Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AS/MS
Y Dirprwy Weinidog Gwasanaethau Cymdeithasol
Deputy Minister for Social Services

Lynne Neagle AS/MS
Y Dirprwy Weinidog Iechyd Meddwl a Llesiant
Deputy Minister for Mental Health & Wellbeing

Llywodraeth Cymru
Welsh Government

Russell George MS
Chair
Health & Social Care Committee

SeneddHealth@senedd.wales

17 January 2024

Dear Russell

Please see attached our response to the specific issues raised by Members in your correspondence of 22 November, following the Joint general Ministerial scrutiny session of 8 November.

Yours sincerely

Eluned Morgan AS/MS
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Written response by the Welsh Government to the Health and Social Care Committee.

Financial pressures

1. **Can you provide the total revenue and capital allocations for each health board, which reflect your written statement on 8 November as well as other in-year allocations the Welsh Government may have made since it published the funding for 2023-24 (as set out in the letter to Health Board Chairs in December 2022) in February 2023?**

   The allocations as set out each year in the main Local Health Boards (LHB) allocation letter are routinely updated for a number of areas on an in-year basis of both centrally held budgets and specific issues that may emerge in-year, such as funding of pay awards. These items are typically listed separately in the letter which accompanies the LHB allocations at the start of a financial year and allocations are issued as the year progresses.

   This year in view of the exceptional financial situation and the impact of inflation and the legacy of Covid on NHS budgets, as a result of the in-year Welsh Government budget exercise we took the approach of issuing a general additional allocation to LHB's as detailed in our written statement on 8 November following the outcome of that in-year exercise.

   Annex 1 provides the updated revenue and capital allocations for each health board as at 31 December 2023.

2. **In your announcement, you noted that each health board will be required to reduce its planned deficit by 10%. What discussions have you had with health boards about this, and how achievable is it? Why did you decide to adopt the same target for all local health boards?**

   The target to reduce planned deficits by 10% was reached following the work undertaken across the Welsh Government this year to reprioritise budgets across portfolios and within the Health and Social Services MEG.

   We have been clear that whilst we would do all we could to support the Boards in 2023/24, that the planned deficit positions were not supportable in full and additional actions would be required to reduce expenditure and forecast deficit positions.

   The percentage represents the residual gap between the additional support we were able to provide and original plans submitted by the Local Health Boards. Given the size of planned deficits across each Health Board, we considered that requiring each organisation to reduce their planned deficit by 10% was the most suitable and equitable way to bridge the gap, and that decisions required on actions to reduce that deficit were best identified and implemented by Local Health Boards. We are working with all organisations to support them to meet their target control totals. There is variation in the delivery of Health Board plans and positions, on an in-year basis, resulting in the challenge to achieving the target control total being more challenging for some Health Boards in terms of additional actions required than others.

3. **Your written statement included a breakdown of the additional £460.2m by constituent element and LHB. It said the £460.2m will be issued to LHBs "proportionately according to the established Local Health Board resource allocation formula". Some of the allocations are recurrent (funding for the underlying deficit contribution/COVID legacy, £150m and £186m for inflation) and others on a non-recurrent basis. On what evidence have you determined the amounts to be allocated to health boards on a recurrent and non-recurrent basis and why have you decided to distribute the funding "according to the established Local Health Board resource allocation formula"?**

   The amounts allocated either recurrently or non-recurrently was based on our assessment of both the funding available at the time of confirmation of those allocations and an assessment of the costs the NHS organisations faced.

   The general approach to allocating funding to Health Boards in NHS Wales is via the resource allocation formula, which is the funding model to support Health Boards in planning and delivering services for the population they serve. This formula considers a number of factors including population which is the primary component of the formula, but also other factors such the differing costs of age and sex, other additional needs such as morbidity, and unavoidable excess costs such as rurality. This formula allows us to allocate funding on an equitable basis to health boards which reflects the needs of their resident populations. As the bulk of these uplifts reflected cost inflation which would be experienced equally across Health Boards in Wales, the most equitable approach was to allocate on the same shares basis as the original allocations made at the start of the financial year.

