care homes in 2018 and the focus on Advanced Care Planning. However, conveyances increased over the latter part of winter in 2019.

It should also be noted that developments in Ambulatory Care in several specialties, Virtual Inpatient (VIP) services for diagnostics and hot clinics for pre-streamed GP referrals could result in an increase in re-admission rates. However this should not increase the overall length of stay of the patient, so efficiency opportunities should remain.

**Table 2**

| source = CHKS | | 2016 | 2017 | 2018 | trend is improving | better than wales |
|---|---|---|---|---|---|---|
| Readmissions (7day) | abuhb | 5.55 | 5.69 | 5.90 | ✗ | ✗ |
| | rest of wales | 4.32 | 4.58 | 4.65 | | |
| Readmissions (14day) | abuhb | 7.76 | 7.98 | 8.07 | ✗ | ✗ |
| | rest of wales | 6.08 | 6.42 | 6.50 | | |
| Readmissions (28day) | abuhb | 10.39 | 10.65 | 10.77 | ✗ | ✗ |
| | rest of wales | 8.31 | 8.73 | 8.79 | | |
| Readmissions (30day) | abuhb | 10.67 | 10.91 | 11.06 | ✗ | ✗ |
| | rest of wales | 8.54 | 8.98 | 9.04 | | |

Benchmarking in section 4 below shows that there are opportunities around readmissions in all secondary care divisions and section 5 sets out plans for delivering

improvement in frequently re-attending and re-admitting groups including focussed work with care homes.

**Performance/Benchmarking – Opportunities for bed reduction**

Further modelling by the Clinical Futures team in March 2019 presents an up to date assessment of the opportunities based on:

- Bed occupancy averaged at 87.3% (this is the percentage bed occupancy reported to WG);
- The current allocation of wards/beds to specialties – an average of beds allocated in 2018/19;
- The predicted bed capacity required for the existing configuration of services and sites assuming current average length of stay performance. This is based on activity rather than the allocation of physical beds (thus removing any issues of outliers, shared accommodation, etc.) – this suggests the capacity actually required to meet current demand;
- The predicted bed capacity required post GUH opening and service changes e.g. inpatient surgery at RGH, but with current average lengths of stay;
- The predicted bed capacity, matching the best quartile average length of stay performance of the CHKS Top 40 Hospitals;
- The predicted bed capacity, matching the mean average length of stay performance of the CHKS Top 40 Hospitals.

The full tables can be seen in Appendix 3. The modelling shows that by achieving upper quartile length of stay performance the original bed reductions (1301 beds total) is achievable. However whilst this modelling is indicative of opportunities for total bed numbers, there is variance in terms of the configuration for GUH and network of enhanced local general hospitals developed through Service Redesign and the signed off Models of Care. The modelling for GUH beds varies from the FBC by 62 beds and from Models of Care requests for beds at GUH by 87 beds (notably the calculation around Neonatal cots varies significantly from the number required in the FBC). Therefore, a pragmatic approach will need to be taken to agree the final bed configuration through the implementation and transition period.

To support the current IMTP financial planning and performance monitoring, undertaken by Corporate Finance teams utilising CHKS and other benchmarking information, has identified areas for efficiency and estimates the associated financial or value opportunity. It is important to note that these are potential opportunities and not always cash releasing opportunities, as the ability to close beds depends on a number of factors, including demand, staffing ratios, flow, operational performance and patient safety.

Key areas of opportunity highlighted by the benchmarking are within the following work types and specialities:

| | Potential Unit Savings | £,000 |
|---|---|---|
| **Operational Efficiency:** | | |
| Non Elective ALOS - 6 beds General Surgery/ 1 bed Urology, ENT, Eyes/ 9 beds Anaesthetics | 17 beds | 842 |
| Elective. ALOS - 9 beds T&O/ 2 beds Dermatology | 11 beds | 545 |
| Pre op - 4 beds General Surgery / 5 beds T&O | 9 beds | 446 |
| Non Elective ALOS - CHKS/Top 5 opps:<br>Gastroenterology = 6 beds/ 0 beds<br>Endocrinology = 19 beds/ 6<br>Cardiology = 8 beds/ 11 beds<br>Respiratory = 3beds/ 0 beds<br>Infectious Diseases = 6 beds/4 beds<br>Geriatric Med (COTE) = 23 beds/ 41 beds | 65 beds | 3,218 |
| Pre Op Gynae | 2 beds | 99 |
| Non Elective ALOS (Obs 5 beds/ Gynae 1 bed) | 6 beds | 297 |
| NHSBN Report - Older Adult bed reductions - Benchmarking Club report | 15 beds | 743 |
| Older adult Inpatient ALOS - exceeding the 27.6 days by between 6 and 15 days on average by site: NHSBN report | 22 beds | 1,089 |
| Non Elective ALOS - GP Other | 13 beds | 620 |
| **Day Surgery/DOSA:** | | |
| DOSA - 3 beds T&O / 1 bed GS | 4 beds | 198 |
| Day Case Rates - 2 beds GS/ 2 beds ENT | 4 beds | 198 |
| **Readmissions:** | | |
| SC | 2083 bed days | 312 |
| F&T | 4592 bed days | 689 |
| USC | 1401 bed days | 210 |
| **TOTAL** | **192beds** | **9,506** |

The benchmarking opportunities would support the bed numbers identified in ABCi and recent Clinical Futures team re-modelling, as well as the original Clinical Futures FBC bed reduction requirement. However this is reliant on a series of actions within Divisional and Health Board IMTPs and whilst growth had been factored into the original planning, secondary care continues to experience operational pressure which has not been mitigated by an increase in occupancy. Therefore, over the past two years any gain in efficiency has either improved operational performance (in 2017) or mitigated worsening performance (winter 2018/19).

## Operational Delivery Plans

There are a number of plans for the operational delivery of efficiencies and bed reconfiguration over the next 2-3 years towards GUH opening within IMTPs. These are summarised as follows:

