Bundle Finance & Performance Committee 26 August 2021

Unfortunately BCU Committee meetings are being held via a virtual platform at present due to Covid19 regulations. Minutes of meetings will be available on the website in due course.

1 09:00 - FP21/126 Welcome, advice of Chair's actions and apologies for absence

Mark Wilkinson
Sue Green

2 FP21/127 Declaration of Interests

3 09:10 - FP21/128 Draft minutes of the previous meeting held on 24.6.21 and summary action plan

FP128a Minutes FPC 24.6.21 Public draft V.02.docx

FP21.128b Summary Action Log.doc

4 09:15 - FP21/129 Board Assurance Framework

Louise Brereton
Recommendation
That the Committee **review and note the progress on the principal risks assigned to it in the BAF.**

FP21.129a BAF FPC Aug 2021.docx

FP21.129b BAF appendix 1 for FP V1.0 as at 17.8.21.pdf

FP21.129c BAF Appendix 2 key field guidance updated.docx

5 for assurance

6 09:25 - FP21/130 Operational Plan monitoring report

Kamala Williams Acting Director of Performance in attendance
Recommendation
The Finance and Performance Committee is requested to
****scrutinise** the report and**
****advise** any areas to be escalated for consideration by the Board.**

FP21.130a OPMR_FPC.docx

FP21.130b Operational Plan Monitoring Report APP1- Position 30 June 2021 FP _FINAL_.pptx

FP21.130c OPMR Appendix 2_202122_Annual Plan programme action plan.pdf

7 09:40 - FP21/131 Quality and Performance report

Kamala Williams Acting Director of Performance in attendance
Recommendation
The Finance and Performance Committee is requested to
****scrutinise*** *the report and**
****advise*** *any areas to be escalated for consideration by the Board.**

FP21.131a Quality and Performance Report template.docx

FP21.131b QP Report (July Position) FINAL V2.0.pdf

8 09:55 - FP21/132 Planned Care Update

Gill Harris
Clive Walsh Interim Director of Delivery in attendance
Recommendation
To* ***note* *that the backlog clearance has commenced with high risk stratified patients being treated in order of priority**
To* ***note* *the update on the specifications and tendering for insourcing and outsourcing**
To **recognise the complexity of the work and the requirement for Executive and Board support in meeting the challenges and opportunities that lie ahead in the recovery programme.**

FP21.132 Planned Care August 21 v4.docx

9 10:10 - FP21/133 Unscheduled Care update

Gill Harris
Roshan Robati, Programme Director for Unscheduled Care USC
Dr Chris Subbe, Senior Clinical Lead for USC
Recommendation
The Committee is asked to **note the update provided on the development of the Urgent and Emergency Care improvement programme of work**

FP21.133 Unscheduled Care Report v5.docx

10 10:25 - FP21/134 Transformation update

Chris Stockport
Recommendation
That the Committee **receives and **notes** this update paper which outlines the further progress made (since the last F&P committee meeting) in re-shaping our transformation function.**

FP21.134 Transformation update.docx

11 10:40 - FP21/135 Capital Programme report Month 4

Neil Bradshaw Assistant Director Planning - Capital
Recommendation
The Committee is asked to **receive and **scrutinise** this report**

FP21.135 Capital Programme Report - Month 4.docx

12 10:50 - Comfort break

13 11:00 - FP21/136 Financial strategy - draft principles

Sue Hill
Recommendation
The Committee is asked to **note the paper**

FP21.136a Finance Strategy - Draft Principles.docx

FP21.136b Finance Strategy - Draft Principles_Final version.pdf

14 11:10 - FP21/137 Finance reports months 3 and 4

Sue Hill
Recommendation
The Committee is asked to **note the Month 3 and 4 reports**

FP21.137a Finance Report M03-22 Template - Final.docx

FP21.137b Finance Report M03-22 Appendix 1 - Final.pptx

FP21.137c Finance Report M04-22 template.docx

FP21.137d Finance Report M04-22 Appendix 1 - Final.pdf

FP21.137e Finance Report M04-22 Appendix 2 - Final.pdf

15 11:30 - FP21/138 Savings report month 4

Sue Hill
Recommendation
That the Committee **note the current savings plans and forecast delivery, along with the opportunities identified to address the recurring savings deficit.**

FP21.138 Savings Update - M4 2021-22 V2.0.docx

16 11:45 - FP21/139 Workforce quarterly report

Nick Graham Associate Director Workforce Planning & Performance in attendance
Recommendation
The Committee is asked to **note the report and planned improvements to reporting.**

FP21.139 Workforce Performance Report v4 Final.docx

17 for approval

18 12:05 - FP21/140 Residential Accommodation – proposal to move to a managed services model

Rod Taylor Estates and Facilities Director in attendance
Recommendation
The Finance and Performance Committee is asked to **approve the following recommendations :**

*1. *To approve the procurement proposal for a residential accommodation managed service model as detailed within this report.**
*2. *To note the continued opportunities to work collaboratively with local social housing providers in developing the service specification.**

FP21.140a Residential Accomodation update_managed service model.docx

FP21.140b Residential Accommodation Appendix 1 WG letter dated the 29th of April 2021 - Residentaial Accomodation SOC.pdf

19 12:20 - FP21/141 Welsh Community Care Information System Business Case (WCCIS)

Chris Stockport
Bethan Jones Senior Responsible Officer Tracey MacGillivray Project Manager in attendance
Recommendation
The Committee is asked to **approve the Welsh Community Care Information System (WCCIS) updated Revenue Business case to allow a phased implementation of the system across Community Services to enable a review of its functionality.**
No additional funding is requested for the current financial year; however a scale up implementation across the Health Board would require an additional £1.1m annually for the three year implementation period and an additional £700k p.a for ongoing support costs post implementation. Capital costs for devices will be requested through discretionary IT Capital bids.

FP21.141 WCCIS report.docx

20 12:40 - Lunch

21 13:05 - FP21/142 Delivery of Primary Care Audiology Services – business case

Chris Stockport
Recommendation
The Committee is asked to **approve implementation of a Primary Care Audiology Service across North Wales, as described within the health board annual plan for 2021/22.**

FP21.142a Primary care Audiology services business case.docx

FP21.142b Primary care Audiology services business case_App1 Business case.docx

FP21.142c Primary care Audiology services business case_App2 EQIA.docx

FP21.142d Primary care Audiology services business case_App3 SED assessment.docx

22 13:20 - FP21/143 Adult and Older Person's Mental Health Unit Glan Clwyd Hospital – Outline Business Case

Teresa Owen
In attendance:
Mike Smith Director of Nursing Mental Health and Learning Disabilities
Neil Bradshaw Assistant Director Planning - Capital
Ian Howard Assistant Director - Business and Strategic Analysis
Recommendation
The Committee is asked to **approve the Business Case for submission to the Board. Subject to Board approval the case will then be submitted to Welsh Government.**

FP21.143a AOPMHU OBC August 2021 v.3.docx

FP21.143b AOPMHU_YGC App1 Mental Health OBC DRAFT 0.5 12.08.2021 Version 5.pdf

FP21.143c AOPMHU_YGC App 2 (Q) Financial Analysis August 21.pdf

FP21.143d AOPMHU_YGC App 3 (N) SED Version 0.05 30.07.2021.pdf

FP21.143e AOPMHU_YGC App 4 (M) EqIA Revised July 2021 V0.02.pdf

23 13:40 - FP21/144 North Wales Endoscopy Service : Insourcing of Endoscopy services

Adrian Thomas Executive Director Therapies and Health Sciences in attendance
Recommendation
Finance and Performance Committee is asked to **approve funding to continue insourcing of Endoscopy Services across the 3 hospital sites for 4 months from August to December 2021 to maintain capacity, address increasing demand, reduce the backlog and ensure safe clinical services for patients.**

FP21.144 Endoscopy Business Case Funding Proposal Aug 21 v1.1.docx

24 13:55 - FP21/145 F02 - Lease Car Policy and Procedure

Sue Hill
Recommendation
The Finance and Performance Committee is asked to **approve the updated version of Financial Procedure F02 – Lease Car Policy and Procedure.**

FP21.145a F02 Lease Car Policy and Procedure_template v2.0.docx

FP21.145b F02 - App 1 Lease Car Policy and Procedures V.03 - FINAL July 2021.docx

FP21.145c F02 -App 2 Lease Car Policy and Procedure - July 2021.EqIA Financial Procedure.docx

FP21.145d F02 - App 3 Lease Car Policy and Procedure - July 2021_OBS Checklist.doc

25 14:00 - FP21/146 External Contracts Q1 report

Sue Hill
Recommendation
The Committee is asked to:
****note****
• the financial position on the main external contracts as reported at Quarter 1 2021/22.
• the work underway in respect of stabilising wider health / patient care contracts and key risks / related activity.
• the impact of Covid-19 on external healthcare contracts.
• the impact and risk posed as a result of Covid-19 revised contracting arrangements adopted for contracts with NHS Providers and Commissioners.
• the work underway in respect of increasing planned care capacity
• the risks associated with the current contractual arrangements with independent care home and domiciliary care providers and actions being taken
• the work underway to increase capacity within the team and develop robust governance and scrutiny arrangements
****approve****
• the proposals in relation to third sector commissioning

FP21.146 External contracts paper Q1.docx

26 For information

27 14:10 - FP21/147 Monthly monitoring reports

Sue Hill
Recommendation
****Note** the contents of the reports that have been made to Welsh Government about the Health Board's financial position for Months 3 & 4 of 2021/22.**

FP21.147a Monitoring reports Months 3&4.docx

FP21.147b MR Report_App 1 M3 2021-22 - Final.pdf

FP21.147c MR Report_App 2 M4 2021-22.pdf

28 14:10 - FP21/148 Business Case Tracker

Ian Howard Assistant Director Strategic and Business Analysis
Recommendation
The Committee is asked to **note the contents of the business case trackers*.*

FP21.148a Business Case Tracker FP paper Aug 21.docx

FP21.148b Business Tracker_App 1Revenue Tracker v2 approved.pdf

FP21.148c Business Tracker_App 2 Capital Tracker 18.08.2021 Final.pdf

29 FP21/149 Summary of Private business to be reported in public

Sue Hill
Recommendation
The Committee is asked to **note the report**

FP21.149 Previous private session items reported in public report.docx

30 FP21/150 Issues of significance to inform the Chair's assurance report

31 14:20 - FP21/151 Date of next meeting

The next meeting to take place will be Performance, Finance and Information Governance Committee on 28.10.21

32 Exclusion of the Press and Public

Resolution to Exclude the Press and Public
"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

DRAFT minutes of the meeting of the Finance and Performance Committee held in public on 24th June 201 via Teams

Present:	
John Cunliffe	Independent Member / Committee Chair
Eifion Jones	Independent Member / Committee Vice Chair
Linda Tomos	Independent Member
In Attendance:	
Louise Brereton	Board Secretary
Andrew Doughton	Audit Wales (*observing)*
Kate Dunn	Head of Corporate Affairs (for minutes)
Nick Graham	Associate Director Workforce Planning & Performance
Sue Hill	Executive Director of Finance
Andrew Kent	Interim Head of Planned Care Improvement *(part meeting)*
Kelsey Rees-Dyke	Project Manager – *observing (part meeting)*
Tom Stanford	Interim Finance Director – Operational Finance
Chris Stockport	Executive Director of Primary Care & Community Services
Mark Wilkinson	Executive Director Planning and Performance
Meinir Williams	Acute Care Director (West)
Jo Whitehead	Chief Executive

Agenda Item Discussed	Action By
FP21/94 Chairman's Welcome and Introductory Remarks **FP21/94.1** The Chair welcomed everyone to the meeting and recorded the following Chair's Actions: 1. Health Board Chair's Action completed on 27.5.21 regarding the tender for the redevelopment of the Critical Care Unit at Wrexham Maelor 2. Dual Committee and Health Board Chair's Action completed on 15.6.21 regarding the recommissioning of orthodontic services in Penrhyndeudraeth 3. Dual Committee and Health Board Chair's Action completed on 21.6.21 to approve contract with Lightfoot Solutions to provide healthcare consultancy and specialist technology services, to aid Winter Planning and delivery and ongoing support.	
FP21/95 Apologies for absence **FP21/95.1** Apologies were recorded for Sue Green, Arpan Guha, Gill Harris and Dave Harries.	

FP21/96 Declaration of Interests FP21/96.1 No declarations of interest were declared.	
FP21/97 Draft minutes of the previous meeting held on 29.4.21 and summary action plan **FP21/97.1** The minutes were approved as an accurate record, and updates were provided to the summary action log	
FP21/98 Board Assurance Framework (BAF) **FP21/98.1** The Board Secretary presented the report indicating there were no material changes to note. She confirmed that all BAF risks had been subject to monthly review and 'check and challenge' at the Risk Management Group (RMG). She highlighted that the BAF continued to evolve as a result of recent discussions at the Audit Committee workshop and at the RMG, and that there was additional support planned via the Good Governance Institute. Members' attention was drawn to two risks where the target score was outside of the agreed risk appetite. The Board Secretary confirmed that once the BAF had been approved by the Health Board these would be remapped however there would potentially still be gaps – for example within the unscheduled care risk. **FP21/98.2** The Chair acknowledged that sometimes a higher risk level outside of the risk appetite would need to be tolerated, but he suggested that there needed to be a mechanism to record this. He was also unclear whether the target was being used to set the tolerance, or whether the target was what the organisation thought it could achieve at a point in time. The Board Secretary would take these points away for further thought. She would also endeavour to ensure a consistent report layout (ie portrait as opposed to landscape) as per Chair's preference. **FP21/98.3** An Independent Member noted that the narrative was better articulated than in previous reports but felt that attention needed to be maintained on ensuring that mitigation did actually happen. The Vice-Chair supported the direction of travel in terms of BAF development and noted it had been a positive session at the Audit Committee workshop. In response to a question regarding the impact of reviewing the ophthalmology business case on BAF20-05, the Chief Executive suggested this would change the likelihood as opposed to the impact, through expediting a more complete solution sooner whilst continuing to mitigate the risk through insourcing and waiting list initiative type activity for cataracts. *[Chris Stockport and Kelsey Rees-Dyke joined the meeting]* **FP21/98.4** It was noted that the current and inherent risk were the same within BAF20-05 and the Board Secretary indicated that this had been highlighted at the RMG also	LB

and whilst there was sufficient mitigation to suggest that the current risk could be reduced there remained an element of nervousness. The Chief Executive indicated that the decision to reduce risk score was affected by the logical versus emotional aspects. **FP21/98.5** In response to a question from the Chair regarding BAF20-17 the Executive Director of Finance confirmed that the Welsh Government (WG) maturity matrix guide for value based healthcare was actively being utilised, and this would be made clearer in the updated risk. **FP21/98.6** The Chair queried why the target risk was less than the risk appetite on BAF20-20 and the Board Secretary would follow this up with the Director of Estates and Facilities. **FP21/98.7** With regards to BAF20-28 the Board Secretary would ensure that future narrative would reflect that the Digital Strategy had now been approved as a framework by the Health Board, whilst acknowledging there was not currently funding identified for its implementation. **FP21/98.8 It was resolved that** the Committee review and note the progress on the Principal Risks as set out in the Board Assurance Framework.	SH LB LB
FP21/99 Annual Plan 2021/22 **FP21/99.1** The Executive Director of Planning and Performance confirmed that an earlier iteration of the Annual Plan had been discussed at the Strategy, Partnerships and Population Health Committee on the 17th June, and that an extraordinary Board Workshop had been arranged for the afternoon of the 24th June. Feedback from the F&P Committee's discussion would be shared at the Board Workshop to enable further refinements to be made ahead of submitting the Annual Plan to WG by the 30th June. The Health Board would receive and endorse the Annual Plan in public on the 15th July. The Executive Director of Planning and Performance confirmed that the Executive Team had supported the Annual Plan at their meeting on the 23rd June pending the strengthening of references to the impact of long covid, and to the work on the development of Diagnostic Treatment Centres (DTCs) and the potential to move towards a managed service model for finance and delivery. He confirmed that a letter had been sent to Dr Andrew Goodall in this regard. The Chief Executive added that the Health Board was in active conversation with WG regarding securing additional resources for planned care recovery, and there was a positive intent around the model of a cataract hub. **FP21/99.2** An Independent Member welcomed the clear articulation within the Annual Plan but commented that it was rather long and there perhaps could have been better use made of appendices without losing the focus on key messages and priorities. She also suggested that section 2.3 (Programme for Government) could have been	

stronger bearing in mind the dynamic discussions with WG, and that linking this section more robustly to the development of a North Wales Medical School would more clearly support an overall holistic vision. The Chief Executive supported this comment. In terms of the length of the document she acknowledged the challenge in meeting a wide range of preferences and needs, however, she confirmed that an easy read summary version would also be produced. **FP21/99.3** The Vice-Chair commented he would wish to have seen more of a workforce focus within the Annual Plan including specific recruitment and retention targets to enable the Board to deliver the plan. It was confirmed that this level of detail was within the supporting documentation and minimum datasets and also was linked to national and local performance reporting. The Chief Executive suggested that officers look at including headline numbers for minimum datasets. **FP21/99.4** The Chair acknowledged the improvements to the Annual Plan although there remained much work to do, including ensuring it could be more timeline based. He suggested that the financial risk and savings elements of the Annual Plan needed to align more closely with the information within the latest finance report, and it was agreed that this would be addressed before submission. He also would wish to see a clearer reference to when the Clinical Services Plan would be available and its implementation timeline. **FP21/99.5 It was resolved that** the Committee receive the draft refreshed plan for discussion, comment and feedback ahead of presentation to the Board Workshop on 24th June. *[Kelsey Rees-Dyke left the meeting]*	MW SH
FP21/100 Quality and Performance Report **FP21/100.1** The Executive Director of Planning and Performance presented the report and highlighted pressures around unscheduled care with attendances now back up to pre-pandemic levels. In terms of planned care he reported modest improvements in the total numbers waiting but an anticipation of worsening performance as the year went on. **FP21/100.2** An Independent Member felt that the disappointing performance was inevitable but at least the reasons were well understood. She sought assurance that patients were being kept informed during their wait for treatment to help them understand the prioritisation process. In response to a comment from the Vice Chair the Executive Director of Planning and Performance confirmed there was separate validation work ongoing to identify patients who no longer needed or wished to remain on a waiting list.	

FP21/100.3 The Chair observed that there were also some positives within the paper in terms of stroke performance and a reduction in Referral to Treatment for the first time since December 2020. It was noted however that where this related to first appointments it would likely impact upon diagnostics performance. **FP21/100.4 It was resolved that** the Finance and Performance Committee scrutinise the report.	
FP21/120 Performance and Accountability Framework : Use and effectiveness **FP21/120.1** The Executive Director of Planning and Performance presented the paper, acknowledging there was more work to do in terms of embedding the framework which had been paused during the pandemic. He clarified that the covering report should have made reference to five divisions not three. **FP21/120.2** The Chair expressed disappointment that it had taken seven months from the framework being approved to the first performance accountability meeting. He also asked that the terms of reference for the Performance Oversight Group be shared. The Chair noted reference to local performance and accountability meetings taking place on a regular basis and it was confirmed that members of the performance team were in attendance and would therefore have a view as to how they were developing. **FP21/120.3 It was resolved that** the Committee note: 1. The Performance and Accountability Framework (PAF) was approved by the Board in November 2020 with a review date of March 2021. 2. The review of the PAF did not take place as planned and subsequent feedback from the Executive Divisional, Divisional and Local Accountability meetings has highlighted variation in the operation of the Framework. 3. Given the variation that has been highlighted, and as the PAF has been in place for six months, it is timely to review its use and effectiveness. 4. A review of the PAF will be undertaken by the Performance Team, with Terms of Reference for the Review to be agreed by the Performance Oversight Group (POG). 5. An update report detailing the process, timescale and progress of the review to be brought to the August F&P meeting. Final findings and recommendations of the review to be shared with the Committee.	MW
FP21/101 Planning Principles and Timetable 2022/25 **FP21/101.1** The Executive Director of Planning and Performance presented the paper which had been developed at the Committee's request. He confirmed it had received general support at the Executive Team meeting although the point had been made that there was work to be done around the levels of planning for different purposes.	

FP21/101.2 An Independent Member welcomed the progress being made and enquired as to expectations from WG or other Health Boards in terms of their approach. The Executive Director of Planning and Performance reported that a strategic framework was expected from WG by the autumn. He indicated that it was apparent from all Wales discussions that all organisations were grappling with similar issues. In terms of a consensus as to the type and amount of information to be provided, the Executive Director of Planning and Performance acknowledged there would always be personal preferences and that the performance team would need to carefully consider the audience eg; the Board, WG and individual members. The Chair added that Committee and Board members would require assurance that the supporting detail is there and accessible, with the narrative wrapped around appropriately to reflect this. He felt there was a need to be clear that performance must be measurable and allow the Board to assess whether the organisation was delivering against expectations. It was suggested that a wider conversation around audiences and perceptions would be helpful at some point. The Board Secretary would look into feasibility of a board workshop session. **FP21/101.3 It was resolved that** the committee: 1. Receive the report 2. Endorse the planning principles and outline timetable for 2022/25	LB
FP21/102 Planned Care Update **FP21/102.1** Andrew Kent (Interim Head of Planned Care Improvement) joined the meeting to present the paper. He recognised the significance of the planned care agenda and the challenges facing the organisation, and noted that in particular the increase in over 52 week waiters was of concern. He reminded members of the implementation of the six point plan to restart, treat and transform care. He referenced the difficulty in the organisation needed to deliver four quarters' of work in three quarters' of time and capacity for the two cohorts (pre Covid patients and the Covid backlog). He reported that separate funding had been received and that the organisation must be SMART in its operational planning and follow the set trajectories in order to utilise the funding effectively to deliver what was required. It was reported that a range of approaches would be implemented including additionality, in-sourcing and out-sourcing, and that transformation would be a key element. Members' attention was drawn to the 'treat' element in that there were two areas where in-patient activity had not yet commenced. Firstly Abergele where there were significant workforce risks in terms of 24/7 medical cover, with the current estimate being a mid July start date. Secondly orthopaedic in-patients in the West. The Interim Head of Planned Care Improvement went onto explain that within Cohort 1 and following validation, around 209 patients had been removed from the waiting list with the remaining patients moving into the 'hard to reach hard to treat' category. For Cohort 2, some 2229 patients had been removed from the list. In terms of transformation, the associated procurement elements had been completed and a paper would be shared at the Planned Care Group and then the Executive Team. In addition the out-sourcing was now out to tender. New pathways were being developed for hip, hand and knee surgery and	

consideration being given to hand surgery being undertaken at Llandudno General Hospital. Finally the Interim Head of Planned Care Improvement confirmed that planned care remained a significant risk scored at 25, although progress was starting to be seen. He noted that the recovery of the planned care position was highly complex and acknowledged it dominated many conversations across a range of forums. **FP21/102.2** The Chair noted an error in the table showing the previous waiting list total. He also noted that the F&P Committee had been listed within the table showing the evaluation of specifications process and queried whether this was appropriate. The Board Secretary would look further into this. In response to a question from an Independent Member relating to the morale of the planned care workforce, the Interim Head of Planned Care Improvement acknowledged it was a very difficult situation and many staff were tired. In addition he was aware of frustrations amongst surgeons who desperately wanted to operate. He suggested that all staff within planned care came to work wanting to do their best for patients and that to see the backlogs growing was very hard. An Independent Member enquired as to the timeframe for the modular theatres and cataract business case. The Interim Head of Planned Care Improvement confirmed that plans for the orthopaedic modular theatre were in the final stages, however, the cataract centre would be some months away. In response to a further question regarding utilising sites to full capacity he confirmed that additionality was commencing via additional clinical sessions in the evenings and weekends. **FP21/102.3 It was resolved that** the Committee: 1. Note that the backlog clearance has commenced with high risk stratified patients being treated in order of priority 2. Note the specifications have been completed for insourcing and outsourcing 3. Note the planning and monitoring being undertaken to ensure quality and value for money for the backlog clearance 4. Recognise the complexity of the work and the recognition of Executive and Board support with the challenges and opportunities that lie ahead in the recovery programme. [*Andrew Kent left the meeting*]	LB
FP21/103 Unscheduled Care Report **FP/21.103.1** The Acute Care Director (West) presented the paper highlighting that the 4 hour Emergency Department (ED) target remained below the 25% aspiration. She noted there had been a recent marked increase in attendances of up to 200 per day in some cases, and performance was compounded by the need to maintain red and green pathways and comply with social distancing. These requirements could amount to a 30% net reduction in capacity. Members were assured that work on improvement plans was moving ahead with pace and that the outcome of bids submitted to WG should soon be known. The Acute Care Director (West) indicated that high numbers of fit for discharge patients were still being seen across sites, and there had been frequent escalation within the ambulance service. It was also noted that the Contact	

First service formed part of the 111 rollout. In terms of performance trajectories these would continue to be monitored against plan but trajectories would need to be adjusted as the improvement plans matured. **FP/21.103.2** The Chair referred to the draft terms of reference for the Urgent and Emergency Care Improvement Group (UECIG) and queried the indication that it was accountable to the F&P Committee. He suggested that if this was the case it would need to be a formal sub-committee of F&P. The Chief Executive and Board Secretary would pick this matter up as part of a governance and alignment conversation outside of the meeting. **FP21/103.3** A discussion took place around the launch of the 111 service and some members indicated that they had not personally seen much coverage or information. Executives assured the Committee that there had been a full range of internal and external communications and media coverage, and examples and details were provided to members. **FP21/103.4 It was resolved that** the Committee: 1. Note progress of the Urgent and Emergency Care Improvement programme Unscheduled Care 2. Note draft terms of reference for the Urgent and Emergency Care Improvement Group 3. Note Tier 1 performance updates for May 2021 across BCUHB, the key drivers attributing to performance alongside identified mitigating actions and anticipated outcomes.	JW LB
FP21/104 Transformation update **FP21/104.1** The Executive Director of Primary and Community Care Services provided a verbal update. He indicated that recent presentations to the Executive Management Group and Board Workshop meetings had been received and there was evidently an appetite for greater pace around this work which was being taken forward around three main areas of activity. These were 1. Supporting the Board to provide strategic level intelligence and translating priorities into a transformational workplan; 2. Coordinating and leading a cohort of prioritised transformational value based care programmes; and 3. Supporting the whole organisation to get involved in transformation. The Executive Director of Primary and Community Care Services reported that the existing teams within the transformation function had moved under his portfolio and there were also plans to deploy additional capacity through WG funding. An outline structure for the wider team had been developed and interviews were being held within the next week for the Director of Transformation. 1:1 conversations were being held with existing teams to work through the transition and there would likely be a brief pause and reflect ahead of moving ahead with new activity. It was suggested that a written report be provided to the next meeting which would outline the programme methodology, set out timeframes as part of a PMO approach, and confirm the monitoring and compliance arrangements.	CS

FP21/104.2 An Independent Member queried how the Targeted Intervention Improvement Framework (TIIF) related to transformation teams and the Executive Director of Primary Care and Community Services acknowledged that the TIIF was recognised as a clear set of priorities to be delivered. He indicated that a dispersed approach had been taken to ensure ownership by teams and the service. In response to a comment from the Vice Chair he also undertook to consider how the transformation agenda could be applied to externally commissioned or outsourced services.	CS
FP21/105 Capital Programme report Month 2 **FP21/105.1** The Executive Director of Planning and Performance presented the paper and indicated there was currently a significant amount of activity in terms of the capital programme. The paper set out timescales for the development of the Adult and Older Persons Mental Health In-Patient Unit on the Ysbyty Glan Clwyd (YGC) site. In relation to the Wrexham Continuity Programme it was noted that changes had been applied since approval of the original business case, and the scheme was now more significant in terms of capital costs. The Executive Director of Planning and Performance reported that historically capital spend had been less during the early part of a financial year, however, 2021/22 was looking to be different in that many schemes had been delayed due to Covid. He added that a wide range of urgent Covid related work continued to be undertaken across all sites. In addition the Executive Team had approved a pause in spending whilst Divisions were required to prioritise their schemes. **FP21/105.2** The Chair noted that the paper did not incorporate the cumulative graph in terms of expenditure which he had previously found helpful. He also queried whether medical equipment replacement was not going to be supported by suppliers in 2021-22, and the Executive Director of Planning and Performance confirmed that some planned replacement costs would need to brought forward. **FP21/105.3 It was resolved that** the Committee receive and scrutinise the report.	
FP21/106 Finance Report Month 1 **FP21/106.1 It was resolved that** the report be noted	
FP21/107 Finance Report Month 2 **FP21/107.1** The Executive Director of Finance presented the paper and highlighted a significant change in the M2 position around the confirmation from WG that the impact of the non-delivery of savings from 2020/21 would be funded as part of the Covid response. A £32.6m allocation had now been confirmed which would allow the Health Board to plan for a small surplus in 2021/22 which would allow some flexibility around the potential to fund some additional schemes. In response to a question from an Independent Member, the Executive Director of Finance confirmed the allocation was	

ring fenced relating to savings and there was an expectation that Covid costs would be offset by Covid allocation monies. The Executive Director of Finance went on to report that savings of £10.2m were still being forecast which was the same position as at M1. Work was ongoing with Divisions around further savings opportunities and a new toolkit to be launched by the Financial Delivery Unit was being reviewed. The Executive Director of Finance reported that forecasting in detail against the Annual Plan would commence from M3. It was also highlighted that agency expenditure had increased in M2 which would be monitored. Opportunities relating to non-pay within primary care prescribing were set out within Appendix 3. The appendix showed how expenditure had grown over the last 12 months by £5.7m and data was also provided for total prescribing costs and numbers of items by Local Authority area. Information was provided on the top ten Drug Cost Baskets of cost increases with Selective Serotonin Re-Uptake Inhibitors being the largest increase at 163%. It was highlighted that the BCUHB Chief Pharmacist had provided a view within section 5. The Chair welcomed the comparison to the rest of Wales in terms of prescribing and enquired whether expected costs going forward had been built into budgets, and the Executive Director of Finance confirmed that where possible this had been addressed. **FP21/107.2** It was confirmed that the staff bonus payment of £17.7m had been fully provided in 2020/21 and would not be a cost pressure within the current year. The estimated pay award impact for the first two months was noted as £1.2m. The Vice Chair felt that the main concern remained the forecast shortfall within the savings plans. The Executive Director of Finance reported that as many members of the finance team had been pulled back from other duties as possible, and the remaining vacancies were being actively recruited to. She was confident in the ability to deliver the £17m savings but confirmed this was wider than just a finance conversation. **FP21/107.3** The Chair expressed concern that savings delivery was already £0.6m averse and raised a point as to whether focus had been lost. The Executive Director of Finance acknowledged that a Covid outbreak in Q4 had affected focus but she was comfortable that sufficient time could now be invested to ensure delivery and to address the position within Divisions too. **FP21/107.4** The Vice Chair enquired whether the prescribing variation across West, Centre and East could be explained and the Executive Director of Finance undertook to look into this further. **FP21/107.5** In response to a question from an Independent Member the Executive Director of Finance confirmed she was confident that in terms of vacancies the budgeted position could support the approach set out in the Annual Plan. She also confirmed that two senior vacancies had now been appointed to. **FP21/107.6 It was resolved that** the report be noted.	SH

FP21/108 Workforce Performance Report **FP21/108.1** The Associate Director Workforce Planning & Performance presented the paper and highlighted that work was now having a positive effect on vacancy rates. A holistic approach was being taken to look at targeted improvement. He drew members' attention to the addition of a medical bank for junior doctors; work being undertaken with Child and Adolescent Mental Health Services (CAMHS) regarding the use of alternative roles to support vacancies; and work associated to the commissioning of a medical school for North Wales. In terms of sickness absence across the organisation this remained around the Welsh average. Finally he welcomed any feedback on the refreshed format of the report. **FP21/108.1** The Vice Chair noted a stark contrast between areas in terms of nursing levels and vacancies and he welcomed the reported success in terms of overseas recruitment. He enquired how carried forward leave would be managed into 2021/22 and whether this would be a pressure. The Associate Director Workforce Planning and Performance confirmed this was being managed locally with central guidance but undertook to provide some detail within the next report if members would find it helpful. An Independent Member enquired whether the requirement for nurses to have specialist qualifications by 2023 had been included in training programmes and whether non-UK trained nurses would have to re-train. The Associate Director Workforce Planning and Performance confirmed there was ongoing support to meet these requirements. He added that the organisation performed fairly well in terms of recruitment but the main challenge was around retention. He suggested that pathways with clinical fellowships was key and that the development of a medical and health sciences school for North Wales would be a catalyst.	NG
FP21/108.2 The Executive Director of Finance noted that the report indicated in terms of establishment there were only 29 GPs in post against a budget of 63. The Associate Director Workforce Planning and Performance acknowledged this was a significant issue and he suggested that the next report could look at providing more detail around how this shortfall was being managed. The Executive Director of Primary Care and Community Services added that some data for directly employed GPs was not accurately recorded and there were complexities in terms of sessions for GPs differing to those of hospital doctors.	NG
FP21/108.3 Independent Members felt the overall format of the report had improved. The Chair suggested that consideration be given to the use of a dashboard at the beginning of the report to provide headline expectations and performance against key measures. The Associate Director of Workforce Planning and Performance would give this some thought. **FP21/108.4 It was resolved that** the Committee note the report and planned improvements to reporting.	NG

FP21/109 Care Packages : Approach to the 2021/22 Fees **FP21/109.1** The Executive Director of Finance presented the paper and confirmed that all associated costs had been provided for within the draft Annual Plan. Work was ongoing with care providers to develop more consistency within the Continuing Healthcare approach and methodology. It was expected that the provision would be fully utilised in year. **FP21/109.2** The Vice Chair enquired whether minimum staffing levels were written into the formal agreements with care homes and the Executive Director of Finance undertook to confirm this outside of the meeting. The Executive Director of Primary Care and Community Services assured members that the Board clearly set out its expectations as a commissioner and inspections did take place within care homes. **FP21/109.3** An Independent Member noted the emphasis on shared social care and expectations to work collaboratively, and enquired whether this would impact on the Board's approach going forward – for example around sharing costs? This was acknowledged as a sound expectation but a conversation that would be particularly challenging as part of inter-organisational relationships **FP21/109.4 It was resolved that** the Committee approve inflationary uplifts for 2021/22 in relation to CHC and FNC and a further additional premium to the CHC rate to support market stability.	
FP21/110 Approval to lease surplus land at Cefni Hospital to Llangefni Town Council **FP21/110.1** The Executive Director of Planning and Performance presented the paper. In response to a query from the Chair as to whether a five year clause was appropriate considering that the Board operated within a three year planning cycle, he indicated that there were no anticipated circumstances in which the organisation would need that area of land. It was also reported that the Llangefni Town Council intended to utilise the land as open space community use. **FP21/110.2 It was resolved that** the Committee approve the granting of a ten year lease with break clause at year five, on a peppercorn rent to Llangefni Town Council.	
FP21/112 Monthly monitoring M1 report - Sue Hill **FP21/112.1 It was resolved that** the Committee note the contents of the report that has been made to Welsh Government about the Health Board's financial position for Month 1 of 2021/22.	

FP21/113 Monthly Monitoring M2 Report **FP21/113.1 It was resolved that** the Committee note the contents of the report that has been made to Welsh Government about the Health Board's financial position for Month 2 of 2021/22.	
FP21/114 Shared Services Partnership Committee Quarter 4 Assurance Report - **FP21/114.1** An Independent Member enquired why there was such a variation in performance against a key target to approve vacancies within five days. The Executive Director of Finance expressed her view that this national target was somewhat unrealistic. The Chair recalled historical issues relating to recruiting managers not being informed when a vacancy was not approved. Officers were not aware if this remained a problem but the Associate Director Workforce Planning & Performance undertook to make enquiries. **FP21.114.2 It was resolved that** the Committee note the report.	NG
FP21/115 Summary of Private business to be reported in public **FP21/115.1 It was resolved that** the Committee note the report.	
FP21/116 Issues of significance to inform the Chair's assurance report **FP21/116.1** To be agreed outside of the meeting.	
FP21/117 Date of next meeting 26.8.21	
FP21/118 Exclusion of the Press and Public **FP21/118.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

BCUHB FINANCE & PERFORMANCE COMMITTEE Summary Action Log – arising from meetings held in public				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
Actions from 29.4.21 meeting:				
Sue Green	**FP21/77 Quality and Performance report** **FP21/77.3** In discussion of Agency cost increases the Executive Director of Workforce & OD agreed to explore how to improve the data provided to better reflect cover for core activity within reporting.	13.5.21	14.6.21 Work underway between WOD/Finance/Operations re categorisation of reporting to assist in providing greater clarity in future reports. Projected completion from July. 18.8.21 The Medical Recruitment Group is being reformed and will use a suite of reporting and BI dashboards to ensure the triangulation of agency usage is directly correlated to vacancies. A presentation of the dashboards will be presented at the August meeting.	August meeting Action to be closed
Andrew Kent Mark Wilkinson	**FP21/78 Planned Care update** Provide 2019 comparison figures in future reports.	14.6.21	10.6.21 This now lies with performance and informatics to include within the quadruple report 24.6.21 Mark Wilkinson suggested this referred to the QaPR which was based on the quadruple aim but he would confirm this with Andrew Kent. Update 6.8.21 - Comparisons to 2019 will be included in the additional information charts in the F&P report	Action to be closed
~~Gavin MacDonald~~ Gill Harris	**FP21/79 Unscheduled Care (USC) update** explore whether there was a correlation between a higher rate of ambulance conveyances and lower acuity	14.6.21	7.6.21 During the COVID pandemic there was a substantial decrease in the number of patients self presenting to the Emergency Departments across North Wales, with only a slight drop in ambulance conveyance rates. Work is ongoing to review conveyances including triage category on arrival and time of departure within 4hours. The number of attendances for triage categories 3, 4 and 5 remained constant during the pandemic which demonstrates those that had been conveyed had on average a lower triage category to reflect a non-life threatening attendance. The MIU conveyances from WAST have remained constantly low which part of the review would confirm that those with injuries from a triage category 4 or 5 may of had their care	

			better served in an alternative service. 24.6.21 John Cunliffe noted the recommendation to close this action however he did not feel the response addressed the issue of a correlation between higher conveyances and acuity levels. Meinir Williams reported that work was ongoing to try and understand what is driving the increase in ambulance demand and in acuity. She was confident however that patients were being conveyed to the right place. She clarified that in terms of the triage categories 1&2 were the highest acuity, 3&4 were minor injuries and 5 was primary care. Jo Whitehead referred to the impact of temporary residents and Meinir Williams confirmed that a spot check at YG had demonstrated the equivalent of 2 wards of non North Wales residents. The point was also made that some patients were attending EDs in lieu of their general practice as were having difficulty in contacting their GP or obtaining an appointment.	Action to be closed
Sue Green	**FP21/79 Unscheduled Care (USC) update** It was agreed that an update on the KB recommendations follow up would be provided in the Workforce report to be provided to the next meeting by the Executive Director of Workforce and OD.	14.6.21	14.6.21 Unscheduled Care Review update being supported by Kendall Bluck commenced under leadership of Gill Harris as SRO. Slight delay in scheduling now resolved. Update to be included in USC and Workforce Report to next meeting. 18.8.21 This will be included in the workforce report for the August meeting	August meeting Action to be closed
Mark Wilkinson	**FP21/81 Business case trackers for revenue and capital business cases** • Format to be revisited in order to provide a more user friendly 'view' electronically. • Provide RAG status against each scheme • Provide trackers quarterly to the Committee	16.8.21	17.6.21 This work is under way and will be completed by the deadline. 16.8.21 The format has been revised as requested. The approach to RAG rating has been reviewed by the Capital Investment Group, and it has been suggested that a RAG rating is useful for capital schemes that are in development. This has now been added to the tracker. For capital schemes that are at the concept stage and revenue cases that have either been developed or are being developed there is no real basis for a	Action to be closed

			RAG rating. The Tracker is being presented to the August meeting. Given that the F&P Committee meets bi-monthly, it is proposed that the tracker is presented at alternate meetings – i.e. at 4-monthly intervals	
Sue Hill	**FP21/76 External Contracts update** • provide the volume of contracts which not under contract • provide a briefing note in regard to how Care Homes risks were captured in BCU risk registers including pre-placements.	14.6.21	16.6.21 A briefing note has been shared with the Committee members 24.6.21 John Cunliffe noted there were a number of gaps in the briefing note and sought assurance that this didn't reflect there were open-ended contracts. Sue Hill undertook to check and confirm. 17.8.21 The contract register has been checked and there are no open ended contracts in place, all contracts let by the Health Board are for defined time periods – further update reported to committee within the external contracts report 26.8.21 .	End July Action to be closed
Actions from 24.6.21 meeting:				
Louise Brereton	**FP21/98.2 BAF** The Chair acknowledged that sometimes a higher risk level outside of the risk appetite would need to be tolerated, but he suggested that there needed to be a mechanism to record this. He was also unclear whether the target was being used to set the tolerance, or whether the target was what the organisation thought it could achieve at a point in time. The Board Secretary would take these points away for further thought. She would also endeavour to ensure a consistent report layout (ie portrait as	16.8.21	Discussion on relationships between risk tolerance and risk target will be progress via work with the GGI which may include recording on the BAF, those risks with target scores remaining outside of the appetite are to be treated or tolerated. Layout of the ABF appendices has been reviewed and made larger/ clearer (although in landscape)	

	opposed to landscape) as per Chair's preference.			
Sue Hill	**FP21/98.5 BAF** In response to a question from the Chair regarding BAF20-17 the Executive Director of Finance confirmed that the Welsh Government (WG) maturity matrix guide for value based healthcare was actively being utilised, and this would be made clearer in the updated risk.	16.8.21	Risk updated to confirm that the maturity matrix is being used.	Action to be closed
Louise Brereton	**FP21/98.6 BAF** The Chair queried why the target risk was less than the risk appetite on BAF20-20 and the Board Secretary would follow this up with the Director of Estates and Facilities.	22.7.21	This has been reviewed by the risk lead and the risk target score is now in line with the risk appetite.	Action to be closed
Louise Brereton	**FP21/98.7 BAF** With regards to BAF20-28 the Board Secretary would ensure that future narrative would reflect that the Digital Strategy had now been approved as a framework by the Health Board, whilst acknowledging there was not currently funding identified for its implementation.	22.7.21	This BAF risk has been updated to reflect the approved Digital strategy within the narrative and as a control.	Action to be closed
Mark Wilkinson	**FP21/99.3 Annual Plan**. The Chief Executive suggested that officers look at including headline	5.7.21	Update 6.8.21 - Plan refresh was submitted to Welsh Government on 30th June and included the workforce minimum dataset (MDS). Comments have been fed back to develop this	Action to be closed

	numbers for minimum recruitment and retention datasets.		aspect going forward alongside a requirement to refresh the MDS on a quarterly basis.	
Sue Hill	**FP21/99.4 Annual Plan** The Chair suggested that the financial risk and savings elements of the Annual Plan needed to align more closely with the information within the latest finance report, and it was agreed that this would be addressed before submission.	30.6.21	The Finance Report and the Annual Plan have been checked for accuracy. Both are correct. The Plan sets a requirement for the delivery of £17m of savings during 2021/22, however not all of the schemes to deliver this sum have been developed. The Finance Report presented the latest position for schemes that have been developed, which has a forecast of £10m. Work is ongoing to identify further schemes which will close the gap to £17m.	Action to be closed
Mark Wilkinson	**FP21/99.4 Annual Plan** The Chair would wish to see a clearer reference to when the Clinical Services Plan would be available and its implementation timeline.	30.6.21	Actioned. The Plan refresh was submitted to Welsh Government on 30th June. Development of the Clinical Services Plan is now progressing under the leadership of the Executive Medical Director.	Action to be closed
Sue Hill	**FP21/109.2** The Vice Chair enquired whether minimum staffing levels were written into the formal agreements with care homes and the Executive Director of Finance undertook to confirm this outside of the meeting	22.7.21	7.7.21 Not specifically included. The RISCA regulations talk about the acuity mix of the residents needs to be matched by the skill mix of the staff on duty at any one time. Specifically for an EMI home there is the requirement for 24hr RMN cover	Action to be closed
Mark Wilkinson	**FP21/120.2 Performance and Accountability Framework : Use and effectiveness** The Chair asked that the terms of reference for the Performance Oversight Group be shared	22.7.21	Update 6/8/21 - POG Terms of Reference were shared with secretariat for circulation to Committee Members as requested.	Action to be closed
Louise Brereton	**FP21/101.2 Planning Principles and Timetable 2022/25** It was suggested that a wider	16.8.21	Board workshop of 2nd December reserved for Annual Planning. Further additional workshop to be planned for November. – date to be confirmed shortly.	Action to be closed

	conversation around audiences and perceptions would be helpful at some point. The Board Secretary would look into feasibility of a board workshop session.			
Louise Brereton	**FP21/102.2 Planned Care update** The Chair noted an error in the table showing the previous waiting list total. He also noted that the F&P Committee had been listed within the table showing the evaluation of specifications process and queried whether this was appropriate. The Board Secretary would look further into this.		This was clarified outside of the meeting with Mark Wilkinson including the authorisation levels within the SORD. The planned care group terms of reference has also been reviewed by the Director of Governance as part of the implementation of the governance review.	Action to be closed
Jo Whitehead Louise Brereton	**FP/21.103.2 Unscheduled Care** The Chair referred to the draft terms of reference for the Urgent and Emergency Care Improvement Group (UECIG) and queried the indication that it was accountable to the F&P Committee. He suggested that if this was the case it would need to be a formal sub-committee of F&P. The Chief Executive and Board Secretary would pick this matter up as part of a governance and alignment conversation outside of the meeting.	22.7.21	The UECIG will not formally report to the F&P Committee but will feed into the Executive Delivery Group structure which is currently being implemented following approval of the integrated governance framework .	Action to be closed
Chris Stockport	**FP21/104.1 Transformation update** It was suggested that a written	16.8.21	Agenda item 26.8.21	Action to be closed

	report be provided to the next meeting which would outline the programme methodology, set out timeframes as part of a PMO approach, and confirm the monitoring and compliance arrangements.			
Chris Stockport	**FP21/104.2 Transformation update** In response to a comment from the Vice Chair consider how the transformation agenda could be applied to externally commissioned or outsourced services.	16.8.21	This has now been included within the Transformation plan and will be further progressed when the Director of Transformation joins the team in September. Alongside, work is currently underway to enhance our commissioning/outsourced function and the Executive Director leading this work is fully engaged with this aspect within the Transformation plan.	Action to be closed
Sue Hill	**FP21/107.4 Finance M2** The Vice Chair enquired whether the prescribing variation across West, Centre and East could be explained and the Executive Director of Finance undertook to look into this further.	22.7.21	The reasons for variation are inherently due to the starting position and demographic challenges of each of the regions, for example within the Central Area are the 2 most deprived areas of the 2,000 across Wales (Welsh Index of Multiple Deprivation, WIMD data). The Chief Pharmacist and his Senior Team have produced a more detailed demographics report and are happy to present this at a future meeting of the F&P Committee.	
Nick Graham	**FP21/108.1 Workforce Performance** The Vice Chair enquired how carried forward leave would be managed into 2021/22 and whether this would be a pressure. The Associate Director Workforce Planning and Performance confirmed this was being managed locally with central guidance but undertook to provide some detail within the next report if members	16.8.21	18.8.21 Work is ongoing and a response will be included in the August Workforce Report	Action to be closed

	would find it helpful			
Nick Graham	**FP21/108.2 Workforce Performance Report** The Executive Director of Finance noted that the report indicated in terms of establishment there were only 29 GPs in post against a budget of 63. The Associate Director Workforce Planning and Performance acknowledged this was a significant issue and he suggested that the next report could look at providing more detail around how this shortfall was being managed.	16.8.21	18.8.21 A response to this will be included in the August Workforce Report	Action to be closed
Nick Graham	**FP21/108.4 Workforce Performance Report** The Chair suggested that consideration be given to the use of a dashboard at the beginning of the report to provide headline expectations and performance against key measures. The Associate Director of Workforce Planning and Performance would give this some thought.	16.8.21	3.8.21 A draft for discussion will be included in the August Workforce Report	Action to be closed
Nick Graham	**FP21/114.1 Shared Services Partnership Committee** The Chair recalled historical issues relating to recruiting managers not being informed when a vacancy was not approved. Officers were not aware if this remained a problem but the Associate Director	22.7.21	3.8.21 Work is ongoing and a response will be provided at the August meeting	

	Workforce Planning & Performance undertook to make enquiries.			

18.8.21

Cyfarfod a dyddiad: **Meeting and date:**	**Finance & Performance (F&P) Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Board Assurance Framework (BAF)**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Liz Jones, Assistant Director, Corporate Governance
Craffu blaenorol: **Prior Scrutiny:**	Risk Management Group
Atodiadau **Appendices:**	Appendix 1 – Updated BAF principal risk sheets Appendix 2 – Key field, control and scoring guidance

Argymhelliad / Recommendation:

That the Committee review and note the progress on the principal risks assigned to it in the BAF.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The BAF incorporates the principal risks that the Board believes could adversely affect the achievement of its strategic priorities. There are currently 22 BAF risks, each with a risk sheet setting out risk scores, controls, mitigation and gaps for action. The risk sheets are live documents that are proactively re-assessed on a monthly basis and adjusted as necessary in response to the changing risk environment. Each risk is allocated to a designated committee for scrutiny and monitoring purposes; the F&P Committee has oversight of 6 principal risks as detailed below. Since the last F&P Committee meeting, each of these has been reviewed by the nominated Risk Lead, supported by the Office of the Board Secretary, and the latest iterations of the risk sheets are presented at Appendix 1.

Cefndir / Background:

The current BAF design and monitoring arrangements were approved by the Board in January 2021. The BAF works in conjunction with the Corporate Risk Register, which is concerned with risks to the organisation's operational objectives as opposed to the BAF's focus on strategic level priorities.

Ownership of the BAF rests with the Board. Day to day responsibility for its co-ordination sits with the Board Secretary, whose team works closely with Risk Leads and other Risk Management colleagues to ensure that it remains a robust, responsive and visible tool. As well as scrutiny by nominated committees, the BAF's principal risks are subject to ongoing monitoring by the Executive Team, Risk Management Group and ultimately the Board itself.

The principal risks in the BAF have been mapped across to the strategic priorities or associated enablers as set out in the Annual Plan. A wholescale review of the BAF will be required in the coming months, to ensure that it remains relevant to the priorities as the Board refreshes its overarching *Living Healthier, Staying Well* strategy. As part of this, risk appetites quoted on each risk sheet will need to be re-evaluated in light of the new Risk Management Strategy and Policy, approved by the Board on 15.7.21. Particular focus will be needed on any target scores that are higher than the refreshed risk appetite. Allocation of risks to committees will also need to be re-mapped in light of the outcomes of the governance review and resulting changes to the committee structure. In addition, following a recent Board Workshop, consideration is being given to adding a BAF risk on sustainability. The services of the Good Governance Institute have been secured to provide expert support to this process in due course.

The updated position on the BAF risks assigned to the F&P Committee is summarised below (this information is also reflected within the relevant BAF risk sheet at Appendix 1):-

BAF21-04 – Timely Access to Planned Care: Actions relating to the 'manual validation' control have progressed. The review of validation techniques and the validation of the Standard Operating Procedure have been completed and this is now ready for deployment. Actions relating to a treatment opt-in system and backlog clearance plans under the 'risk stratification' control have been completed and will become mitigations. The stage 1-3 risk stratification action has had its date extended from July to September. Actions relating to the 'plan' control have been updated to reflect consideration of an interim role. Actions under the 'Once for North Wales' control have either been completed (and will become mitigations) or have had their dates extended by a month. The tender for the outsourcing of orthopaedic activity has now been awarded and further specification for insourcing and outsourcing for other specialties is currently progressing through internal business process. The business case is progressing for an orthopaedic modular ward and theatre on each site. The inherent risk score was previously the same as the current risk score (suggesting that controls and mitigations are not being effective) - this anomaly has been corrected, with the current risk score reduced from 25 to 20, and the target risk score reduced from 15 to 12. However, the target risk score remains higher than the risk appetite.

BAF21-17 – Estates and Asset Development: In order to ensure that the BAF fully reflects the important context of the entirety of estates related risks, in particular the significant strategic challenges posed by the vastness of the Health Board's estate, its age and its fitness for purpose, greater detail has been added to the Estates Strategy control and mitigation columns. The backlog maintenance figures are now more clearly articulated to reflect the Estates Strategy's

role in understanding the size of the problem, together with an explanation of mitigation provided by the annual assessment of investment in infrastructure improvements.

BAF21-15 – Value Based Improvement Programme: The connection between VBHC and the overall Transformation approach has been established in the refreshed Annual Plan. Staff structures and roles are being reviewed to ensure alignment with the overall transformation approach. The business case approach for capturing VBHC principles has been identified. Initial projects are in progress with data capture ongoing to inform the first report to the Finance and Performance Committee in August. The Risk Lead is currently considering the anticipated date by which the target risk score will be achieved. Actions shown as complete this time will be considered for transition over into the control or mitigation columns during the next risk review cycle.

BAF21-18 – Workforce Optimisation: The date relating to the action to develop a clear workforce planning process and policy has been pushed back from June to September 2021, to reflect the date of completion rather than the date of simply getting the development underway. The action to draft the scope of the review of recruitment systems and usage also required more time and its completion date has therefore been pushed back from June to August 2021.The Risk Lead is considering the date by when the target risk score will be achieved. It is noted that this score is higher than the risk appetite.

BAF21-21- Delivery of a Planned Annual Budget: Following the sign-off of the Annual Plan 2021/22 by the Board and submission to Welsh Government, this risk will require a re-set to reflect updated financial planning considerations, the 2022/23 plan December milestone and approvable IMTP requirements. Consideration is being given to merging this risk with the BAF21-20 Annual Operational Plan risk. When the risk is re-established, it will need to incorporate the date by when it is anticipated that the target risk score will be achieved.

BAF21-22- Estates and Assets: In order to ensure that the BAF fully reflects the important context of the entirety of estates related risks, in particular the significant strategic challenges posed by the vastness of the Health Board's estate, its age and its fitness for purpose, greater detail has been added to the Estates Strategy control and mitigation columns. The backlog maintenance figures are now more clearly articulated to reflect the Estates Strategy's role in understanding the size of the problem, together with an explanation of mitigation provided by the annual assessment of investment in infrastructure improvements. The dependency of Estate rationalisation on recommendations emanating from the agile working programme has been made more explicit.

Below is a heat map representation of the BAF current risk scores for the F&P Committee's risks:

Current Risk Level		**Impact**				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood					BAF 21-04	

	Very Likely - 5					
	Likely - 4				BAF21-18	
	Possible - 3			BAF21-17	BAF21-15	BAF21-21 BAF21-22
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol /Strategy Implications
The BAF underpins the effective management of risks to the Board's ability to achieve its strategic priorities.

Opsiynau a ystyriwyd / Options considered
Not applicable.

Goblygiadau Ariannol / Financial Implications
The effective mitigation of risks has the potential to benefit the organisation's financial position, through better integration of risk management into business planning, decision-making and in shaping how care is delivered to patients. This has the potential to lead to better quality care, reduced waste and fewer claims.

Dadansoddiad Risk / Risk Analysis
The individual risk sheets contain details of any related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
There are no legal and compliance issues associated with the delivery of the BAF; the Board has a duty to manage risk to the best of its ability.

Asesiad Effaith / Impact Assessment
No specific or separate EqIA has been completed for this report, as a full EqIA has been undertaken for the new Risk Management Strategy and Policy, to which the BAF reports are aligned.