4. **In your written statement, you note £336m of the additional allocations will be recurrent and "conditional on each Local Health Board making progress towards the level of deficit which we have set for them to work towards ('target control totals')". What does this mean in practice and what will happen if the health boards do not reduce their planned deficits by the 10% target?**

   We are continuing to work with Health Boards to monitor their financial positions, identify actions for improvement, and support their approach to cost reductions and meeting their target deficits, i.e. target control totals.

   The conditionally recurrent allocations act as an incentive to LHBs to meet the deficit reduction requirement I have laid out. Organisations who achieve those target control totals will receive that funding on a recurrent basis. Although not all Boards will achieve those target controls in 2023/24 it is important to have an incentive to continue progress towards financial stability in both this year and future years.

   The 2024/25 allocations continue this approach, the only way to guarantee recurrent funding is to achieve the targets but non recurrent funding will be provided for organisations who continue to engage and make progress with delivering financial sustainability.

5. **In January 2023, your official told the Committee that the Welsh Government would not "bail out organisations that are not managing their core financial position" and it is "not effectively writing off or just giving them money to cover those deficits". How does this fit with the recurrent allocation of £150m to local health boards for the "underlying deficit contribution/COVID legacy". Do you expect the additional funding will put local health boards on a sustainable financial position going forward?**

   In the prior financial year, we agreed to separately fund the costs of Covid and other exceptional costs which had not been taken into account in initial planning for that year, such as the impact of the very high energy prices experienced across the economy. As such our approach was to fund additional costs outside of "core" positions. In 2022/23, six out of the seven Health Boards posted deficit positions against core allocations.

   For the current year we have reshaped our funding approach in light of the pressures experienced by Health Boards. In supporting the NHS to meet the costs of inflationary pressures, Covid legacy impacts and energy costs it was important to recognise that an element of their deficits still included costs which were funded in previous financial years on a non-recurrent basis. This is not a bail out of core positions but a recognition of the on-going increase to the cost base. This includes pressures such as inflation which are cost drivers to all parts of the NHS in the UK, it is not a unique challenge to NHS Wales. For that reason, we are making that support conditionally recurrent.

   Our draft budget demonstrates our commitment to prioritise key front-line services and protect the NHS as much as we are able. Our budget commits to continue the funding provided in year into next financial year and provide a further increase in health funding. Whilst this represents a significant investment, we should be clear that there will still be difficult choices required to achieve a sustainable financial position.

6. **Your official told the Committee that the Welsh Government was holding funding in the Main Expenditure Group to cover the target £123m deficit for local health boards. Why did you decide on that approach rather than allocate additional funding to the local health boards?**

   The target control totals provide a framework for financial control of health boards. They reflect the maximum permitted deficits following the increase in allocations provided in year, following the consistent application of additional funding and planned deficit reductions to Health Boards as set out above.

   As laid out in our written statement the target controls equate to the difference between planned expenditure and the funding provided reflecting costs we are able to recognise this year. The target deficits framework allows a balance between recognition of cost pressures on an equitable basis and holding cover for potential deficit positions, whilst avoiding bail outs for individual Boards who are failing to control their costs in line with national expectations.

Public health

7. **Why has the Deputy Minister been facing challenges in effectively addressing the issue of obesity? Has the Deputy Minister placed adequate emphasis on addressing the commercial determinants contributing to obesity, such as the availability of unhealthy foods?**

Obesity is a complex challenge. Our ten-year strategy *'Healthy Weight, Healthy Wales'* recognises that there is no simple solution. Everyone needs to play a role.

Governments around the world are facing huge challenges from rising levels of obesity, and the solutions are not easy or quick. There are a complex series of inter-related arenas that need action for us to make lasting change. This includes early years and education settings, our food environment, physical activity and active travel and services to support and treat those living with obesity to name just a few.