| Area | Plan | Potential impact | Status |
|---|---|---|---|
| Urgent and Emergency Care | **Elderly Frail Unit expansion** and ambulatory care<br>Providing comprehensive geriatric assessments at the front door and in ambulatory setting to improved assessment length of stay with overall impact on Care of the Elderly (COTE) Lengths of stay on D4E and D4W (54 beds excluding ambulatory care trolleys and chairs) | COTE Ward LOS reduction from 6days to 5 days<br><br>Needs to be fully evaluated but based on 90% occupancy ward bed days saved could equate to 1300 (estimated at £197k at £150 per day) | 7 day service and ambulatory bay in place, small gain in LOS seen, but need to reduce breaches in ambulatory care to achieve full impact |
| | **Ward processes**<br>Re-establishing Model Ward where staffing allows<br>Focus on Expected Date of Discharge compliance<br>Fully compliant with "SAFER" bundle across the Health Board | Improvement in Lengths of Stay towards identified benchmarking opportunities | Discharge Improvement Board set up in May 2019 to provide focus as per IMTP |
| | **Ambulatory Care**<br>Maximising ambulatory care to prevent longer term admissions | Admission avoidance – to be quantified | Ambulatory care in place in RGH and NHH<br>Q1 will see a focus on meeting national guidance and principles |
| | **HCP Call Handling**<br>Part of a wider Clinical Futures programme of work to establish Urgent Care Hubs linked to seamless primary care in and out of hours services and 111 implementation<br>Senior clinical call handling to stream patients pre-hospital to the most appropriate pathways<br>Working with WAST to schedule the arrival of patients for assessment, to avoid overnight stays in assessment units<br>Development of hot clinics to stream patients more effectively | Admission avoidance and reduction in assessment lengths of stay<br><br>Financial impact would need to be evaluated at the end of the pilot | Evaluation of project to inform wider plan for Clinical Futures Urgent Care system – due by end Q2 |
| | **GUH Dependent beds**<br>Centralised acute medical services and improved medical pathways across the urgent care system | Reduction of 15 beds<br><br>Financial impact as per SCCC FBC (section 3 above) | As per GUH timescales |
| Diabetes | **Approved investment in Diabetes** services to be implemented in 2019<br>Consultant and Diabetes Nurse Specialists to | 1 day ALOS reduction – value opportunity of £616k | 1x Consultant and DSNs appointed – this |

| | | | |
|---|---|---|---|
| | fully embed ThinkGlucose™ training<br>Health Care Support Workers to provide "one stop shop" annual reviews for patients with Type 1 diabetes and complex patients ("Super Seven" patients)<br>Further support seamless provision across primary and secondary care to support care closer to home | *This applies to all medical and surgical inpatients who have diabetes rather than Endocrinology specialty* | 3x DSNs appointed<br><br>2019/20 plan – programme of education and full roll out of ThinkGlucose™ |
| Gynaecology and Obstetrics | **GUH dependent beds**<br>Centralisation of Obstetric service<br>Centralisation of Gynaecology service<br>Centralisation of Paediatric service (netted off against increase in Neonatal capacity)<br><br>Enabled by:<br>Pre streaming, access to expert advice, improved direct access to some patient cohorts.<br>Introduction and testing of short stay beds to increase patient flow.<br>Active participation in Primary Care plans for hubs and the role of paediatrics.<br>Identification of below NICU threshold babies that can be managed outside the neonatal ward in a maternity environment (transitional cots).<br>Introduction of a step up and step down pathway in neonates. | Reduction of 33beds | As per GUH timescales |
| | **eLGH Reconfiguration**<br>RGH = 6 Gynae inpatient beds<br>YYF = 1 Gynae inpatient bed<br>NHH – 2 x Midwifery Led Unit inpatient beds<br>YYF – 4 x Midwifery Led Unit inpatient beds<br>YAB and RGH – PODs = zero inpatient beds<br><br>Enabled by:<br>Ambulatory gynaecology rather than theatre<br>Increase focus on laparoscopic and new gyanae interventions in conjunction with new primary care pathways for heavy menstrual bleeding to reduce number of hospital contacts for a patient.<br>Focus on pre streaming and mechanisms that reduce emergency gynaecology flow into ED, pre streaming, GP access to expert advice, WAST direct access to EGAU.<br>Modelling of changes to patient flow into MLUs as a result of centralisation of obstetrics.<br>Increased focus on public health intervention and review of maternity pathways as well as introducing ERAS etc.<br>Introduction of SKYPE between MLUs and Obstetric wards to reduce unnecessary transfers. | Optimum use of beds delivering productivity and efficiency in the context of "care closer to home"<br><br>Financial impact as per SCCC FBC (section 3 above) | eLGH configuration as per eLGH project and GUH timescales.<br><br>Timescales for enabling plans to be determined over next 2 years |
| Surgical pathways | **Pathways include:**<br>Fracture Neck of Femur pathways<br>Development of a unified Breast Unit on YYF site | Reduction in length of stay (to be quantified using | Updated NOF pathways to be established by end |

| | | | |
|---|---|---|---|
| | Extended rehabilitation at RGH (step down) | benchmarking opportunity as a guide) | Q4 2019/20<br><br>Breast as per project timescales |
| | **GUH Dependent beds**<br>Centralisation of Emergency General Surgery service<br>Centralisation of Trauma unit<br>Improved streaming and protection of Elective Surgery<br>Improved DOSA rates<br>Improved Day Surgery rates | Reduction of 38 beds<br><br>Financial impact as per SCCC FBC (section 3 above) | As per GUH timescales |
| Primary Care Transformation | **Compassionate Communities**<br>Focus on the social relationships that support people to stay well in the community based around a network of wellbeing hubs | Admission avoidance – Frome saw up to 30% reduction in Emergency Admissions*<br><br>**Frome numbers were small and this project is in its infancy and is a proof of concept project* | Compassionate Communities support in place, recruitment to Transformation Fund posts ongoing<br><br>Next update on progress at July Urgent Care Board |
| Graduated Care (step up) | **Community Frailty Units**<br>Step up care, providing an ambulatory care model for exacerbation of existing conditions that do not require acute medical input<br>Access to community beds for overnight observation<br>Care provided under the frailty consultants to ensure patients not admitted to acute system | Admission avoidance (to be quantified) | CFUs have been established at both County Hospital (Cedar) and YAB (Sirhowy) - Since November 2018, 292 contacts have taken place in the Cedar Unit. (YAB data pending) |
| Frequent Attenders | **Frequent attenders posts**<br>Substantiate the Alcohol Care Team to co-ordinate consistent care for people with alcohol dependency (inpatients, outpatients and ED attendances, working closely with ED frequent attenders co-ordinator.<br>ED Frequent attender post to co-ordinate the holistic care needs of the top (re)attending patients at ED<br>Care Home Frequent Attenders work, working with Care Home Development team around top attending individuals from care homes and top referring care homes to support people to remain in the home to have their care needs met | Awaiting outcome of Value Team report to quantify the benefits of Alcohol Care Team<br><br>Reduction in Care Home conveyances and readmissions – to be quantified as part of winter evaluation | Alcohol Care Team business case to be presented at PIP<br><br>ED post recruited to, baseline measures and benefits measurement required<br><br>Care Home post well established. Some improvement through Winter but increase in conveyances in March resulting in admissions |

