A meeting of the Finance and Performance Committee will be held on Thursday, 4th July 2019 at 9:30am to 12.30pm in the Executive Meeting Room, Headquarters, St Cadoc's

AGENDA

1	**Preliminary Matters**			
	1.1	**Apologies for Absence** To receive apologies for absence	Verbal	Chair
	1.2	**Declarations of Interest** To receive declarations of interest	Verbal	Chair
9:30 – 9:35	1.3	**Minutes of the Finance and Performance Committee – 1st May 2019**	Attachment	Chair
9:35 – 9:40	1.4	**Action Log**	Attachment	Chair
9:40 – 9:45	1.5	**Matters Arising from the Previous Meeting**	Verbal	Chair
2	**Items for Assurance:**			
9:45 – 10:00	2.1	**Workforce Performance**	Attachment	Director of Workforce and OD
10:00 – 10:15	2.2	**Sickness Absence Report**	Attachment	Director of Workforce and OD
10:15 – 10:30	2.3	**Medical Locum and Agency Compliance**	Attachment	Assistant Medical Director
10:30 – 10:55	2.4	**Performance Dashboard**	Attachment	Director of Finance and Performance
10:55 – 11:15	2.5	**Advance Care Plans (ACPs) and their Value**	Attachment	Assistant Medical Director
11:15 – 11:30	2.6	**Financial Performance**	Attachment	Director of Finance and Performance
11:30 – 12:15	2.7	**Resource Shift**	Attachment	Assistant Director of Finance
12:15 – 12:30	2.8	**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** Wednesday, 9th October 2019 at 1:30pm in the Executive Meeting Room, Headquarters, St Cadoc's		Chair

Finance and Performance Committee
4th July 2019
Agenda Item: 1.3

Aneurin Bevan University Health Board

Minutes of the Finance and Performance Committee held on Wednesday 1 May 2019 in the Executive Meeting Room, St Cadoc's Hospital, Caerleon

Present:

Shelley Bosson	-	Chair, Independent Member (Community)
Catherine Brown	-	Independent Member (Finance)
Cllr Richard Clark	-	Independent Member (Local Government)
Frances Taylor	-	Independent Member (Community)

In Attendance:

Glyn Jones	-	Director of Finance
Claire Birchall	-	Director of Operations
Geraint Evans	-	Director of Workforce and OD
Dr Stephen Edwards	-	Assistant Medical Director
Rob Holcombe	-	Assistant Director of Finance
Sarah Simmonds	-	Assistant Director of Workforce and OD
Gabrielle Smith	-	Performance Audit Lead, Wales Audit Office (observing)
Chris Scott	-	Internal Audit Manager (observing)
Rona Button	-	Corporate Services Manager (Secretariat)

Apologies:

Judith Paget	-	Chief Executive
Dr Paul Buss	-	Medical Director
Nicola Prygodzicz	-	Director of Planning, Digital and IT
Richard Bevan	-	Board Secretary
Debra Wood-Lawson	-	Chief of Staff

FPC 0105/01 Apologies for Absence
The Chair welcomed members and observers to the meeting and apologies for absence were noted.

FPC 0105/02 Declarations of Interest
There were no declarations of interest to be recorded.

FPC 0105/03 Minutes of the Last Meeting – 21 February 2019
Two amendments were requested with the Minutes:

FPC 2102/06 – Workforce Performance/People Plan Update:
The Minutes had noted that there were no dignity at work or bullying and harassment concerns with the staff survey data. However, this was because such issues were taken forward as grievance issues and not recorded as dignity at work concerns, and the Minutes should reflect this position. **ACTION: Secretariat.**

FPC 2102/09 – Strategic Areas of Efficiency: Theatre Productivity:
The financial summary to include the benefits realisation being brought back to the meeting in October 2019, should include user satisfaction data. **ACTION: Claire Birchall/Secretariat**

FPC 0105/04 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 0105/05 Workforce Performance Report:

- **Performance/People Plan**
- **Recruitment and Retention**
- **Welsh Language Update**

Geraint Evans presented the paper to update the Committee on key workforce activity, which included the Month 12 update on workforce performance, an overview of recruitment and retention activity, and work undertaken to implement the Welsh Language Standards across the Health Board.

It was noted that the level of sickness absence was reducing, although this was expected at this time of year. The figure for March 2019 was 5.05% with the Health Board's target remaining at 5%. The average days lost per employee due to sickness absence within the organisation was 19.32 days, with the average in NHS Wales and England reported to be 15 days per person. This equated to 573.74 Whole Time Equivalent (WTE) staff absent every day.

A new Managing Attendance at Work policy had been launched with the aim of reducing sickness absence, and it was noted that wellbeing should be considered alongside sickness absence to support a more 'individualised' approach to sickness management. The cost of having 573.74 WTE off every day was queried, together with the cost of interventions such as an Occupational Health appointment, where the wait had reduced from six to three weeks.

The Committee asked why the organisation's average sickness rate was so high, and it was noted that the Health Board was mid-table within Wales. Training on the new policy would be initially targeted at hotspot sickness areas. The Committee also asked why sickness was so high in the 51-55 age group, and Geraint Evans agreed to provide a breakdown at the next meeting. **ACTION: Geraint Evans**

The Chair questioned whether or not the range of interventions were being evaluated and if there was a communications plan around the posters for staff surveys. It was noted that there were a number of different communications initiatives in place.

The PADR compliance was recorded as 77.05%, with only two Divisions reaching the 85% required compliance rate. It was noted that from next year, PADRs would be linked to incremental pay rises. The Committee requested that the level of PADR compliance within the Corporate Departments be improved during the year. **ACTION: Executive Team**

Staff turnover within the organisation was 8.34% against an All Wales figure of 6.80%. The workforce survival curve was examined, and the Committee agreed that the information provided in the curve would be useful to the organisation as it highlighted at what point leavers left the organisation within a set number of months after their appointment. It would also assist with supporting the retention of staff. The Committee requested further information on the rates for nursing and care staff, including cost and value for money, and Geraint Evans would scope out what the Committee required with Catherine Brown. **ACTION: Geraint Evans/Catherine Brown**

In terms of variable pay, it was reported that the organisation relied heavily on agencies, and the Department would be looking at the substantive workforce with a view to contracting with them in a different way, for example, via a sub-contract.

The Department was trying to accelerate the disciplinary process, in agreement with Trade Union colleagues, which would be beneficial to the organisation and lower the period of uncertainty for staff members.

The Committee discussed agile and flexible working, and it was noted that a toolkit was in place, and workshops were being run across the organisation to highlight the principles which had been agreed by the Executive Team. It was noted that there

was no overarching strategy in place, and that the principles needed to be refreshed. **ACTION: Geraint Evans**

The Committee noted that the organisation was still missing the 60 day recruitment target, and asked whether or not new starters were questioned about the recruitment process. Some new starters were asked, but this was not routinely carried out.

The Welsh Language Standards Update was discussed and it was noted that there were 121 individual standards for the Health Board to comply with within the next two years. The standards were due to 'go live' on 30 May 2019, and required the Health Board to ensure that the Welsh language was not treated less favourably than English, and to promote and facilitate the use of the Welsh language throughout the organisation. The self-assessment presented to the Board in 2018 was substantially green, and as there were so many standards requiring attention, the Committee suggested that the internal Welsh language group focussed on those areas which impacted on patients in the first instance.

It was noted that complaints received in Welsh would be forwarded to the Welsh Language Officer, and it was likely that mystery shopper-type exercises would be carried out by the Welsh Language Commissioner to monitor organisations' compliance with the standards. The Committee was concerned about the apparent risks regarding compliance with the standards under the existing timelines and asked for this to be brought to the Board's attention. The Committee requested that consideration be given to adding the Welsh language standards to the Corporate Risk Register. **ACTION: Secretariat/Richard Bevan**

Sarah Simmonds left the meeting.

FPC 0105/06 Finance Performance Report

The report for the financial year 2018/19 was provided to the Committee by Glyn Jones. The Committee was pleased to note that the Health Board had reported a surplus of £235,000 and therefore met its statutory duty. In addition, thanks were recorded for the capital programme teams involved in the new hospital.

The Committee remained concerned with the significant underlying financial position. Efficiency plans would require further investigation and scrutiny by the Executive Team. A running total on the underlying position was requested, and the

Committee questioned whether or not there was a whole system approach to savings, as little evidence was available of proactive working to improve efficiencies, and the same two areas (elective orthopaedics and ophthalmology) were still being discussed. It was acknowledged that where efficiencies had been achieved, they were often linked to service changes. In future, use of benchmarking data would need to be used as a marker for change rather than as a defence to current practice. Glyn Jones advised that action would be taken with individual service areas regarding efficiencies, and the Committee requested that the Board should be provided with information on the current deficit and how this was being addressed. **ACTION: Glyn Jones/Richard Bevan**

The Committee remained concerned about the underlying financial position, particularly regarding the actions required to sustain the financial balance going forward, and asked for this to be brought to the attention of the Board. **ACTION: Secretariat**

FPC 0105/07 Referral to Treatment Times (RTT) 2018/19 and 2019/20 Delivery Plan

Claire Birchall provided a paper to update the Committee on RTT, and it was reported that since the paper was written, the outturn figure was 112 for March. Future plans were highlighted and it was noted that the 36 week waiting time had been eliminated in all areas except Orthopaedics and Ophthalmology. Following discussions with Welsh Government, there was a new target to clear the remaining 2018/19 patients waiting over 36 weeks by the end of Quarter 1 of the current financial year. The organisation would be able to use backfill arrangements to help clear the backlog. Reducing outpatient waiting times would be crucial to maintaining a zero position month on month; however, sustaining the position was of concern. A revised plan would be on the Executive Team agenda on 13 May. The Committee asked for the concern with RTT to be brought to the attention of the Board. **ACTION: Secretariat**

It was noted that the Health Board was aiming to reduce outpatient demand by 1,222 in a number of scheduled care specialties through the use of Demand Reduction Plans.

The Committee asked if there was further scope to increase the use of the DrDoctor service, and if it could be upscaled relatively quickly and it was noted that this would be possible.

PROMS (patient reported outcome measures) would be used for cataract procedures to influence future decisions.

The Committee also asked if colleagues in Therapy services could assist with triage in orthopaedics and was pleased to note that this would be taking place at the referral stage.

FPC 0105/08 **Strategic Areas of Efficiency: Bed Utilisation**

Claire Birchall provided a report on progress with performance improvements/opportunities to reduce beds, e.g. length of stay, and described the current operational plans to reconfigure the bed base, with the required reductions in preparation for the opening of the GUH. A number of initiatives were underway to implement the bed reduction, and the Committee requested a six-monthly update, which would be added to the Forward Work Programme. **ACTION: Secretariat**

FPC 0105/09 **Integrated Performance Report**

Glyn Jones updated the Committee with the latest position. Whilst an improvement was noted, a significant number of patients were still waiting over 12 hours in A&E Departments, which was disappointing, as the national target, together with the Health Board's own IMTP target was for zero patients to be waiting over 12 hours. The Committee asked for the wording in the report to be amended so that it reflected an accurate position. **ACTION: Glyn Jones/Nicola Prygodzicz**

A number of highlights were also noted, including the sustained mental health position, cancer services achieving the national target of 98% for the 31 day pathway, and ambulance response times within 8 minutes to Category Red calls sustaining performance above the 65% target. A number of significant challenges remained, to improve performance where this was below the expected levels, including Unscheduled Care, and Mental Health and Critical Care DToCs.

The Committee was disappointed that HCAI performance had deteriorated, and was concerned that if safe systems were in place, this should not be the case. It was noted that discussions were currently taking place with Public Health Wales in order to review performance rates.

The Committee observed the decrease in clinical coding rates and felt that these should not be deteriorating. They questioned whether or not this was a risk to the organisation and, if so, what the impact was. Glyn Jones advised that he

was looking to improve the rates and would report back to the Committee at the next meeting. **ACTION: Glyn Jones**

FPC 0105/10 Value Based Healthcare and the impact on delivery of services

The Committee received the report from Glyn Jones and it was noted that 18 projects had been identified for scaling up during the last financial year. The programme for this year was being finalised, and the approach would be to align work on costing and collecting outcomes along the pathway/condition for each project, in order that value could be derived and improvements measured. Evaluation and appropriate rollout would be managed through the Programme governance arrangements. The Value Programme reported to the Executive Board, with further assurance received via the Quality and Patient Safety Committee. As some projects progressed, governance would be enhanced to ensure that clinical, information and financial governance were fully satisfied before rolling out pilot projects.

The Committee noted the excellent work on the programme and looked forward to the scaling up of projects in the future.

FPC 0105/11 Committee Risk Register

The Committee discussed the register and the risks for which the Committee had oversight, which numbered eight at the time of the meeting. The Committee discussed the work around the failure to implement and deliver the priorities in the IMTP (currently at Amber and with a score of 15) and acknowledged that it would be difficult to meet all the IMTP objectives. It was hoped that under the new risk system, this risk could be broken down so that actions could be put in place to mitigate the individual aspects. **ACTION: Glyn Jones/ Richard Bevan**

FPC 0105/12 Items for Board Consideration

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

- Concern about the Health Board's underlying financial position.

FPC 0105/13 Risks for Board Consideration

The following items were to be brought to the attention of the Board:

- Risks regarding Welsh Language standards.
- Maintaining the RTT position.

FPC 0105/14 **Date of the Next Meeting**

The next meeting is due to take place on Thursday 4 July 2019 at 9.30am in the Executive Meeting Room, Headquarters, St Cadoc's Hospital, Caerleon.

Finance and Performance Committee
1 May 2019
Action Sheet

Agreed Actions

Minute Reference	Agreed Action	Lead	Progress/Completed
FPC 0105/03	**Minutes of the Last Meeting – 21 February 2019:** FPC 2102/06 Workforce Performance/ People Plan Update - Change to be made to the Minutes to reflect that dignity at work, and bullying and harassment concerns were taken forward as grievance issues.	**Secretariat**	Completed.
	FPC 2102/09 Strategic Areas of Efficiency: Theatre Productivity - The financial summary, including benefits realisation, being brought back to the October 2019 meeting, should include user satisfaction data.	**Claire Birchall/ Secretariat**	This item has been included on the Committee forward work programme.
FPC 0105/05	**Workforce Performance Report:** Information to be provided on the 51-55 age group regarding sickness absence which was high relative to other age groups.	**Geraint Evans**	Completed – the sickness absence information on age group 51-55 has been incorporated into the separate Sickness Absence report scheduled to be presented at the July meeting.
	PADR compliance within the Corporate Departments to be improved during the year.	**Executive Team**	Workforce report describes the PADR compliance. Each director od responsible for

Minute Reference	Agreed Action	Lead	Progress/Completed
			reviewing and addressing any compliance issues.
	Further information on the retention rates for nursing and care staff to be provided following a discussion between Geraint Evans and Catherine Brown.	**Geraint Evans/ Catherine Brown**	Completed – the information on nursing retention rates has been included in the Workforce Performance Report scheduled to be presented at the July meeting.
	Overarching strategy for agile and flexible working to be implemented and the principles refreshed.	**Geraint Evans**	Agile Working Strategy, Action Plan & Framework to be launched on 31st October 2019.
	Welsh language to be added to the Corporate Risk Register.	**Secretariat/ Richard Bevan**	Completed.
	Risks regarding the Welsh Language standards to be brought to the attention of the Board.	**Secretariat**	Complete. Added to the Assurance Report for the May Board meeting.
FPC 0105/06	**Finance Performance Report:** The Board to be provided with information on the current deficit and how this was being addressed.	**Glyn Jones**	Every finance report to Board and the Committee report the financial position (in-year) and the underlying positon.
	The underlying financial position to be brought to the attention of the Board.	**Secretariat**	Complete. Added to the Assurance Report for the May Board meeting.
FPC 0105/07	**RTT 2018/19 and 2019/20 Delivery Plan:** Concern regarding RTT to be brought to the attention of the Board.	**Secretariat**	Complete. Added to the Assurance Report for the May Board meeting.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Finance and Performance Committee
4th July 2019
Agenda Item: 1.4

Minute Reference	Agreed Action	Lead	Progress/Completed
FPC 0105/08	**Strategic Areas of Efficiency: Bed Utilisation:** Six-monthly update on the initiatives to implement the bed reduction to be added to the Forward Work Programme.	**Secretariat**	Completed – added to the forward work programme.
FPC 0105/09	**Integrated Performance Report:** Wording for the 12 hour wait in A&E Departments to be amended in order that it reflects an accurate position.	**Glyn Jones/ Nicola Prygodzicz**	Completed - amended in the last Board report.
	Report to be received at the next meeting regarding clinical coding rates.	**Glyn Jones**	WAO report to July Audit Committee. Suggest holding on any further reports until this has been considered by the Audit Committee.
FPC 0105/11	**Committee Risk Register:** IMTP risk to be broken down in order that actions can be put in place to mitigate individual aspects.	**Glyn Jones/ Richard Bevan**	Performance dashboard identifies performance against key targets/indicators. This should allow the Committee to seek assurance on actions to address key risks.

Aneurin Bevan University Health Board
Finance and Performance Committee
04 July 2019
Agenda Item: 2.1

2.1

Aneurin Bevan University Health Board
Workforce Performance Update
May 2019

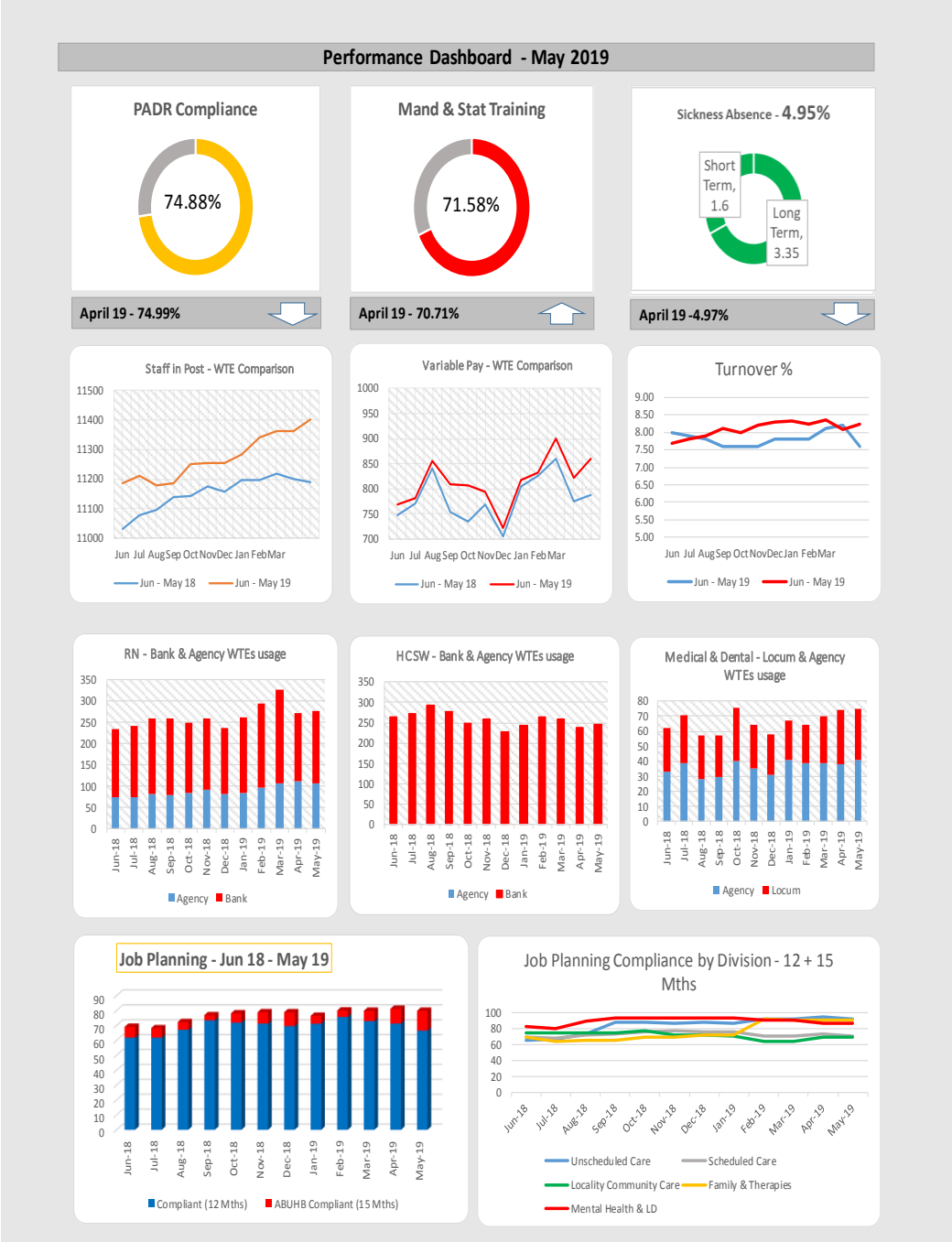
Executive Summary
This report provides an update on key workforce activity including the Month 2 update on workforce performance.

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: 25 June 2019			
Supplementary Papers Attached:			

WORKFORCE UPDATE

SECTION 1 - WORKFORCE PERFORMANCE - MONTH 2 2019-2020

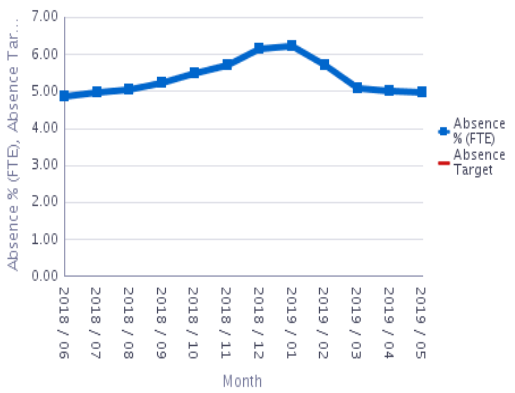
PERFORMANCE DASHBOARD

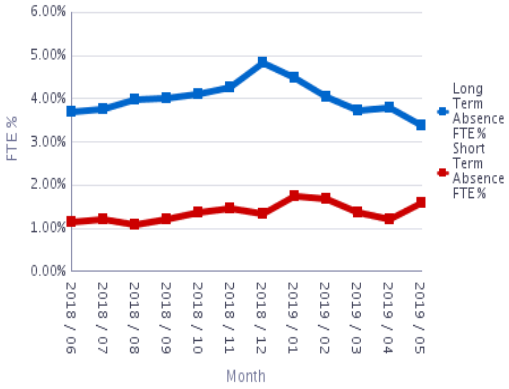


SICKNESS ABSENCE

A more detailed report focussing on sickness absence is provided seperately to this paper.

Sickness absence in May 2019 was 4.95%, which is 0.02% lower than April 2019 (4.97%). The 12 month rolling sickness is 5.37%. The Health Board target remains at 5%.





In May 2019, long term sickness absence was 3.35% which is the lowest percentage in the last 12 months. This is a result of a reduction in the number of longer term episodes between 6 months to over 12 months which has reduced by over 50% (83 episodes) from 159 to 76 episodes.

The table below shows the sickness by episodes by number of days.

Sickness Episodes by number of days	June 2018 Absence Episodes	May 2019 Absence Episodes
0-1	147	155
2	147	156
3	111	125
4	74	80
5	79	67
6	45	34
7	70	66
8-14	105	103
15-21	73	114
22-27	57	81
28 Days - 6 Months	505	572
6 Months - 12 Months	114	63
>12 Months	45	13
Long Term	**664**	**648**
Short Tem	**908**	**981**
Total Number of Episodes	**1572**	**1629**

Sickness Absence Reasons

In May 2019, 27.70% of sickness absence was due to Anxiety/Stress/Depression/Other psychiatric illnesses. The average for the last 12 months is 28.80%.

Outlined in the table below are the Top 10 reasons for sickness absence.

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	27.7
S12 Other musculoskeletal problems	13.3
S28 Injury, fracture	7.6
S98 Other known causes - not elsewhere classified	6.8
S25 Gastrointestinal problems	6.5
S11 Back Problems	6.5
S26 Genitourinary & gynaecological disorders	4.3
S13 Cold, Cough, Flu - Influenza	4.3
S17 Benign and malignant tumours, cancers	3.4
S99 Unknown causes / Not specified	3.1

PERSONAL APPRAISAL DEVELOPMENT REVIEW (PADR)

The current PADR organisational compliance is 74.88%, compared to 74.99% in April 2019.

Division	Reviews Completed %
Corporate Services	69.25
Continuing Health & Funded Nursing Care	83.38
Facilities Division	87.60
Family & Therapies Division	79.56
Locality Primary Care	76.02
Mental Health & LD	74.39
Scheduled Care	64.69
Unscheduled Care	73.44
Total	74.88

2 out of the 17 divisions/corporate departments have reached the required 85% target, Facilities Division and Workforce & OD (included in the corporate figure in the above table).

The new PADR middle manager module and delivery content is being turned into an e-learning package to ensure we have a mixed model of delivery to include both face to face and e-learning. We anticipate that this e-learning

will be available within the next 5 to 6 weeks. In addition, we are working on developing 'Pearl of Wisdom' (a short video clip) using our staff to describe the importance and positive impact of having regular meaningful conversations with their manager or supervisor and recording one of these as a PADR. Both of these developments will add to the resources already available to staff and reduce the impact of release from practice to attend face to face delivery sessions. These additional learning materials will be available on the learning portal for the Clinical Futures Transformation Programme, our PADR resource pages and ESR.

STAFF IN POST / TURNOVER PATTERNS

As highlighted in the table below over the last 12 months the number of staff in post has increased by 214 WTE. Two staff groups have decreased, Nursing & Midwifery Registered (-8 WTE) and HCSW (-13 WTE). Admin & Clerical has increased by +93 WTE.

	Staff In Post - WTE								Turnover %	
Staff Group	Jun-18	Sep-18	Dec-18	Mar-19	May-19	+/-	%	Leavers	Turnover %	All Wales Turnover %
Add Prof Scientific and Technic	335	345	372	398	410	75	22	24	5.38	8.50
Additional Clinical Services	2277	2237	2230	2275	2290	13	1	233	8.24	9.70
Administrative and Clerical	2115	2125	2150	2189	2208	93	4	203	7.42	7.60
Allied Health Professionals	715	730	722	730	726	11	2	88	10.09	7.60
Estates and Ancillary	1087	1072	1068	1077	1068	-19	-2	109	7.29	7.90
Healthcare Scientists	216	226	223	221	221	5	2	28	10.81	6.90
Medical and Dental	965	982	1004	996	1007	42	4	3	5.61	9.20
Nursing and Midwifery Registered	3472	3461	3479	3467	3464	-8	0	359	9.02	7.50
Students	5	6	7	8	7	3	83	0	0.00	0.00
ABUHB	11187	11186	11255	11361	11401	214	2	1047	8.24	7.10

The turnover rate for the Health Board is 8.24% and varies across the staff groups. The three highest groups are Healthcare Scientists 10.81% (All Wales 6.90%), Allied Health Professionals 10.09% (All Wales 7.60%) and Nursing and Midwifery Registered 9.02% (All Wales 7.50%).

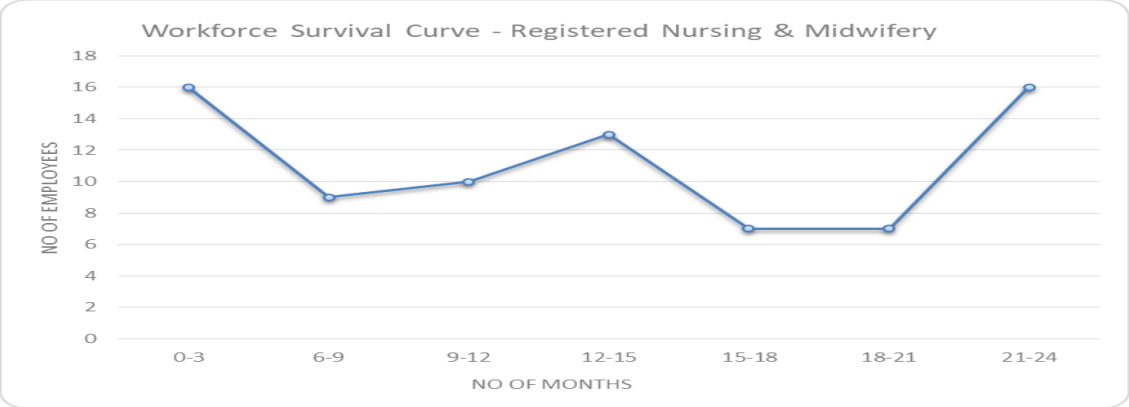
Analysis of Registered Nursing and Midwifery Turnover

Over the last 12 months, 303.64 WTE (355 Heads) registered nurses left the Health Board. 53% is due to voluntary registration, 44% is retirement and 3% other. 11% of leavers worked in the Health Board for less than a year whilst over 20% of leavers had over 30 years' service.

The employee stability index for registered nursing and midwifery is 88.19%, this figure shows that 11.91% of the staff that were employed 12 months ago have now left.

Outlined below is the Workforce Survival Curve which maps the number of leavers plotted against the months of employment. The previous paper outlined the survival curve for all leavers. The information below describes the survival curve for registered nurses.

Of the 355 registered nurses who left, 48 individuals have left within 12 months and 78 individuals have left within 2 years of service.



We have analysed the data specifically for those Registered Nurses who leave at 3 and 12 months.

Leavers after 3 months

Pay Grade	040 CONTINUING HEALTH & FUNDED NURSING CARE	040 FAMILY & THERAPIES DIVISION	040 MENTAL HEALTH & LEARNING DISABILITIES DIVISION	040 PRIMARY CARE & COMMUNITY SERVICES	040 SCHEDULED CARE	040 UNSCHEDULED CARE	Total
Band 5	1	1	3	1	2	1	9
Band 6	1	2	2	1		1	7
Total	**2**	**3**	**5**	**2**	**2**	**2**	**16**

Reasons for Leaving	040 CONTINUING HEALTH & FUNDED	040 FAMILY & THERAPIES	040 MENTAL HEALTH & LEARNING DISABILITIES	040 PRIMARY CARE & COMMUNITY	040 SCHEDULED CARE	040 UNSCHEDULED CARE	Total
Retirement		1	1	1			3
Voluntary Resignation - Better Reward Package			1				1
Voluntary Resignation - Child Dependants		1			1		2
Voluntary Resignation - Other/Not Known	1	1	3	1		2	8
Voluntary Resignation - Relocation					1		1
Other	1						
Total	2	3	5	2	2	2	16

- 16 individuals left the Health Board within 3 months of joining.
- 75% are due to Voluntary Resignation.
- 25% are under 30 years old.

Leavers after 12 months

Pay Grade	040 CONTINUING HEALTH & FUNDED NURSING CARE	040 FAMILY & THERAPIES DIVISION	040 MENTAL HEALTH & LEARNING DISABILITIES DIVISION	040 PRIMARY CARE & COMMUNITY SERVICES	040 SCHEDULED CARE	040 UNSCHEDULED CARE	Total
Band 5	1	2	8	5	6	6	28
Band 6	1	5	6	3	1	1	17
Band 7				2			2
Band 8B			1				1
Total	2	7	15	10	7	7	48

Reasons for Leaving	040 CONTINUING HEALTH & FUNDED NURSING CARE	040 FAMILY & THERAPIES DIVISION	040 MENTAL HEALTH & LEARNING DISABILITIES DIVISION	040 PRIMARY CARE & COMMUNITY SERVICES	040 SCHEDULED CARE	040 UNSCHEDULED CARE	Total
Retirement	0	2	1	2	0	0	5
Voluntary Resignation - Better Reward Package			1	1			2
Voluntary Resignation - Child Dependants		1			1	1	3
Voluntary Resignation - Other/Not Known	1	2	8	5	3	5	24
Voluntary Resignation - Promotion			1				1
Voluntary Resignation - Relocation		2	3		3	1	9
Voluntary Resignation - Work Life Balance			1	1			2
Other	1			1			2
Grand Total	**2**	**7**	**15**	**10**	**7**	**7**	**48**

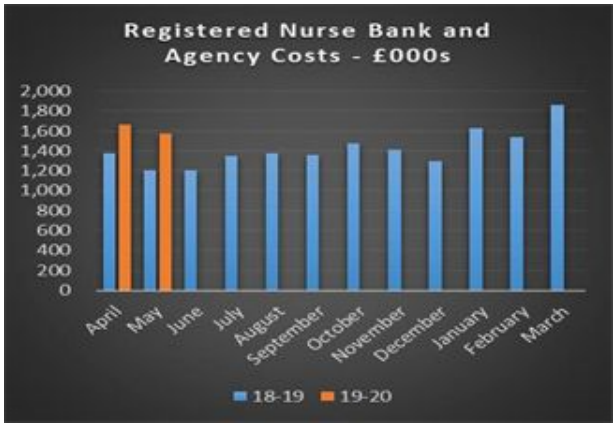
- Of the registered nurses who left in the first 12 months 41 (85%) of the individuals were voluntary terminations and 27% are under the age of 30 years old.
- The highest level of leavers following 12 months are in Mental Health & LD. There is no recruitment problem for Registered Mental Health Nurses.
- Within Mental Health it is anticipated that a number of newly qualified band 5 registered nurses will leave a ward setting after a period of between 12 and 24 months to work in a community setting.
- There are an increasing number of Mental Health nursing posts being developed within GP practices as part of revised service models. This is providing more opportunities for these nurses to work in community settings.

The divisional survival curve information for registered nurses has been shared with Workforce Business Partners to confirm any divisional concerns and identify any actions required.

VARIABLE PAY

In May 2019, 860 WTE was used across all staff groups on variable pay, the usage has reduced by 39 WTE since March 2019. The Health Board relies on variable pay to cover additional capacity beds, specialling, sickness, vacancies, rota gaps and keeping services safe.

Further analysis into the costs / usage is outlined below:



Registered Nursing Bank and Agency - In April/May 2019-2020, £3.240m was spent on registered nurse bank & agency usage. This is an increase of £863k compared to the same time in 2018-2019. This increase is predominately due to vacancies.

Average usage / costs per month

	Average Usage	Average Costs	Average Hourly Costs
Bank	165	£851k	£34.38
Agency	109	£795k	£48.62

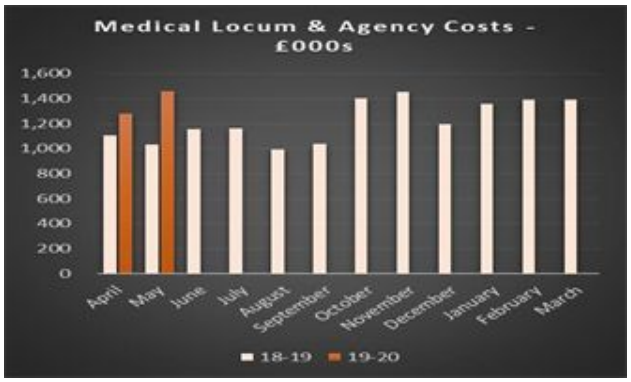
Costs include on costs

HCSW Bank and Agency - In 2019-2020, £1.355m was spent on HCSW bank usage. This is an increase of £116k compared to the same period last year. The increase is predominately due to sickness and vacancies.

Average usage / costs per month

	Average Usage	Average Costs	Average Hourly Costs
Bank	243	£677k	£18.57

Costs include on costs



Medical Locum and Agency - In 2019-2020, £2.734m was spent on Medical locum and agency. This is an increase of £598k compared to the same time last year. The reasons for cover are gaps in rotas arising from recruitment shortages and to ensure our services are safe.

Average usage / costs per month

	Average Usage	Average Costs	Average Hourly Costs
Locum & Agency	75	£1.367m	£121

Costs include on costs

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

ABUHB Key Performance Indicators - Comparison	Compared to Jun 18	May-19	Mar-19	Dec-18	Sep-18	Jun-18
Sickness Absence - In Month %	↑	4.97%	5.05%	6.01%	5.20%	4.89%
Overall Sickness Absence - 12 Month Rolling Year	↑	5.37%	5.25%	5.29%	5.25%	5.22%
Short Term Sickness	↑	1.60%	1.74%	1.81%	1.21%	1.09%
Long Term Sickness	↓	3.35%	3.31%	4.20%	3.99%	3.80%
Financial cost of sickness in last 12 months	↑	£18,941,990	£18,479,376	£ 18,170,728	£ 17,698,858	£ 17,177,038
Staff in Post	↑	11401.18	11361.24	11255.31	11186.17	11173.31
	↑	14362	14334	14157	14033	13953
PADR	↑	74.88%	77.05%	72.06%	71.01%	73.68%
Overtime / Additional Hours	↑	181.79	144.22	129.62	119.63	111.81
Bank Usage - Nursing and Midwifery	↑	169.21	185.62	154.88	177.75	159.89
Bank Usage - HCSW	↓	247.27	216.57	227.11	276.59	265.07
Bank Usage - Other Staff Groups	↓	79.77	87.81	84.76	93.09	87.85
Bank Spend - All Staff Groups	↑	£1,778,409	£2,026,301	£ 1,560,199	£ 1,638,837	£ 1,518,335
Agency usage WTE's - Nursing & Midwifery	↑	106.93	96.98	83.29	80.82	74.65
Agency usage WTE's - HCSW	↓	0.00	0.14	0.00	0.05	0.10
Agency Spend - All Staff Groups	↑	£1,001,166	£1,197,353	£ 824,457	£ 864,005	£ 766,500
Medical Locum Spend	↓	£229,552	£230,815	£ 239,033	£ 202,240	£ 193,005
Medical Agency Spend	↑	£973,395	£1,077,968	£ 781,472	£ 652,103	£ 743,247
Turnover	↑	8.53%	8.34%	8.30%	8.09%	7.69%
Statutory and Mandatory Training	↑	71.58%	70.45%	69.60%	67.94%	64.50%
Job Planning Compliance - Consultants	↑	80%	80%	79%	77%	69%
T18 - Time from Vacancy Requested by manager to unconditional offer 71 days	↓	44.70%	60.70%	63.80%	41.70%	51.60%

A divisional heat map has been developed to highlight the high level the areas that need most support.