Board Assurance Framework 2021/22

Strategic Priority 2: Recovering access to timely planned care pathways

Risk Reference: BAF21-04		Risk Rating	Impact		Likelihood	Score		Appetite
Timely Access to Planned Care								
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due to a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.		Inherent Risk	5		5	25		Low 1 - 6
		Current Risk	4	↔	5	20	↔	
		Target Risk	4		3	12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Finance and Performance Committee. Introduction of further validation staff in Q3/4 non recurring complete. [Update: review of validation techniques and validation SOP completed; now ready for deployment and adoption]	2	1)Scoping of Artificial Intelligence approach to validation requires IT infrastructure and engagement of Informatics to ensure the inclusion of the scheme within the Informatics Business Plan. [Update: this has now been scoped and the AI approach will not be available until May 2022 at the earliest. Action therefore to be deleted] 2)Validation staff being recruited on a fixed term basis to continue with validation work. 3)Subject matter expert reviewing validation exercises for planned care. [Update: Introduction of patient contact validation commenced in July for stage 1 and stage 4. This is a 9 week programme until end of Sept; this will therefore become a mitigation]	1) Closed 2) 31 August 2021 3) Completed
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1)Ensure the waiting list size is continually validated and patients appropriately communicated with. 2)Waiting list initiatives introduced in Q3/4, Business case for Insourcing to support long waiting patients approved via Single Tender Waiver.	1	1) Introduce a system that allows patients to "opt in" for treatment. allowing a communication strategy to support the Q1/Q2 plan. [Update: linked to action 3 above - now implemented - will become a mitigation]. 2) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. 3) Sites and areas are completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022. [Update: complete - will become a mitigation]	1) Completed 2) 1 September 2021 3) Completed
Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Director of Regional Delivery and bi-monthly reporting to the Finance and Performance Committee.	2	Bi-monthly report to Finance and Performance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution. Thus providing continuity and sustained leadership for planned care. Shortlisted candidates. [Update: currently, the post is being considered for an interim role whilst re-advertising for a permanent position]	30 September 2021
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1)Weekly operational group with Divisional General Managers (DGMs) to ensure operational co-ordination of the Once for North Wales approach. 2)Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to Board and Welsh Government. 3) Insourcing for ophthamology introduced in February. 4) Over 52 week recovery plan for the 2019/20 end of March cohort as first phase agreed.	1	1) Introduction of insourcing into the organisation to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times [Update:out for expressions of interest] 2) Agree a strategy for planned care over the next 3 years that will improve the business process and reduce long waiting patients. 3) Review of Ophthamology Business Case in light of Welsh Government Strategy re Cataract Centres. [Update: complete - will become mitigation] 4) Additional internal activity above core is being mobilised via recovery plan. [Update: complete; will become mitigation] 5) Business case being developed for orthopaedic modular ward and theatre on each site. 6) Outsourcing of orthopaedic activity is currently being investigated with the Independent Sector. [Update: outsourcing now awarded- will becomes a mitigation]	1) 30 September 2021 2) 31 August 2021 3) Completed 4) Completed 5) 31 August 2021 6) Completed

Review comments since last report: Actions relating to the 'manual validation' control have progressed. The review of validation techniques and the validation Standard Operating Procedure have been completed and are now ready for deployment - these will transfer to the mitigation column in the next iteration of the risk sheet. Actions relating to a treatment opt-in system and backlog clearance plans under the 'risk stratification' control have been completed and will become mitigations. The stage 1-3 risk stratification action has had its date extended from July to September. Actions relating to the 'plan' control have been updated to reflect consideration of an interim role. Actions under the 'Once for North Wales' control have either been completed (and will become mitigations) or have had their dates extended by a month. The tender for the outsourcing of orthopaedic activity has now been awarded and further specification for insourcing and outsourcing for other specialties is currently progressing through internal business process. The business case is progressing for an orthopaedic modular ward and theatre on each site. The inherent risk score was previously the same as the current risk score (suggesting that controls and mitigations are not being effective) - this anomaly has been corrected, with the current risk score reduced from 25 to 20, and the target risk score reduced from 15 to 12. The anticipated date that the target risk score will be achieved is 31 March 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee and Quality, Safety and Experience Committee	**21 July 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF21-15		Risk Rating	Impact		Likelihood		Score		Appetite
Value Based Improvement Programme									
There is a risk that the Health Board does not understand or use its resources effectively and efficiently due to a lack of implementing an appropriately resourced value based improvement programme. This could impact on the quality of outcomes for the services it delivers.		Inherent Risk	4		4		16		Moderate 8 - 10
		Current Risk	4	↔	3	↔	12	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Finance & Performance (F&P) Committee oversight via standard reporting of opportunities and savings delivered.	2	Contribution to national benchmarking programmes, providing detailed analysis of service areas and opportunities.	3	The June refresh of the Annual Plan will provide further clarification regarding the way in which the VBHC Improvement Programme supports the Health Board's transformational approach. Update - The refreshed Plan identifies VBHC as a key principle within the Board's new quality improvement methodology.	Complete
F&P Committee oversight of benchmarking data & follow up work e.g. Mental Health.	2	Drivers of the Deficit analysis and external benchmarking data used to inform Annual Plan and to identify priorities for tackling efficiency opportunities, linked to service transformation.	1	Staff recruitment to be aligned with Annual Plan and broader transformation programme approach. Integrated quality improvement and transformation structure under development, which will include the VBHC team. Structure to be finalised, job descriptions signed off and banded and recrtuiment commenced.	31st August 2021
Lessons Learnt analysis from COVID reported to Executive Team, with action to mainstream innovation and value opportunities. Reporting of progress to delivering opportunities to F&P Committee.	2	National efficiency framework analysis to identify opportunities and cascade to Improvement Groups and Divisions.	1	Planning and business case approach to be reviewed to capture VBHC principles. Work ongoing to finalise , adopting learning from other Health Board approaches. Update - an approach to capturing VBHC principles has been developed and will now feed into the overall review of business case guidance which is ongoing.	Complete
Clinical Effectiveness Group re-established with oversight of Value Based Healthcare within its brief.	1	1) Executive leadership changed to reflect alignment with the broader transformation approach; Director of Primary and Community Care to lead alongside the Director and Finance. 2) Initial priorities agreed and projects initiated	2	Initial priorities identified e.g. lymphodema and orthopaedic services, with projects being established along with reporting arrangements. Update - Projects underway and adopting VBHC principles	Complete
Executive Team reviewing the opportunities analysis produced for Improvement Groups to identify potential areas of inefficiency to be addressed.	2	Finance Delivery Unit of Welsh Government have designed a maturity matrix for VBHC which will be used to guide and inform the programme of work.	2	Steering group to be established to drive the programme of work, supported by the VBHC structure. Progress reports to be provided to the Clinical Effectiveness Group. Initial group established; the approach to be aligned with the overall transformation approach as part of the Annual Plan refresh. Update - Arrangements to be re-set in line with overall transformation programme and focus on clinical pathways	31 August 2021
		Direct support secured from the National VBHC Team to support the Health Board in developing and implementating the programme.	2	Future system requirements to gather and report upon Patient Reported Outcomes under review as part of the national programme	30 September 2021
		The Draft Plan for 2021/22 confirmed that VBHC is part of the Board's overall transformation approach	2	Programme reporting established and first report submitted to the Finance and Performance Committee	26 August 2021
		Resources have been secured from the strategic support allocation to resource the VBHC Team	2	Utilise the FDU maturity matrix approach to prioritise actions and subsequently undertake a formal assessment of progress.	30 September 2021

Review comments since last report: Status of actions has been reviewed to reflect work undertaken since the last update in June. The connection between VBHC and the overall Transformation approach has been established in the refreshed Annual Plan.Staff structures and roles are being reviewed to ensure alignment with the overall transformation approach. The business case approach for capturing VBHC principles has been identified. Initial projects are in progress with data capture ongoing to inform the first report to the Finance and Performance Committee in August. The Risk Lead is currently considering the anticipated date by which the target risk score will be achieved. Actions shown as complete this time will be considered for transition over into the control or mitigation columns during the next risk review cycle.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Finance and Performance Committee	**20 July 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-17		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets Development									
There is a risk that the Health Board does not systematically review and capitalise on the opportunity to develop its estates and assets due to changes in working practices (for example agile working) which could impact on recruitment, financial balance and the reputation of the Health Board.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy, monitored by Capital Investment Group with oversight at Finance and Performance, and Strategy Partnerships and Population Health Committees and Health Board. [Taken from the current Estates Strategy, the Health Board's risk adjusted backlog maintenance figure is £53.4m and it is estimated that circa £838m of capital investment is required to ensure current estate is fit for purpose and of a reasonable standard. These figures will be updated when the Estates Strategy is refreshed.]	2	1.Disposal or acquisition of assets are signed off by the Board and Welsh Government in line with the BCUHB Scheme of Reservation and Delegation (SoRD). 2.The Health Board undertakes annually an assessment of investment in infrastructure improvements and compliance - annually update backlog maintenance and capital investment requirements through the estates and facilities performance management system (EFPMS). This is a pan Wales return from all Health Boards, which defines the level of investment required within the estate. This information is used annually to update the Estates Strategy and inform both discretionary capital expenditure and all Wales major capital programmes.	3	Health Board, through the Workforce Strategy, to agree the standards for workforce accommodation and changes in agile working practices through modern ways of working - Stronger Together.	31 March 2022
Workforce Strategy monitored by the Health Board.	2	Business Case process in place with oversight by the Executive Team, Capital Investment Group, Finance and Performance Committee and onto Welsh Government.	3	Financial Planning to be agreed and secured to support the change in working practices and a digitally enabled workforce.	31 March 2022
		Collaboration on public sector assets/corporate hubs, and regional working across North Wales.	3	Additional Resources for Asset Management function have been identified through the Health and Safety Business Case to be approved by Finance and Performance Committee.	31 March 2022
				Health Board agreed Estate rationalisation programme over three years 2021 to 2023. 2021-22 overview through Finance and Performance Committee and oversight through the Capital Investment Group.[Disposal/rationalisation will be steered by recommendations coming out of the agile working programme, which also links to Digital]	01 September 2021
				Opportunities to progress corporate accommodation hubs in partnership with North Wales Regional Public Service Providers and Local Authorities.	31 March 2022
				Update Estates Strategy to reflect demands for flexible accommodation hubs and review current and future needs for Office accommodation.	01 September 2021
				The Health Board is progressing a Programme Business Case (PBC) to address fire safety and infrastructure compliance for Ysbyty Gwynedd (YG). This PBC will be submitted to the Health Board for approval and progression to Welsh Government for funding approval. The scope of the PBC will address all risks for YG which are listed within the Corporate Risk Register. Update - the agreed PBC has been submitted to Welsh Government and feedback is awaited.	Awaiting feedback from Welsh Government
				Development of enabling plans i.e. Finance, Workforce, Digital Strategy together with a refresh of Living Healthier, Staying Well [Digital Strategy now approved as a framework by the Health Board, however there is not currently funding identified for its implementation.]	01 September 2021

Review comments since last report: The risk has been reviewed and most actions and dates remain largely unchanged at present, with the exception of progress on the Programme Business Case (PBC) to address fire safety and infrastructure compliance at Ysbyty Gwynedd. This PBC has now been agreed and submitted to Welsh Government, and a response is awaited. A positive response from Welsh Government will constitute a key mitigation. In respect of development of enabling plans, a statement has been added to reflect the fact that the Digital Strategy is now approved as a framework by the Health Board, although there is currently no funding identified for its implementation. The risk appetite is stated as being 'Moderate 8-10' and has a lower target risk score of 6 - the Director of Estates and Facilities is considering a re-set to align the scores. The dependency of Estate rationalisation on recommendations emanating from the agile working programme has been made more explicit, and the associated milestone review date extended from June to September 2021. The anticipated date that the target risk score will be achieved is 30.4.22, as that is when the main delivery phase will commence. In order to ensure that the BAF fully reflects the important context of the entirety of estates related risks, in particular the significant strategic challenges posed by the vastness of the Health Board's estate, its age and its fitness for purpose, greater detail has been added to the Estates Strategy control and mitigation columns. The backlog maintenance figures are now more clearly articulated to reflect the Estates Strategy's role in understanding the size of the problem, together with an explanation of mitigation provided by the annual assessment of investment in infrastructure improvements.

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**21 July 2021**

Linked to Operational Corporate Risks:
CRR20-07 Informatics infrastructure capacity, resource and demand.

Board Assurance Framework 2021/22

Aligned to Key enabler - Effective alignment of our people

Risk Reference: BAF21-18		Risk Rating	Impact		Likelihood		Score		Appetite
Workforce Optimisation									
There is a risk that the Health Board cannot attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could impact on the Board's ability to deliver safe and sustainable services.		Inherent Risk	4		5		20		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)G=Gap; A=Action*	Date
Establishment Control Policy and system in place. Pipeline reports produced monthly for review and action by managers across the organisation. Roster management Policy. Recruitment Policy. Safe Employment Policy.	2	1. Review of Vacancy control process underway to establish a system for proleptic/proactive recruitment against key staff groups/roles. 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention. 3.. Workforce Service Review programme commissioned and commenced.	2	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy including vacancy control and active recruitment pipeline management in place. G. Previous structure for planning and recruitment dispersed across secondary care sites, area teams, MHLD. Once for North Wales approach required. A. Revised delivery group structure developed subject to further refinement and approval. G.Use of technology requires review and improvement A.Scope for review of systems and usage to be drafted. [Update 15.7.21 - completion date pushed back from 30.6.21 to 31.8.21]	31/08/2021 31/07/2021 31/8/21
Workforce plans for each of the core priority programmes: 1. Existing USC delivery. 2. Existing Planned Care Delivery. 3. Existing TTP delivery. 4. USC Surge Plan. 5. Planned Care Recivery Plan. 6. TTP reslience plan. 7. COVID Vaccination Plan.	1	1. Review and development of a clear Workforce planning process. 2. Workforce Service Review programme commissioned and commenced.	1	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy underway *and completed.*	30/9/21
Temporary Staffing Policy. Medical Bank Protocol.	1	1. Temporary Staffing Solutions Plan under development. 2.Medical Bank established with contract with MEDACs in place for 2020/22.	1	G. Temporary bank primarily established to support Nursing and Health Care Support. A. Plan to establish BCU Temporary Staffing Solutions under development. Service to cover all staff groups and include "ready to work" pipeline.	31/07/2021

Review comments since last report: Actions and timelines have been reviewed and updated accordingly. The date relating to the action to develop a clear workforce planning process and policy has been pushed back from June to September 2021, to reflect not just getting the development underway, but also its completion. The action to draft the scope of the review of recruitment systems and usage also required more time and its completion date has therefore been pushed back from June to August 2021. The Risk Lead is considering the date by which it is anticipated that the target risk score will be achieved.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Finance and Performance Committee	**15 July 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF 21-21		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Delivery of a Planned Annual Budget									
There is a risk the Health Board spends in excess of its planned annual budget. Any financial deterioration against the financial plan may result in the Health Board breaching its statutory duties. This could affect the provision of healthcare across North Wales, potentially leading to Welsh Government intervention and reputational damage, impacting on the Health Board's ability to remain sustainable.		Inherent Risk	5		4		20		Moderate 8-10
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Board led annual operational plan, developed and approved in conjunction with Welsh Government, setting out the Health Board's key priorities	2	1. Focused financial modelling and forecasting to deliver efficiency and achieve set Welsh Government targets. 2. A structured programme to demonstrate engagement with all stakeholders to agree a realistic and achievable savings plan 3. Financial and business partnering strategy, offering clear and reliable leadership from senior management team 4. Savings Opportunities and Benchmarking shared with Budget Holders 5. Strategic Support agreed with WG to support transformational change programme to be agreed with Board in March 2021 6. Finance led analytical review of the underlying deficit and cost pressures by Division to establish how much real new money is available to cover pay and inflation 7. Finance led evaluation of the recurrent Forecast Outturn; compare with recurrent budget including the impact of COVID-19 on our spend 8. The Health Board has submitted a draft plan with a £28m financial risk as agreed by the Board.		1. Consistent approach to be adopted across Divisions, in line with best practice, from April '21 2. Finance Team stategy includes as a key outcome to develop our approach to business partnering, to maximise the finance functions contribution to divisional management teams 3. Co-produce 2021/24 Planning principles, timetable and key deliverables with ET, EMG and SPPH Committees. 4. An action plan to address the deficit is being formulated as part of the refresh Plan as at Q1 5. Plans to deliver savings against the agreed Plan need to be finalised. [Update 14.7.21 - a re-set of this risk is required]	Closed
Oversight of financial position and controls through Health Board Committees. Scrutiny through reporting to Welsh Government and the annual statutory Audit	2	1. Formal finance meetings and communication between senior colleagues in the Health Board and Welsh Government 2. Oversight arrangements in place through the Finance & Performance Committee and the Board. 3. Annual assurance of financial position by Audit Wales. 4. Annual financial programmes monitored through the Finance and Performance Committee. 5. Finance report format revised to provide clearer position on financial position and risks. Consistent reporting across all Divisions from April '21. 6. Evaluation in relation to finance capacity and capability to support Divisions in delivering timely financial plans that link to activity and workforce impacts has been undertaken. Gap analysis has been undertaken in conjunction with Divisions to assess what skills they need from finance, to ensure the structure of the team meets the needs of the senior managers		1. Embed ownership of savings by Divisional managers supported by finance. 2. Review consistency of content and format of individual Divisional finance reports.[Update 14.7.21 - a re-set of this risk is required]	Closed

Review comments since last report: Following the sign-off of the Annual Plan 2021/22 by the Board and submission to Welsh Government, this risk will require a re-set to reflect updated financial planning considerations, the 2022/23 plan December milestone and approvable IMTP requirements. The relevant Risk Leads are considering merging this risk with the BAF21-20 Annual Plan risk. When the risk is re-established, it will need to incorporate the date by when it is anticipated that the target risk score will be achieved.

Executive Lead:	**Board / Committee:**	**Review Date:**
Executive Director of Finance, Sue Hill	Finance and Performance Committee	**14 July 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-22		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets									
There is a risk that the Health Board fails to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding. This could impact on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.		Inherent Risk	5		4		20		Moderate 8 - 10
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy in place and approved by the Board in January 2019 with updates provided to the Strategy, Partnership and Population Health Committee. [Taken from the current Estates Strategy, the Health Board's risk adjusted backlog maintenance figure is £53.4m and it is estimated that circa £838m of capital investment is required to ensure current estate is fit for purpose and of a reasonable standard. These figures will be updated when the Estates Strategy is refreshed.]	2	1.Development for business case for key projects identified in key strategies. 2.The Health Board undertakes annually an assessment of investment in infrastructure improvements and compliance - annually update backlog maintenance and capital investment requirements through the estates and facilities performance management system (EFPMS). This is a pan Wales return from all Health Boards, which defines the level of investment required within the estate. This information is used annually to update the Estates Strategy and inform both discretionary capital expenditure and all Wales major capital programmes.	1	Secure WG funding to support Business Cases (short and long term).	31 March 2022
Annual Capital Programme in place and approved by the Finance and Performance Committee with regular reports provided to the committee.	2	Capital Investment Group with representation from all divisions with monthly updates to the Executive Team in place.	2	Rationalisation of the Health Board Estate.[Disposal/rationalisation will be steered by recommendations coming out of the agile working programme, which also links to Digital]	31 March 2022
		Capital Programme based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee.	2	Review undertaken and work is ongoing to secure capacity to deliver all the projects.	30 September 2021
		Selection criteria signed off by the Executive Team which links back to risk, service continuity, service transformation and sustainability.	2	Development of Digital Strategy (due to be presented to the Board on 20 May 2021). [Update - Digital Strategy now approved as a framework by the Health Board, however there is not currently funding identified for its implementation.]	Now approved
		1) Project Teams in place to deliver the business case and projects. 2) 3 year Capital Programme agreed with Executive Team and approved by F&P Committee on 25 March 2021.	1		

Review comments since last report: The risk has been reviewed and all elements remain largely unchanged. In respect of the development of the Digital Strategy, a statement has been added to reflect the fact that the Strategy is now approved as a framework by the Health Board, although there is currently no funding identified for its implementation. The Risk Lead is currently giving consideration to the anticipated date that the target risk score will be achieved. In order to ensure that the BAF fully reflects the important context of the entirety of estates related risks, in particular the significant strategic challenges posed by the vastness of the Health Board's estate, its age and its fitness for purpose, greater detail has been added to the Estates Strategy control and mitigation columns. The backlog maintenance figures are now more clearly articulated to reflect the Estates Strategy's role in understanding the size of the problem, together with an explanation of mitigation provided by the annual assessment of investment in infrastructure improvements.The dependency of Estate rationalisation on recommendations emanating from the agile working programme has been made more explicit

Executive Lead:	**Board / Committee:**	**Review Date:**
Mark Wilkinson, Executive Director of Planning and Performance	Finance and Performance Committee	**21 July 2021**

Linked to Operational Corporate Risks:
CRR20-06 - Informatics - Patient Records pan BCU
CRR20-07 - Informatics infrastructure capacity, resource and demand

Board Assurance Framework Key field guidance/ definitions of assurance levels

BAF Template Item		Please refer to the Risk Management Strategy and Policy for further detailed explanations
Risk Reference		Board Assurance Framework reference number, allocated by the Board Secretary
Risk Description		An uncertainty that something could or may happen that will have an impact on the achievement of the Health Board's Priority. There are 3 main components to include when articulating the risk description (cause, event and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ……
Risk Ratings	Inherent	Without taking into consideration any controls which may be in place to manage this risk, what is the likelihood that this risk will be realised, and if it did, what would be the consequence
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed.
Risk Impact		The consequence (or how bad) if the risk were to be realised, in line with the NPSA Grading Matrix an impact of 1 is a Negligible (very low), with a 5 as Catastrophic (very high)
Risk Likelihood		The probability that the risk will be realised. In line with the NPSA Grading Matrix a likelihood of 1 is this will probably never happen / recur, with a 5 being that it will undoubtedly happen, recur, possibly frequently
Score		Impact x Likelihood of the risk happening
Appetite	Definition	Is defined as the amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities.
	Low	Cautious with a preference for safe delivery options (Score 1 to 6)
	Moderate	Prepared to take on, pursue or retain some risks as a result of the Health Board taking opportunities to improve quality and safety of services (Score 8 to 10)
	High	Open or willing to take on, pursue or retain risks associated with innovation, research and development consistent with the Health Board's Priorities (Score 12-15)

Board Assurance Framework Key field guidance/ definitions of assurance levels

Control	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the magnitude/severity of its potential impact were it to be realised. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise and ensure that care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management] A measure that maintains and/or modifies risk (ISO 31000:2018(en))
	Examples include, but are not limited to:	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklist in place and being implemented which ensures the delivery of an objective - Training in place, monitored and assurance reported - Compliance audits - Business Continuity plans in place, up to date, tested and effectively monitored - Contract Management in place, up to date and regularly monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood and/or lessening or making less severe its impact were it to materialise. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer or take opportunity).
	Examples include, but are not limited to:	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Trained staff - Insurance procured
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the data is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified the data, for example quality, finance and H/R assurance
	3	The third level of assurance comes from assurance provided from outside the Health Board, for example WG, HIW, HSE, and Internal/External Audit etc.

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Operational Plan Monitoring Report (OPMR) – August 2021 (Reporting June 2021 Position)**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson, Executive Director of Planning and Performance
Awdur yr Adroddiad Report Author:	Ed Williams, Head of Performance Assurance Kamala Williams, Acting Director of Performance
Craffu blaenorol: Prior Scrutiny:	The Strategy, Partnerships and Population Health (SPPH) Committee received an earlier version of the report on the 12th August this report has been updated as further information has become available. Updated areas include RAG rating of actions that were previously categorised as To Be Confirmed (TBC) and a review of actions with a deadline of 30th June that were rated as green or amber.
Atodiadau Appendices:	Appendix 1 - Operational Plan Monitoring Report (OPMR) Appendix 2 – BCUHB 2021/22 Annual Plan Programme Action Plan.

Argymhelliad / Recommendation:

The Finance and Performance Committee is requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	✓	**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	✓

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.	**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This report provides a self-assessment by the Executive Leads of the progress being made in delivering the key priority actions contained in the 2021/22 Operational Plan, see appendix 2, as at 30th June 2021.

Cefndir / Background:

Executive Leads review their assigned actions and RAG-rate progress at the end of each quarter. Where an action has been completed this is RAG rated purple. Amber and red ratings apply to

actions where there are risks to delivery or where the action was not delivered in the specified timeframe, for each red and amber rated action a short narrative is provided.

RAG	Every month end	by expected delivery date	Requirements depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: A concise narrative explaining what the issues are, what is being done to resolve them and the level of risk to successful delivery of the Programme within the agreed timescale is provided.
Amber	Some risks being managed	Not Applicable	Where RAG given is Amber: A concise narrative explaining what the issues are, what is being done to resolve them and the level of risk to successful delivery of the Programme within the agreed timescale is provided.
Green	On track, no real concerns	Not Applicable	Where RAG is Green: No additional information required
Purple	Achieved	Achieved	Where RAG is Purple: No additional information required

N/A	Where the Programme or Action is not due to commence in the current reporting period.
TBC	Where the RAG rating for the Programme or Action has not been signed off in time for publication of the report.

Asesiad / Assessment & Analysis

Strategy Implications
Delivery of the operational plan actions is key to implementation of the Board's strategy

Options considered
Not Applicable

Financial Implications
The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on the financial recovery plan of the Board.

Risk Analysis
The RAG-rating reflects the risk to delivery of key actions

Legal and Compliance
This report will be available to the public once published for Finance and Performance Committee

Impact Assessment
The operational plan has been Equality Impact Assessed.

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

2021-22 Operational Plan Monitoring Report

Position as at 30th June 2021
Reported on 26th August 2021

About this Report

- The 2021-22 Annual Plan was approved by the Health Board on the 15th July 2021, this report details progress against the Programme level priority actions that underpin delivery of the Plan.
- The Annual Plan details our response to the priorities we have identified for the year ahead, specifically:
  COVID19 response
  Strengthen our well being focus
  Recovering access to timely planned care pathways
  Improved unscheduled care pathways
  Integration and improvement of mental health services
- For each Programme the responsible Executive Director has provided a RAG (Red, Amber, Green) rated assessment of progress in delivering the actions as at 30th June 2021. Supporting narrative has been included for red and amber rated actions.

RAG	Every month end	by expected delivery date	Requirements depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: A concise narrative explaining what the issues are, what is being done to resolve them and the level of risk to successful delivery of the Programme within the agreed timescale is provided.
Amber	Some risks being managed	Not Applicable	Where RAG given is Amber: A concise narrative explaining what the issues are, what is being done to resolve them and the level of risk to successful delivery of the Programme within the agreed timescale is provided.
Green	On track, no real concerns	Not Applicable	Where RAG is Green: No additional information required
Purple	Achieved	Achieved	Where RAG is Purple: No additional information required

N/A	Where the Programme or Action is not due to commence in the current reporting period.
TBC	Where the RAG rating for the Programme or Action has not been signed off in time for publication of the report.

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Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
E1.1	Pan BCU Support Programmes - Targeted Intervention: The de-escalation for Betsi Cadwaladr University Health Board from Special Measures to Targeted Intervention (TI) outlining areas for further improvement Current piorities identified for improvement: mental health, engagement, leadership, strategy and planning, planned care and performance.	Director of Governance	Milestone actions for delivery by 30th September are identified. These will be reviewed and refreshed on a quarterly basis.	G				
E1.2	Pan BCU Support Programmes - Stronger Together	Executive Director of Workforce & Organisational Development	30th June-30th September discovery; 31st December-31st March design	A				
E.3	Organisational and Leadership Development Strategy 2022-2025	Executive Director of Workforce & Organisational Development	31st December-31st March	N/A				
E3.1	Develop and deploy a programme of work, as per the Strategic Equality Plan, to support the organisation in meeting its Socio-Economic Duty	Executive Director of Workforce & Organisational Development	30th June-31st March	A				
E3.3	Implement Year 2 of the Health & Safety Improvement Plan to ensure staff are proactively protected, supported and safe. This includes providing specific guidance, training and support on legislative compliance. Identifying and supporting staff at greater risk of contracting Covid and providing specific risk assessment advice. Provide adequate manual handling training and support to staff. Investigate incidents and provide, fit test training, risk assessment advice and support staff ensuring environmental and social impacts are monitored and complied with.	Executive Director of Workforce & Organisational Development	30th September	R				

Enabler - Page 2 of 4 Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
E3.4	Security, V&A Improvement Plan	Executive Director of Workforce & Organisational Development	31st March	R				
E3.5	Occupational Health action plan and Safe, Effective Quality Occupational Health services (SEQOSH) accreditation	Executive Director of Workforce & Organisational Development	31st December	A				
E3.6	Delivery of workforce optimisation programme encouraging reduction in temporary premium cost spend and workforce efficiency addressing the following issues: High levels of vacancies, High number of leavers, Aging workforce, High agency spend, Low levels of bank provision	Executive Director of Workforce & Organisational Development	30th September - 31st December	N/A				
E1.3	Pan BCU Support Programmes - Safe Clean Care (SCC) Harm Free	Shared responsibility for sections of SCC Strategy: - Safe Clean Care Harm Free – Safe Place - Safe Clean Care Harm Free – Informatics Executive Medical Director - Safe Clean Care Harm Free – Safe Space Executive Director Nursing & Midwifery - Safe Clean Care Harm Free – Safe Action Executive Director Workforce & Organisational Development - Safe Clean Care Harm Free – Communications & Staff Engagement	30th June - Divisions to identify Business case to address SCC Strategy. 30th September - Approve/engage/research business case and strategy 31st December - 31st March - Implement new ways of working	TBC				

Enabler - Page 3 of 4

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
E.1.6	Creation of a Digital Strategy	Executive Director of Primary & Community Care	31st May	P				
			30th September	G				
E1.7	Deliver Phase 3 of Welsh Patient Administration System implementation	Executive Director of Primary & Community Care	30th June – Re-start the project.	R				
			30th September – System build and data migration.	R				
			31st December – User acceptance testing and training (UAT).	A				
			31st March – Lead to up to implementation in May 2022	A				
E1.8	Deliver Symphony - Phase 1 2020/2021	Executive Director of Primary & Community Care	30th June – Complete implementations in MIUs	P				
E1.9	Deliver Symphony - phase 2 2021/2022	Executive Director of Primary & Community Care	30th June – Data migration testing	P				
E2			30th September – End user training, Go Live period (July), Phase closure	A				
E2.1	Deliver Symphony - Phase 3 2021/2022	Executive Director of Primary & Community Care	30th September – Phase 3 planning	G				
			31st December - to be determined from 30th September planning	G				
			31st March- to be determined from 30th September planning	G				

Enabler - Page 4 of 4 Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
E2.3	Development of the acute digital health record (Cito DHR) pan-BCU	Executive Director of Primary & Community Care	31st December – * Minimum Viable Product (MVP) & two Early Adopters * New scanning contract in place	G				
			31st March – Phase Roll out programme established and underway	G				
E2.9	Strengthen cyber security	Executive Director of Primary & Community Care	30th June-31st March – (Funding to be confirmed)	R				
E1.4	Pan BCU Support Programmes - Living Healthier & Staying Well (LHSW) & Clinical strategy review	Executive Director of Planning and Performance	30th June Review of current strategy plan developed 30th September Aproval of refresh plan approve - Engagement plan developed 31st December/31st March - Engagement process initiated	A				

E1.2: Pan BCU Support Programmes - Stronger Together
Discovery phase underway. 1 2 1 conversations and focus groups (up to 6 invitees) have started. Additional facilitators for focus groups and larger workshops (up to 12 people) are being identified and trained. Master schedule of dates up to mid September for focus groups and workshops created. Live booking system for workshops created, operational from w/b 19th July to enable staff to book into workshops and for line managers to book workshops for groups of staff. Set of guiding principles created outlining process for selection of staff for 1 2 1 conversations, focus groups and workshops. Range of methods of engagement being put in place to facilitate engagement - both digital and face to face - and liaison with line managers ongoing to identify existing forums used for local staff engagement to facilitate the Stronger Together focus groups and workshops. Strategic Oversight Group (Executives) in place together with Tactical Co-ordinating Group. Linkages being made with other key strategic programmes including Safe Clean Care, Harm Free and the refresh of Living Healthier Staying Well.

E1.4: Pan BCU Support Programmes - LHSW & Clinical strategy review
Engagement plan developed. Engagement with key partners and stakeholder groups has commenced. Materials for staff and public being finalised. Review of current evidence from engagement and patient experience underway. Stakeholder relationship survey underway and final report expected early August 2021. Review of needs assessment underway supported by Public Health team and links established with Population Needs Assessment programme (RPB).

E1.7: Deliver Phase 3 of Welsh Patient Administration System (WPAS) implementation
The delay has been caused by the urgent work required to be undertaken by Digital Health Care Wales (DHCW) on the Data Centre and CaNISC (Cancer Network Information System Cymru). An agreed plan is in place for a September/October start and there is a WPAS Technical Oversight Group that is monitoring progress nationally that BCUHB are represented on. In relation to the funding we have provided our Business Case to the Welsh Government and we are working nationally to prepare a response in relation to further information required from the Welsh Government (WG) in relation to the DPIF funding. DHCW has also provided support with the funding requirements to the WG. Due to the timescale of project start in September/October recruitment has started at risk.
The project has been delayed and will start in September/October 2021.

E2: Deliver Symphony - Phase 2 2021/2022
Minor project delay in East Acute caused by delay in the sourcing a Trainer resource from Wrexham Emergency Department. A trainer is being sought. Training strategy is in place.

E2.9: Strengthen Cyber Security
Funding has been secured by way of diverting predicted cost improvements from programmes to recruit cyber security and compliance manager role. Successful recruitment of this role has now taken place and the candidate has accepted the position. Further funding has also been secured to recruit the remaining posts within the cyber security team. Recruitment for these posts will commence during August/September. The action delivery still remains red as there is a National shortage of suitably experienced and qualified personnel in the ICT security sector.

E3.1: Develop and deploy a programme of work, as per the Strategic Equality Plan, to support the organisation in meeting its Socio-Economic Duty
BCUHB response submitted for Welsh Government Consultant on Race Equality Action plan. BCU Race Equality Action Group being established in Q2, chaired by Acting Assistant Director of Organisational Development (ADOD) for Organisational Development with Executive sponsorship. Proposal to include delivery of equality and inclusion duties in divisional accountability and performance reviews under active discussion with Director of Governance and Director of Performance including creation of balanced scorecard to monitor progress with embedding equality duties in operational services. Appointment of 2 additional Equality and Diversity Inclusion Managers secured to further support embedding of equality and inclusion as business as usual and to support provision of additional subject matter expert advice to the organisation. Equality training for all post holders 8A and above (and Band 7 and above) in Workforce & Organisational Development (WOD) underway. Terms of reference of all Equality groups revised to include delivery of Socio-Economic Duty (Equality and Human Rights Forum, Equality Delivery Group, Equality Stakeholder Group).

E3.3: Implement Year 2 of the Health & Safety Improvement Plan
There is a business case that has been to Executives on the 23rd June for training and required further review. There is a revised business case for manual handling training staff and H&S Leadership training going to Executives on the 28th July 2021. The outcome of the business case review, will assist in determining if adequate controls can be implemented to minimise the significant hazards identified.

E3.4: Security, V&A Improvement Plan
There is a business case that has been developed that includes staffing requirements for Security provision for BCUHB and will be viewed on the 28th July 2021 by the Executives. The outcome of the business case review will assist in determining if adequate controls can be implemented to control the hazards identified.

E3.5: Occupational Health action plan and Safe, Effective Quality Occupational Health services (SEQOSH) accreditation
As part of the business case planning work it was identified that a comprehensive immunisation and Health Surveillance programme is required. This forms part of the Occupational Health action plan.

COVID-19 Response - Page 1 of 3

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
E1.5	Enhanced recovery from critical illness The provision of robust and consistent staffing within traditional 'medical' critical care rotas to ensure patient safety	Executive Medical Director	30th June - 30th September Development of Business Case 31st December Business Case submitted for internal sign-off and approval 31st December / 31st March Development of a programme plan, recruitment ready for implementation 2022	A				
C1	Ensure adequate testing capacity is available across North Wales in line with the revised Welsh Government Testing Strategy. * Lab Turnaround Times for swabs is a Public Health Wales (PHW) responsibility * Contracts for Regional, Local and Mobile testing units and Welsh Ambulance Service NHS Trust (WAST) are Welsh Government managed contracts) Testing capability located across the region to ensure the volume of testing slots are adequate and able to provide a test within 24 hours and easily accessible preferably no more than 30 minute drive. Lateral Flow Devices (LFD) issued in accordance with Welsh Government policy; currently manage the distribution across the Health Board and LFD collect points via the existing testing infrastructure for the population who are not able to work from home (all other distribution managed by Welsh Government)	Executive Director of Public Health	Measure through capacity and Turnaround Times. Immediate and to be continued through to 31st March – capacity to be reviewed on receipt of regional modelling from the national team and not expected to be reduced before 31/3/22.	G				

COVID-19 Response - Page 2 of 3

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
C1	Ensure adequate testing capacity is available across North Wales in line with the revised Welsh Government Testing Strategy. * Lab Turnaround Times for swabs is a PHW responsibility * Contracts for Regional, Local and Mobile testing units and WAST are Welsh Government managed contracts) Testing capability located across the region to ensure the volume of testing slots are adequate and able to provide a test within 24 hours and easily accessible preferably no more than 30 minute drive. Lateral Flow Devices (LFD) issued in accordance with Welsh Government policy; currently manage the distribution across the Health Board and LFD collect points via the existing testing infrastructure for the population who are not able to work from home (all other distribution managed by Welsh Government)	Executive Director of Public Health	Immediate and to be continued through to 31st March – capacity to be reviewed on receipt of regional modelling from the national team. No plans to reduce capacity.	G				
			30th September – capacity plans are in the progress of being built now with the planned care services. The target is to ensure there is adequate capacity to provide the required PCR testing within a 72 hour pre treatment period.	G				
			30th September evaluate 31st December devices implemented subject to effectiveness of evaluation	A				
			31st May	G				
			30th June – in place by the end of 30th June and on-going until WG policy determines otherwise	G				
C1.1	Deploy effective tracing service with partners across North Wales to minimise transmission of virus and adapt the service provision as Welsh Government policy evolves.	Executive Director of Public Health	By 30th June and on-going through 2021-22	G				
				A				
C1.2	Continue North Wales liaison on protect agenda coordinating multi-agency response	Executive Director of Public Health	30th September and ongoing	A				

COVID-19 Response - Page 3 of 3

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
C1.3	Implement and deliver the BCUHB mass vaccination programme.	Executive Director Nursing & Midwifery as Senior Responsible Officer (SRO) – Mass Vaccination Programme	The Vaccination Strategy for Wales currently sets out 3 milestones based on the Joint Committee on Vaccination & Immunisation (JCVI) prioritisation advice.	P				
			Milestone 1: To have offered the vaccine to all individuals in cohorts 1–4 by mid February. BCUHB achieved this along with other Health Boards in Wales on 12 February 2021.	P				
			Milestone 2: To have offered the vaccine to all individuals in cohorts 1-9 by mid April. That includes all those aged 50 and over. BCUHB achieved this and along with other Health Boards in Wales on 4 April 2021.	P				
			Milestone 3: It is our aim to offer everyone in the current 10 priority groups their first dose of the vaccine by the end of July 2021. We remain on target to achieve this next milestone.	P				
			Future milestones based on the next phase including the booster programme are expected in Quarter 2 via the Welsh Gpovernment (WG). This will also include guidance and criteria.	G				
			By 31st December					
C1.5	COVID recovery - all Children's Services	Executive Director Primary & Community Care	30th June – Baseline assessment.	G				
			30th September - Service Level plans to deliver agreed.	A				
			31st December-31st March - Ongoing performance monitoring via Regional Childrens Services Group.	A				

E1.5: Enhanced recovery from critical illness
Recruitment of Clinical Psychologists has been unsuccessful. Further adverts will be placed and alternative sources of Clinical Psychologists sought.

C1: Point of Care testing devices to be evaluated and implemented to support the rapid turnaround of tests for patients arriving in departments such as the Emergency Departments (ED). Roche Liat and Lumira devices being evaluated for different departments.
LIAT - Each of the three ED departments have a LIAT device. The rapid diagnosis will aid patient management (8 tests per day).
ID Now - ID Now devices are currently used in Maternity Services. Additional devices are being sought for Ophthalmology and Paediatrics.
Lumira - IT connectivity for Lumira has been identified as the main risk for progressing the use of the Lumira DX system.

C1.1: Deploy effective tracing service with partners across North Wales to minimise transmission of virus and adapt the service provision as Welsh Government policy evolves.
Due to a reduced demand on Tracing services during Q1, the staffing available from the various teams was sufficient to meet demand. The sudden increase in demand during Q2 has necessitated a revised recruitment campaign for Tracing services. Regional modelling relating to predicted future demand was not available until June 21. Staffing requirements have been linked to the likely future demand, and a rolling recruitment programme agreed through the Regional Track, Trace & Protect (TTP) Oversight Group.

C1.2: Continue North Wales liaison on protect agenda coordinating multi-agency response
Under the “Protect” element of Track, Trace & Protect (TTP), proposals were formulated to establish five COVID-19 support Hubs in areas of identified deprivation. During Q1, four of the hubs were established, with the fifth scheduled for early July 2021.

C1.5: COVID-19 Recovery - all Children's Services
Trajectories established for Neurodevelopment and Mental Health Measure (MHM) in CAMHS recovery plans in place

Recovering access to timely planned care pathways - Page 1 of 5

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R1	Continuation of accuRx communication platform, to provide IT infrastructure to enable GPs and other health professionals working in primary care to undertake remote consultations, share information with patients and to update the patients' clinical records with the consultation event.	Executive Director Primary & Community Care - Acting Executive Medical Director	30th June	P				
			30th June	P				
			30th September	G				
			31st December	G				
R1.1	Review the uptake, requirements and patient satisfaction in relation to alternative/new technologies supporting patient access to GMS	Executive Director Primary & Community Care	30th June	P				
			30th June	P				
			31st December	A				
			30th September	G				
			31st December	G				
			31st March	G				
R1.2	Delivery of all Wales access standards through GMS Contract (detailed in non-mandated Quality Assurance and Improvement Framework (QAIF)	Executive Director Primary & Community Care	30th June	P				
			31st March Rolling contractual programme	P				
			30th June-30th September	P				
			30th June-31st March	G				
R1.4	Working with planned care programme leaders to ensure a whole system response to patient demand pressure areas (also refer to planned care section)	Executive Director Nursing & Midwifery	30th June	A				
			30th June	G				
			30th June	A				
			31st March	G				

Recovering access to timely planned care pathways - Page 2 of 5

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R1.6	Further development of the Primary and Community Care Academy	Executive Director Primary & Community Care	30th June	R				
			30th June	R				
			30th September	N/A				
			30th September	N/A				
			31st December	N/A				
			30th September	N/A				
			31st December	N/A				
			31st December	N/A				
			31st December	N/A				
			31st March (published 22/23)	N/A				
R1.7	Development of a North Wales Dental Academy, to include a training unit, General Dental Services (GDS) and Community Dental Services (CDS) provision	Executive Director Primary & Community Care	30th June	P				
			30th June	P				
			30th September	G				
			30th September	N/A				
			31st March	N/A				
R1.8	Implementation of the dental contract reform (as directed by Chief Dental Officer/Welsh Government)	Executive Director Primary & Community Care	31st March	G				
R1.9	Commission additional general dental provision	Executive Director Primary & Community Care	31st December	G				

Recovering access to timely planned care pathways - Page 3 of 5

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R2	Relaunch of a community pharmacy care home enhanced service to form part of our recovery plan.	Executive Director Primary & Community Care	31st March	G				
R2.3	Delivery of advanced practice audiology in primary care and provision of Ear Wax Management Services (subject to business case approval / additional funding)	Executive Director of Primary & Community Care	31st March	A				
R2.7	Delivery of agreed planned care recovery schemes (including additional programme management capacity), to include diagnostics, e.g. endoscopy, laminar flow theatres and inpatient T&O bed provision (including relocation of outpatient therapy provision in Wrexham)	Executive Director Nursing & Midwifery	30th June-Develop and agree a plan	G				
			31st March- delivery of cohort 1 with exception of orthopaedics	G				
R2.8	Build additional capacity to deliver COVID19 safe services, improve patient experience and waiting times.	Executive Director Nursing & Midwifery	31st December	A				
			30th September	A				
			30th September	A				
R2.9	Support orthopaedic patients facing extended waiting times as a result of COVID19 constraints, by delivering a non-surgical treatment programme such as escape from pain, digital apps	Executive Director Nursing & Midwifery	31st December	A				
R3.2	Insourcing to support provision of service for cohort 1&2 Outsourcing specification for Orthopaedics	Executive Director Nursing & Midwifery	30th June	A				
R3.4	Develop the Outpatient transformation programme Including 'Once for North Wales', workforce modernisation and digital enablement of staff and service users with attend anywhere and consultant connect.	Executive Director Nursing & Midwifery	Phased delivery over 12 months from point of recruitment, anticipated delivery by 31st March if recruitment and implementation successful	A				
R3.5	To explore external capacity to support access to treatment	Executive Director Nursing & Midwifery	30th June out to tender, insourcing early July- If these time frames work then outsourcing could be August insourcing September.	A				

Recovering access to timely planned care pathways - Page 4 of 5

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R3.6	Development of sustainable endoscopy services across North Wales	Executive Director Nursing & Midwifery	31st March	A				
R3.7	Deliver suspected cancer pathway	Executive Director Nursing & Midwifery	30th June 69% 30th September 69% 30th December 71% 31st March 75%	G				
R4	Implementation of short term insourcing solutions for computerized tomography, magnetic resonance imaging and ultrasound to significantly reduce the backlog of routine referrals	Executive Director Nursing & Midwifery	30th September	A				
R4.1	Implementation of insourcing solutions for neurophysiology to significantly reduce the backlog of routine referrals	Executive Director Nursing & Midwifery	30th September	A				
R4.2	Development and commencement of implementation of long term plans for sustainable diagnostic services (radiology and neurophysiology)	Executive Director Nursing & Midwifery	31st March	A				
R4.5	Increase specialist cancer therapy staff to meet All Wales benchmark: Produce a business case to appoint specialist allied health professional (dietitians/speech and language therapist)	Executive Director Nursing & Midwifery	30th September	G				
R4.6	Eye Care Services: transform eye care pathway: Enable work to progress on strategic service developments eye care	Executive Director Nursing & Midwifery	Already initiated with pump priming last year, continuation secured through previous funding whilst BC approval expected June 2021 enables re-tendering exercise by end 30th September	G				
R4.7	Enable work to progress on strategic service developments urology	Executive Director Nursing & Midwifery	Procurement by 30th June Delivery Robotic Assisted Surgery (RAS) 30th September Urology redesign and implementation along with RAS training 31st December/31st March 0 tbc by Urology review group July 2021	A				

Recovering access to timely planned care pathways - Page 5 of 5

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R4.8	Implementation of the glaucoma pathway	Executive Director Nursing & Midwifery	31st March	A				
R4.9	Implementation of the diabetic and age-related macular degeneration pathways	Executive Director Nursing & Midwifery	31st March	R				
R10.2	Ensure Safe and Effective Care	Executive Director of Public Health	Action 1: 31st December	A				
			Action 2: WG Initiative	R				
			Action 3: informed by WG timetable	A				
			Action 4: 30th September	A				
			Action 5: 30th June	G				
			Action 6: 30th June	G				
			Action 7: 30th September	A				
			Action 8: 31st March	A				
			Action 9: 31st March	A				
			Action 10: 30th September	A				
			Action 11: 31st December	G				
			Action 12: 31st December	G				
			Action 13: 30th September	A				
R10.4	Implement Sustainable Quality Care	Executive Director of Public Health	Action 1: 30th June	G				
			Action 2: 31st December	A				
			Action 3: 31st March	G				
			Action 4: 31st December	G				
			Action 5: 30th September	G				

Recovering access to timely care pathways - Narrative

R1.1: Review the uptake, requirements and patient satisfaction in relation to alternative/new technologies supporting patient access to GMS
Monthly reports produced detailing level of activity and summary of patient satisfaction. Regular meetings with practices to review support available. Stakeholder meeting scheduled for September 2021. Processes to monitor this have not yet been developed, with the exception of eConsult. This will be further considered in Quarter 2.

R1.4: Working with planned care programme leaders to ensure a whole system response to patient demand pressure areas (also refer to planned care section)
Work has commenced to relauch the waiting times dashboard but previous methodologies no longer provide an accurate estimate of likely waiting times. This is mainly due to the impact of the pandemic in terms of prioritisation of treatment. 'Dummy' reports are to be run in August with a review of usefulness for referrers and new patients. Primary Care colleagues are being kept informed of progress.

Clusters and area teams are working together to develop proposals and other health boards have shared some of their actions. Most developments will require additional funding and there is a concern regarding workforce capacity and fatigue. GP practices are to be asked to provide core data in relation to chronic conditions management in order to best inform proposals.

R1.6: Further development of the Primary and Community Care Academy
Business Case was submitted for review as the first step of the approval process on 22nd June 2021. Awaiting feedback at a meeting arranged for 26th July 2021, before submitting to the Executive Team for considerations.
Further development of the Academy depends on the outcome of the business case. Awaiting approval of business case to progress all actions in this Programme. The Academy continues to successfully deliver ongoing programmes.

R2.3 Delivery of advanced practice audiology in primary care and provision of Ear Wax Management Services (subject to business case approval / additional funding)
Implementation delayed until approvals of Business Case received which is scheduled to be considered at the August Performance, Finance & Information Governance (PFIG) Committee
Current optimal window for recruitment as BSc Audiology students graduate from Swansea University with bursary tie in to work in Wales and from other UK Universities.

R2.8: Build additional capacity to deliver COVID19 safe services, improve patient experience and waiting times.
First pass risk stratification has been undertaken, but requires quality assurance by Secondary Care Management and Clinicians.

R2.9: Support Orthopaedic Patients facing extended waiting times as a result of COVID by delivering non-surgical treatment programmes
Discussed on 9th July 2021 and a view was expressed that non-Orthopaedic waiters could also benefit from support whilst awaiting treatment, which in many cases, would be similar, e.g. increasing activity, decreasing smoking, support with weight management, pain management and symptom control. Services to support these activities already exist and it may be optimal to build on those, rather than work to create a new service. This was reported at the Planned Care Transformation Group on 6th August 2021. We will now wait to obtain a steer as to how the prehab pathway work is to be taken forward.

R3.2: Insourcing to support provision of service for cohort 1&2 and Outsourcing specification for Orthopaedics.
Insourcing specification not yet launched, with a need to resolve the approach with the Orthopaedic LLP in West Wales.
Orthopaedic outsouring contract evaluated and awaiting ratification. Mixed outsourcing tenders expected 06/08/2021.
First pass risk stratification has been undertaken, but requires quality assurance by Secondary Care Management and Clinicians.

R3.4:Develop the Outpatient transformation programme. Including 'Once for North Wales', workforce modernisation and digital enablement of staff and service users with attend anywhere and consultant connect.
2-year Outpatient Strategy, which incorporates allowing improved access for patients and reduce waiting times, including enablers to equality of care across the Health Board, whilst moving BCUHB into a one Health Board with many location model, as opposed to many locations reporting to one Health Board, thus standardising the outpatient administration and patient support function across the Health Board, whilst moving BCU into a digital outpatient service. The benefits mentioned in this initiative will support the delivery of this action.

R3.5: To explore external capacity to support access to treatment
Orthopaedic outsourcing contract evaluated and awaiting ratification. Mixed outsourcing tenders expected 06/08/2021. Insourcing specification not yet launched, with a need to resolve the approach with the Orthopaedic Limited Liability Partnership (LLP) in West Wales.

R3.6: Development of sustainable endoscopy services across North Wales
Final draft business case being reviewed, and once finalised, will progress through the Health Board business case approval process. Capacity and demand has been agreed, and revenue costs calculated, with national funding available for year 1 of £8.2m. Insourcing currently implemented on 3 hospital sites to address backlog and increase demand. Outsourcing procurement process underway, and plan to implement in Q4 2021/22. Recruitment of sustainable workforce also underway.

Project structure in place, with Executive Director Sponsor (Adrian Thomas), and an Senior Responsible Officer (SRO) in place. Planned Endoscopy service based on accredited the Royal College of Physicians Joint Advisory Group (JAG) standards including protocols, Standard Operating Procedures (SOPs) and agreed clinical pathways that underpin the Service. This includes a plan to standardise and update the Endoscopy Management Systems, linking in with other Health Board systems.

R10.2: Implement the National MiS solution for Wales (HIW, November 2020).
The MIS Project Initiation Document (PID) has been presented to the Chief Executive Officers in Wales. Welsh Government have agreed the Job Description for an MIS National Project/ Digital lead but not out to advert yet. One Health Board has procured the BadgerNET solution ahead of a national decision. Confirmation that all 7 HBs in Wales have queried the accuracy of the 2020 Maternity Statistics published by WG in May which informed the WG Maternity Performance Boards with HBs in July. Hence, WG are in active discussions with Digital Healthcare Wales (DHCW) to assess the risk in using or publishing any further data. The National Maternity Data Oversight Group will not be meeting again until a WG/DHCW position is agreed.

R4, R4.1 & R4.2: Implementation of short term insourcing solutions for computerized tomography, magnetic resonance imaging, ultrasound and Neurophysiology to significantly reduce the backlog of routine referrals. Development and commencement of implementation of long term plans for sustainable diagnostic services (radiology and neurophysiology)
Progressing solutions but hampered by difficulties sourcing temporary staff and space as well as in seeking permanent staff.

R4.6: Eye Care Services: transform eye care pathway: Enable work to progress on strategic service developments eye care
Business case agreed/signed-off June 2021, sites progressing recruitment against staffing that enables increased activity delivery. EoL Equipment replacement submission to WG successful/with delivery completed March 2020. National Digital Eye Care Digital systems planned Go Live implementation . Tendering of Primary ODTCS and Primary Practices to extend current & achieve additional Eye Care Pathways in active progression. IVT capacity maximisation pathway development in active development, with: training of nurse-injectors.

R4.7: Enable work to progress on strategic service developments urology.
Agreed destination for robot in Ysbyty Gwynedd. Director of Regional Delivery to produce scoping plan for Urology in August 2021.

R4.8: Implementation of the glaucoma pathway
Glaucoma pathway implemented in Q2 2020. Delivery ongoing with performance trajectory improving. Tendering process in active progression for September 2021

R4.9: Implementation of the diabetic and age-related macular degeneration pathways
Pre-Proliferative Diabetic Pathway for follow-up patients implemented in Q3 2020, performance improvements ongoing. Prudent Diabetic Retinopathy Primary - Secondary care pathway development proposals in development with sites. Clinical engagement events in place to develop additional Pathway proposals for inclusion in August 2021 Outpatient Transformation bid.

Improved unscheduled care pathways - Page 1 of 4

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R1.3	Development of urgent primary care centres as pathfinders, feeding into the national programme of work for primary care.	Executive Director Primary & Community Care	30th June	P				
			31st December	G				
			31st March	G				
			31st March	G				
I1.1	Implementation of Single Care Home Action Plan	Executive Director Primary & Community Care	30th June. Secure Funding for additional Quality Posts. Questionnaire to partners. Hold two workshops to agree components of the Quality Assurance Framework (QAF). Draft QAF by end of 30th June. Recruit to Quality Posts.	G				
			30th September Conclude recruitment and undertake engagement with providers and key stakeholders.	G				
			31st December Refine QAF and commence Implementation.	G				
			31st March Full implementation	G				

Improved unscheduled care pathways - Page 2 of 4

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
I1.2	Transformation of Community Services - Home First Bureau	Executive Director Primary & Community Care	30th June – Baseline data being collected. 30th June – Review of Home First Bureaus 30th September – Review of baseline data 30th September – Home First Business Case approved and all posts recruited to. 30th June – Training and education across system. 30th September – Gap analysis and recruitment 31st March – Ongoing monitoring	G A G A				
I1.3	Transformation of Community Services - Development of Frailty Pathways to deliver on the vison of Welsh Government for sustainable and integrated Community Health & Social Care.	Executive Director Primary & Community Care	Ongoing 30th June – workforce review. 30th September/ 31st December – extend Multidisciplinary Team (MDT) model from South Wrexham to Central Wrexham and North West Wales Centre –30th June – design 30th September – Recruit 31st December – Implement 31st March – monitor East 30th June Marleyfield West - Ysbyty Gwynedd (YG) Frailty unit – on hold, funding not confirmed. Led by acute. West Frailty model in place West - MDTs established in Ynys Mon and Arfon – roll out to remaining areas by 31st December	A G A A A				

Improved unscheduled care pathways - Page 3 of 4

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
I1.5	Community Services Transformation Programme: Continued implementation of regional and area-level transformation plans, aimed at developing place-based, integrated models of care and support increasing skills and capacity within primary care, community health and social care, to deliver care and support in people own homes and communities.	Executive Director Primary & Community Care	30th June-31st March– ongoing implementation of regional and area-level programmes of work	G				
			31st March – Sustainability planning for post programme continuation	G				
I1.7	Increased capacity within Community Resource Teams (CRTs) to support patients to be cared for in their own homes.	Executive Director Primary & Community Care	30th June: Staff recruited with Winter Planning monies to continue in post, linked to Community Resource Teams (CRTs). Data collection 30th September: Evaluation of service and business case to secure ongoing funding and contingency planning for exit strategy 31st December: subject to funding, recruit and deploy additional Healthcare Assistants (HCAs) to support care delivery outside hospital 31st March Secure permanent funding, subject to further evaluation	G				
I1.7	Transformation of Child and Adolescent Mental Health Services (CAMHS) - Targeted Intervention Performance and Improvement Programme.	Executive Director Primary & Community Care	30th June – Baseline assessment	G				
			30th September - Developed Improvement Framework and structure	G				
			31st December -31st March & Ongoing Performance improvement monitored monthly at Strategic CAMHS Improvement Group. Ongoing Self-Assessment in line with reporting to Board Meetings.	N/A				

Improved unscheduled care pathways - Page 4 of 4

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
I2.1	Emergency Department access and patient flow (Welsh Access Model / Emergency Department Quality and Delivery Framework / Frailty and Acute Medical Model)	Executive Director Nursing & Midwifery	31st March implementation Welsh Access Model (WAM) – 31st March KPIs – Complete, although will be periodically published throughout 2021/22 – 30th June, 30th September, 31st December, 31st March	G				
			NESIs PE – Ongoing through to 31st March SE – Ongoing through to 31st March	G				
			PIPs: All to be in place by 31st March	G				
I2.2	Full year effect of 2020/21 Winter Plan and development of Winter Plan 2021/22	Executive Director Nursing & Midwifery	30th September	G				
			30th September	G				
			30th September	A				
I2.3	Same Day Emergency Care (SDEC)	Executive Director Nursing & Midwifery	30th September	A				
I2.4	Developing the unscheduled care hub, 111 service	Executive Director Nursing & Midwifery	30th June - Phase 1	P				
I2.6	Implement Discharge to Recover & Assess (D2RA) pathways through further development of Home First Bureaus in each area	Executive Director Nursing & Midwifery	31st December	A				
I2.7	Stroke Services: Enable work to progress on strategic service development - confirm and agree the stroke service model	Executive Director Nursing & Midwifery	Stroke Prevention – 30th September	G				
			Acute services – 30th September	G				
			ESD – 30th September 20% / 31st December 70% / 31st March 100%	G				
			Specialist Community inpatient beds – 30th September	G				
			Consistent approach to rehabilitation – 31st March	G				

I1.2: Transformation of Community Services - Home First Bureau
Review of Home First Bureau's (HFB) completed and recommendations shared with Area Directors (ADs). East HFB have recruited a clinical co-ordinator to support the co-ordination, links with acute site management and ensure patients. Baseline data collected and report available. Some service is reliant on redeployed staff, and whilst metrics are recorded, further investment is required to fully implement Home First. The East Area team are leading on the update to the business case.
Business case has not been approved and further work has been asked to show where the disinvestment will come from. Currently running Central HFB with redeployed staff and we do not have staffing fully aligned to the business case. To implement HFB recommendations we would need the business case investment as the service is at risk and has been instrumental in managing the loss of beds due to social distancing within the Central Area. East Area team are leading on updating the business case. EAST: Paper written to support Elderly Mentally Infirm (EMI) pathways and supported across acute and area. Working group established. Included as part of priorities within Unscheduled care improvement programme. EAST: Pharmacy have been supporting medicines reconciliations in Care homes and will maintain this work; bringing pharmacy and community services closer together to ensure stronger partnership working West: Business case in development for additional Pharmacy staff capacity to support community hospital / community Resource Teams (CRTs).

I1.3: Transformation of Community Services - Development of Frailty Pathways to deliver on the vison of Welsh Government for sustainable and integrated Community Health & Social Care.
Currently available in Dwyfor and Mon, and parts of Arfon. Meirionnydd solution needs to be looked at. Nurse consultant posts included as part of Hospital@Home bid; therapy consultants being appointed as part of Stroke business case. Ysbyty Glan Clwyd (YGC) frailty units approval has slipped from July to August due to annual leave. The process will seek approval in August for recruitment to start and phased approach to model to begin with existing resources as per model recommendations. Model has been clinically led. Ysbyty Gwynedd (YG) / West Frailty Unit business case completed with submission imminent and then awaiting approval. Marleyfield beds due to open 9th August (following delay due to COVID-19 status of home in early July); confirmation is awaited from Care Home Inspectorate Wales (CIW) regarding the registration. Staff have attended induction and ready to start work. West: Outline discussions have taken place and increased pharmacy capacity included within the final bid.

Improved unscheduled care pathways - Narrative

I2.2: Review of 2021-22 winter schemes including impact and spend to effectively inform winter plan 2021-22
A review of West area schemes was completed in June, the remaining schemes for other areas will be included as part of prioritisation ofwork-streams / projects within the USC Improvement Programme .

I2.3: Further develop and establish SDEC models across the 3 acute sites to better manage urgent care demand into a more scheduled way
A proposal is being submitted to Welsh Government (WG) on 6th August for funding from the WG £25m funding for urgent and emergency care. Successful delivery of a 12 hour / 7 days a week service for medical and surgical ambulatory patients is reliant on additional investment. Response from WG awaited regarding BCU allocation. Contingency plans required to fund part or all of the amount asked for within proposal if not supported by WG.

I2.6: Implement Discharge to Recover & Assess (D2RA) pathways through further development of Home First Bureaus in each area
Home First Bureau (HFB) set up in all 3 Health Communities. As part of the Unscheduled Care Improvement Programme we will look at opportunities to improve working relationships with the Local Authority colleagues as well as improving flow out of the hospital.