## Assessment and Conclusion

## Issues/Risks

The risks and known issues are largely unchanged since the FBC and IMTP baseline in 2015. These are as follows:

| Risk/issue | Mitigation |
|---|---|
| Length of stay reductions not achieved | Bed capacity available at eLGHs<br>Implementation of new models of care and transformational change in primary and community care |
| Staffing - Inability to recruit to additional posts | **Significant workforce planning is being undertaken for all models of care**<br>Prospective staged recruitment and innovative use of new healthcare roles such as Advanced Paramedic Practitioners and Physician Associates |
| Bed occupancy is not uniformly 87.3% - for example paediatric beds should ideally be based on an occupancy of 65-70%. | Pragmatic approach to agreeing final configuration of beds at GUH based on service level modelling |
| Loss of social care capacity due to financial pressure | Active engagement with LA & third sector partners & development of alternatives<br>Transformative models such as Home First |
| Growth assumptions exceeded, including increased throughput in community hospitals | Increased emphasis on Prudent Healthcare to manage gaps and maximising the opportunities that the Value Based Healthcare team can offer<br>Confirmation of community bed numbers required in the context of primary care transformation |
| Step down model of care has potential to increase LOS | Potential to increase occupancy & reduction in demand due to regionalised/networked services such as vascular & major trauma |
| Patient flows not in accordance with modelling | HCP call handling and pre-hospital streaming linked to 111 and primary care in and out of hours triage to ensure patients access the Right Care, First Time |
| Readmissions, mortality and other quality indicators have not been factored in to the calculation of the latest modelling | Operating a Prudent Healthcare model, with a clear focus on safety and quality |

## Conclusion

This paper has provided an update on progress with performance improvements/opportunities to reduce beds e.g. length of stay, readmissions, etc. and described current operational plans to reconfigure the bed base, with required reductions, in preparation for GUH.

Modelling shows that the planned assumptions in the FBC are achievable but with a range of models to demonstrate the impact of not improving productivity and efficiency to CHKS upper quartile. This is supported by financial opportunities that have been identified through CHKS and other benchmarking analysis.

Divisions are working with Clinical Futures Team around the implementation of models of care for the transition to the Grange University Hospital and IMTPs include a range of service changes, service developments and transformation required to achieve the additional opportunities. There are known risks and issues which need to be mitigated

through the workforce, service change and transformational plans being delivered at pace over the next two years.

**Recommendation**

It is recommended that the Finance and Performance Committee takes the following action:

1. Note the contents of the report and assurances around improvement.
2. Note the issues that present risks to delivery.
3. Advise on any further actions that should be undertaken or explored to improve delivery of assurance.

| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | Risk and Issue management is a core component of this report. |
| ***Financial Assessment, including Value for Money*** | The potential financial impact of benchmarking opportunities have been provided in detail in this report |
| ***Quality, Safety and Patient Experience Assessment*** | Urgent Care Board will develop a greater emphasis on Quality, Safety and Experience as the Benefits Management of SCP5 develops. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | There is no anticipated negative impact on protected groups or children. Detailed EAIs are developed through Clinical Futures and Business Planning. |
| **Health and Care Standards** | The IMTPs and Clinical Futures programme supports the delivery of Health and Care Standards |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | IMTPs and Clinical Futures programme describe the delivery of workforce/service change, development and transformation. |
| **The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working** | The range of activities outlined in the report will contribute in the Health Board's approach to the Well Being of Future Generations Act. Planning and will ensure the Health Board maximises the effective use of NHS resources by excellent communication, monitoring and tracking systems in all clinical areas. |
| **Glossary of New Terms** | No new terms have been identified. |
| **Public Interest** | This report is written for the public domain. |

## Appendix 1 - GUH Dependent Beds

| DIVISION | ENABLER | BEDS |
|---|---|---|
| | | |
| Family & Therapies | Centralisation of Obstetric service | -17 |
| Family & Therapies | Centralisation of Gynaecology service | -16 |
| Family & Therapies | Centralisation of Paediatric service | -8 |
| Family & Therapies | Expansion of Neonatal capacity | 8 |
| Scheduled Care | Centralisation of EGS service | -8 |
| Scheduled Care | Centralisation of Trauma service | -12 |
| Scheduled Care | Improved streaming and protection of Elective Surgery | -10 |
| Scheduled Care | Improved DOSA rates | -3 |
| Scheduled Care | Improved Day Surgery rates | -5 |
| Unscheduled Care | Reduced re-admissions / Alcohol pathway | -15 |
| | | |
| **Total** | | **-86** |

# Appendix 2 – Performance Comparisons – Bed day Opportunities showing ABUHB Average Length of Stay in 2018

| ELECTIVE INPATIENTS - Average Length of Stay (excludes 0 los) - Bed Day Opportunity (BDO) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Specialty - ELECTIVES** | **Total Days** | **ABUHB Spells** | **ABUHB ALoS** | **Wales ALoS** | **Top Hospitals ALoS** | **Wales BDO** | **TH BDO** | **performance change** |
| All (including minor specialties) | 33332 | 10089 | 3.30 | 4.06 | 3.89 | | | -0.1 |
| 100 - General Surgery | 7880 | 2306 | 3.42 | 4.69 | 4.16 | | | 0.0 |
| 101 - Urology | 1937 | 965 | 2.01 | 2.65 | 2.42 | | | -0.4 |
| 110 - Trauma & Orthopaedics | 15810 | 3823 | 4.14 | 3.87 | 3.60 | 1021 | 2036 | 0.0 |
| 120 - ENT | 1288 | 995 | 1.29 | 1.83 | 1.77 | | | -0.2 |
| 130 - Ophthalmology | 117 | 98 | 1.19 | 1.51 | 1.81 | | | -0.3 |
| 140 - Oral Surgery | 419 | 112 | 3.74 | 3.71 | 2.62 | 4 | 125 | -1.6 |
| 191 - Pain Management | 4 | 4 | 1.00 | 1.50 | 1.70 | | | -0.2 |
| 300 - General Medicine | 2 | 1 | 2.00 | 6.33 | 8.10 | | | -11.7 |
| 301 - Gastroenterology | 987 | 218 | 4.53 | 6.53 | 4.43 | | 21 | -1.0 |
| 302 - Endocrinology | 14 | 4 | 3.50 | 3.27 | 4.87 | 1 | | 0.3 |
| 303 - Haematology (Clinical) | 13 | 5 | 2.60 | 10.95 | 10.43 | | | -2.7 |
| 320 - Cardiology | 345 | 70 | 4.93 | 3.32 | 2.59 | 112 | 163 | -1.8 |
| 330 - Dermatology | 1111 | 112 | 9.92 | 14.00 | 12.49 | | | -1.2 |
| 340 - Respiratory Medicine | 556 | 166 | 3.35 | 6.61 | 6.10 | | | 0.0 |
| 420 - Paediatrics | 310 | 70 | 4.43 | 4.77 | 4.14 | | 20 | 0.0 |
| 502 - Gynaecology | 2531 | 1136 | 2.23 | 2.64 | 1.90 | | 371 | 0.0 |