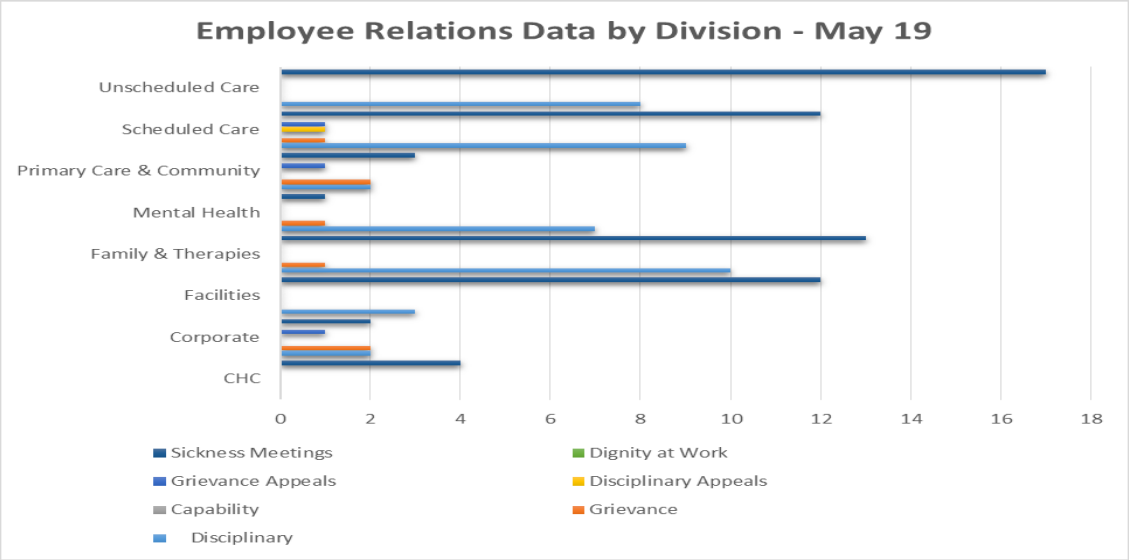
Divisional Heat Map	ABUHB	Scheduled Care	Unscheduled Care	Family & Therapies	Mental Health & LD	Primary Care & Community Services	Facilities	Corporate	CHC
Sickness Absence - In Month %	4.95%	4.94%	5.55%	4.04%	3.90%	5.95%	6.68%	3.88%	3.84%
Sickness Absence - 12 Month Rolling Year	5.37%	5.03%	5.63%	4.78%	5.62%	5.85%	6.60%	4.95%	6.76%
Short Term Sickness	1.60%	1.47%	1.80%	1.42%	1.52%	1.30%	2.30%	1.69%	1.68%
Long Term Sickness	3.35%	3.47%	3.75%	2.62%	2.38%	4.65%	4.38%	2.19%	2.16%
PADR	74.88%	64.69%	73.44%	79.56%	74.39%	76.02%	87.60%	69.25%	83.38%
Turnover	8.53%	8.17%	5.55%	9.46%	10.37%	9.87%	7.48%	9.20%	6.81%
Statutory & Mandatory Training	71.58%	68.74%	67.40%	78.55%	79.14%	77.29%	50.90%	76.09%	82.72%
Disciplinaries	41	9	8	10	7	2	3	2	0
Grievance	7	1	0	1	1	2	0	2	0
Capability	0	0	0	0	0	0	0	0	0
Dignity at work	0	0	0	0	0	0	0	0	0
Time to Recruit	44.70%	34.30%	13.50%	54.50%	57.70%	52.50%	33.30%	72.00%	20.00%

EMPLOYEE RELATIONS

A summary of employee relations activity as at end of May 2019 is outlined in the table and graph below:

Disciplinary	Grievance	Suspensions	Dignity at Work	Raising Concerns
41	7	11	0	2
Last month 42	Last Month 9	Last month 10	Last Month 1	Last month 2

Disciplinary Appeals	Grievance Appeals	Capability	Sickness Meetings
1	3	0	64
Last month 2	Last month 3	Last month 2	Last month 76



A process has been developed and agreed with Trade Union colleagues to support reducing the timeframe for disciplinary processes. This includes appointing Independent Investigation Officers and a case management tool to provide a project management approach to meeting key milestones. Investigating officers have been appointed to the bank and are in the process of receiving training. The case management tool is in use and receiving positive feedback from managers and trade unions representatives. There will be an evaluation of these processes in September 2019 to consider their impact on reducing timelines.

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 an appropriate capacity.

The table below indicates the number of employees suspended as at May 2019, 54% have been over 4 months.

Timescale	**No. Of Employees**
0-3 Months	4
3-6 Months	2
6 Months+	5
Total Number of Suspensions	**11**
Total Number over 4 Months	6

As a result of regular suspension reviews, the number of employees suspended as at 21st June 2019 has reduced to 7. This has been facilitated by formal processes concluding and facilitating returns to work through

temporary redeployments, e.g. in non-patient facing areas where appropriate.

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Finance & Performance Committee 04 July 2019 Agenda Item: 2.2

2.2

Aneurin Bevan University Health Board

SICKNESS ABSENCE REPORT

Executive Summary

The purpose of this paper is to provide the Finance and Performance Committee with an overview of the actions taken and currently in development to support reducing sickness absence. The paper includes an update on:

- The implementation of the new Managing Attendance at Work Policy.
- An overview of recent initiatives, their impact to date and next steps.
- A review of sickness absence data compared to the position across Wales and the UK and how this data is shaping our response.

The Finance and Performance Committee is asked to note the content of the report and provide views.

The Finance & 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, Director of Workforce & OD	
Report Author: Sarah Simmonds, Assistant Director of Workforce & OD, Paula Michell, Senior Workforce Business Partner and Lead for Sickness Absence.	
Report Received consideration and supported by :	

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

Date of the Report:

Appendix 1 - Case Study – Sickness Intervention: Continuing Health and Funded Nursing Care (CHC)

Appendix 2 - Health Board services and interventions which support employee wellbeing

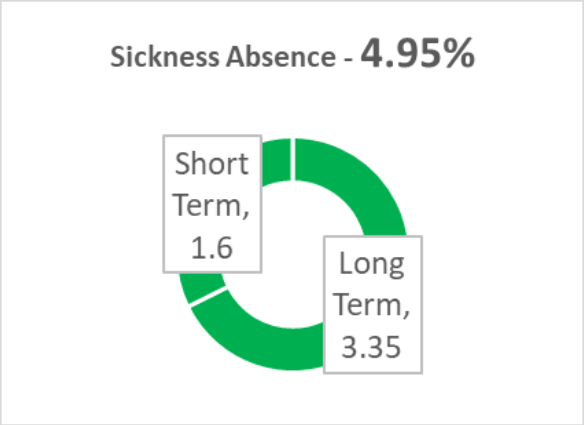
Purpose of the Report

To provide the Finance and Performance Committee with an overview of the actions taken and currently in development to support reducing sickness absence within the Health Board.

2.2

Background and Context

Sickness absence in May 2019 was 4.95%, which is 0.02% lower than April 2019 (4.97%). The 12 month cumulative sickness absence rate is 5.37%.

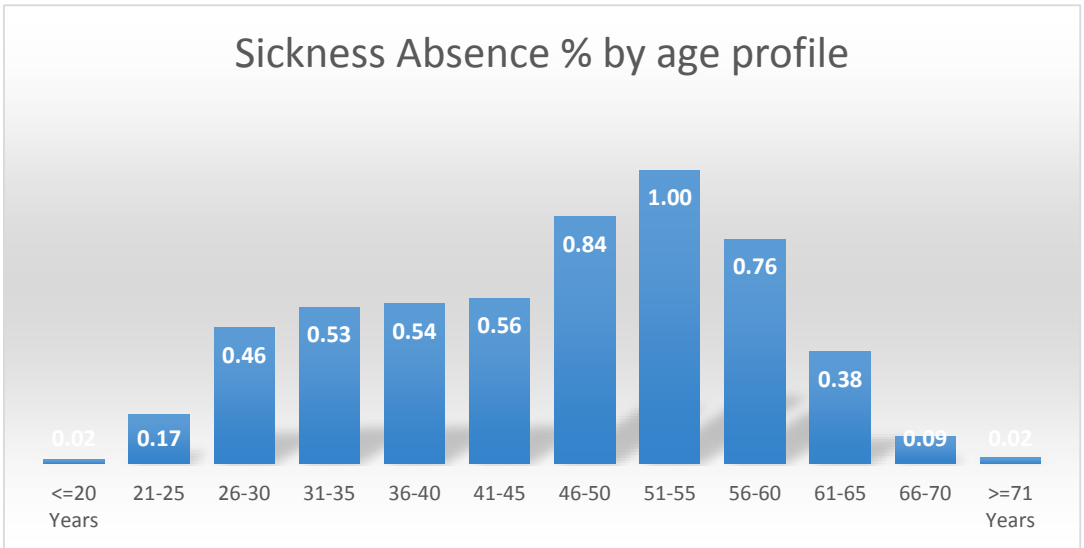


In May 2019, long term sickness absence was 3.35% which is the lowest percentage in the last 12 months. This is a result of a reduction in the number of long term episodes between 6 months to over 12 months which has reduced by over 50% from 159 to 76 episodes.

61% of employees have not had any sickness absence over the last 12 months.

The leading reason for sickness absence is anxiety, stress and depression which in May 2019 constiutied 27.7% of all sickness absence.The average for the year is 28.8%. The reasons for absence are outlined in the table below.

Absence Reason	%
S10 Anxiety/stress/depression/other psychiatric illnesses	27.7
S12 Other musculoskeletal problems	13.3
S28 Injury, fracture	7.6
S98 Other known causes - not elsewhere classified	6.8
S25 Gastrointestinal problems	6.5
S11 Back Problems	6.5
S26 Genitourinary & gynaecological disorders	4.3
S13 Cold, Cough, Flu - Influenza	4.3
S17 Benign and malignant tumours, cancers	3.4
S99 Unknown causes / Not specified	3.1



42% of overall absence is attributed to employees who are 55 years and above.

The New Managing Attendance at Work Policy (MAAW)

The new policy was agreed in Partnership in October 2018 and approved by the Health Board in November 2018. This policy has been designed to shift the emphasis from managing absence to improving attendance at work. Members of the Workforce and OD team have led the development of the all Wales policy and the operational "how to" guides, as well as designing the training programme. The leadership of our team in developing the policy and supporting materials has been recognised at an All Wales level.

It was acknowledged that the new approach would be, for some, a new cultural style. The key principles have been used to inform a range of interventions that are outlined in this paper.

Key principles of MAAW policy
Deliver the implementation of the policy in partnership with Trades Union Colleagues.
Enable managers to use discretion in the implementation of the stages of the policy to promote compassionate management.
Support the health and wellbeing of employees in the workplace.
Support employees to return to work following a period of sickness absence safely and as quickly as possible.
Support employees to sustain their attendance at work by preventing absence when possible.

In line with the national pay deal for Agenda for Change staff for 2018-2021, there is a requirement to reduce cumulative sickness absence rates at an all Wales level to 4.75% by September 2019. Failure to reduce absence to these levels will result in unsocial hours/enhanced hourly payments being withdrawn from occupational sick pay for staff. This will not apply to those employees who have a terminal illness. Therefore, the implementation of the Managing Attendance at Work Policy and its impact on supporting a reduction in sickness absence is subject to intense scrutiny on an all Wales basis.

Implementation and impact of the new policy

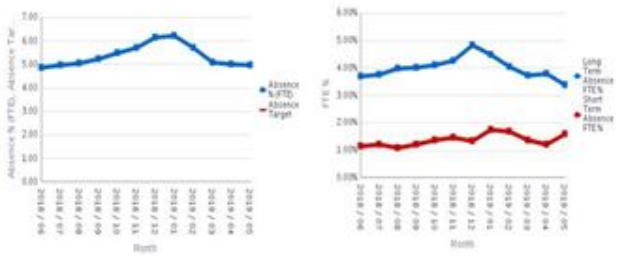
Members of the Workforce & OD team and 18 ABUHB Trades Union representatives have been trained to deliver training on the new policy for Health Board managers. This training has also been embedded into the Health Board's Core Skills for Managers programme to ensure appropriate training for new and aspiring managers.

From July 2019 a slightly different approach will be taken to delivering this training. Training will be delivered to teams, prioritising areas where sickness absence is highest. This decision has been taken following a review of recent reductions in sickness absence in the CHC division. Further detail is outlined later of this paper.

Progress is reported regularly through an All Wales Data Monitoring Group. Members of the Workforce and OD team are part of this group which also provides an opportunity to share good practice across Wales. It provides for the first time a central mechanism for the Health Board to record, collect and compare information on actions which support

reducing sickness absence. For example, recording the number of staff on phased returns or adjusted duties which previously has not been routinely captured.

The table below shows the information that is reported to the All Wales Data Monitoring Group from ABUHB. The information is provided monthly and reporting commenced in February 2019. At present some of the data requires more testing for comparison purposes but provides a useful tool.

<table>
<tr><th colspan="5">Monthly Sickness Data for Aneurin Bevan University Health Board as at February to May 2019</th></tr>
<tr><td colspan="3">Monthly Sickness rate for ABUHB plotted against the sickness target</td><td colspan="2">Rolling 12 Month Sickness</td></tr>
<tr><td colspan="3" rowspan="3">  </td><td>ABUHB</td><td>5.3%</td></tr>
<tr><td>NHS Wales</td><td>5.3%</td></tr>
<tr><td>Target</td><td>5.3%</td></tr>
<tr><td>Short-term/ Long Term Sickness</td><td>No of absences that are agreed as work related</td><td>No of staff on health redeployment</td><td>No of staff on adjusted duties</td><td>No of staff on phased return to work</td></tr>
<tr><td>33% S/T</td><td rowspan="2">2</td><td rowspan="2">8</td><td rowspan="2">9</td><td rowspan="2">30</td></tr>
<tr><td>67% L/T</td></tr>
</table>

Progress on implementation of the policy:

- 364 managers have been trained to date.
- An e-learning package is in development to enhance and widen the reach of training materials.
- Managers have told us that:

  The new policy provides a more informal approach and empowers managers to make decisions to allow staff to return to work on modified or different duties.

  Managers are supportive of the new policy approach of a "therapeutic return to work" which allows employees to test out if they are ready to return, e.g. by attending a team meeting or informal visit to the work place before agreeing a more formal return to work plan.

The information and data above is regularly reviewed at the Health Board's internal sickness absence working group which is attended by colleagues from Trades Unions, divisions and Workforce & OD. The data is used to inform new approaches to managing attendance at work and reducing sickness absence. Some of the new approaches that have been explored are outlined below.

An overview of recent initiatives, their impact to date and next steps

Impact of an additional resource to support sickness absence administrative tasks over the winter period.

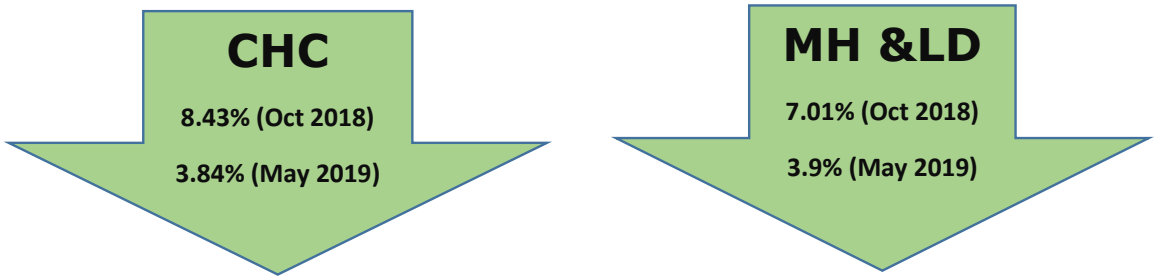
From January to March 2019, a band 3 resource was engaged on a fixed term basis to support managers with administration. The activities of the role included daily review of sickness absence reports and communication with managers to offer administrative support specifically for long term sickness absence. This provided:

- A prompt for managers where absences were in excess of 28 days with advice on next steps.
- A prompt for managers to close sickness recording on ESR in a timely way to ensure more accurate reporting of absence. This helped support a reduction in long term sickness from 4% Jan 2019 to 3.73% Mar 2019.

In addition, this resource allowed the Workforce & OD team to provide targeted support to areas where sickness levels were highest, specifically, to the CHC and Mental Health and LD (MH & LD) divisions. Whilst there were differences in approaches, due to the nature of services and divisional configurations, both projects focused on:

- Engaging managers at all levels in leading sickness absence discussions.
- Training and coaching support focused on the compassionate manager ethos of the MAAW policy. This provided a focus on appropriate wellbeing support and empowering managers to apply discretion to support staff when it was required but also to escalate through the formal stages of the policy when appropriate.
- Sharing sickness absence performance information on a regular basis with teams and ensuring this was reported to senior management teams.
- Improving communication with all staff regarding their responsibilities and the impact of sickness absence on service delivery.

The outcome:



- Positive response from local managers specifically regarding the development of a compassionate manager approach, the focus on wellbeing and use of discretion.
- Divisions have requested to continue with the level of workforce support provided.

A case study in **Appendix 1** details the approach in CHC.

Impact of training managers

A focus on training managers and supervisors for both the CHC and MH & LD divisions suggested that there may be a link between those managers that have attended the managing attendance at work training and absence levels.

A comparison of sickness absence rates to the percentage of managers who have received training for the MAAW policy to date in each division is shown below.

Division	% of managers trained in MAAW policy	Sickness Absence Rate May, 2019
040 CONTINUING HEALTH & FUNDED NURSING CARE (CHC)	10.28	3.84
040 FACILITIES DIVISION	6.07	6.68
040 FAMILY & THERAPIES DIVISION	19.16	4.04
040 MENTAL HEALTH & LEARNING DISABILITIES DIVISION	18.22	3.9
040 PRIMARY CARE & COMMUNITY SERVICES	6.07	5.95
040 SCHEDULED CARE	18.69	4.94
040 UNSCHEDULED CARE	6.54	5.55

Further analysis of the above is being undertaken to understand the full impact of this training. There are a further number of managers that will have received training prior to the implementation of the new policy and all managers will be supported by the workforce team as required.

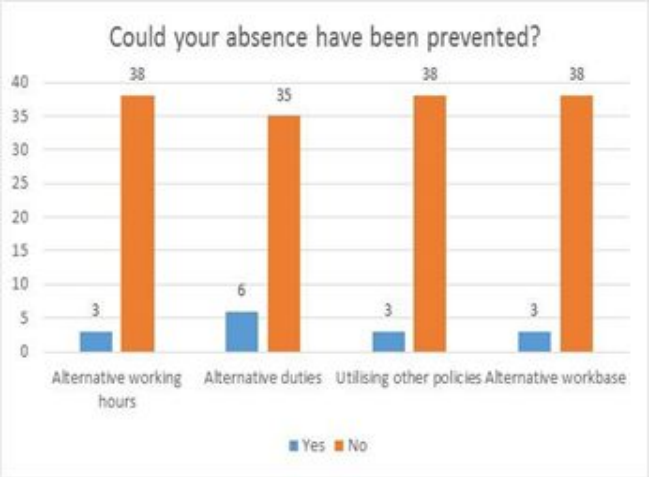
However, initial feedback from managers in CHC and MH&LD divisions have said that coaching and consistent support from the workforce team has been a critical factor in reducing sickness absence. This feedback has been used to inform the new approach of prioritising training for managers in areas of highest sickness absence, this will commence from July 2019.

Impact of a staff questionnaire to gather information on employee experience

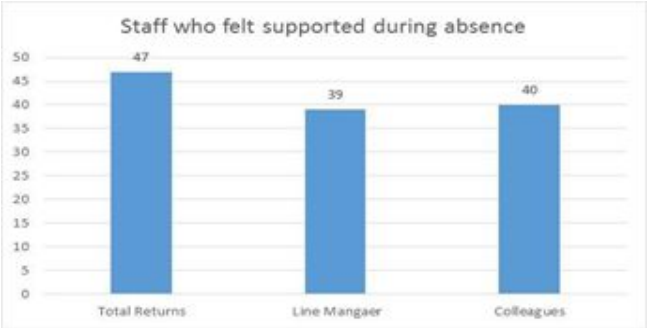
To understand what support may be provided to prevent absence and secure an early return to work a sickness absence questionnaire was developed in partnership with Trades Union colleagues. The aim of the questionnaire was to seek views from employees who had either had a period of long term sickness absence in the past 12 months or a number of short term episodes. Employees were asked to share their experiences confidentially and were advised that these experiences could inform how future cases may be supported.

A total of 260 questionnaires were sent to employees mainly within the Primary Care and Community Division. A return rate of 18% was achieved which equated to 47 staff.

Key findings were:



- 91% of respondents confirmed that their reason for absence was not related to bullying at work.
- 81% respondents indicated that their absences could not have been prevented either by alternative duties or working hours.
- 83% respondents felt supported by their line manager.
- 85% of respondents felt adequately communicated whilst absent from work.
- 40% respondents had been referred to Occupational Health during their period of absence and had found this experience helpful.



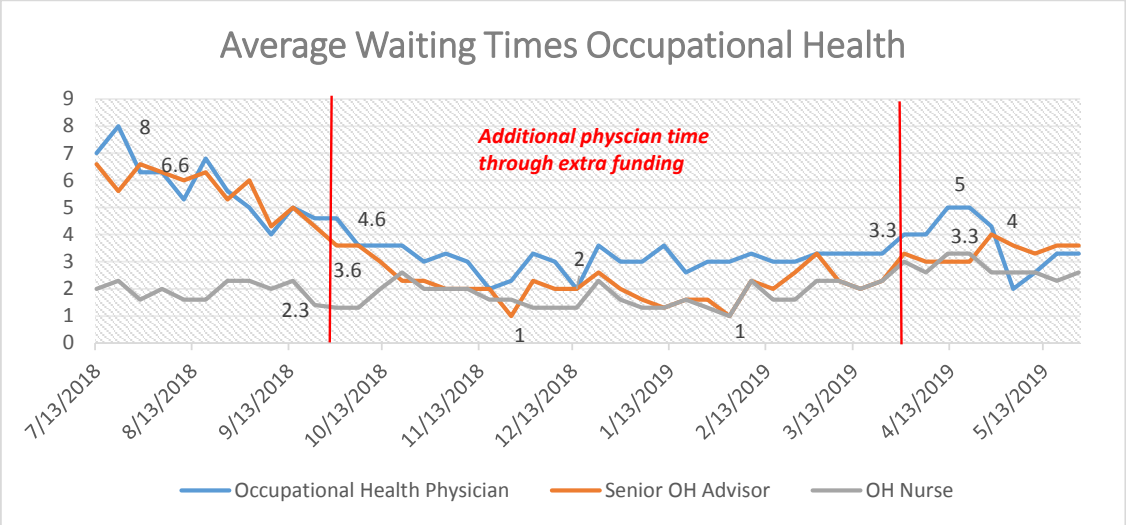
- The responses demonstrated that there was a wide range of support offered to assist a return to work. The most popular were phased returns to work, temporary adjustments to job role, support from colleagues and receiving regular communications.

To strengthen the findings this exercise will be extended beyond the Primary & Community Care Division during July 2019.

Impact of improvements to occupational health access during the winter period

Following the retirement of the previous consultant in Occupational Health and difficulties in recruiting a replacement, Occupational Health utilised Caer Health Care to provide physician advice. An additional investment of £40K was put in place in September 2018 to enable the department to increase its clinic capacity throughout the winter period. Additional funding in terms of secretarial support was also put in place to ensure there were no delays in sharing information with relevant managers. This investment ceased in April 19.

The graph below shows the average waiting times within the Health Board, both before the additional investment and after.



It would appear that waiting times are starting to increase again during May 2019 with waiting times at 31 May 2019 being between 3 and 4 weeks for both physician and senior nurse. We are currently reviewing the number of referrals and numbers of staff referred over May to understand that data.

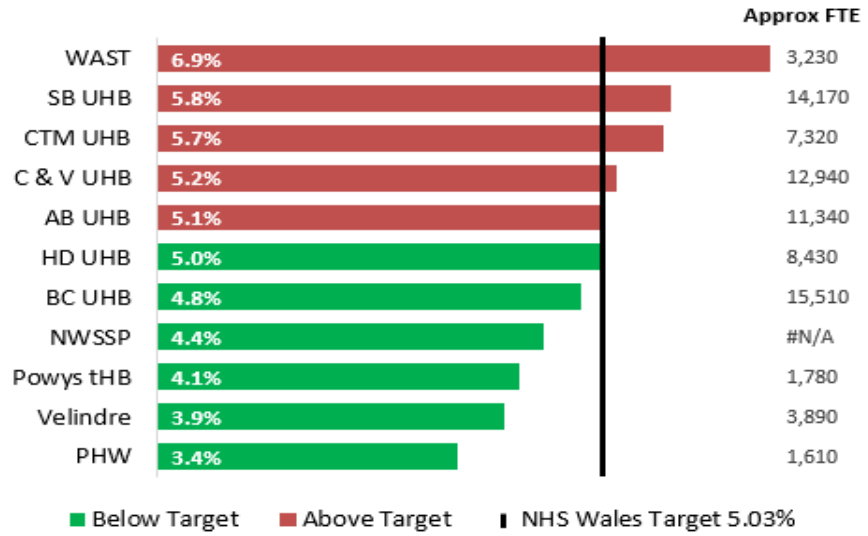
The impact of running 9 physician led clinics has improved waiting times as shown below:

- Waiting times ranged between 5 and 8 weeks for medical opinion but reduced to between 2 and 4 weeks with the support of the additional investment.
- Improved waiting times for the Senior Occupational Health Advisor. Prior to the investment, waiting times ranged between 4.3 and 6.6 weeks across all sites and saw a reduction between 1 and 3.6 weeks thereafter.
- The additional investment allowed 291 more staff to be seen over the winter period (noting that there are likely to be more referrals to OH over this period due to seasonal increases in absence.) This allowed employees to progress the management of their sickness absence/wellbeing issues more promptly.

Additional occupational health support coincides with the reduction in long term sickness reported for May 2019 which has decreased by over 50%. (From 159 in June 2018 to 76 episodes May 2019).

A review of sickness absence data compared to the position across Wales and the UK and how this data is shaping our response

All Wales position - The most up to date all Wales position was available in March 2019. ABUHB position against other NHS Wales organisation is outlined below:



The Health Board's sickness absence level is in line with the all Wales average and is slightly over the all Wales target.

Compared to the larger Health Board's in Wales, ABUHB have the one of the lowest percentages of sickness absence. It is important to recognise the demographics of our local population:

- 80% of our workforce live within the ABUHB area.
- 22% of the population within ABUHB area have poor or fair health, this is 3% higher than the Welsh average 19%.
- 52% are being treated for an illness, this is higher than Welsh average of 51%.

The Health Board will continue to be actively involved in the All Wales Data Monitoring Group to contribute to and learn from best practice across Wales with a view to improving the our position.

UK national position - A recent report produced by Public Health England: Workplace Health, Applying All Our Health, issued in April 2018, stated that that the main reasons for absence across public sector organisations are:

Reason for absence	UK % of overall absence	ABUHB % of overall absence
Mental Health conditions, including stress, anxiety and depression	11.54%	27.7%
Musculoskeletal conditions Musculoskeletal problems, including injury and fracture	21%	20.9%
Colds, coughs and flu	26.1%	4.3%

The Office for National Statistics review of sickness absence in 2017, published July 2018, reported that:

- The private sector had lower sickness levels when compared to the public sector.
- Organisations with over 500 employees have the highest levels of sickness absence.
- The age profile of the organisation has a direct impact on sickness absence levels, e.g. increase in musculoskeletal absences.

We have looked at the data of the national position in the context of ABUHB as set out below.

Review of Sickness Absence by Age Group - is there a pattern of musculoskeletal absence?

A review of sickness absence by age group identifies that 148 wte over 55 year olds are lost due to sickness absence in any given week. This accounts for 25% of the overall sickness absence. Sickness absence for our employees aged 55 or over accounts for 42% of current sickness absence.

The top 5 reasons are outlined below:

Over 55 Year olds

Top 5 Reasons for sickness	LT	ST	Days Lost	WTE Lost
S10 Anxiety/stress/depression/other psychiatric illnesses	214	72	13070	35.80
S98 Other known causes - not elsewhere classified	140	87	9302	25.48
S12 Other musculoskeletal problems	73	44	4425	12.12
S28 Injury, fracture	72	67	4117	11.27
S11 Back Problems	47	66	3824	10.47

Musculoskeletal related absences account for the third most frequent absence for Health Board staff over 55 years old.

Over the last 12 months, there were 1,670 episodes of sickness absence due to Musculoskeletal and Back Pain in total for all age groups. Of the individuals who were absent from work, 76.77% had undertaken their manual handling training.

The table below indicates the compliance rates by staff group compared to cumulative sickness absence rates:

	Manual Handling Training				Rolling Year Sickness Rates
Staff Group	Yes	No	Total	Compliancy Rate	
Add Prof Scientific and Technic	17	7	24	**70.8%**	**3.15%**
Additional Clinical Services	370	118	488	**75.8%**	**8.25%**
Administrative and Clerical	186	48	234	**79.5%**	**4.40%**
Allied Health Professionals	53	9	62	**85.5%**	**2.93%**
Estates and Ancillary	209	72	281	**74.4%**	**6.78%**
Healthcare Scientists	17	3	20	**85.0%**	**3.17%**
Medical and Dental	11	23	34	**32.4%**	**2.04%**
Nursing and Midwifery Registered	419	108	527	**79.5%**	**5.33%**
Grand Total	**1282**	**388**	**1670**	**76.4%**	**5.31%**

It would appear that there is no direct correlation between manual handling training and sickness absence. Although it is acknowledged that improvements in manual handling compliance is required in all areas, particularly those who are more prone to physical activities.

A review of short term absence show that there were 72 episodes of short-term absence for those staff members in the age group 55 years and older. A wellbeing poster has been developed for staff and includes signposting to special leave polices to ensure staff are aware of the support available for unplanned time away from work in unexpected situations, e.g. caring for dependents.

Sickness by reason of stress/anxiety and depression

Stress/anxiety and depression continues to be the main reason for absence. The way current data is captured does not enable the Health Board to understand the underlying causes behind this reason for absence. For example, the reason for absence is recorded on ESR but there is no functionality to provide a secondary reason e.g. whether the absence is work related or due to personal reasons. A snapshot of the current cases supported by Workforce has indicated that 45 absences are due to personal reasons, 13 work-related (not specified) and 39 cases currently not known. The split is as follows:

Data	USC	CHC	SC	F&T	MH	Facilities	Com/PC	Corporate
How many are off due to personal reasons	10	1	13	10	2	6	1	2
How many are work related/ER issues et	2	1	3	3	1	1	1	1
How many don't we know	5	0	3	6	4	13	0	8

Further analysis is underway to better understand the underlying reasons and what additional support can be put in place.

The Workforce & OD team have recently put in place a new system and approach to reducing the timelines for employment relations cases, such as disciplinary and grievance processes. This includes optimising opportunities to use more informal approaches to resolve issues and a fortnightly review of suspensions to support the health and wellbeing of staff during these processes.

A full list of Health Board services and interventions which support employee wellbeing and can be accessed by are detailed in **Appendix 2**.

Sickness by length of absence

It is clear that there has been a large reduction in absences that are between 6 and 12 months when comparing the previous 12 months. However, there is an increase in absence between 15 days and 6 months.

Sickness Episodes by number of days	June 2018 Absence Episodes	May 2019 Absence Episodes
0-1	147	155
2	147	156
3	111	125
4	74	80
5	79	67
6	45	34
7	70	66
8-14	105	103
15-21	73	114
22-27	57	81
28 Days-6 Months	505	572
6 Months-12 Months	114	63
> 12 Months	45	13
Long term	664	648
Short term	908	981
Total number of episodes	1,572	1,629

Further analysis is in progress on absences between 15 days to 6 months to identify appropriate interventions and understand what could be done to reduce absences in these categories.

An information leaflet has been made available to signpost employees and managers to a variety of services and is shared widely across the Health Board. In light of the information above, the leaflet will be directed to anyone absent for more than 15 days. This will help signpost to support mechanisms such as direct access to physiotherapy, road to well-being, occupational health and financial wellbeing support that may support staff to return to work.

Assessment and Conclusion

There are a range of established and developing actions in place to support reducing sickness absence within the Health Board. The new Managing Attendance at Work Policy has provided a framework that empowers managers to make decisions to prevent absence and support early returns to work where appropriate. Whilst the implementation

of the policy and the training are in relatively early stages, the ongoing data monitoring process offers an opportunity to test and review its potential impact.

The paper demonstrates that where there is opportunity for additional support from Workforce & OD, including occupational health, there is a direct impact in reducing sickness absence.

Further work is in progress to better understand the underlying causes of absence related to anxiety, stress and depression and to understand how the Health Board can improve sickness absence with more detailed benchmarking with other NHS and private organisations.

Recommendations
The Finance and Performance Committee is asked to note the content of the report and provide views.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Sickness absence and the wellbeing of the Health Board's workforce is linked to the wider corporate risk of recruitment and retention, specifically the ability to retain our workforce
Financial Assessment, including Value for Money	Reducing sickness absence has the benefit of reducing variable pay where it is required to fill short or long term absences
Quality, Safety and Patient Experience Assessment	Reducing sickness absence supports continuity to support quality patient care and to assist the Health Board deliver safe services.
Equality and Diversity Impact Assessment (including child impact assessment)	An equality and diversity impact assessment is carried out for all Wales policies at a national level.
Health and Care Standards	This report contributes to the good governance elements of the Standards with particular reference to the workforce standard.
Link to Integrated Medium Term Plan/Corporate Objectives	Support achieving Tier 1 target of reducing sickness absence. Providing an appropriate governance to support a workforce to deliver safe, quality care
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	*This section should demonstrate how each of the '5 Ways of Working' will be demonstrated. This section should also outline how the proposal contributes to compliance with the Health Board's Well Being Objectives and should also indicate to which Objective(s) this area of activity is linked.*
	Long Term – Supports effective policy development and arrangements for recruitment governance contributes to a positive impact on patient care and the wider population.

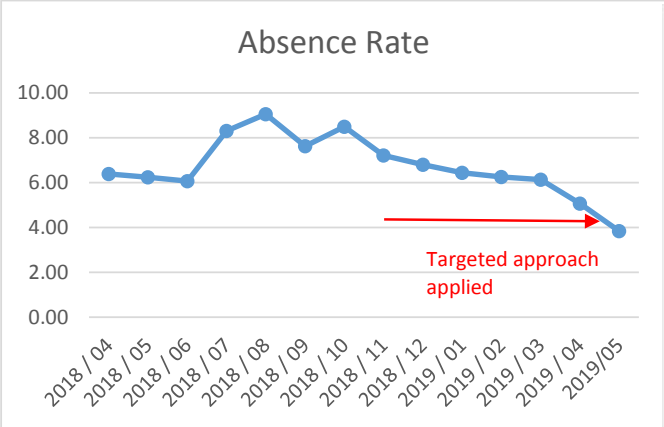
	Integration – Opportunities to work with local and national partners to reduce absence
	Involvement – The work of the Trade Unions take account of the diversity of the membership, staff and population served to ensure policy and service change is equitable.
	Collaboration – Collaboration with external partners is underway to support consistency of approach across NHS Wales organisations
	Prevention – Supports preventing absence and ill health of our workforce and local population.
Glossary of New Terms	Contained within the paper
Public Interest	There is no reason why this information may not be disclosed.

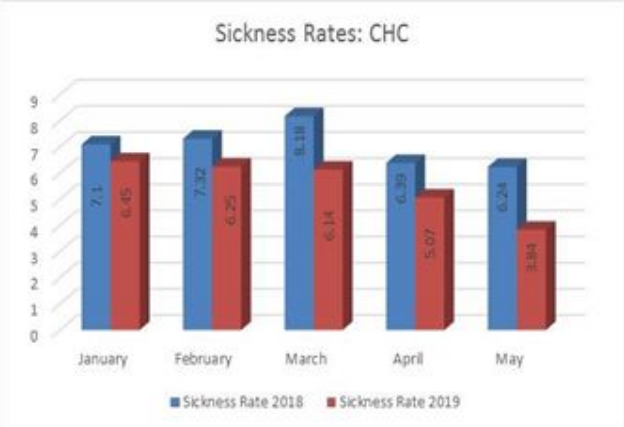
Appendix 1 - Case Study – Sickness Intervention: Continuing Health and Funded Nursing Care (CHC)

1. Background

Continuing Health Care (CHC) has historically been subject to high levels of sickness. CHC's workforce is predominately made up of Healthcare Support Workers and the staff mainly work in patients homes, usually alone or in very small teams. The main reasons for absence is stress/anxiety and musculoskeletal.

2. Overview of absence trends





Over the last 5 months there has been a significant reduction in sickness in comparison to the previous year.

3. What did we do?

- A bespoke support plan was developed to identify the training needs of managers. This included delegating the management of sickness absence responsibilities to a wider number team leaders. This plan has enabled CHC to utilise the skills of those involved in absence management to full effect. This plan has supported managers/supervisors to balance clinical responsibilities with managerial/supervisory tasks and ensured sickness absence was owned by all team members. A number of workshops were facilitated by workforce to identify non-clinical responsibilities.
- Workforce held bi-monthly deep dives in partnership with managers to ensure absence management is being managed appropriately. The outcome of the reviews were fed back at the divisions Divisional Management Team meetings on a bi-monthly basis. A critical success factor to this was that the key senior leadership who were engaged with the plans to reduce sickness absence. This continues to be in place with regular reporting to the senior team.

- Developed an "Attendance Management Resource Pack" which highlights the roles and responsibilities of those involved in absence management and a '10 steps to absence management process' to ensure all staff are aware of the process. These materials were supported by a coaching approach from HR and focusing on policy to practicality.
- Facilitated and embedded a change in the culture through training and communications. The impact of this has been that staff now discuss what options are available to them with their line manager to avoid being absent to work, e.g. alternative duties, swapping shift times. Senior leaders are focusing on the welfare of staff by taking steps to make this happen.
- Workforce attended leadership meetings with Clinical Leads to discuss employee relation concerns, absence management and new approaches to resolving workforce issues.
- Promotion of wellbeing services which are available to employees through staff training days, posters, lunch and learns, social media and team meetings.
- A change in the Senior Management Team with the appointment of two experienced Senior Nurses has proved invaluable.
- HCSW Away Day to ensure that staff felt engaged with the division. Workforce facilitated an "attendance awareness" presentation, which included responsibilities and ethos of the attendance policy. This was an opportunity to promote compassionate leadership and to discuss with the HCSW workforce their personal expectations to support attendance at work. To date, 130 HCSW's have attended these sessions.
- The Division have developed a social media page to improve two way communication and engagement, the division intends to use this platform to communicate improved absence rates.

The specific approach taken along with the implementation of the new All Wales Attendance Management policy has empowered senior leaders to adopt compassionate leadership approaches. This shift in mind set has impacted on the perception towards managing absence, this has cascaded through the division and staff are becoming engaged in the new ways of working. The results has shown that since the targeted approach was introduced, morale has increased, this has been identified at the HCSW away days and absence has reduced.

4. Appendix 2 - Health Board services and interventions which support employee wellbeing

Other activities include a range of support services/sign posting to services to prevent and reduce sickness absence. These include:

Development of a Well Being Poster 	The purpose of this poster was to signpost staff to support that is readily available both internally and externally to the Health Board – the poster is entitled "Help us to help you". This poster has been widely circulated through the cascade mechanism within the Health Board.
Rapid access for employees to key services to prevent or shorten absence 	Proactive promotion of: ➢ Direct access to physiotherapy service ➢ Self-referral process to Occupational Health ➢ Direct access to exercise referral programme ➢ Rapid access service to drug and alcohol team
Menopause Service 	The Health Board has a well-established Menopause Service, which has been promoted throughout the Health Board via a number of roadshows. These sessions have been open to all staff who wish to seek advice and guidance, as well as discussing individual issues directly with clinical lead. There are opportunities for Occupational Health to directly refer to the Nurse Specialist if required.

	• Employee Experience Framework- Launched February 2019 • Various sessions held around ABUHB enabling staff to take time out to relax in a supportive environment. • Individual one to one counselling service • Chill out in the Chapel • Care First, an employee assisted programme • Confidential contact service to support staff who believe they are either subject to workforce bullying or have been accused • Schwartz Rounds • Volunteer Listening Service • Taking Give, Giving Care Rounds • Team focused work to help teams function better • Direct Access to the Well-Being Service • A Self-referral focused therapeutic mindfulness course for staff (8 weeks) is to begin in the autumn of 2019 • Dying to work Charter formally adopted by Health Board • The Primary Care Mental Health Team are running a series of Well-being Wednesdays which offers mindfulness for any member of staff to drop in on the St Cadocs Hospital site each Wednesday at 8.30 am for half an hour • Financial Wellbeing advice and support

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

12TH APRIL 2019
(REPORTING PERIOD 1ST JANUARY – 31ST MARCH 2019)

REPORT TO WELSH GOVERNMENT

WHC/2017/042

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1. INTRODUCTION

The Health Board's plan in response to WHC/2017/042 'Addressing the impact of NHS Wales Medical and Dental Agency and Locum deployment in Wales' 23rd October 2017, was submitted to Welsh Government on 3rd November 2017. This plan described Aneurin Bevan University Health Board's (ABUHB) response to delivering the programme of work. It included its approach for managing short, medium and long term impacts on service delivery and mitigation.