Strengthen our population health focus - Page 1 of 1								
Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
R2.6	Neurodevelopment (ND)- improve access to services to meet WG 26 weeks assessment targets and further develop early intervention post diagnostic services.	Executive Director Primary & Community Care	30th June – Baseline assessment.	A				
			30th September - Improvement Plan and structure to deliver agreed.	N/A				
			31st December/4 - Ongoing performance monitoring via ND Regional Steering Group.	N/A				

Strengthen our population health focus - Narrative

R2.6: Neurodevelopment (ND)- improve access to services to meet WG 26 weeks assessment targets and further develop post diagnostic intervention post diagnostic services and establish early interventional support

Position paper completed for submission to executive team for agreement of funding. Review by WG agreed to support capacity and demand planning for ND services. Identification of capacity through existing tender to support increased capacity through 2021/22.

Integration and improvement of mental health services - Page 1 of 3

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
M1.1	Quality Improvement & Governance: Implementation of ward accreditation to improve fundamentals of care and leadership.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, scope programme of work	R				
			30th September, agree plan for roll-out	N/A				
			31st December/31st March implement	N/A				
M1.2	Workforce Wellness & Organisational Development: We will enhance leadership within the Division and seek to actively support staff in their workplaces to maintain optimum wellbeing.	Interim Executive Director of Mental Health & Learning Disabilities	30th June agree scheme plan	P				
			30th September/31st December/31st March implementation	N/A				
M1.3	Ablett / YGC MH Inpatient Redesign: We will continue to work with Corporate Planning colleagues to design on the YGC site for the provision of Adult and Older People's Mental Health inpatient services in the Central Area.	Interim Executive Director of Mental Health & Learning Disabilities	30th June	P				
			31st March, dependent on planning permissions outcome	G				
M1.5	CAMHS: We will develop an appropriate interface with child and adolescent mental health services to ensure the most effective transition for young people with mental health conditions into adult services.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, develop improvement plan	R				
			30th September, agree plan	N/A				
			31st December-31st March begin to implement improvements	N/A				
M1.6	Safe & Timely Discharge: We will introduce a programme of work across the division to review long length of stay and delayed transfer of care.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, review work to date	P				
			30th September, agree plan and begin roll-out	N/A				
			31st December-31st March, on-going work with adjustments as required	N/A				
M1.7	Dementia Care: Delivery of clinically led, safe and effective services will be further developed aligned with the dementia strategy.	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September develop master scheme	A				
			31st December-31st March begin implementation	N/A				

Integration and improvement of mental health services - Page 2 of 3

Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
M1.8	Older Persons (OPMH): Development of Crisis care support for older adults (over 70) with an acute mental illness over the age of 70 and people of any age living with dementia.	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September develop master scheme with supporting SOPs	R				
			31st December-31st March begin implementation	N/A				
M1.9	Early Intervention Psychosis: Enhancing the current Multi-disciplinary Team with trained and developed multi-disciplinary staff to provide best quality services for patients and families.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	P				
			30th September, begin recruitment	N/A				
			31st December, integrate in to local teams	N/A				
			31st March, evaluate	N/A				
M10	Forensic Services: Development of a model for forensic and low secure provision for both mental health and learning disabilities services in North Wales.	Interim Executive Director of Mental Health & Learning Disabilities	30th June – 30th September develop system pathway with supporting workforce plan	R				
			31st December Develop options appraisal	N/A				
M10.1	Learning Disabilities: We will implement the strategy for learning disabilities services in partnership with people with lived experience, their families, health and social care organisations across North Wales and the voluntary sector.	Interim Executive Director of Mental Health & Learning Disabilities	30th June – 30th September develop system pathway with supporting workforce plan	A				
			31st December Develop future options appraisal	N/A				
			31st March Evaluate work programme to date	N/A				
M10.2	Maternal Care & Perinatal Services: To enhance delivery of clinically led, safe and effective services for mother and babies that require perinatal mental health services.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	P				
			30th September, begin recruitment	N/A				
			31st December, integrate in to local teams	N/A				
			31st March, evaluate	N/A				
M10.3	Primary Care & ICAN: To build on actions from within the Winter Plan and further develop the demand and capacity modelling to continue to review and improve patient flow between primary and secondary care. To work with Primary Care Services together with ICAN to offer direct and rapid access to wider ranging support supported by trauma informed approaches at cluster level.	Interim Executive Director of Mental Health & Learning Disabilities	30th June Engagement with primary care clusters	R				
			30th June Recruitment of OTs for model across North Wales	R				
			30th September Internal and external promotion of ICAN primary care model with GP Clusters and partner agencies	N/A				
			31st December-31st March evaluate impact	N/A				

Integration and improvement of mental health services - Page 3 of 3								
Plan Ref	Programme	Lead Director	Target Date	Jun-21	Sep-21	Nov-21	Jan-22	Mar-22
M10.4	Psychological Therapies: To increase access to psychological therapies across both mental and physical health services.	Interim Executive Director of Mental Health & Learning Disabilities	31st March	A				
M10.5	Rehabilitation Services: To agree a long term model for rehab services and support whole system patient flow pathways.	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September review and agree plan	A				
			31st December, seek Divisional approval and consider funding requirements	N/A				
			31st March finalise plan	N/A				
M10.7	Unscheduled Care & Crisis Response: We will further develop an all age crisis response pathway.	Interim Executive Director of Mental Health & Learning Disabilities	31st December	G				
M10.8	Eating Disorders: To address the significant deficits in service provision for early intervention and treatment and to improve the clinical needs and challenges of current Eating Disorder (ED) service provision in North Wales and North Powys.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	P				
			30th September, begin recruitment	N/A				
			31st December, integrate in to local teams	N/A				
			31st March, evaluate	N/A				
M11	Liaison: To provide an appropriate and consistent psychiatric liaison response across North Wales.	Interim Executive Director of Mental Health & Learning Disabilities	30th June, scope requirements	R				
			30th September, develop and agree a plan	N/A				
			31st December, agree proposals	N/A				
			31st March, implement	N/A				
M11.1	Partnership & Engagement: To deliver clinically led, safe and effective services in partnership with patients, their families, social care and third sector colleagues.	Interim Executive Director of Mental Health & Learning Disabilities	31st December	G				

M1.1: Quality Improvement & Governance: Implementation of ward accreditation to improve fundamentals of care and leadership.
The ward accreditation nurse is in place and is working through with the Heads of Nursing for wards currently white and the plan for movement towards Bronze Currently the 3 white wards (Dyffydwy, Cynan, Aneurin) have had a revisit and are awaiting validation panels later this month.

M1.5: CAMHS: We will develop an appropriate interface with child and adolescent mental health services to ensure the most effective transition for young people with mental health conditions into adult services.
We have completed a business case for 0.8milllion additional transformation funds. This work will support a set of agreed clear objectives to develop transition arrangements. Once Business Case is approved, is It is hopeful that we will complete the initial development of the project action plan by the end of Quarter 2.

M1.7: Dementia Care: Delivery of clinically led, safe and effective services will be further developed aligned with the dementia strategy.
The Covid-19 pandemic impacted on the Dementia Work during 2020 and into 2021 as the focus moved to patient safety, however a lot of this has since been picked up in the last quarter. Additional clinical leadership in the form of two new consultant nurses is anticipated from 1st July. The division is involved in implementing not only the National Dementia Strategy for Wales but also the integrated Dementia Strategy for North Wales and, in planning to meet the new all Wales dementia standards. In particular the division is firmly committed to and involved in the Dementia Strategy Group (DSG) for North Wales which is attended by the Interim Deputy Director for MHLD.

The focus on the six steps continues and is embedded within the 'making every contact count' approach which sits across all Older People's Mental Health (OPMH) services and will be further strengthen as the integrated dementia strategy for North Wales is operationalised. During Q1 the service has not only had to look at restarting services, but also to learn how to deliver services differently and in line with restrictions. This means that the progress has not been as we would have wanted in some areas but in recovering from the upheaval of the pandemic the emphasis is firmly on integrated working to foster progress in subsequent quarters.

With regards to the links with audiology, an Integrated Care Fund (ICF) funded project has been launched in the Gwynedd and Anglesey area to assist with the identification of hearing impairments in patients who have suspected dementia. The hope is to roll this out across all areas BCUHB during 2021/22. The ICF funding has now been extended to 2021/22 as not much data could be gathered during COVID-19.

M1.8: Older Persons (OPMH): Development of Crisis care support for older adults (over 70) with an acute mental illness over the age of 70 and people of any age living with dementia.
We are currently in the process of finalising the Business Case in partnership with OPMH colleagues to provide additional resource to support service change in this area of work. It is hopeful that recruitment will complete by the end of Q2.

M10: Forensic Services: Development of a model for forensic and low secure provision for both mental health and learning disabilities services in North Wales
This work had been initially stepped down due to COVID-19. Demand and Capacity paper has been developed which demonstrates the demand for Low Secure provision in North Wales. An outline business case for Low secure services in North Wales will need to be developed. This will require significant capital investment and project management support which is currently not available.

M10.3: Primary Care & ICAN:
To build on actions from within the Winter Plan and further develop the demand and capacity modelling to continue to review and improve patient flow between primary and secondary care. To work with Primary Care Services together with ICAN to offer direct and rapid access to wider ranging support supported by trauma informed approaches at cluster level.
Project plan in place. Locally agreed protocols – West and East Area protocols agreed. Discussions with Central Area have commenced with protocols discussed. Recruitment process for key staff in West and East Areas planned for June/ July with staff in post by end July – slight delay in process but should align with project plan milestone. West Pilot underway since March 2021 with regional roll out planned for July in East and January in Central. Training Plan in planning stages – roll out August 2021. Evaluation framework finalised awaiting sign off. West and East GP surgeries identified, mapping of provision for Central Area GP surgeries underway. Stakeholder Group(s) will feed into the learning / evaluation process – members to be identified and first meetings to be arranged in West and East by end June. Data sets established. Communication Plan established. Regular Engagement events arranged and wider engagement with 3rd sector.

M10.5: Rehabilitation Services: To agree a long term model for rehab services and support whole system patient flow pathways.
The programme board had been step down during COVID-19. But has now been re-established with an initial board meeting held on the 25/05/2021 where work streams aligned to the programme where reviewed and re-established. Demand and capacity review has been completed and a bed base model under development. Community Resource Team Standard Operating Procedure (SOP) completed in draft for presenting at Clinical Strategy Group alongside revised proposed pathway for Rehabilitation services.

M10.1: Learning Disabilities (LD): We will implement the strategy for learning disabilities services in partnership with people with lived experience, their families, health and social care organisations across North Wales and the voluntary sector.

Learning Disabilities Partnership Board continues to oversee the implementation of the LDS Strategy.

The LD Transformation Project Fund currently has circa £500,000 to be spent by December 2020. It is intended that the majority of this money will be used to support new developments (e.g. pilots, kickstarts) in line with identified priorities in accordance with the North Wales LD Strategy and the mapping and development work of the LD Transformation Project.

Aligned to the transformational work BCUHB and Anglesey LA are also piloting a pooled fund for adults with learning disabilities resident in Ynys Mon who require joint funding to access or sustain supported living arrangements. This is a key project within the LDTP portfolio and a significant step towards formal integrated arrangements between the health board and LD social services.

Pooled Budget Agreement Sign now required by BCUHB Finance – this will require action in Q2.

Review of ECRS services has been recently approved that will include: Scope of review:

- All 4 funded supported living properties: Y Maes, Tawel Fan, Hafan Dawel, Hafanedd
- All 12 individuals within the above properties
- Service model and staffing structure
- Re-visiting the Rightsizing Review, 2016 – completed by FCC and BCU

This is being completed by LD nurse reviewer from CHC and social worker from Flintshire.

With the Focus Areas being:

- Consider the most recent care and support review for all individuals
- Consider the most recent health plans for all individuals
- Comparison of the above information against the Rightsizing Review, 2016
- Consider further or new opportunities, since 2016: telecare/ telehealth, staffing structure
- Consider developing some of the projects to meet the Transformational agenda to include Step up Step down and complex challenging behaviour specialist accommodation services.
- Funding arrangement: CHC, joint funding etc.
- Day services and community opportunities for all individuals
- Service model: training, roles, principles, outcomes
- Covid-19 arrangements: pre-Covid and current support models

The RAG status of the Transformational work is currently Amber, however is on track to deliver in year.

M10.4: Psychological Therapies: To increase access to psychological therapies across both mental and physical health services.

1. We have mapped service provision in Tiers 0/1, identifying workforce gaps which have been addressed in part within the 2021/ 2022 Additional Resources for Mental Health Funding business case proposal.

2. We have submitted Welsh Government (WG) Target Compliance data for adult mental health secondary care specialist psychological interventions, and for the last 3 years progressed steady improvements by ongoing improvement initiatives.

3. Wider workforce gaps have been mapped, including Primary Care Mental Health (PCMH) and Community Mental Health Teams (CMHTs).

4. Implementation of Matrics Cymru and the National Plan guidance has been rolled out.

5. We have set up the Stepped Care Initiative to co-ordinate and lead improvement work across primary, secondary, inpatient, and tertiary services and the Multidisciplinary Teams (MDT) workforce within the Mental Health & Learning Disabilities (MH&LD) Division. Additional clinical provision across all areas and Tiers has been provided, and an on-going training, supervision, and support workforce plan and workshop programme within the MH&LD for MDT staff across multiple tiers and services established. This has delivered training and skill competencies in Cognitive Behavioural Therapy (CBT) , Dialectical Behavioural Therapy (DBT), and standardised remote and in person group and individual psychological therapy/intervention packages for over 100 MDT staff. In addition we have created and linked with this Stepped Care Initiative a new additional dedicated adult mental health training resource of 0.2 wte Clinical psychologist, and 0.4 wte CBT therapist. This has enabled the creation of a Psychological Therapies Training Team in partnership with Child Services and Bangor University. This has now delivered to over 90 MH&LD MDT staff across Adult Services, including Learning Disabilities, Substance Misuse Services, Forensic & Rehabilitation, Adults & Older Adults. A training strategy and plan has been developed in collaboration with the North Wales Psychological Therapies Management Committee (PTMC) and local MDT staff, aimed at standardised and accredited psychological therapies training and CBT Diploma accreditation status for MDT staff across Adult & Child Services.

6. We have secured funding for a Traumatic Stress North Wales Clinical Lead, who will further support Trauma specific and Trauma Informed MDT service provision across the MH&LD Division and adult services in multiple settings. This role will further support a training and support workforce plan for Trauma specific and Trauma informed service provision across MDT services and multiagency whole system working. As part of this initiative, we have secured funds and arranged for 25 MDT clinical staff from across the MH&LD division (from LD, Older Adults, Forensic & Rehab, SMS, and AMH) to attend Eye Movement Desensitization and Reprocessing (EMDR) Training via the EMDR Academy. We have a Training Implementation Plan around this to monitor skill acquisition, uptake of supervision, and implementation (monitoring of provision of EMDR to service users in the service area) to measure the impact of this investment over the next 3 years.

7. This work is part of the Together for Mental Health strategy, and supports the plans and strategic direction of the All Wales Psychological Therapies Management Committee, the North Wales Psychological Therapies Management Committee, Traumatic Stress Wales, the MH&LD's strategic aims, and BCUHB's Targeted Intervention priorities.

M11: Liaison: To provide an appropriate and consistent psychiatric liaison response across North Wales.

We are currently in the process of finalising the Business Case for additional resource to further develop the pathways and workforce within the psychiatric liaison service across North Wales. It is hopeful that once funding is confirmed, recruitment will complete by the end of Quarter 2.

Further Information

Further information is available from the office of the Director of Performance which includes:

- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website www.bcu.wales.nhs.uk
- Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

We also post regular updates on what we are doing to improve healthcare services for patients on social media:

follow @bcuhb
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Board Level Monitoring	Ref	Key Priority COVID-19 response Strengthen our population health focus Recovering access to timely planned care pathways Improved unscheduled care pathways Integration and improvement of mental health services	Lead (Job Title and contact person)	Programme (What)	Action (How)	Programme/Patient Outcome (Why)	Lead Director	Target Date (When)	Risks	Finance	Target improvement linked	Board Level Monitoring	Board or Board Scrutinising Committee
Y	E1.1	Enabler	**Executive Director of Governance programme sponsor (specific actions allocated to Exec lead portfolios)**	Pan BCU Support Programmes - Targeted Intervention The de-escalation for Betsi Cadwaladr University Health Board from Special Measures to Targeted Intervention (TI) outlining areas for further improvement Current priorities identified for improvement: mental health, engagement, leadership, strategy and planning, planned care and performance.	• Engage and communicate internally within the divisions, and with partners and stakeholders on the Maturity Matrix approach (CAMHs and Adult MH). • Progress the joint working between CAMHs and Adult MH, with a focus on financial allocations and the transition pathway. (CAMHS and Adult MH). • Establish the improvement and development group to support the CAMHs programme delivery (CAMHS). • Review the MHLD leadership structure, with leads identified to support the key delivery areas (Adult MH). • Progress the crisis concordat activity to support our clinical pathway focus (Adult MH). • Undertaking a stakeholder mapping exercise and develop a relationship management approach to relevant stakeholders in the domains of patient, partners, staff and public. • Consolidate a team for engagement across the four engagement domains, drawing from best practice. • Use the development of key strategies (i.e. Living Healthier, Staying Well and Clinical Service Strategy) as a PDSA exercise to improve engagement process and outcomes. • Develop an engagement process to encourage openness, transparency and trust with our citizens. Leadership priorities for the next quarter: • Ensuring executive, senior leadership and partner ownership and engagement in the delivery of discovery phase of Mewn Undod mae Nerth/Stronger Together. • Aligning the Board development programme with Mewn Undod mae Nerth delivered by the King's Fund with additional support from the Good Governance institute. • Reviewing clinical leadership support structures and resources to improve multi professional clinical engagement. • Mobilising additional capacity and capability to support transformation, organisational and system development, engagement and governance • Starting the refresh of Living Healthier Staying Well. • Using the refresh as the basis for our Clinical Services Strategy implementation plan. • Develop a revised planning process to allow for a draft approvable IMTP to be agreed for 2022-25. • Implement and embed the Performance and Accountability Framework including regular reviews, appropriate escalation, and revised performance reporting.	Programmes of work have been informed by the established maturity matrices which will be used to assess progress against the targeted intervention framework in 2021/22.	Director of Governance	Milestone actions for delivery by 30th September are identified. These will be reviewed and refreshed on a quarterly basis.		Core Funding	Y	Y	
Y	E1.2	Enabler	**Associate Director of OD**	Pan BCU Support Programmes - Stronger Together	Establish and mobilise the 3 year strategic organisational and system development route map, Mewn Undod Mae Nerth/Stronger Together, comprising 3 phases - Discovery, Design and Deliver. The Discovery phase is an ambitious 3+month engagement process to talk with 10% of the BCU workforce through a combination of 1 2 1 conversations, focus groups and workshops. This extensive engagement across all areas of the Health Board will provide key thematic feedback from staff and provide the foundation for a 9 month design phase of Mewn Undod Mae Nerth/Stronger Together to renew the Health Board's culture and organisational systems, aligned to the Health Board's strategic goals and purpose .	Listening to the experiences of staff working across the Health Board to learn from examples of best practice and understand what may be preventing staff from making further improving delivery of exemplar patient care pathways. The Discovery phase makes no assumptions about what the solutions may be and thus enables the co-production with staff of improvements to the health board's culture and organisational systems.	Executive Director of Workforce & Organisational Development	30th June-30th September discovery; 31st December-31st March design		Core Funding	Y	Y	
Y	E.3	Enabler	**Associate Director of OD**	Organisational and Leadership Development Strategy 2022-2025	The development of an Organisational and Leadership Development Strategy 2022-2025 which is aligned to Mewn Undod Mae Nerth/Stronger Together. The development of the strategy will be informed by the discovery phase of Mewn Undod Mae Nerth/Stronger Together and will be developed as a key part of the subsequent design phase of Mewn Undod Mae Nerth/Stronger Together to ensure the Health Board's organisational design and its leadership are enabled to deliver the Health Board's strategic goals and purpose during the final delivery phase of Mewn Undod Mae Nerth/Stronger Together	An organisational and leadership development strategy aligned to and informed by the strategic organisational and system development route map of Mewn Undod Mae Nerth/Stronger Together to enable delivery of organisational and leadership development interventions that support the Health Board's strategic goals and purpose over the next 3-10 years	Executive Director of Workforce & Organisational Development	31st December-31st March		Investment case for Design phase of Mewn Undod Mae Nerth to include funding to support delivery of the organisational and	Y	Y	
Y	E4.1	Enabler	**Associate Director of OD**	Aligment of Board and senior leadership development as part of the development of an Organisational and Leadership Development Strategy 2022-2025	The development of an Organisational and Leadership Development Strategy 2022-2025 during the design phase of Mewn Undod Mae Nerth - informed by the discovery phase - will include evidence based targetted development programmes for Board members and all senior leaders, as well as for all levels of leaders across the Health Board, inclusive of clinical and non-clinical leaders	To better enable the Health Board to delivery its strategic goals and purpose over the next 3-5 years through providing Board members and senior leaders with evidence based leadership development support and training	Executive Director of Workforce & Organisational Development	Q3-Q4		Investment case to support design phase of Mewn Undod Mae Nerth/Stronger Together to include funding to support	Y	Y	
Y	E4.2	Enabler	**Associate Director of OD**	Continue to execute improvements in staff safety, support, wellbeing and resilience in order to improve attendance, retention and contribution.	Two key programmes will be undertaken to improve Health and wellbeing and creation of a culture of psychological safety. The first will enhance the services available to support staff's mental health through the implementation of a more integrated model of staff wellbeing support services from supporting self-care through to crisis support. The second programme will implement a new Speak Out Safely process, replacing the Safe haven system, to better enable staff to raise concerns confidentially. This will include the creation of a Speak Out Safely Guardian and an MDT to receive, manage and monitor concerns raised, supported by a new on line system for raising concerns in an confidential and anonymous manner	Through the staff wellbeing support service, support and promote enhanced emotional resilience and wellbeing amongst staff, reducing staff absence, improving recruitment and retention, and supporting the Health Board becoming an employer of choice. through the new Speak Out Safely process, support the creation of a culture of psychological safety at work, and through this support the delivery of safe patient care	Executive Director of Workforce & Organisational Development	Q3-Q4 for staff wellbeing service; Q1-Q2 for Speak out safely		12 month investment to support enhanced wellbeing support service agreed. Funding to support new Speak out	Y	Y	
Y	E3.1	Enabler	**Associate Director of OD**	Develop and deploy a programme of work, as per the Strategic Equality Plan, to support the organisation in meeting its Socio-Economic Duty	Implement Year 2 of the Health Board's approved Strategic Equality Plan, delivery being monitored through the Strategic Equality and Human Rights Forum. As well as meeting its Socio-Economic duty and other equality priorities, there will be a focus on race equality with the establishment of a Race Equality Action Plan, taking account of the outcome of the Welsh Government's consultation on Race Equality in 30th June.	Delivery of inclusive patient services and management of staff, ensuring patients with protected characteristics are not disadvantaged in such a way as to adversely impact on health care outcomes and that staff are not disadvantages in terms of recruitment, development, training and promotion opportunities.	Executive Director of Workforce & Organisational Development	30th June-31st March	Public Sector Duty and Socio-Economic duty on risk register	Investment case to expand corporate equality team completed	Y	Y	
Y	E3.3	Enabler	**Associate Director Of Health, Safety & Equality -**	Implement Year 2 of the Health & Safety Improvement Plan to ensure staff are proactively protected, supported and safe. This includes providing specific guidance, training and support on legislative compliance. Identifying and supporting staff at greater risk of contracting Covid and providing specific risk assessment advice. Provide adequate manual handling training and support to staff. Investigate incidents and provide, fit test training, risk assessment advice and support staff ensuring environmental and social impacts are monitored and complied with.	Ensure effective Health and Safety through Make It Safe reviews, incident investigations achieved via incidents reported on Datix, 72 hour reviews undertaken tracking on line lists with liaison with infection control and Track and Trace. This will then determine if it will be required to be reported as a RIDDOR incident inline with legislative compliance which is required within 10 days. Site visits are reported through Quarterly and annual reports to the Strategic Occupational Health Group and QSE. Union partners are kept up to date on compliance issues on a weekly basis. The frequently asked questions and guidance provided to staff is updated when legislation or guidance is changed. The fit testing programme in place to support suitable compliance with COSHH and HSE guidance. A continual programme of fit testing is in place and recorded on ESR system with reports provided to PPE steering group for escalation. A package to ensure that manual handling training is effectively implemented has been presented with a recommended program to move from 58% compliance to 85% within 2 years, risk assessment awareness and management of safety critical systems have established training dates. A full action plan to comply with legislation has been developed for Y2 and evidenced through the appropriate governance structure and reporting on KPI's.	Reduce the risk of transmission patient to patient staff to patients, patients to staff. Ensure safe systems of work are implemented in all service areas.	Executive Director of Workforce & Organisational Development	30th September	BAF risk register programme	Core funding required	Y	Y	
Y	E3.4	Enabler	**Associate Director Of Health, Safety & Equality**	Security, V&A Improvement Plan	Ensure adequate security provision is in place including restraint training, clinical audit system, lone working, lockdown procedure, V&A case management compliance with Welsh Security Framework and further development of the obligatory response to violence collaborative. A 12 month action plan has been developed subject to additional support to review all aspects of the security gap analysis.	Effective management of violence reduces the risks of absenteeism, stress in the workplace leading to better patient safety outcomes and staff retention.	Executive Director of Workforce & Organisational Development	31st March	BAF risk register programme	Core funding required	Y	Y	
Y	E3.5	Enabler	**Associate Director Of Health, Safety & Equality**	Occupational Health action plan and Safe, Effective Quality Occupational Health services (SEQOSH) accreditation	A workplan to establish effective Health Surveillance has been developed to be completed within 12 months. This includes review of respiratory sensitisers, latex, noise, vibration, night workers, nitrous oxide, welding fumes and dusts. A review of wellbeing is in place developing more effective KPI's to report on numbers of people accessing support in conjunction with the Wellbeing Cell. The group plans to report in August 2021 defining progress on action plans. The Occupational Health Team report to the strategic Occupational Health Group. A plan to implement a immunisation programme is defined with the 3 year business case. The SEQOSH accredited system ensures continual reporting on the action plan is being implemented. The Corporate Health Standards form part of the Wellbeing Programme a comprehensive action plan has been developed to maintain accreditation in July 2021.	Continue to maintain all aspects of Safe Effective Quality Occupational Health Service accreditation. Implement a comprehensive immunisation and health surveillance system. Effectively support the staff Wellbeing Strategy and improve mental health support for staff.	Executive Director of Workforce & Organisational Development	31st December	BAF risk register programme	Core funding required	Y	Y	
Y	E3.6	Enabler	**Associate Director of Workforce Planning & Performance**	Delivery of workforce optimisation programme encouraging reduction in temporary premium cost spend and workforce efficiency addressing the following issues: High levels of vacancies, High number of leavers, Aging workforce, High agency spend, Low levels of bank provision	Workforce Optimisation programme structure put in place. Ensure effective recruitment team structures and resources are in place. Workforce KPIs and targets in place and tolerances set to monitor and identify.	Reduction in vacancies and leavers across targeted areas. Reduction in agency spend as a result of filling long term vacancies. Clear workforce KPIs in place to monitor and provide early warning indicators	Executive Director of Workforce & Organisational Development	30th September - 31st December	BAF risk register programme	Business case in place with money identified in the financial plan	Y	Y	
Y	E1.3	Enabler	**Associate Director of Nursing - Infection Prevention, Nursing Midwifery & Patient Services**	Pan BCU Support Programmes - Safe Clean Care Harm Free	Develop a programme of work to ensure we are' Making our place safe through, clean wards, safe bed space, safe entry, safe break and safe change' . Through Safe clinical and non-clinical areas (transfers), safe wards and safe rapid isolation. Ensuring our actions are safe, for patients, visitors and staff. Support the workstreams release more time to care through; Infection prevention and control cockpit development. Building designing and purchasing IT enables solutions Develop tools/ material to support the behavioural change Safe Clean Care workstreams	Providing a safer place providing health for North Wales population, reducing infection spread. identifying areas of improvement across the wards and hospital to support safe care. Improving the place of work for staff, reducing injury at work. Developing and using digital technology solutions to improve delivering and monitoring safe ways of working.	Shared responsibility for sections of SCC Strategy: Chief Operating Officer - Safe Clean Care Harm Free – Safe Place - Safe Clean Care Harm Free – Informatics Executive Medical Director - Safe Clean Care Harm Free – Safe Space Executive Director Nursing & Midwifery - Safe Clean Care Harm Free – Safe Action Executive Director Workforce & Organisational Development - Safe Clean Care Harm Free – Communications & Staff Engagement	30th June - Divisions to identify Business case to address SCC Strategy. 30th September - Approve/engage/research business case and strategy 31st December - 31st March - Implement new ways of working		COVID Funded / Capacity & capability		Y	

y	E.1.6	Enabler	**Head of Programmes, Assurance and Improvement**	Creation of a Digital Strategy	Development and implementation of the digital strategy which has been approved by the Board.	To deliver key enablers across North Wales which will drive digital transformation of care and deliver commitments outlined within the Strategy over the next three years.	Executive Director of Primary & Community Care	31st May	• Approval at Trust Board is not received. • Competing priorities with lack of sustainable investment in digital • National infrastructure and projects may not deliver what is needed and/or at the required pace • Unable to keep up with the pace of digital change to meet the expectations of our patients, carers and staff • Information is not safe • Insufficient staff capability and capacity to deliver the Strategy • Organisational culture and service planning does not change • Lack of enagement from staff	Business Case approval for difference projects will be required.		y	Board & FPIG
	E.1.6							30th September					
y	E.1.7	Enabler	**Project Manager**	Deliver Phase 3 of Welsh Patient Administration System implementation	Phasing and approach agreed	Delivery of a single patient administration system Welsh Patient Administration System (WPAS) -across BCUHB. This will streamline the care process and enable up to date accurate information to be available for service delivery across the Health Board. Improve the ability to manage patient pathways seamlessly throughout the hospitals within the Health Board. Provide timely and accurate information for clinicians and managers. Enable services to modernise in response to changing working models. Reduce variation in scheduling, tracking and reporting throughout the Health Board.	Executive Director of Primary & Community Care	30th June – Re-start the project.	Corporate Risk - CRR10A/INF01 National Infrastructure and Products. Project level risks: There is a risk that key resources (project and services) will not be available to support key activities on the project. There is a risk that project will continue to defer the scope of the data migration iterations. There is a risk that operational users are unable to attend WPAS training There is a risk that slippage in either the BCU or the Velindre data migration plan may impact overall WPAS timescales. There is a risk that BCU do not have sufficient resources to keep up with the demands of a complex data migration activity.	Funding through WG until September 2021. Business case has secured funding for post 2021 required from WG.		y	Board and FPIG
	E.1.7				Support from Welsh Government for continuation of project team in place			30th September – System build and data migration.					
	E.1.7				System in place (pending business case)			31st December – UAT user acceptance testing and training.					
	E.1.7							31st March – Lead to up to implementation in May 2022					
y	E.1.8	Enabler	**Programme Manager**	Deliver Symphony - Phase 1 2020/2021	Implement V2.39 in the West ED and 6 Minor Injury Units associated with the West (including LLGH)	Phase 1 required before WPAS West implementation – West ED and MIUs were previously using PMS to record attendances. Phase 1 complete (with the exception of 2 MIUs which are currently closed with no imminent plans to re-open). The system will bring: • Improved Continuity and Timeliness of Care • Improved Quality of Patient Care, Experience and Safety • Improved Discharge • Improved Data Quality and Standards • Improved Data Sharing across BCUHB and Intelligent • Improved Administration Efficiency The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board.	Executive Director of Primary & Community Care	30th June – Complete implementations in MIUs	Health Board risk - BAF20/28 - Effective Use of Resources Project level risks: • There is a risk that resource may become an issue for the project if Establishment Control/Recruitment cannot be achieved in a timely manner. • There is a risk that Tywyn and Dolgellau MIUs will not be able to implement BCU Symphony at a time which is suitable for both the MIUs and the project team. • There is a risk that generic log on to the system may not be an acceptable method to be used for Information Governance purposes.	Funded		y	Board & FPIG
y	E.1.9	Enabler	**Programme Manager**	Deliver Symphony - phase 2 2021/2022	Upgrade from V2.29 to V2.39 Move East area onto the Health Board Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including 1 minor injury unit associated with the East	Phase 2 will bring improved functionality and the latest version of Manchester Triage. Manchester Triage 1 is currently used within Symphony 2.29 in the East. This version of Manchester Triage is out dated and has been flagged as a significant clinical risk as both presentation flow charts and discriminators have been updated in newer versions. The benefits listed in Phase 1 will also apply to Phase 2. The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board.	Executive Director of Primary & Community Care	30th June – Data migration testing	Health Board risk - BAF20/28 - Effective Use of Resources. Project level risks: •There is a risk that resource may become an issue for the project if Establishment Control/Recruitment cannot be achieved in a timely manner. •There is a risk that Tywyn and Dolgellau MIUs will not be able to implement BCU Symphony at a time which is suitable for both the MIUs and the project team. •There is a risk that generic log on to the system may not be an acceptable method to be used for Information Governance purposes. •Availability of adequate funding (Capital and Revenue) •Availability of key personnel to undertake the enabling activities required for readiness (EMIS, NWIS, BCU Programmes, Information and ED resource)	Funded		y	Board & FPIG
	E2	Enabler						30th September – End user training, Go Live period (July), Phase closure					
y	E2.1	Enabler	**Programme Manager**	Deliver Symphony - Phase 3 2021/2022	V2.39 implemented in Central and 2 minor injury unit's	The completion of the Phase 3 implementation will see all ED/MIU areas using a single system for the time, providing standardisation across BCU in readiness for a move to the National Welsh Emergency Department system. The benefits listed in Phase 1 will also apply to Phase 3. The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board.	Executive Director of Primary & Community Care	30th September – Phase 3 planning	To be determined from planning in 30th September	Funded		y	Board & FPIG
	E2.1				Implement Symphony v2.38 into 2 minor injury units in Central area			31st December - to be determined from 30th September planning					
	E2.1							31st March- to be determined from 30th September planning					
y	E2.3	Enabler	**Head of Patient Records & Digital Integration**	Development of the acute digital health record (Cito DHR) pan-BCU	Deliver the project for the Digital Health Record (4 year project to Nov 2024)	The development of the Digital Health Record will allow a single view of the patient record, having this in place will support the integration with local and national systems and will provide greater access to systems and information that are safe and reducing the use of paper from the how we work. We will have one system that is capable of gathering patient information from scanned records, new content from e-forms and current and future systems. Part of this project is also to develop digital ways of sharing information across our borders.	Executive Director of Primary & Community Care	31st December – * Minimum Viable Product (MPV) & two Early Adopters * New scanning contract in place	The common risks across the digital projects are escalated to our Patient Records Transition Programme. There can be described as * Spectrum of digital readiness and literacy amongst users * BCU is non-compliant with key legislation * Digital readiness of the organisation - infrastructure, hardware and network * Quality of the data within the source system causing data within other linked systems to be inaccurate * A delay to the project achieving its objectives, due to emerging events/issues e.g. Covid, new corporate initiatives	Funded		y	Board & FPIG
	E2.3							31st March – Phase Roll out programme established and underway					
Y	E2.9	Enabler	**Head of ICT**	Strengthen cyber security	Review and identify areas of improvement as part of Cyber Security Providing Assurance that all necessary measures are taking place to reduce and manage the risk of a Cyber security.	Providing Assurance that all necessary measures are taking place to reduce and manage the risk of a Cyber Incident through the deployment of key processes, accreditation and risk management as well as new and emerging technologies.	Executive Director of Primary & Community Care	30th June-31st March – (Funding to be confirmed)	Corporate Risk - ICT01 – Cyber Security There is a risk of cyber security attacks due to a lack of assurance around cyber security threats and lack of a dedicated Cyber Security Team which could lead to a total loss of all Health Board data stored on BCU servers. This could impact patient care, Health Board reputation, confidentiality, and breaches of legislation, financial impact (fines and cost of recovering data). If this risk is not addressed it could lead to the organisation not meeting legislative requirements such as GDPR and NIS-D. We could also be open to Civil suits should patient safety incidents occur as a result of a cyber-attack.	Not funded.		Y	Board & FPIG
Y	E1.4	Enabler	**Assistant Director of Strategy and Planning**	Pan BCU Support Programmes - LHSW & Clinical strategy review	Take stock and check with staff, patients, partner organisations and the public how Covid-19 has affected health and well-being and what we can learn from this experience. Review lessons learnt and strategy successes, challenges, opportunities. Develop plan to implement lessons learnt initiatives into a new strategy with new objectives. Create dissemination of new strategy to ensure engagement with stakeholders	• Check in with our staff, patients, partners and public whether the principles are still valid • Review our strategic priorities to ensure they are consistent with "A Healthier Wales" • Address those elements of LHSW that proved challenging to implement e.g. an integrated system wide approach to healthcare and integrated care pathways • Test the strategy is still relevant in the changed environment • Provide the framework for development of a Clinical Services Plan	Executive Director of Planning and Performance	30th June Review of current strategy plan developed 30th September Approval of refresh plan approve - Engagement plan developed 31st December/31st March - Engagement process initiated		Core Funding	Y	Y	
Y	E1.5	COVID-19 response	**Consultant - Anaesthetics & Intensive Care / Clinical Lead for Critical Care**	Enhanced recovery from critical illness The provision of robust and consistent staffing within traditional 'medical' critical care rotas to ensure patient safety	Enhanced recovery from critical illness by meeting national standards with regards Clinical Psychology (providing integrated Clinical Psychology support within critical care teams), Therapies (providing a structured, individualised rehabilitation programme through dedicated Occupational Therapy, Physiotherapy, Speech and Language Therapy, and Dietetics input) and designated critical care Pharmacist at the three acute hospital sites.	1. Improved quality of patient care during critical illness and during the recovery from critical illness 2. Improved patient safety and quality of care 3. Reduced costs through reduced length of critical care and ward stay, reduced readmission, and decreased longer term healthcare utilisation 4. Equity of access to support across North Wales 5. Raised staff well-being and retention 6. Clinical staff (in particular critical care nursing staff) able to concentrate on core clinical activity The provision of robust and consistent staffing within 'medical' critical care rotas by recruiting experienced critical care nurse or allied health professional staff to advanced clinical practice roles at the three Acute Hospital sites	Executive Medical Director	30th June - 30th September Development of Business Case 31st December Business Case submitted for internal sign-off and approval 31st December / 31st March Development of a programme plan, recruitment ready for implementation 2022	Financial resources Ability to recruitment skilled staff Failure to meet national standards and recommendations Protracted length of patient stay Increased length of time for patients to regain independence Increased dependence at critical care and hospital discharge Inequitable access to clinical psychology and therapy services across North Wales Clinic cancellation due to lack of dedicated nursing staff resource	Business Case to be approved. Circa £1M revenue funding tbc		Y	**QSE & Board**
Y	C1	COVID-19 response	**TTP Programme Director**	Ensure adequate testing capacity is available across North Wales in line with the revised Welsh Government Testing Strategy. * Lab Turnaround Times for swabs is a PHW responsibility * Contracts for Regional, Local and Mobile testing units and WAST are Welsh Government managed contracts) Testing capability located across the region to ensure the volume of testing slots are adequate and able to provide a test within 24 hours and easily accessible preferably no more than 30 minute drive. Lateral Flow Devices (LFD) issued in accordance with Welsh Government policy, currently manage the distribution across the Health Board and LFD collect points via the existing testing infrastructure for the population who are not able to work from home (all other distribution managed by Welsh	Government contracts with an external provider to provider Regional and Local Testing sites – two and four respectively across the region. Note: Government contract with another external provider to provide mobile testing units (MTUs). MTUs move across the region including to more remote areas. They also respond in the event of outbreaks. Activity is monitored for every unit in conjunction with epidemiology reports. To work strategically with partners to agree the most appropriate deployment of the mobile testing units.	PCR testing needs to be undertaken as rapidly as possible for anyone demonstrating Covid symptoms and for cases where the TTP service has recommended a test. The earliest identification of positive cases will help to ensure transmission of the virus is reduced, or prevented. The desired outcome is to minimise and eliminate transmission of Covid.	Executive Director of Public Health	Measure through capacity and Turnaround Times. Immediate and to be continued through to 31st March – capacity to be reviewed on receipt of regional modelling from the national team and not expected to be reduced before 31/3/22.	Inadequate testing capacity – risk that positive cases are either not identified or not identified in a timely manner. Risk is increased transmission. Access to testing – if tests are not accessible, population may be deterred from testing. Public perception, and the need to reiterate core messages (e.g. only essential travelling outside the UK).	COVID Funded		Y	PPPH & Board
	C1				MTUs are used to move around the region 1. reaching more remote communities to improve access to testing, 2. in response to outbreaks and the requirement to rapidly test. The speed of testing. The desired outcome is to minimise and eliminate transmission of Covid.		Executive Director of Public Health	Immediate and to be continued through to 31st March – capacity to be reviewed on receipt of regional modelling from the national team. No plans to reduce capacity.					

	C1			Government)	To maintain the Health Board-operated Community Testing Units to ensure that appropriate PCR testing is provided for patients requiring pre-operative testing, as well as meeting the needs pre-treatment needs of cancer and renal patients. Work with secondary care services to dynamically manage the recruitment and retention of staff to meet service requirements and ensure that capacity/ demand is continuously monitored in line with national and regional data, allowing for surge capacity to be deployed as required	To ensure patients do not have Covid prior to treatment in order to: * Protect the patient – if they are covid positive, they are at greater risk during and following a procedure * Protect other patients from potentially contracting the virus whilst in the care of BCU HB * Protect our workforce by minimising exposure to the virus	Executive Director of Public Health	30th September – capacity plans are in the progress of being built now with the planned care services. The target is to ensure there is adequate capacity to provide the required PCR testing within a 72 hour pre treatment period.	Retaining staff to deliver service. Services providing CTUs with timely information regarding pre op testing plans. Maintaining current CTU locations as other services return to "business as usual" and request the return of facilities.				
	C1				Point of Care testing devices to be evaluated and implemented to support the rapid turnaround of tests for patients arriving in departments such as A&E. Roche Liat and Lumeira devices being evaluated for different departments.	To provide rapid test results to enable departments to treat patients safely on the appropriate pathway in accordance with their Covid-status Improves the decision-making time to protect patients and the workforce	Executive Director of Public Health	30th September evaluate 31st December devices implemented subject to effectiveness of evaluation	IT connectivity to manage test results	COVID Funded (Finance to check if Roche Liat devices are covered by covid funding)				
	C1				Lateral flow testing devices deployed to BCU frontline staff c.17,000; managed through Shared Services for distribution and line managers for registration and replenishment.	One in three people who are covid positive do not demonstrate symptoms. Regular LFD testing aims to identify staff who are asymptomatic to prevent transmission in the workplace, amongst patients, and the wider workforce.	Executive Director of Public Health	31st May	Managing storage and replenishments of kits Staff registering kit and reporting results; if staff are not regularly testing in line with guidance, asymptomatic staff will be missed creating risk of transmission	COVID Funded				
	C1				Create LFD collect points across the region utilising the existing infrastructure such as RTS, LTS and MTUs for the population who are not able to work from home. Also link up with Covid Support Hubs being developed under the Protect agenda.	To provide easy access to LFD kits to the members of the population who cannot work from home. Regular testing to identify asymptomatic cases and reduce the risk of transmitting the virus unknowingly.	Executive Director of Public Health	30th June – in place by the end of 30th June and on-going until WG policy determines otherwise	Public confusion re type of test to use i.e. PCR v LFD	COVID Funded				
Y	C1.1	COVID-19 response	**TTP Programme Director**	Deploy effective tracing service with partners across North Wales to minimise transmission of virus and adapt the service provision as Welsh Government policy evolves.	Ensure there is an adequate resource at a regional and local level to deliver effective tracing in response to the identification of positive cases, including variants of concern and returning travellers	Adequate resources will ensure that tracing responses are rapid as soon as positive cases are confirmed; isolating the positive case and their identified contacts, in turn reducing transmission	Executive Director of Public Health	By 30th June and on-going through 2021-22	Public do not adhere to guidance A third wave exceeds capacity Staff attrition falls below the required threshold Difficult to recruit as the economy opens up as these are temporary roles	COVID Funded		Y	QSE & Board
	C1.1					Resource in place to manage a third wave and skills developed to address international travellers, backward contact tracing, EHO capacity, to ensure the tracing response is as effective as possible in limiting the transmission of the virus	Executive Director of Public Health						
Y	C1.2	COVID-19 response	**TTP Programme Director**	Continue North Wales liaison on protect agenda coordinating multi-agency response	Individuals and communities impacted by Covid can access the support available.	5 'protect' schemes in progress in partnership with WG, with ambition to increase further. The schemes will support individuals impacted by Covid to access LFDs, financial advice, food poverty support, MH support and other locally-identified support services.	Executive Director of Public Health	30th September and ongoing	Funding pulled after initial pilot phase	COVID Funded		Y	
Y	C1.3	COVID-19 response	**Vaccination Programme Lead.**	Implement and deliver the BCUHB mass vaccination programme.	Development of a sustainable delivery model as we move into an annual vaccination and booster programme, in line with evolving national clinical guidance and Welsh Government Strategy. This will ensure we have a strategy for future proofing the programme, transforming it into a 'business as usual' model.	To ensure our citizens have a robust process of planning short, medium and long term within the BCUHB vaccination programme. This will involve being able to respond to changing guidance, changes in vaccine supply and any other interdependency which may require action and a change in approach.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme	The Vaccination Strategy for Wales currently sets out 3 milestones based on the JCVI's prioritisation advice. Milestone 1: To have offered the vaccine to all individuals in cohorts 1–4 by mid February. BCUHB achieved this along with other Health Boards in Wales on 12 February 2021. Milestone 2: To have offered the vaccine to all individuals in cohorts 1-9 by mid April. That includes all those aged 50 and over. BCUHB achieved this and along with other Health Boards in Wales on 4 April 2021. Milestone 3: It is our aim to offer everyone in the current 10 priority groups their first dose of the vaccine by the end of July 2021. We remain on target to achieve this next milestone. Future milestones based on the next phase including the booster programme are expected in Quarter 2 via the WG. This will also include guidance and criteria. By 31st December	Changing guidance, lack of National clarity on the next phase. Meeting legal obligations, having data and other intelligence robust enough to support. Compliance with evolving National Guidance and development of multiple vaccines. Return of redeployed staff, turnover of agency staff. Lack of clarity of the medium and longer term plan. Data quality. IT framework & capabilities	COVID Funded		Y	
	C1.3				Demonstrable equal access to the vaccination programme for all groups with special characteristics or other underserved groups as defined within the North Wales Vaccination Implementation Plan.	To ensure that our citizens within these groups are identified and engaged with to ensure that any inequalities are addressed and mitigated within the programme implementation.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Ensure the mechanisms in place continue with the interpretation of clinical guidance, development of clinical pathways and maintain and review them as required.	To ensure our citizens vaccines are delivered safely, protecting public trust and confidence in the immunisation programme.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Development of a workforce model which will deliver the programme, flexible enough to adapt to the evolving plans from one phase to the next.	To ensure our citizens can reply on a skilled, sufficient and sustainable workforce to deliver their vaccines in the most effective and safe way.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Development of an estates plan which will provide the capacity to deliver the programme, flexible enough to adapt to the evolving plans from one phase to the next.	To ensure our citizens can reply on a skilled, sufficient and sustainable workforce to deliver their vaccines in the most effective and safe way. Provides our citizens with appropriate contact methods and the ability to book vaccination appointments that fit in with their schedule providing the ability to update or amend. This will avoid frustrations caused by having to phone the booking centre.	Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
	C1.3				Develop an efficient contact process and self-service booking system under Welsh Government Guidance.		Executive Director Nursing & Midwifery as SRO – Mass Vaccination Programme						
Y	C1.5	COVID-19 response	**Assistant Area Directors for Children's Services**	COVID recovery - all Children's Services	Establish gap and conduct recovery analysis, establishing new activity and waiting times trajectories of new capacity within current guidelines, develop new plans required to achieve at Service Level across Community and Acute Services	Improved access for Children and young people with reduced waiting times. Developed new ways of working.	Executive Director Primary & Community Care	30th June – Baseline assessment.	Allocation of funding to reduce backlog	Performance Improvement Funding		Y	Board & QSE
	C1.5						Executive Director Primary & Community Care	30th September - Service Level plans to deliver agreed.					
	C1.5						Executive Director Primary & Community Care	31st December-31st March - Ongoing performance monitoring via Regional Childrens Services Group.					
Y	R1	Recovering access to timely planned care pathways	**Assistant Area Directors Primary Care**	Continuation of accuRx communication platform, to provide IT infrastructure to enable GPs and other health professionals working in primary care to undertake remote consultations, share information with patients and to update the patients' clinical records with the consultation event.	Commission a fixed term contract on behalf of GP practices whilst awaiting an all Wales decision to support long term provision.	Supports GPs and other health professionals to communicate more effectively with their patients in the delivery of care; includes medical surveys, text and photo responses, patient triage, text messaging, vaccination booking, and with the plus version video consultations and digital documents. Maintain new ways of working, support recovery and the delivery of access standards.	Executive Director Primary & Community Care - Acting Executive Medical Director	30th June	Risk to implementation: Procurement processes may prevent timely implementation. Need for consistent Data Protection standards and documentation across the health board and multiple independent contractors. Risk if not implemented: Poor patient access to primary care Unsustainable primary care services unable to meet demand	Performance Fund		Y	FPIG
	R1				Interim contract in place for accuRx use by North Wales practices.	Supports social distancing to be achieved within Primary Care premises and more choice of consultation method to be available to patients. Improved access for patients	Executive Director Primary & Community Care - Acting Executive Medical Director	30th June					
	R1				Work with NWIS to agree long term contract requirements	Improved delivery of GMS access standards (see related action below) Efficient use of clinical capacity. MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • Ambulatory sensitive conditions referral numbers	Executive Director Primary & Community Care - Acting Executive Medical Director	30th September					
	R1				All Wales contract in place for accuRx		Executive Director Primary & Community Care - Acting Executive Medical Director	31st December					
Y	R1.1	Recovering access to timely planned care pathways	**Assistant Area Directors Primary Care supported by PC Academy lead**	Review the uptake, requirements and patient satisfaction in relation to alternative/new technologies supporting patient access to GMS	Extend eConsult provision to participating practices.	Improved or maintained access to General Medical Services Monthly eConsult activity and patient satisfaction reports to demonstrate increased access. Efficient service provision MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4	Executive Director Primary & Community Care	30th June	Risk to implementation: Not a contracted requirement to participate. Growing demand as evidence of unmet demand and more patients contacting practices through virtual routes Risk if not implemented: Poor patient access to primary care Unsustainable primary care services unable to meet demand	Primary Care (WG Investment Fund grant – linked to the Academy)		Y	FPIG & Board
	R1.1				Monitor eConsult activity including patient satisfaction		Executive Director Primary & Community Care	30th June					
	R1.1				Monitor patient/clinical satisfaction in relation to video and telephone consultations		Executive Director Primary & Community Care	31st December					
	R1.1				Review access to virtual consultation training		Executive Director Primary & Community Care	30th September					
	R1.1				Review ongoing use and satisfaction with accuRx (and feed information into future contract requirements – see specific action above)		Executive Director Primary & Community Care	31st December					
	R1.1				Feed local learning into the national Strategic Programme to inform future strategies		Executive Director Primary & Community Care	31st March					
Y	R1.2	Recovering access to timely planned care pathways	**Asst Director Primary Care Contracts supported by Asst Area Directors Primary Care**	Delivery of all Wales access standards through GMS Contract (detailed in non-mandated QAIF)	Review 2020/21 performance against standards (validated data released June 21)	Improved achievement of GMS Access Standards Maintained or improved access to primary care GP practice services for patients MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • A&E attendances	Executive Director Primary & Community Care	30th June	Some GP practices may not participate the QAIF is not mandated Investment is required in phone systems to improve access and monitoring. This is a barrier particularly in some of our managed practices. High demand in primary care including c-19 vaccination programme and impact of planned care backlog	Primary Care		Y	FPIG & Board
	R1.2				Support provided to practice managers in interpreting and implementing the requirements of the standards by Primary Care Contract team		Executive Director Primary & Community Care	31st March Rolling contractual programme					
	R1.2				Work undertaken with clusters/practices to identify and disseminate good practice via Access Standards forum		Executive Director Primary & Community Care	30th June-30th September					
	R1.2				Performance reports provided to Board in line with regulatory requirements.		Executive Director Primary & Community Care	30th June-31st March					
Y	R1.4	Recovering access to timely planned care pathways	**Asst Director Primary Care & Community Services, supported by Area Medical Directors and Planned Care Lead**	Working with planned care programme leaders to ensure a whole system response to patient demand pressure areas (also refer to planned care section)	Development of timely and accurate information for current and new patients, and primary care clinicians, regarding care pathways and waiting times	Improved patient communication and provision of alternative services if appropriate, to support patients waiting for planned secondary care, including regular updates. (Activity data will be detailed in the planned care action log) Alleviate patient concerns	Executive Director Nursing & Midwifery	30th June	Risk to implementation: Planned Care leads capacity to fully engage Complexity across specialties and sites Insufficient resourced capacity in primary care to participate Risk if not implemented: Poor patient outcomes and increased clinical risk	Performance Fund –assuming further allocation from WG		Y	FPIG & Board
	R1.4				Ensure robust communication with primary care clinicians regarding waiting times and clinical review processes	Seek feedback from primary care in relation to the impact of waiting list validation and patient queries. Robust management of clinical risk	Executive Director Nursing & Midwifery	30th June					

	R1.4				Development of proposals to manage the backlog of planned care in the primary care sector	MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • All elective activity • Urgent cancer OPD referrals • Urgent non-cancer OPD referrals	Executive Director Nursing & Midwifery	30th June	Primary care unable to cope with additional demand relating to queries and supporting patients whilst they wait				
	R1.4				Link to the transformation of prioritised system wide care pathways, ensuring primary care involvement.		Executive Director Nursing & Midwifery	31st March					
Y	R1.6	Recovering access to timely planned care pathways	**Asst Director Primary Care & Community Services, supported by Academy Manager**	Further development of the Primary and Community Care Academy	PACCA Business Case finalised	Supporting the further implementation of the primary care model in Wales, leading new ways of working and innovation in primary care. Further integrated working with the Strategic Programme for primary care and HEIW Promotion of North Wales as a place to train learn and work; particularly in relation to primary care professions, with targeted recruitment initiatives. (Subject to business case approval), increased numbers of advanced practitioners working in primary care settings Support the sustainability of GMS Primary Care through the development of training posts supernumerary to the costed established to develop a cohort of practitioners who are Primary Care ready. Supported primary care internships, including Physicians Associates Deliver a range of development, training and education programmes to support the development of clinical and non-clinical practitioners. Increase skills and knowledge in Community Pharmacy to meet population need and develop services that can be provided closer to home via an alternative primary care contractor. MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • In-hours GP demand v capacity: number of community pharmacies at escalation level 3 and 4	Executive Director Primary & Community Care	30th June	Risk to implementation: Approval of Business Case and allocation of additional funding Risk if not implemented: Academy not further developed and unable to meet the needs of primary care, both to support innovation but also improve recruitment and sustainability (as a response to the BAF)	Performance Fund		Y	Board & ?QSE
	R1.6				Planning for all programmes, with the completion of the delivery plan 2021/22 (subject to funding), to include:		Executive Director Primary & Community Care	30th June					
	R1.6				Training Hub established and posts advertised		Executive Director Primary & Community Care	30th September					
	R1.6				Level 7 Vocational Education Programme in place		Executive Director Primary & Community Care	30th September					
	R1.6				Community Pharmacy training Programme - 30th September and 31st December due to timing of taught modules at University		Executive Director Primary & Community Care	31st December					
	R1.6				Evaluation Lead and Research Development appointed		Executive Director Primary & Community Care	30th September					
	R1.6				Trainees in post and commencing education programmes / ongoing evaluation of training hub		Executive Director Primary & Community Care	31st December					
	R1.6				New Cohort of Practitioners to join Vocational training Programme		Executive Director Primary & Community Care	31st December					
	R1.6				Further development and testing of competency framework		Executive Director Primary & Community Care	31st December					
	R1.6				End of year report		Executive Director Primary & Community Care	31st March (published 22/23)					
Y	R1.7	Recovering access to timely planned care pathways	**Programme Lead for Dental Academy**	Development of a North Wales Dental Academy, to include a training unit, GDS and CDS provision	Robust programme governance arrangements were established in 2020/21	Increase in number of dentists trained and working in north Wales Additional access to dental services and improved performance against dental access targets. NB This is difficult to provide a definitive level of activity as we are delivering a totally new model (to Wales/UK) for the delivery of services and pushing the boundaries of Contract Reform. Any further covid surge will also impact on this given the strict IP&C required for dental services. Once a preferred provider is appointed additional clarity will be provided; specified activity/targets are not set in the contract, but asked the provider to define innovative delivery methods and with activity targets to be agreed. Further detail will be available in Sept/Oct 21. MDS ref: • Number of AGPs • Number of courses of treatment Also improvement to dental access targets over time (see notes above)	Executive Director Primary & Community Care	30th June	Risk to implementation: Procurement of appropriate provider Ongoing capacity restrictions due to IP&C/covid Risk if not implemented: Poor dental access Ongoing challenges in attracting dental practitioners to north Wales	Primary Care		Y	Board & QSE?
	R1.7				Advertise the contract			30th June					
	R1.7				Award to preferred provider			30th September					
	R1.7				Seek Board & WG approval to award preferred bidder			30th September					
	R1.7				Commission facility			31st March					
Y	R1.8	Recovering access to timely planned care pathways	**Asst Director Dental Services**	Implementation of the dental contract reform (as directed by Chief Dental Officer/Welsh Government)	Implemented by the dental contracts team as a core priority	Delivery of all Wales model of dental care Utilise all aspects of the contract in a flexible manner and deliver increased access, improved responsibility in oral health wellness, better patient outcomes from a dental led, whole system delivered ethos. MDS ref: • Number of AGPs • Number of courses of treatment	Executive Director Primary & Community Care	31st March	Risk to implementation: Ongoing IP&C restrictions due to C-19 Risk if not implemented: Not able to demonstrate delivery of national contract requirements	Primary Care		Y	Board & FPIG?
Y	R1.9	Recovering access to timely planned care pathways	**Asst Director Dental Services**	Commission additional general dental provision	Undertake non-recurring procurement exercise with GDS contractors, commissioning services that will replace lost activity.	Increased access to urgent dental services, general dental services, in a timely manner. Access provision for new patients is expected to continue to increase as GDS services continue to remobilise, although the capacity to accommodate new patients is likely to become more limited during the second half of the year as services become saturated and the patient demand for resumption of routine normal services grows. Deliver CDO expectations for provision of access for new patients across the HB of 1,500 new patients/week for at least 30th June and 30th September (noting that anyone not treated in the preceding 12months is classified as a new patient)	Executive Director Primary & Community Care	31st December	Risk to implementation: Ongoing IP&C restrictions due to C-19 GDS capacity Risk if not implemented: Unable to improve access to dental services	Primary Care and Performance Fund		Y	Board & FPIG?
	R1.9				Increase provision of Urgent and Emergency sessions along with sessions specifically targeted at high needs patients who have traditionally had difficulties accessing GDS services	MDS ref: • Number of AGPs • Number of courses of treatment	Executive Director Primary & Community Care						
Y	R2	Recovering access to timely planned care pathways	**Assistant Director for Pharmacy and Medicines Management (West)**	Relaunch of a community pharmacy care home enhanced service to form part of our recovery plan.	Update of the enhanced service for community pharmacy, including relaunch of Tier one that supports medicines management in care homes.	Effective medicine management via pharmacist to support reduction in admissions to hospital, including improved medicines reconciliation on discharge and reduced readmission of patients due to medicines related harm	Executive Director Primary & Community Care	31st March	Risk to implementation: Restrictions relating to IP&C Community Pharmacy capacity Risk if not implemented: Poor patient outcomes and increase in medication incidents Increase in hospital demand	Primary Care		Y	Board & PPPH or QSE?
	R2				A national review of the specification of the service has commenced led by the All Wales Consultant Pharmacist for community health care.	Supports improved patient outcomes and quality of care.	Executive Director Primary & Community Care						
	R2				Increase provision of Discharge Medication Reviews for patients resident in care homes.	Reduction in medication errors/incidents within the care homes. Increase number of care homes having received level 1 support and completed an action plan. By proxy this will reduce medication errors in care homes. (NB this data is not held by the health board; CSSIW will be approached to advise)	Executive Director Primary & Community Care						
	R2				Commission level 1 service that will support medicines management governance and safe use of medicines within care homes. This covers: • Patient entered care • Transfer of care • Monitoring are review	MDS ref: • Care Homes DES • Emergency admissions	Executive Director Primary & Community Care						
Y	R2.3	Recovering access to timely planned care pathways	**Clinical Director Audiology and Head of Adult Audiology**	Delivery of advanced practice audiology in primary care and provision of Ear Wax Management Services (subject to business case approval / additional funding)	Extension of the advanced practice audiology scheme and implementation of earwax management service across north Wales (subject to business case approval / additional funding)	Compliance with Welsh Health Circular for Ear Wax Management Improved capacity for ear wax management and subsequent reduction in patient concerns Improved patient outcomes and access to specialist services 'closer to home' Support for GP practices to manage audiology demand MDS ref: In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4	Executive Director of Primary & Community Care	31st March	Risk to implementation: Timely approval of business case and confirmation of funding Risk if not implemented: Non-compliance with WHC Unable to support primary care demand & capacity, and delivery of improved access	Performance Fund		Y	Board & PPPH
Y	R1.3	Improved unscheduled care pathways	**Asst Director Primary Care & Community Services, supported by Asst Area Directors Primary Care**	Development of urgent primary care centres as pathfinders, feeding into the national programme of work for primary care.	Presentation to WG of pathfinder proposals for 2021/22 to secure additional funding for current pathfinders (East & Central Areas).	Additional urgent primary care capacity in place to support practices and emergency department service delivery. Monthly activity levels are included in the KPIs; estimated in East Area 1200-1800pm; Central Area 1000pm. Improved patient satisfaction. Timely access to services in response to on the day demand Integrated working with the unscheduled care programme, including 'phone first' and the implementation of 111. MDS ref: • In-hours GP demand v capacity: number of GP practices at escalation level 3 and 4 • A&E attendances	Executive Director Primary & Community Care	30th June	Risk to implementation: Capacity to deliver pathfinders Recruitment of multi-disciplinary workforce Confirmation of funding Recruitment to short term posts Links with 111 and GPOOH as they also change during this period Risk if not implemented: Unable to meet patient demand for unscheduled care in primary and secondary care.	Performance Fund (for West Area) and WG UPCC grant (subject to approval)		Y	PPPH & Board
	R1.3				Further development of UPCC pathfinder in East Area covering 6 clusters		Executive Director Primary & Community Care	30th June					
	R1.3				Commence UPCC pathfinder in North Denbighshire in partnership with mental health third sector		Executive Director Primary & Community Care	30th June					
	R1.3				Development of proposals/business case for a UPCC pathfinder(s) in West Area		Executive Director Primary & Community Care	30th June					
	R1.3				Implementation of UPCC(s) in West Area (subject to approval/funding)		Executive Director Primary & Community Care	31st December					
	R1.3				Participation in national evaluation of all pathfinder UPCCs, with recommendations for a future model of care.		Executive Director Primary & Community Care	31st March					