| NON-ELECTIVE INPATIENTS - Average Length of Stay (excludes 0 los) - Bed Day Opportunity (BDO) | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Specialty - NON-ELECTIVES** | **Total Days** | **ABUHB Spells** | **ABUHB ALoS** | **Wales ALoS** | **Top Hospitals ALoS** | **Wales BDO** | **TH BDO** | **performance change** |
| All (including minor specialties) | 490495 | 62250 | 7.88 | 9.75 | 6.23 | | 102639 | 0.0 |
| 100 - General Surgery | 39620 | 6738 | 5.88 | 6.47 | 5.54 | | 2294 | -0.2 |
| 101 - Urology | 6471 | 840 | 7.70 | 5.87 | 4.53 | 1543 | 2662 | 0.2 |
| 110 - Trauma & Orthopaedics | 37159 | 4089 | 9.09 | 11.92 | 9.87 | | | -0.5 |
| 120 - ENT | 2563 | 831 | 3.08 | 3.29 | 2.73 | | 297 | 0.0 |
| 130 - Ophthalmology | 556 | 64 | 8.69 | 5.72 | 6.05 | 190 | 169 | 1.2 |
| 140 - Oral Surgery | 554 | 217 | 2.55 | 3.05 | 2.98 | | | 0.0 |
| 180 - Accident & Emergency | 5277 | 2421 | 2.18 | 4.49 | 3.42 | | | 0.0 |
| 190 - Anaesthetics | 5224 | 354 | 14.76 | 19.59 | 11.44 | | 1175 | 0.7 |
| 300 - General Medicine | 125853 | 18902 | 6.66 | 9.69 | 6.72 | | | 0.2 |
| 301 - Gastroenterology | 11254 | 1067 | 10.55 | 13.61 | 11.87 | | | -0.1 |
| 302 - Endocrinology | 13944 | 1163 | 11.99 | 10.82 | 10.52 | 1356 | 1707 | -1.0 |
| 303 - Haematology (Clinical) | 2947 | 283 | 10.41 | 10.87 | 10.09 | | 92 | 0.9 |
| 314 - Rehabilitation | 90371 | 2939 | 30.75 | 50.43 | 37.68 | | | -0.1 |
| 320 - Cardiology | 13098 | 1502 | 8.72 | 8.17 | 7.55 | 826 | 1759 | 0.5 |
| 330 - Dermatology | 468 | 52 | 9.00 | 21.57 | 11.09 | | | -2.8 |
| 340 - Respiratory Medicine | 17644 | 1847 | 9.55 | 10.36 | 9.52 | | 66 | 0.0 |
| 350 - Infectious Diseases | 4032 | 297 | 13.58 | 17.30 | 16.14 | | | -0.4 |
| 410 - Rheumatology | 4 | 2 | 2.00 | 7.31 | 8.18 | | | 1.0 |
| 420 - Paediatrics | 18699 | 5923 | 3.16 | 3.30 | 3.15 | | 59 | 0.1 |
| 430 - Geriatric Medicine | 53539 | 3807 | 14.06 | 24.85 | 12.59 | | 5612 | -0.3 |
| 501 - Obstetrics | 15467 | 5617 | 2.75 | 2.78 | 2.58 | | 977 | 0.01 |
| 502 - Gynaecology | 3743 | 1464 | 2.56 | 2.81 | 2.44 | | 167 | 0.16 |
| 560 - Midwife Episode | 1881 | 1215 | 1.55 | 2.35 | 1.90 | | | 0.02 |
| 620 - General Practice (Other) | 8997 | 218 | 41.27 | 31.84 | NA | 2056 | NA | 0.9 |

## Appendix 3 – Clinical Futures modelling: summary (2019)

| Beds | Table 1 (Current allocation, ave Apr 18- Mar 19) | Table 2 (Current LOS, activity based) | Table 3 (As table 2, with GUH beds) | Table 4 (GUH, upper ¼ CHKS LOS) | Table 5 (GUH, mean CHKS LOS) | *GUH* Models of Care Requested beds* | *Variance to Upper 1/4* |
|---|---|---|---|---|---|---|---|
| General Surgery | 151 | 151 | 150 | 121 | 141 | *64* | |
| Urology | 18 | 28 | 27 | 17 | 19 | *8* | *-2* |
| Trauma & Orthopaedic | 185 | 162 | 161 | 135 | 153 | *59* | *-12* |
| ENT | 9 | 14 | 13 | 11 | 13 | *7* | *2* |
| Ophthalmology | 8 | 3 | 3 | 2 | 2 | | |
| Oral Surgery | 1 | 4 | 4 | 3 | 3 | *3* | |
| Accident & Emergency | 16 | 16 | 15 | 15 | 15 | *16* | *-1* |
| Anaesthetics (Critical Care) | 25 | 16 | 16 | 13 | 13 | *28* | *-15* |
| Acute Medicine | 96 | 380 | 380 | 364 | 378 | *32* | *-5* |
| Gastroenterology | 41 | 47 | 47 | 45 | 46 | *32* | *4* |
| Diabetes & Endocrinology | 47 | 53 | 53 | 40 | 40 | | *2* |
| Haematology (Clinical) | 12 | 10 | 10 | 9 | 9 | *16* | *-7* |
| Rehabilitation | 243 | 284 | 285 | 196 | 272 | | |
| Rehabilitation Stroke | 46 | | | | | | |
| Cardiology | 70 | 41 | 40 | 31 | 36 | *24* | *7* |
| Dermatology | | 7 | 7 | 2 | 7 | | *1* |
| Respiratory Medicine | 88 | 60 | 61 | 55 | 61 | *32* | *-8* |
| Infectious Diseases | | 14 | | 2 | 14 | | *2* |
| Neurology | | 4 | | 4 | 4 | | *4* |
| Rheumatology | | 1 | | 1 | 1 | | *1* |
| Paediatrics | 58 | 59 | 59 | 49 | 59 | *56* | *-7* |
| Neonates | 32 | | | | | *37* | *-37* |
| Care of the Elderly | 212 | 84 | 84 | 48 | 57 | | |
| Continuing Care | 15 | | | | | | |
| Obstetrics | 67 | 51 | 50 | 42 | 46 | *51* | *-9* |
| Gynaecology | 28 | 21 | 21 | 17 | 19 | *21* | *-10* |
| Midwifery | 20 | 8 | 10 | 9 | 10 | | *6* |
| GP Other | 30 | 32 | 32 | 32 | 32 | | |
| Community Medicine | 44 | 36 | 36 | 36 | 36 | | |
| **TOTAL** | **1562** | **1586** | **1583** | **1299** | **1486** | ***486**** | ***-84*** |