2. DATA REQUEST

The data requested is outlined in (appendix 2).

3. SUMMARY OF LOCUM AND AGENCY USAGE FOR MARCH 2019

The table below provides summary data on locum and agency usage within the Health Board during March 2019 and identifies usage below and above capped rates. January and February data is attached in Appendix 1.

			Division					
ABUHB Medical & Dental Dashboard	Month : Mar 2019	ABUHB	Scheduled Care	Unscheduled Care	Family & Therapies	Mental Health & LD	Locality Primary Care	Workforce and OD
Shifts Worked	Shifts	1341	188	621	329	116	76	11
Breaches of Cap Rates		848	158	288	277	80	34	11
% of Breaches	%	63	84	46	84	69	45	100
Of which are:								
Agency	Shifts	737	116	180	249	105	76	11
Breaches of Cap Rates		668	116	180	248	79	34	11
% of Breaches	%	91	100	100	100	75	45	100
Total Agency Hours	Hours	**6305**	**1056**	**1389**	**2410**	**803**	**566**	**83**
Locum	Shifts	604	72	441	80	11	0	0
Breaches of Cap Rates		180	42	108	29	1	0	0
% of Breaches	%	30	58	24	36	9	0	0
Total Locum Hours	Hours	**4992**	**792**	**3523**	**540**	**138**	**0**	**0**
Total Overall Hours used (Agency & Locum)		**11297**	**1847**	**4912**	**2950**	**941**	**566**	**83**

In March 2019, 6305 **agency** hours (737 shifts, 63 individual doctors) and 4992 **locum** hours (604 shifts) were worked totalling 11297 hours for both agency and locum. The data shows a split of 54% agency/46% locum usage. Of the 604 **locum** shifts (4992 hours, 165 individual doctors) worked only 180 shifts breached the capped rate resulting in a 30% breach rate.

Of the 737 **agency** shifts worked, 668 (91%) shifts breached the capped rate.

The agency and locum usage and breaches has increased this month to 63%, this is higher than previous month.

Outlined in the tables below is the average hourly rate per grade, comparison to cap rate and hours breakdown.

The table shows that in March 2019, 75% of locum and agency usage is due to vacancies.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Agency and Locum Usage

Grades	Comparison to Cap Rate	Cap Rate	Decrease / Increase	Average Hourly Rate	Mar-19	Feb-19	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun 18	May 18	April 18	Mar 18	Feb 18	Jan 18	Dec 17	Decrease / Increase compare Dec 17 to Mar 19 Hours	Mar-19	Dec-17	Main Reason for increase
Associate Specialist	↓	82.21	↓		75	82	88.69	59.4	44.05	60.14	85.62	50.99	62.75	68.76	66.00	58.63	62.82	50.58	53.03	55.83	↑	4	59	Vacancy
Consultant	↑	97.22	↑		111.31	106.77	108.97	110.72	106.66	105.95	110.47	109.34	106.16	105.17	108.31	107.40	107.55	111.35	108.31	112.63	↓	2608	2616	
Dental core training		56.15					80	40		40	40	40	40	40	35.5	30.99	30.99	30.99	30.99	30.99			61	Vacancy
F1		32.54					32.34	32.54						32.54	32.54	32.54	33.68	32.54		32.54			13	Vacancy
F2	↑	40.36	↑		43.11	39.82	46.79	48.24	46.65	40	48		46.36	38.75	46.03	35.00	41.47	39.87	38.36	40.36	↑	237	5	Vacancy
Specialty Doctor	↑	66.43	↑		74.04	72.29	72.49	75.43	73.57	69.16	65.14	64.35	63.24	63.24	59.28	63.53	59.71	62.01	62.81	60.43	↑	1746	1607	Vacancy
StH (ST3/4 - ST8)	↑	57.05	↑		72.56	72.39	74.53	69.5	68.74	72.22	71.19	69.12	69.24	68.52	66.75	60.88	58.40	59.71	62.00	64.40	↑	2744	1928	Vacancy
StL (CT/ST1 - ST2/3)	↑	45.76	↓		49.89	51.56	50.07	50.64	51.41	50.91	49.03	49.9	49.06	48.34	49.39	49.36	48.80	47.29	48.23	50.45	↑	3959	3709	Vacancy
StRL (ST/CT1 -ST/CT2)		45.76														45.13	45.76							

The average hourly rate across Locum and Agency has increased in 6 out of the 8 grades.

5 of the 6 grades are above the national capped rate.

The main reason for increases is Vacancies.

Agency Usage

Grade	Comparison to Cap Rate	Cap Rate	Decrease / Increase	Average Hourly Rate	Mar-19	Feb-19	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun 18	May 18	April 18	Mar 18	Feb 18	Jan 18	Dec 17	Decrease / Increase compare Dec 17 to Mar 19 Hours	Dec-18	Dec-17	Main Reason for increase
Associate Specialist		82.21					34.13										66.43	66.43						
Consultant	↑	97.22	↓		113.48	115.09	114.61	113.17	115.21	114.84	115.83	116.26	115.91	113.75	114.42	110.08	111.97	111.28	112.09	117.18	↑	1628	1406	Vacancy
F1		32.54												57.00										
F2		40.36					62.01	61.99	61.97		60.00		60.00		54.75		60.00							Vacancy
Specialty Doctor	↑	66.43	↑		74.29	74.16	73.76	73.67	81.06	74.48	69.02	69.17	70.84	67.06	68.83	67.96	69.15	70.96	70.46	71.13	↑	1078	776	Vacancy
StH (ST3/4 - ST8)	↑	57.05	↑		83.53	83.38	80.64	80.29	80.61	80.32	80.09	79.61	77.65	74.66	72.94	75.27	76.99	72.71	72.85	75.51	↑	1732	923	Vacancy
StL (CT/ST1 - ST2/3)	↑	45.76	↓		57.20	58.66	58.26	58.38	58.57	56.78	58.57	58.11	56.98	57.26	59.25	56.39	56.44	52.13	53.65	58.51	↓	1868	2065	Vacancy
StRL (ST/CT1 -ST/CT2)		45.76														45.76	45.76							

All Grades are above the national capped rate.

The main reason for increases is vacancy.

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Locum Usage	Comparison to Cap Rate		Decrease / Increase																	Decrease / Increase compare Dec 17 to Mar 19			
Grade		Cap Rate		Average Hourly Rate	Mar-19	Feb-19	Jan-19	Dec-18	Nov-18	Oct-18	Sep-18	Aug-18	Jul-18	Jun 18	May 18	April 18	Mar 18	Feb 18	Jan 18	Dec 17	Hours	Dec-18	Dec-17	Main Reason for increas
Associate Specialist	↓	82.21	↓		75	82.00	67.2	59.4	44.05	60.14	85.62	50.99	62.75	68.76	66.00	58.63	55.18	46.62	53.03	55.83	↓	4	59	Vacancy
Consultant	↑	97.22	↑		107.88	99.06	93.62	106.21	90.34	90.12	102.02	98.13	81.71	83.16	93.96	101.86	97.11	111.48	101.75	106.34	↓	980	1210	Vacancy
Dental core training		56.15					80.00	40.00		40.00	40.00	40.00	40.00	40.00	35.50	30.99	30.99	30.99	30.99	30.99			61	Vacancy
F1		32.54					32.34	32.54						32.54	32.54	32.54	33.68	32.54		32.54			13	Sickness
F2	↑	40.36	↑		43.11	39.82	40.53	40.38	41.15	40.00	40.00		38.57	38.75	39.50	35.00	39.00	39.87	38.36	40.36	↑	237	5	Vacancy
Specialty Doctor	↑	66.43	↑		73.65	67.72	69.54	78.28	61.82	46.32	36.90	45.57	31.79	37.30	29.27	47.50	32.18	35.98	48.77	47.91	↓	668	831	Sickness
StH (ST3/4 - ST8)	↓	57.05	↓		55.33	56.00	61.05	57.93	55.43	55.65	60.36	57.54	53.52	55.29	59.39	54.72	52.21	54.33	53.50	54.13	→	1012	1005	Vacancy
StL (CT/ST1 - ST2/3)	↓	45.76	↓		43.47	43.98	44.00	43.58	42.89	43.17	42.85	43.90	43.71	42.88	43.51	43.67	42.77	43.71	42.94	41.73	→	2092	1645	Vacancy
StRL (ST/CT1 -ST/CT2)		45.76														42.00								

3 out of the 6 grades are Above the cap rate.

In 3 of the grades there has been an increase in the average hourly rate.

4. INFORMATION REQUESTED IN WHC/2017/042

4.1 Effectiveness of the control framework

(and information about whether any changes have been made as a result of lessons learned during operation).

The internal audit of the Health Board's authorisation and escalation process, testing compliance with Welsh Health Circular 2017/042 gave reasonable assurance, with no material non-compliances identified. A further audit has been undertaken. The draft report will be presented to the Executive team and Audit Committee later this month.

4.2 Updated risk assessment

(Incorporating lessons learned from any practical issues which have arisen during implementation, and the ways that the risks will be mitigated or managed).

Medical planning workshops, aligned to service and workforce plans of the IMTP provided an understanding of the mitigation against medical variable pay expenditure, and identified the particular approaches and timescales being taken to address variable pay in individual areas i.e. rate renegotiation, service redesign and reconfiguration; role redesign; substantive appointment aligned to the IMTP. The specific issues, risks and mitigation were described in previous reports to Welsh Government. The following provides an update on the residual issues and actions taken or proposed to address locum and agency usage and spend.

A review of the original plans from the workshops will take place during June.

5. DIVISIONAL INFORMATION

5.1 Mental Health and Learning Disabilities

The Division continues to have some recruitment issues at Consultant level but has seen an improvement in recruitment at junior and middle grade levels. Medical agency expenditure has reduced considerably and remained relatively stable over the period with only essential service posts being covered.

The Division continues to utilise a number of strategies designed to reduce the reliance on locum and agency whilst ensuring responsive, sustainable service provision:-

- The Division has made further attempts to recruit to the long standing consultant gaps in older adult (Caerphilly) and Adult (Newport

Inpatient) without success to date. Therefore these posts continue to be covered by agency appointments. However, the most recent advertisement for the Caerphilly older adult post has attracted applicants and hopefully an appointment will be made in the near future.

- The successful recruitment of fixed term appointments (FTA) to cover training vacancies at junior level has increased significantly within the last quarter. As of April 2019, 5 junior doctor posts remain unfilled (1 older adult, 2 learning disabilities, 2 CAMHS) meaning all essential service posts are covered (including two candidates currently within the recruitment process). Many of the fixed term appointments recruited within the last quarter have displayed an interest in joining the training scheme in the future, two juniors having already secured their training places within the August 2019 rotation.
- The increase in the number of FTAs appointed has covered many gaps within the junior doctor out of hours rota which now is a 1:12 rota. From August 2019 the number of junior vacancies is expected to remain stable, with a potential further reduction following the start of two incoming trainees on the Medical Training Initiative scheme (MTI), although timescales around these start dates are yet to be confirmed.
- Middle grade recruitment has also seen some improvement, with the number of vacancies in all specialties reduced to 4 in total, following the successful appointment to vacancies in both North and South Monmouthshire adult services in March 2019. Agency locum cover is still required for one middle grade vacancy within Caerphilly adult services, although attempts to cover this post with agency has been unsuccessful to date. The division has utilised feedback from agency medical staff to review the suggested job plan in the hope of attracting more candidates.
- The middle grade salary scale remains an issue but attempts to retain successful candidates through initiatives such as earlier calculation of salary scale point are proving beneficial. There is little incentive for Clinical Fellows on banded rotas to convert to Speciality Doctors (if eligible for the grade) due to the differential in earnings.
- A range of workforce options including expanding ANP posts, potential development of non-medical responsible clinician posts, Physician Associates (PAs) and skill mix changes are being explored. Two PA posts have been advertised as part of the 2019 recruitment round. Three additional ANP posts have recently been advertised as part of the crisis transformation programme. However there are difficulties in recruiting into these posts. The Health Board has also supported the move to appoint two Physician Associate posts (one in Adult and one in Older Adult Mental Health Services).

- Significant service changes have been delivered in Older Adult and Learning Disabilities services over the last two years resulting in lower bed numbers and enhanced community services. Learning Disabilities are currently undertaking a review of community services and the medical workforce model needed to support the new service model.
- Work is ongoing in continuing to take forward the transformational change in the adult crisis services. A pilot of a single crisis assessment service, with consultant support being job planned to provide consultant advice at the front end, is planned to commence around July 2019.
- Acute adult inpatient remodelling work is ongoing, with options for future bed configuration based on a graduated care model being considered. Further developments in host families and crisis house are also being developed which should assist in reducing demand on inpatient services.
- Further discussion is continuing regarding the sustainability of current medical workforce model through the divisional Medical Workforce Group.

5.2 Unscheduled Care

The Unscheduled Care division continues work to reduce locum and agency workers and the number of capped rate breaches.

Service/role re-design

The division will shortly be appointing an additional six Physician Associates (PA's) to support the medical team and the junior doctor vacancies in the following areas:

- A&E
- Respiratory
- Elderly Frailty Unit
- Gastroenterology
- Diabetes
- Emergency assessment unit

It is acknowledged that the first year of employment for PAs will consist of an internship and therefore will require a higher level of supervision.

Workforce planning for Clinical Futures and specifically the opening of the Grange University Hospital (GUH) have reviewed roles and patient pathways. This has led to Advanced Nurse Practitioners (ANPs), Emergency Nurse Practitioners (ENPs) and Clinical Nurse Specialists (CNS) supporting service models where possible.

Ten Clinical Fellows have also been appointed in advance of the opening of the GUH and will shortly be starting in the acute sites. YYF will have 2, NHH 3 and RGH 5 – this will further reduce reliance on locum and agency for junior gaps.

5.3 Scheduled Care

While the overall position remains unchanged since the last report, the division is undertaking a scoping exercise in line with IMTP plans to extend the use of alternative roles such as ACCP, Nurse Practitioners, Physician Associates and Surgical Care Practitioners to resolve some of the medical workforce gaps and provide alternative capacity. However, this will be supported by periods of training for up to 2/3 years in some cases.
Active recruitment continues with some previously hard to fill posts successfully recruited to, specifically in Ophthalmology, albeit with delayed start dates through to 2020.

Scheduled Care have experienced a number of suitable candidates choosing to take offers in other Health Boards due to salary. In order to mitigate this the division are looking to have greater engagement with Directorate Clinical Directors at the point of recruitment.

The Division is utilising all avenues to recruit through schemes such as BAPIO, finder agencies with Health Board protocols and traditional recruitment avenues. To date schemes such as BAPIO have been unsuccessful and a protracted process. A key example being, a BAPIO applicant appointed in December 2017 being rejected by the Royal College in March 2019.

5.4 Family & Therapies

Active recruitment continue and the overall position remains unchanged since the last report.

6. FINANCE

Target Period – Performance against the 35% target

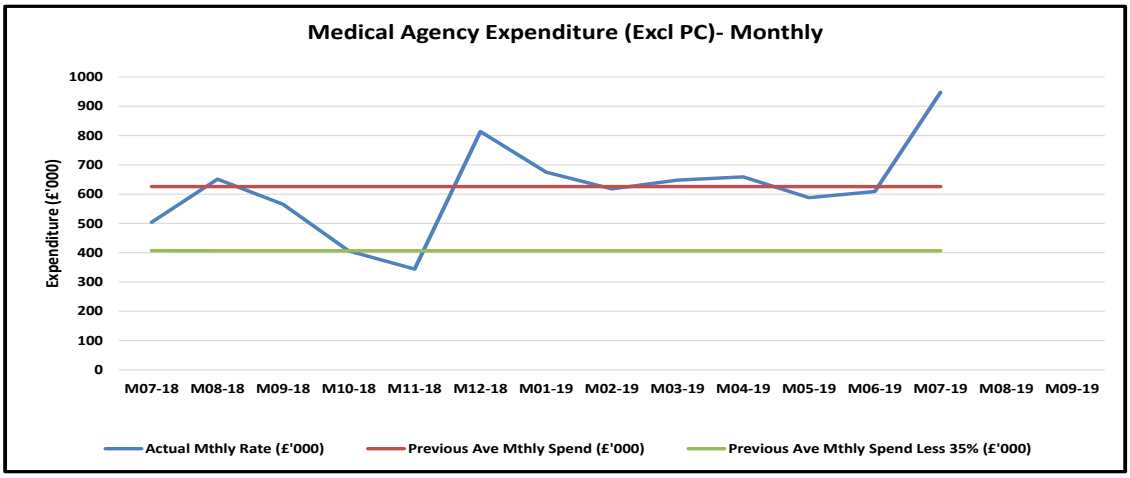
The WHC describes an expectation of a 35% reduction in agency only expenditure by November 2018, from a baseline period of 1st November 2016- 31st October 2017.

The Health Board's agency expenditure for the above reference period is assessed as £7.508m in financial year 2017/18 (based on actual spend for October 2017 and also excluding service transfers to Powys made within the

baseline reference period). The monthly average spend over this period is £0.626m.

A 35% reduction in medical agency expenditure equates to £2.6m per annum; resulting in a reduced annual expected spend of £4.880m, and monthly expected spend of £0.407m for the reference period of November 2017 to October 2018.

At the end of the target period (October 2018), the spend for the previous 12 months totalled £7.525m, which was £0.025m more than the expenditure in the reference period, and £2.645m greater than the 35% target spend.



Quarter 4 2018/9 – Performance (Exc PC)

In Quarter 4 2018/9, medical agency expenditure increased by £2.848m from Quarter 3, to a total spend of £9.268m for the financial year. This compares to spend of £7.508m in. The key cost drivers to the expenditure remain as follows:-

- Ophthalmology – long-term sickness cover for 6-7wte.
- Orthopaedics and other Scheduled Care – RTT performance delivery actions and cover for 10 agency posts in Orthopaedics.
- Paediatrics/Obstetrics & Gynaecology: increasing costs of sustaining existing rotas across sites
- Emergency Department / COTE - issues remain sustaining rotas across multiple sites as well as covering vacancies. Coupled with sickness this remains a significant pressure across the Health Board.
- Occupational Health – covering vacant posts

7. EMERGING ISSUES/LESSONS LEARNED

- Agencies

The difficulties highlighted in previous reports persists in respect of agencies being unwilling to work with the Health Board to encourage Doctors to adhere to the capped rates. Advice from the procurement team is that the agencies are only bound to adhere to the CCS rates which for some specialities are above the cap and therefore there is little than can be done on a wider basis to address this.

- Application of WLI rates

The Health Board has been aware for some time that the WLI rate has been applied to ad hoc locum cover and has been addressing this issue. However, the introduction of the caps has raised further issues in respect of this where a non-contractual term "backfill" is being used and seen to be attracting WLI rate, despite the cover constituting a locum at ad hoc locum rates. Whilst the Health Board works to reduce these rates it will initially report these as ad hoc locum hours and a breach of the capped rate.

Indication from the Welsh Government on an all Wales approach to defining this will ensure consistency and aid reduction of the inflated WLI rate down to the cap.

8. PATCHWORK (PREVIOUSLY CALLED LOCUM TAP) PILOT

Implementation of the Patchwork Medical Locum Bank system commenced in November 2018, the pilot has been successfully implemented in A&E departments in both the Royal Gwent and Nevill Hall hospitals and Medicine Nevill Hall Hospital.

To date benefits of the systems are:-

- Shifts released quickly via the Patchwork app so Doctors can browse and book shifts instantly.
- Improved accuracy in monitor hours worked and paid.
- Timesheets processed in a timely manner in line with payroll timetable so doctors are paid within month.
- Increased number of Doctors willing to do locum bank shifts i.e. increased numbers on the Medical Locum Bank.
- Real time data on locum activity and spend.
- A 360 degree evaluation of the system will take place during May/June.

9. CONCLUSION

There is an ongoing demand for use of medical locum and agency staff. The principle reason for this is to cover vacancies in order to maintain clinical safety and activity.

Work to reduce the number of hours of agency continues to be worked on by the divisions – through substantive appointment, through development of non-medical roles, and there will be some additional efficiency for a number of services through centralisation of acute services on a single site.

Reducing locum and agency usage in the difficult recruitment climate remains a considerable challenge.

APPENDIX 1

ABUHB Medical & Dental Dashboard	Month : Feb 19	ABUHB	Scheduled Care	Unscheduled Care	Family & Therapies	Mental Health & LD	Locality Primary Care	Workforce and OD
Shifts Worked	Shifts	1250	205	396	452	112	74	11
Breaches of Cap Rates		748	150	201	288	64	34	11
% of Breaches	%	60	73	51	64	57	46	100
Of which are:								
Agency	Shifts	746	143	157	261	100	74	11
Breaches of Cap Rates		654	142	143	260	64	34	11
% of Breaches	%	88	99	91	100	64	46	100
Total Agency Hours	Hours	**6346**	**1157**	**1224**	**2571**	**758**	**555**	**83**
Locum	Shifts	504	62	239	191	12	0	0
Breaches of Cap Rates		94	8	58	28	0	0	0
% of Breaches	%	19	13	24	15	0	0	0
Total Locum Hours	Hours	**4166**	**647**	**2840**	**543**	**137**	**0**	**0**
Total Overall Hours used (Agency & Locum)		**10511**	**1804**	**4063**	**3113**	**894**	**555**	**83**

ABUHB Medical & Dental Dashboard	Month : Jan 19	ABUHB	Scheduled Care	Unscheduled Care	Family & Therapies	Mental Health & LD	Locality Primary Care	Workforce and OD
Shifts Worked	Shifts	1311	224	586	271	180	38	12
Breaches of Cap Rates		795	175	256	213	121	18	12
% of Breaches	%	61	78	44	79	67	47	100
Of which are:								
Agency	Shifts	785	172	192	207	166	36	12
Breaches of Cap Rates		670	167	175	178	120	18	12
% of Breaches	%	85	97	91	86	72	50	100
Total Agency Hours	Hours	**6751**	**1418**	**1722**	**1998**	**1254**	**270**	**90**
Locum	Shifts	526	52	394	64	14	2	0
Breaches of Cap Rates		125	8	81	35	1	0	0
% of Breaches	%	24	15	21	55	7	0	0
Total Locum Hours	Hours	**4392**	**676**	**3111**	**469**	**136**	**0**	**0**
Total Overall Hours used (Agency & Locum)		**11143**	**2094**	**4833**	**2467**	**1390**	**270**	**90**

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Appendix 2 – Data – MARCH 2019

Tables 2a,b,c,d - A summary of the reasons for A&L usage

a. External agency bookings below the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Other - see comments	5	38	£ 66.43	£ 2,491.13
Sickness	1	13	£ 42.00	£ 525.00
Vacancy (Non-Deanery)	63	471	£ 67.92	£ 31,714.00
Grand Total	69	520	£ 67.09	£ 34,739.84

b. External agency bookings above the cap

Reasons	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Exclusion (Suspension)	21	158	£ 69.75	£ 10,985.63
Other - see comments	68	516	£ 104.82	£ 54,352.80
Sickness	8	103	£ 70.24	£ 7,165.60
Special Leave	26	243	£ 74.55	£ 18,190.14
Vacancy	545	4767	£ 85.58	£ 396,690.12
Grand Total	668	5786	£ 84.79	£ 487,384.28

c. Ad hoc ADH bookings below the cap

Reasons	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Annual Leave	25	181	£ 49.44	£ 9,436.08
Other - see comments	3	36	£ 64.29	£ 2,185.76
Reduced Duties	3	17	£ 57.05	£ 969.85
Sickness	38	339	£ 63.16	£ 20,605.43
Study Leave	18	141	£ 51.11	£ 6,747.50
Vacancy	231	2026	£ 51.03	£ 100,285.93
Establishment Shortfall	4	37	£ 51.25	£ 1,857.50
Additional Activity	1	8	£ 55.00	£ 440.00
Restricted Duties	5	53	£ 60.00	£ 3,180.00
Other	4	29	£ 47.50	£ 1,380.00
Vacancy	79	623	£ 45.57	£ 28,207.50
Winter Pressure	13	103	£ 55.00	£ 5,665.00
Grand Total	424	3591	£ 49.85	£ 180,960.56

d. Ad hoc ADH bookings above the cap

Reasons	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A/L	4	16	£ 144.75	£ 2,316.00
Annual Leave	6	40	£ 92.48	£ 3,569.34
Other - see commen	6	24	£ 144.25	£ 3,462.00
Sickness	31	248	£ 78.50	£ 19,204.50
Study Leave	7	67	£ 64.04	£ 3,595.50
Vacancy	86	766	£ 82.87	£ 61,464.00
Perfect Weekend	19	121	£ 166.67	£ 20,167.07
Establishment Short	6	32	£ 91.95	£ 2,873.85
Restricted Duties	4	29	£ 87.92	£ 2,409.96
Other	3	24	£ 107.96	£ 2,516.68
Winter Pressure	8	37	£ 133.04	£ 4,783.24
Grand Total	180	1402	£ 99.87	£ 122,766.64

Tables 3a,b,c,d - A summary of the speciality of A&L usage

a. External agency bookings below the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Adult services - mental health	24	186	£ 67.17	£ 12,353.40
Frailty	42	311	£ 66.43	£ 20,626.52
Older adult services - mental health	2	15	£ 85.00	£ 1,275.00
Paediatrics	1	9	£ 57.05	£ 484.93
Grand Total	69	520	£ 67.09	£ 34,739.84

b. External agency bookings above the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Adult services - mental heal	40	310	£ 87.49	£ 27,313.40
Care of the Elderly	91	677	£ 96.68	£ 65,428.93
Frailty	21	158	£ 69.75	£ 10,985.63
General Medicine	84	672	£ 69.73	£ 46,861.44
General Surgery	9	115	£ 73.33	£ 8,410.00
Obs & Gynae	143	1423	£ 73.92	£ 106,659.20
Occupational Health	11	83	£ 144.00	£ 11,880.00
Older adult services - menta	39	293	£ 85.77	£ 25,087.50
Ophthalmology	81	608	£ 119.98	£ 72,887.85
Paediatrics	105	979	£ 74.46	£ 72,580.77
Palliative Care	13	98	£ 94.95	£ 9,257.63
Stroke	5	40	£ 77.99	£ 3,119.60
Trauma & Orthopaedics	24	295	£ 64.48	£ 24,062.34
Urology	2	38	£ 75.00	£ 2,850.00
Grand Total	668	5786	£ 84.79	£ 487,384.28

c. Ad hoc ADH bookings below the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	147	1190	£ 48.26	£ 57,313.12
Acute Medicine (on-call)	17	139	£ 50.23	£ 6,862.98
Adult services - mental health	10	131	£ 42.34	£ 5,536.04
Anaesthetics	17	159	£ 67.18	£ 11,530.00
Care of the Elderly	8	64	£ 31.86	£ 5,083.28
General Medicine	161	1351	£ 47.14	£ 61,727.33
General Surgery	5	43	£ 55.00	£ 2,365.00
Neonates	6	76	£ 45.76	£ 3,477.76
Obs & Gynae	30	197	£ 70.00	£ 13,525.00
Paediatrics	15	152	£ 53.88	£ 8,020.05
Urology	8	90	£ 40.00	£ 5,520.00
Grand Total	424	3591	£ 49.85	£ 180,960.56

d. Ad hoc ADH bookings above the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	98	741	£ 97.41	£ 66,823.64
Anaesthetics	30	281	£ 62.10	£ 20,932.00
General Medicine	10	38	£ 136.55	£ 5,173.50
General Surgery	1	13	£ 40.00	£ 520.00
Obs & Gynae	29	116	£ 156.08	£ 18,105.00
Older adult services	1	8	£ 55.00	£ 412.50
Oral Surgery	7	128	£ 60.00	£ 7,680.00
Urology	4	78	£ 40.00	£ 3,120.00
Grand Total	180	1402	£ 99.87	£ 122,766.64

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Tables 4a,b,c,d A summary of grade of A&L usage

a. External agency bookings below the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Consultant	2	16	£ 110.90	£ 1,716.82
Specialty Doctor	64	476	£ 66.46	£ 31,600.59
StH (ST3/4 - ST8)	1	9	£ 57.05	£ 484.93
StL (CT/ST1 - ST2/3)	2	20	£ 48.50	£ 937.50
Grand Total	69	520	£ 67.09	£ 34,739.84

b. External agency bookings above the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Consultant	213	1613	£ 113.51	£ 183,178.26
Specialty Doctor	75	603	£ 80.97	£ 48,288.15
StH (ST3/4 - ST8)	175	1723	£ 83.68	£ 149,311.39
StL (CT/ST1 - ST2/3)	205	1848	£ 57.29	£ 106,606.49
Grand Total	668	5786	£ 84.79	£ 487,384.28

c. Ad hoc ADH bookings below the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Associate Specialst	1	4	£ 75.00	£ 300.00
Consultant	59	451	£ 73.87	£ 32,364.16
F2	17	126	£ 40.00	£ 5,040.00
Specialty Doctor	33	266	£ 50.81	£ 16,540.78
StH (ST3/4 - ST8)	88	752	£ 52.18	£ 40,720.77
StL (CT/ST1 - ST2/3)	226	1993	£ 43.16	£ 85,994.84
Grand Total	424	3591	£ 49.85	£ 180,960.56

d. Ad hoc ADH bookings above the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Consultant	77	529	£ 133.94	£ 61,126.88
F2	11	111	£ 47.91	£ 5,331.00
Specialty Doctor	58	403	£ 86.64	£ 35,626.28
StH (ST3/4 - ST8)	24	261	£ 66.89	£ 15,169.98
StL (CT/ST1 - ST2/3)	10	99	£ 50.50	£ 5,512.50
Grand Total	180	1402	£ 99.87	£ 122,766.64

Tables 5a,b,c,d - A summary of the location of A&L usage

a. External agency bookings below the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Blaenau Gwent	21	158	£ 66.43	£ 10,462.73
Caerphilly	21	153	£ 66.43	£ 10,163.79
Chepstow	21	158	£ 66.43	£ 10,462.73
Monmouth	1	8	£ 68.18	£ 511.35
NHH	1	9	£ 57.05	£ 484.93
STC	1	8	£ 106.79	£ 854.32
Talygarn	1	13	£ 42.00	£ 525.00
YYF	2	15	£ 85.00	£ 1,275.00
Grand Total	69	520	£ 67.09	£ 34,739.84

b. External agency bookings above the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
County	21	158	£ 69.75	£ 10,985.63
Monmouth	20	150	£ 68.18	£ 10,227.00
Newport	18	135	£ 108.58	£ 14,657.63
NHH	194	1849	£ 82.23	£ 150,969.87
RGH	331	2831	£ 85.79	£ 241,530.26
STC	20	160	£ 106.79	£ 17,086.40
YAB	20	150	£ 72.70	£ 10,905.00
YYF	42	315	£ 89.93	£ 28,327.50
STW	2	39	£ 70.00	£ 2,695.00
Grand Total	668	5786	£ 84.79	£ 487,384.28

c. Ad hoc ADH bookings below the cap

Locattion	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
NHH	48	383	£ 60.90	£ 23,853.73
RGH	296	2496	£ 48.49	£ 120,033.93
Talygarn	10	131	£ 42.34	£ 5,536.04
YYF	14	112	£ 36.96	£ 7,183.28
Nevill Hall Hospital	56	469	£ 52.13	£ 24,353.58
Grand Total	424	3591	£ 49.85	£ 180,960.56

d. Ad hoc ADH bookings above the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
NHH	25	180	£ 110.14	£ 17,886.00
RGH	104	813	£ 100.43	£ 69,347.84
YYF	2	12	£ 100.63	£ 997.50
Nevill Hall Hospital	49	397	£ 93.40	£ 34,535.30
Grand Total	180	1402	£ 99.87	£ 122,766.64

Table 6 – For the Ten highest paid individuals in the organisation

	Agency/Locum	Specialty	Reason	Grade	Hrly Rate Paid	Hours Worked	Sum of Total cost of shift
A1	Agency	Older adult services - mental health	Vacancy	Consultant	£ 115.00	157.50	£ 18,112.50
A2	Agency	Adult services - mental health	Vacancy	Consultant	£ 106.79	157.50	£ 16,819.43
A3	Agency	Care of the Elderly	Vacancy	Specialty Doctor	£ 101.99	158.00	£ 16,114.42
A4	Agency	Care of the Elderly	Vacancy	Specialty Doctor	£ 104.00	142.50	£ 14,820.00
A5	Locum	A&E	Vacancy	Specialty Doctor	£ 77.00	187.50	£ 14,437.50
A6	Agency	Ophthalmology	Vacancy	Consultant	£ 119.98	120.00	£ 14,397.60
A7	Agency	Ophthalmology	Vacancy	Consultant	£ 119.98	120.00	£ 14,397.60
A8	Agency	Ophthalmology	Vacancy	Consultant	£ 119.98	120.00	£ 14,397.60
A9	Agency	Ophthalmology	Vacancy	Consultant	£ 119.98	120.00	£ 14,397.60
A10	Agency	Ophthalmology	Vacancy	Consultant	£ 119.98	120.00	£ 14,397.60

Table 7 – For the Ten longest serving Agency individuals in the organisation

	Agency/Locum	Specialty	Reason	Grade	Location	Hrly Rate Paid	Hours Worked	Total Cost of Shift
A1	Agency	Ophthalmology	Vacancy	Consultant	RGH	£ 119.98	15	£ 1,799.70
A2	Agency	Ophthalmology	Vacancy	Consultant	RGH	£ 119.98	60	£ 7,198.80
A3	Agency	Older adult services - mental health	Vacancy	Consultant	YYF	£ 115.00	82.5	£ 9,487.50
A4	Agency	Ophthalmology	Vacancy	Consultant	RGH	£ 119.98	157.5	£ 18,896.85
A5	Agency	Ophthalmology	Vacancy	Consultant	RGH	£ 119.98	157.5	£ 18,896.85
A6	Agency	Ophthalmology	Vacancy	Consultant	RGH	£ 119.98	157.5	£ 18,896.85
A7	Agency	Adult services - mental health	Vacancy	Specialty Doctor	Monmouth	£ 66.43	82.5	£ 5,480.48
A8	Agency	General Medicine	Vacancy	Specialty Doctor	YYF	£ 66.43	144	£ 9,565.92
A9	Agency	Trauma & Orthopaedics	Vacancy	StL (CT/ST1 - ST2/3)	RGH	£ 60.00	50	£ 3,000.00
A10	Agency	Adult services - mental health	Vacancy	Consultant	STC	£ 97.22	75	£ 7,291.50

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

February 2019 Data

Feb-19

Tables 2a,b,c,d - A summary of the reasons for A&L usage

a. External agency bookings below the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Sickness	1	15	£ 69.50	£ 1,007.75
Vacancy	91	696	£ 71.47	£ 48,479.14
Grand Total	92	711	£ 68.67	£ 49,486.89

b. External agency bookings above the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Exclusion (Suspension)	15	113	£ 69.75	£ 7,846.88
Other - see comments	38	295	£ 114.68	£ 33,976.75
Sickness	4	37	£ 69.63	£ 5,363.50
Special Leave	20	151	£ 72.70	£ 10,941.35
Vacancy	577	5040	£ 86.50	£ 426,821.50
Grand Total	654	5635	£ 85.55	£ 484,949.98

c. Ad hoc ADH bookings below the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A/L	7	28	£ 75.00	£ 2,100.00
Annual Leave	9	52	£ 56.91	£ 2,868.32
Other - see comments	1	9	£ 45.00	£ 382.50
Reduced Duties	3	37	£ 57.05	£ 2,096.59
Sickness	29	242	£ 50.53	£ 18,049.15
Special Leave	1	4	£ 50.00	£ 200.00
Study Leave	13	126	£ 42.69	£ 5,387.50
Swap/Gap	2	15	£ 60.55	£ 1,089.81
Vacancy	317	2695	£ 51.84	£ 143,730.73
Visa Delay	2	24	£ 45.00	£ 1,440.00
Establishment Shortfall	2	18	£ 55.00	£ 990.00
Restricted Duties	3	38	£ 57.05	£ 2,139.38
Other	3	25	£ 50.00	£ 1,240.00
Winter Pressure	15	110	£ 54.00	£ 6,020.00
Parental Leave	3	38	£ 45.00	£ 1,687.50
Grand Total	410	3458	£ 49.86	£ 189,421.47

d. Ad hoc ADH bookings above the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A/L	11	44	£ 144.07	£ 6,339.01
Annual Leave	7	55	£ 81.27	£ 4,193.28
Other - see comments	2	8	£ 143.25	£ 1,146.00
Sickness	10	84	£ 114.49	£ 8,283.08
Special Leave	1	4	£ 146.25	£ 585.00
Study Leave	2	20	£ 61.00	£ 1,165.50
Vacancy	39	330	£ 83.52	£ 24,336.84
Perfect Weekend	14	101	£ 166.67	£ 16,833.67
Establishment Shortfall	2	14	£ 77.00	£ 1,078.00
Restricted Duties	3	29	£ 84.81	£ 2,398.57
Other	1	11	£ 60.00	£ 630.00
Winter Pressure	2	13	£ 110.84	£ 1,273.35
Grand Total	94	711	£ 108.68	£ 68,262.29

Tables 3a,b,c,d - A summary of the

a. External agency bookings below the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Adult services - mental health	28	212	£ 72.45	£ 15,427.18
Frailty	40	300	£ 66.43	£ 19,929.00
General Medicine	14	112	£ 60.21	£ 7,542.96
Obs & Gynae	1	12	£ 40.00	£ 480.00
Older adult services - mental health	8	60	£ 85.00	£ 5,100.00
Trauma & Orthopaedics	1	15	£ 69.50	£ 1,007.75
Grand Total	92	711	£ 68.67	£ 49,486.89

b. External agency bookings above the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Adult services - mental health	32	246	£ 87.48	£ 21,850.72
Care of the Elderly	72	541	£ 94.54	£ 51,103.73
ENT	1	8	£ 68.00	£ 612.00
Frailty	15	113	£ 69.75	£ 7,846.88
General Medicine	71	571	£ 73.74	£ 42,036.08
Obs & Gynae	190	1956	£ 74.14	£ 145,612.87
Occupational Health	11	83	£ 144.00	£ 11,880.00
Older adult services - mental health	32	240	£ 85.00	£ 20,400.00
Ophthalmology	104	780	£ 119.98	£ 93,584.40
Paediatrics	70	603	£ 71.06	£ 43,212.47
Palliative Care	19	143	£ 94.95	£ 13,530.38
Trauma & Orthopaedics	34	317	£ 63.73	£ 31,030.46
Urology	3	38	£ 60.00	£ 2,250.00
Grand Total	654	5635	£ 85.55	£ 484,949.98

c. Ad hoc ADH bookings below the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	116	935	£ 48.49	£ 44,629.98
Acute Medicine (on-call)	3	37	£ 57.05	£ 2,096.59
Adult services - mental health	12	137	£ 42.00	£ 5,943.00
Anaesthetics	14	120	£ 63.36	£ 7,735.00
Care of the Elderly	3	16	£ 32.92	£ 2,097.20
General Medicine	176	1411	£ 48.45	£ 69,374.32
General Surgery	8	117	£ 71.31	£ 9,198.42
Neonates	1	12	£ 57.05	£ 684.60
Obs & Gynae	23	147	£ 58.22	£ 10,226.00
Oral Surgery	11	84	£ 58.64	£ 12,195.00
Paediatrics	22	210	£ 53.99	£ 11,268.43
Trauma & Orthopaedics	7	65	£ 38.47	£ 4,132.94
Urology	14	168	£ 40.00	£ 9,840.00
Grand Total	410	3458	£ 49.86	£ 189,421.47

d. Ad hoc ADH bookings above the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	48	395	£ 106.00	£ 38,481.20
Anaesthetics	8	94	£ 65.13	£ 6,115.00
General Medicine	10	49	£ 133.77	£ 6,177.25
Obs & Gynae	17	68	£ 144.31	£ 9,813.01
Paediatrics	11	106	£ 74.19	£ 7,675.84
Grand Total	94	711	£ 108.68	£ 68,262.29