Healthy food environments play a crucial role in contributing to a reduction in levels of obesity. That is why, following the consultation on Healthy Food Environments last year, I set out my intention to bring forward subordinate legislation in 2024 to restrict the placement and price promotion of products high in fat, sugar, and salt.

Healthcare access

8. **To what degree is the Welsh Government evaluating the effectiveness of international models of health and care, and what can Wales learn from different countries' approaches to health and care service delivery, and public health and prevention?**

As a Government we are committed to developing our approaches in line with international evidence of what works. Wales is part of the Wellbeing Economy Government Network alongside Scotland, New Zealand, Finland and Iceland which brings together governments, advancing the aim of a wellbeing economy. A Wellbeing Economy puts our human and planetary needs at the centre of its activities, ensuring that these needs are all equally met, by default.

Wales is also helping to build, promote and progress wellbeing economies (within and beyond Wales) from a health perspective by working closely with the WHO Regional Office for Europe. This collaboration is enabled by a Memorandum of Understanding (MoU) between the Welsh Government and the WHO Regional Office for Europe focusing on enabling sustainable investment and solutions for accelerating progress towards healthy prosperous lives for everyone in Wales and in the WHO European Region.

A recent International Horizon Scanning and Learning Report published by Public Health Wales on 28 September 2023 introduces health equity and the five essential conditions and is the first of a series of reports delving into each of the five essential conditions in more detail.

OECD PaRIS survey

Wales is one of 20 countries, and the only UK nation, taking part in the OECD's Patient-Reported Indicator Survey (PaRIS) on people living with chronic conditions. This survey will be the first international outcomes-based benchmarking of adults with a chronic condition managed by GP practices. The survey is being carried out by the Welsh Value in Health Centre on behalf of Welsh Government and NHS Wales. The survey asks questions of both patients and providers and is expected to report in the autumn of 2024. It is anticipated that the survey will support a better understanding of the health and care needs of the Welsh population and provide valuable insights on health literacy to inform future public health campaigns.

Social care workforce

9. **Could the Deputy Minister tell us more about any specific action to retain existing staff in the sector, both in the next 12 months and longer term (given the recent Social Care Wales workforce survey findings that over a quarter of all registered care staff expect to leave the sector within the next 12 months, and 44% in the next five years)?**

As a Government we are absolutely committed to addressing the recruitment and retention issues in the sector, however we know that programmes of work being developed to create the sustainable workforce we need, are not quick fixes, and come with the realism that it will take time to feel the impact within the workforce. I have previously mentioned a range of work that will in time, improve conditions for the workforce such as:

- The social worker bursary we have prioritised to continue funding in 2024-25. Our increased funding made a difference to the increase in uptake during this academic year, meaning more students training to become social workers.

- The WLGA are leading work focusing on national approaches to terms and conditions for social workers. This aims to support and attract individuals to the profession and reduce movement of qualified staff due to varying terms and conditions.

- Through the Social Care Fair Work Forum trade unions, employers and Welsh Government continue to work in social partnership on what steps can be taken to improve terms and conditions for social care workers, with improved opportunities for career progression. This includes the development of a draft Pay and Progression Framework for the social care sector that aims to provide more consistent pay, progression and development opportunities by setting out broad bands of roles within social care, aligned with skills, learning and pay levels.

- Through Canopi, Welsh Government also provides social care staff confidential and free access to various levels of mental health support.

We are committed to continue working with the sector and stakeholders to support both recruitment and retention in social care. The demand for social care will continue to grow, so it's essential we all have effective workforce planning systems in place to

meet this demand. With partnership working and the dedicated and skilled workforce already in place, I am committed to overcoming our current challenges.

10. In relation to care staff vacancies, the Deputy Minister said that Welsh Government has made a lot of progress in this area and now has "much more solid data". She agreed to write to the Committee with more detail on this point [RoP, paras 165-170].

Work on improving the data in relation to social care vacancies is on-going, and we continue to work with partners to strengthen and enhance the information we have access to.