*Bed capacity at GUH as per FBC = 464 beds

2.6

Finance and Performance Committee
1st May 2019
Agenda Item: 2.6

# Aneurin Bevan University Health Board

## Value Based Healthcare and the impact on delivery of services

### Executive Summary

| **The Committee is asked to:** (please tick as appropriate) | |
|---|---|
| Approve the Report | |
| Discuss and Provide Views | ✓ |
| Receive the Report for Assurance/Compliance | ✓ |
| Note the Report for Information Only | |

**Executive Sponsor:** Glyn Jones, Director of Finance & Performance

**Report Author:** Glyn Jones, Director of Finance & Performance

**Report Received consideration and supported by :**

| **Executive Team** | | **Committee of the Board [Committee Name]** | **Finance & Performance Committee** |
|---|---|---|---|

**Date of the Report: 18th April 2019**

**Supplementary Papers Attached:**
Appendices 1-3

### Purpose of the Report

***To outline the work plan for the Value Based Health Care Programme, including resource savings and how these are impacting on the delivery of services.***

**Background**

The Health Board embarked on its value based approach to health improvement and healthcare delivery during 2014/15 financial year. Appendix 1 provides links to further information on the value based health care approach and the "case for change". Initially, the approach comprised:

- Identifying senior level commitment – Board, Executive Director sponsorship,
- Appointment of an Assistant Medical Director lead on value based health care – to champion the principles, build relationships and clinical engagement, and
- Identifying a patient pathway (Parkinson's Disease) to test the feasibility of collecting outcomes.

Since that time, the Value Based Health Care Programme has grown to include:

- A Virtual Value Team – programme/project management, clinical and costing/ business intelligence support,

- Procurement of an IT platform (DrDr) – to enable collection of outcomes at scale, and
- Support process mapping, collection of outcomes and costing of pathways across a number of conditions.

**2018/19 Value Programme**

In 2018/19 the formal project management structure around value based health care was enhanced, with a view to scaling up the approach, with a work plan agreed by the Executive Team in May 2018. This formalised some of the Programme Management and accountability arrangements and agreed a work plan which would support the following 18 projects:

1. Cataracts
2. Parkinson's Disease
3. Inflammatory Bowel Disease
4. Psoriasis
5. Foot and Ankle
6. Pulmonary Rehabilitation
7. Epilepsy
8. Lung Cancer
9. Ankylosing Spondylitis
10. Pleural disease
11. Myeloma
12. Alcohol Liaison Service
13. Urinary Flow
14. Hips and knees
15. Memory Assessment Service (Dementia)
16. Heart Failure
17. ICU
18. Adult weight management

**Using Technology**

The Value Programme uses a digital platform (DrDoctor) to enable electronic collection of patient outcomes, linked to patient care. This allows remote data collection as well as collection of outcomes in-clinic and avoids manual collection – providing the potential to collect outcomes at scale.

The Health Board also uses the DrDoctor system to share key information with patients and send appointment reminders by SMS or e-mail.

The integration of PROMs data collection, using the same system, means that patients become familiar with it and also understand that responding is part of their overall care. The data allows clinicians to have patient-led discussions about the care and outcomes which matter to patients.

Appendix 2 provides a summary of 6 of the value based projects, outlining:

- The aim/scope of the project, and
- Impact on delivery of services, patients and staff.

**Benefits**

The value based health care approach aims to improve outcomes for patients making best use of resources. The examples identified are reporting:

- Changes in services to improve access and avoid unnecessary patient appointments/travel time,
- More appropriate use of clinic/clinical time
- More appropriate prescribing, and
- More efficient use of clinical resources including improved productivity.

Many of the projects piloted are in areas where there is increasing demand for services (e.g. ophthalmology, dementia, IBD, etc.). Therefore, the improved productivity/use of resources is being demonstrated through cost avoidance as opposed to cash releasing savings – "bending the cost curve". For example:

- Ophthalmology – cataracts: outsourcing a further 162 cases would cost c£160k, and
- Heart failure – the opportunity staff cost/saving is c£11k.

The spend incurred on the Value Team was c£358k during 2018/19.

Further details on the Value Based Health Care programme can be found using the link in Appendix 3.

**2019/20 Value Programme**

The Value Programme has a joint executive lead (Medical Director and Director of Finance & Performance), reports to the Executive Board and provides further assurance through the Quality Patient Safety Committee. As some of the projects progress, programme governance is being enhanced to ensure that clinical, information and financial governance are fully satisfied before rolling out pilot projects. This will be undertaken through a Value Steering Board reporting to the Executive Board.

The Programme for the current year is being finalised with a number of potential projects being considered, including:

- Diabetes,
- Expanding the work on dementia to include the pathway within community and inpatient settings,
- Children and young people's mental health,
- Prostate cancer,
- Stroke,
- Chronic Obstructive Pulmonary Disease (COPD),
- Colorectal Cancer, and
- Adult autism – health and social care.

The approach going forward will be to align work on both costing and collecting outcomes along the pathway/condition for each project, so that value can be derived and improvements measured.

Evaluation and rollout (where appropriate) will be managed through the Programme governance arrangements described, with a view to "handing back" projects where they have demonstrated improved value and changes have been implemented and become part of "business as usual". This will allow the Programme Team to move on and support further projects.

| **Recommendation** |
|---|
| **The Committee is asked to note this report.** |

| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The Value Programme has governance arrangements in place to assess and manage risk. The value based approach supports the achievement of value-for-money which is highlighted in the risk register. |
| ***Financial Assessment*** | A value based approach to healthcare delivery should support improved value for money, making best use of available resources. |
| ***Quality, Safety and Patient Experience Assessment*** | The Value Based Programme aims to improve outcomes for patients, including the provision of safe services. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | There are no implications for Equality and Diversity impact. |
| **Health and Care Standards** | Value based healthcare aims to maximise outcomes for patients making best use of resources. The Programme contributes to the delivery of all the Standards. |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | The Value Based Programme is a key approach within the Health Board's approved IMTP. |
| **The Well-being of Future Generations (Wales) Act 2015 –<br>5 ways of working** | The Value Based Programme aims to deliver against the five ways of working:<br>• Long Term: improving outcomes for patients includes delivering care which improves long-term health.<br>• Integration: improving outcomes for patients requires services to operate in an integrated way.<br>• Involvement: collection of outcomes enables patients and clinicians to discuss and jointly agree the appropriate care<br>• Collaboration: Delivery of care along pathways requires individuals, teams and organisations to work collectively<br>• Prevention: improving outcomes requires appropriate preventative care to be considered and made available. |

| | |
|---|---|
| **Glossary of New Terms** | *COPD – Chronic Obstructive Pulmonary Disease*<br>*IBD – Inflammatory Bowel Disease*<br>*ICU – Intensive Care Unit*<br>*IMTP – Integrated Medium Term Plan*<br>*PROM – Patient Reported Outcome Measure*<br>*SMS – Short Message Service*<br>*VBHC – Value Based Health Care* |
| **Public Interest** | This report is written for the public domain. |