	R1.3				Local review of UPCC pathfinders, including cost benefit analysis to determine future requirement for north Wales		Executive Director Primary & Community Care	31st March					
y	I1.1	Improved unscheduled care pathways	**Community Services lead**	Implementation of Single Care Home Action Plan	Development and Implementation of the Quality Assurance Framework	• All residents in a North Wales Care Homes receive safe, high quality and equitable care at all times. • That the Health Board is able to commission services that are fit for purpose, with a focus on improving health, reducing health inequalities, prevention, early and timely intervention and excellent end of life care. • Ensure that residents / patients are cared for in the most appropriate setting, promoting improved patient / resident flow between care settings. • Enhancing the quality of life for people with care and support needs. • Safeguarding and protecting from avoidable harm. • Ensuring that people have a positive experience of care. • Strong commissioning process that gives high quality of care as well as value for money Ensure evidenced based practise and improved quality outcomes. • Delaying and reducing the need for care and support, Reduction of unplanned admissions and attendances to ED, Reduction in falls, Pressure Ulcers, safeguarding referrals, medication errors, infection outbreaks. • Targeted interventions in area of inequality and deprivation. • Improved recruitment and retention in care homes, Improved access to joint training and education, Reduction in care Homes being managed through Escalating Concerns.	Executive Director Primary & Community Care	30th June. Secure Funding for additional Quality Posts. Questionnaire to partners. Hold two workshops to agree components of the QAF. Draft QAF by end of 30th June. Recruit to Quality Posts.	Capacity of team, potential of further Covid outbreaks Market stability and viability of the care home sector			y	Board & QSE
	I1.1							30th September Conclude recruitment and undertake engagement with providers and key stakeholders.					
	I1.1							31st December Refine QAF and commence Implementation.					
	I1.1							31st March Full implementation					
y	I1.2	Improved unscheduled care pathways	**Assistant Area Director (AAD) - Intermediate Care & Specialist Medicines and AADs of Community Services** **AAD Pharmacy and Medicines Management**	Transformation of Community Services - Home First Bureau	Development and implementation of a Home First Team in line with Home First Bureau Business Case.	Discharge to recover and assess is a National programme of work. National measures agreed and reported since March 21 in order to start collecting the baseline information. National measures reported since March 21 • Measure 1 – No. of people transferred on to each D2RA pathway. • Measure 2 - % of those transfers that took place within 48 hours of decision being made. • Measure 3 - % people transferred to a D2RA pathway a co-produced recovery plan in place. • Measure 4 - % of people transferred out of D2RA pathway to usual place of residence. • Measure 5 - % of people readmitted to Hospital within 28 days (post D2RA pathway). Benefits • Reduction in unnecessary admissions into hospital. • Improvement patient pathway with minimal delays. • Patients receiving care at home rather in hospital. • Improved patient flow to maximise acute bed capacity. • Improved patient experience and more joined up care. Discharge Medicines review to be completed by community pharmacy to enable medicines reconciliation at change of care setting in line with NICE guidance.	Executive Director Primary & Community Care	30th June – Baseline data being collected. 30th June – Review of Home First Bureaus 30th September – Review of baseline data 30th September – Home First Business Case approved and all posts recruited to. 30th June – Training and education across system. 30th September – Gap analysis and recruitment 31st March – Ongoing monitoring	TThe D2AR investment in the Central Area has focussed on the provision of addition HCA staff, working over 7 days. Early evidence is demonstrating how these staff are enabling more care to be deliver in patients' homes. There is insufficient funding to maintain the posts for the full year. ICF funding not guaranteed post March 2022. Risk of staff leaving if contracts can't be renewed and notice having to be given to some staff Longer stays in acute and community hospitals	Performance Fund		y	Board & FPIG?
	I1.2				Recruit to the staffing model outlined in the business case (confirmation that this has been approved is required).		Executive Director Primary & Community Care						
	I1.2				Consolidation and mapping all of our resources to support discharges including CHC, HFB, Frailty, D2RA, therapies and CRT. Fully implement Discharge to Assess capacity within the community.		Executive Director Primary & Community Care						
	I1.2				East - Development of pathways out of hospital to support D2RA – e.g. EMI pathways. Pharmacy support needs to be included as part of the CRT. To support domiciliary and care homes to administer medication safely to people in their own homes. Supports care closer to home	Discharge Medicines review to be completed by community pharmacy to enable medicines reconciliation at change of care setting in line with NICE guidance.	Executive Director Primary & Community Care						
Y	I1.3	Improved unscheduled care pathways	**AAD Community Services West** **AADs Community Services**	Transformation of Community Services - Development of Frailty Pathways to deliver on the vison of Welsh Government for sustainable and integrated Community Health & Social Care.	COTE linked to CRTs and MDTs at pre crisis point (West only).	• Pilot impact of COTE support within CRTs (West) • Supports the expansion of Community Transformation work beyond South Wrexham. • Sustainable COTE workforce. • Improved patient care and avoiding unnecessary hospital admissions or increased lengths of stay. • Improved patient experience and avoiding hospital admission and reducing length of stay. • Discharge Medicines review to be completed by community pharmacy to enable medicines reconciliation at change of care setting in line with NICE guidance.	Executive Director Primary & Community Care	Ongoing	Short term cost pressure whilst services cross over. Risk we won't have the funding. Can't recruit the right type of resources	Core Funding		Y	Board & QSE
	I1.3				Develop innovative workforce models to reduce risk of COTE consultant vacancies – eg nurse consultants; therapy consultants (East)		Executive Director Primary & Community Care	30th June – workforce review. 30th September/31st December – extend MDT model from South Wrexham to Central Wrexham and NWW.					
	I1.3				YG & YGC Frailty units established and staff recruited		Executive Director Primary & Community Care	Centre –30th June – design 30th September – Recruit 31st December – Implement 31st March – monitor					
	I1.3				Frailty model embedded into community services and intermediate care approach to utilise step-up beds from primary care more consistently. Partnership working with LAs for Marleyfield step down beds (East).		Executive Director Primary & Community Care	East 30th June Marleyfield West - YG Frailty unit – on hold, funding not confirmed. Led by acute.					
	I1.3				Inclusion of pharmacy requirements for frailty units /services, ED and SDEC (and all other clinical developments) in all three acute sites as part of the MDT team.		Executive Director Primary & Community Care	West Frailty model in place West - MDTs established in Y'sys Mon and Arfon – roll out to remaining areas by 31st December					
Y	I1.5	Improved unscheduled care pathways	**Community Transformation Regional Programme Manager**	Community Services Transformation Programme: Continued implementation of regional and area-level transformation plans, aimed at developing place-based, integrated models of care and support increasing skills and capacity within primary care, community health and social care, to deliver care and support in people own homes and communities.	Joint programme with Local Authorities in order to: Expand and strengthen Community Resource Teams so as to meet the needs of the local population.	• Better and more seamless, integrated care and support within the community, that delivers what matters to the people of North Wales. By strengthening community services (including primary care, community health, social care and the third and community sector) the programme supports a shift towards prevention, early intervention, and well-being. This in turn will support demand management for secondary care services and statutory social care. • Integrated working will ensure the better co-ordination of services, reduce duplication and waste and ensure that care and support is delivered at the right time, in the right place and by the right person. Strengthen the role of digital technology in delivering future. focused and person-centred care	Executive Director Primary & Community Care	30th June-31st March– ongoing implementation of regional and area-level programmes of work	Short-term Transformation and ICF funding not aligned to longer-term delivery timescales for change. Risk that programme momentum may slow once grant funding ceases.	WG Transformation Fund		Y	Board & PPPH
	I1.5				Strengthen place-based working through the development of integrated health and social care localities, leadership and governance.		Executive Director Primary & Community Care	31st March – Sustainability planning for post programme continuation					
	I1.5				Develop an integrated workforce model able to deliver increasingly complex care within the community.		Executive Director Primary & Community Care						
	I1.5						Executive Director Primary & Community Care						
	I1.5				Expand the role of the community and third sector in delivering 'what matters' programme		Executive Director Primary & Community Care						
Y	I1.7	Improved unscheduled care pathways	**Assistant Area Director – Primary & Community Care**	Increased capacity within CRTs to support patients to be cared for in their own homes.	Employ additional HCSWs within CRTs in the Central Area, working from 7.30am to 9pm, 7 days per week.	Patients needing additional short term care in their own homes can be supported, avoiding unnecessary hospital admission. Patients no longer requiring acute care can be discharged to recover in their own homes. Patients with increased care needs, for example double handed care visits, can be discharged earlier / avoid admission to hospital while recovering or awaiting an increase in their package of care. Increased number of patients wishing to die at home can be supported to do so. Reduced demand on acute and community hospital beds. Contribution to reduced LOS. Contribution to reduced DTOC. Contribution to BCU implementation of D2AR pathways. Improved patient experience (being cared for at home, rather than in hospital). (Continuation of scheme implemented in Winter 2021, which has increased capacity in Enhanced Care services and, with the Home First Bureau, contributed to a 430% increase in patients listed for community hospital being discharged home instead).	Executive Director Primary & Community Care	30th June: Staff recruited with Winter Planning monies to continue in post, linked to CRTs. Data collection 30th September: Evaluation of service and business case to secure ongoing funding and contingency planning for exit strategy 31st December: subject to funding, recruit and deploy additional HCAs to support care delivery outside hospital 31st March Secure permanent funding, subject to further evaluation	Risk that there is insufficient capacity of other CRT staff and GPs to provide care (capacity put in place as GPs and DNs have said that they can manage more people at home with sufficient support staff, so currently, not an issue). Risk that NHS HCSWs are increasingly relied upon to provide domiciliary care where Dom Care Agency services are not available	FYE £1.045m D2AR funding secured to fund additional HCAs already employed until end of September. Need to secure remaining monies for full staffing and for 31st December and 31st March.		Y	Board & FPIG (in support of reducing DToC?)
	I1.7				Use additional capacity to facilitate provision of care and support in patients' homes		Executive Director Primary & Community Care						
Y	I1.7		**Children & Young People Area Director**	Transformation of Child and Adolescent Mental Health Services (CAMHS) - Targeted Intervention Performance and Improvement Programme.	Two year improvement plan. A maturity matrix approach has been developed and agreed to support transformational change required, enabling an organisational focus on improvement priorities: Strategy & Sustainability Workforce Enhanced Care Pathways Access Involvement & Participation Psychological Therapies Provision Transition	Strengthened Regional leadership capacity and enhanced Regional governance embedded across services. Development of long term CAMHS Strategy with clinical, stakeholder and public involvement. Crisis care teams further developed to support children and young people presenting in crisis regarding self-harm, suicidal ideation and acute mental health difficulties. Improved Access to service for assessment and intervention to meet Mental Health measure targets	Executive Director Primary & Community Care	30th June – Baseline assessment	Timely allocation of Funding to implement Regional Transformation Structure. Workforce recruitment to deliver	Performance Improvement Fund & WG MH Funding Allocation		Y	Board & QSE
	I1.7						Executive Director Primary & Community Care	30th September - Developed Improvement Framework and structure			Performance Improvement Fund & WG MH Funding Allocation		
	I1.7						Executive Director Primary & Community Care	31st December -31st March & Ongoing Performance improvement monitored monthly at Strategic CAMHS Improvement Group. Ongoing Self-Assessment in line with reporting to Board Meetings.					
y	I2.1	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Emergency Department access and patient flow (Welsh Access Model / Emergency Department Quality and Delivery Framework / Frailty and Acute Medical Model)	Welsh Access Model implemented and access principles and priorities adopted across all sites – emergency department access pathway to include a 'Contact First' system, 'Streaming Hub', and 'Wait & Care System', leading to more efficient navigation of patients Pioneering key performance indicators verified and published for each site – 'Time to 'Triage', 'Time to Clinician', 'Outcome'	• Improved clinical outcomes by EDs through focus on efficiency and effectiveness to reduce time to triage and time to clinician. • Improved patient experience and quality of care within ED through a standardised pathway and direction to the most appropriate department in a timely manner – in line with the Welsh Access Model. • Enhanced engagement of ED workforce. • Increased value for money achieved from ED funding through innovation, improvement, adoption of good practice and eliminating waste. • Reduced patient harm from seamless journey to the right healthcare professional first time and improved health outcomes through effective triaging methods. • Improved patient experience through collection of live qualitative patient data and	Executive Director Nursing & Midwifery	31st March implementation WAM – 31st March KPIs – Complete, although will be periodically published throughout 2021/22 – 30th June, 30th September, 31st December, 31st March	Funding of improvement support workforce – funding has now been confirmed through the National EDQDF Team until March 2022.	Performance Fund		y	Board & FPIG

	I2.1				National Enablers for Service Improvement (NESIs) – Collection, analysis and evaluation of patient and staff feedback, with findings being fed into internal Health Board improvement groups to support service development initiatives	experience. • Improved staff experience through analysis of qualitative feedback to inform changes in the department. • Improved patient safety and experience through implementation of a number of pathway improvement projects that focus on reducing delays and directing the patient to the right clinical outcome first time. • Reduced harm, improved patient experience and improved flow from utilisation of pre hospital pathways where appropriate. • Improved quality, reduced variation as a result of a standardised suite of Guidelines to ensure the same high standard of care regardless of where patients access services		NESIs PE – Ongoing through to 31st March SE – Ongoing through to 31st March				
	I2.1				Implementation of Pathway Improvement Projects (PIPs) for; ambulance handover & triage; clinical guidelines; navigation, and engagement to achieve CAREMORE standards. This will involve completion of scoping documentation and establishment of local working groups by 30th June. The programme of work and actions agreed nationally in place by 30th September. Pilot of PIPs across three BCU sites within 31st December and data Analysis & Evaluation (Local & National) within 31st March	• Improved quality and value as a result of a reduced number of unnecessary or duplicated investigations leading to efficiency savings • Improved patient experience and reduce harm from navigating patients to alternative services before they enter the system for triage. This proactive approach to patient management will ensure patients receive the correct care option in the most appropriate setting in a timely manner, while reducing the demand on ED.		PIPs: All to be in place by 31st March				
y	I2.2	Improved unscheduled care pathways	**Unscheduled Care**	Full year effect of 2020/21 Winter Plan and development of Winter Plan 2021/22	Established acute and community surge plans	• Prevention of harm by ensuring patients only stay in hospital for the appropriate amount of time • Improved patient safety and experience through facilitation of efficient and safe discharges to the most appropriate environment	Executive Director Nursing & Midwifery	30th September	Workforce recruitment	Core Funding / WG Funding		y	Board & FPIG
	I2.2				Specific winter schemes implemented to meet increased demand during Winter as well as Covid19 demand			30th September					
	I2.2				Review of 2021-22 winter schemes including impact and spend to effectively inform winter plan 2021-22			30th September					
y	I2.3	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Same Day Emergency Care (SDEC)	Further develop and establish SDEC models across the 3 acute sites to better manage urgent care demand into a more scheduled way	Aligned to USC improvement programme • Improve patient / staff experience and reduce harm through avoiding unnecessary ED attendances / delays • Improved patient experience through being seen by the right healthcare professional first time • Maximise use of ambulatory care / SDEC service to ensure patients are only admitted when absolutely necessary • Efficient flow across the whole system will improve patient & staff experience; improve quality / reduce harm	Executive Director Nursing & Midwifery	30th September	Workforce recruitment	WG Funding through additional USC allocation (recurring)		y	Board & FPIG
y	I2.4	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Developing the unscheduled care hub, 111 service	Implementation of 111 in north Wales to integrate call handling and nurse assessment functions of GPOOH and NHSD into a single service. 111 will provide public facing access to urgent health information, advice and signposting for onward care.	Aligned to USC improvement programme • Improve patient safety, experience and clinical outcomes through timely transfer of information to support clinical decision making and care • Minimised duplication in assessment processes • Support delivery of services closer to patients home and improve self care rates • Support for patients to choose the right service at the right time • Reduced pressure on emergency care services and improved patient flow through reduced unnecessary ED attendances • Efficient service delivery with improved direction to alternative services	Executive Director Nursing & Midwifery	30th June - Phase 1	Workforce	HB allocation of National 111 programme		y	Board & FPIG
y	I2.6	Improved unscheduled care pathways	**Unscheduled Care programme lead**	Implement Discharge to Recover & Assess (D2RA) pathways through further development of Home First Bureaus in each area	Further develop and embed the Home First Bureaus to support development of D2RA pathways following Executive approval of business case and support the step up and step down model of care in the community, to both avoid admission and support early discharge for medically stable patients	Establishment of Home First Bureaus in each area to support discharge planning: i) reduce delayed discharges ii) reduce unnecessary waits for assessments in hospital iii) reduce DTOCs iv) increase in number of patients returning home v) increase in short term step-down placements vi) reduction in long term placements vii) increase in assessments of patients post discharge leading to viii) shorter lengths of stay and releasing beds ix) improved patient flow across USC system This work is aligned to the USC improvement programme • Improve flow across the whole USC system through implementation of relevant discharge pathways and reduced patient delays • Improved patient safety and experience through facilitation of efficient and safe discharges to the most appropriate environment • Reduce harm by reducing patient length of stay to minimum	Executive Director Nursing & Midwifery	31st December	Workforce/Recruitment			y	Board & FPIG
y	I2.7	Improved unscheduled care pathways	**Unscheduled Care programme lead/ Area Director East**	Stroke Services: Enable work to progress on strategic service development - confirm and agree the stroke service model	Development of business case to improve stroke services across a whole system approach that will provide a "Once for North Wales" network approach to ensure consistency of clinical outcomes for Early Supported Discharge and Specialist Integrated Community In-patient Rehabilitation services. Phase 1 service proposal focuses on: Prevention including improved AF detection	The outcomes have been adapted from the WG Stroke Delivery Plan and cover the six elements of the stroke pathway and are linked to : • better management of AF, faster, effective acute care and Rehabilitation • better management of AF and the Health Board Health and Well Being Strategy of weight loss and smoking cessation Improved patient outcomes through; • reducing the risk of stroke through the prevention pathway	Executive Director Nursing & Midwifery	Stroke Prevention – 30th September	Affordability of the new model Workforce recruitment & retention Ability to maintain 65% & 85% occupancy rates Suitability of estates to provide an appropriate rehabilitation environment	Performance Fund		y	Board & FPIG
	I2.7				Strengthening of acute services across 3 DGH sites; including improved OOH pathway for diagnosis; treatment and recovery	• improving quality of life through an improved 72 hour Acute pathway and Specialist Rehabilitation with ESD and in-patient beds • improving quality of care and patient experience through an improvement in the total pathway • reducing disability through an improved 72 hour Acute pathway and Specialist Rehabilitation with ESD and in-patient beds • improving survival rates through an improved 72 hour pathway		Acute services – 30th September				
	I2.7				Development of Early supported discharge (ESD) across the 3 areas	• reduced variation across NW • Improve Sentinel Stroke National Audit Programme and related performance criteria • Improve compliance with Stroke Guidelines (Royal College of Physicians recommendations) • Reduced disability and reliance on social care • Improved prevention through reduced risk of another stroke		ESD – 30th September 20% / 31st December 70% / 31st March 100%				
	I2.7				Specialist community inpatient rehabilitation beds across the 3 areas	• Improved patient safety and outcome through timely swallowing assessments: improved access to occupational therapy, physio therapy, speech and language therapy interventions • Improved patient experience through early supportive discharge processes • Improved staff experience with improved recruitment and retention of specialist staff Measures of patient experience and outcomes will be aligned to the standards for stroke care throughout the pathway.		Specialist Community inpatient beds – 30th September				
	I2.7				A consistent approach to Stroke Rehabilitation across all sites in proportion of confirmed stroke patients receiving specialist rehabilitation and length of stay			Consistent approach to rehabilitation – 31st March				
Y	R2.6	Strengthen our population health focus	**Assistant Area Directors for Children's Services**	Neurodevelopment (ND)- improve access to services to meet WG 26 weeks assessment targets and further develop early intervention post diagnostic services.	Implement ND Performance 2 year Improvement Plan.	Improved access for Children and young people with reduced waiting times. Service offer post-assessment & treatment / intervention. Work with National group to develop case for service post assessment.	Executive Director Primary & Community Care	30th June – Baseline assessment.	Allocation of Funding.	Performance Fund		Y	Board & QSE
	R2.6				Management and review existing waiting list and plan to reduce waiting times within core capacity and commissioning of private provider to reduce backlog.		Executive Director Primary & Community Care	30th September - Improvement Plan and structure to deliver agreed.	Timely agreement of Full Tender for external provider to support backlog.				
	R2.6				Develop Workforce Strategy and plan. Recruit and implement new model of working.		Executive Director Primary & Community Care	31st December/4 - Ongoing performance monitoring via ND Regional Steering Group.					
Y	R2.7	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	Delivery of agreed planned care recovery schemes (including additional programme management capacity), to include diagnostics, e.g. endoscopy, laminar flow theatres and inpatient T&O bed provision (including relocation of outpatient therapy provision in Wrexham)	Provide recovery plans for each site for for Cohort 1 & 2 by mid-May. This will include extra capacity, insourcing requirement and outsourcing and workforce requirements	The recovery plan will reduce by March 2022 all over 52-week waiters, except orthopaedics within cohort 1. Cohort 2 patients (covid backlog) will then be treated reducing/eliminating long waiters and moving the organisation back towards a risk stratified/36 week position	Executive Director Nursing & Midwifery	30th June-Develop and agree a plan	Inconsistent planning Inconsistent trajectories Inability to link finances to trajectory workforce may not be available to deliver this additionally. Not sufficient resources to clear backlog 1&2 Not treating patients in turn Unscheduled care disruption to planned care and/or further covid outbreaks further urgent demand into the system above core may also require additionally	Performance Fund	Y	Y	Board & FPIG
	R2.7				Develop a plan for physiotherapy regarding their relocation	Trajectories by mid may for the Cohort 2 reduction in over 52 week waiters		31st March- delivery of cohort 1 with exception of orthopaedics					
Y	R2.8	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	Build additional capacity to deliver COVID19 safe services, improve patient experience and waiting times.	P1-and P2 risk stratified patients are treated in order, followed by re-introduction of P3-4 activity. Insourcing and weekend capacity plan.	Will ensure that high risk stratified patients will be treated in accordance with appropriate timelines	Executive Director Nursing & Midwifery	31st December		performance fund	Y	Y	Board & FPIG
	R2.8				Continually review capacity of external providers to deliver more activity, to support more efficient services	contracting reviewing external capacity on a monthly basis		30th September					
	R2.8				Introduce super green pathways to protect elective capacity	Provides ring fenced capacity to ensure minimum disruption to core and additional activity, ensuring reducing in long waits and value for money		30th September					
Y	R2.9	Recovering access to timely planned care pathways	**North Wales Musculoskeletal Network Delivery Manager**	Support orthopaedic patients facing extended waiting times as a result of COVID19 constraints, by delivering a non-surgical treatment programme such as escape from pain, digital apps	Programmes developed to support patients whilst they are awaiting an extended period of waiting	The six-point recovery plan includes schemes to support patients whilst awaiting their procedure, such as Escape from pain and habilitation programmes. These will support healthier living and improve mobility	Executive Director Nursing & Midwifery	31st December	Funding for programme. Workforce to deliver model Patient uptake Facilities to deliver the model	transformational Funding	Y	Y	Board & QSE
	R2.9				Implement 'Escape from Pain' programme for orthopaedics using digital app for orthopaedics,								
	R2.9				Develop a communication tool introduction of Orthopaedic habilitation programmes to support patients mobility and general health whilst awaiting an intervention	Improve mobility and prevent extended length of stay once ready for their operation. Prevents further complications			requires business case and option appraisal				
Y	R3.2	Recovering access to timely planned care pathways	**Hospital management teams/Head of Planned Care Improvement**	Insourcing to support provision of service for cohort 1&2	Tender specification for insourcing	This will provide additional capacity to the organisation in the form of insourcing and outsourcing	Executive Director Nursing & Midwifery	30th June	Tendering process not completed on time unable to allocate the insourcing work due to lack of providers Unable to provide facilities for insourcing company.	Performance funding transformational funding	Y	Y	Board & FPIG
	R3.2			Outsourcing specification for Orthopaedics	Tender specification for outsourcing	this modelling will allow the organisation to understand, capacity required, cost and trajectories to reduce long waiters in the organisation							

	R3.2				Demand and capacity modelling complete to treat all over 52 week waiters and to get the organisation to 36 weeks								
Y	R3.4 R3.4	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	Develop the Outpatient transformation programme Including 'Once for North Wales', workforce modernisation and digital enablement of staff and service users with attend anywhere and consultant connect.	Approve and recruit outpatient transformation programme team to progress the work across all sites Transforming outpatient department for 'Once for North wales' approach.	Allowing improved access for patients and reduce waiting times. Development of further straight to test pathways. Reduce face to face consultations will provide further OPD capacity reduce follow up backlog Will reduce Outpatient waiting times and give patients more choice will support deliver of Suspicious Cancer pathway will support delivery of 16 week out-patient target	Executive Director Nursing & Midwifery	Phased delivery over 12 months from point of recruitment, anticipated delivery by 31st March if recruitment and implementation successful	supported by executives unable to recruit lack of clinical ownership/leadership	performance fund	Y	Y	Board & FPIG
Y	R3.5 R3.5	Recovering access to timely planned care pathways	**Head Of Planned Care Improvement**	To explore external capacity to support access to treatment	External providers canvassed on fortnightly basis to assess available capacity Fortnightly review of capacity to assess any external capacity available	To establish availability of additional capacity to reduce waiting times – below 52 weeks by March 2022	Executive Director Nursing & Midwifery	30th June out to tender, insourcing early July- If these time frames work then outsourcing could be August insourcing September. Hope that helps	unable to resource further capacity unable to reduce backlogs costs	Performance funds transformational funds	Y	Y	Board & FPIG
Y	R3.6 R3.6	Recovering access to timely planned care pathways	**Endoscopy Network Manager**	Development of sustainable endoscopy services across North Wales	Deliver on 2 year endoscopy plan, adopting an outsourcing, insourcing model, whilst recruiting substantively to enable the demand and capacity gap to be resolved. Develop and initiate a recruitment plan responding to future predicted growth in all aspects of the services (including BSW) spanning 2021/22 – 2023/4. Standardising clinical and operational processes and procedures, supporting the formation of the 'North wales Endoscopy Service' supported by an improved endoscopy IT system.	Reduce diagnostic and endoscopy waiting times, improve cancer outcomes	Executive Director Nursing & Midwifery	31st March	Recruitment of workforce	Core Funding	Y	Y	Board & FPIG
Y	R3.7 R3.7	Recovering access to timely planned care pathways	**Divisional General Manager Cancer Services, Cancer Services**	Deliver suspected cancer pathway	1. Increased rapid access breast cancer clinic capacity across the Health Board – business case approved by Executive Team June 2021; these clinics have been provided on an ad hoc basis since November 2020 and can now be established as part of core activity once new posts are recruited to 2. Continuation of the early diagnosis lung cancer pathway which ensures patients with a suspicious chest X ray are directed straight to CT – funded in 2021/22 with a business case for ongoing funding being developed 3. Development of one stop neck lump clinics – project team established and pathway agreed; business case to be submitted this month 4. One stop rapid diagnosis clinic for patients with vague but concerning symptoms – project manager in post, project team established and pathway agreed; business case to be submitted this month 5. Increase in Clinical Nurse Specialist and support roles to support patients with their diagnosis and provide direct clinical care as appropriate – business case submitted and to be considered by Health Board business case review team in July 6. Patient navigators to track pathways and escalate delays – funded in 2021/22 with a business case for ongoing funding submitted and awaiting approval. 7. Pathway improvement posts to work with clinical teams to introduce the National Optimal Pathways for cancer ensuring pathways are as streamlined, efficient and effective as possible – business case submitted, awaiting approval (NB one post already funded by Wales Cancer Network and going through recruitment process)	Improve cancer outcomes reduce mortality ensuring rapid assessment of patients with suspected cancer	Executive Director Nursing & Midwifery	30th June 69% 30th September 69% 30th December 71% 31st March 75%	not enough out-patient capacity to achieve new standard pathways not sufficient to deliver new model Cancer services do not have a high profile in the organisation	Performance Fund transformational funds	Y	Y	Board & FPIG
Y	R4 R4	Recovering access to timely planned care pathways	**Directorate General Manager, Nwmcs, North Wales Managed Clinical Services**	Implementation of short term insourcing solutions for computerized tomography, magnetic resonance imaging and ultrasound to significantly reduce the backlog of routine referrals	Insourcing contract in place with external provider Additional mobile scanners / staffing in place	Reduction in backlog of patients waiting over 8 weeks for scan. Stretch project to reduce waits to 6 weeks	Executive Director Nursing & Midwifery	30th September		Core Funding	Y	Y	Board & FPIG
Y	R4.1 R4.1	Recovering access to timely planned care pathways	**Directorate General Manager, Nwmcs, North Wales Managed Clinical Services**	Implementation of insourcing solutions for neurophysiology to significantly reduce the backlog of routine referrals	Insourcing contract in place with external provider Additional clinic space / staffing in place	Reduction in backlog of patients waiting over 8 weeks for scan. High Street locations identified as ideal for this service.	Executive Director Nursing & Midwifery	30th September		Performance fund	Y	Y	Board & FPIG
Y	R4.2 R4.2	Recovering access to timely planned care pathways	**Directorate General Manager, Nwmcs, North Wales Managed Clinical Services**	Development and commencement of implementation of long term plans for sustainable diagnostic services (radiology and neurophysiology)	Recruitment to medical, scientific / allied health professional, supporting and administrative posts Identification of estates and equipment priorities	Recruitment to agreed sustainable service models. Identification of suitable space to operate from.	Executive Director Nursing & Midwifery	31st March		Core Funding	Y	Y	Board & FPIG
Y	R4.5 R4.5 R4.5 R4.5 R4.5 R4.5 R4.5 R4.5	Recovering access to timely planned care pathways	**Clinical Director Therapy Services, Therapies & Health Science**	Increase specialist cancer therapy staff to meet All Wales benchmark: Produce a business case to appoint specialist allied health professional (dietitians/speech and language therapist)	Development of referral pathways particularly for upper gastrointestinal and hepatobiliary and pancreatic cancer which are Wales cancer network priorities and the Health Boards strategic priority for pelvic cancer services Development of self-management information Implement timely interventions at all stages of the cancer journey for communication, eating and drinking, leading to faster progression to oral diet and fluids, reduction in the need to rely on radiologically inserted gastrostomy / percutaneous endoscopic gastrostomy enteral feeding, reduction in the costs of enteral feed and dietary supplements Use patient recorded outcome measures / holistic needs assessment and treatment summaries in line with person centred care philosophy across Wales Development of programmes of education to upskill generalist therapy staff, and multi professional teams supporting self- management; efficient use of resources and supporting increased numbers of patients and carers. Development of education programmes to upskill generalist therapy staff is required thus supporting increased numbers of patients and carers.	Improved communication due to attendance at multi-disciplinary teams with improved multi-professional and interagency working. Increased equity of access to allied health professionals and rehabilitation programmes	Executive Director Nursing & Midwifery	30th September		Core Funding	Y	Y	Board & QSE
Y	R4.6	Recovering access to timely planned care pathways	**Site Acute Care Director**	Eye Care Services: transform eye care pathway: Enable work to progress on strategic service developments eye care	Work with Eye Care Collaborative Group in place and robust with good engagement and appropriate structure in place to receive proposals and agree recommendations to HB. Linked in to all All Wales Groups Develop a Business Case to support strategic direction approved by PCTG and to Executive Management. Identify Priorities to include Increased capacity for IVT, implementation of Digital Eye Care system together with replacement of EoL equipment and lastly the re-tendering for Eye Care pathways to be delivered by Primary Care ODTCs	These actions allow the development of strategic direction for ophthalmology and developing a 2-3 year plan will support the delivery of a cataract service that will reduce the patients waiting times Implementation will enable increased capacity to treat wet AMD patients requiring specific treatment intervals to mitigate sight reduction (circa 570 extra treatments per week) Delivery of electronic referrals and image sharing reducing attendance at secondary care for stable glaucoma patients undertaken by Primary Care Optometrists	Executive Director Nursing & Midwifery	Already initiated with pump priming last year, continuation secured through previous funding whilst BC approval expected June 2021 enables re-tendering exercise by end 30th September	Required approval for BCUHB and WG Funding	Core Funding as part of Annual Business Plan 2021	Y	Y	Board & FPIG
Y	R4.7	Recovering access to timely planned care pathways	**Site Acute Care Director**	Enable work to progress on strategic service developments urology	Development of the urology plan (Robotic Assisted Surgery (RAS) Procurement) Completion of All Wales procurement process by end 30th June In parallel review of Business case to support RAS and Urology re-design for BCUHB approval	The plan will help address the demand and capacity imbalance and will support the reduction of waiting times and the development of a specialised centre of excellence for patients in north Wales	Executive Director Nursing & Midwifery	Procurement by 30th June Delivery RAS 30th September Urology redesign and implementation along with RAS training 31st December/31st March 0 tbc by Urology review group July 2021	Required approval for BCUHB and WG Funding	Performance Fund	Y	Y	Board & FPIG
Y	R4.8	Recovering access to timely planned care pathways	**Site Acute Care Director**	Implementation of the glaucoma pathway	Implemented and delivery on going. Performance against trajectory good with improvements on going as we work towards re-tendering process	As above with regards to the Eye Care Strategy, along with an additional 7,200 appointments (300 referral refinement)	Executive Director Nursing & Midwifery	31st March	Required approval for BCUHB Funding	Core Funding	Y	Y	Board & FPIG
Y	R4.9	Recovering access to timely planned care pathways	**Site Acute Care Director**	Implementation of the diabetic and age-related macular degeneration pathways	Review and identify areas of improvement for pathways Agree and implement pathway service improvements.	Updated pathways being reviewed	Executive Director Nursing & Midwifery	31st March	Required approval for BCUHB Funding	Core Funding	Y	Y	Board & FPIG
Y	R10.2 R10.2 R10.2 R10.2 R10.2 R10.2 R10.2 R10.2 R10.2 R10.2 R10.2 R10.2	Recovering access to timely planned care pathways	**Clinical Leads and Matron**	Ensure Safe and Effective Care	1. Implement the recommendations of the HIW National Review of Maternity Services (November, 2020) 2. Implement the National MIS solution for Wales (HIW, November 2020). 3. Implement the new outcomes measures and KPIs for the revised WG 5-Year Strategy. 4. Benchmarking exercise against NICE Quality Standards 5. Demonstrate progress in using the Maternity Voice Group in co-producing the service model, 6. Ongoing monitoring of safety equipment checks. 7. Reflect workforce plans with national standards for maternity services. 8. Implement 'Mothers and Babies Reducing Risk through Audits and Confidential Enquiries' (MBRRACE) recommended Local and National improvement initiatives to reduce stillbirth 9. Implementation of the GAP/GROW I + II 10. Mortality and Morbidity multi-professional reviewed carried out to conform to MBBRACE and perinatal mortality review tool (PMRT) requirements. 11. Promoting normality in first pregnancy, latent phase project in community. 12. Ensure compliance with the C-Section Tool Kit to maintain Elective C-Section rates under 10% by increasing external cephalic version (ECV) and maximising vaginal birth after caesarean (VBAC) Opportunities. 13. Implement the MBRRACE and Each Baby Counts (EBC) Recommendations.	1. Safe and effective care, delivered in line with national standards, Welsh Government performance measures, MBBRACE, Each Baby Counts, RCOG and NICE guidelines. 2. A Midwifery Informatics System 3. Maternity Service User Engagement Strategy 4. Reduction of birth intervention and induction of labour via latent phase community project. 5. Reduced C-section rates	Executive Director Of Public Health	Action 1: 31st December Action 2: WG Initiative Action 3: informed by WG timetable Action 4: 30th September Action 5: 30th June Action 6: 30th June Action 7: 30th September Action 8: 31st March Action 9: 31st March Action 10: 30th September Action 11: 31st December Action 12: 31st December Action 13: 30th September	MIS is a WG introduction as is out of our direct control and Saving Babies' Lives – securing the right USS capacity remains a risk	Core Funding		Y	Board & QSE
Y	R10.4 R10.4	Recovering access to timely planned care pathways	**Head of Women's Services**	Implement Sustainable Quality Care	1. Ensure staffing levels are birth rate plus and RCOG compliant 2. Reduction of activity in contract agreement with CoCH services,	1. Birth Rate Plus compliant 2. Care closer to home 3. Sound and robust governance and risk management system 4. CSIM Workforce Sustainability	Executive Director Of Public Health	Action 1: 30th June Action 2: 31st December	Welsh Government Birth Rate Plus plans / reviews.	Core Funding		Y	Board & QSE

	R10.4				3. Implement the 21/22 Revenue Business Development Plans.			Action 3: 31st March						
	R10.4				4. Develop stronger governance systems, for performance and accountability.			Action 4: 31st December						
	R10.4				5. National CfSM Peer Review by WG and Clinical Supervision Resource Mapping.			Action 5: 30th September						
Y	M1.1	Integration and improvement of mental health services	**Interim Director of Nursing**	Quality Improvement & Governance: Implementation of ward accreditation to improve fundamentals of care and leadership.	Proceed in completing ward accreditation by scoring as a minimum bronze across all of our inpatient wards.	• To improve service delivery and experience / outcomes for patients / families / carers by meeting fundamental standards for inpatient nursing • To increase the number of wards achieving a bronze award or above	Interim Executive Director of Mental Health & Learning Disabilities	30th June, scope programme of work	Links with corporate services and support to deliver	MHLD Revenue	Y	Y	Board & QSE
	M1.1							30th September, agree plan for roll-out					
	M1.1							31st December/31st March implement					
Y	M1.2	Integration and improvement of mental health services	**Interim Director of Operations**	Workforce Wellness & Organisational Development: We will enhance leadership within the Division and seek to actively support staff in their workplaces to maintain optimum wellbeing.	By further embedding the Wellness, Work & You Strategy.	To improve the skill mix to address shortfalls in service provision To ensure multi-disciplinary staff are trained to provide best quality services for patients	Interim Executive Director of Mental Health & Learning Disabilities	30th June agree scheme plan		Transformation Funding	Y	Y	Board & QSE
	M1.2				Develop a meaningful communication strategy.	To provide effective recruitment and retention To ensure our staff are well, supported and engaged		30th September/31st December/31st March implementation					
	M1.2				Develop a sustainable workforce plan including training to support the service redesign & improvement initiatives	Will have a safe, sustainable and stable leadership structure							
Y	M1.3	Integration and improvement of mental health services	**Programme Director**	Ablett / YGC MH Inpatient Redesign: We will continue to work with Corporate Planning colleagues to design on the YGC site for the provision of Adult and Older People's Mental Health inpatient services in the Central Area.	Progress the business case through gateway reviews and continuation of planning requirements.	To provide services which meet the strategic direction outlined within Together for Mental Health in North Wales and deliver the model of care developed through the Quality & Workforce groups; To provide an environment that supports staff to deliver safe, effective care to patients, carers and families; To deliver the flexibility to respond to future need – the solution should be designed to respond to future changes in service delivery	Interim Executive Director of Mental Health & Learning Disabilities	30th June	Delay in planning permissions	Capital Investment	Y	Y	Board & QSE
	M1.3							31st March, dependent on planning permissions outcome					
Y	M1.5	Integration and improvement of mental health services	**Medical Director, Head of Nursing CAMHS**	CAMHS: We will develop an appropriate interface with child and adolescent mental health services to ensure the most effective transition for young people with mental health conditions into adult services.	Develop effective and timely transition arrangements that support young people into adult services.	To provide a seamless services for patients / younger persons transitioning into Adult MH Services. To evidence based data sets, triangulated benchmarking with local data will underpin our work To have a clearly defined proposal for model of crisis care	Interim Executive Director of Mental Health & Learning Disabilities	30th June, develop improvement plan	Delay in recruitment processes. Availability of skilled and trained staff. Lack of project support.	Transformation Funding	Y	Y	Board & QSE
	M1.5				Develop effective joint working arrangements between adult mental health, child and adolescent mental health services and local authority professionals			30th September, agree plan					
	M1.5				In partnership we will develop and implement CYP workforce plan and recruit to specific roles.			31st December-31st March begin to implement improvements					
Y	M1.6	Integration and improvement of mental health services	**Medical Director**	Safe & Timely Discharge: We will introduce a programme of work across the division to review long length of stay and delayed transfer of care.	Develop a process to ensure timely escalation for issues relating to delayed transfer of care, long length of stay and out of area patients	To reduce long length of stay, delayed transfers of care and out of area placements To provide care closer to home	Interim Executive Director of Mental Health & Learning Disabilities	30th June, review work to date	Fragility of care home sector	MH&LD baseline budget	Y	Y	Board & QSE
	M1.6							30th September, agree plan and begin roll-out					
	M1.6							31st December-31st March, on-going work with adjustments as required					
Y	M1.7	Integration and improvement of mental health services	**OPMH Clinical Lead**	Dementia Care: Delivery of clinically led, safe and effective services will be further developed aligned with the dementia strategy.	Work with partners to promote and support initiatives to reduce the risk and delay onset of dementia, including links between hearing loss and dementia.	To have a defined model of care that meets the population demand and is of the highest quality evidence base To improve holistic approach to care To ensure that staff are trained and developed multi-disciplinary staff to provide best quality services for patients	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September develop master scheme	Demographic change.	TBC	Y	Y	Board & QSE
	M1.7				Extend support services so that all with patients with dementia and mild cognitive impairment have access to support, tailored to them, to incorporate the six steps into their daily life.			31st December-31st March begin implementation					
y	M1.8	Integration and improvement of mental health services	**OPMH Clinical Lead**	Older Persons (OPMH): Development of Crisis care support for older adults (over 70) with an acute mental illness over the age of 70 and people of any age living with dementia.	Work with Area Teams and LA partners, develop a team approach to support care home in order to avoid crisis situations.	To reduce the use of clinically unjustified out of area placements and provide care closer to home To have a clear admission criteria and planned discharge	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September develop master scheme with supporting SOPs	Delay in recruitment processes. Availability of skilled and trained staff. Failure to recruit.	Transformation Funding	Y	y	Board & QSE & PPPH?
	M1.8				Further define a vision for service provision for older person's mental health.	To define model of inpatient care that meets the population demand and is of the highest quality evidence base Improved holistic approach to care							
	M1.8				Define and implement the proposed model of crisis care	To have trained and developed multi-disciplinary staff to provide best quality services for patients To have more people having quicker access to services providing appropriate and timely crisis support to maintain people receiving care in their own homes.		31st December-31st March begin implementation					
	M1.8				We will recruit a crisis care team	To reduce avoidable and emergency admissions To provide support to EMI and commissioned care home settings							
y	M1.9	Integration and improvement of mental health services	**Interim Director of Nursing**	Early Intervention Psychosis: Enhancing the current Multi-disciplinary Team with trained and developed multi-disciplinary staff to provide best quality services for patients and families.	Develop and implement agreed early intervention in psychosis model of care	To provide an equitable service across North Wales To provide swift access to dedicated service / practitioner To provide each patient / family with a crisis and management plan	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	Delay in recruitment processes. Availability of skilled and trained staff. Availability of space for resource	Transformation Funding	Y	y	Board & QSE
	M1.9							30th September, begin recruitment					
	M1.9				We will recruit to specific workforce dedicated to this service	To reduce in emergency admissions To reduce bed occupancy and out of area placements		31st December, integrate in to local teams					
	M1.9				We will develop integrated pathways	To provide a service for younger persons and adults		31st March, evaluate					
y	M10	Integration and improvement of mental health services	**Consultant Psychiatrist**	Forensic Services: Development of a model for forensic and low secure provision for both mental health and learning disabilities services in North Wales.	Develop whole system patient flow pathways.	To reduce placements outside of Wales by providing care closer to home To strengthen commissioning arrangements More people having quicker access to services To have trained and developed multi-disciplinary staff to provide best quality services for patients	Interim Executive Director of Mental Health & Learning Disabilities	30th June – 30th September develop system pathway with supporting workforce plan		Likely to require a full business case	Y	y	Board & QSE
	M10				We will define required establishment and workforce plan.			31st December Develop options appraisal					
	M10				We will develop options for secure service provision / service transformation to inform robust service business case.	To strengthen partnership approach to achieving best outcomes for patients / families / carers							
y	M10.1	Integration and improvement of mental health services	**Interim Director of Operations**	Learning Disabilities: We will implement the strategy for learning disabilities services in partnership with people with lived experience, their families, health and social care organisations across North Wales and the voluntary sector.	Define the required establishment and skilled workforce.	To provide care provided closer to home and reduce out of area placements To improve patient / carer experience through effective partnership working	Interim Executive Director of Mental Health & Learning Disabilities	30th June – 30th September develop system pathway with supporting workforce plan	Availability of skilled and trained staff.	Healthier Wales & ICF Funding	Y	y	Board & QSE
	M10.1				We will review and develop commissioning arrangements								
	M10.1				We will further develop fully functioning multi-disciplinary teams to provide best quality services for patients including preventative models of care.			31st December Develop future options appraisal					
	M10.1				We will define the new model for assessment and treatment and domiciliary care.			31st March Evaluate work programme to date					
y	M10.2	Integration and improvement of mental health services	**Medical Director**	Maternal Care & Perinatal Services: To enhance delivery of clinically led, safe and effective services for mother and babies that require perinatal mental health services.	Work proactively to develop the existing service pathways and ensure alignment to Welsh Government guidance	• To ensure our services are aligned to Welsh Government guidance • To reduce mental illness in the mother and improve the mother-infant relationship • To provide regular and on-going training to allied mental health and primary care colleagues to improve the understanding and knowledge of perinatal mental health • To have a multi-skilled and specialist workforce to support our patients	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	Delay in recruitment processes. Availability of skilled and trained staff. Availability of space for resource	Transformation Funding	Y	y	Board & QSE
	M10.2				We will provide dedicated professionals as above would allow a more seamless process, more flexibility	• To provide a modernised service by developing integrated pathways • To reduce the need for out of area placements and support care closer to home • To ensure our services are aligned to Welsh Government guidance • To reduce mental illness in the mother and improve the mother-infant relationship • To provide regular and on-going training to allied mental health and primary care colleagues to improve the understanding and knowledge of perinatal mental health • To have a multi-skilled and specialist workforce to support our patients • To provide a modernised service by developing integrated pathways • To reduce the need for out of area placements and support care closer to home		30th September, begin recruitment					
	M10.2				We will improved access to specialist clinical expertise specifically early intervention and treatment by recruiting additional specialised staff			31st December, integrate in to local teams					
	M10.2							31st March, evaluate					
y	M10.3	Integration and improvement of mental health services	**Clinical Lead Occupational Therapist**	Primary Care & ICAN: To build on actions from within the Winter Plan and further develop the demand and capacity modelling to continue to review and improve patient flow between primary and secondary care. To work with Primary Care Services together with ICAN to offer direct and rapid access to wider ranging support supported by trauma informed approaches at cluster level.	Develop locally agreed protocols and project plan with Clusters.	To provide effective and efficient service delivery including released general practitioner time. To deliver care at or as close to home as possible To provide access to the right information, when needed to improve mental health and wellbeing e.g. number of individuals supported through ICAN community hubs To provide the best possible outcome, diagnosed early and treated in accordance with clinical need To provide staff that are fully engaged in delivering excellent care and support to	Interim Executive Director of Mental Health & Learning Disabilities	30th June Engagement with primary care clusters	Availability of skilled and trained staff.	Transformation Funding	Y	y	Board & QSE
	M10.3				We will recruit key staff members dedicated to support the work			30th June Recruitment of OTs for model across North Wales					
	M10.3				We will roll out Primary care Mental Health Practitioners to current ICAN Test sites with a wider roll out across the Region								
	M10.3				We will develop a training plan			30th September Internal and external promotion of ICAN primary care model with GP Clusters and partner agencies					

	M10.3				We will develop an evaluation framework	patients and families							
	M10.3				We will identify further GP surgeries for roll out	To provide standardised systems and processes To reduce the number of referrals into MH primary care services (< MHM part 1)		31st December-31st March evaluate impact					
	M10.3				We will share learning and evaluation at regular time points with division, clusters and wider partners								
y	M10.4	Integration and improvement of mental health services	**Head Of AMH Clinical Psychology & Psychological Services**	Psychological Therapies: To increase access to psychological therapies across both mental and physical health services.	Review of existing offer and service provision and develop an improved model of care.	• To improve interventions based on good quality and timely research and best practice • To train staff to deliver excellent care and support to patients and families • To standardised systems and processes • To improve access to services and reduce waiting times	Interim Executive Director of Mental Health & Learning Disabilities	31st March	TBC	TBC	Y	y	Board & QSE
	M10.4				We will develop workforce plan								
y	M10.5	Integration and improvement of mental health services	**Head of Operations**	Rehabilitation Services: To agree a long term model for rehab services and support whole system patient flow pathways.	Develop a plan in relation to Specialist Bed Based Care with the driving principle being – Right Care, Right Time Right Place.	• To reduce placements for low secure provision outside of Wales and provide care closer to home • To have an agreed establishment and workforce plan • To have strengthened commissioning arrangements • To have trained and developed multi-disciplinary staff to provide best quality services for patients • To reduce in patient transport	Interim Executive Director of Mental Health & Learning Disabilities	30th June-30th September review and agree plan	Identified funding stream	Likely to require a full business case	Y	y	Board & QSE
	M10.5				We will define the bed based care and community model			31st December, seek Divisional approval and consider funding requirements					
	M10.5				We will review our estate requirements								
	M10.5				We will develop our workforce model			31st March finalise plan					
y	M10.7	Integration and improvement of mental health services	**Medical Director**	Unscheduled Care & Crisis Response: We will further develop an all age crisis response pathway.	Work with our 3rd sector partners to develop a pathway to include crisis, community and home treatment provision.	To reduce use of inappropriate s136 To reduce the use of clinically unjustified out of area placements	Interim Executive Director of Mental Health & Learning Disabilities	31st December	TBC	Additional resources for MH 2021 – 22	Y	y	Board & QSE
	M10.7				We will develop a business case to secure funding	To have clearly defined admission criteria and planned discharge that's linked to community alternatives To have a defined crisis pathway							
y	M10.8	Integration and improvement of mental health services	**Head Of Specialist Tier 3 Eating Disorders Service**	Eating Disorders: To address the significant deficits in service provision for early intervention and treatment and to improve the clinical needs and challenges of current Eating Disorder (ED) service provision in North Wales and North Powys.	Develop and implement the provision of a MARSIPAN 'Team' to facilitate medical and psychiatric admissions for ED patients (MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa, Royal College of Physicians, 2014).	To meet the targets for review within a week for urgent cases and 4 weeks for all cases by the specialised team	Interim Executive Director of Mental Health & Learning Disabilities	30th June, agree master scheme	Delay in recruitment processes. Failure to recruit. Availability of skilled and trained staff.	Transformation Funding	Y	y	Board & QSE
	M10.8					To have dedicated professionals to allow a more seamless process, more flexibility, and the ability to offer more 'slots' / availability to service access		30th September, begin recruitment					
	M10.8				We will work collaboratively alongside existing staff in CAEDS and therefore strengthen the ED workforce.	To improve access to specialist clinical expertise in ED at Tiers 1 and 2 and specifically early intervention and treatment.		31st December, integrate in to local teams	Lack of project support. Availability of space for resource				
	M10.8					To provide a service for younger persons and adults		31st March, evaluate					
y	M11	Integration and improvement of mental health services	**Head of Operations**	Liaison: To provide an appropriate and consistent psychiatric liaison response across North Wales.	Review the evidence based data sets, triangulated benchmarking with local data.	• To have a defined model of care that meets the population demand and is of the highest quality evidence base • To have trained and developed multi-disciplinary staff to provide best quality services for patients • To increase more people having quicker access to services providing appropriate and timely crisis support • To reduce avoidable admissions • To reduce unplanned/avoidable admissions/attendances at ED	Interim Executive Director of Mental Health & Learning Disabilities	30th June, scope requirements	Delay in recruitment processes. Failure to recruit. Availability of skilled and trained staff. IT to support NHS 111 implementation	Transformation Funding	Y	y	Board & QSE
	M11				We will undertake capacity modelling			30th September, develop and agree a plan					
	M11				We will define the proposed model of service we will further develop pathways & workforce, and improve patient experience.			31st December, agree proposals					
	M11							31st March, implement					
y	M11.1	Integration and improvement of mental health services	**Interim Deputy Director**	Partnership & Engagement: To deliver clinically led, safe and effective services in partnership with patients, their families, social care and third sector colleagues.	Review of Canlad (third sector working) arrangements.	To ensure all key stakeholders are involved in and at the heart of everything we do To have strengthened commissioning arrangements	Interim Executive Director of Mental Health & Learning Disabilities	31st December	N/A	N/A	Y	y	Board & QSE & PPPH?
	M11.1				We will establish joint working approach with area teams to ensure joint planning, engagement and delivery of joint pathways								
	M11.1				We will re-instate our Patient Experience Group & Together for Mental Health Partnership Board								

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Quality and Performance Report – August 2021 (Reporting July 2021 Position)**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson, Executive Director of Planning and Performance
Awdur yr Adroddiad Report Author:	Ed Williams, Head of Performance Assurance Kamala Williams, Interim Director of Performance
Craffu blaenorol: Prior Scrutiny:	The report has been scrutinised by the Interim Director of Performance
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Finance and Performance Committee is requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	☑	**Ar gyfer sicrwydd For Assurance**	☑	**Er gwybodaeth For Information**	☑
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

Delivery Measures

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until such time as the NHS Wales Delivery Framework for 2021-22 is formally published (due mid to late August 2021).

Changes from the last Quality and Performance Report

Welsh Government has stood down the use of Delayed Transfers of Care (DToC) as a measure and replaced by Discharge to Recover and Assess (D2RA). The measures to monitor D2RA have yet to be confirmed, information on D2RA is now included in this report.

Information on virtual outpatient activity has been included to highlight the work of the Health Board's Outpatient Transformation Programme.

The pandemic has resulted in a significant increase in the number and length of time people are waiting for treatment. Risk Stratification of waiting lists, introduced in 2020/21, aims to mitigate the risk of harm for patients facing an extended wait for treatment. Clinicians determine the level of risk of harm for each patient on their waiting list and prioritise them for treatment accordingly. Information regarding the Risk Stratification is included in this report under the Referral to Treatment Time section.

Summary of performance

Pressures on the unscheduled care system continue Emergency Department performance fell in July with 67.02% of patients seen within 4 hours compared to 67.65% in May. Attendances in Emergency Departments and Minor Injury Units are continuing to increase and are approaching pre-COVID levels. The number of patients waiting over 12 Hours in our Emergency Departments increased to 2,383 compared to 2,118 in May. The number of patients experiencing ambulance handover delays of an hour or more also increased to 1,602 compared to 1,331 in May.

Performance against the stroke care measures improved slightly in July with 28% of patients admitted to a Stroke Assessment Unit within 4 Hours compared to 25.6% in June 2021, whilst this represents an improvement, the target is 59%. The proportion of patients reviewed by a Stroke Consultant within 24 hours, improved to 74% in July 2021 compared to 68% in June 2021; the target is 85%.