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Tables 4a,b,c,d A summary of grade

a. External agency bookings below the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Consultant	8	62	£ 110.90	£ 6,867.28
Specialty Doctor	74	567	£ 66.57	£ 37,729.61
StH (ST3/4 - ST8)	4	32	£ 50.00	£ 2,400.00
StL (CT/ST1 - ST2/3)	6	50	£ 50.83	£ 2,490.00
Grand Total	92	711	£ 68.67	£ 49,486.89

b. External agency bookings above the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Consultant	207	1568	£ 115.25	£ 181,062.07
Specialty Doctor	66	503	£ 82.68	£ 43,108.75
StH (ST3/4 - ST8)	166	1618	£ 84.19	£ 141,811.96
StL (CT/ST1 - ST2/3)	215	1947	£ 58.88	£ 118,967.19
Grand Total	654	5635	£ 85.55	£ 484,949.98

c. Ad hoc ADH bookings below the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Associate Specialist	2	13	£ 82.00	£ 820.00
Associate Specialst	2	0	£ 32.32	£ 1,551.12
Consultant	55	415	£ 67.92	£ 38,870.76
F2	11	97	£ 39.82	£ 3,910.00
Specialty Doctor	47	403	£ 56.25	£ 23,418.10
StH (ST3/4 - ST8)	89	808	£ 50.90	£ 45,744.01
StL (CT/ST1 - ST2/3)	201	1697	£ 43.51	£ 74,067.48
FY2	3	26	£ 40.00	£ 1,040.00
Grand Total	410	3458	£ 49.86	£ 189,421.47

d. Ad hoc ADH bookings above the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Associate Specialst	4	16	£ 144.00	£ 2,304.00
Consultant	42	264	£ 139.84	£ 34,448.26
Specialty Doctor	11	78	£ 116.76	£ 8,602.60
StH (ST3/4 - ST8)	25	229	£ 74.17	£ 16,340.44
StL (CT/ST1 - ST2/3)	6	62	£ 59.67	£ 3,732.00
FY2	6	63	£ 45.00	£ 2,835.00
Grand Total	94	711	£ 108.68	£ 68,262.29

Tables 5a,b,c,d - A summary of the

a. External agency bookings below the cap

Blaenau Gwent	20	150	£ 66.43	£ 9,964.50
Caerphilly	8	60	£ 66.43	£ 3,985.80
Chepstow	20	150	£ 66.43	£ 9,964.50
Monmouth	4	30	£ 68.18	£ 2,045.40
Newport	12	90	£ 66.43	£ 5,978.70
NHH	1	12	£ 40.00	£ 480.00
RGH	1	8	£ 45.00	£ 360.00
STC	4	32	£ 106.79	£ 3,417.28
YYF	21	164	£ 70.37	£ 12,282.96
STW	1	15	£ 69.50	£ 1,007.75
Grand Total	92	711	£ 68.67	£ 49,486.89

b. External agency bookings above the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
County	15	113	£ 69.75	£ 7,846.88
Monmouth	16	120	£ 68.18	£ 8,181.60
Newport	24	180	£ 105.17	£ 18,930.38
NHH	176	1639	£ 81.56	£ 134,231.06
RGH	348	3009	£ 87.17	£ 263,250.67
STC	16	126	£ 106.79	£ 13,669.12
YAB	21	158	£ 72.70	£ 11,504.78
YYF	35	263	£ 90.06	£ 23,640.00
STW	3	30	£ 69.67	£ 3,695.50
Grand Total	654	5635	£ 85.55	£ 484,949.98

c. Ad hoc ADH bookings below the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Newport	1	16	£ 34.13	£ 546.08
NHH	53	447	£ 58.11	£ 28,379.55
RGH	181	1524	£ 48.36	£ 84,490.35
Talygarn	12	137	£ 42.00	£ 5,943.00
YYF	37	290	£ 54.03	£ 19,272.70
STW	4	34	£ 34.82	£ 2,332.94
Nevill Hall Hospital	68	572	£ 49.27	£ 27,704.35
Royal Gwent Hospital	54	439	£ 47.78	£ 20,752.50
Grand Total	410	3458	£ 49.86	£ 189,421.47

d. Ad hoc ADH bookings above the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
NHH	20	168	£ 89.67	£ 13,275.84
RGH	25	136	£ 129.50	£ 15,290.01
Other	1	13	£ 97.22	£ 1,215.25
Nevill Hall Hospital	27	219	£ 103.26	£ 20,575.29
Royal Gwent Hospital	21	176	£ 109.51	£ 17,905.91
Grand Total	94	711	£ 108.68	£ 68,262.29

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

January 2019 Data

Feb-19

Tables 2a,b,c,d - A summary of the reasons for A&L usage

a. External agency bookings below the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Sickness	1	16	£ 34.13	£ 546.08
Vacancy	114	947	£ 67.99	£ 68,712.73
Grand Total	115	963	£ 67.51	£ 69,258.81

b. External agency bookings above the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Annual Leave	8	63	£ 63.78	£ 3,999.50
Exclusion (Suspension)	16	120	£ 69.75	£ 8,370.00
Other - see comments	48	371	£ 112.13	£ 41,771.23
Sickness	7	66	£ 79.44	£ 9,254.76
Special Leave	18	135	£ 74.23	£ 10,867.30
Study Leave	2	20	£ 84.50	£ 1,690.00
Vacancy	567	4819	£ 95.81	£ 426,055.42
Establishment Shortfall	5	54	£ 84.80	£ 4,578.00
Other	1	8	£ 79.37	£ 634.96
Winter Pressure	12	120	£ 81.90	£ 9,888.00
Parental Leave	1	12	£ 55.00	£ 660.00
Grand Total	685	5788	£ 88.27	£ 517,769.17

c. Ad hoc ADH bookings below the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Annual Leave	21	137	£ 68.22	£ 7,160.00
Maternity	3	38	£ 81.09	£ 3,649.05
Other - see comments	7	64	£ 35.86	£ 2,168.30
Sickness	27	255	£ 59.18	£ 16,728.50
Special Leave	4	38	£ 54.02	£ 2,971.35
Study Leave	7	45	£ 47.86	£ 2,155.00
Swap/Gap	2	23	£ 45.00	£ 1,350.00
Vacancy	326	2811	£ 47.46	£ 143,192.81
Perfect Weekend	1	3	£ 97.22	£ 291.66
Establishment Shortfa	6	47	£ 53.46	£ 2,483.50
Other	4	34	£ 43.75	£ 1,460.00
Winter Pressure	1	5	£ 55.00	£ 275.00
Grand Total	409	3497	£ 49.96	£ 183,885.18

d. Ad hoc ADH bookings above the cap

Reason	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A/L	9	36	£ 105.67	£ 3,804.00
Annual Leave	5	36	£ 64.84	£ 2,236.82
Maternity	2	24	£ 63.05	£ 1,621.35
Sickness	11	72	£ 100.95	£ 7,076.86
Special Leave	3	24	£ 45.00	£ 2,160.00
Study Leave	12	77	£ 77.65	£ 5,128.00
Vacancy	52	414	£ 82.86	£ 26,404.36
Perfect Weekend	15	90	£ 166.67	£ 15,000.30
Establishment Shortfa	6	39	£ 77.00	£ 3,003.00
Additional Activity	1	10	£ 166.67	£ 1,583.37
Other	1	6	£ 166.67	£ 1,000.02
Winter Pressure	8	59	£ 110.63	£ 5,715.05
Grand Total	125	885	£ 90.05	£ 74,733.12

Tables 3a,b,c,d - A summary of the speciality of A&L usage

a. External agency bookings below the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Adult services - mental health	46	345	£ 66.43	£ 22,918.35
Care of the Elderly	1	16	£ 34.13	£ 546.08
Frailty	18	135	£ 66.43	£ 8,968.05
General Medicine	16	138	£ 65.09	£ 8,995.90
Obs & Gynae	29	275	£ 72.56	£ 19,858.82
Trauma & Orthopaedics	5	54	£ 66.43	£ 7,971.60
Grand Total	115	963	£ 67.51	£ 69,258.81

b. External agency bookings above the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	55	512	£ 73.35	£ 37,685.56
Adult services - mental health	52	399	£ 86.72	£ 34,730.32
Care of the Elderly	85	639	£ 96.74	£ 61,808.05
ENT	4	47	£ 65.00	£ 3,040.00
Frailty	16	120	£ 69.75	£ 8,370.00
General Medicine	50	418	£ 84.67	£ 35,116.56
General Surgery	7	64	£ 88.31	£ 10,443.73
Obs & Gynae	72	760	£ 73.85	£ 56,287.65
Occupational Health	12	90	£ 144.00	£ 12,960.00
Older adult services - mental health	68	510	£ 74.41	£ 37,950.00
Ophthalmology	125	938	£ 119.98	£ 112,481.25
Paediatrics	106	963	£ 77.39	£ 78,928.26
Palliative Care	2	15	£ 94.95	£ 1,424.25
Trauma & Orthopaedics	24	243	£ 63.67	£ 21,491.04
Urology	7	74	£ 63.57	£ 5,052.50
Grand Total	685	5788	£ 88.27	£ 517,769.17

c. Ad hoc ADH bookings below the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	117	939	£ 48.46	£ 45,082.92
Acute Medicine (on-ca	12	104	£ 45.51	£ 8,512.02
Adult services - menta	13	129	£ 42.00	£ 5,397.00
Anaesthetics	27	297	£ 65.33	£ 19,395.00
Care of the Elderly	1	16	£ 34.13	£ 546.08
General Medicine	185	1478	£ 46.55	£ 67,681.81
General Surgery	10	114	£ 73.63	£ 12,213.30
Neonates	7	85	£ 50.60	£ 4,296.04
Obs & Gynae	22	160	£ 67.12	£ 9,376.00
Oral Surgery	4	64	£ 60.00	£ 3,840.00
Trauma & Orthopaedic	3	38	£ 45.00	£ 2,025.00
Urology	8	75	£ 40.00	£ 5,520.00
Grand Total	409	3497	£ 49.96	£ 183,885.18

d. Ad hoc ADH bookings above the cap

Specialty	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
A&E	78	565	£ 97.37	£ 51,890.75
Acute Medicine (on-ca	1	3	£ 97.22	£ 291.66
General Medicine	2	7	£ 132.94	£ 896.86
General Surgery	2	24	£ 63.05	£ 1,621.35
Obs & Gynae	27	148	£ 86.22	£ 11,422.00
Older adult services -	1	8	£ 115.00	£ 862.50
Oral Surgery	1	11	£ 80.00	£ 840.00
Paediatrics	8	66	£ 54.29	£ 3,548.01
Trauma & Orthopaedic	3	24	£ 45.00	£ 2,160.00
Urology	2	30	£ 40.00	£ 1,200.00
Grand Total	125	885	£ 90.05	£ 74,733.12

Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Tables 3a,b,c,d - A summary of the speciality of A&L usage

a. External agency bookings below the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Associate Specialist	1	16	£ 34.13	£ 546.08
Specialty Doctor	84	664	£ 66.43	£ 48,493.90
StH (ST3/4 - ST8)	25	235	£ 74.06	£ 17,344.82
StL (CT/ST1 - ST2/3)	5	48	£ 59.56	£ 2,874.00
Grand Total	115	963	£ 67.51	£ 69,258.81

b. External agency bookings above the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Consultant	264	2001	£ 114.61	£ 233,567.31
F2	14	127	£ 62.01	£ 7,843.88
Specialty Doctor	72	525	£ 82.31	£ 46,672.13
StH (ST3/4 - ST8)	167	1608	£ 81.62	£ 133,781.87
StL (CT/ST1 - ST2/3)	168	1526	£ 58.22	£ 95,903.98
Grand Total	685	5788	£ 88.27	£ 517,769.17

c. Ad hoc ADH bookings below the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Associate Specialist	4	30	£ 72.75	£ 1,905.00
Associate Specialist	1	16	£ 34.13	£ 546.08
Consultant	59	585	£ 72.67	£ 46,864.10
F1	6	60	£ 32.34	£ 1,940.30
F2	24	215	£ 38.67	£ 8,212.00
Specialty Doctor	26	183	£ 55.36	£ 10,581.44
StH (ST3/4 - ST8)	65	553	£ 51.88	£ 31,326.72
StL (CT/ST1 - ST2/3)	223	1832	£ 43.99	£ 80,620.49
Consultant On-Call	1	24	£ 78.71	£ 1,889.04
Grand Total	409	3497	£ 49.96	£ 183,885.18

d. Ad hoc ADH bookings above the cap

Grade	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Associate Specialist	1	0	£ 45.00	£ 1,080.00
Associate Specialist	2	8	£ 143.25	£ 1,146.00
Consultant	38	224	£ 126.14	£ 26,839.34
Dental core training	1	11	£ 80.00	£ 840.00
F2	10	85	£ 45.00	£ 3,825.00
Specialty Doctor	41	325	£ 78.53	£ 24,591.23
StH (ST3/4 - ST8)	22	169	£ 88.15	£ 13,540.27
StL (CT/ST1 - ST2/3)	10	64	£ 44.23	£ 2,871.28
Grand Total	125	885	£ 90.05	£ 74,733.12

Tables 5a,b,c,d - A summary of the location of A&L usage

a. External agency bookings below the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
Blaenau Gwent	18	135	£ 66.43	£ 8,968.05
Chepstow	46	345	£ 66.43	£ 22,918.35
NHH	13	113	£ 80.99	£ 9,122.29
RGH	17	170	£ 64.50	£ 11,096.54
YYF	16	146	£ 64.41	£ 9,181.98
STW	4	30	£ 66.43	£ 6,377.28
Royal Gwent Hospital	1	24	£ 66.43	£ 1,594.32
Grand Total	115	963	£ 67.51	£ 69,258.81

b. External agency bookings above the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
County	16	120	£ 69.75	£ 8,370.00
Monmouth	23	173	£ 68.18	£ 11,761.05
Newport	8	60	£ 131.74	£ 7,904.25
NHH	164	1470	£ 83.73	£ 131,297.80
RGH	286	2418	£ 98.88	£ 232,730.17
STC	26	204	£ 106.79	£ 21,731.77
YAB	19	143	£ 72.70	£ 10,390.04
YYF	70	525	£ 76.40	£ 40,110.00
Newport	3	23	£ 55.00	£ 1,237.50
STW	2	0	£ 66.48	£ 3,191.04
Nevill Hall Hospital	38	334	£ 68.50	£ 22,683.56
Royal Gwent Hospital	30	321	£ 76.88	£ 26,362.00
Grand Total	685	5788	£ 88.27	£ 517,769.17

c. Ad hoc ADH bookings below the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
NHH	47	421	£ 62.07	£ 29,607.29
RGH	215	1821	£ 47.91	£ 88,936.41
Talygarn	13	129	£ 42.00	£ 5,397.00
YYF	10	88	£ 60.06	£ 9,077.52
Nevill Hall Hospital	81	745	£ 49.11	£ 36,910.30
Royal Gwent Hospital	43	295	£ 48.66	£ 13,956.66
Grand Total	409	3497	£ 49.96	£ 183,885.18

d. Ad hoc ADH bookings above the cap

Location	No of Individuals / Bookings	Hours Worked	Avg Hourly Rate	Total Costs (without on costs for Internal Locum)
NHH	25	173	£ 76.38	£ 12,743.02
RGH	20	129	£ 77.84	£ 8,396.86
YYF	1	8	£ 115.00	£ 862.50
Nevill Hall Hospital	39	300	£ 94.41	£ 26,629.16
Royal Gwent Hospital	40	276	£ 99.82	£ 26,101.59
Grand Total	125	885	£ 90.05	£ 74,733.12

Aneurin Bevan University Health Board
4th July 2019
Agenda Item: 2.4

Aneurin Bevan University Health Board

Integrated Performance Report
Finance and Performance Committee

Executive Summary

To provide an update on the current performance of the Health Board at the end of months 1 and 2 of 2019/20, where available, in delivering key performance measures as set out in the performance dashboard and outlined in the National Outcomes and Performance Framework.

The National Performance measures are summarised in the following key areas:

Elective treatment access:

- The number of RTT 36 week breach patients increased in May 19 with 478 compared to 271 in April. 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. The first two months of 19/20 have been challenging with continued emergency pressures and service plans not delivering the required level of treatments. Anecdotally, it is understood that the implications of current pension/tax issues is affecting the level of additional work being undertaken by some of the Health Board's medical staff. Ophthalmology is dependent on outsourcing for a number of the 36 week breach patients which it is anticipated will improve the breach numbers. Whilst this increase is a concern the position is significantly improved on the same period last year (May 18) where there were 1090 patients breaching 36 weeks.
- RTT 26 week compliance in March decreased slightly to 90.2% compared to 91.2% in April. Whilst this is still slightly below the IMTP profile of 90.6% this is a significant improvement on the May 18 compliance of 89.8%.

Diagnostic access:

- The 8 week diagnostic target was missed in May with 6 patients breaching the target although this is an improvement on the April position (31). This is a significant improvement on the same period last year May 18 (279). The breach patients were all within the urodynamic service.

Therapies access:

- The 14 week therapy target was missed in May 19 with 1 patient breaching the 14 week target. However, this is still an improvement on the same period last year (May 18) with 15 patients breaching 14 weeks.

Mental health access:

- Sustained performance throughout the last quarter above the 80% target for Primary Care Mental Health Measures for assessment with 86.9% in April 19. However, there was a decrease in performance against the 80% target for interventions with 78.3% in April 19. Additional assessment clinics are being arranged where possible to provide cover for sickness and vacant posts. Demands on the service throughout April and May mean performance targets for initial intervention are unlikely to be achieved in the short term, and plans are in place to correct this in June, including expanded group provision for both adults and children.

- Sustained performance of the CAMHS measure of 80% with 100% of patients waiting less than 28 days at the end of May 19. The implementation of the SPACE wellbeing (development of single point of access, multi-agency panels) which became operational in all five boroughs at the end of March has had an impact on the excellent performance.
- A deterioration in performance in the percentage compliance of valid care treatment plans completed with 87.1% in May against the target of 90%.
- A decrease in performance for the CAMHS Neurodevelopmental pathway with 76.6% in May 19 against the 80% target. The drop in performance has in part been effected by key staff sickness.

Unscheduled Care access:

- Ambulance response times within eight minutes to Category Red Calls sustained performance above the 65% target with 71.4% in May. This is an improvement on last month's position of 70%.
- Unscheduled Care continues to be a key area of concern. The 4 hour A&E target performance increased slightly in May 19 with 77.6% compared to 76.8% in April. This remains below the national target and outside of the IMTP profile of 82.5% in May. 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 March, April and May than previous corresponding months for the past 8 years.
- A slight improvement in May with 629 ambulance handovers over 60 minutes compared to 735 in April 19 although a deterioration on the position in the same period last year, May 18 (239). This remains outside of the IMTP profile.
- The 12 hour A&E target improved in May 19 with 648 patients compared to 852 in April 19. This remains outside of the national and IMTP target it is a deterioration on the same period last year (331 – May 18).

Cancer Access:

- Urgent Suspected 62 day cancer treatment times continued to deteriorate in April with 85.8% compared to 87.3% in March. 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 the 62 day pathway. Referrals for cancer overall remain above 2,000 per month with the number in May over 2200. The sustained increase is being factored into the demand and capacity plans for the Single Cancer Pathway. The national 98% target was not achieved for the NUSC 31 day pathway in April with 95.6% compliance.

  Alongside the 2 cancer measures, compliance against the Single Cancer Pathway has indicated that the health Board is in a strong position in readiness for the start of formal reporting in June.

Primary care out-of-hours:

- There has been an improvement in performance in Out of Hours (OOH) with 70% of very urgent patients seen within 60 minutes in May 2019 compared to 68% in April 2019.
- In May, unfilled hours for medical staff decreased with 11% of GP shifts unfilled (383 hours), the lowest since February 2019. However, unfilled nurse shifts have increased significantly to 29% (769 hours), the highest since recording in 2016.

Outpatient Follow-up access:

- The number of outpatient appointments overdue their follow-up target date in all specialties (unbooked) increased in May 19 with 18,568 compared to 17,604 in April. Whilst this is an increase it is below the IMTP profile of 20,050. Profiles for 19/20

have been produced to reduce delayed follow up appointments however, pressure on RTT targets are having an impact on delayed follow up capacity. Additional measures have been brought in by Welsh Government to focus on specific reductions e.g. a reduction of 15% in the total follow up waiting list by the end of March 2020. Services are having to amend and develop plans to incorporate these requirements. These will continue to be monitored at the monthly Delayed Follow up Group chaired by the Interim Associate Director of Operational Delivery. This remains an important priority for the Health Board.

Stroke care:

- With effect from April 19, Welsh Government confirmed that there would 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 patient's 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. Historic data has been collated in relation to the changed measures which provide useful performance comparisons. Compliance against the percentage of stroke patients directly admitted to a stroke ward increased in April 19 to 55.6% compared to 52.6% in March. The percentage of stroke patients receiving the required minutes for speech and language therapy was 69.3% compared to 60.7% in March. Compliance against the percentage of stroke patients who receive a 6 month follow up assessment is measured through clinic audits and will be available quarterly. The impact of the data collection requirements will need to be evaluated by the service.

Prevention:

- Sustained performance of over 95% for children who received 3 does of the revised '6 in 1' vaccine by age 1 with 95.3% at the end of March 19 against an All Wales compliance of 95.4%

Outpatient attendance:

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

DToC:

- May performance for Delayed Transfers of Care (DToCs) for mental health patients was maintained with 2 patients being delayed. This is within target and IMTP. Delayed Transfers of Care for non-mental health patients increased slightly from 61 in April to 63 in May which is within target and IMTP. Both measures have improved from the same period last year but for those delayed, the main reasons are due to community care arrangements and patient family issues.

Critical Care DToC:

- May performance for Critical Care DToC has deteriorated 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 beds to transfer critical care patients to when it is appropriate to do so.

Safe and effective care:

- HCAI performance deteriorated in May in two of the measures. In confirmed c-difficile cases there was an improvement on April performance with 22.1 cases per 100k in against a target of ≤25 cases per 100k. There was little change to staph aureus infections with 20.1 which is 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 76.8 in April to 82.4 in May which is outside of the target of ≤61 cases per 100k

Clinical Coding:

- Monthly clinical coding completeness performance decreased from 76.9% in January to 75.2% in February. This is below the annual 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 significantly in April 19 with 65% compared to 38% in March. Whilst this is outside of the target of 75%, this is higher than for the same period last year (April 18, 38%). 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. Compliance trajectories with monthly targets for improvement in concerns performance are in place with the Health Board's divisions and are discussed at Divisional Assurance meetings.

Serious Incidents

- The number of serious incidents reviewed and assured, on a timely basis, increased in May to 58% compared to 37% in April.

Workforce:

- Sickness absence was achieved and maintained in both April and May with 5%, six of the eight divisions across the Health Board are now achieving the 5% target. This is within the IMTP profile. PADR compliance slightly decreased in May 19 with 74.9% compared to 75% in April, with just one of the eight divisions 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 Board 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 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: 17 June 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.			

2.4

Purpose of the Report
This report provides a high level overview of performance at the end of months 1/2 against the Integrated Medium Term Plan (IMTP) with a focus on delivery against key national targets included in the performance dashboard.

Recommendation
The Board is asked to: • 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 – 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.
	Long Term – *can you evidence that the long term needs of the population and organisation have been considered in this work?*
	Integration – *can you evidence that this work supports the objectives and goals of either internal or external partners?*
	Involvement – *can you evidence involvement of people with an interest in the service change/development and this reflects the diversity of our population?*

	Collaboration – *can you evidence working with internal or external partners to produce and deliver this piece of work?*
	Prevention – *can you evidence that this work will prevent issues or challenges within, for example, service delivery, finance, workforce, and/or population health?*
Glossary of New Terms	*No new terms.*

Integrated Performance Dashboard

May 19

Domain	Sub Domain	Measure	Reporting Frequency	Report Period	IMTP Target	National Target	Current Performance	IMTP Status	Previous Performance	In Month Trend	Performance Trend (13 Months)	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
TIMELY CARE	RTT	Patients waiting less than 26 weeks for treatment	Monthly	May-19	90.6%	95%	**90.2%**		91.2%			89.8%	90.8%	91.0%	89.3%	88.9%	90.0%	91.1%	90.4%	90.3%	91.8%	92.0%	91.2%	90.2%
		Patients waiting more than 36 weeks for treatment	Monthly	May-19	0	0	**478**		271			1090	848	910	1159	1067	1214	769	249	336	469	112	271	478
		Patients waiting more than 8 weeks for a specified diagnostic	Monthly	May-19	0	0	**6**		31			279	502	417	663	407	283	71	4	60	13	0	31	6
		Patients waiting more than 14 weeks for a specified therapy	Monthly	May-19	-	0	**1**		1			15	3	31	9	13	5	0	0	0	5	0	1	1
	FUNB	Patients not booked for follow-up and delayed past their target date	Monthly	May-19	20050	12000	**18568**		17604			18513	18768	19857	20550	20567	19562	20012	21415	19603	18065	15433	17604	18568
	STROKE	% stroke patients directly admitted to acute stroke unit ≤4 hours	Monthly	Apr-19	65.1%	60.2%	**55.6%**		52.6%			64.8%	61.7%	42.9%	51.5%	37.5%	41.8%	63.3%	39.7%	41.2%	61.7%	52.6%	55.6%	
		% of stroke patients assessed by a stroke consultant ≤24 hours	Monthly	Apr-19	-	84.2%	**100.0%**		96.2%			72.0%	83.3%	83.6%	89.2%	79.4%	84.8%	74.7%	98.6%	95.7%	97.9%	96.2%	100.0%	
		% of stroke patients receiving the required minutes for speech and language therapy	Monthly	Apr-19	-	53.5%	**69.3%**		60.7%			47.1%	49.2%	49.4%	59.9%	57.7%	54.0%	57.4%	49.8%	44.6%	42.9%	60.7%	69.3%	
		% of stroke patients who receive a 6 month follow up assessment	Quarterly	Dec-18	-	41.6%	**47.3%**		41.6%				31.4%			41.6%			47.3%					
	ED	Category A ambulance response times within 8 minutes.	Monthly	May-19	65.0%	65.0%	**71.4%**		70.0%			76.3%	74.9%	78.8%	71.0%	76.0%	75.2%	73.3%	72.1%	67.2%	71.0%	73.8%	70.0%	71.4%
		Number of ambulance handovers over one hour	Monthly	May-19	275	0	**629**		735			239	178	293	357	461	432	363	495	689	519	558	735	629
		% patients waiting < 4 hrs in A&E figures inc. YAB & YYF	Monthly	May-19	82.5%	95.0%	**77.6%**		76.8%			79.6%	82.5%	78.8%	78.5%	78.6%	78.4%	78.3%	74.8%	76.2%	76.6%	78.5%	76.8%	77.6%
		Number patients waiting > 12 hrs in ABUHB A&E departments	Monthly	May-19	275	0	**648**		852			331	246	349	389	450	374	437	470	692	619	561	852	648
	CRITICAL CARE	Critical care delayed transfers of care (4 hrs) days lost - nhh	Monthly	May-19	-	22	**28**		22			24	15	16	34	43	42	32	28	14	24	46	22	28
		Critical care delayed transfers of care (4 hrs) days lost - rgh	Monthly	May-19	-	44	**55**		44			28	60	82	72	68	70	62	35	53	86	118	44	55
	CANCER	Delivery of the 31 day cancer standards for non-usc route	Monthly	Apr-19	97.5%	98.0%	**95.6%**		98.2%			98.0%	97.0%	96.3%	96.3%	99.2%	96.4%	96.3%	97.7%	99.5%	97.5%	98.2%	95.6%	
		Delivery of the 62 day cancer standards for usc route	Monthly	Apr-19	90.2%	95.0%	**85.8%**		87.3%			80.0%	87.0%	82.5%	82.2%	85.5%	89.9%	86.2%	91.3%	88.0%	91.3%	87.3%	85.8%	
		Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	Monthly	Apr-19	-	80.5%	**79.5%**		81.4%							76.6%	80.6%	79.7%	85.4%	79.6%	81.5%	81.4%	79.5%	
	MENTAL HEALTH	Assessment by LPMHSS within 28 days of referral.	Monthly	Apr-19	80.0%	80.0%	**86.9%**		80.5%			91.5%	86.8%	87.7%	83.2%	82.9%	91.0%	84.5%	84.0%	88.7%	86.0%	80.5%	86.9%	
		Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health.	Monthly	May-19	-	80.0%	**64.4%**		60.0%			68.4%	69.0%	67.1%	66.8%	62.9%	70.1%	69.6%	66.3%	66.1%	67.4%	62.4%	60.0%	64.4%
		Interventions ≤ 28 days following assessment by LPMHSS.	Monthly	Apr-19	80.0%	80.0%	**78.3%**		83.7%			80.8%	85.2%	82.7%	81.2%	80.9%	82.3%	82.5%	80.4%	83.4%	82.0%	83.7%	78.3%	
		CTP Compliance	Monthly	May-19	90.0%	90.0%	**87.1%**		90.5%			90.9%	91.2%	87.4%	90.9%	90.8%	90.6%	90.6%	90.2%	91.1%	90.1%	90.3%	90.5%	87.1%
	CAMHS	4+ Weeks Waiting List	Monthly	May-19	-	84.4%	**100.0%**		84.4%			83.3%	87.7%	94.3%	89.0%	95.6%	96.0%	98.0%	97.0%	94.4%	88.0%	93.5%	84.4%	100.0%
		Neurodevelopmental (ISCAN) Waiting List	Monthly	May-19	80.0%	80.0%	**76.6%**		75.9%			83.3%	81.1%	81.0%	72.4%	67.4%	67.1%	80.6%	86.5%	84.8%	84.9%	82.9%	75.9%	76.6%
	Primary Care	Urgent Calls Returned in 20 mins	Monthly	May-19	82.4%	85.0%	**83.0%**		85.0%			89.0%	88.0%	84.0%	88.0%	87.0%	88.0%	80.0%	80.0%	76.0%	81.0%	80.0%	85.0%	83.0%
		Very Urgent Seen within 1 hour	Monthly	May-19	69.0%	68.0%	**70.0%**		68.0%			78.0%	76.0%	64.0%	67.0%	75.0%	69.0%	86.0%	65.0%	79.0%	65.0%	72.0%	68.0%	70.0%
		Routine calls advised in 60 minutes	Monthly	Mar-19	-	69.0%	**73.0%**		69.0%			83.9%	80.4%	76.1%	86.3%	83.0%	78.6%	81.0%	74.1%	70.0%	69.0%	73.0%		
EFFECTIVE CARE	DTOCS	Number of dtocs for people all ages - mh	Monthly	May-19	4	2	**2**		2			2	2	4	3	3	7	3	3	3	6	7	2	2
		DTOCs per 10,000 for people all ages - mh	Monthly	Apr-19	-	0.03	**0.03**		0.12			0.03	0.03	0.07	0.05	0.05	0.12	0.05	0.05	0.05	0.1	0.12	0.03	
		Number of dtocs for people >75years non-mh	Monthly	May-19	74	73	**63**		61			73	60	54	61	73	86	97	65	74	69	95	61	63
		DTOCs per 10,000 for people >75years non-mh	Monthly	Apr-19	-	14.8	**12.20**		18.20			14.8	12.1	10.9	12	13.8	17.5	18.6	12.4	12.63	12.51	18.2	12.2	
	CODING	% valid principle diagnosis code ≤ 1 month after episode end date	Monthly	Feb-19	-	95%	**75.2%**		76.9%			87.0%	88.5%	86.3%	76.1%	87.6%	84.7%	69.1%	82.5%	76.9%	75.2%			
STAYING HEALTHY	INFLUENZA	Uptake of influenza vaccination among 65 years and over (seasonal)	Monthly	Mar-19	-	75%	**69.5%**		69.5%								39.7%	61.8%	67.1%	69.5%	69.5%	69.5%		
		Uptake of influenza vaccination among under 65's in risk group (seasonal)	Monthly	Mar-19	-	55%	**46.6%**		46.6%								21.1%	38.3%	42.5%	46.6%	46.6%	46.6%		
		Uptake of influenza vaccination among health care workers with direct pt contact	Monthly	Mar-19	-	60%	**60.5%**		60.5%								34.0%	50.0%	56.0%	60.0%	60.5%	60.5%		
	CHILDHOOD IMMUNISATION	% of children who received 3 doses of the '6 in 1' vaccine by age 1	Quarterly	Mar-19	95%	95%	**95.3%**		95.9%				96.2%			95.8%			95.9%			95.3%		
		% of children who received 2 doses of the MMR vaccine by age 5	Quarterly	Mar-19	91.5%	95%	**93.2%**		91.9%				89.7%			90.3%			91.9%			93.2%		
	SMOKING CESSATION	Smokers making quit attempt (full year extrapolation)	Quarterly	Sep-18	-	1.25%	**0.0%**		0.8%				0.8%			0.0%								
		Smokers who are CO validated as quit at 4 weeks	Quarterly	Dec-18	-	40%	**41.2%**		43.0%				45.0%			43.0%			41.2%					
DIGNIFIED CARE	PAP	Manifesto commitment for procedures cancelled > once	Monthly	Mar-19	-	35%	**35.4%**		34.5%			31.3%	37.2%	37.1%	25.0%	22.7%	29.2%	40.4%	37.2%	37.0%	34.5%	35.4%		
	COMP	Timely (30 day) handling of concerns and complaints	Monthly	Apr-19	56%	75%	**65.0%**		38.0%			50.0%	58.0%	41.0%	36.0%	53.0%	47.0%	52.0%	41.0%	30.0%	32.0%	38.0%	65.0%	
STAFF AND RESOURCES	DNAS	Patients who dna - new opa - specific specialties	Monthly	May-19	6.20%	6.5%	**6.2%**		6.5%			6.3%	6.2%	6.6%	6.4%	6.4%	6.6%	6.2%	6.7%	6.8%	6.7%	5.9%	6.5%	6.2%
		Patients who dna - follow-up opa - specific specialties	Monthly	May-19	6.45%	6.5%	**6.8%**		6.5%			7.3%	6.5%	6.8%	6.5%	6.8%	7.6%	6.6%	6.9%	6.8%	6.9%	6.4%	6.5%	6.8%
	WLOD	% PADR / medical appraisal in the previous 12 months	Monthly	May-19	72.40%	85%	**74.9%**		75.0%			73.9%	73.7%	72.3%	72.2%	71.0%	71.4%	71.7%	72.1%	72.3%	69.9%	77.1%	75.0%	74.9%
		Monthly % hours lost due to sickness absence	Monthly	May-19	-	5%	**5.0%**		5.0%			4.8%	4.9%	5.0%	4.9%	5.2%	5.4%	5.6%	6.0%	6.1%	5.6%	5.1%	5.0%	5.0%
SAFE CARE	HCAIS	Cases of e coli per 100k population (rolling 12m)	Monthly	May-19	65.6	61.2	**82.36**		76.8			78.6	75.0	64.5	98.8	77.1	56.4	87.5	32.3	62.1	66.7	86.1	76.8	82.4
		Cases of staph aureus per 100k pop (rolling 12m)	Monthly	May-19	24.0	18.9	**20.09**		20.8			34.3	20.8	32.3	16.1	27.1	38.3	27.1	28.2	14.0	26.6	26.0	20.8	20.1
		Clostridium difficile cases per 100k pop (rolling 12m)	Monthly	May-19	32.6	25.2	**22.10**		22.8			30.2	25.0	24.2	24.2	31.2	20.2	37.5	34.3	24.0	22.2	28.1	22.8	22.1
	INCIDENTS	Patient safety solutions wales alerts and notices not assured on time	Monthly	Mar-19	-	0	**4**		4			0	0	1	3	3	4	3	5	4	4	4		
		% serious incidents assured on time	Monthly	May-19	45.0%	90%	**58.0%**		37.0%			64.0%	52.0%	55.0%	68.0%	53.0%	50.0%	50.0%	29.0%	29.0%	56.0%	66.0%	37.0%	58.0%
		Never events	Monthly	May-19	0	0	**1**		0			0	0	2	0	0	1	0	0	0	0	0	0	1
Efficiency & Productivity	Theatre	Theatre Utilisation (RGH)		May-19	85%	86%	**86.4%**		85.8%			85.0%	85.4%	84.5%	86.0%	81.5%	85.2%	87.9%	80.0%	82.2%	83.6%	85.5%	85.8%	86.4%
		Theatre Utilisation (NHH)		May-19	85%	89%	**86.9%**		89.0%			90.9%	88.5%	89.7%	87.8%	88.2%	86.6%	88.4%	90.4%	85.1%	85.7%	90.6%	89.0%	86.9%
	Average LoS	Elective Surgical AvLoS (RGH)		May-19	Improve	3.12	**2.4**		3.1			3.02	2.72	2.81	2.59	2.76	3.08	2.64	3.44	2.99	3.10	2.50	3.12	2.37
		Elective Surgical AvLoS (NHH)		May-19	Improve	4.19	**2.7**		4.2			4.15	4.08	4.08	4.08	4.05	4.39	3.62	4.88	3.78	3.76	3.31	4.19	2.72
		Emergency Medical AvLoS (RGH)		May-19	Improve	7.56	**7.7**		7.6			7.68	7.13	7.02	6.51	7.02	6.89	7.40	6.79	7.29	7.21	7.08	7.56	7.70
		Emergency Medical AvLoS (NHH)		May-19	Improve	7.34	**7.8**		7.3			7.27	6.09	5.98	5.92	6.33	7.12	6.69	6.77	7.37	7.27	7.29	7.34	7.82
	Readmissions	Readmission Rate Within 28 Days (CHKS)		Feb-19	Improve	0.07	**0.06**		0.06703			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		May-19	Improve	122	**123.0**		122.0			61	38	95	55	172	163	103	54	125	94	109	122	123

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

If measures are no longer in the Delivery Framework, current perfromance is measured against previous month

2.4

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board 4th July 2019 Agenda Item: 2.5

2.5

Aneurin Bevan University Health Board
Advance Care Planning (ACP)

Executive Summary

Advance Care Planning is a national driver to support people who have life limiting illness and particularly those who may be approaching their last year of life. The aim is to ensure that people are identified early to enable the best care to be planned in advance, using age appropriate tools, communication and documentation. ACP should be integral to the roles of all health and social care professionals across all Divisions, however this can prove challenging when trying to obtain measurable outcomes.

ACP is a priority of the End of Life Care Board and captured within the ABUHB End of Life Delivery Plan. A Workstream has been established which will promote collaborative working, support innovation or research proposals and includes identification and sharing of learning. Dr Aoife Gleeson, Consultant in Palliative Medicine is the project lead for ABUHB.