Local authorities are also providing monthly data to Welsh Government around workforce status and the pressures resulting from any vacancies and absence. This data is shared with stakeholders to support sector planning and delivery.

The *WeCare Wales* platform is continuing to develop with the intention of providing more detailed and accurate vacancy and recruitment data. During 2024 the aim is for more data to be made available relating to the number and types of vacancies in social care. This will also help to make links to the outcome of vacancies and how many vacancies are filled.

Social Care Wales continues to lead on the collection of workforce data. On an annual basis, an in-depth report is provided on the status of the workforce, which includes vacancy data.

11. The Social Care Wales workforce survey found that half of care workers receive no sickness pay when ill. Can the Deputy Minister give an indication of when social care workers can expect to see tangible improvements in this specific area?

Officials continue to work in social partnership with the Social Care Fair Work Forum to explore recommendations made by the Forum to us earlier in the year on short-, medium- and long-term action on sickness pay.

Work has focussed on enhancing wrap-around services in areas, such as wellbeing is a fundamental principle which underpins the health and social care workforce strategy and menopause support, which is currently being progressed.

Last year Canopi, which is funded by Welsh Government and run by Cardiff University, extended its confidential and personalised service of support and advice to social care staff, including frontline social care workers, personal assistants, and administrative and managerial staff. This service offers social care staff free access to self-help and guided self-help resources, support from colleagues and virtual therapy sessions.

Turning to the next financial year the pressures we have sought to address this year will be even more difficult next year, however as a Government we will continue to make financial decisions guided by our principles and values, protecting the people of Wales and Welsh public services as much as possible from the current pressures we face.

12. In relation to the social worker bursary, the Deputy Minister agreed to provide figures for the increase in uptake of the social work degree [RoP, paras 195-199].

As at December 2023 I can confirm that figures show 174 new students taking up the social worker bursary in 2023/24, in comparison to 154 in the previous year. This does come with a caveat that throughout the academic year this can change with students deciding either not to pursue courses or beginning courses later in the academic year. Until the end of this academic year these figures have and could continue to vary slightly.

<u>Unpaid carers and hospital discharge</u>

13. Last winter, the Welsh Government announced extra 'step down' capacity, with additional community beds to help with hospital discharge pressures. What was the learning from this, and how has it influenced preparations to ease pressures this winter?

In winter 2022/23 we brought partners together through a Care Action Committee in order to focus on developing extra community 'step down' beds to support system flow. In total an additional 678 step down beds/or community equivalent were established.

Learning from the exercise illustrated the benefits and impacts of health and social care partners working together in a targeted way to support wider system performance. This targeted approach also helped to focus efforts on areas of greatest impact.

Using a similar method, in 2023 we have placed a targeted focus on monitoring and reducing delayed pathways of care due to assessment delays. They have also challenged health and social care delivery partners to increase the capacity of trusted assessors to support more timely assessment and discharge. Between February and November 2023 the numbers of trusted assessor functions were increased by 105% (from 144 – 296) and the assessment delays reduced by 24% (from 1010 – 769)

Building on this approach, moving into winter 2023/24 we have re-established the Care Action Committee and set three key priority areas for action, providing an additional £8.24m to support this work. The three main priorities are;

- Reduced pathways of care delays due to assessment delays.
- Increased community nursing hours at weekends.
- Increase in number of people supported through enhance community care (virtual wards).

The Care Action Committee is meeting monthly to monitor progress and the impacts of this targeted work.

Waiting times – diagnostic testing and therapy interventions

14. The recovery target is to increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024. What are the reasons behind the challenges and extended waiting times in audiology and endoscopy (identified by Cardiff and Vale UHB)?

Increase in audiology waits: Due to pathway redesign in ENT services, a number of pathways have been redirected to audiology as appropriate for their clinical need. This has resulted in waits for first hearing aids increasing. The health board have indicated they have targeted investment plans for Q4 (January to March 2024) to address this backlog in audiology. They are aiming to get waits back below 14 weeks, while also working on more sustainable plans for future delivery.