As is the case in the rest of the UK, the disruption caused by the pandemic continues to impact upon capacity to deliver planned care services at the pre-COVID-19 rates, resulting in an increase in waiting times. In July 2021, the numbers waiting over 36 weeks for assessment or treatment increased at 54,265 compared to 53,024 in June. The number of patients waiting over 52 weeks also rose in July at 41,317 compared to 41,130 in June 2021.

The number of patients waiting over 8 weeks for diagnostic tests at 7,138, and the number waiting for therapy, 1,335 rose for the first time in several months in July 2021 compared to 6,028 and 1,019 respectively in June 2021.

For June 2021, 72.9% of patients started treatment within 62 days of suspicion of cancer against a target of 75%. Although below the target rate, BCU remains one of the best performing Health Boards in Wales in terms of the Suspected Cancer Pathway.

At 183,065, the total number of patients waiting on the ‘Follow Up’ waiting list, rose for the second month in July 2021. The number of patients more than 100% overdue their follow up date also increased at the end of July 2021 at 54,265 from 53,186 in June.

Performance against the eye care measure has remained static at 43.85% in July 2021 compared to 44.23% in June. The predicted continuous improvement is not occurring at the expected pace.

The trend for staff sickness rate over the last 6 months (January to June) has been one of improvement however; July saw an increase to 5.34% but remains lower than at the same period in 2020. COVID-19 related sickness also increased slightly to 0.4% from 0.3% in June 2021.

Performance Appraisal Development Review (PADR) Rates have fallen in the last couple of months to 69.4% completed by end of July 2021 whilst Mandatory Training rates remain static at 83.4%.

In July 2021, the combined Agency and Locum cost was 7.4%, 0.5% down on June 2021.

Cefndir / Background:

This report outlines performance against the key performance and quality measures identified as a priority for the Health Board.

The Executive Summary pages of the QAP sets out performance against the key measures contained within the 2020-21 Welsh Government National Delivery Framework. The National Delivery Measures are derived from the Framework and are aligned to the Quadruple Aims set out in 'A Healthier Wales', Welsh Government's long term plan for health and social care.

Asesiad / Assessment & Analysis

Strategy Implications

The National Delivery Measures align to the National Delivery Framework, which supports 'A Healthier Wales' and the Health Boards Annual Plan.

Options considered

Not Applicable

Financial Implications

The delivery of the measures contained within the Health Board's Annual Plan will have direct and indirect impact on the financial position of the Board.

Risk Analysis

The COVID-19 pandemic has produced a number of direct and indirect risks to the delivery of care across the healthcare system.

Legal and Compliance

This report will be available to the public once published for Finance and Performance Committee

Impact Assessment

The Report has not been Equality Impact Assessed

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality and Performance Report

Finance and Performance Committee

Performance to 31st July - Presented on 26th August 2021

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About this Report

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until such time as the NHS Wales Delivery Framework for 2021-22 is formally published (due mid to late August 2021).

In this month's report the following additions have been made:-

- **Outpatient Virtual Activity**
- **Discharge to Recover and Assess (D2RA), replacement of the Delayed Transfer of Care (DToC) measure**
- **Risk Stratification within Referral to Treatment section**

Report Structure

The format of the report reflects the latest published National Delivery Framework which relates to 2020-21 and aligns to the quadruple aims contained within the statutory framework of 'A Healthier Wales'.

The report is structured so that measures complementary to one another are grouped together. Narratives on the 'group' of measures are provided, as opposed to looking at measures in isolation.

This report contains data showing the impact of the pandemic on referrals, planned care activity and waiting lists.

Performance Monitoring

Performance is measured via the trend over the previous 6 months and not against the previous month in isolation. The trend is represented by RAG arrows as shown below.

Performance has improved over the last 6 months

Performance has got worse over the last 6 months

Performance remains the same

Ongoing development of the Report

The Quality & Performance Report for this Committee, together with the sister report for Quality, Safety & Experience Committee and for the Health Board are in the process of being redesigned.

The Integrated Quality & Performance Report will take a proactive approach towards providing assurance. It is supported by a set of frameworks and methodologies that will provide objective and replicable levels of assurance on content.

Executive Summary

The committee are asked to note the following:

Quadruple Aim 2: Unscheduled Care
Pressures on the unscheduled care system continues and performance in our Emergency Departments fell in July to 67.02% of patients seen within 4 hours compared to 67.65% in May. Attendances in Emergency Departments and Minor Injury Units are continuing to increase and are approaching pre-COVID levels. The number of patients waiting over 12 Hours in our Emergency Departments increased again to, 2,383 compared to 2,118 in May. The number of patients experiencing ambulance handover delays of an hour or more also increased in May at 1,602 compared to 1,331 in May.

Performance against the stroke care measures improved slightly in July with 28% of patients admitted to a Stroke Assessment Unit within 4 Hours compared to 27% in May 2021 (against a target of 59%). The rate of patients reviewed by a Stroke Consultant within 24 hours fell at 74% in July 2021 (against a target of 85%) compared to 82% in May 2021.

Delayed Transfers of Care (DToC) has been replaced by the Discharge to Recover & Assess (D2RA).

Quadruple Aim 2: Planned Care
As in the rest of the UK, the disruption caused by COVID-19 continues to severely impact upon our capacity to deliver planned care services at the pre-COVID-19 rates result in increased waiting times. In July 2021 the number of people waiting over 36 weeks increased at 54,265 in July compared to 53,024 in June. The number of patients waiting over 52 weeks also rose in July at 41,317 compared to 41,130 in June 2021.

The number of patients waiting over 8 weeks for diagnostic tests at 7,138, and the number waiting for therapy, 1,335 rose for the first time in several months in July 2021 compared to 6,028 and 1,019 respectively in June 2021.

For June 2021, against a target of 75%, 72.9% of patients started treatment within 62 days of suspicion. Although below the target rate, BCU remains one of the best performing Health Boards in Wales in terms of the Suspected Cancer Pathway.

At 183,065, the total number of patients waiting on the 'Follow Up' waiting list, rose for the second month in July 2021. The number of those patients that are more than 100% overdue their follow up date also rose at 54,265 at the end of July 2021 from 53,186 in June.

Performance against the eye care measure has remained static at 43.85% in July 2021 compared to 44.23% in June. The predicted continuous improvement is not occurring at the expected pace.

Quadruple Aim 3: Workforce
The trend for staff sickness rate over the last 6 months (January - June) has been one of improvement however, July saw an increase to 5.34% but remains lower than at the same period in 2020. COVID-19 related sickness also increased slightly to 0.4% (from 0.3% in June 2021).

PADR Rates have fallen in the last couple of months to 69.4% completed by end of July 2021 whilst Mandatory Training rates remain static at 83.4%.

Quadruple Aim 4: Agency /Locum Spend
In July the combined Agency and Locum cost was 7.4%, 0.5% down on June 2021.

Quadruple Aim 4: Primary Adult Dental Services
The percentage rate of adults re-attending primary dental services rose to 28.3% in Quarter 4 of 2020/24 (compared to 21.3% in Quarter 3 of 2020/21). Providers have solely focussed upon provision of urgent and emergency dental care during the ongoing COVID-19 pandemic. In some areas, minimum routine work has been provided. An additional factor is the reduction in available appointment times due to the additional cleaning down of surgeries required between appointments. Recovery to pre-COVID-19 pandemic levels of service is dependent upon the installation of appropriate ventilation systems in all our primary dental practices and this work is ongoing.

COVID-19 Measures

Measure	at 16th August 2021
Total number COVID-19 Vaccinations given BCU HB	1,006,663
Total Number who have received both 1st and 2nd doses of vaccine	484,645
Total number of completed tests for COVID-19 (last 7 days)	21,822
% Tests turned around within 24 Hours (Last 7 days)	95%
Average turnaround time (Last 7 days)	Less than 1 Hour
COVID-19 incidence per 100,000 population (last rolling 7 days)*	239.7
% Prevalence of Positive Tests (last rolling 7 days)*	15.6%
Number of in-Hospital Deaths - Confirmed COVID-19* (between 10th and 17th August 2021)	7

Source: BCU IRIS Coronavirus Dashboard, accessed 19th August 2021

** PHW Coronavirus Dashboard Accessed 16th August 2021 data as at 15th August 2021*

COVID-19: Narrative

- After a period of stabilisation, community transmission is increasing across all Local Authorities (LA) areas in North Wales. Denbighshire has the highest incidence rate over last 7 days at 352.2 per 100,000 (test results reported up to 12.08.21) All counties in North Wales are amongst the highest in Wales, with the exception of Anglesey, which is also now experiencing increasing rates. Positivity rate over last 7 days varies but all are over 10%, with Denbighshire highest at 18.9%.
- As previously reported, Delta variant is now the most common variant in confirmed cases. There are currently no major concerns regarding new variants circulating.
- Highest volume of new positive results is amongst the 16 – 29 and 30-49 year age groups.
- Hospital admissions have fluctuated, with some signs of increase in recent days, although remaining significantly lower when compared to previous periods of similar community transmission levels. As at 17.08 there were 9 patients in critical care across North Wales.
- “Red” care home numbers have reduced since the implementation of new guidance regarding single positive cases, but whole system capacity remains stretched, particularly in regard to domiciliary care capacity
- Overall GP consultations for suspected COVID-19 or acute respiratory infections had stabilised but are now showing signs of upturn consistent with rises in community rates.
- The vaccination programme continues to deliver well, with all adults over age 18 having been offered the vaccine. initiatives are continuing to seek to encourage uptake amongst groups that are to date underserved, and to reduce the numbers of people failing to attend for their appointments. The extension of eligibility to younger people and planning for the booster programme is underway, awaiting final confirmation from Joint Committee for Vaccinations & Immunisations (JCVI) of prioritised groups.

Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self management

People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lies, It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Following cessation of screening services in April 2020 (due to the COVID-19 Pandemic) all screening services are up and running in Wales. Reduction of the backlog caused by the cessation of services remains a priority for the Health Board and for Public Health Wales.

At this time, data for uptake of screening services is not available as Public Health Wales are putting all their informatics resources into the reporting and monitoring of COVID-19.

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.

There will be an equitable system, which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will be designed to reduce the time spent in hospital, and to speed up recovery. The shift in resources to the community will mean that when hospital based care is needed, it can be accessed more quickly.

Top 5 Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Jul 21	Number of patients waiting more than 36 weeks for treatment	0	54,265	↓
Jul 21	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	0	50.90%	↓
Jul 21	Number of Ambulance Handovers over 1 Hour	0	1,602	↓
Jul 21	Number of patients waiting more than 8 weeks for diagnostic test	0	7,138	↑
Jul 21	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	2,118	↓

Quadruple Aim 2: Unscheduled Care Measures

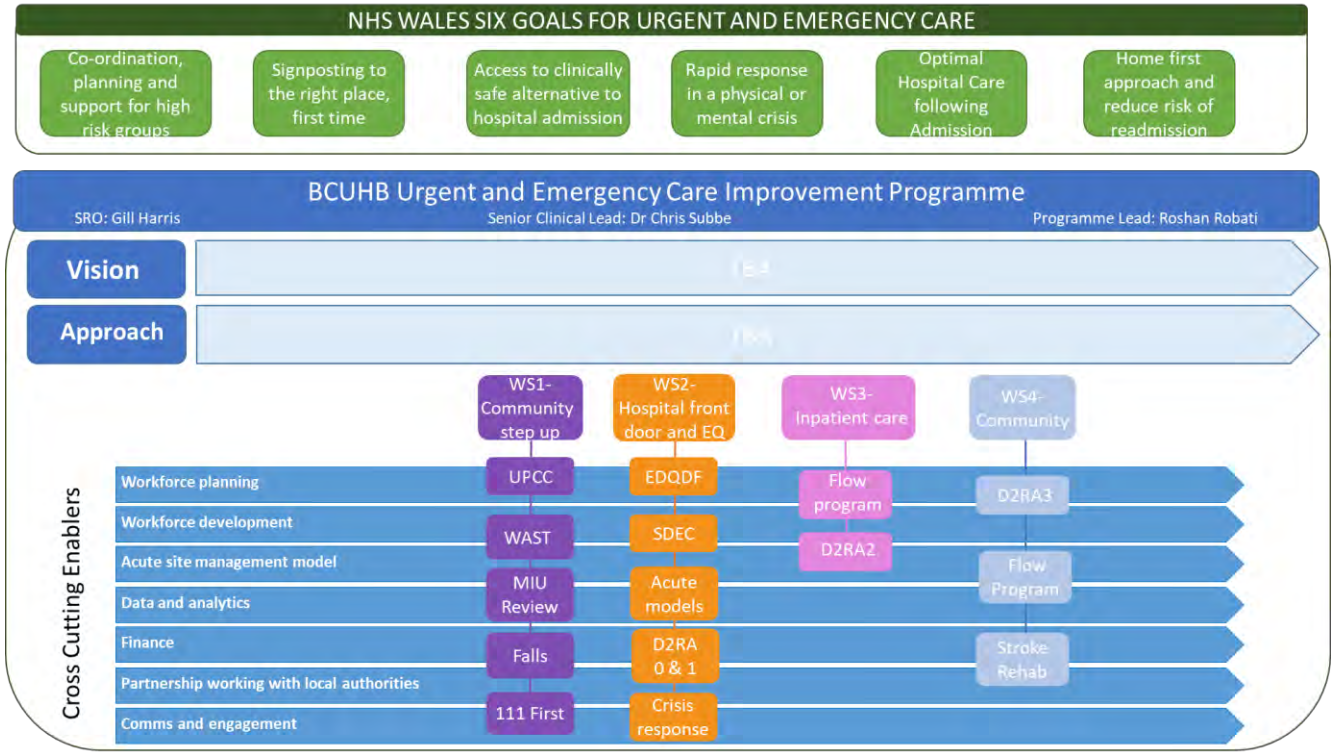
Period	Measure	Target	Actual	Trend
Jun 21	Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within **1 hour** of their initial call being answered	90%	**90.72%**	↓
Jul 21	Percentage of emergency responses to red calls arriving within (up to and including) **8 minutes**	>= 65%	**50.90%**	↓
Jul 21	Number of Ambulance Handovers over **1 Hour**	0	**1,602**	↓
Jul 21	Percentage of patients who spend less than **4 hours** in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	>95%	**67.02%**	↓
Jul 21	Number of patients who spend **12 hours** or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	**2,383**	↓
Jul 21	Number of patients who spend **24 hours** or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	**411**	↓

Period	Measure
Jul 21	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within **4 hours** of the patient's clock start time.
Jul 21	Percentage of patients who are assessed by a stroke specialist consultant physician within **24 hours** of the patient's clock start time
Jul 21	Percentage compliance against the therapy target of an average of **16.1 minutes** of Speech and Language Therapist input per stroke patient
Q4 20/21	Percentage of stroke patients who receive a **6 month** follow up assessment*
May 21	Percentage of survival within 30 days of emergency admission for a hip fracture**

**Stroke 6 month followup Time is reported 6 mont*
***Hip fracture survival reported 3 months in arrear*

Quadruple Aim 2: Emergency Departments and Minor Injury Units (1)

The Health Board, in partnership with Welsh Government's National Collaborative Commissioning Unit (NCCU), and working with clinical and operational teams across the Health Board have developed a revised improvement programme for Urgent & Emergency Care which identifies 4 key work streams that oversee a suite of projects which aim to reduce harm, deliver improved outcomes and quality of care for patients and ensure a better experience for patients and staff across the whole urgent and emergency care system. The programme structure demonstrated below:



The strategic aim of the revised improvement programme is to identify and prioritise the significant contributors for poor patient experience and organisational performance to facilitate the transformation of Urgent & Emergency Care. Initial work has been undertaken to review existing data, local and national reports, observe practice and engage with clinical and operational teams across the 3 health economies for understanding of the current position and challenges across the system. It is recognised that a whole system approach is required to tackle the challenges in urgent and emergency care and the scope of the programmer therefore covers the whole pathway from community, front door, hospital care and post hospital care.

Quadruple Aim 2: Emergency Departments and Minor Injury Units (2)

Key observations so far of challenges within the Urgent & Emergency Care system;

1. **Redistribution at the front door:** While Emergency Departments (EDs) have been under immense pressures on all three sites, the number of patients presenting is not significantly different from 2 years ago, with the important change that flow has shifted from Minor Injury Units (MIU) to Emergency Departments.

2. **Interface with social care:** The number of patients labelled as 'Medically Fit for Discharge' (MfD) in secondary and community hospitals has incapacitated most other work. Whilst it is recognised that a number of MfDs are awaiting internal processes, other observations include: i) The proportion of elderly patients referred to 'rehabilitation' or 'care packages' is significantly higher than in other areas of the UK with comparable population challenges. ii) A high number of vacant residential home beds and high number of care homes closed to new admissions; iii) Waits for social services are significant and workflow is difficult to understand from the NHS aspect.

3. **Inefficiencies at the front door:** An increasing proportion of patients are admitted through EDs with approx. 60% of cases sequentially reviewed by two doctors of equal experience (one from Emergency Medicine and one from the relevant specialty). Slow flow within and out of ED results in unacceptable delays in ambulance handovers. Many patients presenting during the day are seen by the relevant specialty during the night or the next day (in contrast to the recommended approach of 'doing todays work today'). Same day discharge rates are circa 20% on all three sites with national data from the UK suggesting a mean of 40% same day discharge rates. Same Day Emergency Care (SDEC) units are currently seeing only a fraction of this target population.

4. **Inefficiencies in hospital:** There are significant inefficiencies for pathways in-hospital, both in the way that patients travel and how clinical teams are deployed. Patients' journeys often involve multiple stops through ED, admission areas and acute & rehabilitation wards which according to national studies, invariably leads to 1-2 extra bed days. There is some in-reach of specialties to admission areas on all three sites but limited evidence for job-planning to make this a robust and reliable process. The majority of clinical teams care for patients on multiple wards with wards supporting patients from up to 12 teams, which creates a barrier to trusting relationships between doctors and nurses in the management of complex conditions and doesn't support effective and efficient working. Documentation systems and ward routines are often comprehensive but seldom focused on specific outcomes. There is a need for consistent and transparent criteria for enabling transfer of care of the patients acute condition or functional abilities from hospital to the community. There is a mismatch between patient flow into EDs and discharges out of the hospital and a lack of sufficient number of discharges early in the day and on Fridays / weekends exacerbates overcrowding in EDs.

Quadruple Aim 2: Emergency Departments and Minor Injury Units (3)

Programme Actions:

The work streams will start work in August and will include engagement of all stakeholders including those in training**.** Projects and deliverables within the improvement programme are being prioritised to ensure teams have capacity to deliver the projects and realise the impact. Each priority work stream and project will have a detailed implementation plan to identify and deliver improvements required to realise aims and objectives of the work stream and will also have a plan on a page.

Initial priority focus area for each work stream is as follow:

- **Work stream 1 – Step-up in the Community**: i) ensure patients receive care in the right place first time Urgent Primary Care Centre (UPCC) and MIU review.
- **Work stream 2 – Hospital Front door**: i) Emergency Department Quality & Delivery Framework (EDQDF) & Emergency Quadrant (EQ) site configuration; ii) Optimisation of Same Day Emergency Care
- **Work stream 3 – In-patient Care**: i) Flow programme (board rounds, criteria led discharge, stranded patients, MfD, discharge profile, buddy wards, Local Authority LA interface, 'SAFER')
- **Work stream 4 – Step down into the community**: i) Hospital @ Home

Anticipated outcomes

The initial programme of work aims to achieve measurable impact within 12 months for those initiatives that focus on optimising existing systems with longer term timescales for interventions requiring capital / estates works or substantial recruitment to teams. Progress and impact of the improvement program will be measured against a number of metrics, many of these are current performance metrics but the program aims to focus at the performance of teams. Metrics would usually be described for macro-, meso- and micro-systems, with macro-systems describing the health economy, meso-systems the organisation and its departments and micro-systems, individual clinical teams. It is important that metrics are transparent for all and relevant to measure impact of change. The following table depicts some of the suggested metrics for each work stream;

Suggested Metric	System Level	Work stream	Frequency
Level of escalation	Macro	2	Daily
Number of patients in the ED	Meso	2	Hourly
% of same day discharges	Meso	2	Weekly
Number of direct discharges from a single ward (compared to sister wards)	Micro / Ward	3	Weekly
Number of discharges that day	Meso	3	Hourly
% of frail elderly patients discharged home	Micro / Ward	4	Weekly
Comparative ward metrics	Micro / Ward	3,4	Weekly

Quadruple Aim 2: Emergency Departments and Minor Injury Units (4)

Initial anticipated outcomes from projects expected to have the highest impact :

- A change in the functioning of MIUs could potentially decrease presentation at the EDs by 5-10%.
- Hospital@Home model potentially decrease admissions of patients over the age 85 by 5-10%.
- Increase in the same day discharge rates (currently just over 20%) with the aim to increase these and bring in line with the national average of 40% through reconfiguration and expansion of Same Day Emergency Care (SDEC) models. This is also expected to improve Time to See Clinician and turnaround in ED.
- Improve Average length of stay (LoS) for patients admitted to hospital through focused Flow improvement initiatives that are expected to impact large number of patients and the opportunity to change beliefs and behaviors of staff.

A number of enabling plans are being developed to support delivery of the improvement programme including: communications & engagement; workforce planning & development; acute site management model; data & analytics; finance.

Weekly workshops will be held that will focus on the delivery of the projects which will include;

- A redesign of criteria for presentation in MIUs
- Discussion around staffing models and opening hours
- Consideration to synergies with GPs Out-of-Hours services and their location
- A redesign of physical structure and processes for SDEC
- Agreement on aspiration for Medicine, Surgery & Orthopaedics with modelling of physical space requirements to allow reliable functioning at 90th percentile of demand.
- Development of improved pathways and standards
- Delivery of effective and efficient board rounds including the underpinning educational program
- Review of outlying systems based on mathematical principles
- Agreement on standards and training of senior clinicians to improve impact
- Sharing of sample job-plans to facilitate consistent and reliable delivery.
- Learning from D2RA, Hospital@Home and Home-First programs based in hospital and community, sharing of standards, training and pathways between different teams.

High level risks to delivery & mitigating actions:

- Capacity within teams to deliver programme: i) maintain focus on programme priorities to ensure teams have capacity to deliver and realise impact; ii) Weekly meetings will monitor progress and review any barriers to delivery
- Extensive recruitment to multi-disciplinary workforce including medical, nursing and allied healthcare professionals: i) Health Board wide recruitment and training plan; ii) Workforce redesign
- Increasing demand above planned levels: i) Continue to monitor data and assess

Quadruple Aim 2: Discharge to Recover & Assess (D2RA)

Key Drivers of performance

Staffing – resources (in particular domiciliary care) to support care provision at home affecting ability to undertake true D2RA principles in discharging patients out of hospital settings.

1. Permanent funding required for weekend working / extended hours to address gaps in workforce capacity particularly in some Community Resource Teams (CRTs) / therapy resources to support D2RA.
2. Delays in transferring patients onto pathway 4. Local Authorities requesting assessments to be completed as an inpatient (lack of change towards D2RA)
3. Infection Prevention Control (IPC) issues impacting on ability to discharge due to COVID positive / contacts and carers / family isolating

Actions being taken:

1. Some slippage supporting therapy posts in West and Dietician appointment awaited (Q3)
2. Ongoing work in Home First/CRT team (East) to make resources available by maximising right sizing current care provision within current generic health and social care resources. Ongoing discussions with Wrexham/Flintshire in the joint use of staff resources for patients on pathway 2 and their discharge and reablement journey.
3. D2RA team to provide follow up within reasonable catchment area until handover can occur and communications to be developed. Gaps have been identified and business case required to enhance 7 day Therapy CRT rapid response – outcome of business case expected Q3.
4. The Home First Bureau (HFB) East will be extended to 7 day from September 2021. Nursing and therapy capacity in the HFB to support 7 day assessment of patients will continue to improve into autumn and winter months. A trusted assessor role is being established across East Health Economy to support the earlier identification of patients from all acute wards, where the biggest impact can be made.
5. Working group established to support implementation of cultural change across agencies to support D2RA model (ongoing).
6. Regular monitoring and review of delays of patients unable to be discharged on correct pathway to identify and address blockages (ongoing / daily).
7. Linking with WOD for support with sickness management (ongoing)
8. Ongoing evaluation of D2RA service joint KPIs (Q3)

Timelines:

The majority of the actions are taking place on an ongoing basis with regular daily, weekly or twice weekly meetings as appropriate to review delays in transferring patients to the correct pathway.

Risks

- Lack of additional and sustained domiciliary care provision will continue to impact on discharge from acute settings.
- Number of COVID-19 positive homes unable to accept new / existing patients back.
- Staffing vacancies within therapies for both Acute and Community Sites – inability to provide a fully functional 7 day working service.
- Non recurrent funding & funding that does not include 7 day working / extended hours will reduce the effectiveness of outcomes.

Quadruple Aim 2: Stroke Services

Key Drivers of performance

- Access to Stroke Co-ordinators; Timeliness of referrals for CT scan dependent upon having stroke Coordinators; Availability of beds on Acute Stroke Unit (ASU)

Actions being taken

- To understand delays in compliance with the 4 hour target for getting stroke patients to an ASU bed, an initial review of Emergency Department (ED) data, for December 2020 & January 2021, was undertaken**,** following which it was agreed that we undertake a weekly "deep dive" of all patients that were discharged to a Ward from ED, with a new stroke diagnosis. This was commenced in May 2021 and included Head of Nursing (HoN) Medicine, Directorate General Manager (DGM) Emergency Care, Prysor Ward Manager, Stroke Specialist Nurse, Occupational Therapy, Physiotherapy, Operational Lead and our operational improvement manager. From these weekly meetings, there are a number of factors impacting our ability to reach the target including:
    - Pre-alerts from Welsh Ambulance Service NHS Trust (WAST) to ED
    - Pre-alert from ED informing the Stroke Team of admissions in ED
    - COVID-19 swab results
    - Stroke Bed availability due to escalating on Prysor Ward
    - Missed opportunities within ED triage to identify patients as stroke.
- Working with site management team to ensure two beds are ring-fenced on ASU. Sisters on ASU identifying patients each day for discharge and step down
- The missed opportunities by triage nurse was discussed with stroke nurses and they have agreed to complete a training video to be shared with ED staff to support triage of stroke patients.
- In East there has been the loss of capacity in only having 1 substantive stroke consultant since June. In addition, there has been leave which has been covered but still from only 1 consultant. From mid-August, there will be improvement as there will be the substantive consultant alongside an NHS locum and an agency locum. This should improve response times with increased capacity to respond to patients.

Risks

- Reduction of acute stroke beds in Ysbyty Gwynedd (YG) to 7 total. There is an expectation that funding will be moved to Area Team. Discussion have commenced with regards to possible relocation of the Acute Stroke Unit from Prysor ward.
- Poor compliance with target of patient arriving in ASU within 4 hours. Ongoing weekly 'deep-dive' meeting being held to evaluate reasons for delays and develop plans/actions to address these
- Identified some potential issues in central with the ongoing delivery of the stroke thrombectomy rota in terms of job planned time availability of consultants

West - Stroke Care – July 2021 Performance

4Hr – Admission to ASU – 33% YG, CT Scan <= 1 hour - 44%, <= 12 hours – 100%, Thrombolysis for eligible patients – 100%, OT, Physio and SALT review <=72 hours – all 100%

East Stroke care – June 2021 Performance

4 Hr – Admission to ASU 23% CT in 1 hour 38% Swallow screen in 4 hours 58% Consultant review in 24 hours 81%

AHP performance data

- Access to OT/PT/SALT within 72 hours have improved from May.
- Therapy inpatient standards in relation to amount of therapy delivered have also improved**.**

Quadruple Aim 2: Planned Care Measures

Period	Measure	Target	Actual	Trend
Jun 21	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	75%	**72.90%**	↑
Jul 21	Number of patients waiting more than 8 weeks for a specified diagnostic	0	**7,138**	↑
Jul 21	Number of patients waiting more than 14 weeks for a specified therapy	0	**1,335**	↑
Jul 21	Percentage of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments	>= 95%	**43.80%**	↓
Jul 21	Percentage of patients waiting less than 26 weeks for treatment	>= 95%	**46.39%**	↓

Period	Measure
Jul 21	Number of patients waiting more than 36 weeks for treatment
Jul 21	Number of patients waiting more than 52 weeks for treatment
Jul 21	Number of patients waiting for a follow-up outpatient appointment
Jul 21	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%
Q1 21/22	Percentage children regularly accessing NHS Primary Dental Care

Quadruple Aim 2: Referral to Treatment and Risk Stratification

Actions completed:

- Capacity modelling complete for Orthopaedics and Ophthalmology, focus now on Urology, directed by the Planned Care Group
- Pathway lead appointed
- Managerial lead for Diagnostic and Treatment Centre appointed and in post, currently establishing the governance framework for this programme of work
- Cancer services have undertaken a review and proposed a new approach for cancer services across North Wales with the introduction of a new group focusing on prevention to end of life, aligning a strategic vision for North Wales for Cancer care going forward.

Actions ongoing:

- Reviewing Q2-4 capacity plan and derived demand with Planning and Performance team to understand potential year-end forecast and any further capacity required over coming months. Winter planning consultation with stakeholders taking place, including the relationship with unscheduled care including bed modelling to ensure the sustainability of planned are in the coming winter months. Theatre dashboard in final stages of development with Informatics providing intelligence and focus on improvement. Insourcing/outsourcing underway in Endoscopy and a range of diagnostic procedures including Cardiology, with specifications providing significant capacity, with rollover on a yearly basis available, and a no activity guarantee clause, allowing flexibility – more than 4 organisations expressed an interest
- Appointment of insourcing/outsourcing lead due to be advertised in August. Each acute site given further administration support to ensure that each list will be filled with the right patient once mobilisation has occurred. Implementation of 'Getting It Right First Time' (GIRFT), with service reviews of orthopaedics, ophthalmology, urology due to commence in November, and the high volume low complex value based pathway work with the national team commencing in a similar timeframe. Three key pathways of hips, knees and hands has commenced, supported by the national team. Discussions ongoing with WG on Diagnostic and Treatment Centre, and expressions of interest for clinical leaders currently ongoing.
- All planned care activity now recommenced including orthopaedic in-patient activity at Centre and West sites. In July this was not to full capacity, but is now expected to be.
- Backlog clearance has commenced with high risk stratified patients being treated in order of priority (see graph p.40). The re-start of elective activity is focused on reducing the Priority 3 backlog before moving on to the Priority 4 patient group. All sites and areas have re-commenced core activity and are also seeing or validation cohort 1 and 2 patients - treated and blended into the core activity, currently through additional clinical sessions, virtual consultations or through the two long waiting validation exercises. The Planned Care Group is monitoring progress.

Risks/challenges:

- Challenge between delivering timely backlog treatments for patients and the need to deliver core activity, not just this year but for several years to come for certain key specialties. Impact of reduction in beds due to COVID-19 distancing regulations and reduction in overall capacity for the same reasons will make this winter challenging, and this includes the sustainability of planned care. COVID-19 restrictions and reductions in beds causing disruption within the theatre environment. Recognition of the complexity of the work.

Quadruple Aim 2: Cancer

Issues Affecting Performance

- In June 2021, 298 out of 409 (72.9%) of patients were treated in target. Main reasons for patients not being treated in target were:
  - Complex diagnostic pathways (13%)
  - Patient related reasons e.g. patient unavailability for next stage of pathway (9%)
  - Delay to first outpatient appointment (14%)
  - Delay to endoscopy (14%)
  - Delay to other diagnostics, primarily on urology pathway (14%)

Actions and Outcomes

- Suspected cancer referrals from primary care have been above pre-COVID levels since February 2021 (135% pre-COVID levels in June). Additional temporary outpatient capacity has been created where possible in order to meet demand and reduce delays. The Executive Team has approved the business case for an additional four permanent rapid access breast clinics each week in order to ensure patients are seen in a timely manner on a sustainable basis.
- A pilot one stop neck lump clinic is being held on 16th August to reduce diagnostic delays and inform the development of a business case for a sustainable service if successful
- The business case for a vague symptoms rapid diagnosis clinics to reduce pathway waits has been submitted to the Executive Team for review in August
- Endoscopy insourcing continues to reduce waiting times; a full endoscopy business case for a sustainable service has been developed

Timeline for delivery of improvement

- All business cases to be completed by end of Quarter 2 with implementation in autumn/winter 2021/22.

Risks and Mitigations

- Cancer diagnoses were approximately 400 less (April 2020-March 2021) compared to 2019/20. There may therefore be an increase in patients presenting at later stage which would place pressure on oncology services; currently seeing expected numbers of stage 4 cancer presentations but reduction in stage 1 presentations. Risk escalated to Health Board and business case for additional oncology support approved by the Executive Team in July.
- Currently approximately 600 patients still active on a suspected cancer pathway over day 62 due to pathway delays above (note majority will not have cancer but pathway has not yet been completed; conversion rate from referral is approximately 10%). All delays escalated to operational managers

Quadruple Aim 2: Cardiology

No update has been received. Narrative remains as reported previously as still relevant with regards timelines.

Key Drivers of performance:

- Impact of COVID-19 has resulted in reduced capacity to allow for social distancing and Infection Prevention & Control (IPC) measures has impacted on waiting times for patients being longer that the 8 week target
- National recruitment challenges
- Department growth has resulted in restrictive footprints creating infrastructure and estates difficulties
- Potential capacity challenge for the service regardless of COVID-19 impact which will need to be addressed

Actions being taken:

- There is additional activity being undertaken in various guises across North Wales, primarily to support echo waiting lists, these include; Central providing additional capacity to the West to support the echocardiography waiting list.
- Recruitment of the Health Education & Improvement Wales (HEIW) training posts is nearly complete. There had been an error with BCUHB being an option available to students but this was resolved and we potentially have 2 practitioner training programmes (PTP) posts of the 4 available and 4 Scientist Training programmes (STP) posts recruited to. Funding needs to be identified for the 2 PTP post as well as training support for across North Wales.
- An innovation bid submission by the Community Cardiology Team to the Heart Conditions Implementation Group has been successful in achieving funding for a year up to £191,500 to provide improved community cardiology diagnostics during 2021-22.
- Outsourcing of heart monitors is still on-going in East and they are also developing a drive through clinic.
- A demand and capacity exercise is still on going, as this work has not previously been completed for cardiac diagnostics and is more complex than originally thought.

Timelines:

- Demand and Capacity exercise completion by end of Quarter 2 of 2021/22
- Additional activity on-going – no end dates currently
- Recruitment of STP posts end of April and in place Quarter 3 of 2021/22.

Risk

- Workforce restrictions – to include succession planning, sickness and expansion
- Demand & Capacity – complexity proving difficult and a risk of the data not being as meaningful as first thought
- Continuing Pandemic implications

Quadruple Aim 2: Diagnostic Waits - Endoscopy

Diagnostics Performance - Endoscopy

Key Drivers of performance

- Lack of capacity to meet the demand, resulting in long waiting times for patients. Current waiting times show that 65% of Diagnostics waits and 33.71% of our surveillance patients are overdue. This equated to 2,540 and 1,880 patients respectively. BCU has the longest wait for its Bowel Screening wales (BSW) patients across all Health Boards.
- Impact of COVID – reducing capacity to approximately 60%, resulting from downtime requirements through enhanced infection control policies. Procedures have been limited to Urgent Suspected Cancer (USC) and urgent patients due to available capacity.
- Recruitment challenges resulting in vacancies and staff that do not have the required competencies.
- Poor estate and IT infrastructure, resulting in inefficiencies. i.e. labour intensive processes due to poor IT, limitations in capacity, high risk processes i.e. decontamination.

Actions being taken

- Demand and capacity modelling has been undertaken and as a result a review of the estates with options to resolve capacity constraints have been submitted to the North Wales Endoscopy Group (NWEG). Estates work underway for a 3rd room in Wrexham to provide a further 10 procedure lists, procurement of Modular system in progress, timescales being agreed
- The Endoscopy Business Case for Building a Sustainable Workforce by 2022 is being submitted for approval. The case asks for the recruitment of substantive staffing to enable some of the additional insourcing capacity to be retained to balance the equation of capacity and demand. Timescales under review.
- Insourcing has been procured until December 2021 as the business case approval process proceeds, which will see backlog resolved. A review of the endoscopy ventilation systems is also being undertaken to see if it is possible to increase air changes so that downtime can be reduced, resulting in a potential increase in productivity ongoing.
- The Workforce work stream has developed a recruitment strategy which will include training and development and competency framework to build the workforce and contribute to Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation.
- An digital IT system dedicated to endoscopy has been agreed by the planned care board and executive team, which will contribute to the resolution of some of the inefficiencies. Specification agreed with the operational and informatics teams, Business Case in progress, Project Management in place, plan for implementation January 22

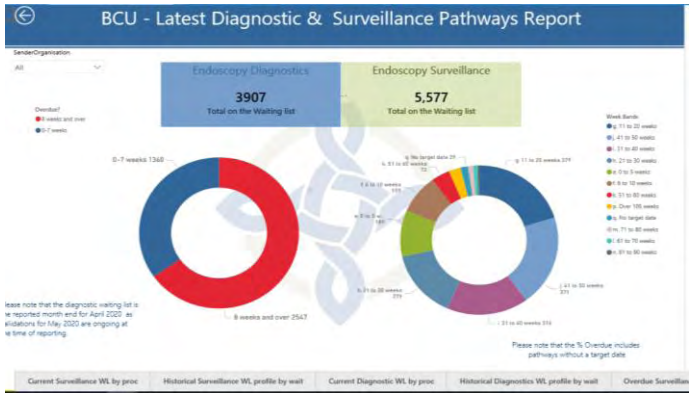
Timelines

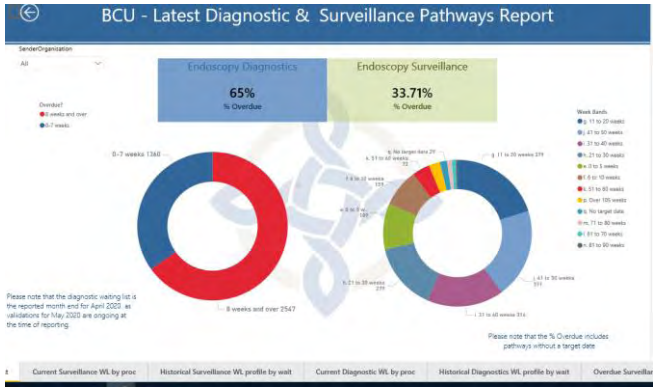
- Timelines are identified above, progress to date at Q1 in following slide
- Insourcing is showing positive results but will need to continue to include Q2 and substantive recruitment will need to be agreed to enable the service to meet demand and reduce the backlog. Impact of estates work in Wrexham to be realised December 21, modular procurement approx. 16 -30 weeks depending on supplier

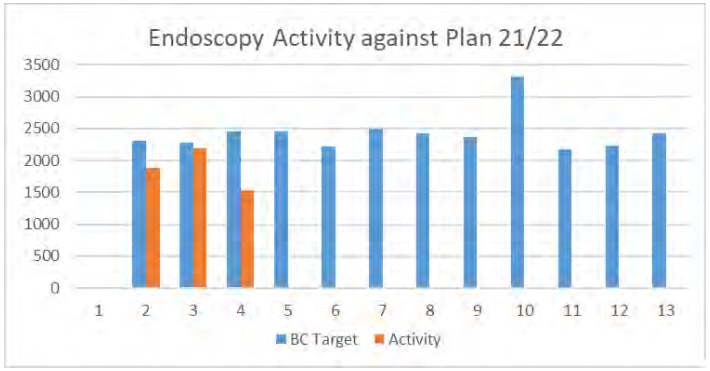
Risk

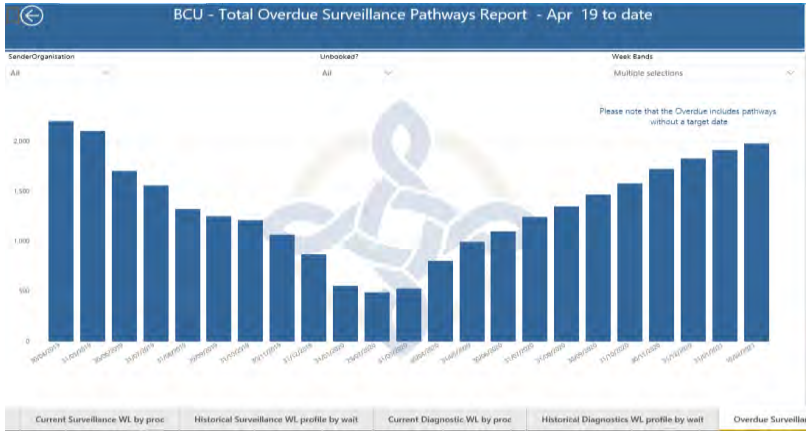
- Issues with the pandemic, continued reduction in list capacity
- Capital funding for estate improvement for endoscopy and decontamination

Quadruple Aim 2: Diagnostic Waits - Endoscopy

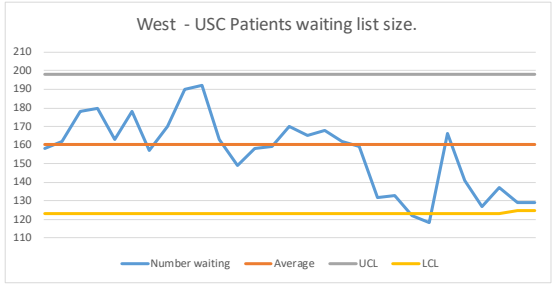


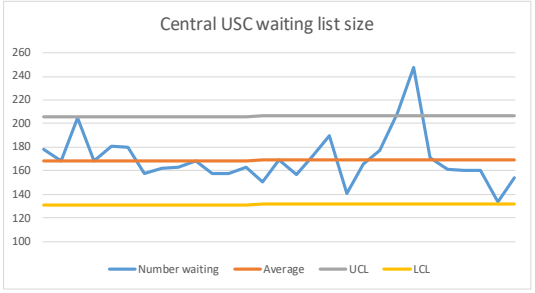


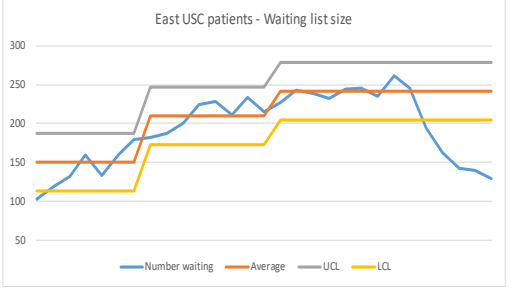




SPC's showing impact of insourcing.







Demand and Capacity modelling 2020 - 2024

2020/21 End Position	West	Centre	East
Gap based on continued capacity and continuance of 70% NEP referral rate	-4,814	-1,763	-4,723
Solution - Q4 insourcing delivery	1,200	800	1,200
Residual Gap at 31st March 2021	**-3,614**	**-963**	**-3,523**
2021/22 Baseline demand			
Derived Demand for time period	9,482	7,043	7,043
Expected growth as per NEP 6.5%	616	458	458
5% inefficiency (DNA) applied to expected growth and DD	505	375	375
Baseline Derived Demand for 2021/22	**10,603**	**7,876**	**7,876**
Expected combined demand for 2021/22	**14,217**	**8,839**	**11,399**
Capacity identified for 21/22	5,292	2,772	4,116
Expected gap in 2021/22 if capacity stays the same	**8,925**	**6,067**	**7,283**
Combined North Wales 2021/22 gap		22,274	
Baseline Demand for 2022/23 (would need to add gap from 21/22 if present)	11,857	8,807	8,807
Baseline Demand for 2023/24	13,259	9,848	9,848
Weekly additional lists required to bridge he gap based on 48 weeks			
8 points per list 2021/22	23	16	19
8 points per list 2022/23	31	23	23
12 points per list 2021/22	21	15	15
12 points per list 2022/23	23	17	17

Quadruple Aim 2: Diagnostic Waits – Radiology and Neurophysiology

Radiology:
The number of patients waiting over 8 weeks for radiology diagnostics is currently 2,473, an increase of 317 on the end of June position. Small reductions in CT and MRI breaches (163 / 224 breaches respectively) are offset by an increase of 440 patients waiting over 8 weeks for an ultrasound scan (with 2,011 patients waiting over 8 weeks). The fundamental issue within the ultrasound service remains staffing, with vacancies within the service, and difficulty securing agency staff, especially at YG, but affecting all sites. Radiology senior management team is meeting weekly to develop and implement plans to continue to steady improvement that has been achieved over the last 9 months.

Neurophysiology:
The number of patients waiting over 8 weeks is 502, an increase of 9 from end June 2021 position. There are 100 Electromyography (EMG) consultant-led breaches and 402 Nerve Conduction Studies (NCS) physiologist-led breaches. A locum physiologist has been identified and subject to pre-employment checks, will commence during August for regular 3 days per week sessions in the East area, where most breaches exist. The expectation is that the NCS breaches will reduce over the coming months. Dates are urgently being sought for further EMG insourcing from the existing contract ahead of completion of new tender in September.

Quadruple Aim 2: Follow Up Outpatient Waiting List

Pathway design

- Investigating the 'Canterbury' tool to support pathways, this tool is already being used by other Health Boards. The Canterbury tool facilitates the development of pathways, which are created in partnership with Primary and Secondary care. The tool drives pathway reviews and captures agreed pathways for reference/ guidance. Outputs from the tool will form part of the Transformation and Efficiency programme which aims to support a reduction in acute care demand.
- Meetings and discussions with Trauma and Orthopaedic (T&O) consultants regarding the use of See On Symptom (SOS) and Patient Initiated Follow Up (PIFU) pathways are progressing.

Postal surveys of outpatients awaiting treatment

- 17,000 questionnaires sent, with 6% response rate so far.
- Removals are 16% of 6%, therefore 1% so far.
- The question wording within the letter is set by Welsh Government, but the Ophthalmic Clinical Team has raised a concern that the question cannot be answered by the patient, and this will need to be discussed further.

Stage 1 Validation

- Go live this week, 5 week deployment plan with 9 – 12 week closure (dependant on patient response)

Efficiency Programme

- Benefits have been calculated for East and Centre work is underway to quantify for West via Outpatient (OP) Efficiency dashboard
- Drumbeat in West live from 23rd July chaired by the Hospital Director supported by OP Transformation Programme Manager.
- West OP dashboard is now live this completing the OP Efficiency dashboard rollout
- Validation standardisation is complete and ready for the Head of Access
- Securing Improvement resource to look at application of the access policy in particular <6 week clinic cancellations and Did Not Attend (DNA) discharge
- Deep dive in Dermatology – East is concluding

- Head of Ambulatory Care post now advertised
- Outpatient's 2 year strategy in final draft this week

Quadruple Aim 2: Virtual Outpatient Activity

E-Referral
West Site is preparing to move to the Welsh Patient Administration System (WPAS) and with this the template clean and standardisation in readiness for migration on single WPAS Q1/Q2 2022. East sites are moving to single Patient Administration System (PAS) at the end of 2022. These changes will enable the attachment of an e-referral solution.

Electronic Outcome Forms
Following a review of e-Outcome forms (in partnership with Health Board Informatics Team) looking to take forward an integrated e-outcome form with WPAS. Next steps will be to establish as a operational project where the [outcome] form is defined as there is currently variation across the Health Board.

Video Consultation
- AttendAnywhere – We are scoring the project lead for this programme where the two main objectives are to support the deployment and increase utilisation (where clinically viable) The deployment model is mapped soon to be published this being on and individual bases on request and on a speciality bases the first being Trauma & Orthopaedics. As funding has been approved informatics are reciting to support the deployment with the project manger starting next week if recruitment this week is successful.

- Group Consultations – Staff in place and currently planning the first session with online patient assessment in place.

Advice and Guidance
The Consultant Connect (CC) end of year report is being issued. BCU are the third highest use of the CC product as a vehicle to support Advice and Guidance for telephone advice and guidance and the highest for message advice and guidance. BCU has the highest dependency on the National Consultant body (provided by Consultant Connect ltd) for advice and guidance. Efforts are now on increasing advice and guidance delivered locally. In discussion with WG regarding 2022/23 when the initial platform provided by CC contract ends, in preparation for 2022/23 and beyond.

Quadruple Aim 2: Eye Care (1)

Key Driver:
Utilisation of agreed Glaucoma, Diabetic Retinopathy and Corona virus Cataract Pathway (Integrated delivery between Primary and Secondary care).
Key enabler of above is National Digital Electronic record & E-Referral Programme (see Eye Care slide 2).

Benchmarking
National/BCU benchmarking/learning inbuilt into Multidisciplinary Team (MDT) /pan-organisation engagement/ pathways/ performance reports: via: Webinars/Eye Care Collaborative Commissioning (ECCG)/Local Eye Groups (LEGs).
Waiting times is main concern trend (historic/ backlog due to COVID-19).
Pan BCU stratification established.

Actions:
-Reset Governance: ECCG Governance framework (achieved). Sites progressing consistent Local Eye Group* meetings & action logs. (Partially achieved*)
-Identify delivery targets for high risk specialities (Glaucoma/D. Retinopathy/AMD). E.g. Primary care Data gathering for later Medical virtual review (On track)
-Review/agree Key Performance Indicators (KPI) Age-related Macular Degeneration (AMD) targets in reference to National evidence base/clinical consensus whilst awaiting updated National pathway via engagement sessions. (On track)
-Coronavirus Cataract pathway: Clinical Lead/Planning/Estates informing Regional Cataract Centre planning (On track)
Progression of business case opportunities to utilise primary care to support pathway transformation (On track)
-Ongoing work to confirm Cataract current delivery plan. R1 (Glaucoma/D. Retinopathy KPI implementation plans including outcome from business case support)

Key Risks/Opportunities for change
Clinical & Operational Senior Leadership constraints/conflicting COVID-19 priorities impacting on engagement re: implementation/monitoring
>Redress: 2:3 Sites consistently delivering Local Eye Group meetings/ongoing Action Logs & Monitoring. *East Operational Management progressing.
KPI Data Quality gaps adversely impacting on establishing dashboards/ demand & capacity analysis/ recovery & delivery trajectories/KPI monitoring
>Redress: Delayed Pan BCU Data Quality gaps redress actions. Rollout March 21. (Outstanding all sites)
Significant opportunities to reduce Inequity of wait times. Pan BCU Cataract PTL (Patient Treatment List) is key equity enabler with reduced uptake/transfer of patients
>Redress: a. Exploring through planned care (Once for North Wales)
b. Establish Pan BCU operational/monitoring process. Sites advised in discussion with Heads of Performance. Agreed ECM Programme support Pan BCU Standard Operating Procedure (SOP) -Sept 21.
Significant under performance against high risk (R1 risk stratification) patient pathway targets.
>Redress. Progress backlog reduction trajectory April 21: [Glaucoma: East & West (Progressing) Central (Achieved)] [D. Retinopathy: West (Outstanding) East & Central (Achieved)
Reduction in Cataract delivery Pan BCU due to COVID-19
>Redress. Options in development to progress recovery of activity and backlog. Cataract Regional Centre & Mitigation planning in progression.

Escalation: Risks/opportunities and Monthly reports shared/escalated to Senior Managers/Clinical Lead (via Monthly ECCG Meeting/Highlight & KPI reports/Action Logs

Quadruple Aim 2: Eye Care (2)

Ophthalmology Performance Digital Programme
Key Driver:
Delivery of National Digital Programme (Key Enabler of National Pathways)
-Electronic Patient Record (EPR) implementation
-E-Referral Implementation

Benchmarking
-National Programme: Shared via Wales Ophthalmology Planned Care Programme (WOPCB)
-Equipment training commenced March, EPR Equipment Webinars in April 2021 plus EPR system training from Welsh Government (WG) April 2021

Actions:
-Arrive/install Welsh Government funded (£1.3M equipment by 31st March 2021: (Achieved March 2021)
>Site/Clinician training in Zeiss equipment April-June 2021 rolling. “Mop up” sessions for new/return to clinical activity staff in progression (On track)
>Server delivery (Zeiss & IT partnership) June 2021 (Achieved July 2021)
>Establish Electronic Patient Record (EPR)/E-Referral Implementation team/delivery plan. Updated to reflect National Programme developments (June 2021)
>Progression of Business Case to resource BCU Digital implementation/sustainability. WG funded posts progress (Achieved June 21)
>Reset of Governance/communication framework. Digital Programme sub-group of ECCG with updated ToR established (June 21)
>Funding confirmation for (WG Capital) Digital Regional/programme and BCU System revenue posts (Achieved June 21).

Key Risks/Opportunities for change
Clinical/Operational/Informatics constraints/conflicting priorities impacting on engagement
Redress: Progressing Digital Lead expressions of Interest
Clinical Lead vacancies (Pan BCU and Site leads vacancies in 2:3 sites)
Redress: Sites progression of Clinical Leads establishment.

Key Barrier Trends:
Challenging delivery-demands from timescales of National roll-out will be supported by Business case agreement. Clinical engagement challenges from Ophthalmologist Clinical lead gaps/vacancies. Sites progressing.
Escalation:
Escalation of Risks/opportunities and Monthly reports shared/escalated to Senior Managers/Clinical Lead (via Monthly ECCG Meeting) and Planned Care Transformation Group, Secondary Care Group and BCU Performance group

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable

New models of care will involve a broad multi-disciplinary team approach where well-trained people work effectively together to meet the needs and preferences of individuals. Joint workforce planning will be in place with an emphasis on staff expanding generalist skills and working across professional boundaries. Strategic partnerships will support this with education providers and learning academies focussed on professional capability and leadership.

Measures

Period	Measure	Target	Actual	Trend
Jul 21	Personal Appraisal and Development Review (PADR)	>= 85%	69.40%	↓
Jul 21	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	>= 85%	83.23%	→
Jul 21	Percentage of sickness absence rate of staff	< 5%	5.34%	↑
2020	Staff Enagagement Score*		73.00%	↓
2020	Percentage of staff who would be happy with care by their organisation if friend/ relative needed treatment*		59.70%	↓

** Published July 2021*

Data for **July 2021** (Unless otherwise stated)
Presented on 26th August 2021

Quadruple Aim 3: Narrative – Sickness & Absence

Key Drivers of Performance:

- COVID19 related sickness absence has increased slightly to 0.4% (0.3% in June). This reflects a significant increase in staff testing positive to 169. This was just 5 in May, increasing to 45 in June).
- Non COVID19 related sickness absence increased by 0.1% to 5.4% (which is the highest in the last 12 months).
- Stress related absence remains the biggest cause of absence with approximately 4 times more days lost than the 2nd largest cause (musculo skeletal problems). It remains the biggest cause of absence by a considerable margin for all areas. As previously stated, the incidence of colds / flu has been much lower this year, due both to the successful flu campaign and social distancing.
- The highest levels of sickness absence are in Additional Clinical Services, Estates and Ancillary and Nursing and Midwifery. Additional Clinical Services sickness rates are high across the organisation from 6.15% in Wrexham Maelor to 9.68% in MHLD. Nursing sickness levels are high on all 3 secondary care sites and MHLD – 6.18% to 6.65%. all areas, acute sites and MHLS have high sickness rates for Additional Clinical Services.

Actions Being taken:

- Work is ongoing to strengthen control measures to reduce transmission, including booking systems for areas where social distancing is otherwise not possible and reinforcing messages on remote working. The messages have not changed following relaxation of some restrictions
- Psychological / Emotional Health and Wellbeing support to staff has been strengthened, and continues to be developed further.
- Workforce and OD continue to support hotspot areas
- Staff in priority groups 1 – 4 who have not previously taken up the offer of vaccination are being encouraged by line manager to get vaccinated in order to protect themselves, patients / service users and the wider community.
- Joint task and finish group is in place to support processes to support shielding staff with a return to work (now approximately 22 who have not yet been able to return in some capacity)

Timelines:

- Further conversations with staff re taking up vaccination

Risk:

- Further increase in stress related absence

Quadruple Aim 3: Narrative – PADR

Key Drivers of performance

- Performance and Appraisal Development Review (PADR) Compliance for July has seen a decrease down to 69.37%. For the previous 3 months PADR compliance has been over 70%.
- 5 divisions have seen an increase this month, 2 have remained the same and 14 have seen a decrease.
- The highest increase was 5.4% in Strategy Executive, the highest decrease was 10.6% in Finance Executive.

Actions being taken

- League tables to be shared with senior managers across the organisation with tailored reports being offered to support line managers to take corrective action to increase compliance, with a particular focus on those areas that have reported a decrease in PADR rates.
- Undertake a concurrent communications exercise across the health board to support increased completion of PADRs
- Tailored virtual PADR session held on 27th July with Dietetics YG for new team leaders to ensure best practice is applied during PADR conversations
- Further tailored sessions to be arranged with new managers and supervisors in Estates & Facilities West
- Tailored Electronic Staff Record (ESR) support for deputy DGM at YGC held on 14th June on issues relating to supervisor hierarchies which is impacting on divisional compliance

Timelines

- League tables to be shared with senior managers across the organisation by 4th August with the offer of tailored support by Workforce and Organisational Development (WOD). This should allow time for planning and improvements to take place.
- Communications exercise to promote increased PADR rates to be undertaken during August and September
- Any other requests for detailed reports and/or support to be provided on an on-going basis.

Risk

- Although COVID related activity may now start to reduce, the risk remains that the pressure on increase in activity to achieve performance targets may take the focus away from conducting PADRs.

Quadruple Aim 3: Narrative – Mandatory Training

Key Drivers of performance

- Mandatory training compliance at level 1 has further increased across all Mandatory training subjects in July 2021 to 83.39%. BCUHB remains as one of the highest in Wales for compliance with mandatory training. The Health Board also remains the highest in the UK in relation to E-learning completions.
- A further extension of temporary contracts within vaccination centers has been implemented from the end of June 2021 to the end of October 2021. This will continue to affect overall compliance as staff working solely in vaccination centers are not required to complete all attached competencies of Level 1 Mandatory training.
- Completion of Mandatory training remains low for Estates and Facilities and for Medical & Dental staff.

Actions being taken

- Activity has commenced to pilot a virtually delivered Mandatory training day to replace the pre-COVID-19 Mandatory training days held across sites. Specific Mandatory training virtual events are being implemented for Medical and Dental staff aimed to increase compliance with this specific staff group. Subject Matter leads in Health and Safety and Safeguarding have produced specific workbook training materials for use with Estates and Facilities staff.
- Although not possible to remove specific Mandatory training compliance for staff allocated to contracts within the mass vaccination centers it is noted that if they were removed it would increase the current compliance figure to 84.71%. Reports detailing non-compliance related to staff with temporary contracts has been forwarded to specific area leads.