Funding was received via Macmillan for two ACP Facilitators for Aneurin Bevan University Health Board to support the ACP work stream. This funding was for a 3 year period and will cease July 2019. The Macmillan ACP Facilitators have a key role within the ACP work stream in taking a collaborative approach, working with primary, secondary, care home and voluntary sectors to develop and implement an ACP Model to embed the ethos of ACP across Gwent.

How can we prove Advance Care Planning makes a difference?

There is increasing pressure throughout the world to provide evidence based studies related to how ACP actually makes a different. This year at the EAPC World Congress several studies across the world demonstrated that finding the most appropriate outcome measures related to measuring the impact of ACP is our biggest challenge. The most recent RCTs have tried to compare measures such as Quality of Life, anxiety scores, depression scores for individuals but these are still arguably not the most appropriate measures to demonstrate what actual impact an ACP has on the individual, their family and their loved ones, the healthcare team that support them and the healthcare services that provide their care.

The debate suggested that the most important thing we should be focussing on is how ACP can positively impact a person's view of their future. Within the dissemination of our ACP model in ABUHB there has been a wealth of anecdotal evidence filtering through. This is telling us about the positive impact of having the ACP conversation and negative

impact if they have not. Individuals are telling us that ACP positively changes their experience of their healthcare and positively impacts on the way they live their life until they die.

Individuals express that it helps them keep in control of what happens to them, they feel listened to, it gives them peace of mind that their affairs are in order and empowered to live their life to the full.

Families express how knowing that they were able to do exactly what their loved one wanted during their illness, at the end of their life and after they died had such a positive impact on how they have coped with their grief. Too often many have relayed the negative consequences and negative impact on their grief when they didn't know what their loved one would have wanted and missed the opportunity to have that discussion.

HCPs also relay their personal and professional experiences of ACP which directly support what the individuals and families are telling us. They too can relay too many negative consequences to individuals and their families when no one is actually aware of the person's wishes and preferences. This is compared to the satisfaction of knowing that the care they provided was directly in line with that person centred care. HCPs feel empowered to be able to plan future care that is patient centred, using appropriate resources in line with prudent healthcare.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	**X**
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	
Executive Sponsor: Dr Stephen Edwards, Deputy Medical Director	
Report Authors: Joanne Lane, Sian Hughes	
Report Received consideration and supported by :	

Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: 25th June 2019			
Supplementary Papers Attached:			

Purpose of the Report

The purpose of the report is to provide an overview of the value of Advance Care Planning (ACP) and to provide any evidence of the benefit in terms of delivering preferred place of care/death.

Background and Context

Advance Care Planning is used to ensure that people are identified early to enable the best care to be planned in advance, using age appropriate tools, communication and documentation and should be integral to the roles of all health and social care professionals across all Divisions.

The main focus under the theme of *Supporting Living and Dying Well* has been to promote and embed the principles of Advance Care Planning into practice. ACP is a priority of the End of Life Care Board and captured within the ABUHB End of Life Delivery Plan. A collaborative approach between ABUHB and the third sector has led to several developments to support the ACP agenda. A collaborative launch of the triple E model took place in June 2017 and this model is being promoted across ABUHB. This model focuses on 3 main areas which are engagement, education and empowerment.

Engagement - There will continue to be a focus on rolling engagement programmes for the public and professionals.
Education – an e learning programme has been completed and has been embedded into practice, this is accompanied by champion workshops to empower ACP champions in raise awareness and facilitate uptake of education in their designated areas.
Empowerment – The pilot project of education and facilitation in the respiratory outpatients has been undertaken. A further piece of work with heart failure specialist nurses has led to successful sustainable changes that have been embedded into their practice.

Assessment and Conclusion

It should be recognised that, despite ACP being driven by the End of Life Care Board (EOLCB), there are areas of silo working associated with ACP across the Health Board. This is being addressed through strengthening divisional engagement with EOLCB, and by running broad engagement events around end of life care to share learning and best practice. Engagement with divisions is also being reviewed in light of the findings of the NACEL (National Audit of Care at the End of Life) in development of an action plan.

The following examples aim to depict benefits associated with projects that have been driven by the ACP Workstream.

Engagement

The awareness and engagement element of the initiative aims to increase the awareness of the benefits of ACP through numerous events using several interactive methods. The engagement events have gained momentum and have developed into a successful component of the ACP initiative. The events include a range of activities including informal table top stands at hospital sites and public events, presentations, bespoke discussions and Q & A sessions across Gwent. Interactive activities have been used and evaluated well, they have proven to be an excellent tool to encourage ACP conversations.

The ACP facilitators promote and share the project aims and objectives to several professional meetings with local authority and health care professionals across Gwent. They have also formally presented and provided poster presentations to numerous influential conferences internally and externally to Gwent. They both participated in a YouTube Video promoting Macmillan's Fighting Talk Report. The facilitators are keen to write ACP articles for publication, and have published in Mac Voice and a second has been submitted to the International publication and a third is currently being finalised.

From September 2016 to May 2019, 295 events have been provided which has resulted in over 5207 contacts with members of the public, HCP's and stakeholders. There have been over 1977 one to one conversations which have included patients, carers and staff. These conversations have generated a wealth of anecdotal feedback where individuals have shared their personal and cherished experiences.

Several leaflets, posters and postcards have been devised to support both the public engagement and educational elements of the initiative. Recent work with the Older People's Commissioner for Wales team has resulted in incorporating ACP awareness information into the new publication of 'How to Age Well' booklet and more recently the development of a second more informative leaflet specific to ACP, 'Advance Care Planning – Planning for your future – has received final signoff and is awaiting printing. These leaflets are aiming to be used throughout Wales and are currently available on ABUHB intranet Patient Information Page. Currently work is in progress of creating an ACP specific webpage of the available ACP information, tools and signposting, to guide and support staff. ABUHB also has an ACP specific Twitter account which is gaining following.


How to age well - DRAFT - cover 1.pdf


ACP_Guide_(eng).pdf

<u>Education</u>

Having worked closely with the support of an IT expert and representatives from primary, secondary, voluntary and third sector to support partnership working and acknowledging individuals expertise and knowledge, the blended e learning model at foundation and intermediate level has been developed and has been used and well evaluated by complex care team, district nurses, respiratory and heart failure nurses. This is available on Learning @ NHS Wales and ESR.

The blended e-learning is aimed at all health and social care professionals and is the minimum requirement for the ACP education. The model also has facilitated support and at intermediate level provides a structured development programme which leads towards individuals being recognised as ACP champions. It is anticipated that the ACP Champions will take ownership of the ACP concept and process within their area of practice and will encourage the cascading of ACP throughout the UHB

Facilitation of education is carried out in collaboration with ABUHB ACP facilitators, primary care and third sector partners. Between September 2016 and May 2019, 1999 health, local authority, private and third sector staff have either undertaken the e-learning module, bespoke classroom education or awareness sessions. In addition to the e-learning, the palliative care, memory, frailty and All Wales Renal teams and some district nurses and residential/nursing home staff have commenced the clinical championship training programme. The respiratory and heart failure teams have also completed the Sage & Thyme & Advanced Communication Skills which complements the ACP training package.

The evaluation of the blended e learning has been extremely positive, with significant increase in knowledge and understanding of ACP and definite improvements with staff confidence and commitment levels. A recent study involving heart failure clinical nurse specialists commended the training and report that it has been crucial in embedding ACP into their day to day practise

Training remains ongoing for Advance Care Planning for the workforce of nursing and residential homes. The number of ACP's in place for nursing home (general) residents is approximately 65-70% and for (general) residential home residents, approximately 40-45%.

Educational support is being provided across 6 ABUHB primary Care Practices and supporting the GP practise team, district nursing and residential/nursing homes incorporated with the pilot project for the evaluation of the Vision Palliative Care Toolkit.

The current target is 80% for nursing home residents and 50% for residential home residents should have an ACP in place. Training is being delivered across all Boroughs by the professional development team on a rolling programme, where all care home staff are invited.

An End of Life seminar was held in ABUHB on November 2018 which focused on a patient story / complaint, which addressed the relevant themes including communication and ACP. 144 people attended with excellent feedback. It is anticipated that this will be an annual event.

Empowerment

The following are examples of projects that have been undertaken via the ACP Workstream which provide details of facilitating empowerment across services within the Health Board, the benefits and outcomes.

Heart Failure Nurses to Change Practice

R&D approved service improvement evaluations are demonstrating how the ACP champion training programme is empowering specialist teams to integrate ACP positively into their practice. A particular example of this is demonstrated with a group of heart failure specialist nurses who have had access to the ACP champion training programme including ACP e-learning, workshops and communication skills training. The quantitative pre and post training data as well as a qualitative focus group study is currently being analysed and will be written up and published. Results are clearly demonstrating the positive impact the training is having on changing practice within specialist teams, integrating ACP in a positive and proactive way and demonstrating that this ACP training programme has the potential to be transferable to other multidisciplinary areas of practice.

"The ACP is part of the parcel of what I talk about within care of heart failure"

"We've just embedded it [ACP], *it's just there now"*

As a result of this training the heart failure team are now using triggers and the prognostic indicator tool as part of their assessment to identify appropriate individuals for ACP discussion. They have changed their review sheet to include the triggers for ACP discussion and these are also being included in letters to GPs. These changes are making measurable differences and data is being collected within an audit. The GP letters now include what part of the ACP process has been discussed with individuals and highlights what needs to be continued. ACP is now included in the annual objectives for the heart

failure team and also appears in the PADR for individual initiatives. ACP is now being included in heart failure education sessions for the generalist and is being extended to undergrad and post grad heart failure education at university. The heart failure team are now embedding ACP into their MDT discussions and most importantly removing their own agenda and instead listening to the individual's wishes and preferences for their future.

In conclusion the project has supported the following changes in practice within the service;

- Listen to the person more, remove own agenda
- ACP now integrated into heart failure education sessions
- Prognostic indicator tool now used as part of clinical assessment
- Prognostic indicator tool added to review sheet which includes ACP triggers for each patient
- ACP triggers are included in GP letters
- GP letter documentation now also includes ACP with what' been done and what needs to be continued
- Annual objectives for team now include ACP
- PADR now include individual's ACP initiatives
- Commenced an audit to review triggers to measure outcomes

<u>360 Pilot</u>

A Pilot has been undertaken with 6 GP practices across Gwent in collaboration with Primary Care, Out of Hours, Palliative care and across sector collaboration – NHS, Macmillan (Macmillan GP Facilitator) and Marie Curie (Marie Curie Research Fellow). This also includes the development of Vision 360 e-coding template. The aim was to increase Primary care health care professionals' (HCPs') ACP knowledge and the offer of ACP conversation to Primary Care patients. Data was captured as alongside the pilot to capture the impact and benefits.

As part of the pilot approximately 150 district nursing and care/nursing home staff have been trained in ACP.

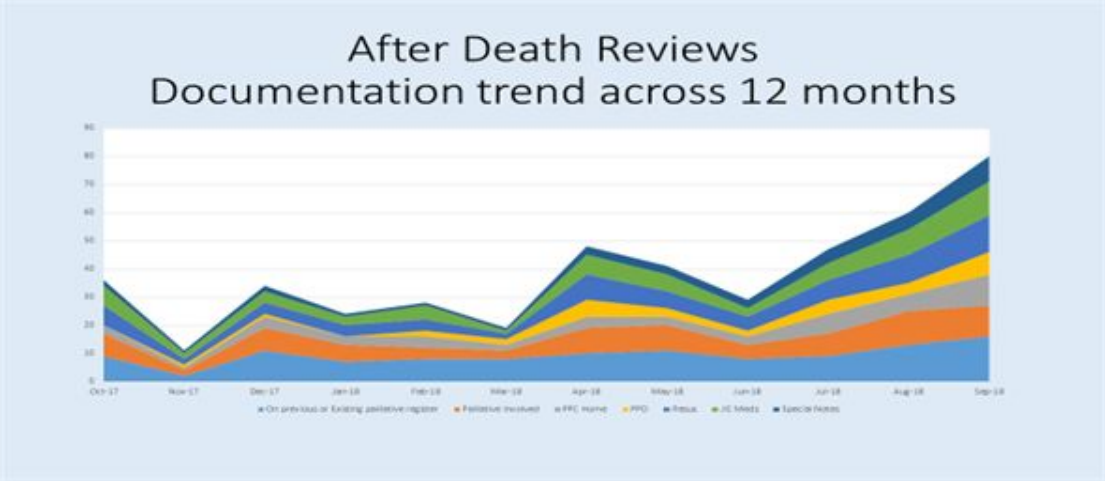
The following table compares ACP data recorded in the 6 month period prior to the intervention and 6 month intervention period. For example, a 10 fold increase in preferred place of death and 9 fold increase in documentation of Anticipatory prescribing.

ACP	Total documented during 6 month pre intervention	Total documented during 6 month intervention	X fold increase..
Preferred place of care	16	43	*2.6
Preferred place of death	4	39	*10
Resuscitation status discussed	2	40	*10
Resuscitation status recorded	32	55	*1.7
Anticipatory prescribing completed	3	27	*9

The chart below details after death reviews of patients on the palliative MDT register and shows a 2 to 5 fold increase in documentation of data during the pilot.

ACP	Pre-intervention	Post-intervention	X fold increase..
Preferred Place Care	6%	14%	*2.3
Preferred Place of Death	2%	11%	*5.5
Resuscitation Status	8%	20%	*2.5
Anticipatory Prescribing	8%	17%	*2
OOH Communications	3%	12%	*4

The pilot has supported overall increase in the documentation, which includes patients on the palliative case register, completion of special notes, resus status, just In Case (JIC) medication, Preferred Place of Care (PPC) and Preferred Place of Death (PPD).



Overall, the pilot has supported;

- Increase in the number of ACP discussions

- Increase in recording of patients ACP wishes
- Improved dissemination of ACP information to relevant healthcare professionals (HCPs)

Respiratory Project

The overall aim of this pilot study is to determine the impact of the ACP triple E facilitation model on the ACP of patients with malignant and non-malignant respiratory diseases who are under the care of 6 respiratory consultants in respiratory outpatient departments.

The project comprised of a case note study of 60 patients for evidence of documented ACP discussions pre intervention and approximately 6 months post and 12 months post intervention and also evaluation of HCPs knowledge and understanding of ACP pre intervention, immediately post e-learning and then 6 months post and 12 months post intervention.

This project remains ongoing and awaiting a retrospective evaluation of post intervention.

National Audit of Care at the End of Life (NACEL)

This was a casenote audit of 80 patients who died in hospital, completed in December 2018. It was recognised that further work was required across hospital settings in relation to End of Life Care and ACP. Recommendations from the audit highlighted the following areas for improvement;

- Focus effort on increasing use of the Care Decisions Tool for Last Days of Life Care
- Improve communication skills for all staff, but particularly medical staff.
- Address the needs of all families of dying patients.
- Look at ways to improve the environment in which our patients die
- Aim for a shift in culture.
- Increase engagement from all specialties.

The report has been shared with divisions, for the EOLCB to oversee development of an action plan in response to the audit findings.

All-Wales Advanced Care Planning

ABUHB is an active participant in the all-Wales work on ACP. Some of the work is featured on the Welsh resource website advancecareplan.org.uk

Capture of outcome data

It remains challenging to capture outcome data based on each individual ACP. Paper=based records require a manual casenote review approach. ABUHB has piloted electronic ACP capture, and is in discussion on when a national approach to this (led by

NWIS) will be expected. An evaluation is being developed with WAST to see the impact of call/conveyance rate at a nursing home level.

Recommendation
The Finance & Performance Committee are asked to note the content of this paper.

Supporting Assessment and Additional Information	
Risk Assessment (including links to Risk Register)	Facilitation of ACP throughout all Divisions.
Financial Assessment, including Value for Money	Linked to End of Life Care Board Delivery Plan and IMTP.
Quality, Safety and Patient Experience Assessment	Positive impact on patient experience and the quality of end of life care provided to patients.
Equality and Diversity Impact Assessment (including child impact assessment)	Any actions will be equality impact assessed as required.
Health and Care Standards	Links to Standard – Dignified Care; 4.1d – Advance Care Planning, End of Life Care and addressing the needs of the dying person.
Link to Integrated Medium Term Plan/Corporate Objectives	Linked to End of Life Care Board Delivery Plan and IMTP.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** Facilitation of the triple e-model using engagement, education and empowerment has supported changes in practice for current and future generations impacting positively on patient care.
	Integration – Working collaboratively has improved patient outcomes
	Involvement – The triple e-model focusses on empowering staff to make a positive difference for patients.
	Collaboration – collaborative working with patients, all Divisions, Primary Care, Out of Hours, palliative care and third sector partners to deliver the best possible outcomes for patients.
	Prevention – Involving patients in decisions regarding their care helps them keep in control of what happens to them, they feel listened to, it gives them peace of mind that their affairs are in order and empowered to live their life to the full.
Glossary of New Terms	No new terms.
Public Interest	Can be published in the public domain.

2.6

Aneurin Bevan University Health Board
Finance and Performance Committee
Agenda Item: 2.6

Aneurin Bevan University Health Board

Finance Performance Committee
Financial Performance Report – May (Month 2) 2019/20

Executive Summary

This report sets out the following:

- The financial performance at the end of May and forecast for 2019/20 – against the statutory revenue and capital resource limits,
- The revenue reserve position at the 31st May 2019,
- The Health Board's cash position and compliance with the public sector payment policy,
- A value for money focus on postponed operations and Adalimumab Biosimilar (Humira) Switch,
- A financial assessment of the risks and opportunities in delivering year-end financial balance,
- Actions required to deliver financial balance, and
- Specific Welsh Government Financial Monthly Monitoring Returns sections.

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

Table 1: Performance against key financial targets 2019/20

Performance against key financial targets 19/20
+Adverse / () Favourable

Target	Unit	Current Month	Year to Date	Trend	Year-end Forecast
Revenue financial target To secure that the HB's expenditure does not exceed the aggregate of it's funding in each financial year. *This confirms the YTD and forecast variance.*	£'000	431	1,082	↓	**0**
Capital financial target To ensure net Capital Spend does not exceed the Capital Resource Limit. *This confirms the curent month and YTD expendiutre levels along with the % this is of total forecast spend.*	£'000 £123m	10,845 9%	22,371 18%	↔	**£123m spend** **0 variance**
Public Sector Payment Policy To pay a minimum of **95%** of all non NHS creditors within 30 days of receipt of goods / invoice (by Value)	%	97.4%	97.5%	↑	**>95%**
Cash balances Cash balance held by the Health Board to not exceed 5% of monthly cash draw down from WG	£'000	n/a	3,092	↔	**Within Target Level**

Performance against Statutory Requirements 19/20

Ensure the aggregate of the HB's expenditure does not exceed the aggregate of its funding in a 3 year period	✓
Prepare & Submit a Medium Term Plan that is signed off by Welsh Ministers	✓

The revenue financial risk is assessed as a potential deficit of £7m.

Recommendations:

The Committee is asked to note:

- The financial performance at the end of May and forecast for 2019/20, against the statutory revenue and capital resource limits.
- The financial risk assessment,
- The Health Board's cash position and compliance with the public sector payment policy,
- The value for money topics,
- The actions required to deliver financial balance, and
- The Welsh Government Financial Monthly Monitoring Returns sections.

The Board 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 [Committee Name]**	

Date of the Report: 20th June 2019

Supplementary Papers Attached:

Appendices Pages 10-45

Purpose of the Report

The purpose of this report is to present the Health Board's financial performance in delivering its statutory financial objectives and targets, including:

- A report of the financial position, both the year to date and year end forecast,
- A financial assessment of the risks and opportunities,
- Value for Money topics: Postponed Operations and Adalimumab Biosimilar (Humira) Switch,
- Recommendations of actions to support achievement of financial balance and improved underlying financial position, and
- The Welsh Government Financial Monthly Monitoring Returns sections.

Assessment and Conclusion

1. Revenue Performance

At the end of May 2019, the year to date financial position is a £1.082m deficit. The in-month variance to plan is mainly due to:

- Continued expenditure on premium rate workforce, including medical and nursing agency, this is driven by vacancies, sickness and RTT target delivery within acute specialties.
- Additional bed capacity, including Holly Ward, remaining open for an extended period of time has meant additional workforce costs - £387k year to date - with both Unscheduled Care and Primary & Community Care Divisions forecasting further costs in June. To note, any further spending plans for 'winter' capacity in 2019/20 are not included within the current forecast, however recurrent investments made in 2018/19 should mitigate some of this risk.
- Savings delivery is not in line with original plan profile, therefore there remains a significant risk relating to the delivery of the savings.
- Spending is lower than expected on drugs and litigation, with some non-recurrent benefits resulting from Continuing Health Care retrospective settlements.
- The forecast position is financial balance on the basis that in year actions will deliver a reduction in spend/increased savings.

Savings

The Health Board's IMTP requires savings of £16.8m, savings schemes are in place and delivering for £10.6m, the balance of saving plans are expected to deliver later in the year via schemes relating to delivering performance and efficiency improvements, identified through local and national benchmarking opportunities. It is expected that the required savings target will be achieved and exceeded to support further investments.

Funding

The Plan and forecast assume only the funding that has been received or has been confirmed by Welsh Government (WG). However, there is additional funding being held for: Digital Technologies, Clinical Services, Mental Health 'A Healthier Wales' and Mental Health Service Improvement Fund. To access this additional funding the Health Board will be submitting bids to access additional mental health funding and is in discussion with Welsh Government about accessing funding to support service developments in line with IMTP priorities.

At this stage, no additional funding has been assumed for either performance targets or winter pressures.

Expenditure

Financial performance against each of the delegated budget areas is set out in the appendices. The key messages are:

Pay:

- Spend continues above budgeted levels due to on-going use of variable, premium cost workforce to fill gaps due to vacancies, sickness and additional capacity.
- Allowing for A4C Wage Award, workforce costs are broadly in line with previous months.
- Premium spend on agency and locum workforce remains a cause for concern.
- Medical workforce costs continue to operate above budget with continued non achievement of the medical agency 'cap' spend reduction target of 35%, with medical agency expenditure significantly higher than the WG target. In month, spend is approximately £600k above target.

Continuing Health Care:

- CHC (Adult complex care) continues to report low level growth in patient numbers, a trend that has continued from 2018/19. There has been a net decrease in patients of 24 since March 2019. The Division has also benefitted from settling some retrospective claims.
- Mental Health CHC spend is still forecast to increase significantly.

Prescribing:

- Primary Care drugs (prescribing) expenditure is forecasting a minimum of financial balance, based on the latest prescribing data (April 2019).

External Commissioning:

- At month two all contracts are performing broadly in line with forecast expectations – However activity data is sometimes a month in arrears. Long Term Agreements with NHS Wales's bodies have been agreed.

Referral To Treatment (RTT):

- Orthopaedic elective activity is 130 cases behind the plan for the year to date, 56 cases in month 1 and 74 behind in month 2.
- The forecast assumes that these cases will be treated later this year, as part of achieving RTT targets. However, this may require undertaking additional sessions using premium workforce solutions. The estimated cost of recovering all year to date RTT under-performance, at WLI rates, is £92k.
- Trauma majors are operating at 22 cases above average in month 2, with an associated cost of £90k.There was a high number of fractured neck of femur cases (NOF's) in May.

Revenue Reserves

- The Health Board is holding in-year reserves, for specific funding issues in line with the budget delegations approved by the Board.
- Discretionary reserves are now being used to partly offset some of the deficits in the delegated financial positions, to support delivery of financial balance. Further detail is provided in the appendices.

- Where appropriate, slippage on spending plans will be factored into the level of reserves available to support the Health Board position.

Value for Money Review – Postponed Operations

Background:

The NHS Wales Efficiency Healthcare Value & Improvement Group identified a significant opportunity across Wales, to deliver improvements to the rate of postponed procedures. Based on 2018/19 data, the opportunities specifically endorsed for improvement related to short term (on the day, or with one days' notice) postponed or cancelled procedures for non-clinical reasons. It concluded that each Health Board should undertake action relating to these opportunities. In support, a national Task & Finish group will be established by Welsh Government (WG).

Current Position:

To give some sense of scale to this potential opportunity, a financial value has been attributed to the main specialties where significant gains have been identified, being General Surgery (GS) and Trauma & Orthopaedics (T&O). The potential financial impact is presented below.

The National Efficiency Healthcare Value & Improvement Group assessed the range of non-clinical reasons for postponement for those patients given notice of 1 day or less. For ABUHB the total number in 2018/19 was 3,417. Almost 49% of this total related to cancellations in General Surgery (GS) and Trauma & Orthopaedics (T&O).

The table below sets out the split of the non-clinical reasons for cancellation/postponed procedures and an associated financial value, by comparing the ABUHB % of all elective procedures with the English mean %. A financial average of the 2018/19 and 2017/18 data has been taken, resulting in an estimated **£1.2m** opportunity value.

	Elective Postponed / Cancelled Procedure		Zero/1 day Procedure Cancellations 2018-19	
	Responsible Area	**Cancellation Reason - Non Clinical**	**GS**	**T&O**
	Theatre Management:	Administrative Error	14	26
		Clinical Staff Unavailable	69	82
		Emergency Admission	70	292
		Equipment Unavailable	102	24
		List Overrun	62	78
		Other – Non Clinical	41	122
	Divisional / Project Management:	Intensive Care Unit / High Dependency Unit Beds Unavailable	234	38
		Ward Beds Unavailable	231	214
Data set 1 2018/19	Total Zero/1 day Cancellations Apr 2018 to Mar 2019 - Data set 1		823	876
			£m	**£m**
	WG - 2018/19 Estimated Total Opportunity per annum when compared to England Mean Performance 2017/18		**0.673**	**0.555**
Data set 2 2017/18	Total Zero/1 day Cancellations Apr 2017 to Mar 2018 - Data set 2		725	940
			£m	**£m**
	NHSBM -2017/18 Estimated Total Opportunity when compared to England Mean Performance 2017/18		**0.558**	**0.622**
	Average of both Data sets - Estimated Total Opportunity per annum as a Financial Value (FYE)		**0.616**	**0.588**
	Average of both Data sets - Total for GS and T&O		**1.204**	

The financial opportunity is calculated using the waiting list initiative (WLI) weekend sessional rates, assuming that a weekend WLI session can be 'saved' by creating additional core capacity and avoiding a session cancellation. Using these assumptions, the General Surgery and T&O associated financial opportunity of £1.2m in a full year could be cash releasing.

Whilst acknowledging that not all cancelled operations/procedures would result in a missed theatre slot, the above table does demonstrate that there are significant gains to be made if the Health Board achieved the mean performance in England. It should also be noted that this is a conservative estimate as the above table does not include:

- all of the specialties that have cancelled operations for non-clinical reasons (a further 1,700 procedures),
- cancelled operations for clinical reasons (an additional 4,084 procedures), and
- the gains related to at least one day bed occupancy prior to cancellation, which could be converted into an actual procedure related length of stay.

Value for Money Review – Adalimumab Biosimilar (Humira) Switches

An Executive Team paper was presented and agreed in 2018/19 to fund additional posts within Pharmacy (£85k) to enable a switch from the patented drug (Humira) to adalimumab biosimilar. This decision was based on the potential achievement of price savings and 'switch' savings and the confidence from the previous good record of implementing such switches.

The potential price saving is £1.5m and switch savings is £0.3m.

Current performance indicates the switch savings are yet to be delivered and still present an opportunity. See appendix for details.

Next Steps:

The Executive Board will oversee actions through implementation of the Theatres Improvement Programme and other related improvement work (e.g. patient flow, critical care).

The Medicines Management Board is reviewing actions to increase the uptake in the appropriate use of Humira, with a review by end November 2019.

Actions required to deliver financial balance

- Divisions to develop and deliver plans to achieve financial balance.
- Any investments or developments need to be supported by savings, in addition to the level identified in the IMTP to deliver financial balance.
- An efficiency delivery process is being driven through the Executive Board, as well as through the existing divisional assurance meetings and delegated budget management arrangements.

2. Capital performance

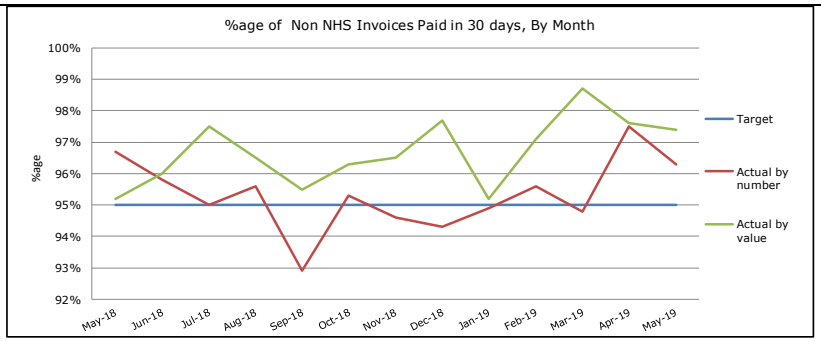
The Capital Programme was approved by the Board in March 2019. The current resource limit is £123.9m with planned expenditure of £122.433m and uncommitted discretionary capital funding of £1.496m. A number of emerging priority schemes are being developed to utilise this unallocated discretionary funding. The year to date expenditure is £22.371m (18.3% of the annual expenditure) which primarily relates to the Grange University Hospital. The year-end capital forecast is breakeven.

3. Cash position

The Health Board is planning to manage within its cash allocation and will also aim to hold a cash balance of no more than 5% of its monthly cash draw down (best practice/notional target). The cash balance held at the end of May is £3.092m which is less than the target balance of 5% of the Health Board monthly cash draw down from Welsh Government, therefore, the target has been achieved.

4. Public Sector Payment Policy (PSPP)

The Health Board has achieved the target to pay 95% of the number of Non-NHS creditors within 30 days, in May, both for value and number of invoices (96.3% by number and 97.4% by value). The graph below shows the trend for a rolling twelve month period.



5. Risks and Opportunities

The revenue forecast is breakeven, with a financial risk currently assessed as £7m. Risk factors include RTT delivery/ potential 2018/19 RTT funding claw back, under delivery of savings plans, potential winter pressures driving additional spend. Opportunities exist with further efficiency savings and non-recurrent opportunities being reviewed each month.

Recommendation

The Committee is asked to note:

1. The financial performance at the end of May and forecast for 2019/20, against the statutory revenue and capital resource limits.
2. The financial risk assessment,
3. The Health Board's cash position and compliance with the public sector payment policy,
4. The Postponed Operations and Adalimumab Biosimilar (Humira) switch value for money reviews,
5. The actions required to deliver financial balance, and
6. The Welsh Government Financial Monthly Monitoring Returns sections.

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, including Value for Money	This paper provides details of the financial position of the Health Board as at Month 02 and the forecast position for 2019/20. It identifies the key financial risks and actions required to manage them. It also identifies the potential to improve efficiency and deliver improved value for money.

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	**Long Term –**
	Integration –
	Involvement –
	Collaboration –
	Prevention – 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 New Terms	See Appendix
Public Interest	This report can be published.

Appendices - Detailed Analysis

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Divisional Revenue Financial Performance (Month 02 – 2019/20)

Month 2 - May 2019	Full Year Budget £000s	YTD M2 Reported Variance £000s	YTD M1 Reported Variance £000s	Movement M1 to M2 £000s
Operational Divisions:-				
Primary Care and Community	243,335	259	128	132
Prescribing	95,112	(41)	(13)	(28)
Community CHC & FNC	63,553	(844)	(152)	(692)
Mental Health	90,747	122	252	(129)
Director of Primary Community and Mental Health	238	(19)	(12)	(7)
Total Primary Care, Community and Mental Health	**492,984**	**(522)**	**203**	**(726)**
Scheduled Care	189,176	2,654	1,226	1,427
Unscheduled Care	104,136	1,871	989	883
Family & Therapies	103,304	42	56	(14)
Estates and Facilities	58,442	177	59	118
Director of Operations	269	80	58	22
Total Director of Operations	**455,327**	**4,824**	**2,388**	**2,437**
Corporate Divisions	**73,076**	**(736)**	**(261)**	**(475)**
Specialist Services	**142,790**	**0**	**0**	**0**
External Contracts	**67,256**	**0**	**(160)**	**160**
Capital Charges	**23,727**	**(1)**	**(1)**	**(0)**
Total Delegated Position	**1,255,160**	**3,565**	**2,169**	**1,396**
Total Reserves	**19,712**	**(2,483)**	**(1,517)**	**(966)**
Total Income	**(1,274,872)**	**0**	**(0)**	**0**
Total Reported Position	**0**	**1,082**	**651**	**431**

A number of areas remain a considerable distance from the break-even requirement. Of particular concern is Scheduled and Unscheduled Care which have a deficit of £4.5m as at month 2, these two Divisions are increasing the deficit, on average, by £2.2m per month, albeit savings plans are expected to increase in delivery in later months.

These overspends are being partly offset by other Divisions and the Health Board reserve, resulting in a £1.082m deficit at month 2.

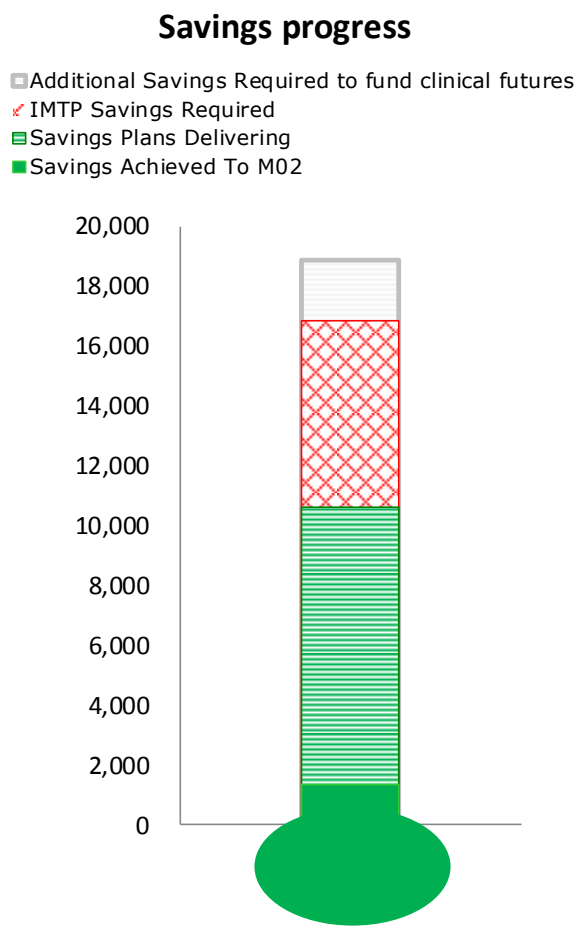
Areas of expenditure driving the Scheduled Care position are: Nursing and Medical agency to cover vacancies including 12 rota gaps in Orthopaedics, WP10's (drugs), Theatre non pay (implants) and one off costs for incremental arrears.

Areas of expenditure driving the Unscheduled Care position are: Medical Staffing (YYF, COTE and coverage of Holly Ward), Registered Nursing (sickness and ED), HCSW (sickness and enhanced care) and additional coverage in EAU, Medical & Surgical equipment and continued winter/additional bed capacity.

The favourable movement in Community CHC in month 2 is the release of provisions held for retrospective claims which have been settled.

The unfavourable movement in the Estates & Facilities Division is a result of one off cost pressures, these include; the cost of an unexpected pension top up payment, an increase in catering provisions, one off lift repairs and the expectation of the payment of the insurance excess for the demolition of Pembroke Villa following a recent fire.

Savings Delivery - Overall View

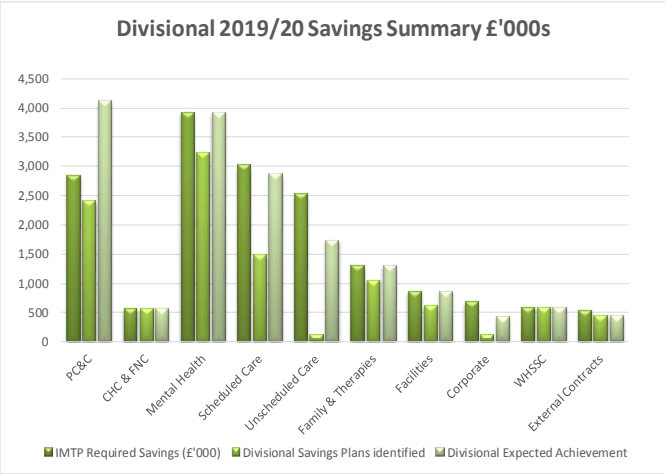


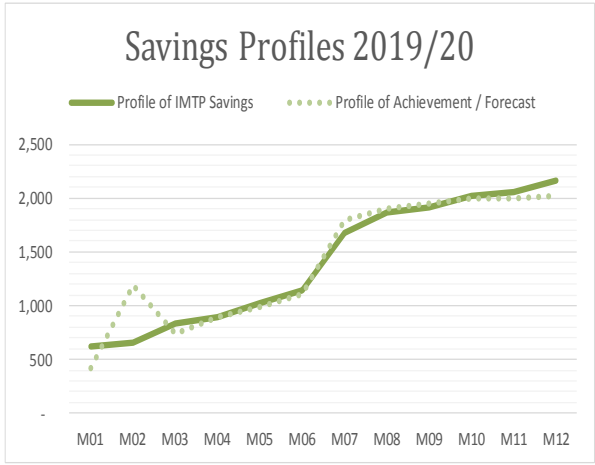
Divisionsal Savings Plans	IMTP
Primary Care and Community	- 1,370
Prescribing	- 1,480
Community CHC & FNC	- 570
Mental Health	- 3,922
Director of Primary Community and Mental Health	-
Total Primary Care, Community and Mental Hea	**- 7,342**
Scheduled Care	- 3,019
Unscheduled Care	- 2,526
Family & Therapies	- 1,302
Estates and Facilities	- 858
Director of Operations	-
Total Director of Operations	**- 7,705**
Corporate / Exec budgets:-	
Corporate Other	- 574
Medical Director	- 100
Total Corporate Divisions	**- 674**
Specialist Services	
WHSSC	- 592
EASC	-
Total Specialist Services	**- 592**
External Contracts	
External Commissioning - LTAs'	- 539
Total External Contracts	**- 539**
Total Delegated Position	**- 16,852**

Savings required to meet the IMTP are £16.8m, of which the Divisions have plan currently delivering to achieve £10.6m. Further savings plans are expected to deliver later in the year via schemes relating to delivering performance and efficiency improvements identified through comparative benchmarking opportunities identified locally and nationally. This is now an immediate and urgent action.

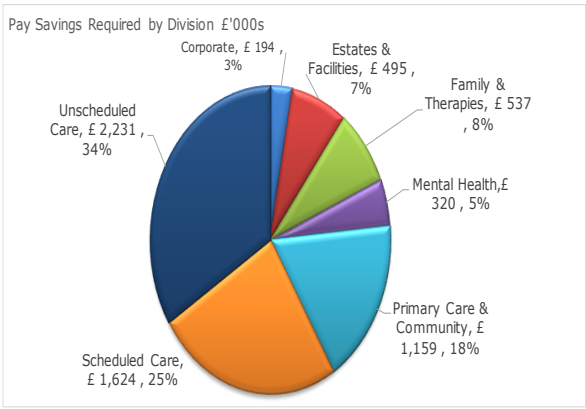
Non delivery of savings plans is a substantial risk for achievement of the IMTP and break-even position.