**Appendix 1: Case for Change references (for information)**

1. The path to sustainability: Health Foundation (October 2016)
https://www.health.org.uk/sites/health/files/PathToSustainability_0.pdf

2. The Strategy that will fix healthcare: Michael E. Porter, Thomas H. Lee, MD (October 2013)
https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

3. Tackling Wasteful Spend on Health: OECD (October 2017)
https://www.oecd-ilibrary.org/social-issues-migration-health/tackling-wasteful-spending-on-health_9789264266414-en

## Appendix 2 – Summary of Example Projects within the Value Programme

| Project Area | Aim/Scope | Impact |
|---|---|---|
| Parkinson's Disease | • Test the use of the ICHOM standard set to measure outcomes (patient and clinician perspective.<br>• Understand the IT solutions/challenges. | • Utilisation of PROMS in direct care improves patient centeredness and experience.<br>• Changes in the pathway which allocate individuals to services based upon need are expected to improve access.<br>• Allocating appropriate clinic appointments and releasing time to care is improving staff experience and wellbeing.<br>• Efficient data presentation is expected to improve medication governance and reduce the incidence and impact of comorbidities.<br>• Virtual appointments will avoid unnecessary and costly time and travel for consultations. |
| Ophthalmology – cataracts | • National costing exercise including process mapping cataract pathway<br>• Local collection of ICHOM standard PROMs data | • Planned increase in theatre utilisation – additional 162 cases which would avoid potential outsourcing of treatments.<br>• Opportunity to identify alternative pathway for some patients who may not benefit from surgery (visual acuity unchanged or worse in 20% of patients reporting outcomes). |
| Inflammatory Bowel Disease | • Collected PROMs and undertook local costing of service | • Reduce need for unnecessary follow-up appointments, where symptoms are stable and controlled (c28%).<br>• Patients can be seen more promptly when needed.<br>• Cost avoidance given increased demand and better use of clinic appointments. |
| Dementia (Memory Assessment Service) | • Local costing exercise and collection of patient and clinical outcomes across 5 LA areas | • Clinically-led transformation that has questioned and changed 'locked' clinical practices.<br>• Moving towards equitable services with appropriate levels of variation on the basis of local needs, overall cost variance between the boroughs has reduced by 24%.<br>• Where implemented, the new pathway is meeting waiting time targets.<br>• Capacity in the service has increased from 2 to 3 new patients per clinic.<br>• This increased capacity allows us to meet rising demand until 2021. |
| Heart Failure | • Collection of PROMs and other clinical data | • Reconfiguration of CNS work plans enabled implementation of two new clinics<br>• 11 additional follow-up appointments per week.<br>• Capacity released is equivalent to around £11k per year in staff time. |
| Psoriasis | • Collection of in-clinic and remote PROMs<br>• Establish virtual clinics<br>• Local costing exercise | • Staff resource reduced from 30 minutes in clinic to 10 minutes in virtual clinic.<br>• Benefits for patients including time, travel and missed activities.<br>• Virtual clinic reduces clinic appointment costs from £57 to £7, giving a non-cashable financial benefit of £50 per patient contact.<br>• Continue effective prescribing whilst replacing / removing ineffective medicines. |

## Appendix 3

https://issuu.com/danbdavies/docs/the_evolution_of_vbhc_final

| | |
|---|---|
| GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board | Finance and Performance Committee<br>1st May 2019<br>Agenda Item: 2.7 |

2.7

# Aneurin Bevan University Health Board

## COMMITTEE RISK REPORT

### Executive Summary

This paper provides an overview of the profile of the current risks for which the Finance and Performance Committee are responsible for monitoring as at the end of February 2019. The risk profile of the Health Board is continuing to be revised and reworked.

| **The Finance and Performance Committee is asked to:** (please tick as appropriate) | |
|---|---|
| Approve the Report | |
| Discuss and Provide Views | |
| Receive the Report for Assurance/Compliance | ✓ |
| Note the Report for Information Only | |

**Executive Sponsor:** Glyn Jones, Director of Finance and Performance

**Report Author:** Kay Barrow, Acting Head of Corporate Governance

**Report Received consideration and supported by :**

| | | | |
|---|---|---|---|
| **Executive Team** | ✓ | **Committee of the Board [Committee Name]** | |

**Date of the Report: 24th April 2019**

**Supplementary Papers Attached:**
1 - Risk Dashboard – March 2019

### Purpose of the Report

This report is provided for assurance purposes to highlight for the Committee the risks that are assessed as the key risks to the Finance and Performance Committee and the Health Board's successful achievement of our strategic objectives within the IMTP.

### Background and Context

Risk management is a process to ensure that the Health Board is focusing on and managing risks that might arise in the future. Also, in situations where there are continuing levels of inherent risk within current issues that the organisation or in our partnership work is being responded to. Active risk management is happening every day throughout all sites and services of the Health Board. Nevertheless, the Health Board's risk management system and reporting also seeks to ensure that the Board is aware, engaged and assured about the ways in which risks are being identified, managed and responded to across the organisation and our areas of responsibility.

The strategic risks referenced within this report have been identified through work by the Board, Committees, Executive Team and items reported through the Health Board's management structures with regard to the implementation of the IMTP, for which the Finance and Performance Committee have oversight.

***Table from the updated Risk Management Strategy – January 2017***

| Consequence Score | Likelihood Score | | | | |
|---|---|---|---|---|---|
| | **1 Rare** | **2 Unlikely** | **3 Possible** | **4 Likely** | **5 Almost certain** |
| **5 - Catastrophic** | 5 | 10 | 15 | 20 | 25 |
| **4 - Major** | 4 | 8 | 12 | 16 | 20 |
| **3 - Moderate** | 3 | 6 | 9 | 12 | 15 |
| **2 - Minor** | 2 | 4 | 6 | 8 | 10 |
| **1 - Negligible** | 1 | 2 | 3 | 4 | 5 |

## 2. Finance and Performance Risk Register and Dashboard Report

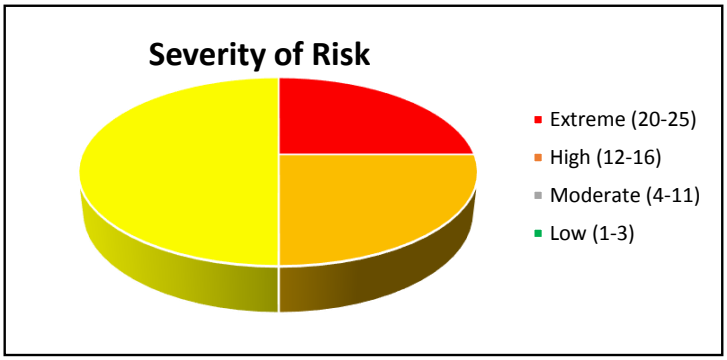
As outlined above, the dashboard reports are generated from the Health Board's Corporate Risk Register. The reports seek to provide in-overview:

- The key risks for which the Finance and Performance Committee has responsibility;
- The current profile of risks in that strategic objective area and their potential impact;
- Whether risks have worsened, remained unchanged or had been mitigated since the last assessment;
- Historical context of each risk i.e. how long it has been at its level on the Corporate Risk Register;
- The report will also show any risks that have been withdrawn in the last reporting period or whether there are new risks.