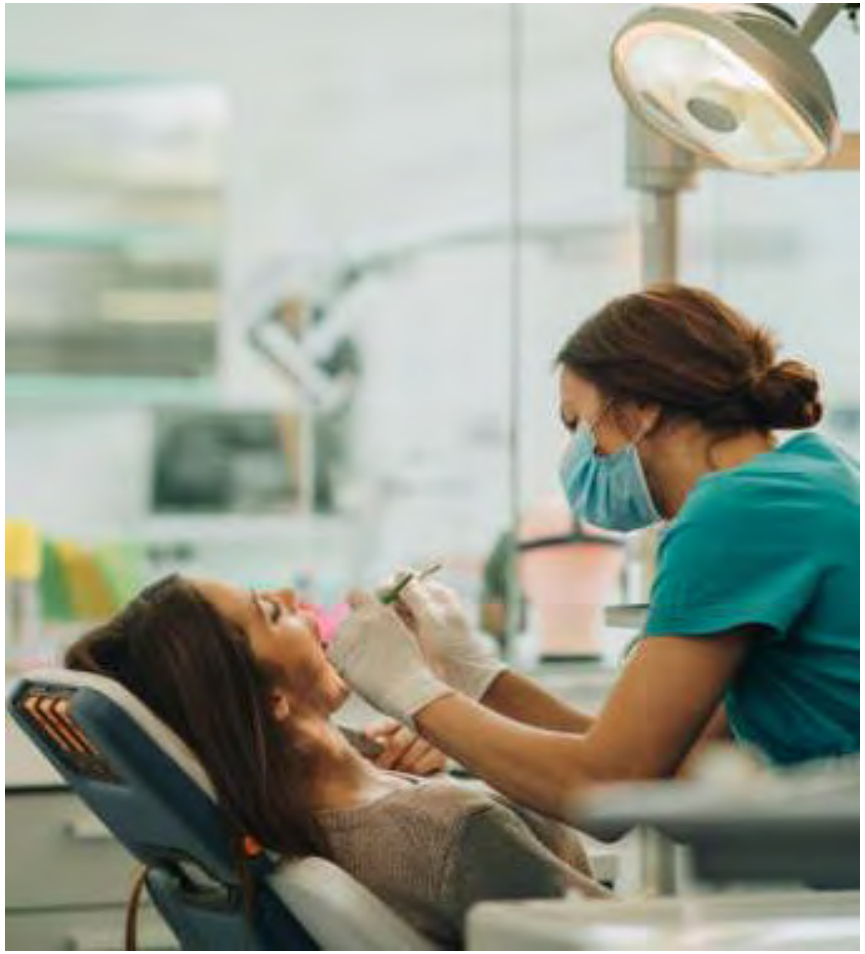
Timelines

- Monitoring of compliance figures continues on a regular basis in order to identify any areas of concern.
- Training for Medical staff will be available before the end of August 2021.

Risk

- COVID-19/ Business as Usual related work impacts upon training delivery.
- Social distancing restrictions affects delivery of training within existing training facilities, this affecting the safe ‘face to face’ classroom occupancy for specific courses.

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation enabled by data and focussed on outcomes.



Measures

Period	Measure	Target	Actual	Trend
Q1 21/22	Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months*	TBA	**28.30%**	↑
Q4 20/21	Percentage of critical care bed days lost to delayed transfer of care - Intensive Care National Audit & Research Centre (ICNARC) definition*	Reduce	**10.50%**	↑
Jul 21	Agency spend as a percentage of total pay bill	Reduce	**7.40%**	↓

**** Based on 12 month trend***

Quadruple Aim 4: Narrative – Agency & Locum Spend

Key Drivers of Performance

- Non-core agency, bank and overtime pay spend saw a slight decreased in July from £8,938,000 in June to £8,676,000 in July.
- Agency spend is down by £263k at £3,469,632 (4.9% of total pay); Locum spend is down by £133k at £1,787,126 (2.5% of total pay); WLI spend is up by £189k at £359,718; Bank spend is down by £80k at £1,993,839 (2.8% of total pay). There is a general trend of decreased spend across non-core pay with the exception of WLIs which can be linked to the increase in activity across Planned Care as the recovery programme is ongoing.
- Medical Agency spend is down from £1.69m to £1.33m month on month (June-July) with a corresponding increase in WLI spend of £177k month on month (June-July). The increase in WLI spend can be linked to the increased activity across Planned Care as the recovery programme is ongoing.
- Nursing Agency spend is up from £1.38m to £1.41m, bank spend has stayed constant at £382k and overtime increased by £14k. The increase in agency spend can be linked to the increase in unscheduled care activity and activity across Planned Care as the recovery programme is ongoing.

Actions being taken

- Proactive recruitment drives for Medical and Dental staff are commencing with work to secure a number Physicians Associates and ST 1 doctors being taken forward this correlates to number of other workforce optimisation initiatives that are being mobilised to support reduce the Health Boards reliance on temporary staffing.
- The focus on Nursing recruitment is increasing as capacity is released from COVID response with overseas nurse programmes underway and expanding, with a major recruitment campaign being launched alongside the Clinical Fellowship programme this will lead to increased nursing capacity and support progression and retention across the nursing workforce.
- Support is in place to focus on increased recruitment to hotspots with the implementation of the recruitment pipeline report and nursing workforce dashboard.

Timelines

- Refreshed clear medical and nursing recruitment plans now in place and being rolled out across identified areas such as band 5 nursing hotspots.
- Enhanced temporary staffing service process developed and now in place, alongside a fast-track medical agency hiring process to ensure timely supply of medics to BCUHB.

Risk

- The service delivery model and replication of predominantly bed-based services will continue to result in challenges in respect of rotas.
- It is acknowledged that there is a UK shortage of nurses (band 5 in particular), therefore recruitment campaigns will reduce rather than eradicate the vacancy levels.
- Quarantine rules for overseas travel may reduce the run rate of overseas nurses commencing employment.
- The lack of shielding staff being able to return to clinical posts and the effects Long COVID-19 on staff could result in being unavailable to work for longer periods of time.

Quadruple Aim 4: Narrative – Adult Dental Services

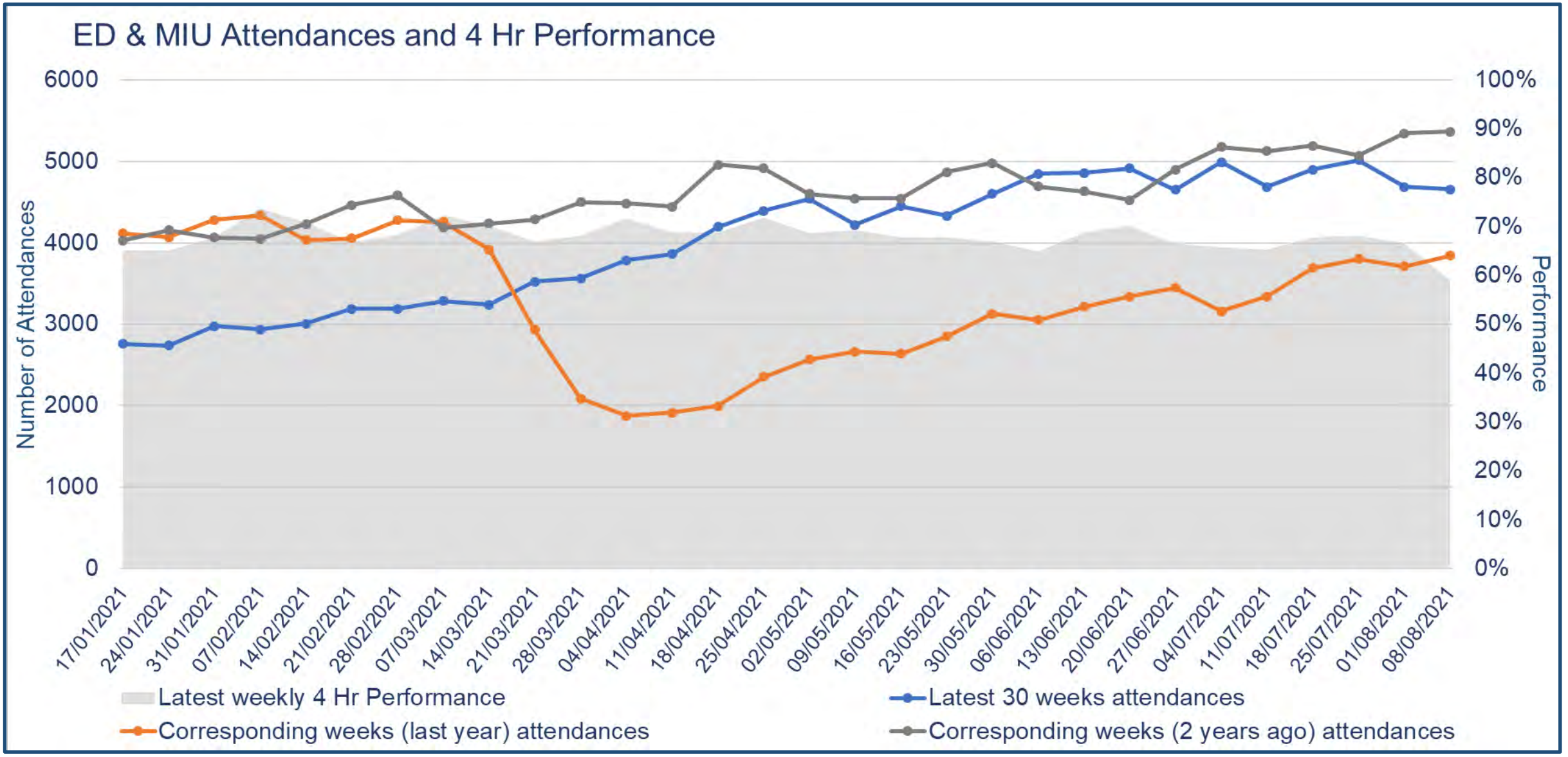
The percentage rate of adults re-attending primary dental services between 6 and 9 months rose to 28.3% in Quarter 4 of 2020/21 (compared to 21.3% in Quarter 3).

Providers focus has been on the provision of urgent and emergency dental care during the pandemic as a consequence in some areas minimum routine work has been provided. An additional factor is the reduction in available appointment times due to the additional cleaning required between appointments.

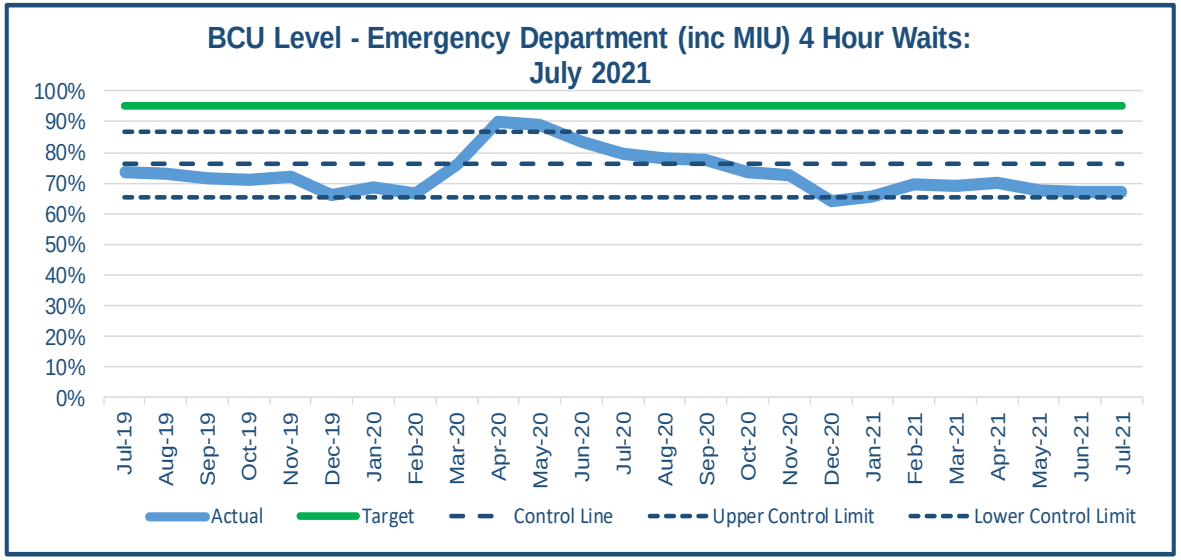
Recovery to pre-COVID-19 pandemic levels of service is dependent upon the installation of appropriate ventilation systems in all our primary dental practices and this work is ongoing.

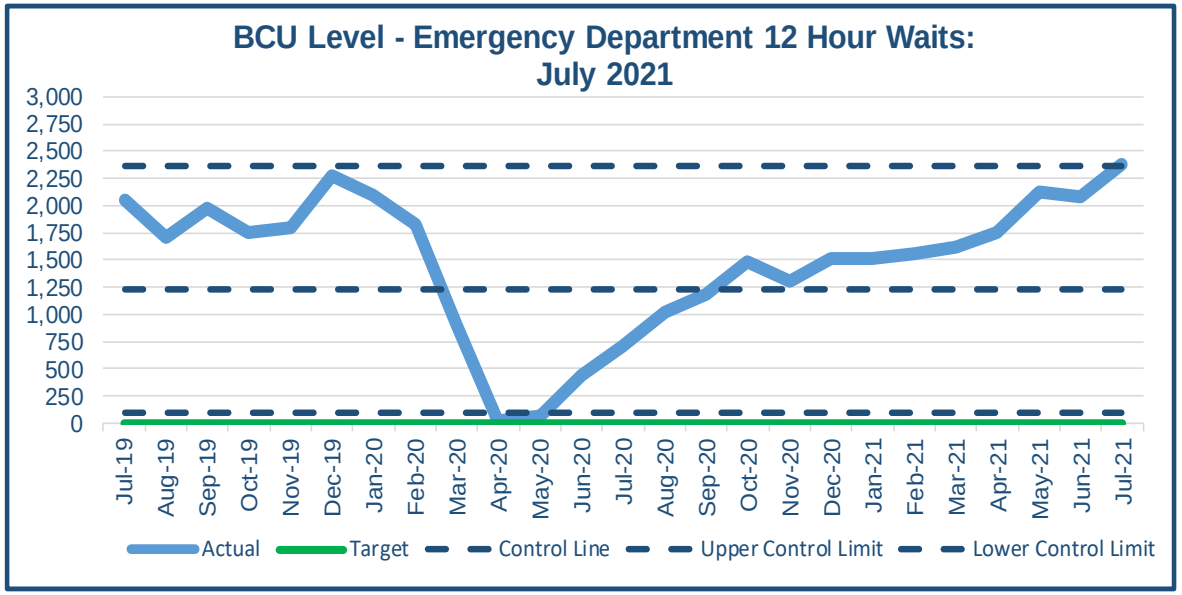
Additional Information

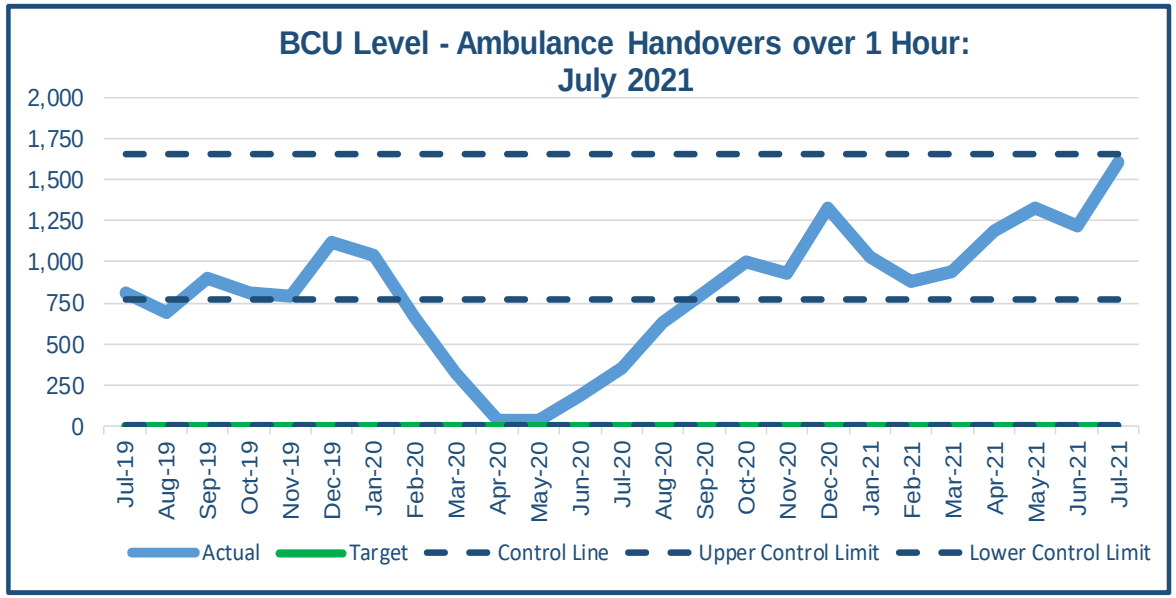
Quadruple Aim 2: Unscheduled Care: Attendances (1)



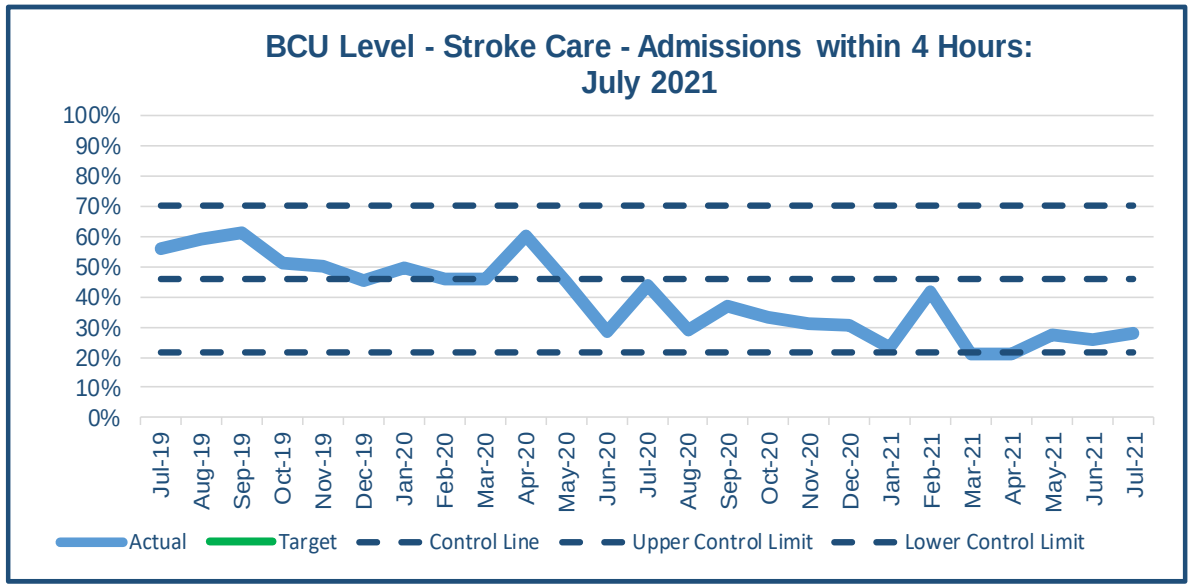
Quadruple Aim 2: Unscheduled Care (2)

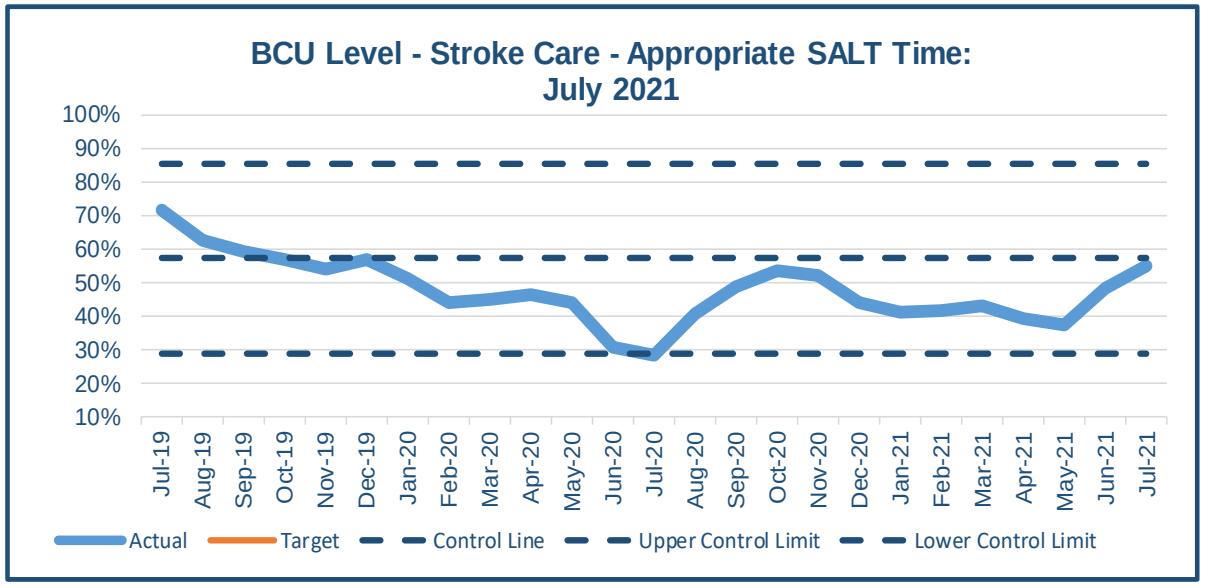


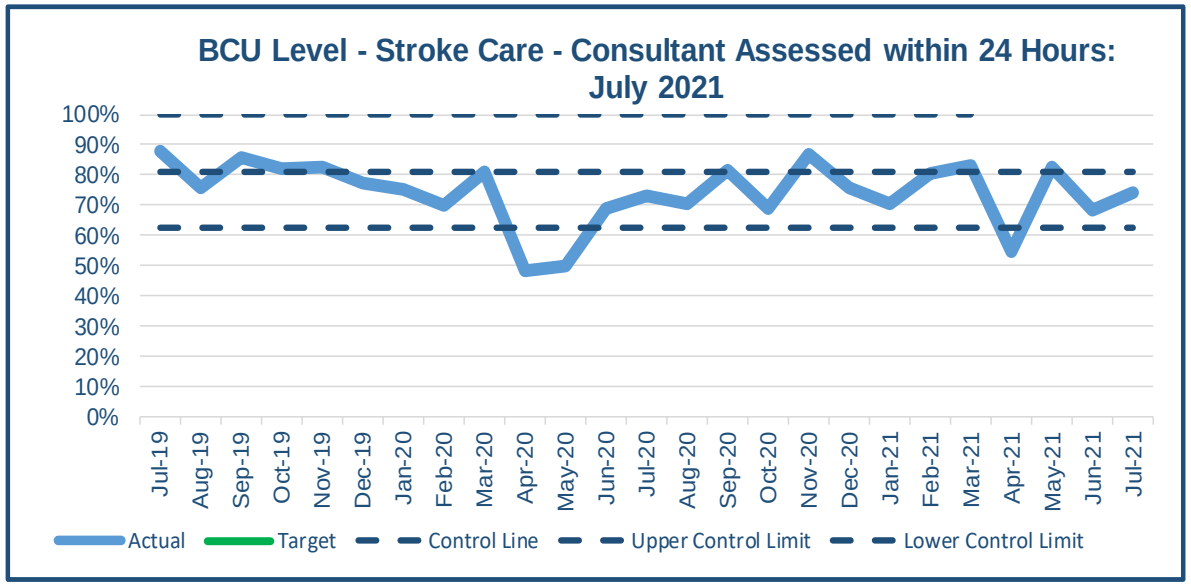


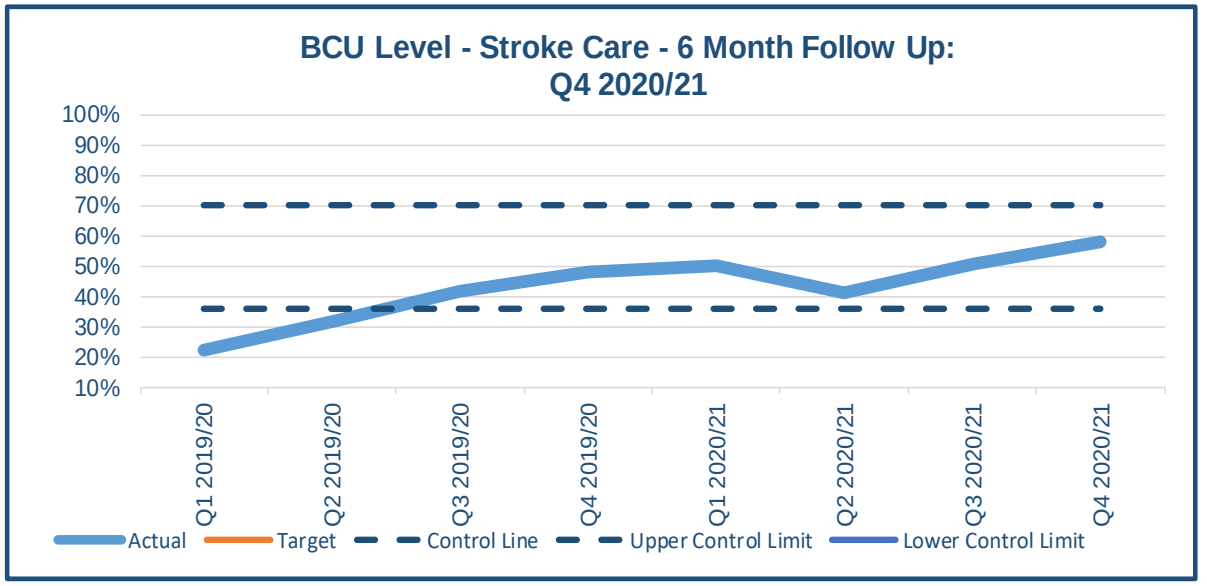


Quadruple Aim 2: Unscheduled Care (3)









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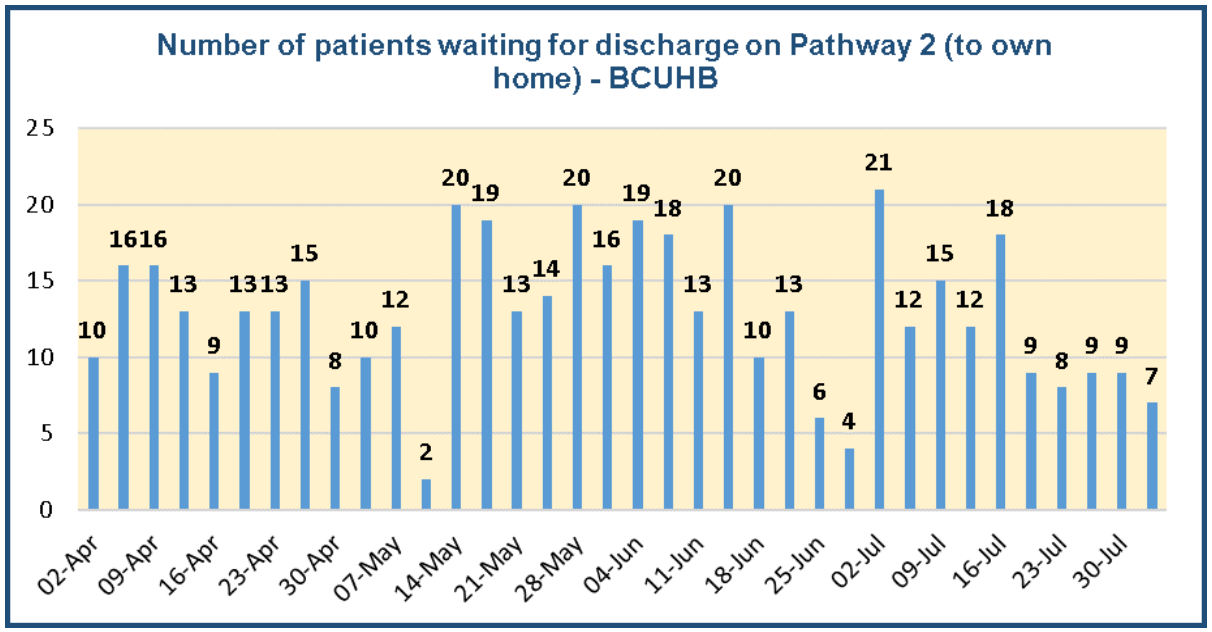
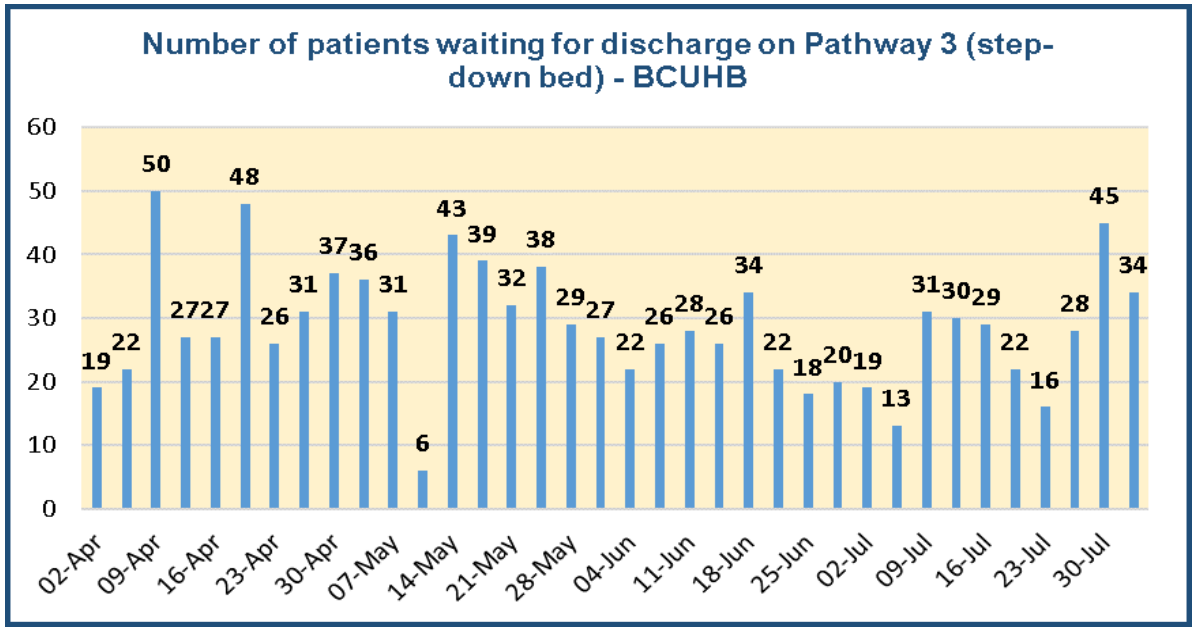
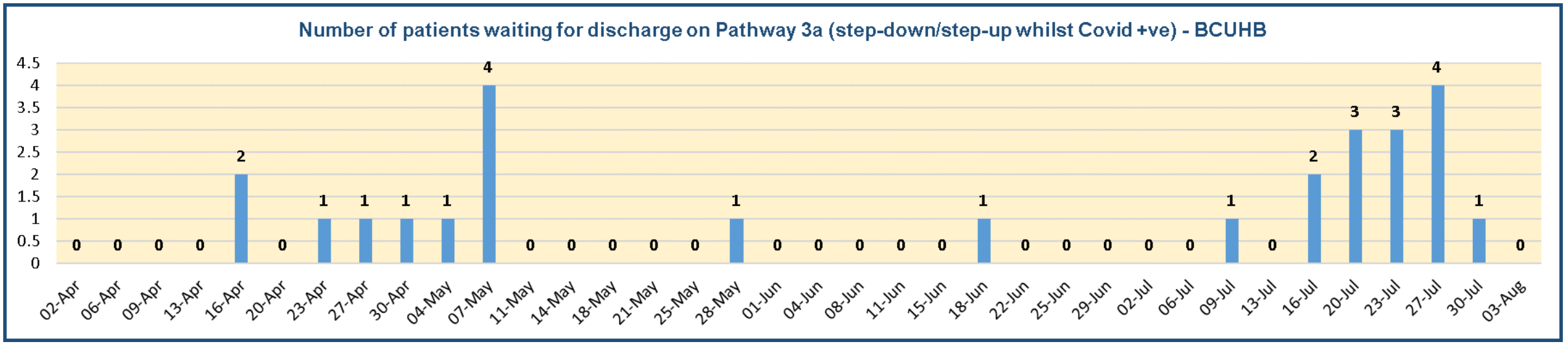
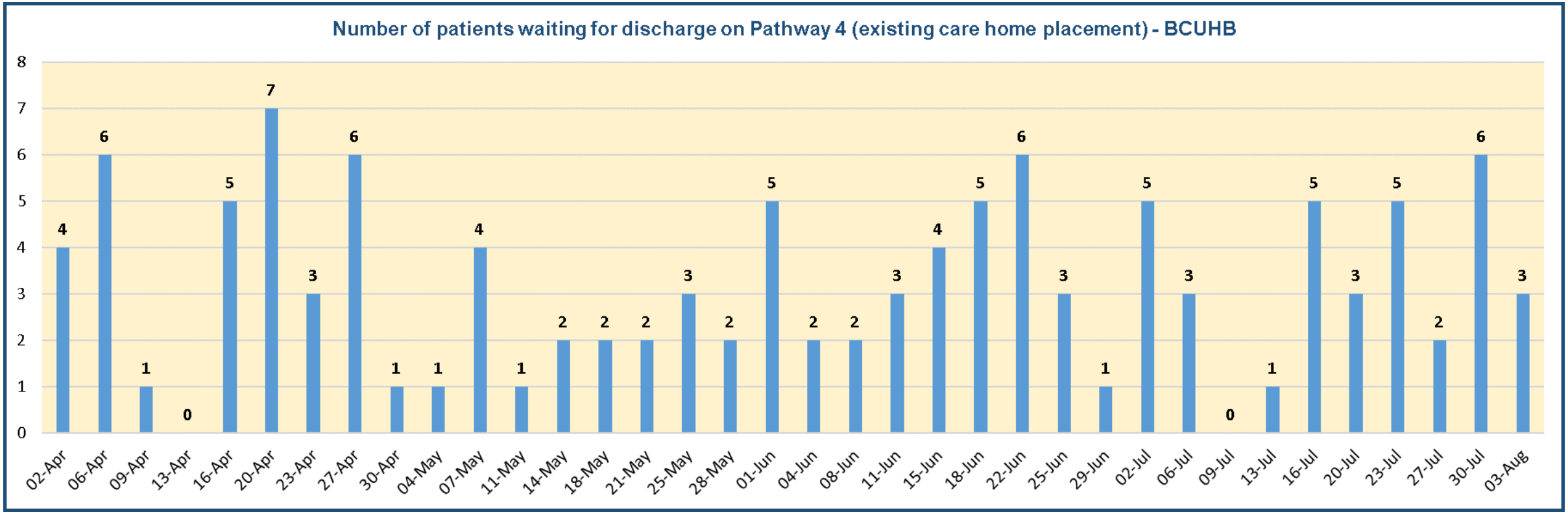






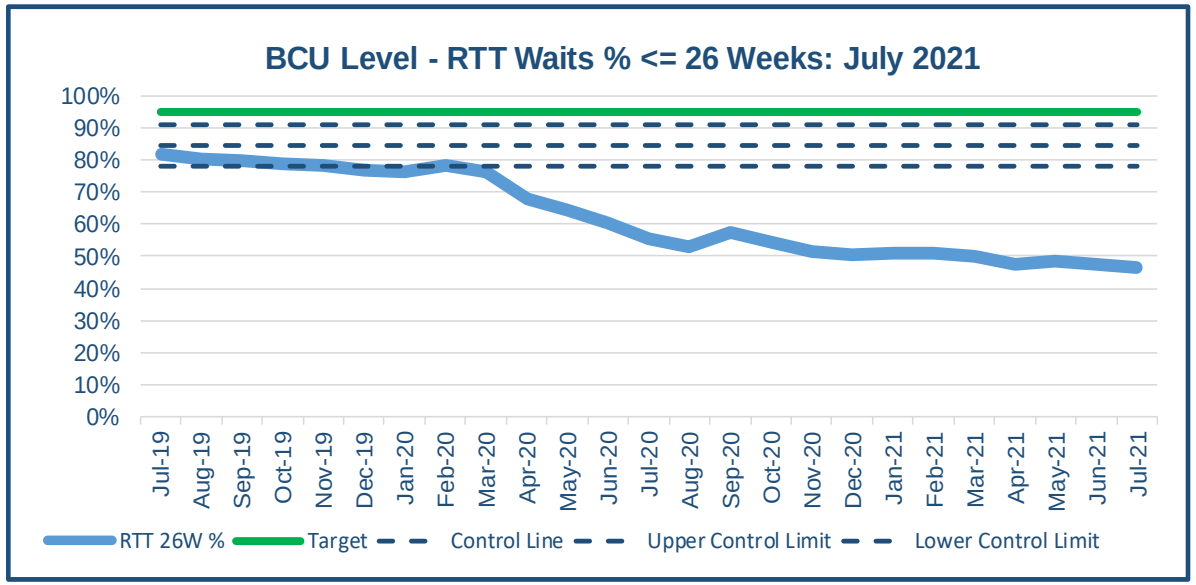
Quadruple Aim 2: Unscheduled Care (3)

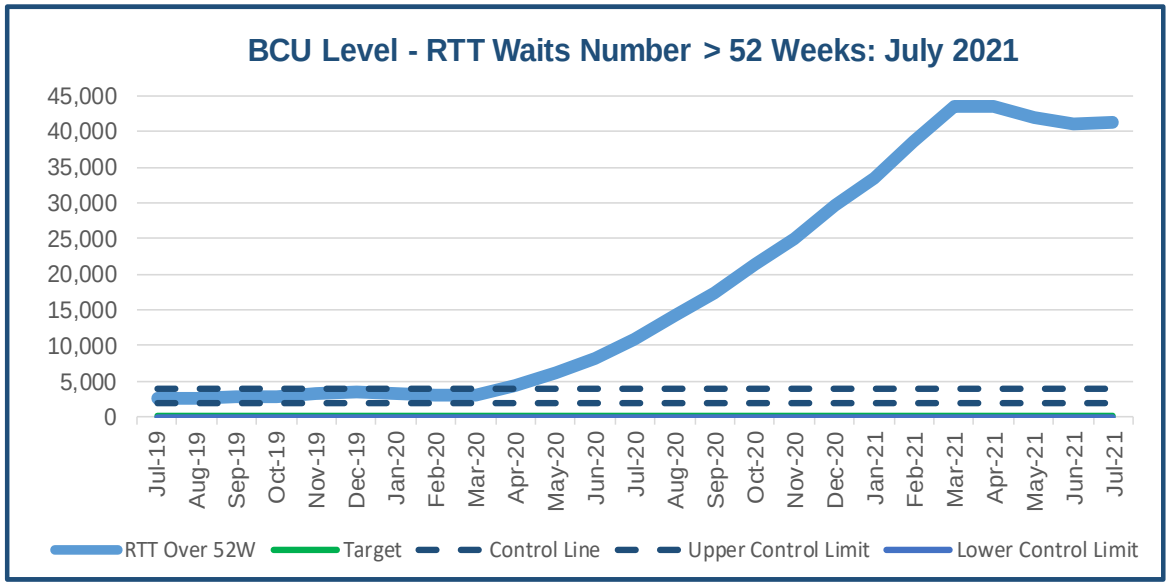


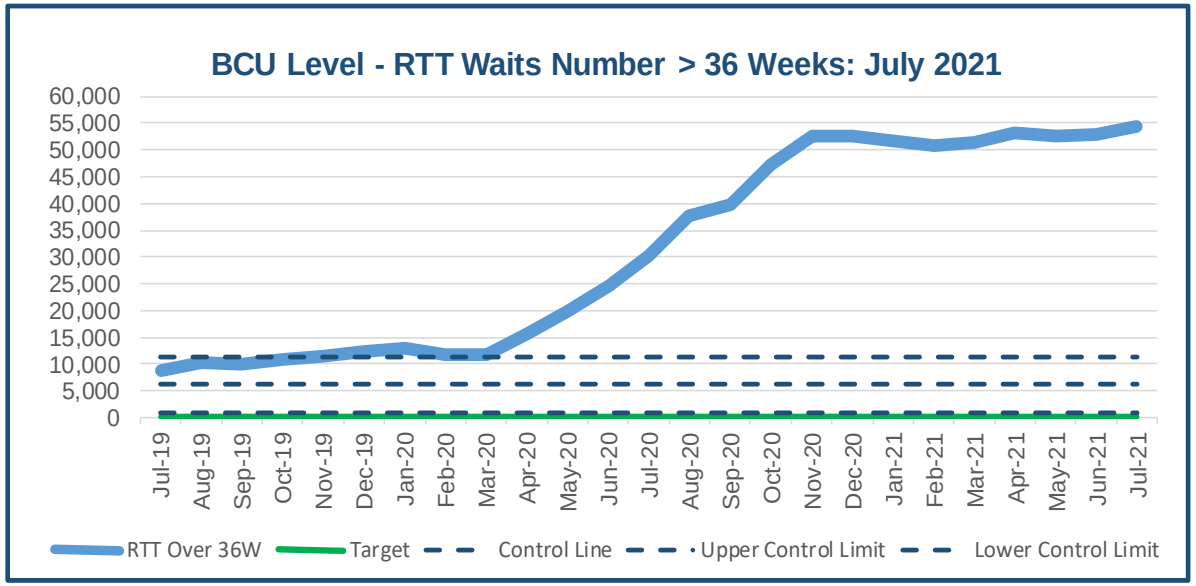
The Discharge and Flow slides demonstrate the numbers of patient delayed at the twice weekly census points (Tuesday & Friday) on Discharge to Recover then Assess (D2RA) Pathways 2, 3, 3a and 4. Further information on the D2RA process can be found at: [Hospital discharge service requirements: COVID-19 | GOV.WALES]

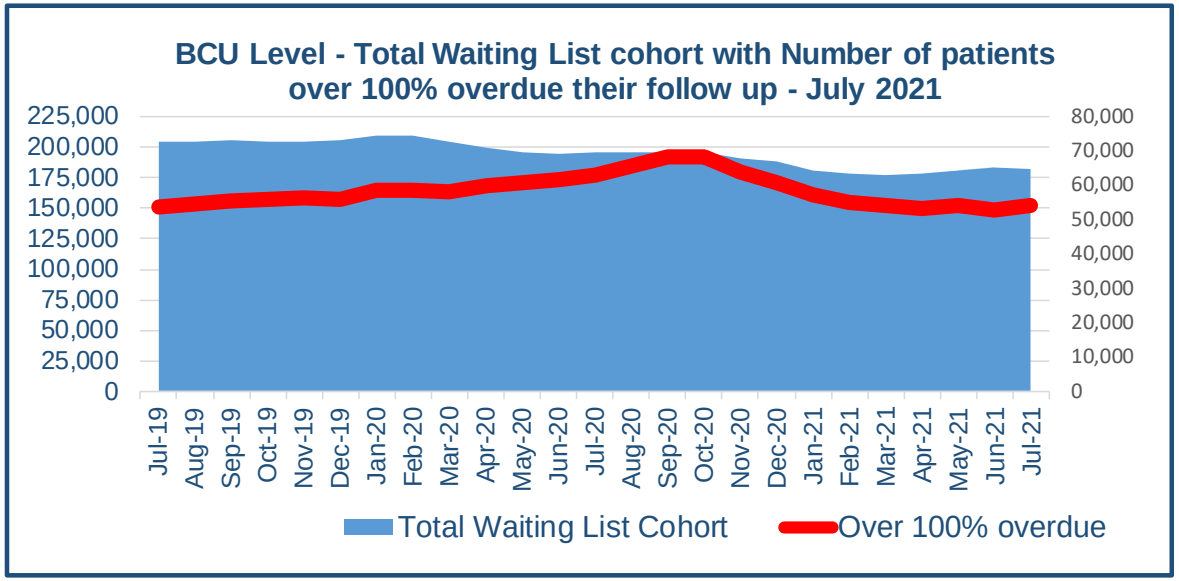
N.B.: These pathways do **not** include Mental Health patients

Quadruple Aim 2: Planned Care (1)



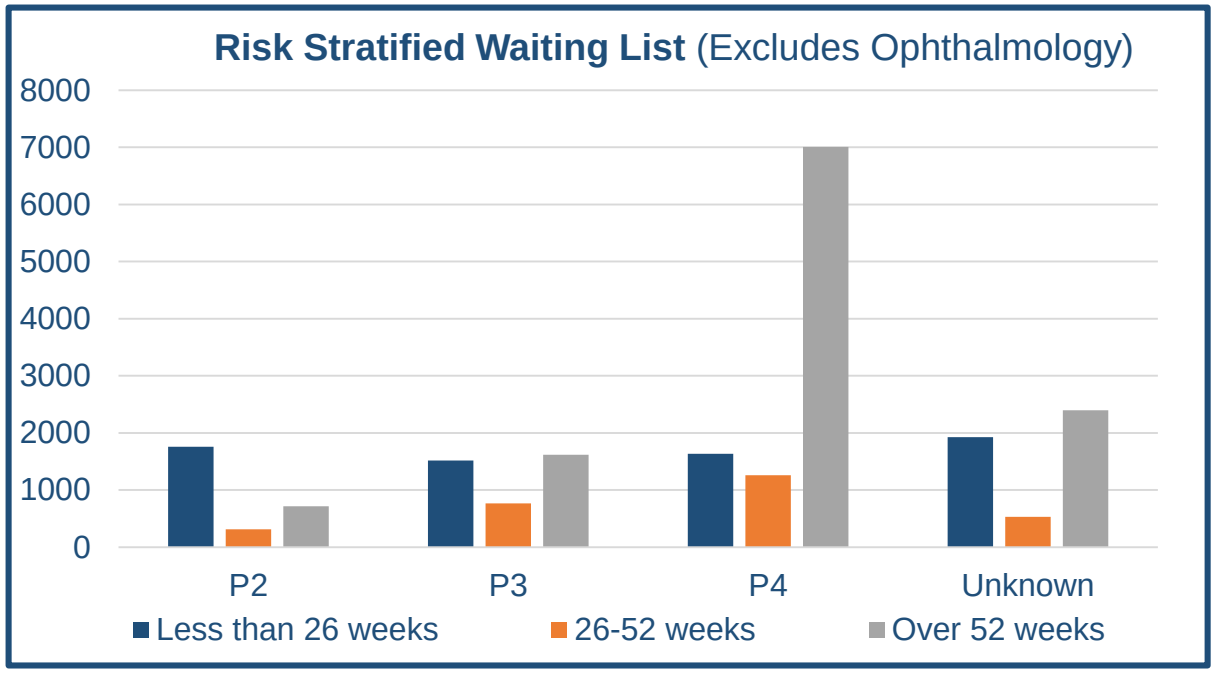




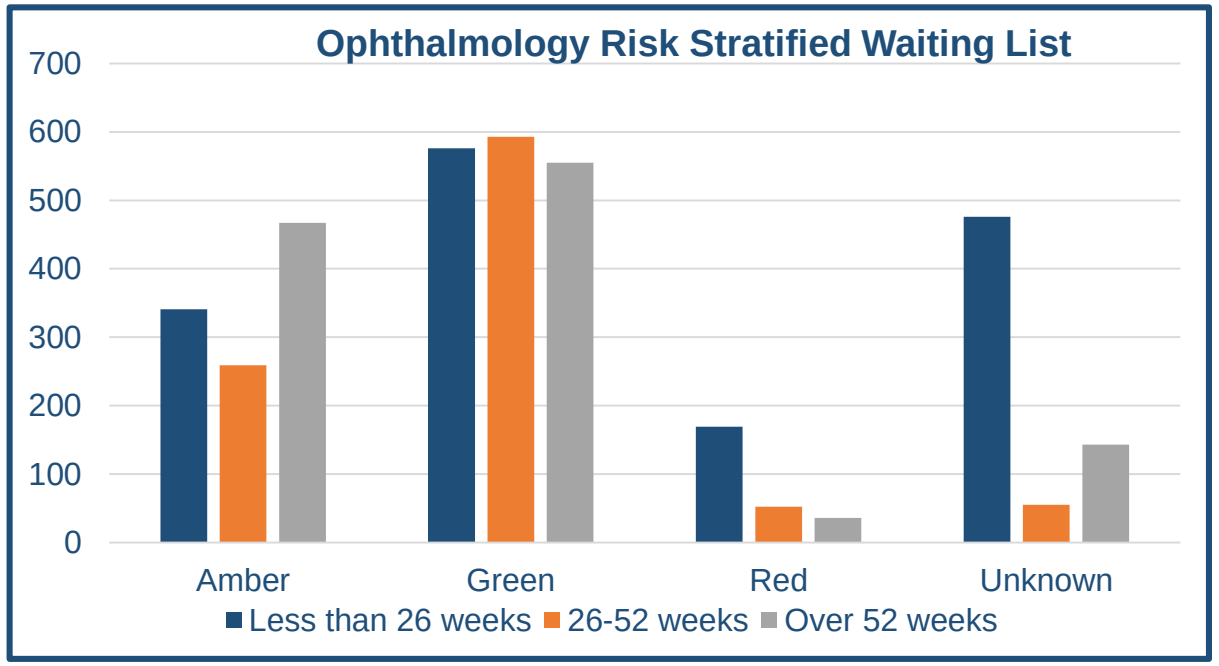


Quadruple Aim 2: Planned Care (2)

Waiting List by Risk Stratification

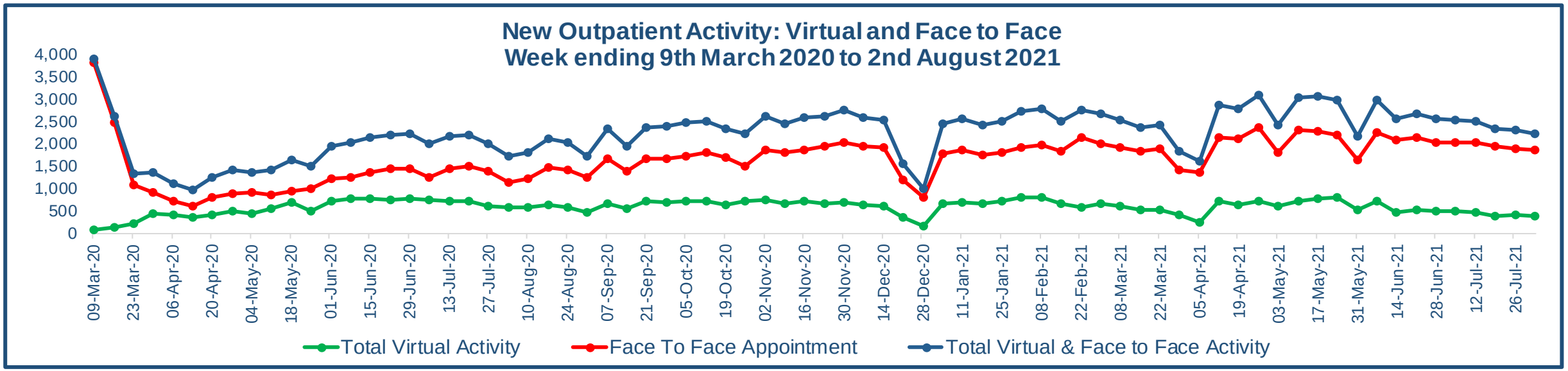


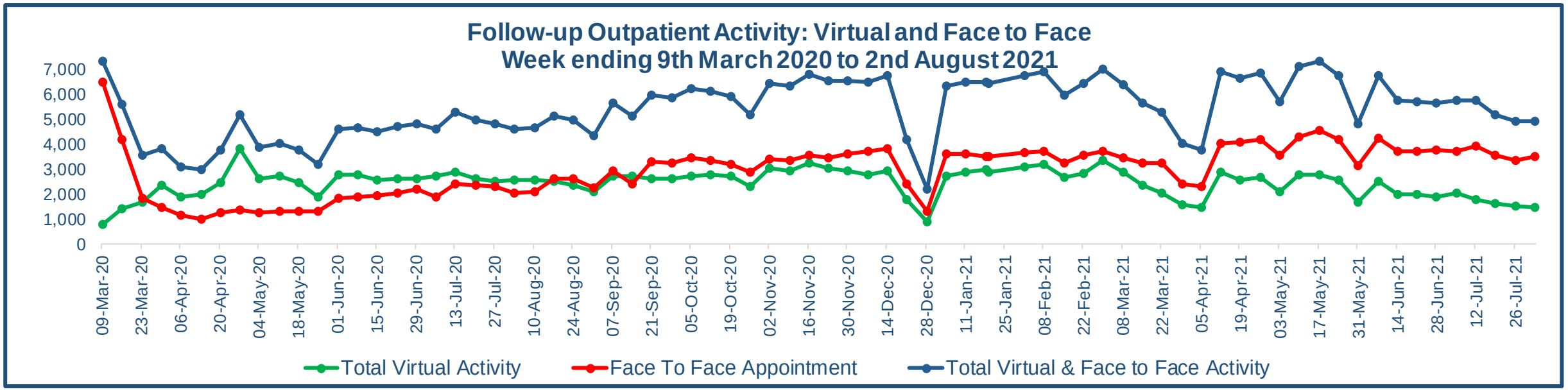
Source BCU HB IRIS : Accessed 15.157pm 9th August 2021
Data includes Admissions Waiting List for all specialties and excludes Endoscopy



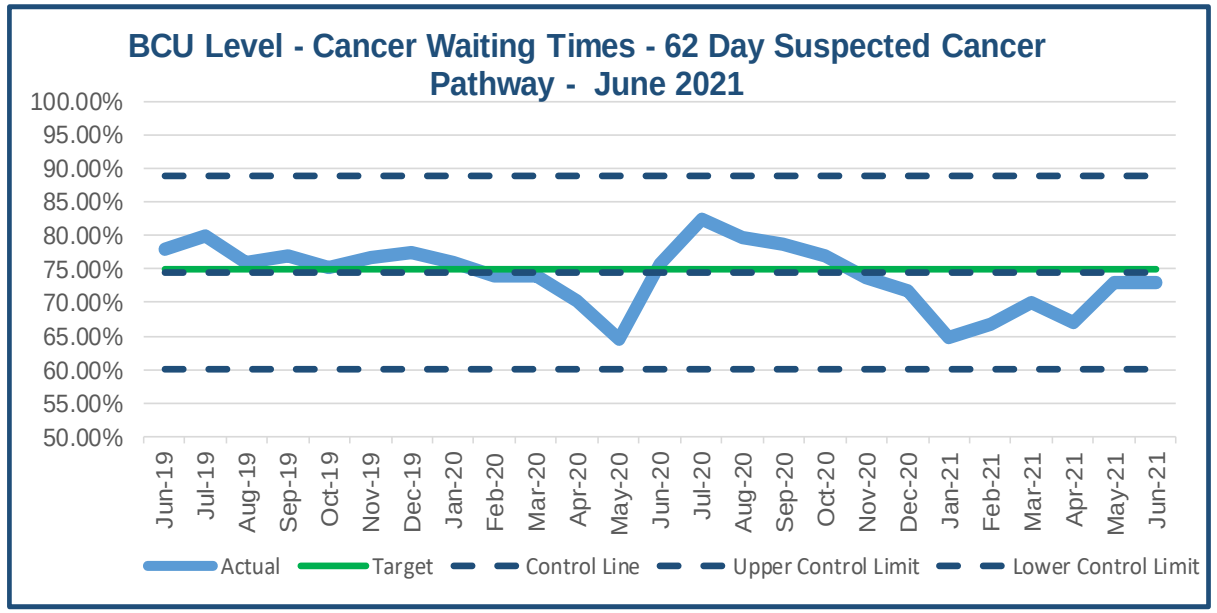
Source BCU HB IRIS : Accessed 15:15pm 9th August 2021
Data includes Waiting List for Ophthalmology Only

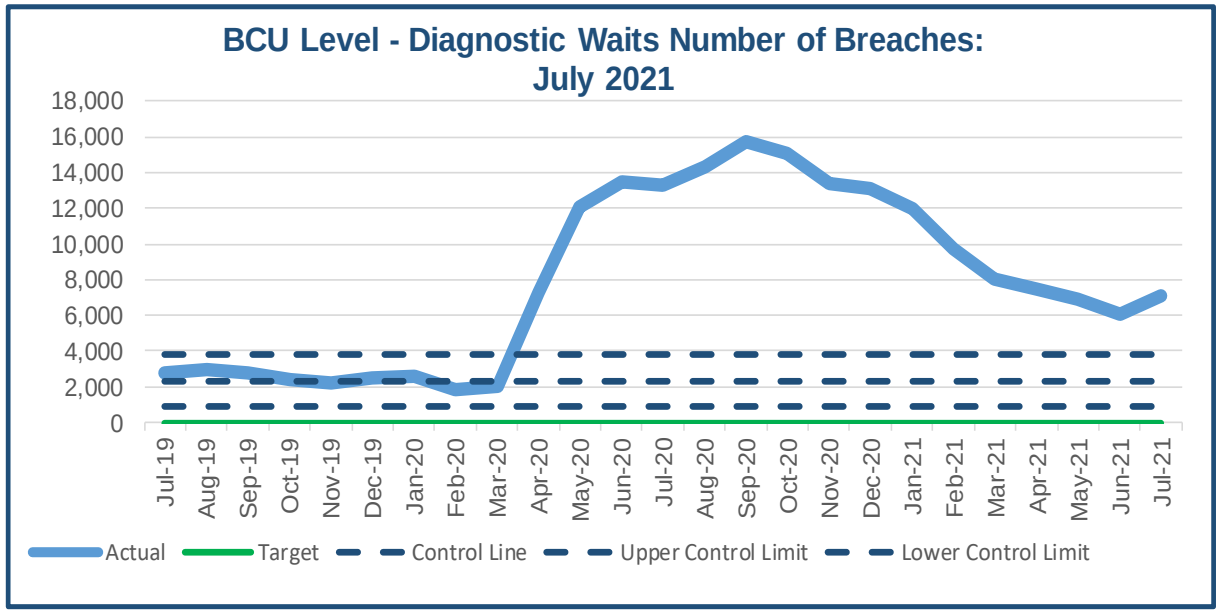
Quadruple Aim 2: Charts Planned Care (3)

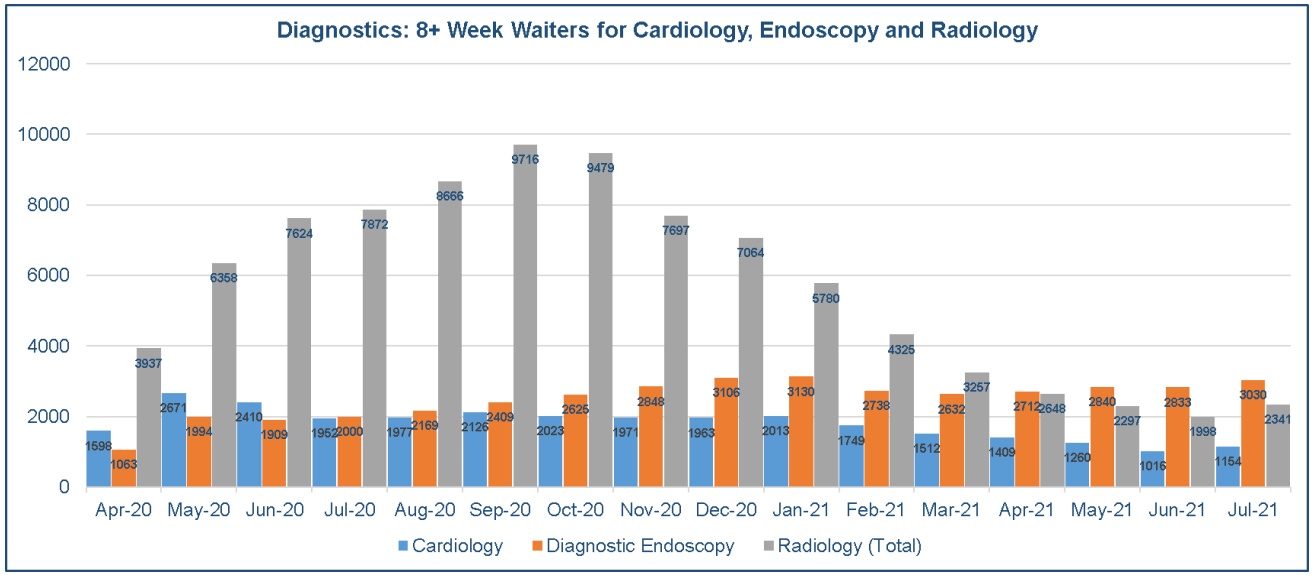




Quadruple Aim 2: Planned Care (5)