Savings Delivery – Detail





Savings Category	£'000
Pay	6,560
CHC and Funded Nursing Care	3,807
Medicines Management (Primary & Secondary Care)	2,828
Non Pay	1,682
Commissioned Services	1,299
Accountancy Gains / income generation	676
Total by Category	**16,852**
Pay Savings - Further breakdown	£'000
Pay - Variable Pay	3,138
Pay - Changes in Staffing Establishment	2,342
Agency - Reduced usage of Agency/Locums paid at a pre	1,080
Total Savings by Pay Category	6,560



Savings required to breakeven per the IMTP financial plan is £16.852m. The majority (circa 60%) of annual schemes are starting to deliver in year.

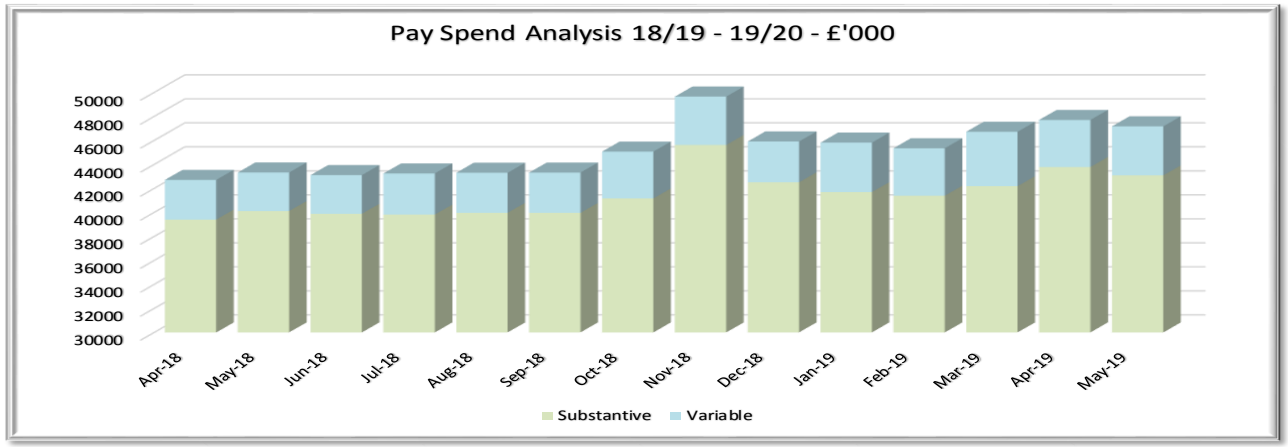
The savings profile graph shows this pictorially.

Currently delivery risk is most significant in the Scheduled Care and Unscheduled Care divisions.

The largest of the savings categories is Pay, a breakdown over pay categories and by Division is included.

Pay Expenditure

Monthly Trends (Please note scale of the Y Axis)



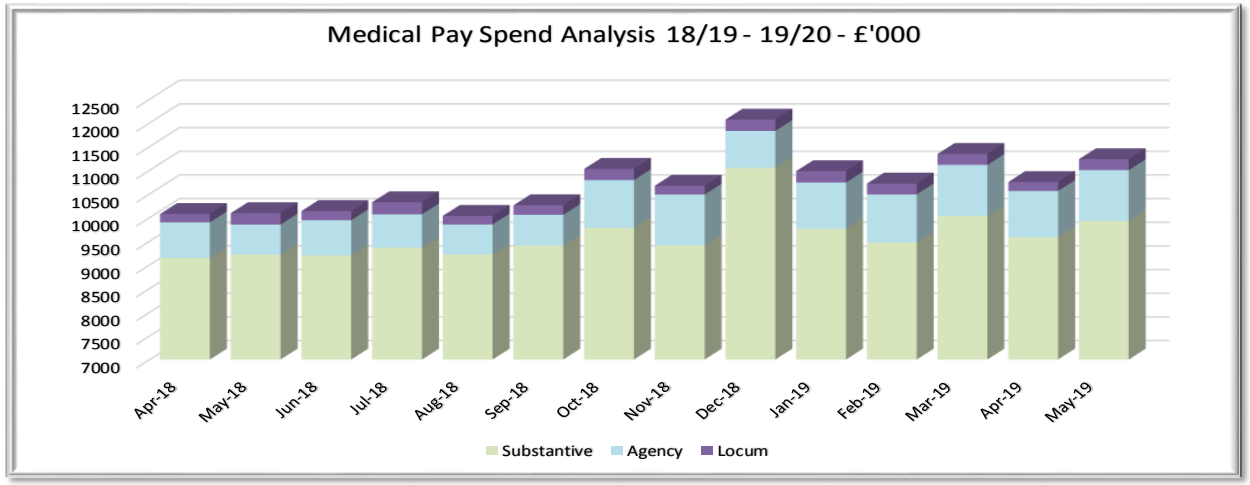
					Wage Award Uplifts and backdated Payments						Top of Scale one of Payment		
£'ms	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Total: Rolling 12mth
NURSING & MIDWIFERY REGISTERED	13.5	13.5	13.7	13.4	14.5	15.7	13.8	14.4	14.3	14.8	15.2	14.7	171.7
MEDICAL & DENTAL	10.1	10.3	10.0	10.3	11.0	10.7	12.1	11.0	10.7	11.3	10.8	11.2	129.6
ADMIN & CLERICAL	6.3	6.2	6.3	6.3	5.3	7.3	6.5	6.5	6.4	6.7	6.8	6.7	77.3
NURSING HCSW	4.6	4.6	4.7	4.5	5.0	5.6	4.6	4.8	4.8	4.9	5.0	4.9	58.0
ALLIED HEALTH PROFESSIONALS	2.6	2.6	2.6	2.6	2.7	3.1	2.7	2.7	2.7	2.8	3.0	2.8	33.0
ESTATES & ANCILLIARY	2.6	2.5	2.6	2.5	2.8	3.3	2.6	2.7	2.7	3.0	2.9	2.8	32.9
PROF & TECH/HEALTHCARE SCIENTISTS	2.4	2.3	2.3	2.4	2.6	2.8	2.5	2.7	2.7	2.8	2.9	2.8	31.1
ADDITIONAL CLINICAL SERVICES	1.0	1.1	1.1	1.0	1.1	1.3	1.1	1.1	1.1	1.1	1.2	1.1	13.2
18/19 & 2019/20 Average	44.8	44.8	44.8	44.8	44.8	44.8	44.8	44.8	44.8	44.8	47.4	47.4	
Total	**43.1**	**43.2**	**43.3**	**43.0**	**45.1**	**49.7**	**46.0**	**45.8**	**45.3**	**47.4**	**47.7**	**47.2**	**546.8**

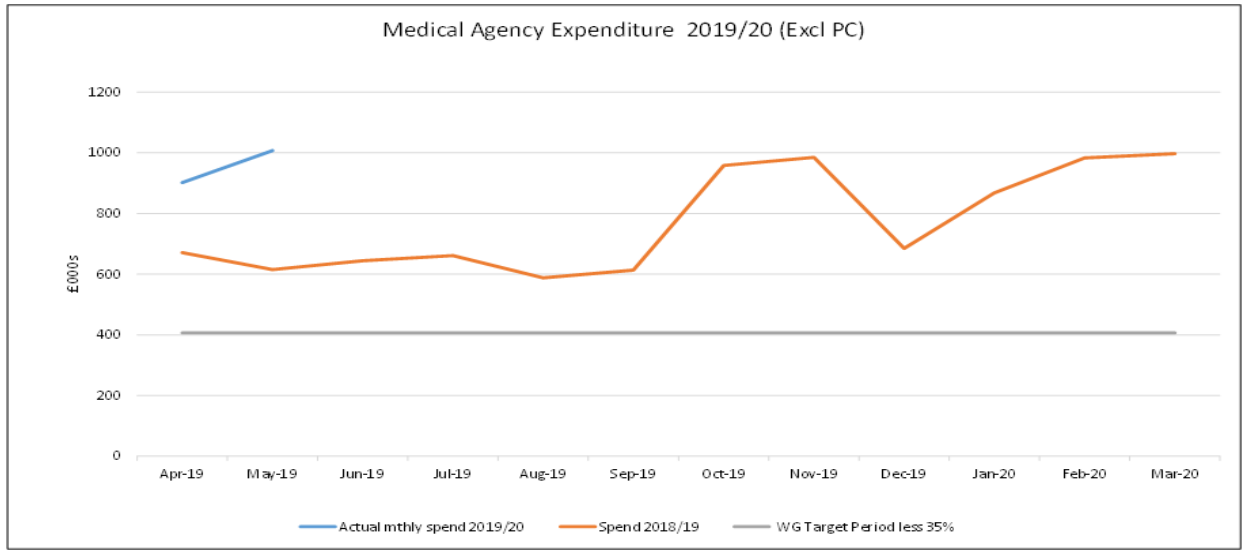
Some of the anomalies in the pay expenditure profile are related to the wage award. The 2018/19 A4C award was paid in October 2018 with the back pay paid in November 18 and M&D uplift paid from December. The 2019/20 A4C award was paid from April 2019 along with a top of scale one off payment (£1.8m). The non-consolidated payment was fully funded for all Delegated Budgets.

Average substantive staff expenditure per month in 2018/19 was £41m, in May 2019 spend is £43m, this difference is partly explained by the 2019/20 wage award – the A4C award costs approximately £460k per month. The largest increases in substantive pay are F&T, Sch and UNS Care and Estates & Facilities.

The second table shows the expenditure for each pay group for a rolling twelve month period in descending order.

Medical & Dental Expenditure (Please note scale of the Y Axis)





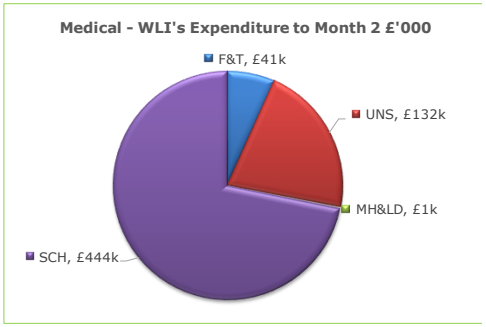
Medical Pay, including substantive and variable is increasing in spend compared to 2018/19, in fact only December 18 (wage award) and March 19 have a higher spend than May 2019 in the last 14 months.

The average spend for 2019/20 is almost £350k per month higher than 2018/19, this relates to both Substantive and Agency expenditure.

The 2019/20 wage award for Medical Staff is not yet agreed.

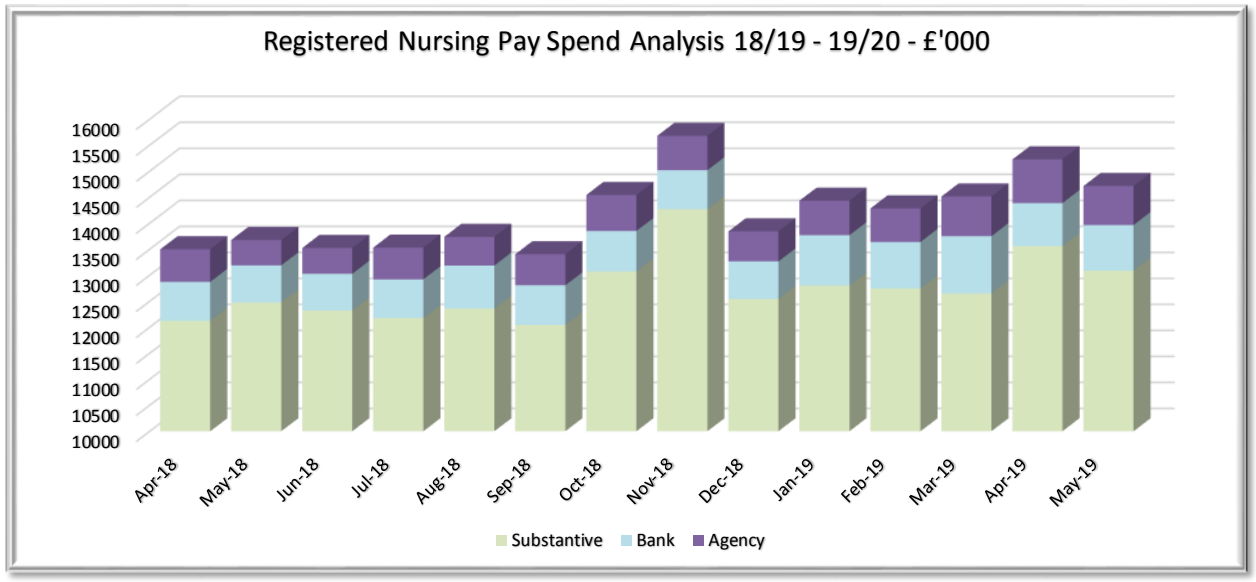
Medical Agency continues to be a pressure in Family & Therapies Division - paediatric services and gynaecology, Scheduled Care Division - Ophthalmology and Trauma & Orthopaedics and Unscheduled Care Division - COTE, ED and YYF Junior Doctors.

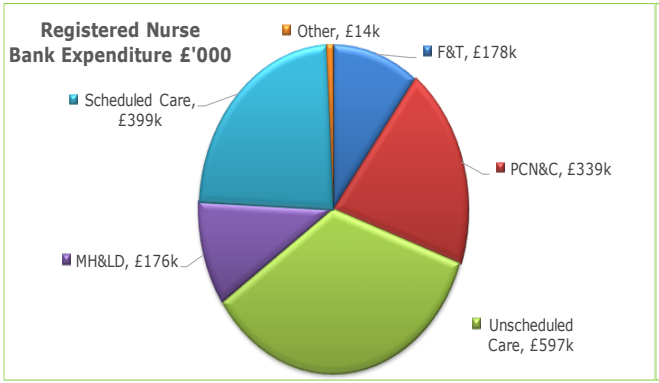
Waiting list initiatives are a regular cost within the Acute Divisions, in 2018/19 averaging £339k per month, April 2019 saw a reduction but expenditure is back to £339k in May 2019. The main areas within Scheduled Care are Anaesthetics, T&O and Radiology and for Unscheduled Care its Gastroenterology and Cardiology, a Divisional split is in the table below:

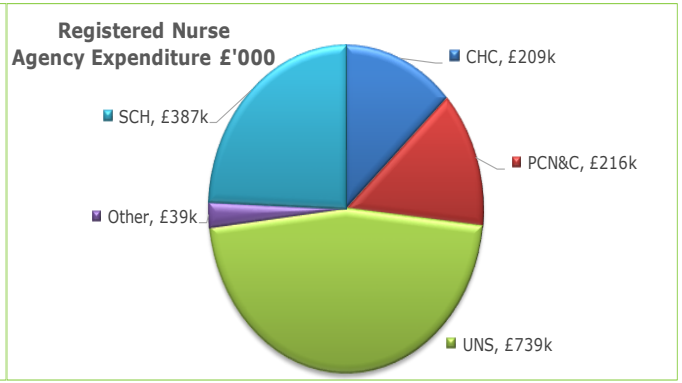


The HB continues to fail to achieve the reduction in Medical Agency spend.

Registered Nursing Expenditure (Please note scale of the Y Axis)







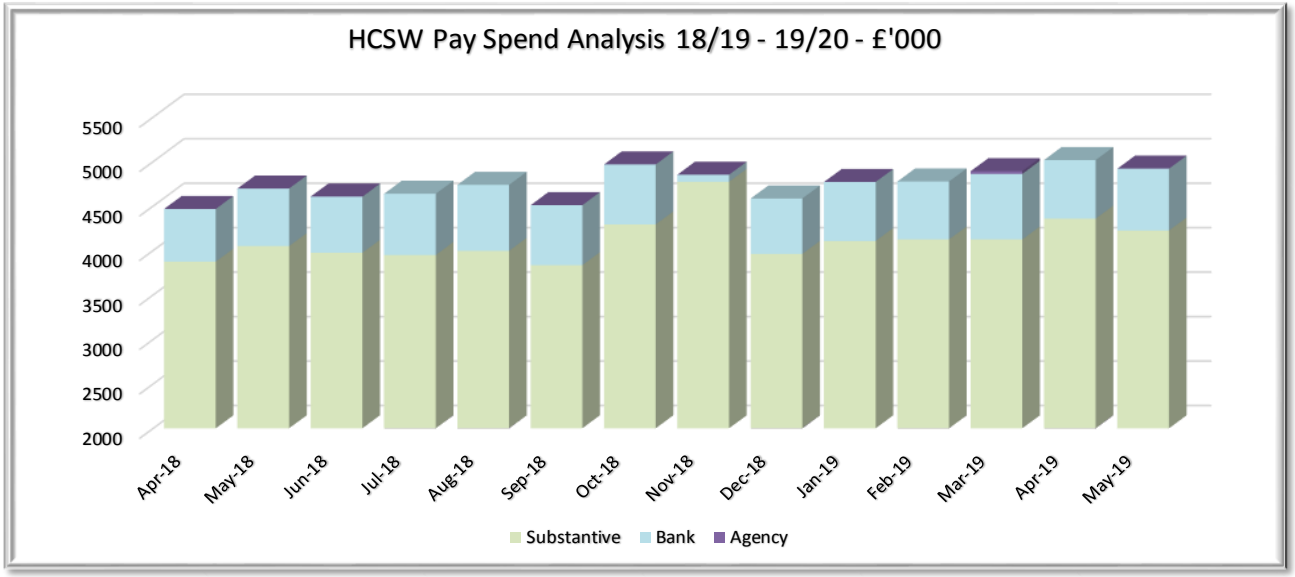
Substantive wages include the 19/20 inflationary wage award and the non-recurrent consolidated payment made in April.

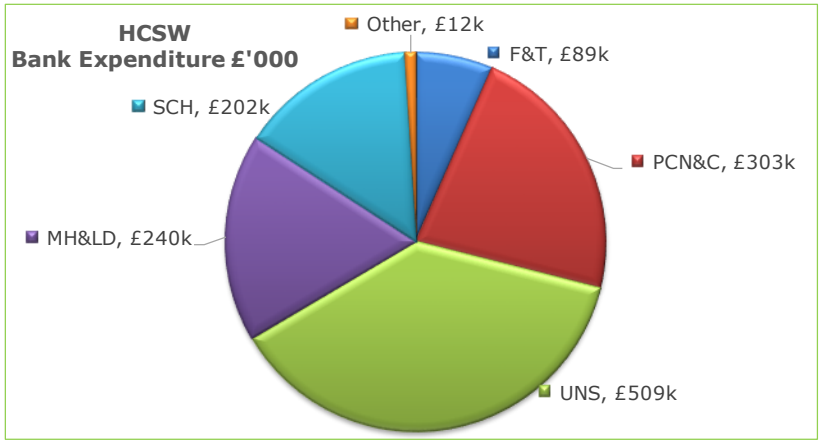
Vacancies and sickness continue to be a pressure across a number of services.

The registered nurse agency average expenditure in 2018/19 was £614k per month, the average of months 1 and 2 for 2019/20 is £795k per month, an increase of £181k. This is in three main areas: Unscheduled Care, Scheduled Care and Primary Care and Networks.

In particular this is within Scheduled Care (General Surgery, Urology & Orthopaedics), Unscheduled Care (RGH & NHH Medicine) and Community services (PCN).

Health Care Support Workers Expenditure (Please note scale of the Y Axis)



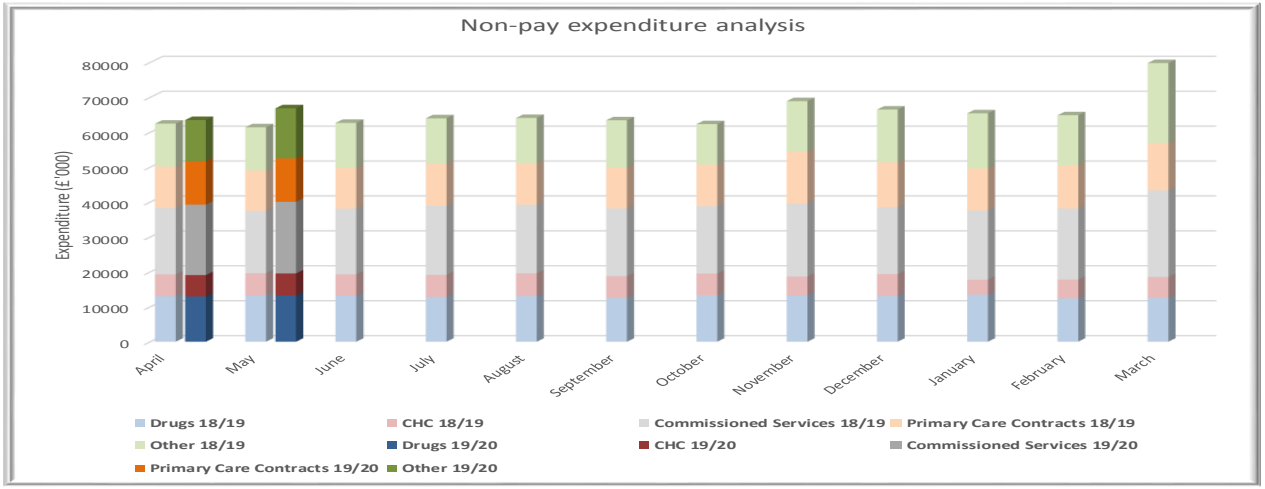


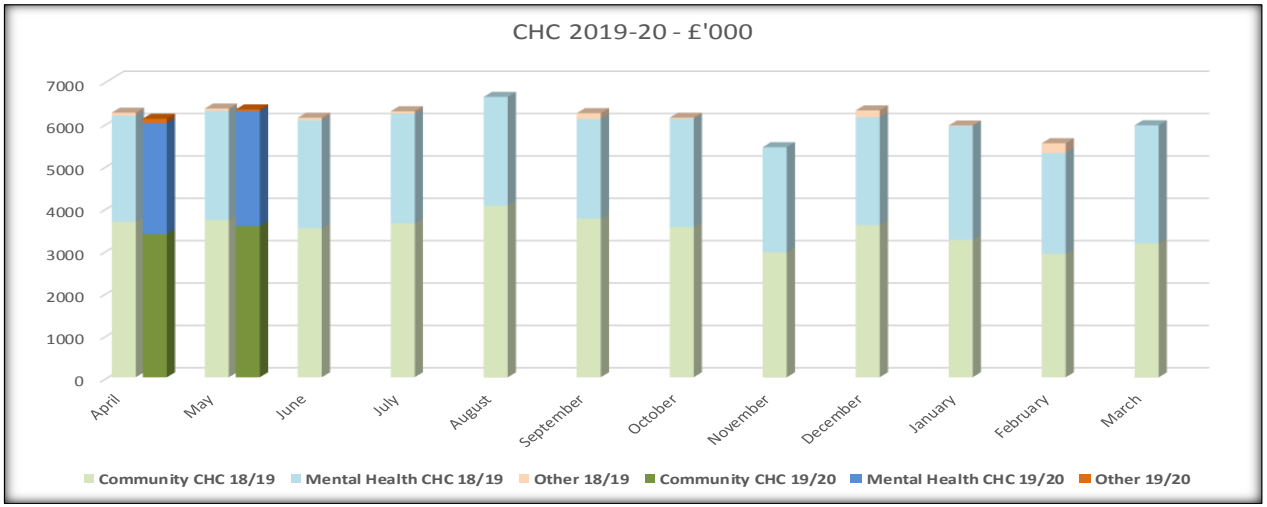
Substantive wages include the 19/20 inflationary wage award and the non-recurrent consolidated payment made in April. Allowing for this, the 2019/20 spend so far is in line with 2018/19.

Sickness continues to be a pressure across a number of services, along with enhanced care within Unscheduled Care.

In 2019/20 the agency spend is negligible.

Non Pay Expenditure

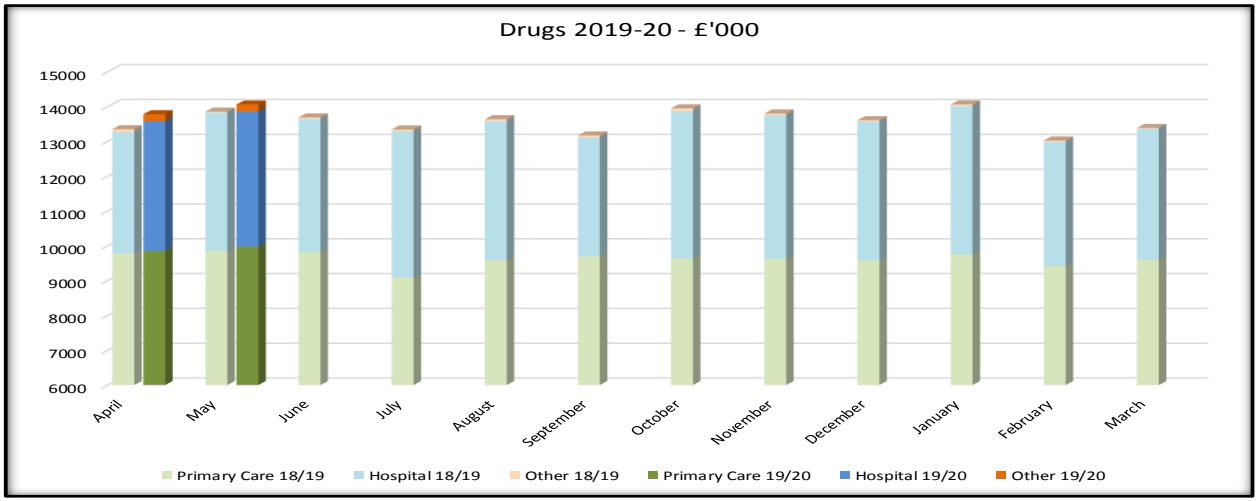




Expenditure for month 2 non pay is broadly in line with expenditure during 2018/19, the main difference in month 2 is an increase in the expenditure within Commissioned Services for planned growth and developments in 2019/20.

Growth continues to be low for Mental Health Continuing Healthcare but there is a risk this could rise as it is heavily reliant on the success of recent investments and savings schemes (e.g. PICU)

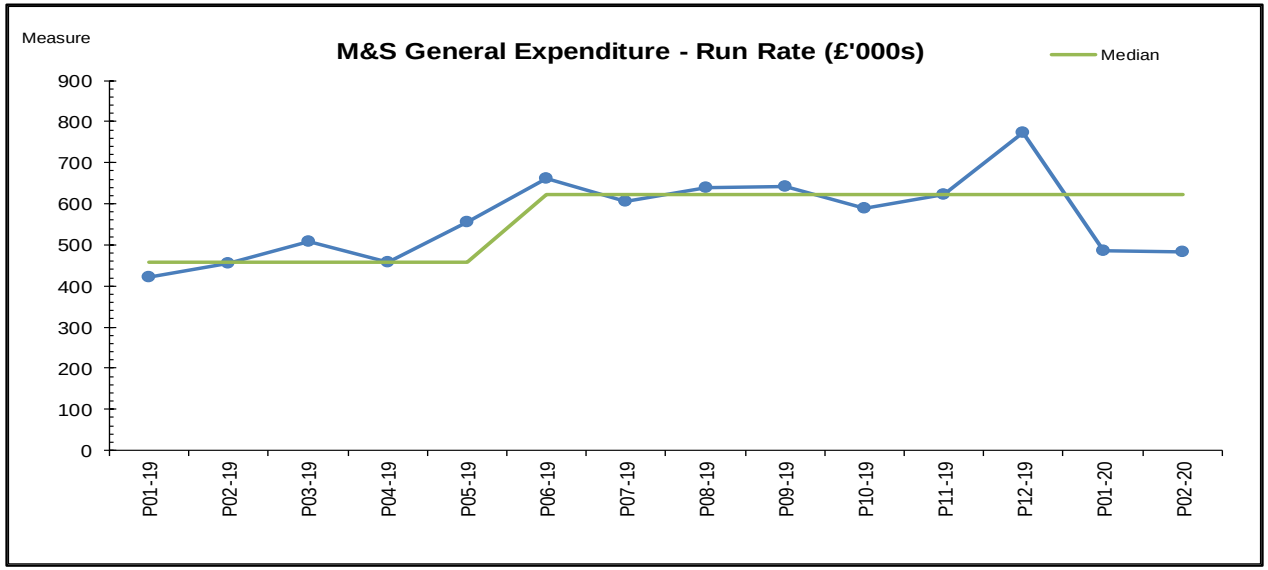
Adult Continuing Healthcare benefitted from the release of a provision in month 2, but even excluding this and offsetting a small spike in 1-2-1 care in month the expenditure remains low in comparison to previous levels of spend. The number of CHC patients is now at its lowest since the Health Board started recording figures, from 1,115 in July 2015 to 710 in May 2019, with a reduction in 24 patients since March 2019.



Primary Care prescribing is in line with the forecast with a small underspend for 2019/20 expected (-£274k).

Scheduled Care drugs expenditure was slightly above budget this month, mainly WP10's, particularly in Haematology and Ophthalmology.

Respiratory drugs remain a risk for Unscheduled Care but an opportunity exists with the Neurology Valproate Clinics starting soon (epilepsy drug).



60% of M&S (medical & surgical consumables) expenditure is in Scheduled Care with spend of £589k. Unscheduled Care (particularly Theatres) is the next biggest user with 23% of total spend and spend of £226k.

Capital Planning

Summary Capital Plan Month 2 2019/20	2019/20 Original Plan £000	Revised Plan £000	Spend to Date £000	Forecast Outturn £000
Source				
Discretionary Capital:-				
Approved Discretionary Capital Funding Allocation	10,814	10,814		10,814
NBV of Assets Disposed - Anticipated	420	420		420
Total Approved and Anticipated Discretionary Funding	11,234	11,234		11,234
All Wales Capital Programme Funding - Approved	112,695	112,695		112,695
Total Capital Funding / Capital Resource Limit (CRL)	**123,929**	**123,929**	**0**	**123,929**
Applications:				
Discretionary Capital:-				
Statutory Allocations	625	625	94	625
Commitments B/f From 2018/19	1,427	1,513	127	1,178
Informatics National Priority	1,800	1,800	106	1,800
Imaging National Priority	1,045	1,045	0	1,045
Fees to develop AWCP Potential Schemes	120	120	0	120
Lift Replacement Programme NHH / RGH	820	820	0	820
Ward Upgrade Programme	1,500	1,500	0	1,500
Sustainability Schemes - Estates	1,122	1,260	21	1,260
Sustainability Schemes - Equipment Replacements	1,344	1,480	7	1,390
Total Discretionary Capital	**9,804**	**10,163**	**354**	**9,738**
Unallocated Discretionary Capital Programme Funding				**-1,496**
All Wales Capital Programme:-				
Grange University Hospital	110,522	110,376	21,657	110,376
111 Programme	436	443	4	443
Fees for East Newport Health & Wellbeing Centre Development	298	244	47	244
Fees for Tredegar Health & Wellbeing Centre Development	273	317	174	317
CT Scanner Replacement at RGH	745	801	0	801
Fees for HSDU	421	418	79	418
EOY Replacement Imaging Equipment	0	12	0	12
EOY - IM&T - Cyber Security	0	65	57	65
EOY - Additional Equipment Replacements	0	19	0	19
Total AWCP Capital	**112,695**	**112,695**	**22,016**	**112,695**
Underspend forecast against AWCP CRL				**0**
Total Programme Allocation and Expenditure	**122,499**	**122,858**	**22,371**	**122,433**

The statutory target is to ensure net capital spend does not exceed the Capital Resource Limit set by the Welsh Government.

The Grange University Hospital scheme remains on programme with an approved budget of £110.5m for 2019/20. Current forecasts suggest expenditure for 2019/20 of circa £105m, leaving circa £5.5m as headroom should costs increase over the remainder of the year. WG have indicated they will continue to review the approved budget, quarterly, removing any unrequired allocation whilst retaining a level of contingency to cover changes in forecasts.

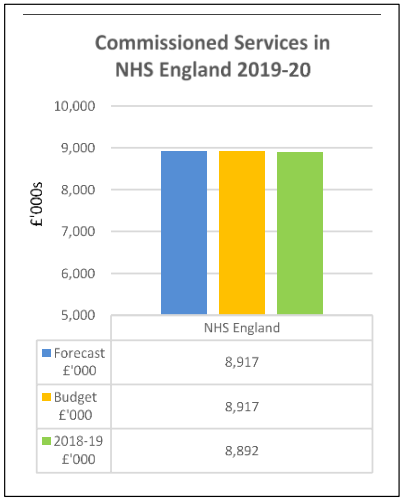
Works at the RGH Aseptic Suite continue and are now anticipated to complete in June.

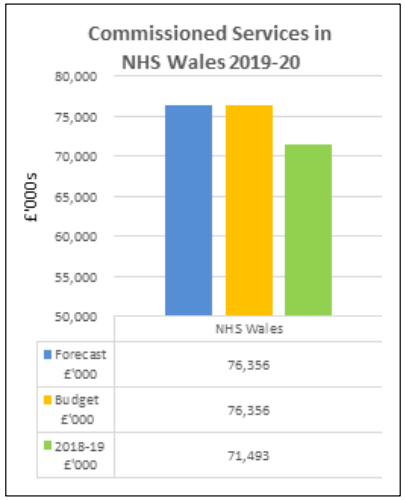
Work is underway to complete the Outline Business Cases for the Primary Care Pipeline schemes for Tredegar and East Newport and the Full Business Case for the HSDU at GUH for Board approval in Q2.

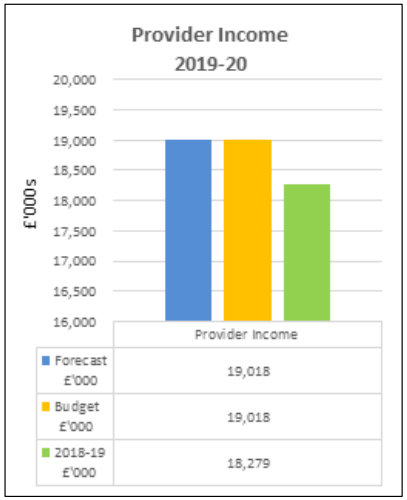
A number of emerging priority schemes are being developed to utilise the £1.5m unallocated discretionary funding.

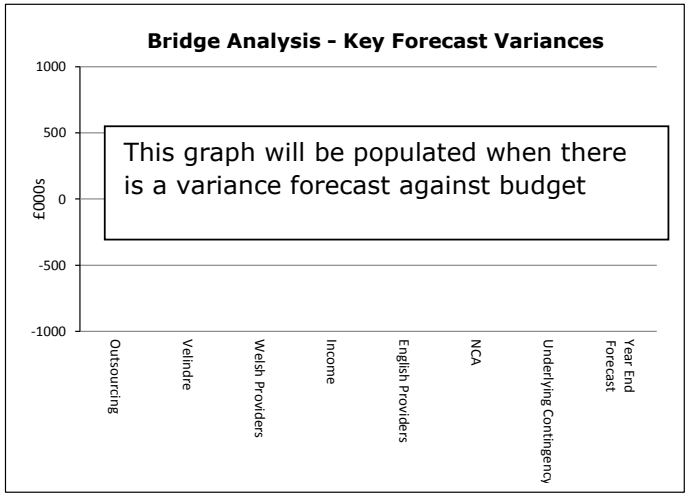
Contracting and Commissioning

At Month 2 the financial performance for Contracting and Commissioning is a year to date break-even and forecast year end position of break-even. The key elements contributing to this position at Month 2 are as follows:









Commissioned Services

(NHS England)

YTD Variance £nil

Commissioned Services

(NHS Wales)

YTD Variance £nil

Provider Income

YTD Variance £nil

Forecast 2019-20 **Break-Even**

The forecast is currently break even consistent with the IMTP submission.

The year to date and forecast positions reflect the IMTP submission which identified a small increasing trend in activity in NHS England.

Current negotiations with DoH may impact Tariff prices for 2019/20.

Outsourcing costs will emerge from month 3 as activity is delivered.

The year to date and forecast position for commissioned services in NHS Wales is reflective of the 18-19 outturn activity, adjusted for non-recurrent services, unavoidable cost pressures and supported developments.

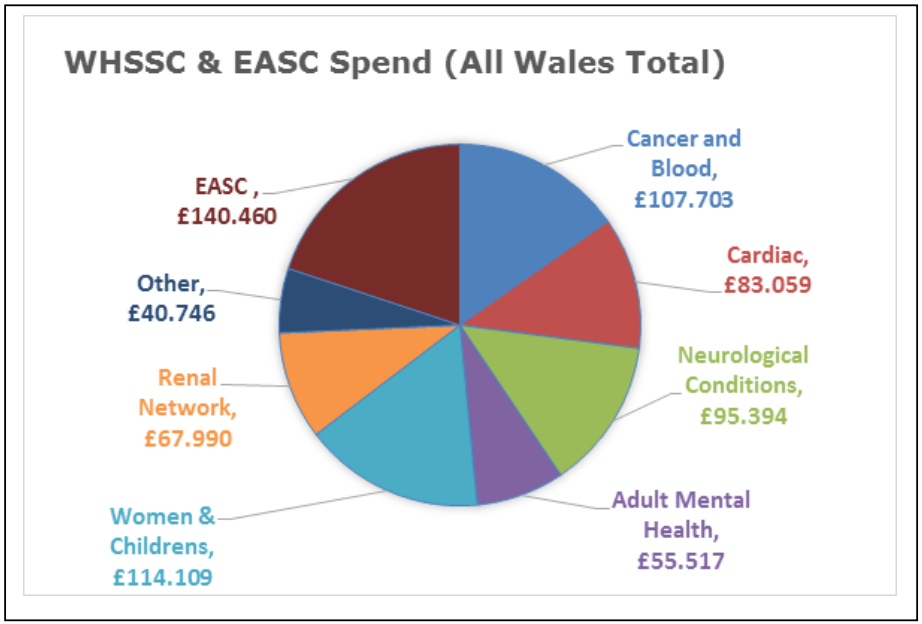
The year to date and forecast assumes that the increased contract and NCA income received in 2018-19 is recurrent.

Key Issues 2019-20

- All LTAs have been agreed with documentation drafted by ABUHB and sent to other Welsh organisations for signature.
- The nationally agreed inflationary uplift of 2% has been funded and is reflected in the above position.
- The 1% Healthier Wales commissioner development funding has been factored into Welsh provider LTAs also.