The risks for the purposes of the dashboards have been summarised to make them more accessible to the Committee. The detail of the risks, their assessment, controls and mitigating actions continue to be expressed within the full Corporate Risk Register, which is presented to the Audit Committee at each meeting.

There are currently 8 risks on the Finance and Performance Risk Register. These are broken down by the following levels of risk severity.

| Risk By Severity | |
|---|---|
| Extreme (20-25) | 2 |
| High (12-16) | 2 |
| Moderate (4-11) | 4 |
| Low (1-3) | 0 |



In relation to the changes to the assessed risks since the last report, the following changes have been made:

**Risks with a Reduced Score:**

- **Risk:** Failure to achieve financial balance at the end of 2018/19. This risk has reduced from 12 to 8.

- **Risk:** Failure to efficiently manage out-patient demand and modernise out-patient services. This risk has reduced from 15 to 10.

**Risk with an Increased Score:**

- There were no risks assessed as having an increased score in the last month.

**New Risks**

- **Risk:** Resources may not be used in the most effective way to optimise achievement of the Health Board's priorities. This risk has been initially assessed as a score of 9.

| **Assessment and Conclusion** |
|---|
| This paper provides an overview of risks as at the end of March 2019. |

| **Recommendation** |
|---|
| The Finance and Performance Committee is asked to consider this report and note the identified risks as the current strategic risks for the Health Board as at the end of March 2019. |

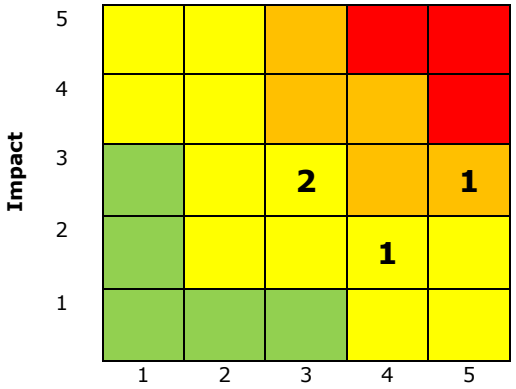
| **Supporting Assessment and Additional Information** | |
|---|---|
| **Risk Assessment (including links to Risk Register**) | The coordination and reporting of organisational risks are a key element of the Health Board's overall assurance framework. |
| ***Financial Assessment, including Value for Money*** | There may be financial consequences of individual risks however there is no direct financial impact associated with this report. |
| ***Quality, Safety and Patient Experience Assessment*** | Impact on quality, safety and patient experience are highlighted within the individual risks contained within this report. |
| ***Equality and Diversity Impact Assessment (including child impact assessment)*** | There are no specific equality issues associated with this report at this stage, but equality impact assessment will be a feature of the work being undertaken as part of the risks outlined in the register. |
| **Health and Care Standards** | This report would contribute to the good governance elements of the Health and Care Standards for Wales. |
| **Link to Integrated Medium Term Plan/Corporate Objectives** | The risks against delivery of key priorities in the IMTP, will be outlined as specific risks on the risk register. |

| | |
|---|---|
| **The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working** | Not applicable to this specific report, however WBFGA considerations are included within the consideration of individual risks. |
| **Glossary of New Terms** | None |
| **Public Interest** | Report to be published. |

## Corporate Risk Dashboard Report as at end of March 2019

| IMTP STRATEGIC OBJECTIVE: | Enabler Risks Associated with Delivery of IMTP |
|---|---|
| KEY THEME ACTIONS: | • No specific SCPs – these areas overarch and underpin the IMTP |
| These areas are not directly associated with SCPs, but will if mitigated, facilitate the delivery of the plan. | |

**RISK PROFILE REPORT**




**Key:**

**= Risk Worsened**

**= Risk Unchanged**

**= Risk Mitigated**

### Description of Risk and Action and if Risk Mitigated, Unchanged or Worsened Since Last Assessment

**15**

**Since April 2018**

**RISK**: Failure to implement and deliver the priorities in the IMTP
**IMPACT**: The Health Board will not be meeting its objectives to respond to assessed population needs and Welsh Government Targets.
**ACTION**: Monitoring of performance through divisional structures and Board oversight via Finance and Performance Committee continues and detailed plans have been developed. Delivery Framework has been adopted by the Executive Board in July 2018.
**OWNER**: Director of Planning, Digital and IT
**OVERSIGHT**: Executive Team and Finance and Performance Committee

## Corporate Risk Dashboard Report as at end of March 2019

| | |
|---|---|
| | **Previous Score** 12 — Since Nov 2018<br>**Current Score** 8<br><br>**RISK**: Failure to achieve financial balance at end of 2018/19<br>**ACTION**: Funding confirmed by Welsh Government as part of IMTP approval. Focus required on delivering actions to manage residual financial risk and delivering performance targets required to retain Welsh Government performance funding (£3.1m).<br>IMTP Delivery Framework and Divisional Assurance meetings in place which will incorporate implementation of savings plans and delivery of service and workforce plans within available resources.<br>There is a risk that the RTT target of 0 patients waiting longer than 36 weeks will not be met. However, the level of funding which might be recovered by Welsh Government, based on the projected number of breaches at 31/3, is now expected to be accommodated within an overall balanced financial position.<br>**OWNER**: Chief Executive and Director of Finance and Performance<br>**OVERSIGHT**: Finance and Performance Committee and Board |
| | 9 — Since Sept 2018<br><br>**RISK**: Risk of insufficient capacity and resources to deliver the planned Clinical Futures Programme.<br>**IMPACT**: The delivery timetable could be compromised and the quality of the design work and engagement could be affected.<br>**ACTION**: Programme Management arrangements have been put in place, areas of work being prioritised. Additional roles have been identified and appointed to over the last period.<br>**OWNER**: Director of Planning, Digital and IT<br>**OVERSIGHT**: Finance and Performance Committee |