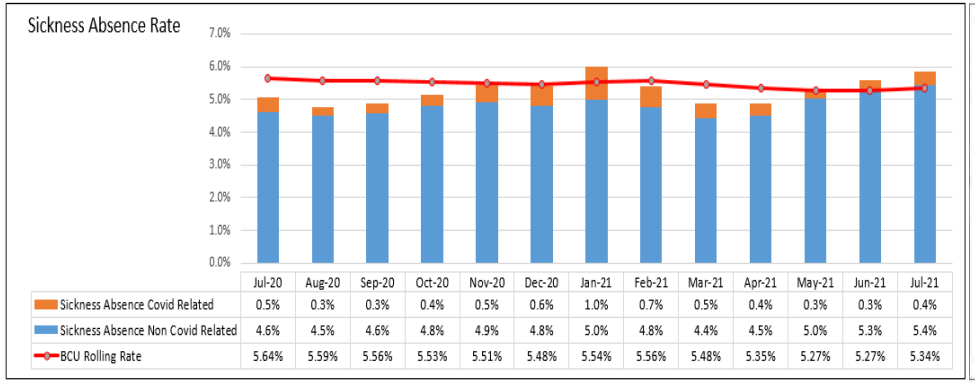




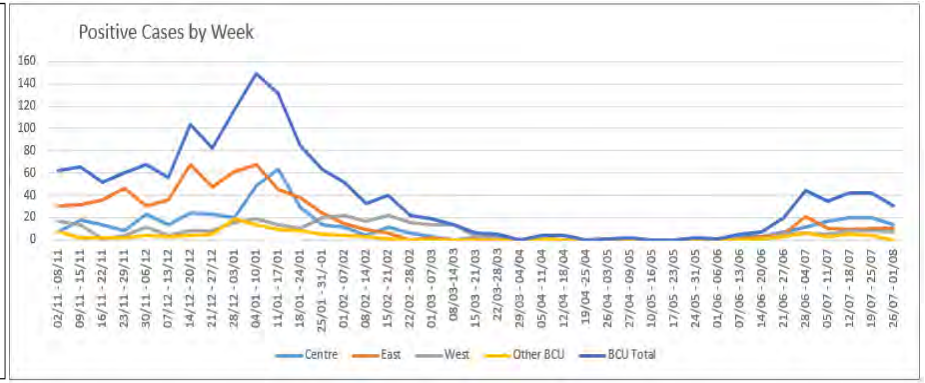


Quadruple Aim 3: Charts

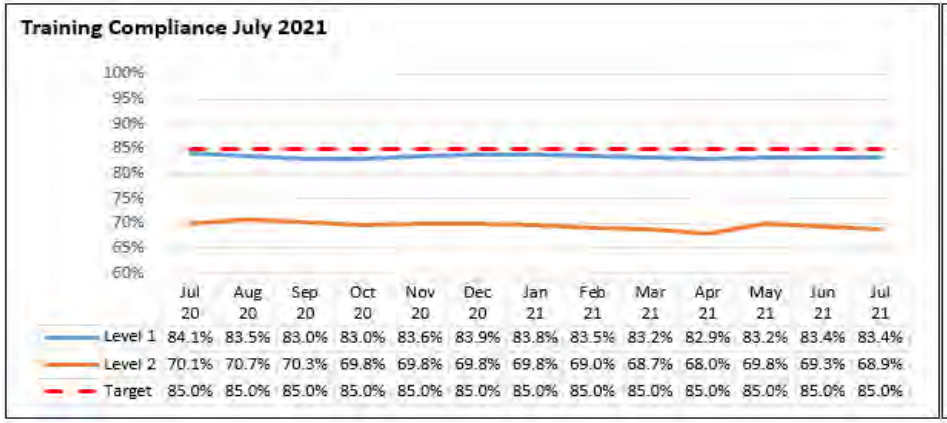
Sickness Absence Rates



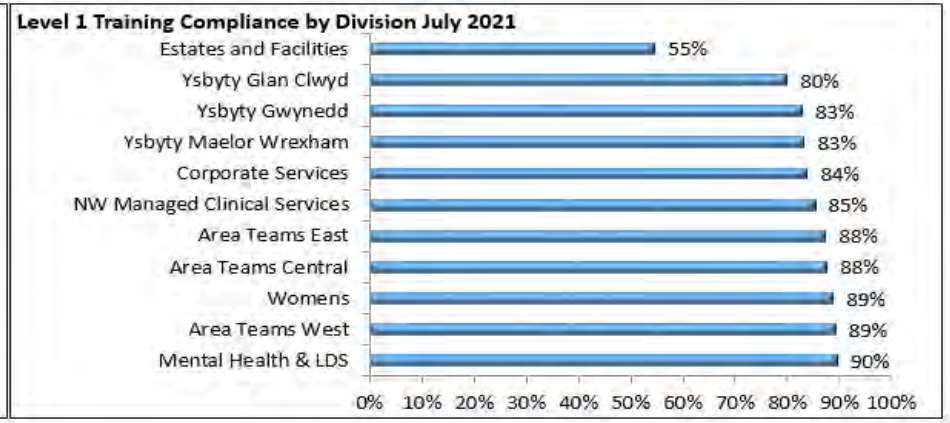
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Sickness Absence Covid Related	0.5%	0.3%	0.3%	0.4%	0.5%	0.6%	1.0%	0.7%	0.5%	0.4%	0.3%	0.3%	0.4%
Sickness Absence Non Covid Related	4.6%	4.5%	4.6%	4.8%	4.9%	4.8%	5.0%	4.8%	4.4%	4.5%	5.0%	5.3%	5.4%
BCU Rolling Rate	5.64%	5.59%	5.56%	5.53%	5.51%	5.48%	5.54%	5.56%	5.48%	5.35%	5.27%	5.27%	5.34%



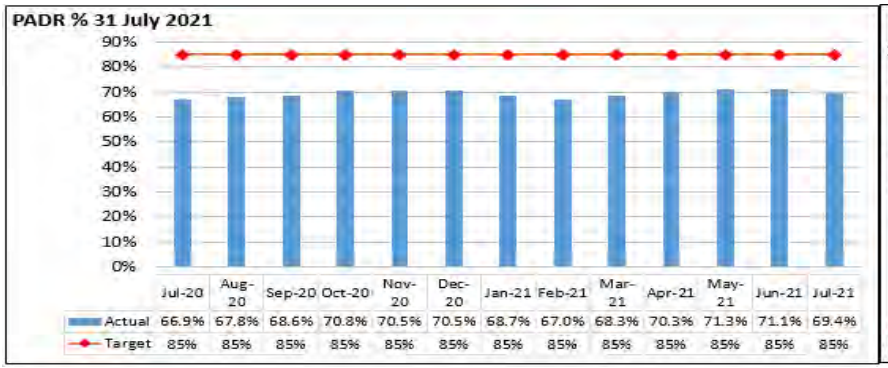
Core Mandatory Training Rate



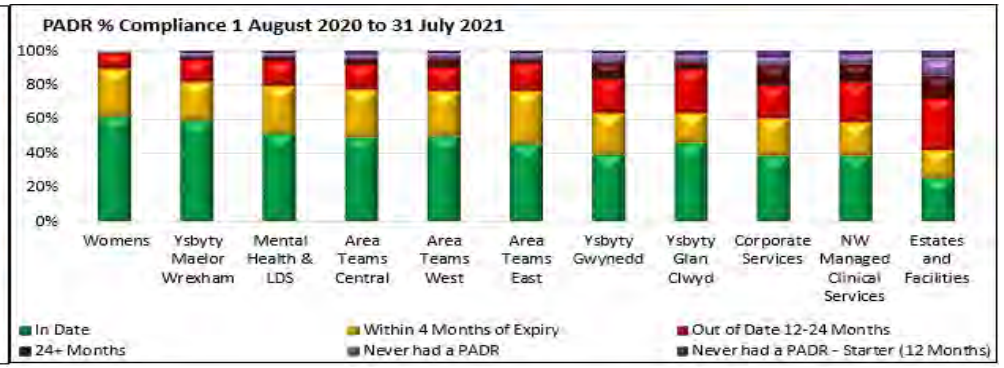
	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Level 1	84.1%	83.5%	83.0%	83.0%	83.6%	83.9%	83.8%	83.5%	83.2%	82.9%	83.2%	83.4%	83.4%
Level 2	70.1%	70.7%	70.3%	69.8%	69.8%	69.8%	69.8%	69.0%	68.7%	68.0%	69.8%	69.3%	68.9%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



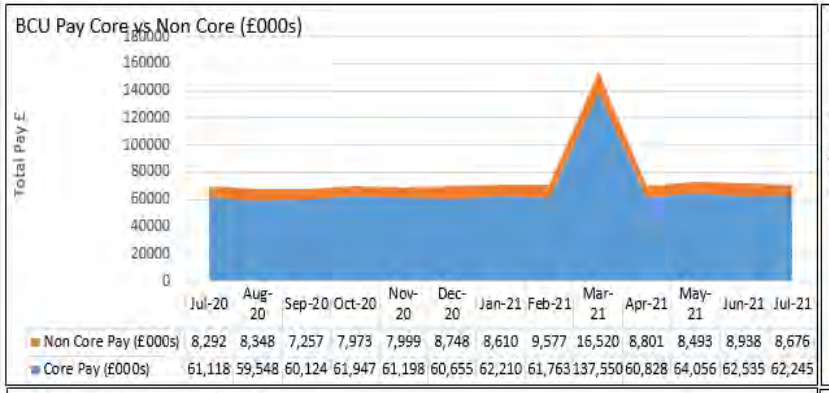
PADR

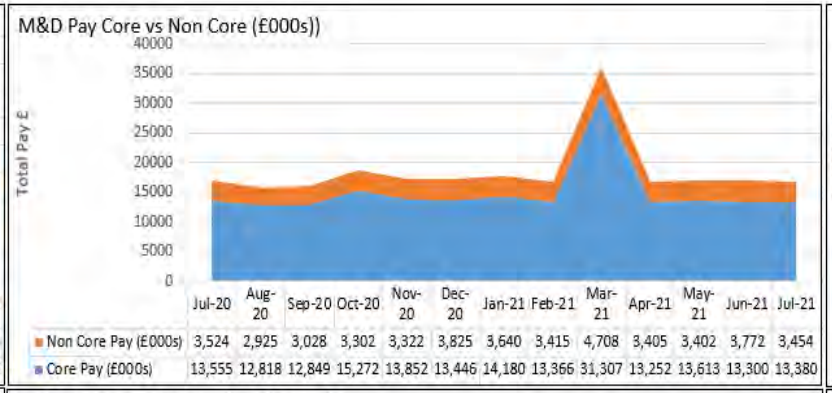


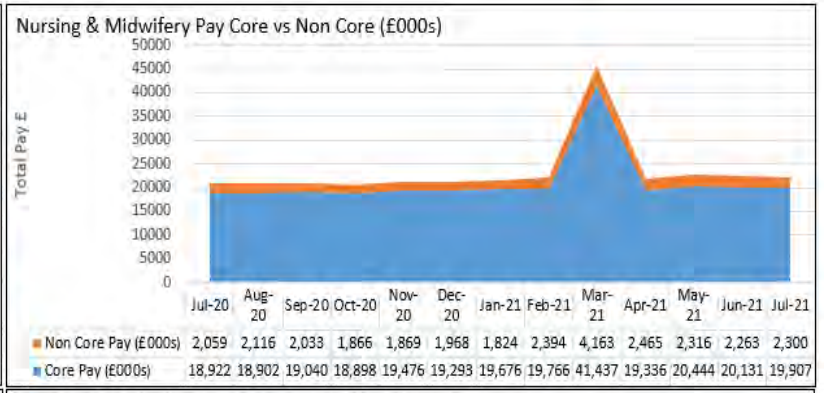
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Actual	66.9%	67.8%	68.6%	70.8%	70.5%	70.5%	68.7%	67.0%	68.3%	70.3%	71.3%	71.1%	69.4%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

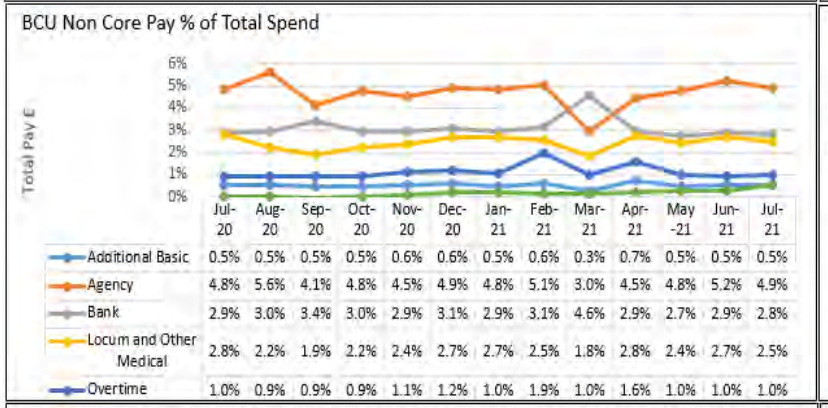


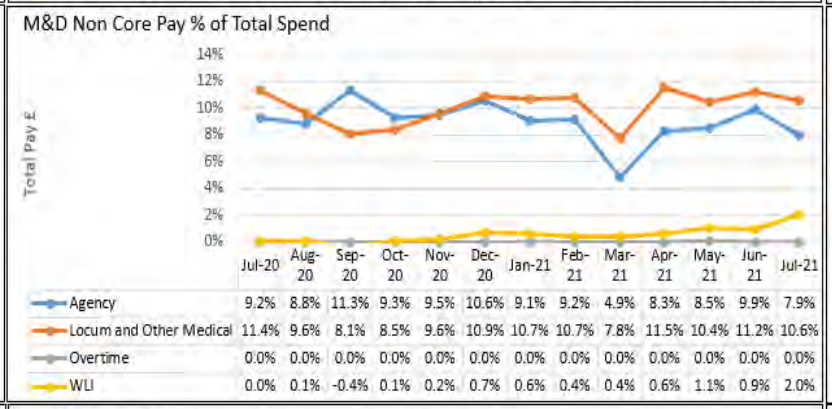
Quadruple Aim 4: Narrative – Agency Spend

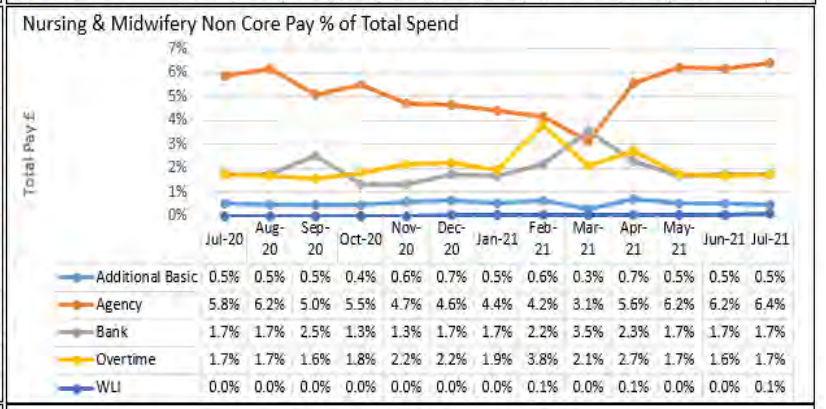


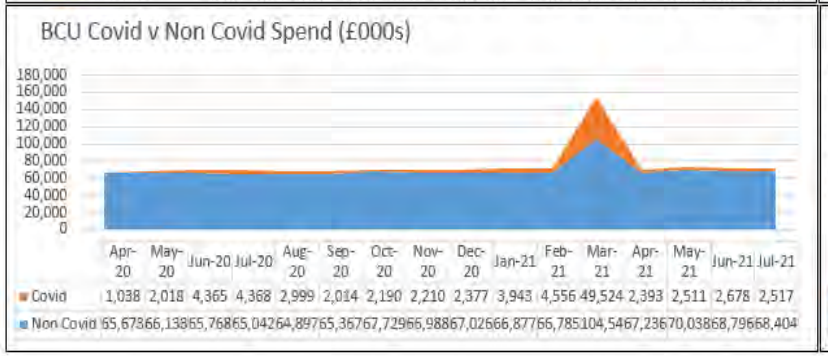


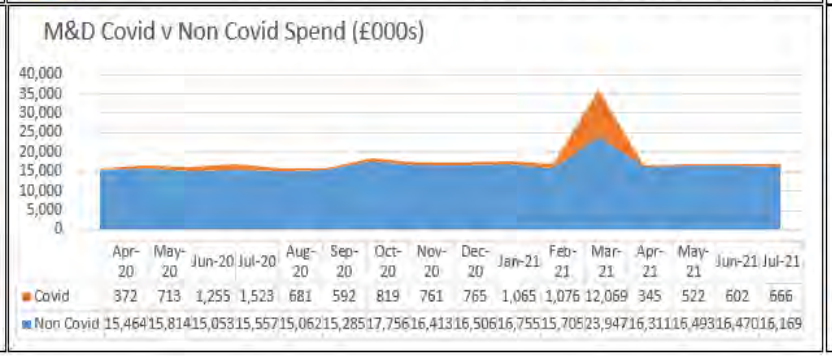


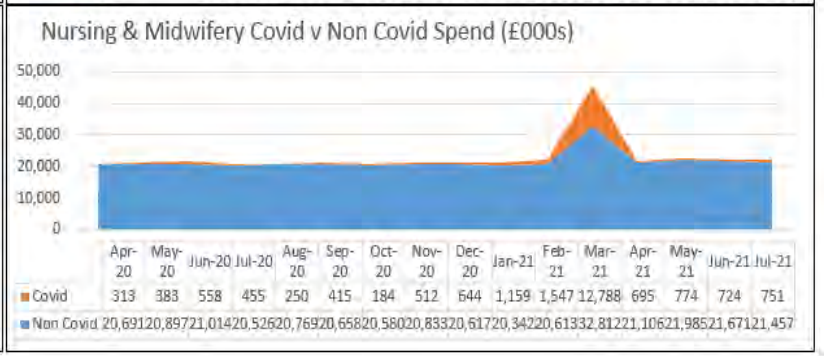












Further Information

Further information is available from the office of the Director of Performance which includes:

- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website www.bcu.wales.nhs.uk
- Stats Wales https://statswales.gov.wales/Catalogue/Health-and-Social-Care

We also post regular updates on what we are doing to improve healthcare services for patients on social media:

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Planned Care update**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Deputy Chief Executive
Awdur yr Adroddiad **Report Authors:**	Andrew Kent, Interim Head of Planned Care Clive Walsh, Interim Director of Regional Delivery
Craffu blaenorol: **Prior Scrutiny:**	Gill Harris, Deputy Chief Executive Executive Team
Atodiadau **Appendices:**	Appendix 1- definition of Cohorts 1&2 Appendix 2 -Activity undertaken by BCUHB against cohort 1 Appendix 3- Activity undertaken by BCUHB against cohort 2

Argymhelliad / Recommendation:

To **note** that the backlog clearance has commenced with high risk stratified patients being treated in order of priority
To **note** the update on the specifications and tendering for insourcing and outsourcing
To **recognise** the complexity of the work and the requirement for Executive and Board support in meeting the challenges and opportunities that lie ahead in the recovery programme.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	**X**	**Er gwybodaeth For Information**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The paper continues with the updates to the Finance and Performance Committee on the three major elements of the six point recovery plan and the progress to date in validating and treating patients waiting in the post-covid pandemic.

Cefndir / Background:

The recovery of planned care continues to be a complex problem. The recovery is based on understanding the current capacity against the historical patient demand (core activity), and being able to treat the further backlogs which developed during the pandemic. For the next few years the

HB will need to maintain core activity and be able to run sustainable additional capacity to clear backlogs. There are other variables to take into account, including unscheduled care pressures, further COVID-19 spikes plus any other internal disruptions we may experience such as staff sickness and isolation. This provides the context for the scale of the recovery for planned care.

Asesiad / Assessment & Analysis

Strategy Implications

The recovery plan fits into the overall strategic direction of planned care. It leads into the timescales for any potential Diagnostic and Treatment Centre (DTC) and supports the single cancer pathway and early diagnostics. By removing backlogs, it enables patients to have more timely access to their required treatment.

Options considered

Options for the provision of DTC services were considered by the Board in May 2021 as part of the Strategic Outline Case.

Financial Implications

There are significant financial implications to this recovery plan that are being worked through. The completed plans to deliver this activity are due at the end of April 2022. The Finance team are supporting the planned care programme to cost each element of the recovery plan.

Risk Analysis

The current risk score of potentially causing harm and unable to achieve the national standard of 36-week waits is 25. A number of controls are being implemented but have not yet been operationalised. The risk score was reviewed in July 2021.

Legal and Compliance

The Insourcing and Outsourcing specifications will be subject to a full procurement process and Welsh Government ministerial approval. A compliance governance framework is illustrated in the document.

Impact Assessment

An impact assessment regarding health inequalities will be undertaken once the plans have been confirmed and scrutinised.

Introduction

The paper continues the updates to the Finance and Performance Committee on the recovery of planned care, which is in three components:

- Re-start and sustainability
- Treating our patients
- Transformation

This paper informs and updates the committee on the six-point recovery plan with the connected three key elements described above.

Context

Re-start and sustainability

The current distribution of the waiting list (8th August) is shown in the table below:

New DSU stage	0-25	26-31	32-35	36-51	52 +	Total
Grand Total	73,880	5,748	4,322	12,484	42,134	138,568

As a comparison with previous reports, the total waiting list size has grown since the 8th of June by 16,369, approximately 8,000 patients each month. During this period the number of patients waiting over 52 week reduced by around 2,000. The Planned Care Group will be monitoring this change closely, and the 36-51 week wait cohort is increasing.

The re-start of elective activity is focused on reducing the Priority 3 backlog before moving on to the Priority 4 patient group. All planned care activity has now recommenced including orthopaedic in-patient activity at both the Centre and West sites. It is recognised in July this was not to full capacity but is now expected to continue.

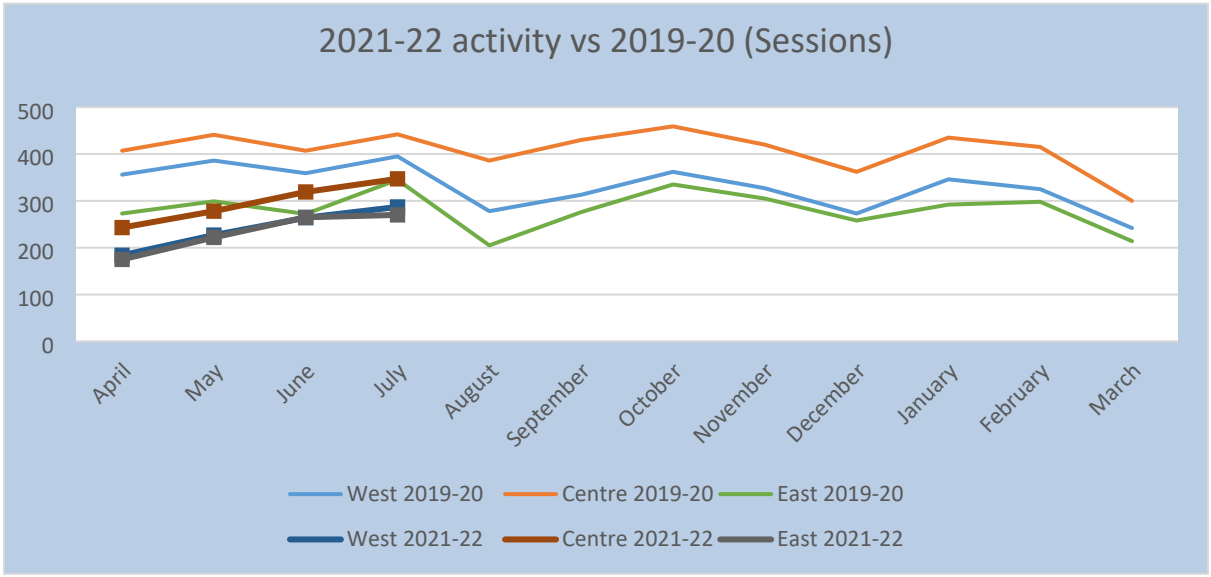
The Planned Care Group is now reviewing the quarter 2-4 capacity plan and anticipated demand through the planning and performance team, to understand potential year-end forecast and what further capacity will be required over the coming months.

Winter planning is also being developed in conjunction with stakeholders, and the capacity relationship with unscheduled care is being worked through, including bed modelling. The aim is to minimise the disruption to planned care in the coming winter months. However, the Committee will note that reduction in bed capacity due to COVID-19 distancing regulations will make this winter challenging for the organisation and the sustainability of both unscheduled and planned care.

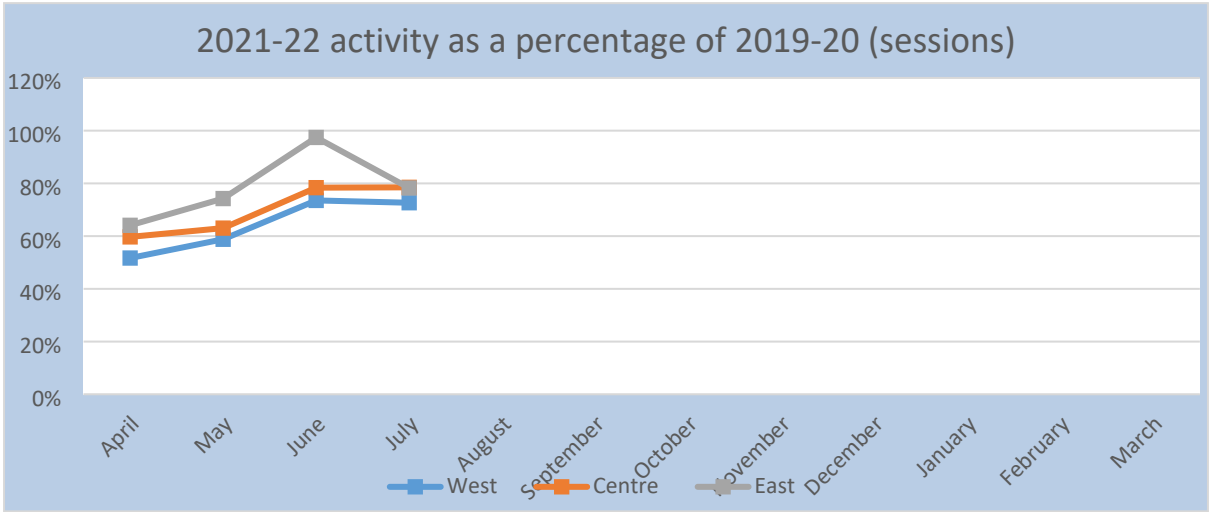
Treating our patients

Theatre activity

The graphs below show activity in the post-COVID environment with theatre activity still being below the previous year's activity. The Committee will note that all three sites remain below the previous year's outturn. June 2019 showed reduced activity in the East sector.



The graph below demonstrates current activity as a percentage of the 2019 level with all sites achieving between 75- and 80% of previous theatre activity. This is consistent with other providers in Wales. A theatre dashboard is in its final stages of development with the Informatics team to support the improvement programme in this area.



Cohort 1&2

As reported in the previous section, all sites and areas have re-commenced core activity and are also seeing or validating Cohort 1 and 2 patients. These are treated and blended into the core activity, currently through additional clinical sessions, virtual consultations or through the two long-waiting patient validation exercises.

The detail of the cohort numbers are found in the appendices of this paper. Cohort 1 is currently 1,721 patients (a reduction of 519) and Cohort 2 is currently at 33,718 (a reduction of 4,589).

Capacity modelling is complete for Orthopaedics and Ophthalmology and the attention of the planned care group is now Urology. These three specialties are the largest by volume requiring recovery and will be the subject of the transformation element of the recovery programme.

Previous papers have described the challenge of delivering timely backlog treatments for patients and the need to deliver core activity, not just for this year but for several years to come.

In order to support and sustain these levels of activity a number of specifications have been written and are now being deployed. This is shown below:

Specification	**OPD**	**Daycase**	**In-patient**	**Current status**
Orthopaedic outsourcing	Yes	Yes	Yes	Awarded, commencing patient activity in October
Orthopaedic Insourcing	Yes	Yes	No	Planned tender in August
Mixed speciality outsourcing	Yes	Yes	Yes	Expressions of interest received. Retendering
Mixed speciality Insourcing	Yes	Yes	No	Planned tender in August

The above tenders include key specialties such as dermatology. The Committee will recognise that other insourcing and outsourcing is underway in Endoscopy and a range of diagnostic procedures including cardiology.

The tenders for orthopaedic outsourcing have been evaluated and the decision has received approval.

These contracts will provide a significant amount of capacity and have the ability to rollover on a yearly basis and do not have an activity guarantee, allowing the HB as much flexibility as possible. We have had more than four organisation give expressions of interest.

The role of an insourcing and outsourcing lead is due to be advertised in August and each acute site has been given funding for further administrative support to ensure

that each list will be filled with the right patients once mobilisation has occurred. It has not been possible to recruit to the short-term contracts, so longer term arrangements are being considered.

The need to retender for the mixed specialty outsourcing contract will lead to delay in expanding capacity. The specialties (and patients) most impacted by this delay are likely to be General Surgery and Urology, and further mitigations will therefore be considered.

Transformation

Over the first half of the year, the Planned Care Group has focused on the mobilisation, re-start and treatment of the backlog patients. A significant amount of this activity is now moving to business as usual and the Group is now commencing the transformation phase for planned care services. This will drive the move towards new models of care, reducing variation and improving efficiency within the services.

Outpatients

As reported previously, the Attend Anywhere business case has been approved and two programme managers have been appointed and commenced within the organisation. Their remit is to roll out the software, training and awareness of the benefits of virtual consultations to ensure uptake. Further reports on the benefit realisation of this programme will be brought to this Committee.

The Associate Director of Ambulatory Care has been appointed and is due to commence in early September. This role will be a key appointment to the Planned Care Group, supporting the efficiency and transformation programme within outpatients. This will aligning to the patient administration system upgrade to scope and deliver a “Once for North Wales” booking and appointment system, allowing an improved offer and waiting times for patients. Part of the remit is the improvement of patient communications during that booking process and this should reduce the overall health inequalities produced by the long access waiting times.

The recruitment of a substantive replacement for the Head of Planned Care was unsuccessful, so further options are being considered to replace this key role within the organisation.

The Executive Team has agreed to participate in the “Getting It Right First Time” (GIRFT) programme and two key pieces of work are due to commence in the Autumn. First, the service reviews of Orthopaedics, Ophthalmology, Urology will commence in November, and the High Volume Low Complexity pathway work will commence in a similar timeframe with the national team. The development of three key pathways of hips, knees and hands has commenced and this will be supported by the national team as well.

The appointment of the pathway lead within the BCUHB Transformation Team has been successful.

Discussions continue with Welsh Government on the Diagnostic and Treatment Centres (DTCs). The HB has set out the arguments for an urgent decision on this

development in writing and through several meetings with WG in Aug 2021. A variety of permutations is being considered, taking into account speed of implementation and funding available. A managerial lead for the DTCs has been appointed and is now in post and expressions of interest regarding clinical leaders is currently out within the organisation. The managerial lead is currently establishing the governance framework for this programme of work.

There are benefits from all these elements being pulled together and working seamlessly as we move towards this significant opportunity, but there is the potential for the transformation programme to function separately, if required, and still deliver benefits.

To support the transformation work, Cancer services have undertaken a review and proposed a new approach for cancer services across North Wales, developing a strategic vision for North Wales for Cancer care. The scoping paper is currently being taken to the Executive Team for approval.

Risk register

The Committee will note from this paper the scale of the situation and the current risk continues to be twenty-five with a target risk of fifteen. Mobilisation of the infrastructure is almost now in place with key appointments and awarding of key contracts. In September, the risk will be re-assessed again to ensure movement towards the target risk.

Conclusion

Significant movements occurred in June/July in the delivery of both core and backlog activity. The three key elements are all linked to the six-point recovery plan, which is the road map for planned care transformation. Some elements have taken longer than anticipated to put into place but these short delays have given the opportunity to provide more resilience and sustainability for the planned solutions.

Recommendations:

To note that the backlog clearance has commenced with risk-stratified patients being treated in order of priority.

To **note** the update on the specifications and tendering for insourcing and outsourcing.

To recognise the complexity of the work and the requirement for Executive Team and Board support with the challenges and opportunities that lie ahead in the recovery programme.

Authors: Andrew Kent, Interim Head of Planned Care

Clive Walsh, Interim Director of Regional Delivery

August 2021

Appendix 1

Cohort definition

- Cohort 1 - Pre-covid backlog as of 31/03/2020
- Cohort 2 - Covid backlog as of 1/04/2020 - 09/04/2021

Appendix 2

Activity undertaken by BCUHB against cohort 1

Row Labels	Sum of 16/05/2021	Sum of 01/08/2021	Difference current week versus 16th May 2021
100 - General Surgery	235	196	-39
101 - Urology	223	175	-48
110 - Trauma & Orthopaedics	780	569	-211
120 - ENT	124	98	-26
130 - Ophthalmology	50	31	-19
140 - Maxillo-Facial Surgery	457	427	-30
141 - Restorative Dentistry	0	0	0
143 - Orthodontics	20	20	0
171 - Paediatric Surgery	0	0	0
191 - Pain Management	34	17	-17
300 - General Medicine	1	0	-1
301 - Gastroenterology	65	57	-8
302 - Endocrinology	126	18	-108
303 - Clinical Haematology	0	0	0
320 - Cardiology	0	0	0
330 - Dermatology	46	45	-1
340 - Respiratory Medicine	0	0	0
341 - Respiratory Physiology	0	0	0
361 - Nephrology	0	0	0
410 - Rheumatology	22	23	1
420 - Paediatrics	5	5	0
430 - Geriatric Medicine	0	0	0
502 - Gynaecology	52	40	-12
Grand Total	**2240**	**1721**	**-519**

Note: The negative numbers indicates a reduction in the cohort numbers

Appendix 3

Activity undertaken by BCUHB against cohort 2

Specialties	16/05/2021	Sum of 01/08/2021	Difference current week versus 16th May 2021
100 - General Surgery	4684	3893	-791
101 - Urology	3010	2693	-317
110 - Trauma & Orthopaedics	9777	8630	-1147
120 - ENT	4624	4137	-487
130 - Ophthalmology	6183	5429	-754
140 - Maxillo-Facial Surgery	2691	2521	-170
141 - Restorative Dentistry	12	4	-8
143 - Orthodontics	377	318	-59
171 - Paediatric Surgery	0	0	0
191 - Pain Management	608	508	-100
300 - General Medicine	4	0	-4
301 - Gastroenterology	1094	1018	-76
302 - Endocrinology	547	444	-103
303 - Clinical Haematology	0	0	0
320 - Cardiology	53	5	-48
330 - Dermatology	1607	1540	-67
340 - Respiratory Medicine	200	121	-79
341 - Respiratory Physiology	540	449	-91
361 - Nephrology	72	31	-41
410 - Rheumatology	294	269	-25
420 - Paediatrics	9	12	3
430 - Geriatric Medicine	148	109	-39
502 - Gynaecology	1773	1587	-186
Grand Total	**38307**	**33718**	**-4589**

Note: The negative numbers indicate a reduction in the cohort number

Cyfarfod a dyddiad: **Meeting and date:**	**Finance & Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Unscheduled Care update**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director of Nursing & Midwifery / Deputy CEO
Awdur yr Adroddiad **Report Author:**	Roshan Robati, Programme Director for Unscheduled Care (USC) Dr Chris Subbe, Senior Clinical Lead for USC Claire Brennan, Head of Office
Craffu blaenorol: **Prior Scrutiny:**	Review by Executive Director of Nursing & Midwifery / Deputy CEO
Atodiadau **Appendices:**	BCUHB Urgent & Emergency Care Improvement Programme plan

Argymhelliad / Recommendation:

The Committee is asked to note the update provided on the development of the Urgent and Emergency Care improvement programme of work

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	✓	**Er gwybodaeth** **For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This report provides an update to the Committee on the improvement programme of work for the whole urgent and emergency care system that ultimately aims to avoid harm, ensure delivery of quality and performance standards and quality of care, improve patient outcomes and provide a better experience for patients and staff.

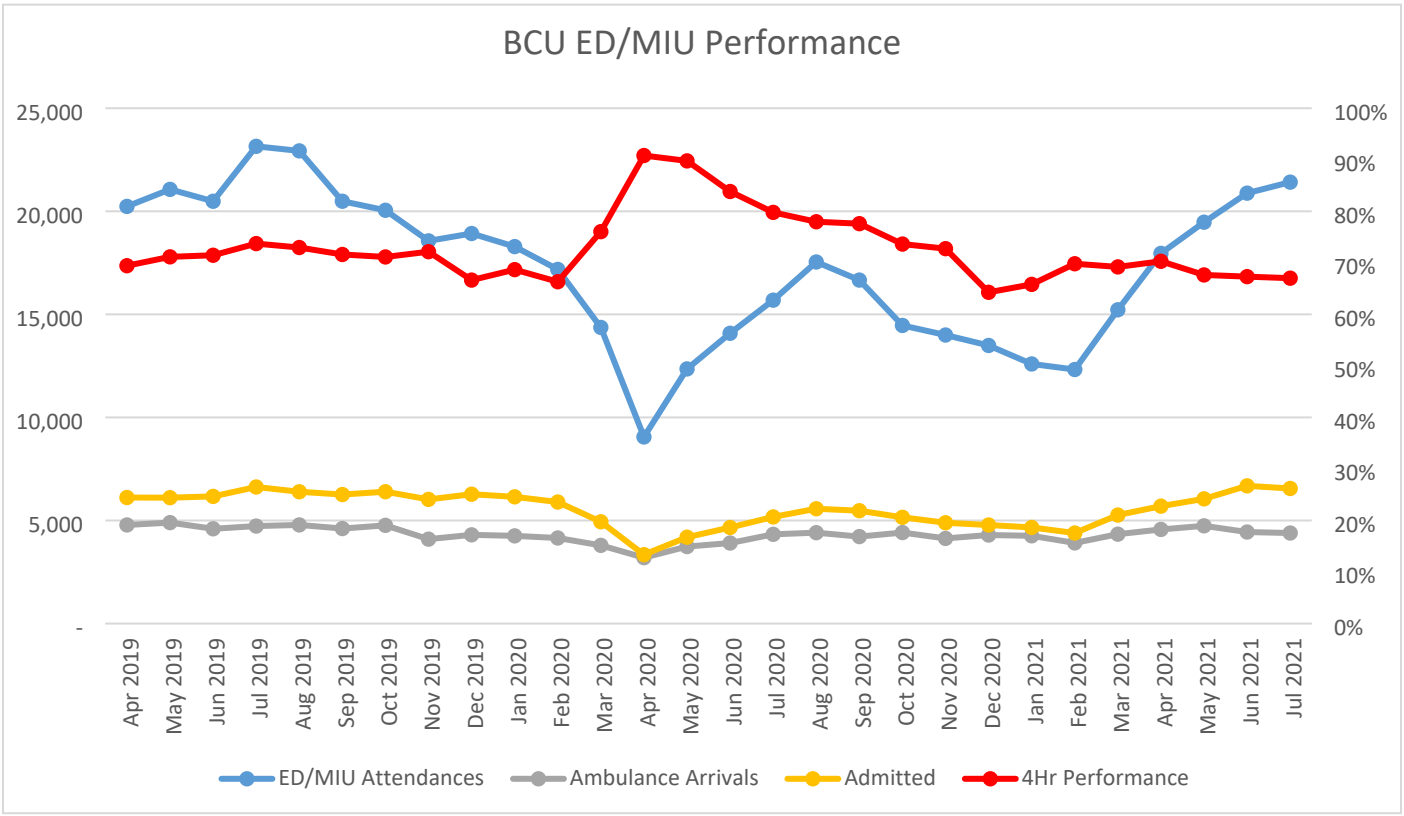
This focused transfomation programme is in recognition of the ongoing challenges on the urgent and emergency care system and the need to support and enable staff to effectively and safely deliver the necessary services to meet the need of our population.

Cefndir / Background:

Emergency Department (ED) performance

Performance of the Health Board, measured against a suite of national indicators is currently judged to be poor compared to other organisations with similar geographic and population challenges. The Health Board's 4 hour ED performance has remained below the 95% standards for some considerable time and is one of the key indicators of the daily pressures across the urgent and emergency care system where patients are experiencing unacceptable delays in the department due to lack of flow across the whole system and an inability to offload patients from ambulances.

The following graph shows depicts the Health Board's ED monthly data for 4 hour performance, the number of attendances, admissions and Wales Ambulance Services Trust (WAST) arrivals for the period from April 2019 to July 2021.



The continued increase in attendances, alongside the reduced capacity in our EDs to ensure adherence to social distancing and the need to continue with the separation of red and green pathways, means that overcrowding in ED is felt more acutely. Whilst the rate of new Covid-19 infections is reducing, challenges remain within EDs in the unpredictable shift in green and red patients who continue to present to the departments and this year this is exacerbated by an increased number of tourists to the North Wales area due to the international travel restrictions. The acuity of patients presenting to EDs remains high.

In addition, the reduction in bed base across the Health Board, in order to comply with social distancing requirements (circa.10% reduction in bed base), delays in specialty bed waits as well as swabbing delays for direct admission has further impacted on flow across the whole system resulting in delays in admitting patients from the EDs. Our capacity is further impacted by the number of staff who have to self-isolate.

A number of initiatives have tried to address the situation but have not lead to measurable impact and in recognition of the ongoing and unprecedented challenges the revised Urgent and Emergency care improvement programme sets out to identify and prioritise significant contributors for poor patient experience and organisational performance to facilitate transformation of Unscheduled Care to improve patient outcomes, experience and quality of care.

Unscheduled Care Improvement Programme

The scope of the unscheduled care improvement programme covers the whole system from community to front door for unscheduled care and for in-hospital care and post hospital care. This whole system approach aims to tackle the system wide problems across unscheduled care and ensure the transformation of patient centred care that aims to:

- reduce harm
- improve patient outcomes
- improve patient and staff experience
- secure partnership working with WAST, Local Authorities and the Third Sector.

The improvement programme work is being supported by the National Commissioning Collaborative Unit (NCCU) and is locally being clinically led, which is considered a key factor to the delivery of the programme. Dr Chris Subbe has been appointed to the post of Senior Clinical Lead who is driving this programme of work forward, supported by a Programme Director, Programme Manager and analytical support. The programme will continue to work closely with staff including clinical colleagues, partners and wider stakeholders to facilitate, implement and embed change. The Deputy Chief Executive will be the Senior Responsible Officer (SRO) for the programme. This is an extensive long term transformational work that requires commitment from colleagues at all levels across the Health Board and in close working with other partners such as local authorities, WAST, Welsh Government and others.

The USC programme plans are aligned to the six goals for urgent and emergency care, articulated within the Welsh Government (WG) framework, set out in Figure 1 below;

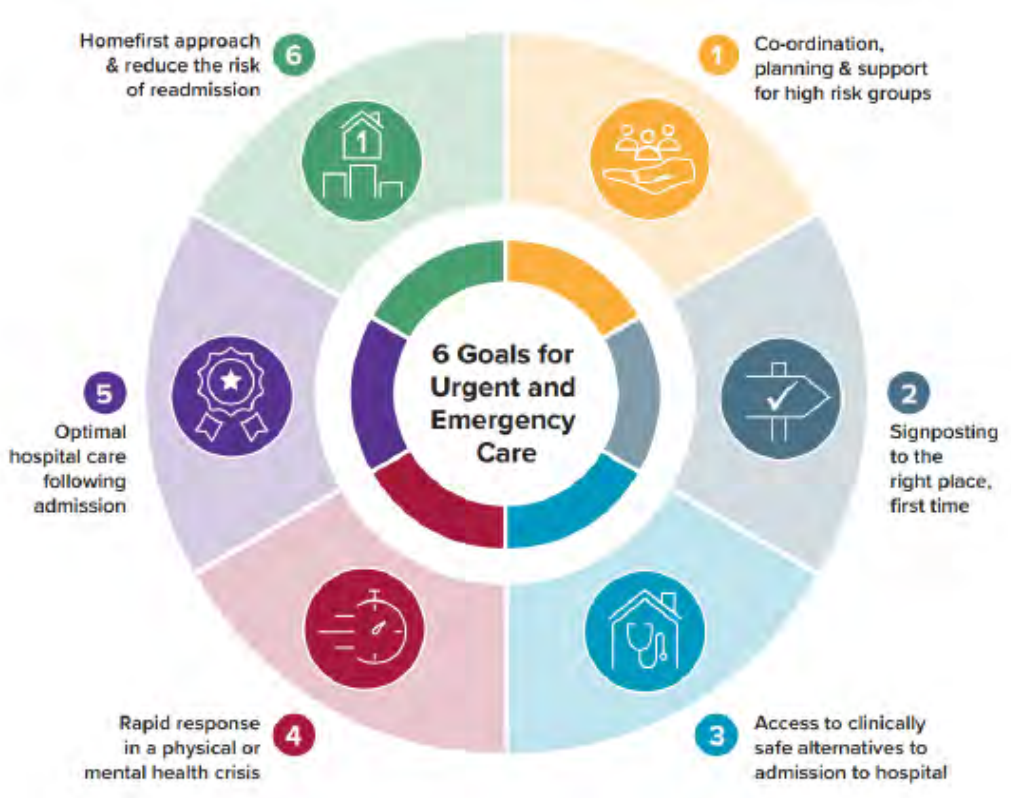


Figure 1: WG 6 goals for urgent and emergency care

Asesu a Dadansoddi / Assessment & Analysis

Following on from the initial review phase undertaken by the National Commissioning Collaborative Unit (NCCU) with teams across the Health Board, the urgent and emergency care transformation programme became operational in July 2021 and has focused on reviewing existing data, local and national reports, observing practice and speaking to clinical and operational teams across the three areas. Given the publicly highlighted pressures the initial review has mostly focused on the acute hospital sites but acknowledges root causes in wider systems and societal change.

The following initial, key-observations have been identified so far:

1. **Redistribution at the front door:** While Emergency Departments have been under immense pressures on all three sites, the number of patients presenting is not significantly different from those two years ago, with the important change that flow has shifted from Minor Injury Units to Emergency Departments.

2. **Interface with social care:** The number of patients who are labelled as 'Medically Fit for Discharge' (MFD) who are held in the secondary and community hospitals has incapacitated most other work. Whilst it is recognised that internal delays for MFD are attributable to internal processes there are a number of other observations:
   - The proportion of elderly patients who are referred to 'rehabilitation' or 'care packages' in North Wales is significantly higher than that in other areas of the United Kingdom with comparable population challenges.
   - There is a high number of vacant residential home beds and high number of care homes closed to new admissions
   - Waits for social services are significant and workflow is difficult to understand from the NHS side.

3. **Inefficiencies at the front door:** An increasing proportion of patients are admitted through the Emergency Departments.
   - In about 60% of cases these patients are sequentially reviewed by two doctors of equal experience (one from Emergency Medicine and one from the specialty).
   - Slow flow within EDs and out of ED result in unacceptable delays in ambulance handovers
   - Many patients present during the day but are subsequently seen by the relevant specialty during the night or the next day (in contrast to the recommended approach of 'doing todays work today').
   - Same day discharge rates are at about 20% on all three sites with national data from the UK suggesting a mean of 40% same day discharge rates.
   - Same Day Emergency Care (SDEC) units are seeing only a fraction of this target population.

4. **Inefficiencies in hospital:** There are significant inefficiencies for pathways in hospital both in the way that patients travel and in the way that clinical teams are deployed.
   - Patients' journeys often involve multiple stops through ED, admission areas, acute wards and rehabilitation wards. Any move between areas leads to one-two extra bed days according to national studies. There is some in-reach of specialties to admission areas on all the three sites but limited evidence for job-planning to make this a robust and reliable process.
   - The majority of clinical teams care for patients on multiple wards with wards supporting patients from up to 12 teams. This is a serious barrier to trusting relationships between doctors and nurses required for management of complex conditions, it disables effective and

efficient work and has a detrimental effect on the experience of patients, nursing staff and doctors – with particular challenges for doctors in training.

- Documentation systems and ward routines are often comprehensive but seldom focused on specific outcomes. For many patients there are not transparent criteria for what is needed to enable transfer of the care of their acute condition or functional abilities from hospital to the community.

It is recognised that there is a mismatch between patient flow coming to EDs and discharges out of the hospital with a lack of sufficient number of discharges early in the day and on Friday and weekends which exacerbates ED overcrowding.

As previously presented to the Board, the urgent and emergency care programme plan is comprised of four main workstreams with a range of projects aligned to each of the workstreams (see Appendix 1). These initiatives have been identified with clinicians and operational managers to improve experience and outcomes of patients and are linked to a suite of performance metrics. These projects and deliverables within the programme are being prioritised to ensure teams have the capacity to deliver the projects and realise the impact. Each priority workstream and project will have a locally owned detailed implementation plan to identify and deliver improvements required to realise aims and objectives of the workstream and a plan on a page.

These four workstreams will be operationalised during August with weekly workshops established over an initial 9 week period that will incorporate breakout sessions to enable a focus on both the interface between area and acute as well as a detailed focus on the development and implementation of interventions, concluding with deliverables for review the following week. The four workstreams and the proposed priority area of focus are set out below;

Workstream 1: Step-up in the community, including priority focus on:

- A redesign of criteria for presentation in Minor Injury Units (MIUs)
- Discussion around staffing models and opening hours
- Consideration to synergies with GP Out-Of-Hours services and their location

Workstream 2: Hospital front door, including priority focus on:

- A redesign of physical structure and processes for Same Day Emergency Care
- Agreement on aspiration for Medicine, Surgery and Orthopaedics on the three sites with modelling of physical space requirements to allow reliable functioning at the 90th percentile of demand.
- Development of improved pathways and standards

Workstream 3: In-patient care, including priority focus on:

- Delivery of effective and efficient board rounds including the underpinning educational program
- Review of outlying systems based on mathematical principles
- Agreement on standards and training of senior clinicians to improve impact
- Sharing of sample job-plans to facilitate consistent and reliable delivery

Workstream 4: Step-down into the community, including priority focus on:

- Learning from Discharge to Recover & Assess (D2RA), Hospital@Home and Home-First programs based in hospital and community. The main focus of this

workstream might therefore be in the sharing of standards, training and pathways between the different teams

The programme works under the following assumptions:

- The initial work is aimed to achieve measurable impact within 12 months. This precludes any interventions that require major building work or appointment of whole teams and is mainly focused on optimising existing systems.
- The four interacting workstreams will facilitate priorities and not create silos.
- Unscheduled Care is a high priority for both hospital performance and a *sine-qua-non* to enable a restart of Scheduled Care at scale. Clinical and Operational leads will therefore prioritise this work in their diaries and for allocation of team resources.
- Change should be prioritised by the likelihood to be achievable and the size of impact aiming for measurable change in the order of at least 5% from existing baseline i.e. a reduction of patients admitted under a certain specialty by 5%, a reduction in length of stay of at least 5%.
- Change that is restricted to change within BCUHB is to be prioritized over change that requires collaboration of external partners.

Plans on a page have been developed for each of the four workstreams and as mentioned above will also be developed for each of the illustrative projects within all workstreams. These implementation plans set out the strategic aim, objectives, outcomes, priority issues and key tasks as well as some of the measures of success and targets, including;

Measures of Success
• Increased % of patients seen in MIUs
• Decreased number of patients seen in EDs
• Increased proportion of patients referred as emergencies discharged on the same day
• Increased number of patients seen straight in SDEC
• % of USC intake who are managed with a ‘0’ day LOS split by source of referral
• Increased number of discharges per ward per week
• Decreased median length of stay per ward
• Stable number of readmissions
• Reduced number of ‘Medically Fit for Discharge’ patients
• Reduced median length of stay for patients with frailty syndromes
• Number of patients with frailty syndromes / >85 years of age admitted to hospital for more than 72 hours
• Number of bed-days of Medically Fit for Discharge patients taken up per week per hospital
• Reduce length of stay in community hospitals

Enabler plans for the programme are also in the process of being developed around workforce, training, technology, finance and communications. All localities have agreed the importance of patient flow being a system wide responsibility and the need for it to be embedded into business as usual across the system, ensuring that local plans are integrated with effective inpatient ward processes with systems that empower nursing and medical staff.

The improvement programme aims to implement whole system transformation in response to the recognised challenges that will also address the serious concerns raised by our ED colleagues and build on the national Emergency Department Quality Delivery Framework (EDQDF) programme that sets out to define '*what good looks like'* for patients accessing ED, with agreed care standards, a uniform approach to measuring activity and a nationally agreed model of care for Emergency Departments to enable optimisation of clinical outcomes and patient and staff experience.

The programme of work will be overseen by an Urgent & Emergency Care Improvement Group chaired by the Senior Clinical Lead. It will follow a standardised agenda, monitoring progress of plans aligned with agreed patient focused outcomes, identifying opportunities for improvement and learning to reduce risk and improve service delivery. In addition, the programme team comprising of the Deputy Chief Executive / Executive Director of Nursing & Midwifery (Programme SRO), Senior Clinical Lead and Programme Director will hold regular meetings with the Acute Directors and Area Team Directors of the three health communities to ensure operational delivery of the Urgent and Emergency Care priorities.

Work will also continue with stakeholders to ensure detailed plans are in place to commence the transformation of work to understand the prioritisation of interventions to be implemented within subsequent 30 day development and implementation phases and identify what additional support is needed from programme team, executive team and the NCCU. The longer term plans for 90 days and beyond will secure wider engagement with clinicians to co-design interventions and issuing of regular feedback to clinical teams.

The independent urgent and emergency care review undertaken by Kendall Bluck to map skills within the multidisciplinary teams against organisational priorities was reviewed and refreshed considering changes within Health Care post pandemic. As a result, a refreshed business case for a new workforce model within ED is being implemented and a proposal for further developing SDEC has also been developed. Engagement has commenced with stakeholders to initiate a pan North Wales recruitment plan and campaign with confirmed timelines. The proposed workforce plan is directly linked to the activity analysis, agreed and developed with the teams, and where appropriate in line with best practice standards such as National Institute for Clinical Excellence (NICE) and Royal College guidance.

In addition, a proposal for further development of the 111 First programme has been submitted to Welsh Government. These business cases are key to the progression and delivery of the relevant projects associated with the workstreams and where relevant will support access to funding to enable progression, to be agreed with WG.

There will be a focus around management of system-wide escalation and processes for providing mutual aid to improve flow within the whole system.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

Bids are in place for relevant projects against the Welsh Government £25m for Urgent and Emergency care in line with the 4 key deliverables: Contact First, Urgent Primary Care Centres, Same Day Emergency Care models and Remote clinical support and optimising conveyance as well as funding for programme management support.

Dadansoddiad Risk / Risk Analysis

Board Assurance Framework (BAF) 20-02 for Safe and Effective Management of Unscheduled Care within strategic priority 1 for Safe Unscheduled Care, describes the risk that "…*the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided*". Mitigating actions to reduce harm, improve patient outcomes and better patient and staff experience across the urgent and emergency care system are in the process of being confirmed in line with the improvement programme of work and revised governance and reporting arrangements.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

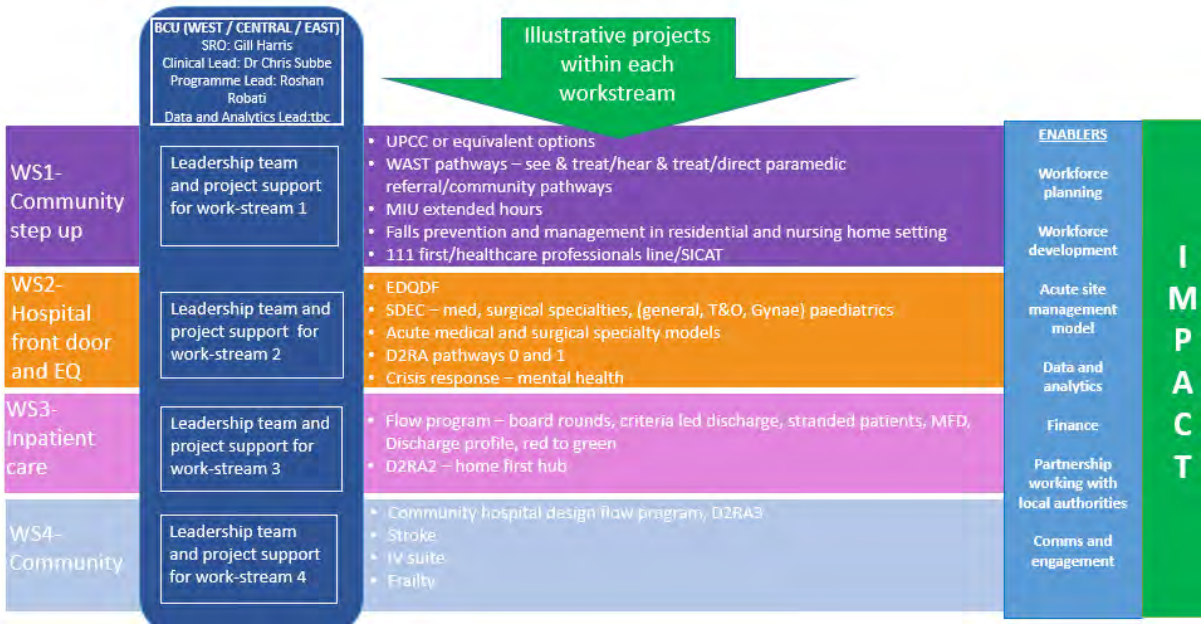
N/A

Asesiad Effaith / Impact Assessment

N/A

Appendix 1

BCUHB Urgent and Emergency Care programme plan



Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Transformation Update**
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary Care & Community Services
Awdur yr Adroddiad Report Author:	Chris Stockport, Executive Director Primary Care & Community Services
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	Appendix 1: Transformation Update for Board members, 26 July 2021

Argymhelliad / Recommendation:

That the committee receives and notes this update paper which outlines the further progress made (since the last F&P committee meeting) in re-shaping our transformation function.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The redevelopment of our approach to strategic transformation continues at pace.

The attached appendix, recently provided to Board members, provides an overview of some of the activity that has been underway.

The pace of development will further increase in the next two months as two key appointees, the Director of Transformation, and the Deputy Director, commence formally.