WHSSC & EASC

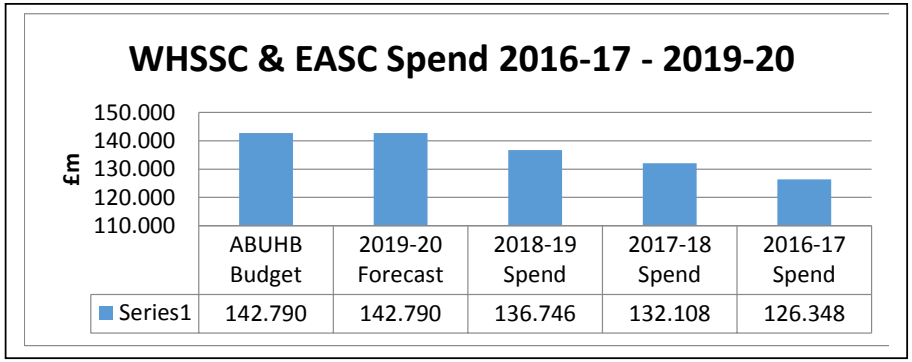
At Month 2 the financial performance for WHSSC & EASC is breakeven;

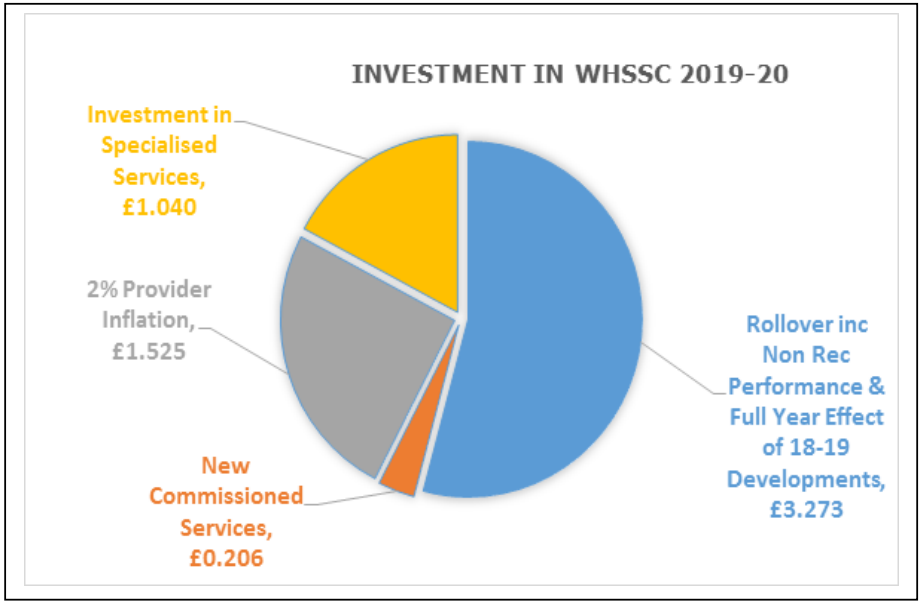


WHSSC Integrated Commissioning Plan 2019-20

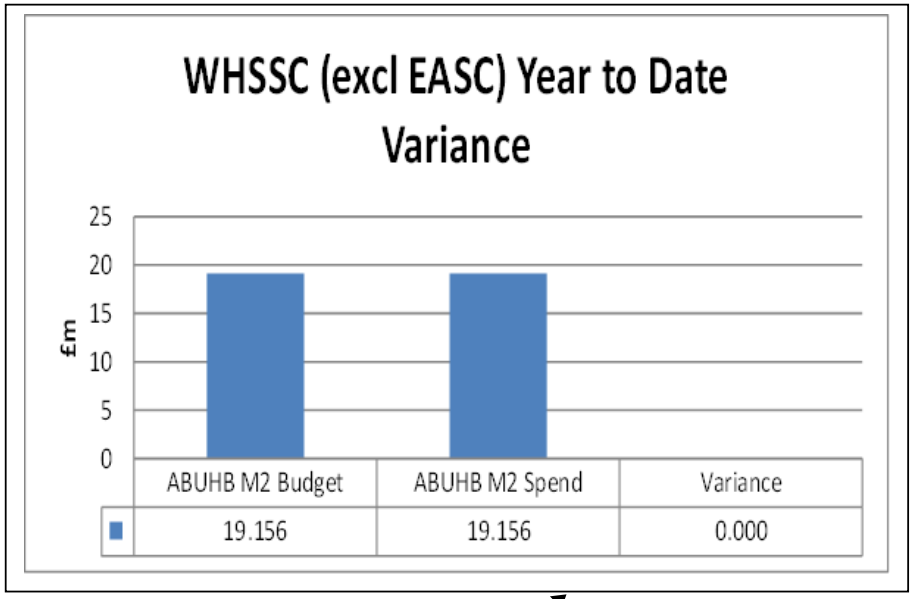
The WHSSC Joint Committee & EASC approved the following IMTP commitments

	Budget £m	Forecast £m	Variance £m
WHSSC	114.936	114.936	0
EASC	27.854	27.854	0





WHSSC Analysis (Continued)



Emergency Ambulance Services Committee (EASC)

The Month 2 forecast position includes £27.854m of expenditure in respect of EASC. This represents the ABUHB share of the All Wales investment in EASC in 2019-20 in accordance with the risk sharing principles.

	£m
EASC 2018-19 Rollover	25.895
2% Inflation + Developments/Allocations	1.959
Forecast 2019-20	27.854

ABUHB do not receive a separate allocation for EASC with the position reported as part of the All Wales position in the WHSSC tables.

The position reflects £0.301m development funding for the Paramedic Banding Scheme and £0.197m for the Advanced Paramedic Practitioner Programme.

- The Month 2 position reflects the WHSSC IMTP agreed at Joint Committee
- Ongoing risks to the position include:
  - LTA performance
  - Potential HRG4+ and other English tariff funding issues
  - Delivery against the agreed investment schemes in the WHSSC IMTP
  - Risk management of the service implications of the investments not agreed in the WHSSC IMTP

Balance Sheet

Balance sheet as at 31st May 2019

	2019/20 Opening balance £000s	31st May 2019 £000s	Movement £000s
Fixed Assets	651,749	669,439	17,690
Other Non current assets	94,339	96,210	1,871
Current Assets			
Inventories	7,573	7,599	26
Trade and other receivables	70,110	69,003	-1,107
Cash	984	3,092	2,108
Non-current assets 'Held for Sale'	420	420	0
Total Current Assets	79,087	80,114	1,027
Liabilities			
Trade and other payables	143,854	140,920	-2,934
Provisions	132,810	131,921	-889
	276,664	272,841	-3,823
	548,511	**572,922**	**24,411**
Financed by:-			
General Fund	430,993	455,552	24,559
Revaluation Reserve	117,518	117,370	-148
	548,511	**572,922**	**24,411**

Other non-current assets - relates to the increase of Welsh Risk Pool claims due in more than one year since the end of 2017/18.

Inventories - the increase in year relates to changes in stock held within the divisions.

Trae & Other Receivables - the main movements since the end of 2018/19 relate to:

- An increase in the value of debts outstanding on the Accounts Receivable system since 2018/19 to the end of May £0.1m.
- A decrease in the value of both NHS & Non-NHS accruals of £2.7m, of which £1.0m relates to the decrease of Welsh Risk Pool claims due in less than one year, £0.7m relates to a decrease in NHS & Non NHS accruals and £1.0m relates to a decrease in VAT and other debtors since the end of 2018/19.
- A decrease in the value of both NHS & Non-NHS accruals of £2.7m, of which £1.0m relates to the decrease of Welsh Risk Pool claims due in less than one year, £0.7m relates to a decrease in NHS & Non NHS accruals and £1.0m relates to a decrease in VAT and other debtors since the end of 2018/19.
- An increase in the value of prepayments held of £1.5m.

The cash balance held in month 02 is £3.092m.

Trade & Other Payables - the movement since the end of 2018/19 relates to a number of issues the most significant of which are:

- An increase in Capital accruals (£9.0m)
- An increase in NHS Creditor accruals (£5.7m)
- A decrease in the level of invoices held for payment from the year end (£10.8m)
- A decrease in non NHS accruals (£2.6m)
- An increase in Tax & Superannuation (£1.2m)
- An increase in other creditors relating to timing of Primary Care payments (£19.8m)
- An increase in payments on account (£0.8m)

Due to the increase in the provision for clinical negligence and personal injury cases based on information provided by the Welsh Risk Pool of £0.6m, a decrease in the claims for Continuing Healthcare of £1.4m, and a decrease in the provision for early retirements of £0.1m since the end of 2018/19.

General Fund - represents the difference in the year to date resource allocation budget and actual cash draw down including capital.

Health Board Funding – WG Allocations (£1.25bn) and Other Income (£99m)

WG Revenue Resource Limit Allocations		
Description	**Value £m**	**Recurrent / Non Recurrent**
Allocations Received		
Initial Allocation: HCHS	1,089.3	R
Initial Allocation: GMS	97.3	R
Initial Allocation: Pharmacy	31.5	R
Initial Allocation: Dental	27.9	R
Sub - Total Allocations Rec'd	**1,246.0**	
Anticipated Allocations		
(Provider) Substance Misuse & increase	2.6	R
(Provider) SPR's	0.1	R
(Provider) CDA's	0.3	R
I2S Led Lighting	(0.1)	R
Eating Disorders	0.1	R
Treatment Fund	1.5	R
CAMHS In Reach Funding	0.1	R
Technology Enabled Care National Programme (ETTF)	0.5	R
Invest to Save - RN Recruitment	(0.1)	NR
Nursing Informatics	0.1	NR
National Professional Lead and National Director Primary Care	0.3	R
National Professional Lead Planned Care	0.2	R
Invest to Save DHR Phase 1	(0.5)	R
Invest to Save DHR Phase 2	(0.1)	R
Invest to Save Omnicell	(0.3)	R
Adjustment to baseline funding - Transfer to NHS Collaborative - Cardiac Network Funding	0.1	R
ESMCP Control Room Solution	0.3	R
WHSSC ARRP	(0.0)	R
Carers Funding	0.2	NR
funding Pilot Phase Patient Flow Programme ETTP	0.2	NR
Unsociable Hours/ Holiday on Overtime Pay	0.3	NR
GMS Refresh	1.6	R
Pharmacy Trainees anticipated allocation	0.2	R
Dental trainees anticipated allocation	1.1	R
Sub - Total Anticipated Allocations	**8.5**	

Total WG Allocations Expected 2019/20	**1,254.5**

The recurrent baseline funding for the Health Board from WG is £1.242bn: on top of this the HB has received £4.072m in year allocations and is expecting to receive a further £8.541m. The largest of the anticipated allocations is the Substance Misuse (£2.6m) this has been approved by the APB and the letter from the Chair to WG is underway, and the New Treatment Fund (1.53m) - one instalment has been received. All of these allocations are delegated to the appropriate budget holder and feature within the financial plan.

Furthermore the HB has now received the first instalment of the Transformation Fund - implementing a seamless system, of £1.447m, which will be delegated accordingly.

Allocations are only anticipated when there is confirmation from WG, usually via a policy lead so are considered very low risk.

WG continue to hold some funding centrally that may be subject to a bidding process, the HB would expect to be in receipt of a share of this. These relate to funding allocations such as the Mental Health Service Improvement fund, A Healthier Wales, Digital Technology, Clinical, quality and value, prevention and early years. Funding relating to these areas are currently excluded from the financial plan.

The HB also expects to receive income from other sources. At month two this is expected to be approximately £99m; at least a third of this is expected from other Health Bodies, plus from Local Authorities, dental charges, Laundry and canteen income. Actual income in 2018/19 reached £103m.

Reserves

The Health Board is holding £19.7m in reserves, as part of the budget delegation process £9.594m is being held to support the underlying position of the operational Divisions and is expected to be delegated to Divisions as financial plans are agreed with Executives / Board. This funding is supporting the year to date and forecast financial position so is not available for investments.

The remainder of the reserves are earmarked, per the budget delegation process for various items;

- Specific IMTP pressures, the larger items include: Office 365 £800k, RGH Car Parking £486k, WHSSC Risk Share £2.466m, Infected Blood inquiry £115k, Legal team £115k plus other smaller values
- Funding expected to transfer to other Health Bodies; NEPTS transfer to WAST £2.2m
- Specific WG Allocations, such as GMS 'A Healthier Wales' £975k, National Director of Planned Care £155k and the first instalment of the Transformation fund – £1.477m.

The HB has **no** contingency or uncommitted reserves. Where investment is required and WG funding isn't available the equivalent level of cash releasing savings and efficiencies will be required to be identified before the investment takes place.

Furthermore, Clinical Futures investments (Board March 2019) which generate additional spend will need to be funded through additional savings over and above the IMTP savings target.

Value for Money focus topic – Adalimumab Biosimilar (Humira) Switch

Background:

An Executive Team paper was presented and agreed in 2018/19 to fund additional posts within Pharmacy to enable a switch from the patented drug (Humira) to adalimumab biosimilar. This decision was based on the potential achievement of price savings and 'switch' savings and the confidence from the previous good record of implementing such switches. The following information was provided:

ABUHB total number of issues: 8,057 (October 2017 – September 2018)

ABUHB patients reported across all specialities as at December 2018: 323

Annual Spend: £2,837,192 (October 2017 – September 2018)

If all patients switch to the biosimilar a potential **£1.844m** savings should materialise on a full year basis. This assumed

- a 55% price reduction (estimated at £1.560m), and
- a further 10% assumed for switching to the biosimilar (estimated at a further £0.284m).

The stages agreed were as follows:

- Biosimilar contract negotiated nationally by central procurement
- Pharmacy arrange and agree SLA with biosimilar homecare company
- Directorates undertake patient switchover when patients present to clinic
- Pharmacy set up new scheme, arrange clinical check process, enter clinical details onto database, obtain purchase orders, set up invoicing etc.
- Target delivery date 1st January 2019.
- Timeframe for full switch was to complete by July 2019.

As a result the Executive Team agreed to provide funding on a recurrent basis as follows:-

2018/19: £23,145

2019/20 recurrently: £85,380

This was to fund 1.0 WTE band 8A Pharmacist and 1.0 WTE band 3 Clerical post.

Current Summary Assessment:

Adalimumab expenditure for the 2018/19 financial year was approximately £2.595m. This included an estimated price saving of £0.59m for the period when the Humira price decreased.

The level of the existing patient switch planned has not been achieved with around 15 out of approximately 340 patients being switched as at May 2019.

The full year savings effect of the price decrease would be approximately c. **£1.57m.**

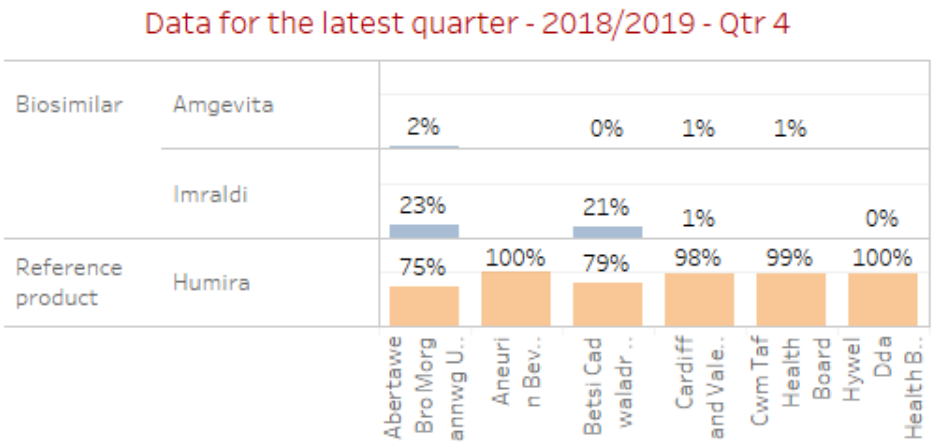
As a result the additional saving opportunity if all patients are switched would be approximately **£0.27m**.

This would mean our historical spend of £2.8m should shift to circa £1m per annum for the same level of patients.

Current progress to date:

The additional clerical post was recruited in late 2018 however the additional pharmacist post is currently being covered through additional hours. The pharmacy directorate intends to appoint to this post later in 2019. The additional staff are now set up to clinically validate homecare prescriptions and have processed all the necessary arrangement to accept the transfer of patients and any new prescriptions prescribed as the switches progress.

Currently uptake and agreement from Consultants to switch is very low and is not in line with plan, however new patients are now being initiated. The graph below indicates that the uptake of the biosimilar is below that of other Health Boards in NHS Wales.



The low uptake is due to a number of factors dependant on the specialty, these are summarised below:-

- Rheumatology – pressure on clinics, 6-8 week homecare processing. Awaiting patients to attend their next out-patient clinic.
- Gastroenterology – lack of IBD nursing resource in order to progress switching of patients.
- Dermatology / Paediatrics – awaiting progression from other specialities before proceeding and homecare processing.

Current performance (As at May 19) indicates 15 of approximately 340 patients have been switched:

Gastroenterology – 8 out of approximately 150 patients

Rheumatology – 7 out of approximately 125 patients

Dermatology – 0 out of approximately 60 patients

Paediatrics – 0 out of 5 patients

The current opportunity value for 100% switch is c. £0.3m however this will be higher due to the increasing patient cohort.

It should be noted that the originators of humira are likely to reduce their price further in order to try and maintain market share.

Next steps:

The additional saving scheme should benefit the Unscheduled Care, Scheduled Care and Family and Therapies Divisions to a lesser degree. None of the Divisions are currently reporting additional savings due to switches. The savings will start to be reported from June onwards as the prescriptions are changed to the adalimumab biosimilar.

Whilst the rheumatology and dermatology specialities are starting new patients on the biosimilar, there continues to be some resistance with regards to switching current patients. One of the reasons for this is due to a further opportunity whereby patients are prescribed the adalimumab biosimilar in rheumatology through WP10HP's – this is being given further consideration.

Within gastroenterology, the current clinical resource will need review and amendment in order to progress switches. Given the value of savings, there is an opportunity to invest temporarily in order to complete this switches.

The view of some specialties is that the length of time to process new homecare prescriptions has increased and the reasons for this need to be clarified and confirmed with specialities. The appointment of a full time pharmacist should eliminate any additional processing time as necessary.

Conclusion:

The May Medicines Management Board agreed to push a 6 month implementation programme for delivery of at least 85% switches.

Action needs to be taken to work with the prescribing Consultants to facilitate the switching of the prescriptions, an understanding of the difficulties and any actions that could facilitate easing this will need to be planned in order to realise the benefits of the initial investment in Pharmacy and deliver the full potential savings.

Welsh Government Financial Monthly Monitoring Returns

The Welsh Government 'WHC 2019-013 2019.20 Monitoring Returns' requires Health Boards to share sections of the Monthly Monitoring returns with the Board / Committee. This consists of:

- Narrative
- Table A: Movement
- Tables C,C1, C2, C3: Savings and
- Table F : Risks

Narrative

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

MONITORING RETURN FOR MONTH 2 2019/20

Director of Finance Commentary for the period ended 31st May 2019

INTRODUCTION

The purpose of this narrative is to provide a commentary on the financial monitoring returns being submitted to the Welsh Government (WG) by the Aneurin Bevan University Health Board (ABUHB) for the period to 31st May 2019 (Month 2 2019/20). This commentary will provide an overview of the financial position and performance of the Health Board as at month two of the 2019/20 financial year. It will also provide a detailed narrative, where required, on each of the tables within the accompanying returns, in the format prescribed by WG.

This commentary will also respond, as far as is possible, to the issues highlighted in the WG response letter. The progress made on these issues is set out by way of an action log included as an Annex 1 to this commentary.

The financial detail and associated commentary included in these returns fully aligns to those included in the Health Board's internal and public Board papers which will be presented on: 17th July 2019, 25th September 2019 and 27th November 2019 ***(Action Point 1.13)***. The required monitoring returns tables will be included in papers for the ABUHB Board Finance and Performance Sub-committee, the dates of which are: 4th July 2019 and 9th October 2019. To note dates for meetings in 2020 are yet to be arranged.

In response to Actin Point 1.14, the Board Governance arrangements for the signing off of the monthly monitoring returns in the absence of either the Chief Executive or the Finance Director are:

- In CEO absence the Deputy CEO,
- In DOF absence AFD.

In response to Action Point 1.15; the Health Board is planning to spend to at least the level of the ring fenced allocations for each of the areas within table B1 of the allocation paper and GMS and Dental.

- Mental Health & LD spending is in excess of the ring-fenced element
- The whole ICF and specific ICF Autism funding is being spent in line with agreed plans
- Baseline depreciation funding is anticipated to be fully spent. Forecast strategic depreciation and impairment requirements will be submitted via the non cash returns at the end of June.
- Ring fenced funding plans are in place for palliative Care, Delivery Plans, Dental and GMS.

Actual YTD and Forecast Position 2019/20 (Tables A and B)

Table A –Movement of Opening Financial Plan to Outturn

The IMTP submitted to Welsh Government in January 2019 identified a break-even position although noting financial risk for 2019/20.

Following submission of the IMTP on the 30th January 2019 the ABUHB financial plan has been updated to reflect the position as at month 1. The Health Board now has the following opening financial plan:-

- Underlying deficit brought forward of £11.4m
- Additional cost pressures identified of £47.2m
- Additional funding of £41.8m
- £16.8m of identified savings (inc. income generation and accountancy gains)

In response to Action Point 1.1: you query the changes in the cost pressures, savings and accountancy gains (to note it should read income generation as accountancy gains is unchanged) in comparison to the submitted IMTP. In line with ***WHC 2019/013: 2019/20 LHB & Trust Monthly Financial Monitoring Return Guidance, page 4***, the Health Board has worked to ensure its financial plan at the start of the year is more robust when compared to the IMTP submitted in January and will, therefore, be monitoring performance throughout 2019/20 against the plan now set in month 1.The relevant extract is replicated below:

'Due to the recently revised planning framework timeframe, it is acknowledged that the summary of the opening plan in Table A may have changed by the first month's monitoring submission. Whilst the total outturn of the opening plan must agree to the latest IMTP (or AOP), the breakdown in lines 1 – 10 may have changed due to the organisation finalising a robust plan by the start of the year.

Also due to revised planning framework timeframe, the Returns for 2019/20 will therefore be monitoring the financial performance against a plan that is fixed at Month 1. All saving plans and mitigating actions that were assumed in the opening plan outturn, which remain unidentified at Month 1 are automatically

removed from the forecast outturn in the first submission. All additional actions after Month 1, will appear as 'in year' changes.'

Any change in the reporting of the opening plan would cause inconsistency with the Board reporting.

In response to Action Point 1.2, the additional cost pressures refer to winter capacity and premium payments as referred to in the key messages below.

As at month 2 the Health Board forecasts a break-even financial position with a worst case financial risk of £7m.

Monthly Positions

Actual YTD

The month one reported financial position is a deficit of **£1.082m;** this is presented as such on the face of ***Table B – Monthly Positions***. The table below details the outturn financial position analysed over the Health Board's organisational structure of Divisions and Corporate Departments:-

Month 2 - May 2019	Full Year Budget £000s	YTD M2 Reported Variance £000s
Operational Divisions:-		
Primary Care and Community	243,335	259
Prescribing	95,112	(41)
Community CHC & FNC	63,553	(844)
Mental Health	90,747	122
Director of Primary Community and Mental Health	238	(19)
Total Primary Care, Community and Mental Health	**492,984**	**(522)**
Scheduled Care	189,176	2,654
Unscheduled Care	104,136	1,871
Family & Therapies	103,304	42
Estates and Facilities	58,442	177
Director of Operations	269	80
Total Director of Operations	**455,327**	**4,824**
Corporate Divisions	**73,076**	**(736)**
Specialist Services	**142,790**	**0**
External Contracts	**67,256**	**0**
Capital Charges	**23,727**	**(1)**
Total Delegated Position	**1,255,160**	**3,565**
Total Reserves	**19,712**	**(2,483)**
Total Income	**(1,274,872)**	**0**
Total Reported Position	**0**	**1,082**

Key messages within the Month 2

The financial position as at the end of May is a deficit of **£1.082m** with the key issues in the month being:-

- 'Continued expenditure on premium rate workforce solutions, including medical and nursing agency, this is driven by vacancies, sickness and RTT target delivery within acute specialties.

- Additional bed capacity, including Holly Ward, remaining open for an extended period of time has meant additional costs in month, £387k year to date, with both Unscheduled Care and Primary & Community Care Divisions expecting further costs in June. To note, plans for 'winter' capacity in 2019/20 are not included within the current forecast, however recurrent investments made in 2018/19 should mitigate some of this risk.

- Savings delivery is not in line with original plan profile therefore, there remains a risk relating to the delivery of the savings.

- Spending is lower than expected for drugs and litigation, with non-recurrent benefits reported for Continuing Health Care settlements.

- The forecast position is expected to remain balanced as in year actions are expected to deliver to plan.

Table A1 – Underlying Position

This table has been reviewed, and completed for month 2. The Month 2 position indicates a current brought forward position of £11.4m with a carry forward position of £7.9m which is in line with the Health Board's financial plan.

In Section A – the value of £4.8m for "Other Non-recurring factors" relates to additional performance solutions, the assumption of non-recurrent expenditure in line with the new treatment fund and specific initiatives such as additional car parking spaces which is regarded as non-recurrent expenditure ***(Action Point 1.5)***. These will be reviewed on an ongoing basis. There is one validation error on the tables regarding the full year effect of cost pressures which we have been unable to rectify in month 2, liaison with your colleagues before month 3 will be necessary.

Section B indicates that the key pressure areas remain Medical & Dental, Nursing (both registered and unregistered) as well as across other staffing groups. The key drivers for these pressures are vacancies as well as sickness, enhanced care and additional activity (RTT/seasonal pressures).

Section C indicates that the key pressures remain in Scheduled and Unscheduled Care, there is underlying pressure related to Mental Health CHC shown within Mental Health.

In response to Action Point 1.3, the non-recurring WG funding of £3.061m relates to the treatment fund where this funding is provided non recurrently but the costs are recurrent.

In response to Action Point 1.4, the cost avoidance outside of savings plans of £2.027m relate to CHC and prescribing.

In response to Action Point 1.7, as requested the WG income has been moved from the underlying position but is being used to support the sustainability of the recurrent cost base of ABUHB as per the approved IMTP strategy.

In response to Action Point 1.8, the recurring savings have been reviewed this month and although this will be reviewed monthly, at this stage the HB is comfortable with its current assessment.

In response to Action Point 1.9, the FYE assessment of recurring savings have been reviewed this month and although this will be reviewed monthly, at this stage the HB is comfortable with its current assessment.

The savings assessment will be completed on a monthly basis, in line with well established ABUHB governance processes and subject to any input difficulties (corrupted tab / protected 'free text' cells) will be updated for month 03. We would like to investigate this further with you during the month.

Table B & B1 – Monthly Positions, Net Expenditure Profile Analysis; Section C DEL/AME Depreciation & Impairments

Table B has been completed as per guidance.

Expenditure profiles have been collated through Divisional submissions. These will be refined and tested especially as and when key changes to assumptions are made.

Spend variables are volatile and remain under constant review throughout the financial year.

Material movements of actual expenditure from forecast expenditure for month 2 are:

- Income; this relates to and is offset by the non-cash limited (within Primary Care Contractor) and Medical Negligence and Personal Injury Claims (within joint financing).
- Continuing Healthcare; this is as a result of reduced numbers of patients, Mental Health had fewer starters than discharges and Community has a continued reduction in starter levels.

The effect of these on future profiles is being reviewed.

Allocations

The Month 1 financial position is based on total allocations of **£1,254.545m**, this consists of **£1,246.004m** confirmed Welsh Government allocations and **£8.541m** of anticipated allocations.

WG Revenue Resource Limit Allocations		
Description	**Value £m**	**Recurrent / Non Recurrent**
Allocations Received		
Initial Allocation: HCHS	1,089.3	R
Initial Allocation: GMS	97.3	R
Initial Allocation: Pharmacy	31.5	R
Initial Allocation: Dental	27.9	R
Sub - Total Allocations Rec'd	**1,246.0**	
Anticipated Allocations		
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(Provider) SPR's	0.1	R
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Eating Disorders	0.1	R
Treatment Fund	1.5	R
CAMHS In Reach Funding	0.1	R
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Invest to Save - RN Recruitment	(0.1)	NR
Nursing Informatics	0.1	NR
National Professional Lead and National Director Primary Care	0.3	R
National Professional Lead Planned Care	0.2	R
Invest to Save DHR Phase 1	(0.5)	R
Invest to Save DHR Phase 2	(0.1)	R
Invest to Save Omnicell	(0.3)	R
Adjustment to baseline funding - Transfer to NHS Collaborative - Cardiac Network Funding	0.1	R
ESMCP Control Room Solution	0.3	R
WHSSC ARRP	(0.0)	R
Carers Funding	0.2	NR
funding Pilot Phase Patient Flow Programme ETTP	0.2	NR
Unsociable Hours/ Holiday on Overtime Pay	0.3	NR
GMS Refresh	1.6	R
Pharmacy Trainees anticipated allocation	0.2	R
Dental trainees anticipated allocation	1.1	R
Sub - Total Anticipated Allocations	**8.5**	

Total WG Allocations Expected 2019/20	**1,254.5**

The Health Board is also anticipating funding for any M&D wage award above 1% and shares of centrally held funding.

Table B; Section D Accountancy Gains

Some CHC accountancy gains have been released in month 2.

Table B; Section E Committed Reserves & Contingencies

The Health Board holds a small number of reserves for specific issues with no contingency. The relevant expenditure for these issues has been profiled in section A. This is necessary for items such as strategic underlying position funding, WHSSC commitments, specific cross-divisional initiatives and earmarked posts to ensure they reflect the correct expenditure categories.

Table B1 – Net Expenditure Profile Analysis

This table has been completed in line with guidance for Month 2.

Table B2 – Pay & Agency

This table has been completed in line with guidance for Month 2. Agency/locum (premium element is indicated in the table rather than full agency costs) is used for a number of reasons.

The forecast expenditure has been undertaken but will require amendment/refinement. There is an assumption that expenditure will increase for performance solutions.

Savings Plans (Table C, C1, C2 & C3)

These tables have been completed in line with guidance. The Health Board's total savings forecast as at month 2 £16.852m.

Savings plans have been reviewed, this is completed on a Divisional basis and collated centrally. Work was undertaken to copy this into the submission for month 2, however, there were problems with copying in the collated information and then in updating free text lines, this led to over 100 errors on the savings tab that couldn't be corrected and impacted other tables, therefore, much of the savings data remains the same as month 1 however in month and achievement and savings titles have been manually updated.

Welsh NHS Assumptions (Table D)

This table has been completed for month 2. **In response to Action Point 1.12** the Health Board has agreed the income and expenditure with HEIW.

Resource Limits (Table E)

This table has been completed for month 2.

There a number of anticipated allocations which we will liaise with your WG colleagues in order to try and confirm throughout the financial year. In particular the APB has agreed the spending plan for substance misuse and the Chair is due to correspond with WG to confirm this which should enable the release of the £2.6m.

Risk Management (Table F)

This table has been completed in line with guidance for 2019/20. The risk factors included are currently assessed as performance targets and un-achievement of savings plans. Risks and opportunities continue to be reviewed and assessed for their probability and possible impact.

Statement of Financial Position (Table G)

This table is not required for month 2.

Cash Flow Forecast (Table H)

The cash balance held at the end of May is £3.092m which is within the target balance of 5% of the Health Board monthly cash draw down. The Health Board did not require the working capital cash allocation of £1.938m in 2018/19 because final movements in working capital balances were more favourable than were originally forecast.

There was also an additional capital working capital allocation of £0.907m and an additional £1.594m of the 2018/19 CRL which was not drawn down in 2018/19 due to year end creditors being higher than anticipated.

The Health Board will review the need for this cash in 2019/20 through the working capital balances exercise carried out later in the year.

Public Sector Payment Compliance (Table I)

This table is not required for month 2.

Capital Schemes & Other Developments (Tables J, K & L)

These tables have been completed for month 2.

Aged Welsh NHS Debtors (Table M)

At the end of May 2019 the Health Board had 5 invoices and 1 credit note outstanding with other Welsh Health Bodies totalling £47,846.51.

1 invoice with Cwm Taf Morgannwg University Health Board for £39.10. We have received confirmation that this will be paid week commencing 10th June 2019.

2 invoices with Powys Teaching Health Board totalling £37,540.63. 1 invoice for £39,624.17 was paid on 11.06.2019 leaving a credit note of -£2,083.54 which was agreed as part of the agreement of balances exercise in month 12 to be taken by Powys.

3 invoices with NWIS totalling £10,266.78. I invoice for £1,093.56 was paid on 4th June 2019 with a confirmed payment date of week commencing 10th June 2019 for the remaining 2 invoices.

Other Issues

Risk Management

Claims submitted to the Welsh Risk Pool at the end of May total £2.439m. No reimbursement has been made by the Welsh Risk Pool for claims submitted in April and May 2019.

Creditors

Attached to the returns is a separate file containing the following information in relation to outstanding creditors:-

- All outstanding creditors we currently have identified with other Welsh Health bodies as at the end of May 2019.
- Response to the month 01 list of creditors circulated as part of the monthly reply letter.

Glyn Jones

Deputy Chief Executive / Director of Finance and Procurement

Dirprwy Brif Weithredwr / Cyfarwyddwr Cyllid a Chaffael

Judith Paget

Chief Executive

Prif Weithredwr

Table A: Movement of Opening Financial Plan to Forecast Outturn

Aneurin Bevan ULHB **Period : May 19**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 11 should reflect the corresponding amounts included within the latest IMTP submission to WG
Lines 1 - 11 should not be adjusted after Month 1

		In Year Effect £'000	Non Recurring £'000	Recurring £'000	FYE of Recurring £'000
1	Underlying Position b/fwd from Previous Year - as per 3 year plan (Surplus - Positive Value / Deficit - Negative Value)	-11,405	0	-11,405	-11,405
2	New Cost Pressures - as per 3 year plan (Negative Value)	-47,207		-47,207	-49,677
3	**Opening Cost Pressures**	**-58,612**	**0**	**-58,612**	**-61,082**
4	Identified Savings Plan (Positive Value)	16,176	5,783	10,393	11,254
5	Savings / Mitigating Actions Yet To Be Identified (Positive Value)				
6	Welsh Government Funding (Positive Value)	41,760	3,061	38,699	41,760
7	Net Income Generated (Positive Value)	376	226	150	150
8	Planned Accountancy Gains (Positive Value)	300	300	0	0
9	Release of Uncommitted Contingencies & Reserves (Positive Value)				
10					
11	**Opening Financial Plan**	**0**	**9,370**	**-9,370**	**-7,918**
12	Cost Pressures b/fwd from Previous Year - unidentified within 3 year plan (Negative Value)				
13	Opening Plan Savings - Forecast (Underachievement) / Overachievement	-363	-363	0	1
14	Additional In Year Identified Savings - Forecast (Positive Value)	362	362	0	0
15	Additional In Year Identified Accountancy Gains (Positive Value)	0	0	0	0
16	Additional Net Income Generated (Positive Value)	0	0	0	0
17	Non Identification of Savings / Mitigating Actions Yet To Be Identified in Opening Plan	0	0	0	0
18	Release of Previously Committed Contingencies & Reserves (Positive Value)	0			
19	Additional In Year Welsh Government Funding (Positive Value)	0			
20		0			
21		0			
22		0			
23		0			
24		0			
25		0			
26		0			
27		0			
28		0			
29		0			
30		0			
31		0			
32		0			
33		0			
34		0			
35		0			
36		0			
37		0			
38	**Forecast Outturn (- Deficit / + Surplus)**	**0**	**9,369**	**-9,370**	**-7,917**

Table C: identified Savings Schemes

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

This Table is currently showing 0 errors

			1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			YTD variance as %age of YTD	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	CHC and Funded Nursing Care	Budget/Plan	215	179	224	273	276	303	379	382	375	398	401	403	394	3,807		3,381	426			
2		Actual/F'cast	106	179	224	273	276	303	389	392	395	420	423	427	285	3,807	7.47%	3,381	426	45	3,762	4,122
3		Variance	(110)	0	0	0	0	0	10	11	21	22	22	23	(110)	(0)	(27.79%)	(0)	0			
4	Commissioned Services	Budget/Plan	106	106	113	113	113	113	113	113	103	103	103	103	212	1,299		1,131	168			
5		Actual/F'cast	86	86	103	103	103	103	103	103	103	103	153	153	172	1,299	13.23%	1,131	168	0	1,299	1,499
6		Variance	(20)	(20)	(10)	(10)	(10)	(10)	(10)	(10)	0	0	50	50	(40)	(0)	(18.88%)	0	0			
7	Medicines Management (Primary & Secondary Care)	Budget/Plan	73	82	90	96	111	120	329	377	377	387	391	397	155	2,828		1,069	1,758			
8		Actual/F'cast	94	195	86	96	110	119	326	362	376	384	388	295	289	2,828	10.22%	1,069	1,758	25	2,803	2,980
9		Variance	21	113	(4)	0	(1)	(1)	(4)	(15)	(1)	(3)	(3)	(102)	134	0	86.04%	(0)	0			
10	Non Pay	Budget/Plan	48	28	109	107	127	128	182	182	182	182	182	233	76	1,692		250	1,442			
11		Actual/F'cast	48	390	109	107	127	128	182	182	182	182	182	233	438	2,054	21.31%	612	1,442	1,357	697	697
12		Variance	0	362	0	0	0	0	0	0	0	0	0	0	362	362	477.77%	362	0			
13	Pay	Budget/Plan	282	289	314	341	388	439	637	745	753	784	786	794	571	6,551		1,822	4,729			
14		Actual/F'cast	44	99	87	114	161	281	779	894	905	936	939	948	143	6,188	2.31%	1,822	4,366	4,356	1,832	1,957
15		Variance	(238)	(190)	(227)	(227)	(227)	(158)	142	150	152	152	153	155	(427)	(363)	(74.92%)	0	(363)			
16	Primary Care	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	724	683	850	930	1,015	1,102	1,640	1,798	1,789	1,853	1,863	1,929	1,407	16,176		7,654	8,523			
20		Actual/F'cast	377	949	609	693	777	933	1,778	1,933	1,961	2,025	2,085	2,055	1,326	16,176	8.20%	8,016	8,160	5,782	10,393	11,255
21		Variance	(347)	266	(241)	(237)	(238)	(169)	138	135	172	171	222	126	(81)	(1)	(5.78%)	362	(363)			
22		Variance in month	(47.91%)	38.86%	(28.39%)	(25.49%)	(23.41%)	(15.31%)	8.44%	7.53%	9.61%	9.25%	11.92%	6.53%	(5.78%)							
23		In month achievement against FY forecast	2.33%	5.87%	3.76%	4.28%	4.80%	5.77%	10.99%	11.95%	12.12%	12.52%	12.89%	12.71%								

Please note that this table excludes Accountancy gains (£0.376m) and Income Generation (£0.3m), which is the difference between this figure and the £16.8m quoted in the savings section of this report.