Increase in endoscopy waits: While additional capacity has been secured and delivered it has been targeted at supporting effective and timely cancer pathways, aiming to achieve the internal management target of 14 days. They have indicate this will be achieved by January 2024. The health board is then prioritising surveillance patient pathways with an aim to clear the backlog by February 2024. Additional capacity comes online in 2024 through recent Welsh Government investment this will start to reduce the routine over 8-week backlog which my officials will closely monitor.

15. How are you currently addressing the need for timely access to diagnostics to alleviate patient anxiety and what immediate steps are being taken to support faster and more accurate diagnostic tests?

Timely diagnostic tests are a critical step in effective planned care pathways. This is one of the commitments of the planned care recovery plan. A national diagnostic board and strategy has been established to provide clinical leadership and national guidance to improve diagnostic planning and delivery. This is supported by dedicated resources in the NHS executive to ensure the NHS implement the national guidance locally and regionally.

Pathway redesign both at the referral stage with primary care and in hospital pathways are identifying the most effective time for tests as early as possible in the pathway.

Through the national pathway alliance work, referral pathways are being developed to identify where it is most appropriate that they go straight to an agreed diagnostic test, the aim being to speed-up the process of identifying what treatment may be required. This is being led by the national clinical implementation networks of the planned care programme working with primary care and the diagnostic network.

Significant investment has been provided to improve the availability of diagnostic equipment, supported on some hospital sites by additional mobile units.

Agreed diagnostic tests are an integral part of the nationally agreed cancer pathways. Cancer diagnostic pathways are prioritised to support an early diagnosis and treatment. The significant increase in referrals seen in 2023 has put additional pressure on diagnostics in particular endoscopy.

As you indicate early diagnostics with appropriate tests can significantly help to elevate worry. The high percentage (over 90%) of suspected cancer pathways that turn out not to be cancer, demonstrates how timely diagnostics can help to elevate worry.

October 2023 data demonstrates this fact:

- **16,535** pathways were **opened during the month** following a new suspicion of cancer. This was 583 higher than the previous month and 986 higher than the same month last year.
- **14,889** pathways were **closed** following the patient being informed that they do not have cancer. This was 899 higher than the previous month and 298 higher than the same month last year.

I previously indicated to further support future diagnostic capacity national work is being undertaken by HEIW to identify future training and recruitment needs for the diagnostic workforce of the future. Each of the three regions have plans to develop regional diagnostic services based on the national guidance and future pathways, this will require additional staff.

16. **What is your long-term strategy for investment in research and development for diagnostic technologies. Is the healthcare infrastructure fit for purpose to support the implementation of new innovations, including diagnostic labs and equipment?**

The Diagnostics Strategy for Wales, published in April 2023, identified the need to focus on research and innovation. This includes having trusted partnerships with industry and academia to drive investment and create an environment for collaborative working across organisational boundaries.

Welsh Government have continued to invest in diagnostics – as an example, Canolfan Iechyd Genomig Cymru / Wales Genomic Health Centre opened in December 2023 provides clinical and research laboratories and purpose-built clinical spaces to facilitate trusted partnerships, bringing patients right alongside research to continually expand treatment options and improve care outcomes.

Investment has been made in the RISP (Radiology Informatics System Procurement) Programme which will see all Radiology Information Systems including PACS (Picture Archiving and Communication system for storing and transmitting images) standardised to create a single national imaging system within Wales. This will have many benefits including reducing the risk of repeat examinations for patients, reduced number of incidents due to insufficient or missing information and supporting regional and national working. There is a staged approach to implementation of RISP within Health Boards but it is due to be fully in place by 2026.

The national Laboratory Information Management System (LIMS2) has also been invested in with upgrades due for completion across all Health Boards by August 2025.