## Corporate Risk Dashboard Report as at end of March 2019

| | |
|---|---|
| | **9** **New Risk**<br>**RISK:** Resources may not be used in the most effective way to optimise achievement of the Health Board's priorities.<br>**IMPACT:** The Health Board would not achieve its identified priorities in the most effective way.<br>**ACTION:** The Health Board has an approved IMTP, which identifies the key priorities regarding the improvement of health for its population and the allocation of resources to support this.<br>Budgets are delegated through the organisation based on the priorities set out in the IMTP.<br>Key IMTP delivery risks, including service, workforce and financial performance are scrutinised at the Finance & Performance Committee. The Finance & Performance Committee will also periodically review the allocation and shift in resources to support the Health Board's priorities. The Executive Board/Team and monthly Divisional assurance meetings monitor delivery and progress against key risks, including service, quality/safety, workforce and financial performance. The Health Board's Value Based Health Care Programme aims to improve outcomes for patients making best use of available resources (improving value). This Programme reports to the Quality Patient Safety Committee.<br>**OWNER:** Director of Finance & Performance<br>**OVERSIGHT:** Board, Finance & Performance Committee and Quality & Patient Safety Committee |

## Corporate Risk Dashboard Report as at end of March 2019

| IMTP STRATEGIC OBJECTIVE: | Improving access and flow and reducing waits (SCP 5 & 6) |
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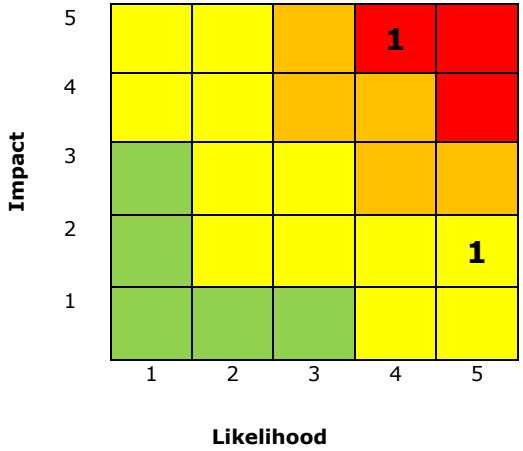
| KEY THEME ACTIONS: | • SCP 5 – Urgent and Emergency Care<br>• SCP 6 – Planned Care |
| To develop coherent, co-ordinated, high quality urgent and emergency care that works seven days a week, and where possible 24 hours a day. In accordance with patient expectations whilst delivering the best clinical outcomes. To secure improvements in efficiency and productivity that in combination with prudent healthcare, will improve access and deliver high quality, affordable and sustainable services. | |
| **RISK PROFILE REPORT**<br>  <br> | **20**<br>**Updated Dec 2018**<br>**RISK**: Failure to meet the needs of the local people in relation to emergency care provision including WAST provision.<br>**IMPACT**: Not meeting Welsh Government targets and patients will not receive services they require in a timely way.<br>**ACTION**: Ongoing monitoring is provided on a weekly basis at meetings with the Divisions and through the Urgent Care Board. New models of care have been introduced. Winter Plan being implemented and being monitored. Turnaround Team in place identifying quick and sustainable change opportunities across the urgent care pathway.<br>**OWNER**: Director of Operations<br>**OVERSIGHT**: Finance and Performance Committee |

## Corporate Risk Dashboard Report as at end of March 2019

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| | Previous Score: 15<br>Since March 2017<br>Current Score: 10<br>  <br>**RISK**: Failure to efficiently manage out-patient demand and modernise outpatient services.<br>**IMPACT**: Patients undertake unnecessary journeys to hospital, inappropriate use of capacity and delays which could result in patient harm due to delayed follow-up.<br>**ACTION**: Review of out-patient transformation approach with proposed clinically led model. Work has been undertaken which has resulted in the number of delayed follow-ups with no booked appointment reducing from 27,500 to 18,000 at the end of February 2019. Work of the Outpatient Collaborative continues with a focus on reducing unnecessary follow-up out-patient attendance.<br>**OWNER**: Director of Operations<br>**OVERSIGHT**: Finance and Performance Committee |

## Corporate Risk Dashboard Report as at end of March 2019

| IMTP STRATEGIC OBJECTIVE: | Service Sustainability (SCP 7) |
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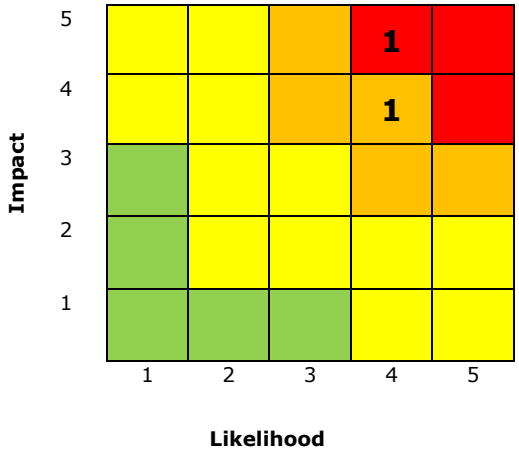
| KEY THEME ACTIONS: | • SCP 7 – Service Sustainability |
| To ensure that the Health Board focuses on the transition of services that are fragile and present sustainability issues over the next three years and in particular in advance of the SCCC. | |

**RISK PROFILE REPORT**




**20**

**Revised Dec 2018**

**RISK**: Failure to recruit and retain appropriately skilled staff and senior leadership to deliver high quality care.
**IMPACT**: Negative impact on patient care and service delivery due to lack of skilled workforce, low staff morale, increased sickness and turnover.
**ACTION**: Plans in place to maximise recruitment and increase retention in all identified areas including registered nurses and medical staff. Development of recruitment materials to support recruitment campaigns and improve online presence. Working closely with the national campaign "Train, Work, Live" which has recently been extended to Pharmacy.
Significant recruitment risks include:
Nursing hard to fill areas - NHH and RGH wards - Recruitment of overseas nurses living within the local community has been successful however, some current delays in meeting the requirements for NMC registration. Working closely with all Wales campaigns including student streamlining.
Medical hard to fill areas – Mental Health, Medicine and Emergency Medicine, Paediatrics, Obs & Gynae. A number of actions are in place to minimise risk, for example, overseas recruitment (BAPIO), rolling generic advertisements, social media campaigns, work on introduction programmes for overseas doctors, rotational posts and working closely with the Deanery and HEIW

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| | | **OWNER**: Director of Workforce and OD, Acting Director of Nursing, Medical Director and Director of Therapies and Health Science<br>**OVERSIGHT**: Finance and Performance Committee |
| | **16**<br>**Since May 2018** | **RISK**: Insufficient levels of capital funding for estate requirements<br>**IMPACT**: Health Board will be unable to meet the levels of refurbishment required for Health Board to meet its plans<br>**ACTION**: Detailed capital programme that is regularly re-prioritised by the Executive Team. Opportunities maximised with regular dialogue with Welsh Government. Sustainability challenges regarding imaging and informatics priorities are a particularly concern. Issue escalated to Directors of Planning and Chief Executives. Comprehensive Estates Strategy in development<br>**OWNER**: Director of Planning, Digital and IT<br>**OVERSIGHT**: Finance and Performance Committee |