Table C1: Savings – Pay Analysis

Table C1- Savings Schemes Pay Analysis

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			*YTD variance as %age of YTD Budget/Plan*	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Changes in Staffing Establishment	Budget/Plan	123	131	153	158	163	163	238	238	241	241	241	241	254	2,332		1,032	1,300			
2		Actual/F'cast	44	99	84	89	94	94	295	302	308	308	308	308	143	2,333	6.13%	1,032	1,300	1,805	528	643
3		Variance	(80)	(31)	(69)	(69)	(69)	(69)	56	64	66	66	66	66	(111)	0	*(43.63%)*	0	0			
4	Variable Pay	Budget/Plan	92	92	94	117	127	178	300	408	409	438	439	446	183	3,139		191	2,948			
5		Actual/F'cast	0	0	2	25	35	155	319	427	428	457	458	468	0	2,776	0.00%	191	2,585	2,190	585	595
6		Variance	(92)	(92)	(92)	(92)	(92)	(22)	19	19	19	19	19	21	(183)	(363)	*(100.00%)*	0	(363)			
7	Locum	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Agency / Locum paid at a premium	Budget/Plan	67	67	67	67	98	98	98	98	103	105	106	106	133	1,080		599	481			
11		Actual/F'cast	0	0	0	0	32	32	165	165	169	171	173	173	0	1,080	0.00%	599	481	361	719	719
12		Variance	(67)	(67)	(67)	(67)	(67)	(67)	66	66	66	66	67	67	(133)	(0)	*(100.00%)*	(0)	0			
13	Changes in Bank Staff	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
14		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
15		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
16	Other (Please Specify)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
17		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
18		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
19	Total	Budget/Plan	282	289	314	341	388	439	637	745	753	784	786	794	571	6,551		1,822	4,729			
20		Actual/F'cast	44	99	87	114	161	281	779	894	905	936	939	948	143	6,188	2.31%	1,822	4,366	4,356	1,832	1,957
21		Variance	(238)	(190)	(227)	(227)	(227)	(158)	142	150	152	152	153	155	(427)	(363)	*(74.92%)*	0	(363)			

Table C2: Savings – Agency / Locum Paid Analysis

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

		Month	1	2	3	4	5	6	7	8	9	10	11	12	Total YTD	Full-year forecast	YTD as %age of FY	Assessment		Full In-Year forecast		Full-Year Effect of Recurring Savings
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar			YTD variance as %age of YTD Budget/Plan	Green	Amber	non recurring	recurring	
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000				£'000	£'000	£'000	£'000	£'000
1	Reduced usage of Agency/Locums paid at a premium	Budget/Plan	67	67	67	67	98	98	98	98	103	105	106	106	133	1,080		599	481			
2		Actual/F'cast	0	0	0	0	32	32	165	165	169	171	173	173	0	1,080	0.00%	599	481	361	719	719
3		Variance	(67)	(67)	(67)	(67)	(67)	(67)	66	66	66	66	67	67	(133)	(0)	(100.00%)	(0)	0			
4	Non Medical 'off contract' to 'on contract'	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
5		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
6		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
7	Medical - Impact of Agency pay rate caps	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
8		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
9		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
10	Other (Please Specify)	Budget/Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
11		Actual/F'cast	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0
12		Variance	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0			
13	Total	Budget/Plan	67	67	67	67	98	98	98	98	103	105	106	106	133	1,080		599	481			
14		Actual/F'cast	0	0	0	0	32	32	165	165	169	171	173	173	0	1,080	0.00%	599	481	361	719	719
15		Variance	(67)	(67)	(67)	(67)	(67)	(67)	66	66	66	66	67	67	(133)	(0)	(100.00%)	(0)	0			

Table C3: Savings – Tracker

Table C3 - Savings Tracker

Summary of Forecast Savings (£000's)	Cash-Releasing Saving (Pay)	Cash-Releasing Saving (Non Pay)	Cost Avoidance	Savings Total	Income Generation	Accountancy Gains
Planned Care	1,251	1,131	46	**2,428**	60	0
Unscheduled Care	2,231	63	35	**2,330**	0	0
Primary and Community Care (Excl Prescribing)	1,159	50	95	**1,304**	66	0
Mental Health	320	0	0	**320**	40	0
Clinical Support	537	0	0	**537**	0	0
Non Clinical Support (Facilities/Estates/Corporate)	689	384	250	**1,322**	210	0
Commissioning	0	1,299	0	**1,299**	0	0
Across Service Areas	0	0	0	**0**	0	0
CHC	225	3,156	426	**3,807**	0	300
Prescribing	0	1,481	0	**1,481**	0	0
Medicines Management (Secondary Care)	0	1,347	0	**1,347**	0	0
Total	**6,412**	**8,911**	**852**	**16,176**	**376**	**300**

Table F: Risks

	Table F - Overview Of Key Risks / Opportunities Affecting Forecast Outturn	FORECAST YEAR END			
		Worst Case	Likelihood	Best Case	Likelihood
		£'000		£'000	
	Current Reported Forecast Outturn	(0)		(0)	
	Risks (negative values)				
1	Non delivery of Saving Plans/CIPs	(1,000)	Medium		
2	Continuing Healthcare				
3	Prescribing				
4	Pharmacy Contract				
5	WHSSC Performance				
6	Other Contract Performance				
7	GMS Ring Fenced Allocation Underspend Potential Claw back				
8	Dental Ring Fenced Allocation Underspend Potential Claw back				
9	Performance targets	(6,000)	Medium		
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
	Opportunities (positive values)				
23					
24					
25					
26					
27					
28					
29					
30	Total Risks /Opportunities	(7,000)		0	
31	Total Amended Forecast	(7,000)		(0)	

Glossary

A		
A&C – Administration & Clerical	A&E – Accident & Emergency	A4C - Agenda For Change
AME – (WG) Annually Managed Expenditure	AQF – Annual Quality Framework	AWCP – All Wales Capital Programme
B		
B/F – Brought Forward	BH – Bank Holiday	
C		
C&V – Cardiff and Vale	CAMHS – Child & Adolescent Mental Health Services	CCG – Clinical Commissioning Group
C/F – Carried Forward	CHC – Continuing Health Care	Commissioned Services – Services purchased external to ABUHB both within and outside Wales
COTE – Care of the Elderly	CRL – Capital Resource Limit	
D		
DHR – Digital Health Record	DNA – Did Not Attend	DOSA – Day of Surgery Admission
E		
EASC – Emergency Ambulance Services Committee	EDCIMS – Emergency Department Clinical Information Management System	EoY – End of Year
ETTF – Enabling Through Technology Fund		
F		
F&T – Family & Therapies (Division)	FBC – Full Business Case	FNC – Funded Nursing Care
G		
GMS – General Medical Services	GP – General Practitioner	GWICES – Gwent Wide Integrated Community Equipment Service
GUH – Grange University Hospital		
H		
HCHS – Health Care & Hospital Services	HCSW – Health Care Support Worker	HIV – Human Immunodeficiency Virus

HSDU – Hospital Sterilisation and Disinfection Unit		
I		
IMTP – Integrated Medium Term Plan	IPTR – Individual Patient Treatment Referral	I&E – Income & Expenditure
L		
LoS – Length of Stay	LTA – Long Term Agreement	
M		
MH **–** Mental Health		
N		
NCN – Neighbourhood Care Network	NCSO – No Cheaper Stock Obtainable	NICE – National Institute for Clinical Excellence
NHH – Neville Hall Hospital	NWSSP – NHS Wales Shared Services Partnership	
O		
ODTC – Optometric Diagnostic and Treatment Centre		
P		
PCN – Primary Care Networks (Primary Care Division)	PICU – Psychiatric Intensive Care Unit	PrEP – Pre-exposure prophylaxis
PSPP – Public Sector Payment Policy		
R		
RGH – Royal Gwent Hospital	RN – Registered Nursing	RRL – Revenue Resource Limit
RTT – Referral to Treatment		
S		
SCCC – Specialist Critical Care Centre	SCH – Scheduled Care Division	SCP – Service Change Plan (reference IMTP)
SLF – Straight Line Forecast	SpR – Specialist Registrar	
T		
TCS – Transforming Cancer Services (Velindre programme)	T&O – Trauma & Orthopaedics	
U		

UHB / HB – University Health Board / Health Board	USC – Unscheduled Care (Division)	
V		
VCCC – Velindre Cancer Care Centre		
W		
WET AMD – Wet age-related macular degeneration	WG – Welsh Government	WHC – Welsh Health Circular
WHSSC – Welsh Health Specialised Services Committee	WLI – Waiting List Initiative	WLIMS – Welsh Laboratory Information Management System
WRP – Welsh Risk Pool		
Y		
YAB – Ysbyty Aneurin Bevan	YTD – Year to date	

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board	Aneurin Bevan University Health Board Finance Performance Committee Day, Date, June 2019 Agenda Item: XX

2.7

Aneurin Bevan University Health Board

Hospital & Out of Hospital Comparative Spend Analysis

Executive Summary

This report provides the Committee with an update of the ABUHB expenditure comparisons between Hospital spend, Out of Hospital spend and overhead spend for the 4 year period 2015/16 to 2018/19 financial years.

Key points to note:
2018/19 Health Board expenditure excluding capital charges was £1,221m of which 51.1% (51.5% 17/18) related to in hospital delivery, with 43.3% (43.6%) related to out of hospital services and 5.6% (4.9%) for overheads.

Over the 4 year period, Hospital Spend increased by £80m (12%), while Out of Hospital Spend increased by £45m (8%).

In terms of ABUHB spending percentage proportions, hospital spend increased by 0.9% over 4 years but there was 0.4% decrease in 2018/19. Out of Hospital expenditure proportionately decreased by 1.4% over 4 years with a 0.3% decrease in 2018/19.

It is worth noting that the level of out of hospital expenditure has significantly increased partly due to investments such as WG transformational funding, Integrated Care Fund (ICF) and specific mental health funding. However this is off-set by increasing acute hospital expenditure including the impact of wage award increases in 2018-19.

The Board is asked to: (please tick as appropriate)	
Approve the Report	
Discuss and Provide Views	x
Receive the Report for Assurance/Compliance	
Note the Report for Information Only	

Executive Sponsor: G. Jones, Director of Finance and Performance			
Report Author: R. Holcombe, Assistant Finance Director			
Report Received consideration and supported by :			
Executive Team		**Committee of the Board [Committee Name]**	
Date of the Report: June 2019			
Supplementary Papers Attached: **NB. A detailed presentation will be provided to the Committee to consider alongside this paper.**			

Purpose of the Report

Following the analysis provided in 2018/19, this report provides the Committee with an update of the ABUHB expenditure comparisons between Hospital spend, Out of Hospital spend and overhead spend for the 4 year period 2015/16 to 2018/19 financial years.

Background and Context

The National and ABUHB strategy is to prioritise service delivery outside of the hospital setting where appropriate. This aligns to the Clinical Futures Programme and Well-being of Future Generations Act. In June 2018, an initial review was undertaken to determine how Health Board expenditure aligned with this strategic direction. Given there is no definitive criteria nationally to determine this, a pragmatic approach was used. This allocated expenditure using cost centre analysis, local knowledge and where possible internal information.

The expenditure was separated into three categories namely, hospital service delivery, out of hospital service delivery and overheads. This report will focus on Hospital and out of Hospital spend as the most significant value areas.

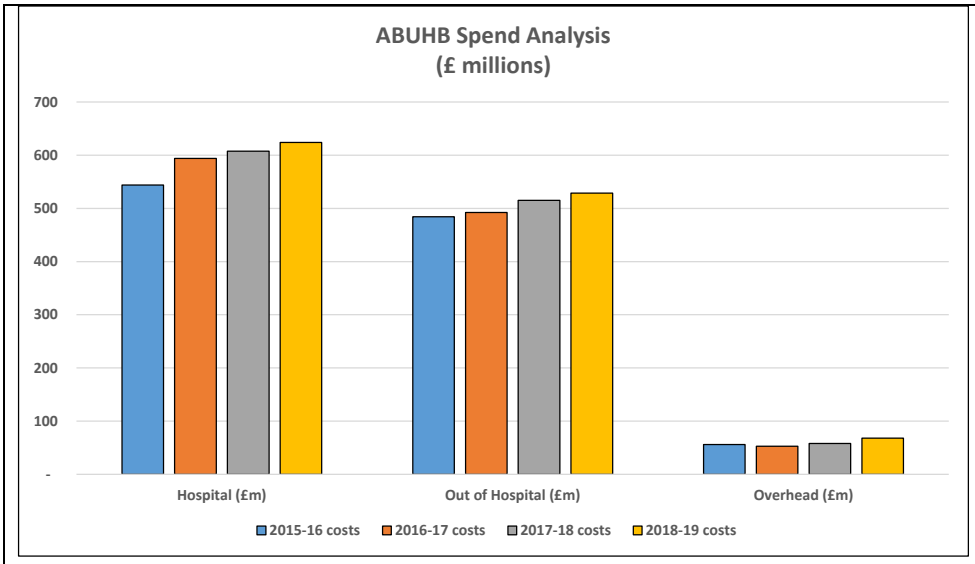
For this update, the 2018/19 figures have been produced and capital charges have been removed as they would skew the results and they are fully funded by Welsh Government. The radiology and pathology costs have been split on the basis of diagnostic requests from either hospital departments or Primary Care professionals.

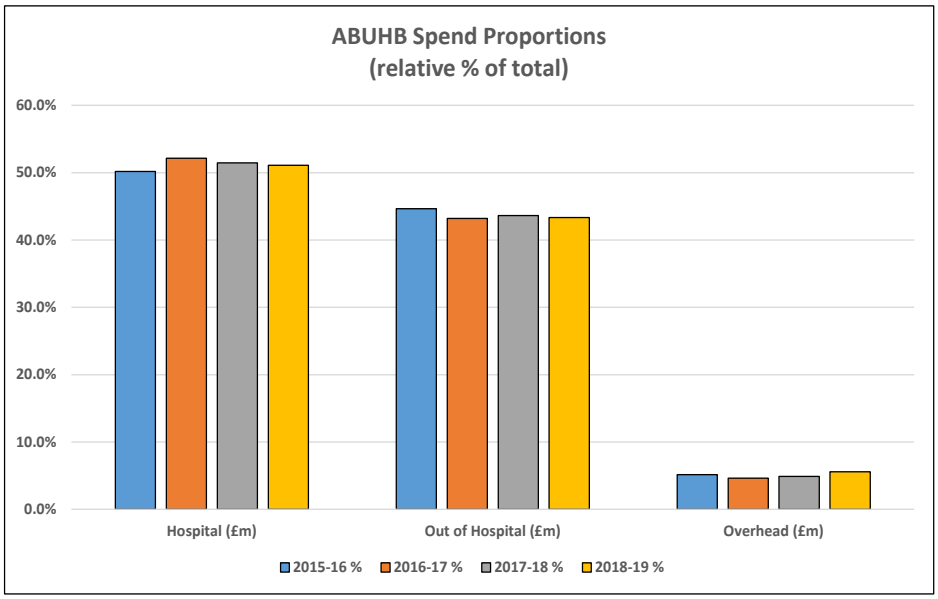
Assessment and Conclusion

The 2018/19 Health Board expenditure excluding capital charges was £1,221m of which:

- £624m/51.1% (51.5% 17/18) related to in hospital delivery,
- £529m/43.3% (43.6% 17/18) related to out of hospital services and
- £68m/5.6% (4.9% 17/18) for overheads.

This is summarised as below:-





The graphs indicate the following key messages:-

- Hospital Spend increased by £80m (12%) over 4 years.
- Out of Hospital Spend increased by £45m (8%) over 4 years
- In terms of ABUHB spending percentage proportions, hospital increased by 0.9% over 4 years but there was 0.4% decrease in 2018/19. Out of Hospital expenditure proportionately decreased by 1.4% over 4 years with a 0.3% decrease in 2018/19.

The level of out of hospital expenditure has significantly increased partly due to investments such as WG transformational funding, Integrated Care Fund (ICF) and specific mental health funding. This is off-set however by increasing acute hospital expenditure especially given wage award increases in 2018-19.

A breakdown of the 2018-19 expenditure is shown below:-

Aneurin Bevan Health Board (Hospital v Out of hospital care)	Hospital (£)	Out of hospital (£)	Overhead (£)	Total (£)
Operational Divisions:-				
Primary Care and Community	28,801,655	307,158,921		335,960,576
Community CHC & FNC		60,058,744		60,058,744
Mental Health	20,759,034	68,489,929		89,248,963
Director of Primary Community and Mental Health	32,307	715,037		747,345
Total Primary Care, Community and Mental Health	**49,592,996**	**436,422,632**	**-**	**486,015,628**
Scheduled Care	186,148,568	16,611,517		202,760,085
Unscheduled Care	107,837,610	2,049,152		109,886,762
Family & Therapies	58,875,737	43,104,077		101,979,814
Estates and Facilities	45,768,111	1,524,753	12,875,795	60,168,659
Director of Operations	1,596,273		- 1,849,588	- 253,315
Total Operational Divisions	**400,226,299**	**63,289,499**	**11,026,207**	**474,542,006**
Corporate / Exec budgets:-				
Corporate Departments	359,543	959,632	50,740,606	52,059,782
Medical Director / Litigation	1,185,327	1,185,327	6,169,913	8,540,566
Total Corporate Divisions	**1,544,870**	**2,144,959**	**56,910,519**	**60,600,348**
Specialist Services				
WHSSC & EASC	110,966,269	25,781,000		136,747,269
Total Specialist Services	**110,966,269**	**25,781,000**	**-**	**136,747,269**
External Contracts				
LTA's & ACCESS	61,597,016	1,282,069		62,879,085
Total External Contracts	**61,597,016**	**1,282,069**	**-**	**62,879,085**
Total Delegated Position	**623,927,450**	**528,920,158**	**67,936,727**	**1,220,784,335**
Percentage	**51.11%**	**43.33%**	**5.57%**	

Next steps:

The analysis and evaluation of this work is an on-going exercise. The finance team will progress this work as follows:-

- Re-run this exercise for 2019/20
- Refine the analysis for key areas such as therapies, estates and facilities, pathology and radiology.
- Review overhead costs
- Note the categorisation of IMTP investment proposals to capture costs for preventative, out of hospital and those costs which are transformational in nature, shifting resources where possible.
- On-going work with National costing colleagues and with the Finance Delivery Unit to consider the possibility of developing a national approach to facilitate benchmarking and allocative efficiency work.

NB. A detailed presentation will be provided to the Committee to consider alongside this paper.

Recommendation

The Committee is requested to note, consider and discuss the updated analysis.

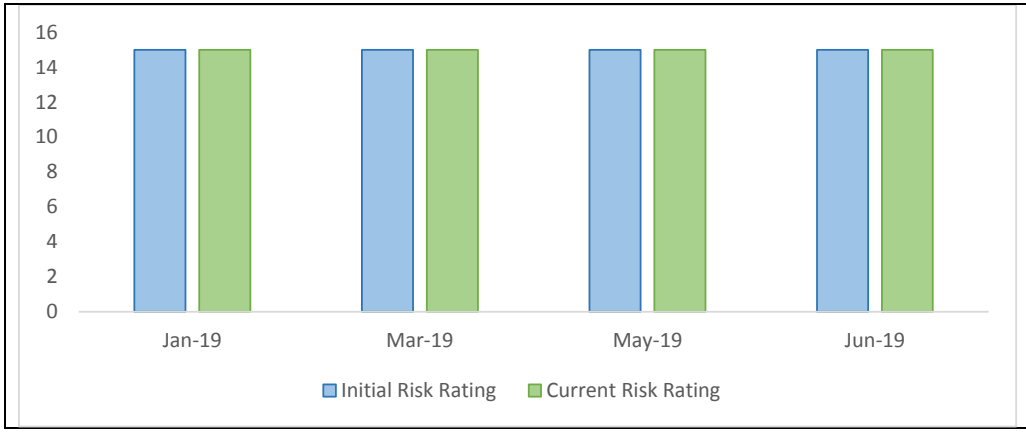
Supporting Assessment and Additional Information

Risk Assessment (including links to Risk Register)	There is a risk the ABUHB strategy to increase relative investment into out of hospital services is not being achieved.

Financial Assessment, including Value for Money	There is no direct financial assessment but a presentation of past investment profiles.
Quality, Safety and Patient Experience Assessment	This paper links to AQF target 9 – to operate within available resources and maintain financial balance.
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 analysis links with the ABUHB strategy to increase relative investment into out of hospital services.
The Well-being of Future Generations (Wales) Act 2015 – 5 ways of working	**Long Term –** **Integration** – **Involvement** – **Collaboration** – **Prevention –** 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. The spend analysis provides an overview of where actual spend has been made.
Glossary of New Terms	No new terms.
Public Interest	This report can be published.

Corporate Risk to a Page Report – June 2019

CRR001	**Director Lead:** Director of Planning, Digital and IT	**Date Opened:** July 2018
	Assuring Committee: Executive Team and Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Failure to implement and deliver the priorities in the IMTP	**Target Risk Review Date:** Monthly review undertaken
	Impact: The Health Board will not be meeting its objectives and priorities to respond to assessed population needs and Welsh Government Targets.	



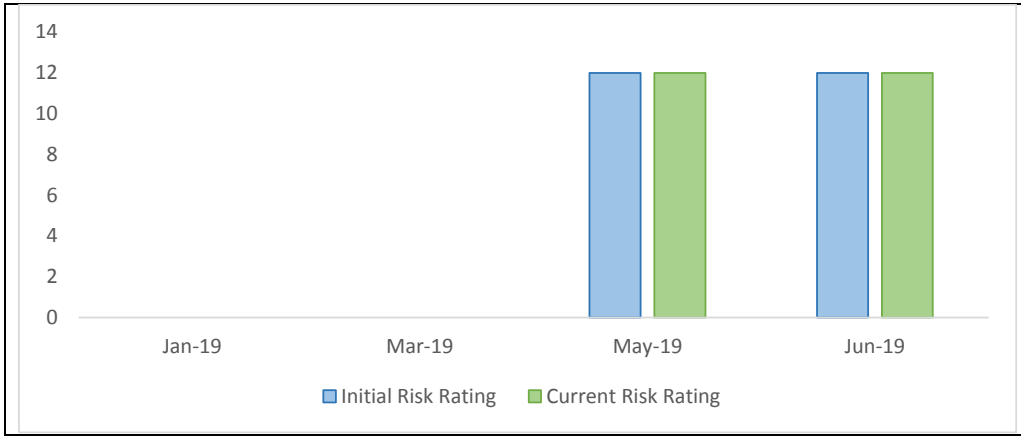
	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⇔		

Controls in place	**Further action to achieve target risk score**
• Monitoring of performance through divisional structures and Board oversight via Finance and Performance Committee continues and detailed plans have been developed. • Executive Team led Divisional Assurance Meetings in place. • Delivery Framework has been adopted by the Executive Board.	• Continued focus on achieving financial breakeven targets at year end. • Continued focus on the ability to achieve performance targets in accordance with Plan and Welsh Government targets/expectations. This is reviewed regularly at Executive Team to ensure that the Health Board meets its performance trajectories

Assurances	**Links to**
• Working the Delivery Unit and Reporting • Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Board meetings	**Strategic Priorities in the IMTP** Links to Priority – All IMTP priorities

Corporate Risk to a Page Report – June 2019

CRR057		
	Director Lead: Chief Executive and Director of Finance and Performance	**Date Opened:** November 2018
	Assuring Committee: Finance and Performance Committee and Board	**Date Last Reviewed:** June 2019
	Risk: Failure to achieve financial balance at end of 2019/20	**Target Risk Review Date:** Monthly review undertaken
	Impact: Funding confirmed by Welsh Government as part of IMTP approval	



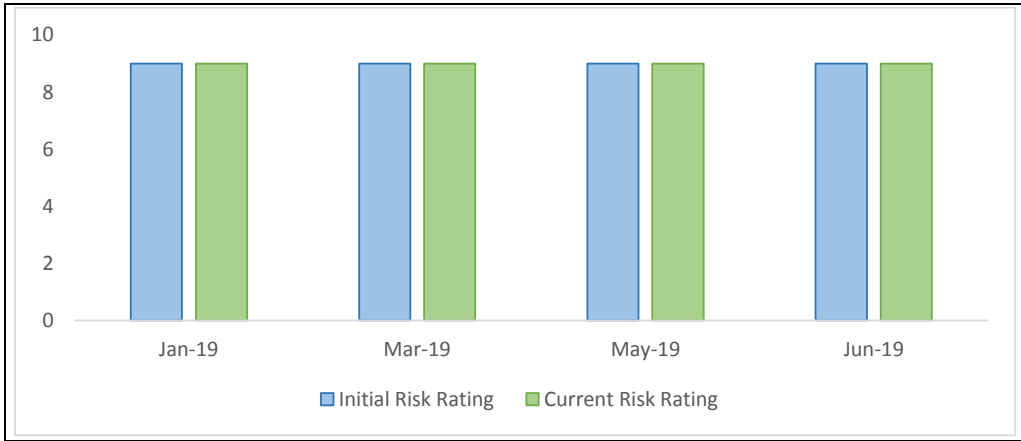
	Consequence	Likelihood	Score
Initial Risk Rating	4	3	12
Current Risk Rating	4	3	12
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⇔		

Controls in place	**Further action to achieve target risk score**
(i) Delivery of savings plans essential to deliver financial balance. Approx. £7m savings requirement with savings delivery plans yet to be identified. (ii) 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. (iii) Performance funding (£3.1m) received in 2018/19 conditional on meeting RTT targets.	• RTT Delivery Plan agreed by Executive Team. Welsh Government informed that 0>36weeks target will not be met at Q1 but expectation that it will be met by Q2. Ongoing discussions with WG regarding funding delivery assumptions • Increased focus on efficiency opportunities, through Executive Board.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Internal savings plans • IMTP Delivery Framework and Divisional Assurance Meetings • Performance and Finance Reports • Direct engagement through Business Partner model.	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report – June 2019

CRR046	**Director Lead:** Director of Planning, Digital and IT	**Date Opened:** December 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Risk of insufficient capacity and resources to deliver the planned Clinical Futures Programme.	**Target Risk Review Date:** Monthly review undertaken
	Impact: The delivery timetable could be compromised and the quality of the design work and engagement could be affected.	



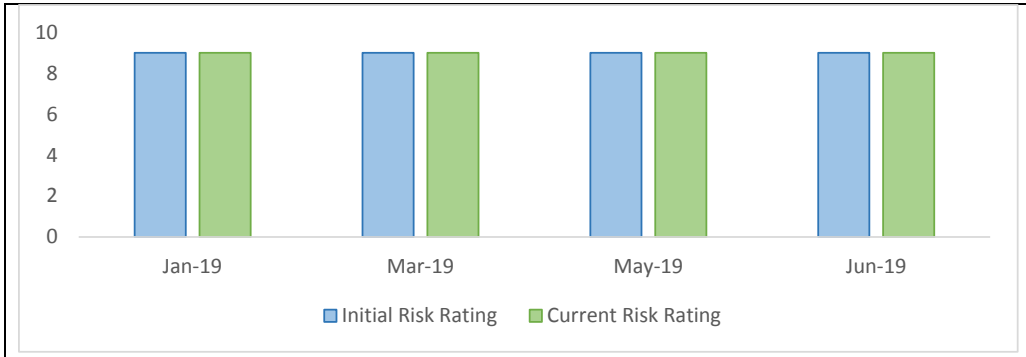
	Consequence	Likelihood	Score
Initial Risk Rating	3	3	9
Current Risk Rating	3	2	6
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⇔		

Controls in place	**Further action to achieve target risk score**
• 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. There is a constant monitoring of resource requirements across the 6 work streams	A Delivery Board review of Terms of Reference to prescribe in more detail the expectations of roles of the board. This is as part of the action plans from a recent internal audit.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Board meetings	**Strategic Priorities in the IMTP** Links to Priorities – 3, 4, 9 and 10.

Corporate Risk to a Page Report – June 2019

CRR055	**Director Lead:** Director of Finance & Performance	**Date Opened:** January 2019
	Assuring Committee: Board, Finance & Performance Committee and Quality & Patient Safety Committee	**Date Last Reviewed:** June 2019
	Risk: Resources may not be used in the most effective way to optimise achievement of the Health Board's priorities.	**Target Risk Review Date:** Monthly review undertaken
	Impact: The Health Board would not achieve its identified priorities in the most effective way.	



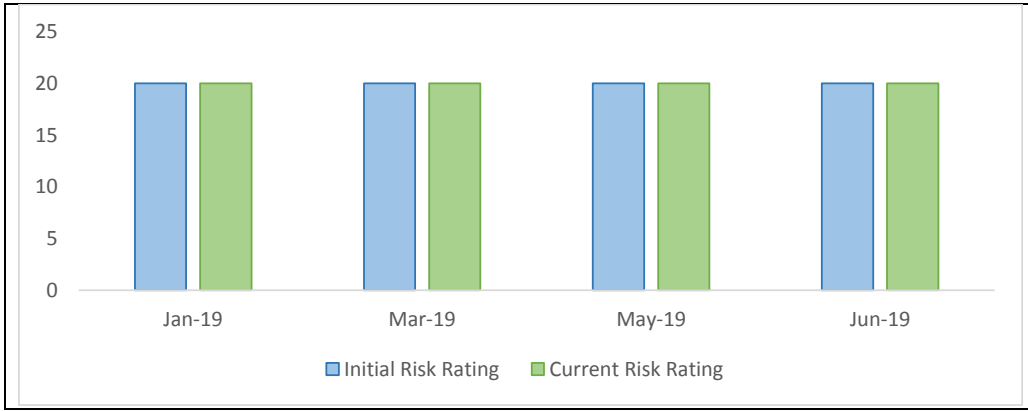
	Consequence	Likelihood	Score
Initial Risk Rating	3	3	9
Current Risk Rating	3	3	9
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⇔		

Controls in place	**Further action to achieve target risk score**
• 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. • Budgets are delegated through the organisation based on the priorities set out in the IMTP. • 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.	• Continuing focus on IMTP delivery risks • Maximising the opportunities presented by value based healthcare approach.

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Internal savings plans • IMTP Delivery Framework and Divisional Assurance Meetings • Performance and Finance Reports • Direct engagement through Business Partner model. • Value based healthcare reports	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of June 2019

CRR012	**Director Lead:** Director of Operations	**Date Opened:** December 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Failure to meet the needs of the local people in relation to emergency care provision including WAST provision.	**Target Risk Review Date:** Weekly review undertaken
	Impact: Not meeting Welsh Government targets and patients will not receive services they require in a timely way.	



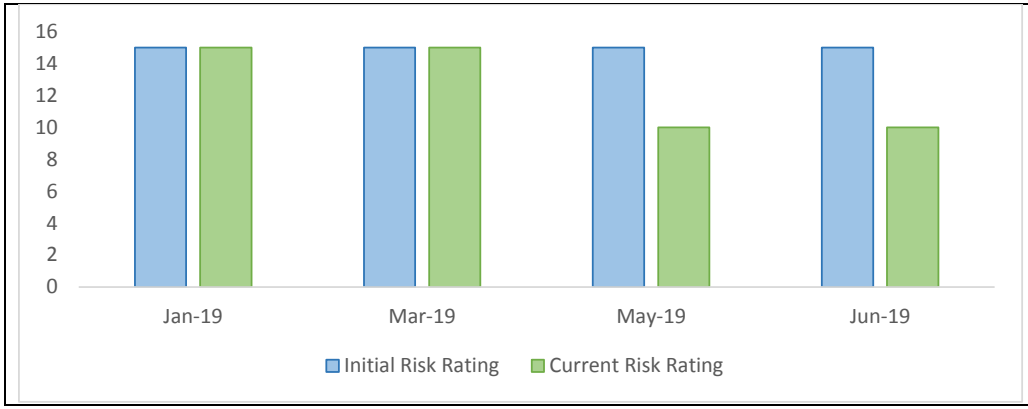
	Consequence	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⟷		

Controls in place	**Further action to achieve target risk score**
• 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. • Executive Led Improvement Programme in place monitoring improvements on a weekly basis, and tracking any progress/risks.	• Evaluation Report of the Winter Plan to be presented to the May 2019 Board regarding impact of actions. Further learning to be discussed.

Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** Links to Priority number 6.

Corporate Risk to a Page Report - as at end of June 2019

CRR018	**Director Lead:** Director of Operations	**Date Opened:** March 2017
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Failure to efficiently manage out-patient demand and modernise outpatient services	**Target Risk Review Date:** Monthly review undertaken
	Impact: Patients undertake unnecessary journeys to hospital, inappropriate use of capacity and delays which could result in patient harm due to delayed follow-up.	



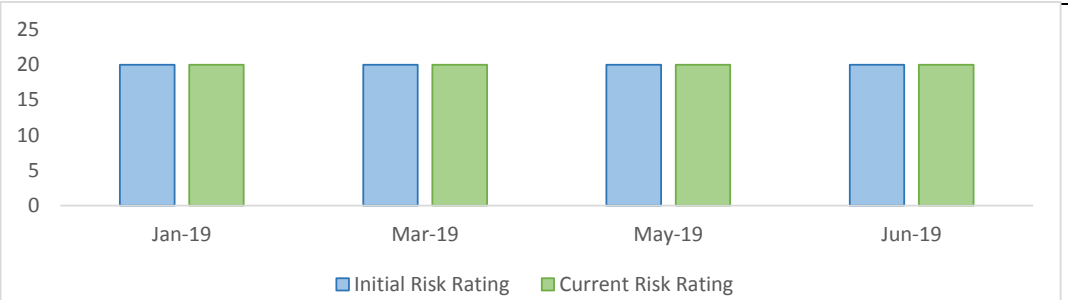
	Consequence	Likelihood	Score
Initial Risk Rating	5	3	15
Current Risk Rating	5	2	10
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⇔		

Controls in place	**Further action to achieve target risk score**
• 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 15,433 at the end of March 2019. • Development of an Outpatient Improvement Board focus on reducing unnecessary follow-up out-patient attendance, and modernise the Outpatient Pathway.	• Implementation of the Out-patient improvement plans developed by the Out-patient Improvement Board.

Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** Links to priority 7.

Corporate Risk to a Page Report - as at end of June 2019

CRR029	**Director Lead:** Director of Workforce & OD, Acting Director of Nursing, Medical Director, Director of Therapies and Health Science	**Date Opened:** March 2017
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Failure to recruit and retain appropriately skilled staff and senior leadership to deliver high quality care.	**Target Risk Review Date:** Weekly review undertaken
	Impact: Negative impact on patient care and service delivery due to lack of skilled workforce, low staff morale, increased sickness and turnover.	



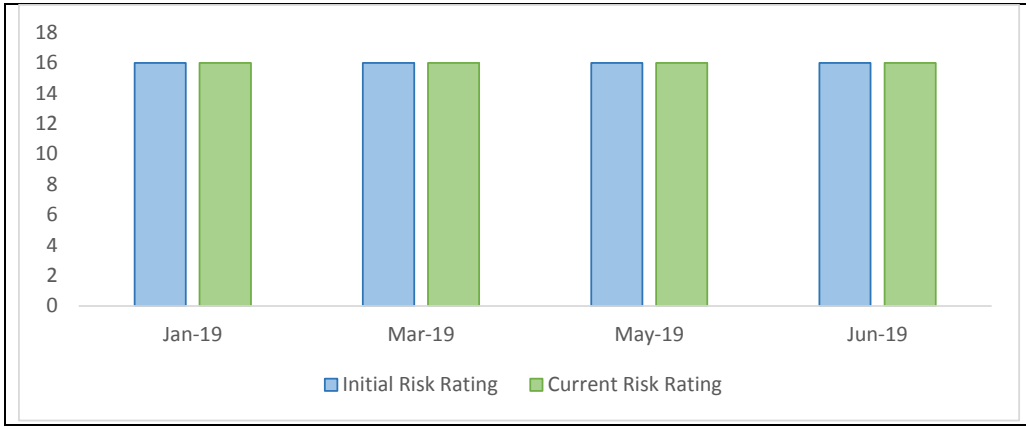
	Consequence	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite Level Low	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⟷		

Controls in place	**Further action to achieve target risk score**
• Plans in place to maximise recruitment and increase retention in all identified areas including registered nurses and medical staff. • Launch of new recruitment materials and webpages to support recruitment campaigns and improve online presence. • Continue to work closely with the national campaigns, including "Train, Work, Live". • Continued focus in the area of nursing on hard to fill areas - NHH and RGH wards with revised Recruitment Strategy. • Individual Ward risk reviews undertaken of actions and plans by Executive Team. • Medical hard to fill areas – Mental Health, Medicine and Emergency Medicine, Paediatrics, Obs & Gynae. A number of actions are in place to minimise risk, i.e. 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. • Reconsider skill mix to support staffing on acute wards, actions include opportunities for multi-disciplinary teams (flexible use of therapy staff and new roles such as Physician Associates) enhanced health care support worker roles in ward areas and multidisciplinary team working in Primary Care settings. • Flexible reward arrangements in place.	• Continued focus on the workforce plans in support of the Clinical Futures Programme • Continued implementation of the Nurse Staffing Act • Implementation of the agreed Recruitment Strategy • Development of an overseas nursing campaign

Assurances	**Links to**
• HIW Reports • Working the Delivery Unit and Reporting • Community Health Council Reports • Internal Audit and Wales Audit Office Report • Reports from the Learning Committee and Lessons Learnt Reports • Divisional Reports including assessments of Health and Care Standards	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of June 2019

CRR005	**Director Lead:** Director of Planning, Digital and IT	**Date Opened:** May 2018
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Insufficient levels of capital funding for estate requirements	**Target Risk Review Date:** Monthly review undertaken
	Impact: Health Board will be unable to meet the levels of refurbishment required for Health Board to meet its plans	



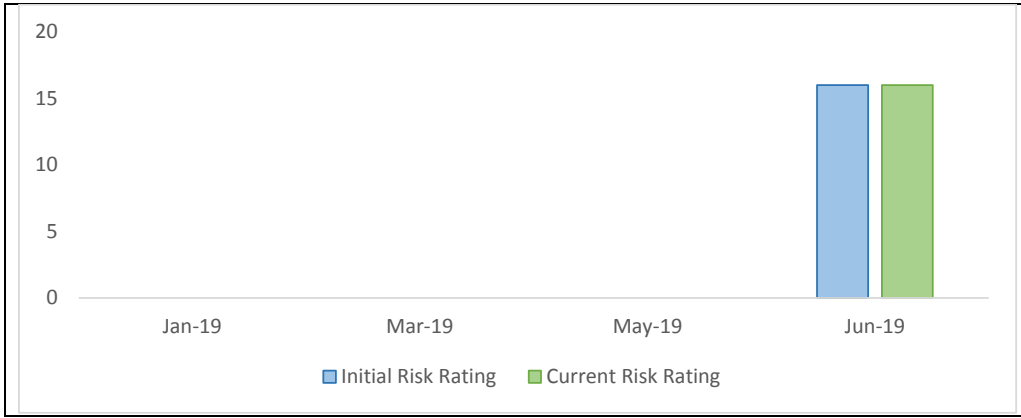
	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	Risk remained unchanged ⇔		

Controls in place	**Further action to achieve target risk score**
• Detailed capital programme that is regularly re-prioritised by the Executive Team and agreed by the Board. • Opportunities maximised with regular dialogue with Welsh Government. • Issue escalated to Directors of Planning and Chief Executives. • Comprehensive Estates Strategy agreed and being implemented.	• Implementation of the agreed Estates Strategy in line with Clinical Futures. • Implementation of the agreed Capital Programme. • Further more detailed development of LGH plans post GUH opening • Engagement with WG re future capital requirements linked to the Estate Strategy

Assurances	**Links to**
• Internal Audit and Wales Audit Office Report • Divisional Reports including assessments of delivery • Reports from Divisional Assurance Meetings • Delivery Framework updates • Executive Board meetings • The Grange University Hospital Project Board and Clinical Futures Delivery Board	**Strategic Priorities in the IMTP** This is an enabling risk in support of the delivery of all priorities of the IMTP.

Corporate Risk to a Page Report - as at end of June 2019

New Risk	**Director Lead:** Director Of Operations	**Date Opened:** June 2019
	Assuring Committee: Finance and Performance Committee	**Date Last Reviewed:** June 2019
	Risk: Failure to effectively deliver waiting list/access targets due to demand or capacity issues	**Target Risk Review Date:** July 2019
	Impact: Potential delays in treatment which could result in harm to the patient	



	Consequence	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite Level Low Business Driver – Level Low)	This section will be completed in future reports following the Health Board's review and approval of a new risk appetite statement.		
Movement since last presented to Board in May 2019	New Risk		

Controls in place	**Further action to achieve target risk score**
• Weekly monitoring and reporting of all elective waiting lists, diagnostics and therapy waiting times led by Director of Operations/Associate Director of Ops against agreed Demand and Capacity Plans • Monitoring of plan, variance and recovery actions at monthly Divisional Assurance meetings • Escalation of any variance and requirement for revision of plans/recovery • Local and National Planned Care programme compliance • Variance reporting to Executive Team and Finance and Performance Committee • Divisional governance processes to risk manage those patients who are more urgent/vulnerable	• Bid to WG for additional RTT funding to support extra activity will reduce future risk score • Continual review of additional opportunity to maximise capacity, efficiency, modernisation, demand management • Development of DrDoctor capacity to better communicate with patients on waiting lists

Sources of Assurances	**Links to**
• Divisional and corporate reports • HIW reports • Working closely with the WG Delivery Unit • Internal Audit and WAO reports • Community Health Council reports	**Strategic Priorities in the IMTP** Linked to SCP 6