Recent capital funding for Diagnostics supported additional digital storage for Pathology services in every Health Board to enable current Digital Cellular Pathology

services to continue and for Genomics, additional shared archival storage which enables Genomic Partnership Wales to deliver on their own and partners data protection needs and safeguarding requirements and uninterrupted operations without the threat of running out of storage space, based on current projected need.

Cancer waiting times

17. **The recovery target is for cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026. In August 2023, 57.3% of cancer patients started their first definitive treatment within 62 days of first being suspected with cancer (the current target is 75%). Why is the performance in addressing cancer significantly below the desired standards, and what factors contribute to these challenges?**

Cancer incidence (the number of new cases) has been rising over the long-term. This reflects that the population is both growing and ageing, therefore there are more people, and more people are living longer, which means more cases of cancer will be diagnosed. Health boards and trusts can to some extent keep pace with increases in demand for treatment, as this rises at a relatively low rate per year. However, there are three other aspects that make the rise in demand for cancer care difficult to treat within target time.

The first is that in order to diagnose cancer earlier, the NHS is deliberately referring people at very low risk of having cancer, to identify more cases at earlier stages, because their treatment options will be better. In other words, the NHS is referring tens of thousands more people to find cancers earlier. These all require investigation and outpatient care and limits the capacity of the NHS to arrange treatment for those that are confirmed to have a cancer.

The second factor is that the cost and complexity of the care now available to treat cancer has increased significantly. For instance, there are now multiple lines of therapy available for the same conditions, meaning patients are treated for much longer in many cases. New treatments are often more complex to plan and deliver. For instance, if they require genomic testing and more toxicity management. Some new cancer therapies can also be very expensive, such as CAR-T.

It is also now widely accepted that multi-disciplinary management (care involving lots of different specialist clinicians) produces better outcomes. This means pathways require the involvement of many different specialists, both medical and non-medical, to manage each patient.

The third factor is the general increase in demand for wider planned care. People being referred, investigated, and to some extent treated for cancer, require access to services that deliver most other planned care. Examples of this would include consultation with the GP, referral for a CT or MRI scan, an outpatient appointment with a medical specialty other than oncology, and access to some forms of surgery. These services deliver a much larger volume of care for non-cancer cases. Therefore, increases in population need for services such as imaging and endoscopy, have knock on implications for the capacity that is available to investigate and treat cancer. The allocation of the available NHS capacity requires constant reassessment of the

relative clinical urgency of all the demand facing health boards. In other words, apart from oncology services delivered through the three regional tertiary centres, most of the cancer pathway is delivered by general NHS capacity for planned care.

This pattern is seen across the UK and is not confined to Wales. However, there is also one additional factor specific to Wales. We have overhauled how we measure people waiting for cancer care. We merged the old USC and Non-USC pathways into one single cancer pathway and started the waiting time clock at an earlier point: the 'point of suspicion'. This is unique in the UK and means we count everyone on one pathway, and we start the waiting time clock earlier than other parts of the UK. We have also overhauled how we identify and track patients – which led to an increase in the number of people being tracked in health boards as being on a cancer pathway.

Nonetheless, improvement in cancer waiting time performance is a national planning priority. This is clearly described in the NHS planning framework, the NHS performance framework, and in the way the national accountability processes for NHS oversight are delivered. There is regular and frequent contact with the NHS on cancer performance. This includes additional dedicated accountability meetings specifically for cancer performance. Cancer performance is also a key factor in a number of health board escalation statuses. And in recognition of the need to recover cancer performance, funding has been confirmed to support the NHS Executive to lead a national intervention to implement nationally agreed pathways of care to improve cancer performance for the three most challenged types: urological, gynaecological, and lower gastrointestinal cancers. This work includes wider improvements to how health boards forecast and plan their required diagnostic and treatment activity.

18. **Can you confirm that all GP practices in Wales have access to a rapid diagnostic centre (RDC)?**

    Yes, all health board populations now have access to a Rapid Diagnostic Centre.

19. **How is the Welsh Government planning to expand the availability and accessibility of RDCs, and what strategies are in place to ensure their effectiveness in improving healthcare services?**

    Health boards are responsible for planning and delivering healthcare services, including Rapid Diagnostic Centres, according to their population need. The National Strategic Network for Cancer has developed a national service specification for RDCs that health boards should use to plan their service and its evaluation of the national Rapid Diagnostic Centre programme is due by the end of March 2024. Previous evaluations of the pilot sites indicated RDCs are well liked by patients and clinicians, are cost effective, shorten the patient pathway, and are successful at identifying or ruling out cancer among people with vague symptoms of the disease. The Welsh Government issued a Welsh Health Circular to health boards on implementing national optimal pathways, and this includes a pathway for vague symptoms. We are also working with health boards to integrate RDC data into cancer waiting time data.

Waiting times - the seven 'exceptionally challenging specialties'

20. How extensively are health boards using insourcing, outsourcing and engaging the private sector to tackle waiting time challenges?

The Welsh Government does not hold this level of detail, as it is the NHS who are responsible for commissioning, this will vary by health board depending on their local need. Health boards have been encouraged to commission additional resources as they feel appropriate including working with NHS England and the private sector. We have been very clear that this has to form part of their overall financial envelope. Additional investment above their core allocation has been provided to support additional commissioning this has been manged locally by each HB to support their own agreed provider plans.

Annex 1

LHB Revenue Allocations	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Main LHB Allocation (WHC/2022/034)	1,480.447	1,821.130	1,104.716	1,178.483	995.576	353.011	1,029.959	**7,963.322**
Underlying Deficit - £150m (Conditionally Recurrent)	28.800	33.300	20.300	22.800	19.200	6.300	19.300	**150.000**
Inflationary Uplift - £186m (Conditionally Recurrent)	35.700	41.300	25.100	28.300	23.800	7.900	24.000	**186.100**
Inflationary Uplift - £75m (Non Recurrent)	14.400	16.700	10.100	11.400	9.600	3.200	9.700	**75.100**
Excess Energy Cost - Qtr. 1 and 2 (Part of £49.2m)	3.106	3.270	3.317	3.505	1.432	0.796	1.950	**17.376**
A4C NHS Recovery Staff Payment (3%)	13.194	18.156	14.893	11.620	10.287	2.263	12.499	**82.912**
Planned Care Transformation & Recovery Fund	6.040	7.160	6.400	7.300	6.600	1.000	15.500	**50.000**
Mental Health - In-Year Allocations	7.498	9.436	6.213	7.470	6.323	4.844	6.022	**47.806**
COVID 19 related support - Qtr. 1 and 2	5.964	7.728	6.619	4.456	4.311	1.667	4.742	**35.487**
Dental & Pharmacy (Primary Care) Contract Uplift (5%)	3.499	3.718	2.807	2.679	2.165	0.781	2.420	**18.069**
Other In Year Allocations	20.007	29.487	15.519	17.812	11.676	6.975	12.422	**113.899**
Technical Adjustment - IFRS16 & Baseline Depreciation Adjustment	24.710	12.126	17.085	8.636	9.570	1.968	9.776	**83.871**
Total Revenue Resource Limit (RRL) as at 31/12/23	**1,643.365**	**2,003.511**	**1,233.069**	**1,304.462**	**1,100.540**	**390.705**	**1,148.290**	**8,823.942**

LHB Capital Allocations	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	Hywel Dda UHB	Powys THB	Swansea Bay UHB	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Discretionary Capital Budget as at 1/4/2023	6.614	11.399	11.020	6.533	5.435	0.993	4.795	**46.789**
Allocations from All Wales Capital Programme	46.725	14.553	21.785	62.775	35.258	3.676	35.948	**220.720**
Technical Adjustment - IFRS16	-0.211	1.732	7.347	0.154	0.834	0.068	15.522	**25.446**
Total Capital Resource Limit (CRL) as at 31/12/23	**53.128**	**27.684**	**40.152**	**69.462**	**41.527**	**4.737**	**56.265**	**292.955**