Cefndir / Background:

In recent months the Board has made a formal commitment to reshape our transformation programme, to both increase capacity and to better coordinate this strategically. The executive responsibility for oversight of transformation lies with the current Executive Director for Primary Care and Community Services. An ambitious programme of work to bring together existing transformational expertise, supplement it, and map out a strategic direction is now underway. This strategic direction will be firmly aligned to 'A Healthier Wales' and built upon the principles of person-centred, value-based care.

Asesu a Dadansoddi / Assessment & Analysis

A. Key areas to note since last F&P Committee meeting:

- **Establishment of a Transformation team structure, within the available resource envelope**

Following appointment of the senior team, review of the structures of teams transferring in, and the anticipated team build for the scope of transformation planned, has been completed and a team structure formulated and costed. This lies within the available resource envelope and will not require Organisational Change Process (OCP). A sustained, streamlined approach to addressing the substantial vacancies is now commencing.

- **Agreement of 3 Planes of Transformation and the Principles of Transformation**

The premise that successful transformation will occur on three planes – local, system, and Board level, has been widely welcomed across different fora. We have formally adopted this model upon which to build an embracing approach to transformation.

Principles to underpin transformation have also been well-received. 7 principles have now been formally adopted:

1. **Citizen anchoring** In everything, the anchoring point will be the person/citizen/patient

2. **Coordination** Coordination of quality improvement and transformation (QI&T) effort and direction is important to ensure the outcome is greater than the sum of the parts.

3. **Consistent approach** Consistency of method and approach is important. This is a repeated experience within other successful QI systems. What's more, QI&T can be confusing and intimidating, and consistency of methodology and language helps to reduce this.

4. **Everyone's business** Quality Improvement and Transformation is everyone's business. We all have two jobs – to do our job, and to improve our job.

5. **The goal of transformation** Transformation is not a goal in itself - transformation must be to provide better value and experience

6. **Values and outcome focused** To deliver transformational change our approaches need to be powered around values and desired outcomes

7. **Permission** Our systems and processes must be appropriately permissive when change or improvement is required

- **BCU Pathways**

We have now completed creation of a version 1 methodology, which is built upon the learning from other organisations. This needs more sharing and testing within BCUHB than has so far occurred, but as iterative development will be inevitable we will do this through testing with some early Pathways as well as seeking feedback in parallel upon the proposed methodology.

In order to support involvement and feedback in the proposed Pathway methodology we have set up a temporary micro-site providing a fictional example and giving the ability to feedback. This can be found at www.bcupathways.com

Work is also now underway to create a substantive Pathways site upon which to host our Pathways and related resources. This will inter-weave with our Public BCU website and our Staff BCU intranet.

- **Progression of conversations with Improvement Cymru and Lean methodology**

Productive conversations have been occurring with colleagues in Improvement Cymru (IC), in support of our interest in using 'Lean' healthcare principles. This partnership will continue to develop. Associated with this we are currently exploring setting up formal partnerships with 'Lean' industry partners currently operating in north Wales (outside of healthcare). We believe these partnerships could create important opportunities to develop our capability in applying 'quality improvement' science whilst also building up relationships within the north Wales economy.

- **Analytics**

Work is now underway with Lightfoot, establishing the greater use of predictive analytics in BCU. This has commenced with a focus upon unscheduled care activity. Engagement sessions between Lightfoot and BCU staff to show the real time analytics tools available have started to occur.

B. Work due to start imminently:

- **Increased recruitment drive**

  As referred to above, a streamlined approach to addressing the substantial vacancies within the team is now commencing.

- **Development of Continuous Improvement (CI) toolkit**

  The scope of a Continuous Improvement toolkit has been established, and work to complete the delivery of this will occur using ring-fenced time made available as the recruitment drive increases capacity.

- **Prioritisation**

  As recruitment progresses to create 'value based' care leadership capacity we will progress work to create the prioritisation infrastructure required to ensure we focus system transformation around those areas of greatest value. This work will involve colleagues from across the Health Board including public health, finance and planning colleagues.

- **Work Programme (granular)**

  We will soon be publishing our strategic plan for Transformation, with a more granular timetabled plan sat behind it.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance **Legal and Compliance** There are no specific legal and compliance issues within this update paper.
Asesiad Effaith / Impact Assessment **Impact Assessment** There are no specific impact assessment within this update paper.

Transformation Update

Chris Stockport

July 21

This paper provides a brief update for the Board regarding our progress establishing a coordinated Transformation function. The scene is currently fast-moving, and this paper reflects a number of areas of work that are decided and being progressed, as well as a number of areas of work that are still being worked through in conversation with colleagues across BCUHB and partners.

Appointment of Director for Transformation

An appointment of Director of Transformation – Paolo Tardivel – has now been made, and satisfactory pre-employment processes are completed.

Paolo was an extremely strong candidate with extensive transformation experience (both operationally and theoretically) at VSM level in BT Open Reach. The interview process was weighted to ensure a good assessment of person-centredness, value based practice and an understanding of a Healthier Wales; Paolo demonstrated a deep understanding of all of these arenas. We were particularly pleased given that Paolo has grown up in the Vale of Clwyd, has a young family rooted in north Wales, and wishes to be an active part of the transformation of the health service he and his family use.

Paolo officially commences in mid-September 2021, but in the meantime he and I have weekly meetings and he is already actively involved in shaping the Transformation team.

Appointment of Deputy Director for Transformation and Head of Clinical Pathways

We appointed Neil Windsor as Deputy Director for Transformation on a 12 month secondment basis last week. Neil will help move through the practical development of the team whilst we wait for Paolo to begin. They will also combine this role with being Head of Clinical Pathways (more details of the programme below).

3 Planes of Transformation

We have discussed the concept of three planes of transformation – local, system and strategic, at a number of staff events now, and this approach has been warmly received. We are therefore embedding this approach within a detailed formal Transformation Strategy, currently being drafted.

Principles of Transformation

Principles underpinning our transformation strategy have also been shared and initial principles have been set as follows:

- **Coordination**
  Coordination of quality improvement and transformation (QI&T) effort and direction is important to ensure the outcome is greater than the sum of the parts.

- **Consistent approach**
  Consistency of method and approach is important. This is a repeated experience within other successful QI systems. What's more, QI&T can be confusing and intimidating, and consistency of methodology and language helps to reduce this.

- **Everyone's business**
  Quality Improvement and Transformation is everyone's business. We all have two jobs – to do our job, and to improve our job.

- **Citizen anchoring**
  In everything, the anchoring point will be the person/citizen/patient

- **The goal of transformation**
  Transformation is not a goal in itself - transformation must be to provide better value and experience

- **Values and outcome focused**
  To deliver transformational change our approaches need to be powered around values and desired outcomes

- **Permission**
  Our systems and processes must be appropriately permissive when change or improvement is required

Incorporating existing teams into a single Transformation function

The first phase of this work is now complete. This involved bringing together the Service Improvement Team, QI Hub, and PMO, in to a single functional unit accountable through the Director of Transformation to a single Executive.

The second phase of this work is underway. This involves working through the wider organisation to identify any ad hoc roles that are best aligned and assimilated in to the Transformation function going forwards.

Creating the new Transformation Team structure for the future

This is also complete. This involved the creation of a new structure for transformation that included those roles brought in during phase one alongside additional roles specified to ensure the team is equipped to deliver the function required of the Transformation team. This has been costed to ensure it remains within

the financial envelope available and is now being recruited to. There are considerable vacancies that will need to be filled before the team can fully deliver against expectations.

Value Based Care team

Now that we have agreed which existing teams will be incorporated into our transformation team, undertaken 1:1's and established the broad structural form required to deliver the required function we will progress to a recruitment and training process to fill significant gaps within the current establishment. This will commence with the appointment of key Value Based Care posts because this will then allow us to embed VBC concepts and methods into the emerging work plan of the wider team at an early stage.

True Transformation, Small Transformation and Continuous Improvement

Taking on board experience from elsewhere alongside observations from those with specific experience, we are clarifying the different skills required to deliver 'true, large scale transformation projects' against smaller transformation projects and continuous improvement. All have a role to play and this clarification exercise will allow us to ensure the right skill mix within the teams.

Transformational Analytics

There is an analytics work programme that is emerging which is complex and multi-faceted. We have opted to formalise a transformational analytics team that will be embedded within transformation but with strong relationships with existing analysts across the organisation.

As part of this, work with Lightfoot has now commenced. In the first instance they will be analysing our datasets through an unscheduled care lens, to create questions and challenge for consideration in a number of clinical symposia. It is expected that this will then in turn identify clinically-led priorities for unscheduled care transformation.

Pathways Programme and Exemplar site

The 'BCUHB Pathways' programme is a large scale change transformation programme. It will need to run permanently as a part of the 'way we [now] do things around here'. Done correctly this piece of work has the potential to be an absolute game-changer for us, reaching into every corner of the organisation clinically and operationally. It also has huge potential to influence external opinions of BCUHB, and professional visibility which in turn could and should positively influence recruitment and engender an appetite to be a leading healthcare organisation.

We have a little bit of a 'chicken and egg' situation whereby explaining the magnitude of opportunity and scope of 'BCUHB Pathways' is difficult until people can see and feel the potential through the first few pathways produced. We believe it will then progress rapidly.

Both to encourage broad thinking, and to ensure the process is right before rapid progression, we are taking time to get the methodology and first few pathways right.

To help people to start to visualise the scope and potential of this approach we are currently creating a number of resources, based upon a (currently) fictitious cataract pathway to help people visualise the

scope and potential of this approach. Although based upon the all-Wales cataract pathway, it is fictitious in the sense that the BCU example has not been co-created with the teams in BCU, and is there simply to demonstrate potential. This example, along with other resources is being placed on an 'Introduction to BCU Pathways' demonstration microsite – this should be completed within the next few weeks and I will forward a link as soon as possible.

Alongside we will soon be progressing to test our draft methodology with a small number of real pathways.

Planned Care Transformation

We are taking a pragmatic approach with our planned care transformation programme which had already started. There are a number of WG 'transformation' programmes that are underway with which we are engaging and this – rightly – will continue. In time these will align more tightly with the Pathways work but at present the pathway work has not developed enough and so we will do supplementary work to retrofit relevant BCUHB Pathway products pathways in due course. That way we can engage nationally in the planned care programme now.

Recruitment & Training

Due to the combination of vacant posts, internal secondments, and additional capacity, we now have a large number of posts to recruit to, and this will begin in earnest shortly.

Before doing so, we are scoping our capacity to provide internal training in order to be prepared to offer internal opportunities as well as appropriate external opportunities to those interested in transformation, analytics and programme management. Conversations with Improvement Cymru have been progressed and they will be providing additional support and expertise to deliver this training.

Continuous Improvement and Transformation internal website & resource library

Work will soon commence on creating an internal portal for staff to obtain access to resources (in multiple formats) to help with continuous improvement and transformation. This will become a key component of the new BCU intranet and supported by Stronger Together this will underline that continuous improvement and structured transformation 'is the way we do things around here'.

Work Programme

The above articulates the current work programme which, understandably, is focused upon system architecture and set-up.

As this thinking has progressed we are turning our attention now to a work programme which is based upon specific programmes of work, each with agreed expected outcomes, kept on track through robust programme management. A draft of this will be shared alongside our formal Transformation Strategy as soon as possible.

Summary

Appointment of Director for Transformation	Completed
Appointment of Deputy Director for Transformation & Head of Pathways	Completed
Transformation Strategy	
▪ 3 Planes of Transformation	Agreed
▪ Principles of Transformation	Agreed
▪ Detailed strategy to provide for Board discussion	Underway
Transfer of existing teams into single transformation function	Completed
Sub-structure for future transformation function agreed, and within budget	Completed
Recruitment to VBC sub-function	Being planned
Team recruitment – rest of sub-functions	Not yet underway
Transformational analytics	
▪ Lightfoot analytics programme underway	Programme live
▪ BCU transformational analysts recruited	Not yet underway
BCU Pathway Programme	
▪ BCUHB Pathways Methodology	Proposed methodology completed
▪ Example site and video walkthroughs illustrating scope, approach, and potential	Underway
Transformation/Continuous Improvement BCU Toolkit and Website	Not yet underway
Internal team training programme	Being planned
Detailed work programme aligned to Transformation strategy	Underway

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Capital Programme Report - Month 4**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson, Executive Director of Planning and Performance
Awdur yr Adroddiad Report Author:	Neil Bradshaw – Assistant Director – Capital Denise Roberts – Financial Accountant Tax & Capital
Craffu blaenorol: Prior Scrutiny:	Capital Investment Group Executive Team
Atodiadau Appendices:	0

Argymhelliad / Recommendation:

The committee is asked to receive and scrutinise this report.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	**x**	**Ar gyfer sicrwydd For Assurance**	**x**	**Er gwybodaeth For Information**	
If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The purpose of this report is to brief the committee on the delivery of the approved capital programme to enable appropriate monitoring and scrutiny. The report provides an update, by exception, on the status and progress of the major capital projects and the agreed capital programmes.

The report also provides a summary on the progress of expenditure against the capital resources allocated to the Heath Board by the Welsh Government through the Capital Resource Limit (CRL).

Cefndir / Background:

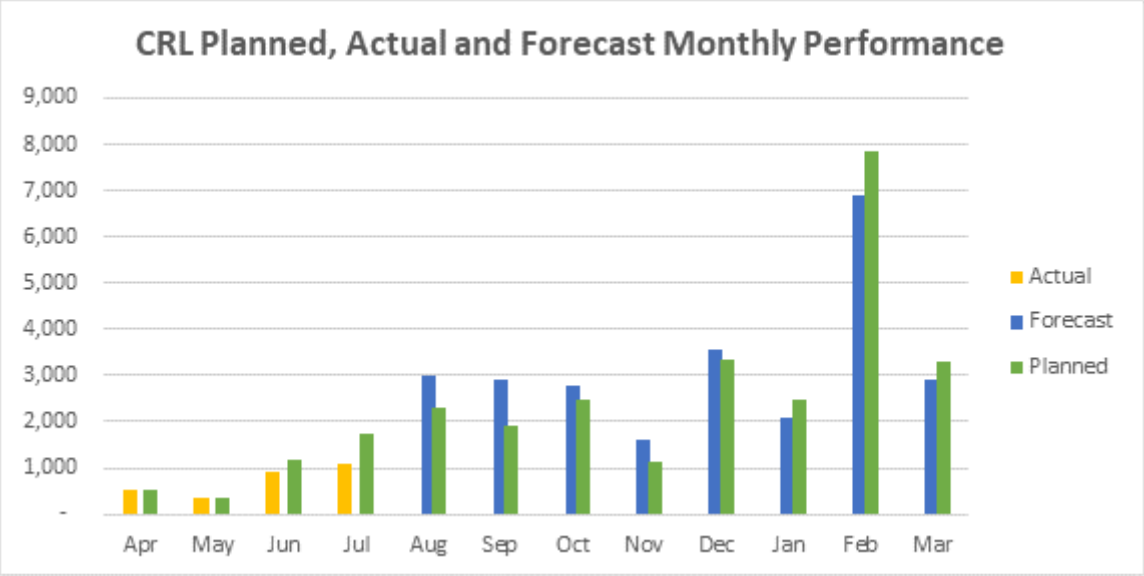
The agreed capital funding from all sources may be summarised as follows:

Capital Programme	**£ '000**
All Wales Capital Programme	14,672
Discretionary Capital	12,921
Total Welsh Government CRL	**27,593**
Capital Receipts	185
Donated Funding	800
TOTAL	**28,578**

Asesiad / Assessment & Analysis

Expenditure Planned/Actual

The graph shown below sets out the planned expenditure profile for the year and the actual expenditure to date and projected to year end.



Major Capital Schemes (>£1m)

Adult and Older Persons Mental Health Inpatient Unit Redevelopment, Ysbyty Glan Clwyd (YGC)

The Outline Business Case is included as a separate agenda item.

Decommissioning of the Field Hospitals

Following Chair's Action to approve the procurement, contractors have been appointed and works progressed on site. We are currently on programme to meet the following agreed dates:

- Ysbyty Enfys Brailsford - is due to be handed back to Bangor University by the end of August
- Ysbyty Enfys Llandudno – will be handed back to Conwy County Borough Council by November, phase 1 will be handed back by the beginning of September to allow planned events to go ahead.
- Ysbyty Enfys Deeside – the former leisure centre, skate park and support accommodation will be handed back to Flintshire County Council by the end of October. The former ice rink is to be retained as a local vaccination centre and potential surge capacity until 31 March 2022.

Wrexham Continuity Programme

Work has continued in considering the implications of learning from the pandemic and the potential impact on the scope of the project. Further workshops have been held with users to consider potential design solutions to address the additional risks and to consider the consequences, benefits and mitigations of each option. The work focused on the ward areas in the first instance as these were deemed likely to have the greatest impact, both positive and negative. The workshops included clinical (medical, nursing, therapies and diagnostics) and management staff from all divisions (and local directorates) together with infection prevention colleagues and

representatives of the hospital management team, finance, workforce, health & safety, communications and estates together with the Project Team. The workshops considered a series of indicative ward design solutions and assessed the benefits and consequences of each.

The workshops concluded that consideration should be given to increasing the scope to address the additional risks identified. However, it was noted that in making the existing wards compliant there would be a significant impact in terms of reduction in beds and, whilst this reduction could be mitigated by retaining the planned decant wards, there would be further risks introduced with respect of workforce and on-going revenue support. Furthermore, increasing the scope will significantly increase the cost of the works and the planned programme for implementation.

These factors change the dynamics of the project and threaten the intended differentiation between the continuity project and the wider transformational programme; specifically how any future transformational proposals would integrate with the risk and compliance project if the latter has a significantly higher capital cost and a much longer delivery timeline when compared to the original business continuity proposals.

Given the significance of the additional risks identified, the fact that services will need to be decanted irrespective of the scope of the works, the likely increase in cost and the potential impact on the wider transformation programme the determination of the scope of the continuity programme is a key decision for the Health Board. Following a review of the issues the Executive Team believe that this should be the subject of a future workshop with the Health Board to determine the way forward.

Ysbyty Gwynedd Risk and Compliance Programme Business Case (PBC)

Following the Health Board's approval of the PBC we have received the initial scrutiny comments from Welsh Government. The project team are working through the comments and a further report will be submitted to this committee.

Capital Programme 2021/22

As previously reported the agreed capital programme made provision for an over commitment of £2.545m to allow for in year slippage. This equated to 18% of the discretionary allocation or 9% of the total funding available. It was noted that a number of factors threaten to increase this potential over commitment to £3.85m and risk delivery of the CRL.

The committee agreed that the current programme expenditure be slowed in the short term to allow the programme to be reviewed and aligned with BCU's changing priorities and that no further contracts, or Purchase Orders, are placed until they have been reviewed and supported by the Capital Investment Group (CIG).

To assist with this review divisions and capital programme leads were requested to review their programme and rate each scheme as follows on the basis of risk to patient /staff safety:

Red – Must proceed this year
Amber – Can be slipped over two years 21/22 and 22/23
Green – Can be slipped to next year

Following this review the Capital Investment Group and Executive Team reviewed the responses and recommended the following expenditure is deferred to 2022/23:

	£m
YGC PACU	0.057
YWM bathrooms to maternity	0.200
Brynteg clinic	0.250
Ysbyty Bryn Beryl phase 3	0.600
Heddfan Phase 3	0.100
Estates programme	0.396
Informatics programme	0.540
Medical devices programme	0.200
TOTAL	**2.340**

The above reduces the over commitment to £1.51m which is considered acceptable. It should be stressed that there is no intention for the above schemes not to progress but their implementation will be delayed. All schemes will be fully worked up such that if the position improves, or we secure additional funding, they will be able to swiftly proceed.

Since this review the Welsh Government have indicated that additional capital funding may be made available to Health Boards this year. This provides us with the potential opportunity to reinstate the original programme and address other in-year cost pressures. The funding will be required to be spent by 31st March 2022 and thus we have focused upon schemes that are within our programme and can be quickly procured and delivered. The following were identified as a priority:

Priority	£m (inc VAT)	Scheme
1	2.500	Increase critical care capacity at YMW to support unscheduled and planned care recovery
2	2.000	Fit out ward void at YGC. This additional capacity is critical to support planned care recovery and address nosocomial risks (introduction of mechanical ventilation to wards 10).
3	4.500	Capital costs (enabling and equipment) in support of additional modular capacity for planned activity.
4	0.250	Informatics devices in support of community services enhancing virtual consultations.

Priorities 1 and 2 are currently within our programme and have been procured and are progressing. If successful in being supported this would release circa £4.5m from the current programme to allow the full programme to be reinstated, meet other in-year cost pressures and potentially bring forward schemes from next year. We were asked to submit our schemes within three working days and there is currently no indication of the funding available nor the timescale for approval. A further verbal update will be provided to the committee.

Strategic Implications
The capital programme is in accordance with the approved Operational Plan.

Financial Implications
The report sets out the capital investment required to deliver the agreed projects together with the progress, variances and mitigating actions to deliver the agreed discretionary programme and to meet the identified cost pressures and risks.

Risk Analysis
There is a risk that full implementation of the agreed projects and discretionary programme may result in the Health Board being overcommitted against the CRL and fail to meet changing operational priorities.

Legal Compliance
The planned projects and discretionary programme assist the Health Board in meeting its' statutory and mandatory requirements.

Impact Assessment
The capital programme is in accordance with the approved Operational Plan and the associated impact assessments. Major All Wales funded capital schemes are subject to specific impact assessments.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Finance Strategy – Draft Principles**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Sue Hill, Executive Director of Finance
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Finance
Atodiadau **Appendices:**	Appendix: Finance Strategy – Draft Principles

Argymhelliad / Recommendation:

It is asked that the paper is noted.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad/cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	✓

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable.

Sefyllfa / Situation:

The purpose of this paper is to give an overview to the Committee of the proposed financial strategy and its draft principles.

Cefndir / Background:

In line with the refresh of the annual plan for 2021/22 and the three-year plan for 2022-2025, we are also progressing a longer-term financial strategy for the Health Board.

This is focused around having an overall plan on a page, which can then be broken down into six key areas. The Appendix presents the proposed financial strategy and its draft principles.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications

This paper aligns to the strategic goal of attaining financial balance.

Opsiynau a ystyriwyd / Options considered

Not applicable.

Goblygiadau Ariannol / Financial Implications The establishment of a longer-term financial strategy for the Health Board will help to identify the key issues and areas where focused work needs to progress, in order for the Health Board to achieve financial balance in the long term.
Dadansoddiad Risk / Risk Analysis Not applicable.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance Not applicable.
Asesiad Effaith / Impact Assessment Not applicable.

Financial Strategy: draft principles

Sue Hill

Executive Director of Finance

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Actions to Date & Next Steps

- Actions to Date
  - ❑ Reviewed by Execs and EMG
  - ❑ Feedback received
  - ❑ Workshop to be set up with senior management teams

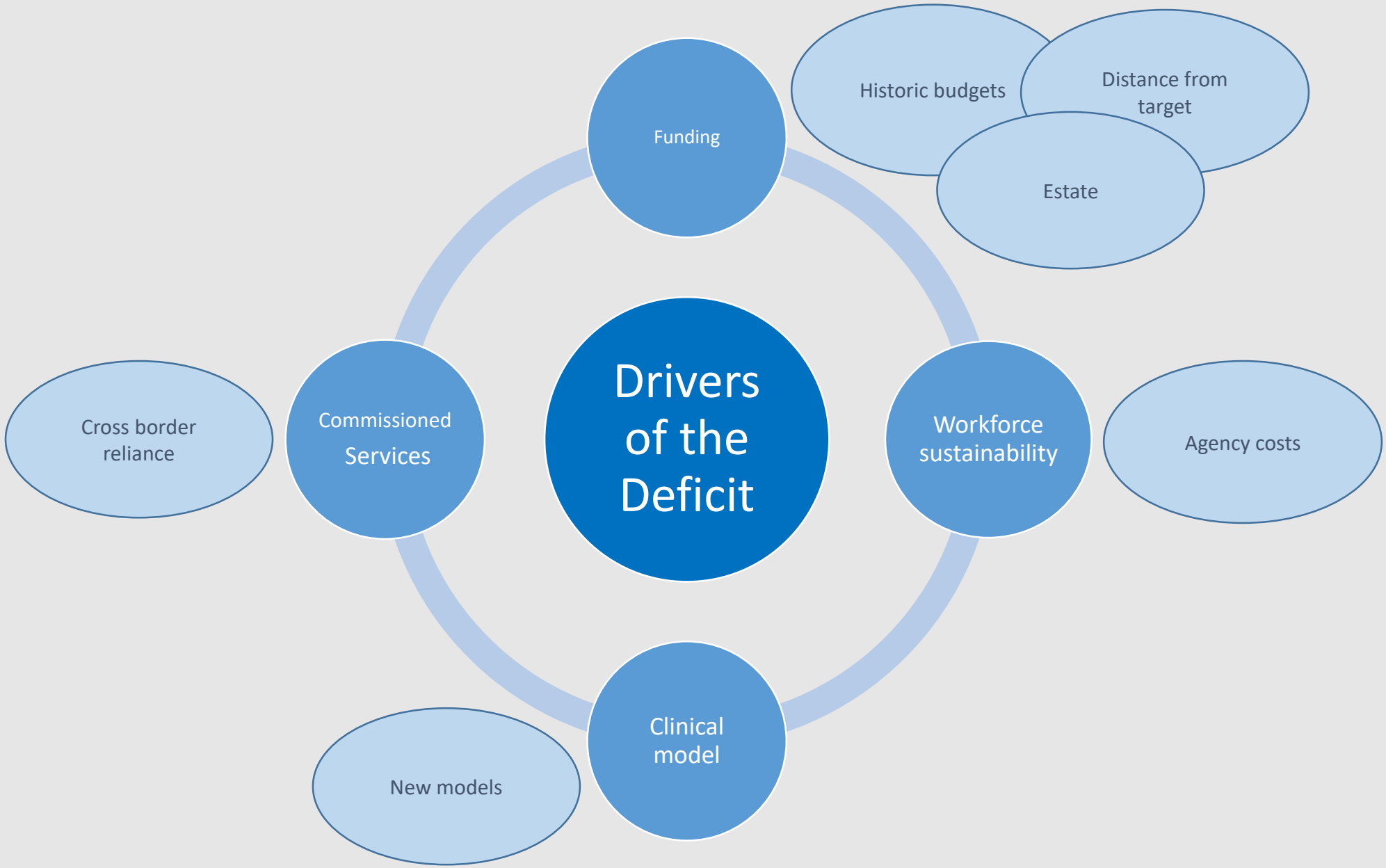
- Next Steps
  - ❑ 1st Draft of Financial Strategy to F&P in October

The Financial Strategy will align with the Transformation programme by weaving in our Clinical, Estates and Digital Strategies

Financial Strategy: Supporting Information

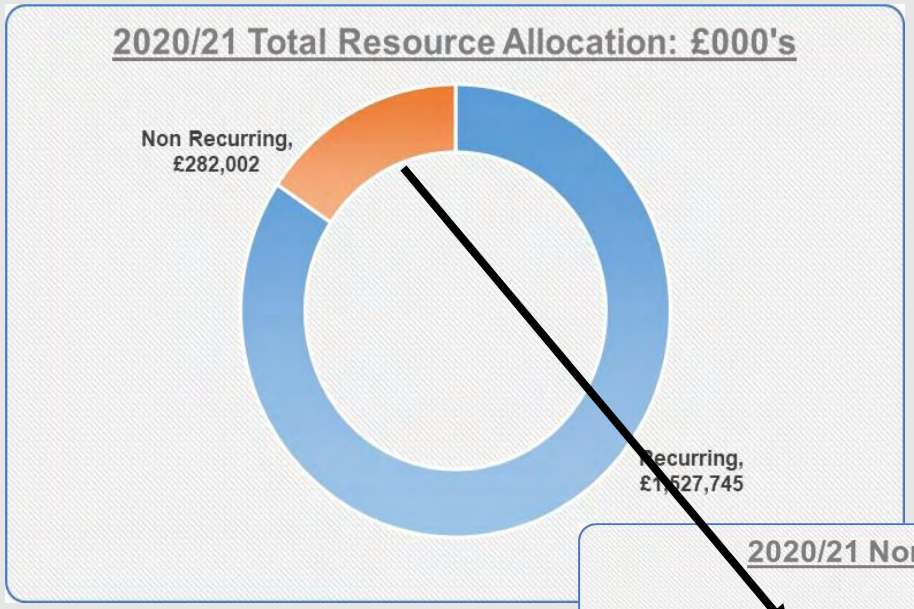
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

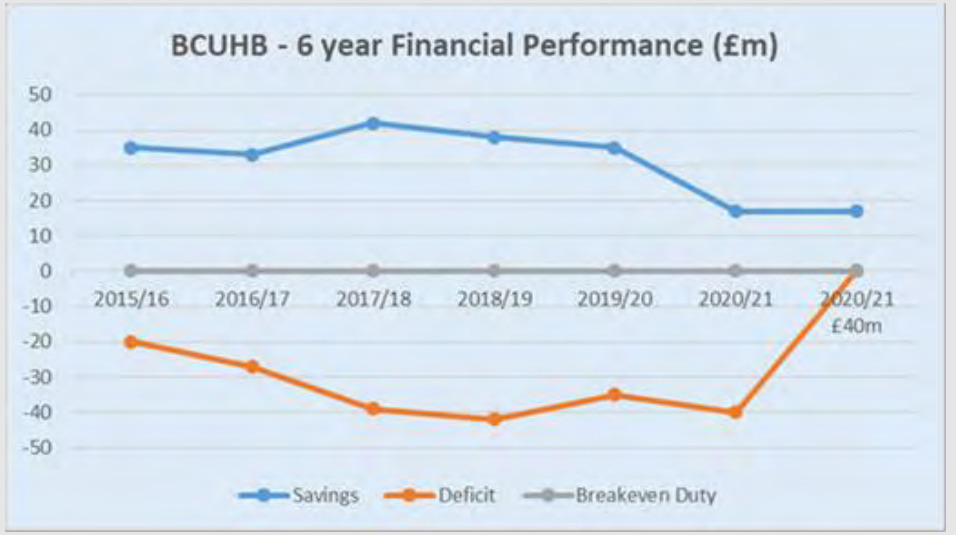
1. Drivers of the Deficit

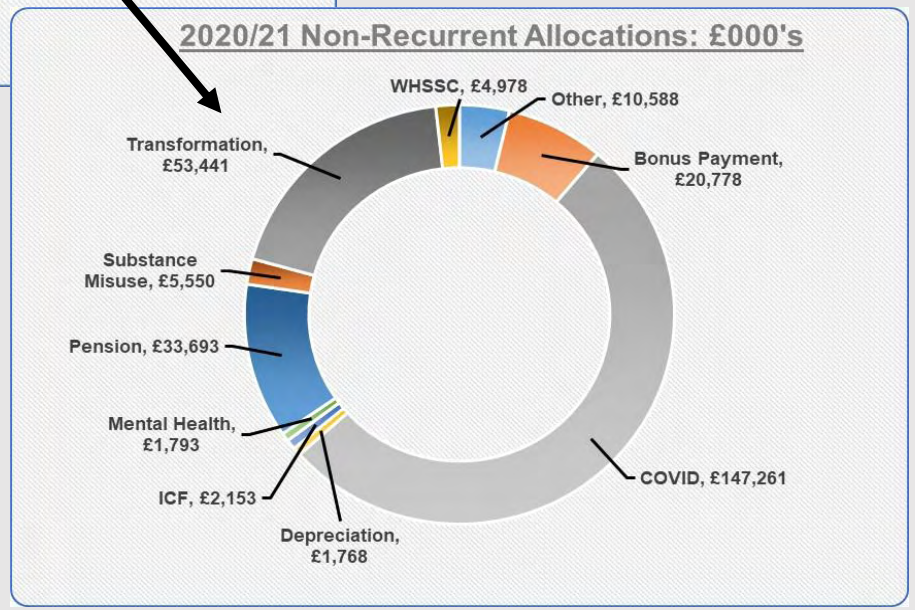


2. Resource allocation

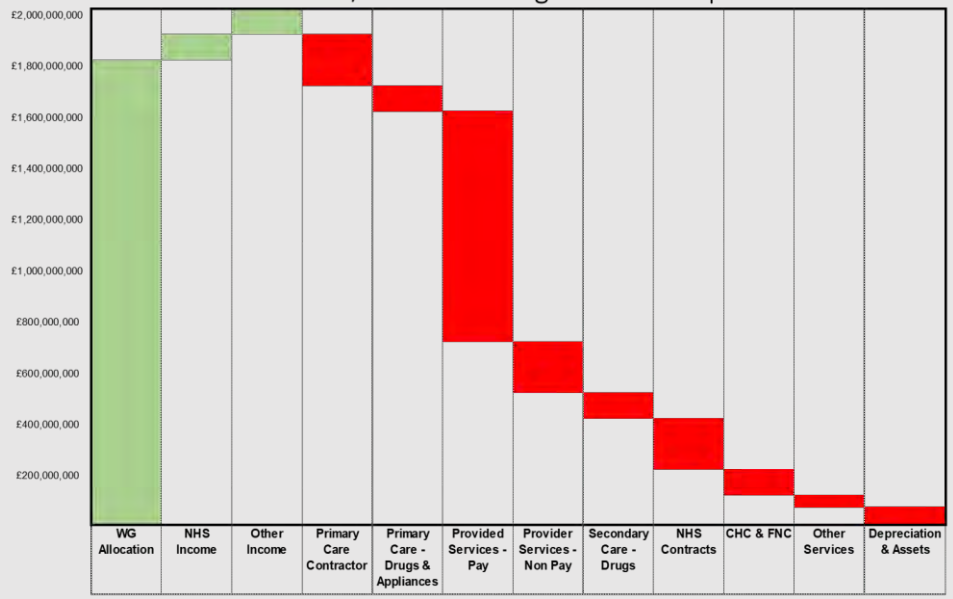
- Where have we come from?



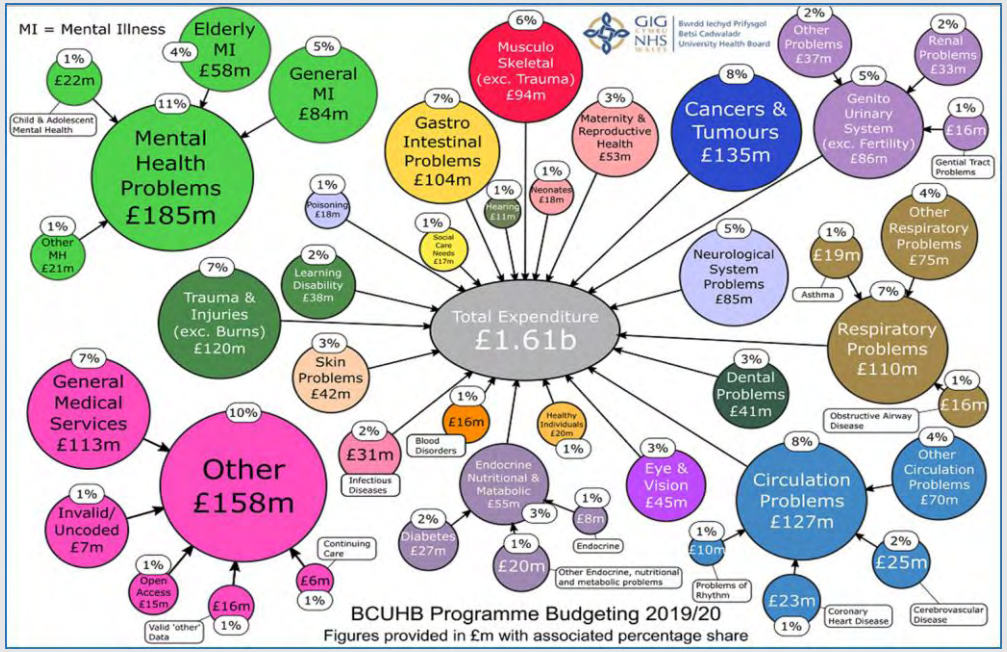


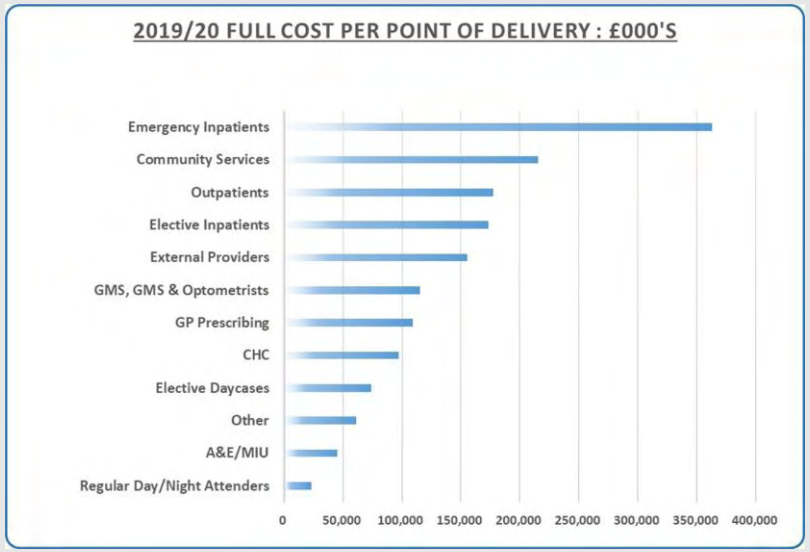


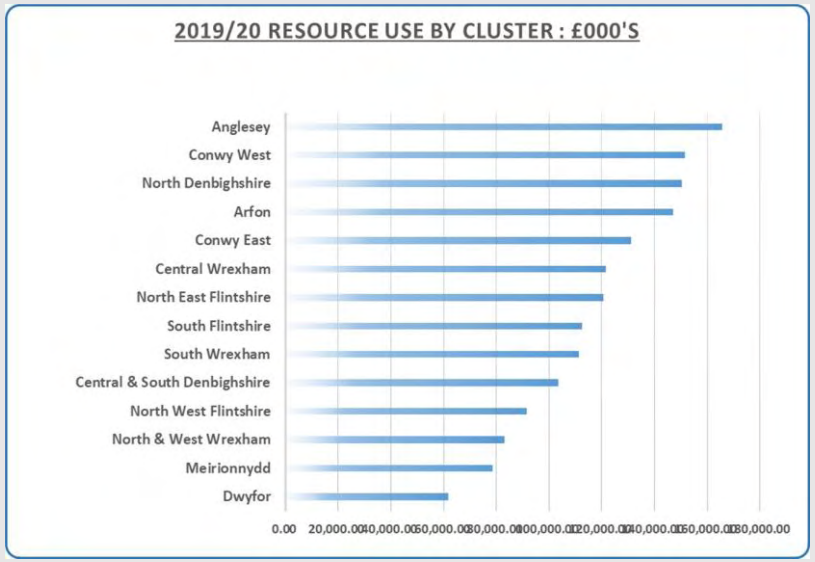
2020/21 – Achieving a £0.5m surplus

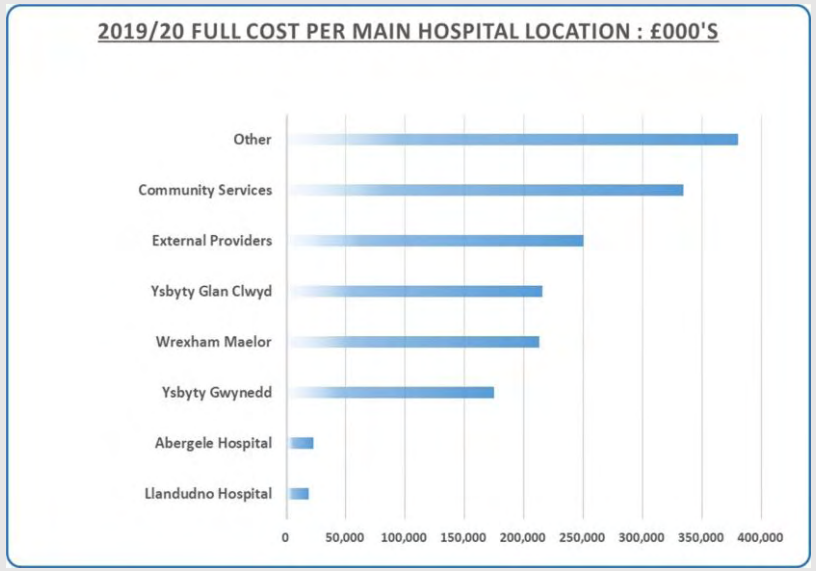


2. Resource allocation



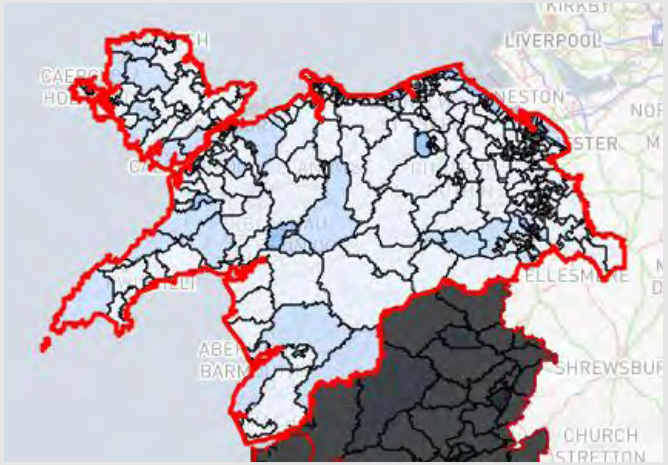






2. Resource allocation

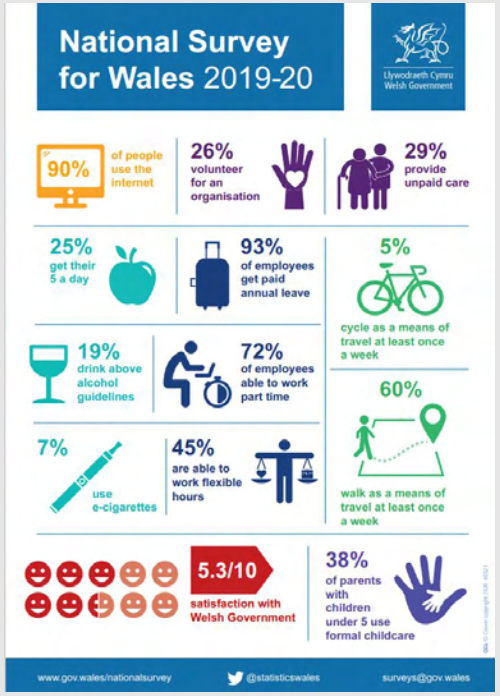
Welsh Index of Multiple Deprivation (WIMD) 2019

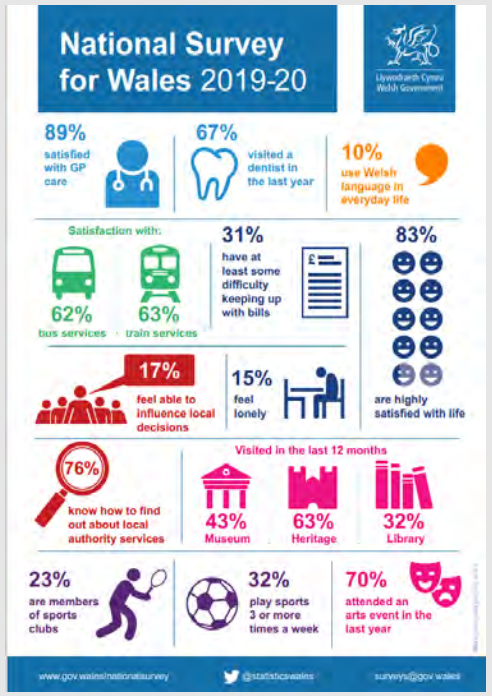


Betsi Cadwaladr University Health Board contains 423 LSOA's (22.2% of the 1909 total LSOAs in Wales)

Of the top 10% of Most Deprived LSOA's across Wales 23 are within BCU

The lowest ranked (most deprived) 2 LSOAs across Wales are both within BCU (both in Rhyl)





Life Expectancy Comparison by LHB

Compared to Wales

Wales
Significantly better
Similar
Significantly worse

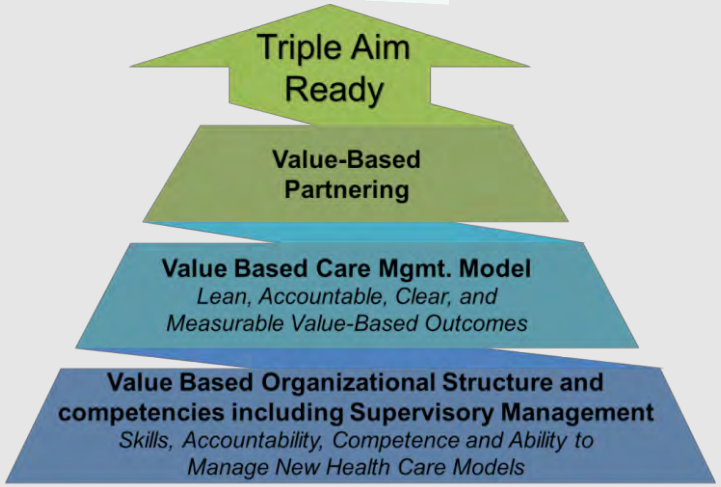
	Wales	Betsi Cadwaladr UHB	Powys THB	Hywel Dda UHB	Swansea Bay UHB	Cardiff and Vale UHB	Cwm Taf Morgannwg UHB	Aneurin Bevan UHB	ABM UHB	Cwm Taf UHB
Healthy life expectancy at birth (females), 2015 to 2017 (Years)	62.0	64.8	68.9	62.0		62.0		59.0	61.5	59.6
Healthy life expectancy at birth (males), 2015 to 2017 (Years)	61.4	64.3	66.4	62.5		61.9		58.5	60.6	56.9
Life expectancy at birth (females), 2015 to 2017 (Years)	82.3	82.4	84.2	82.9	81.7	83.0	81.0	81.9		
Life expectancy at birth (males), 2015 to 2017 (Years)	78.3	78.9	79.6	78.6	77.2	78.7	77.6	78.0		

Produced by Public Health Wales Observatory. Please consult the technical guide for full details on how these indicators are calculated and data sources.

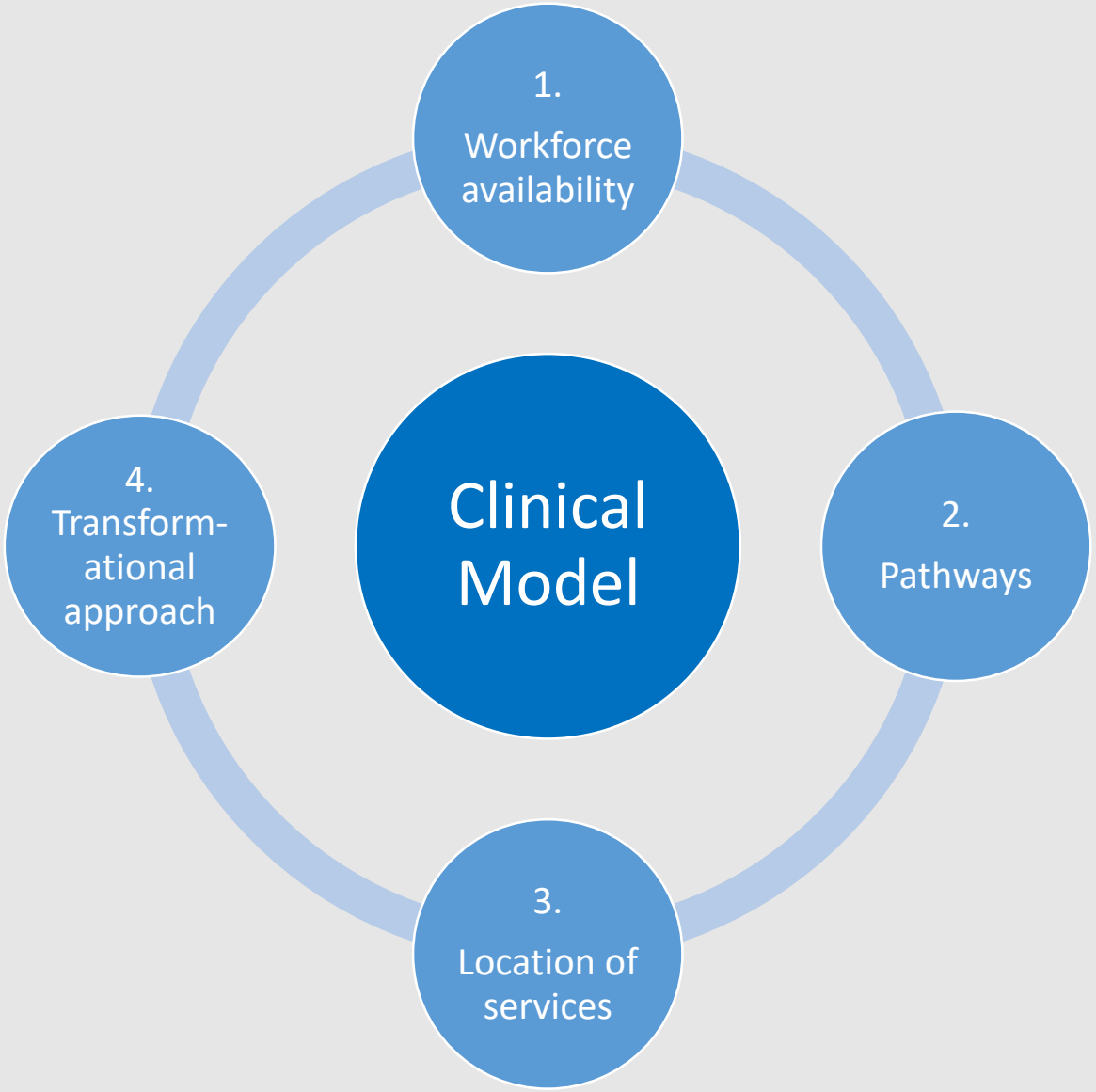
2. Resource allocation

- Where do we need to be?

VALUE BASED CARE



3. Clinical Model



4. Healthcare Commissioning

Commissioning Intentions

Commissioning Intentions – The Plan

National Priorities	Local Priorities	Efficiency & Productivity programme- VBHC	Activity Planning - Informatics	Outcome Measures – Performance
	COVID 19 Response		✓	
	Mental Health	✓	✓	✓
	Unscheduled Care	✓	✓	✓
	Planned Care Recovery	✓	✓	✓
	Wellbeing			✓

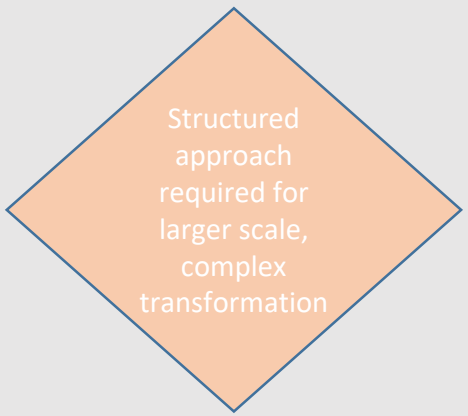
Internal Contract Mgt – Acute, MH, Community, P Care
External Contract Mgr – NHS & Private providers
Improved Productivity & Outcomes

5. Transformation Opportunities

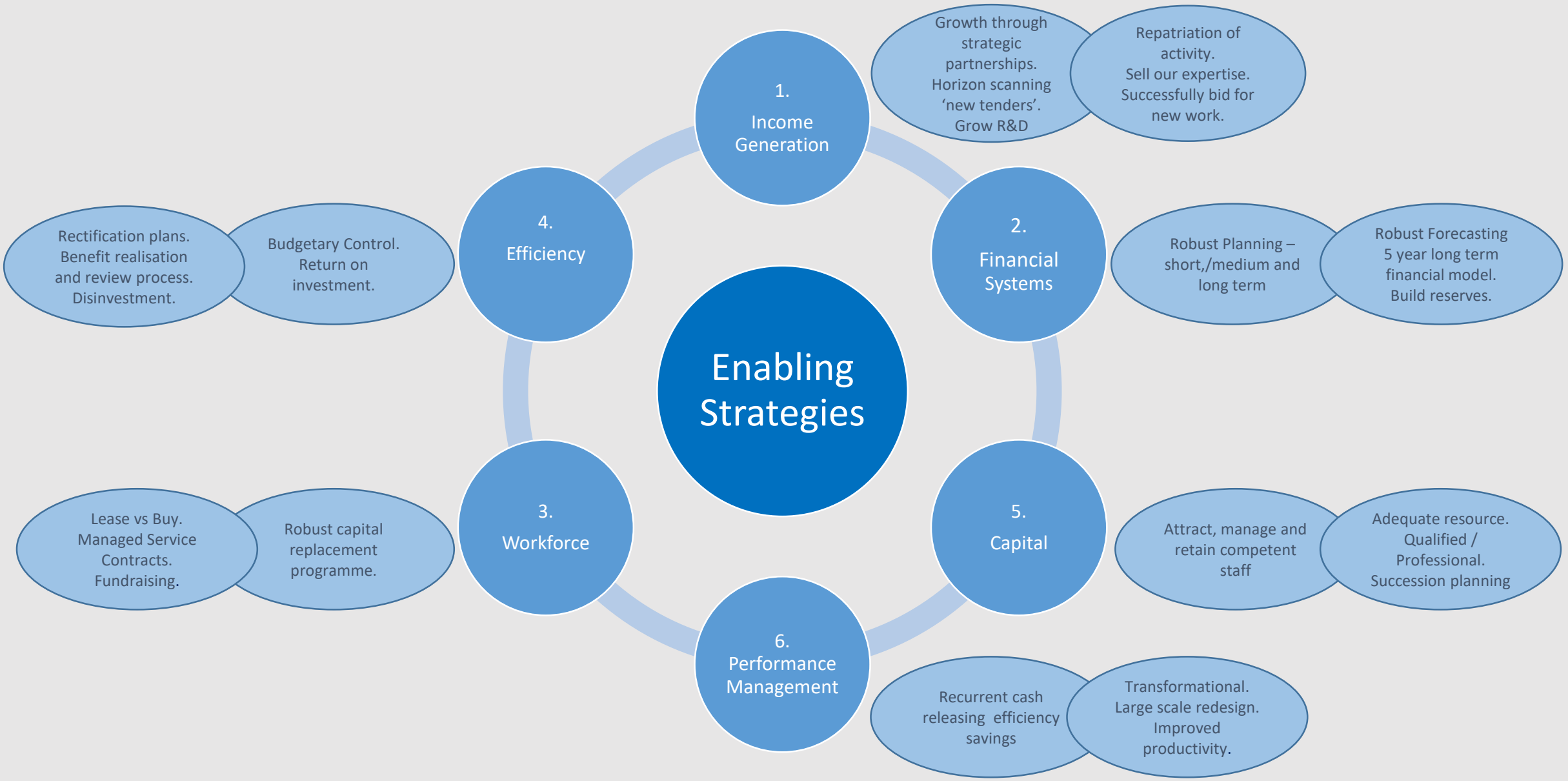
- What is the potential size of the opportunity?

5. Transformation Opportunities

- Emerging Thoughts - The Three Planes of Transformation



6. Enabling Strategies



Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Finance Report Month 3 2021/22**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tom Stanford, Interim Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Finance
Atodiadau **Appendices:**	Appendix 1: Finance Report Pack

Argymhelliad / Recommendation:

It is asked that the report is **noted**.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad/cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	✓	**Er gwybodaeth** **For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable.

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the draft unaudited financial performance of the Health Board as at June 2021.

Cefndir / Background:

The refreshed financial plan for 2021/22 was submitted to Welsh Government at the end of June. This provided the latest forecasts and assessments for the year, including the impact of COVID-19. It also incorporated the additional funding notified to the Health Board in Quarter 1, to offset the impact of the undelivered savings from 2020/21.

The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

The potential of a COVID-19 3rd wave and the related workforce constraints are the main risk to the delivery of the schemes relating to the £42.0m this year and so the Health Board is actively identifying alternative schemes which can be mobilised in order to ensure we maximise the opportunity to improve performance.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications
This paper aligns to the strategic goal of attaining financial balance and is linked to the well-being objective of targeting our resources to those with the greatest need.

Opsiynau a ystyriwyd / Options considered
Not applicable – report is for assurance only

Goblygiadau Ariannol / Financial Implications

	Month 3 £m	YTD £m	Forecast £m
Actual Position	0.0	(0.1)	0.0
Planned Position	0.0	0.0	0.0
Variance	0.0	0.1	0.0

- The in-month position is a small surplus of £0.02m, which gives a cumulative surplus position of £0.06m. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

- The forecast position has been maintained at a balanced position for the year

- The total impact of COVID-19 in June, including all costs offset by expenditure reductions, is £7.2m. The forecast total impact of COVID-19 is currently is £108.2m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government funding has fully offset the impact of COVID-19.

Dadansoddiad Risk / Risk Analysis
There are two risks to the financial position, with a combined total of £5.3m. Risks are detailed in the report pack.

BCU risks are reported separately via the Risk Register.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Not applicable.

Asesiad Effaith / Impact Assessment
Not applicable.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Finance Report
June 2021: M03-22

Sue Hill

Executive Director of Finance

Executive Summary

Objective

To provide assurance on financial performance and delivery against Health Board financial plans and objectives and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.

Positives & Key Assurances

- ✓ Current month balanced position and cumulatively a small surplus reported.
- ✓ Balanced position forecast for the year.
- ✓ Increase of £1.2m in savings forecast for the year.
- ✓ Key financial targets for cash, capital and PSPP all being met.

Issues & Actions

- ➢ Delivery of the planned care recovery and transformation schemes - the potential of a COVID-19 3rd wave and the related workforce constraints are the main risk. The Health Board needs to quickly identify alternative schemes which can be mobilised at pace, in order to ensure we maximise the opportunity to improve performance.

Key Messages

- ❖ The forecast position for 2021/22 is balanced, reflecting the revised financial plan submitted to Welsh Government at the end of June.
- ❖ Expenditure related to the £30.0m funding for the Performance Fund and £12.0m Strategic Support is included in the forecast based on the phasing of costs by individual schemes. These indicate a stepped increase in spend over the remaining months of the year. This cost profile is dependent on operational teams implementing approved plans at pace and so it is imperative that these are rapidly implemented.
- ❖ Savings forecast has increased to £11.5m, but only £7.8m of this is recurring. The Health Board needs to identify £17.0m of recurring savings this year in order to start reducing the underlying deficit.

Summary of Key Numbers

Month 03 Position

In month position is balanced
Balanced

Cumulative position is surplus of £0.06m
£0.06m favourable

Forecast

Reflects additional funding to cover the impact of the undelivered savings from 2020/21

Balanced

Divisional Performance

Area Teams	£1.0m favourable
Secondary Care	£2.4m adverse
Mental Health	£0.2m adverse
Corporate	£1.5m adverse
Other	£3.2m favourable

Savings

In-month: £1.1m against plan of £1.4m
£0.3m adverse

YTD: £2.5m against plan of £4.2m
£1.7m adverse

Savings Forecast

£11.5m against plan of £17.0m

£5.5m adverse

COVID-19 Impact

£21.0m cost YTD
£108.2m forecast cost
Funded by Welsh Government

£nil impact

Income

£35.4m against budget of £34.5m

£0.9m favourable (2.6%)

Pay

£208.1m against budget of £207.6m

£0.5m adverse (0.2%)

Non-Pay

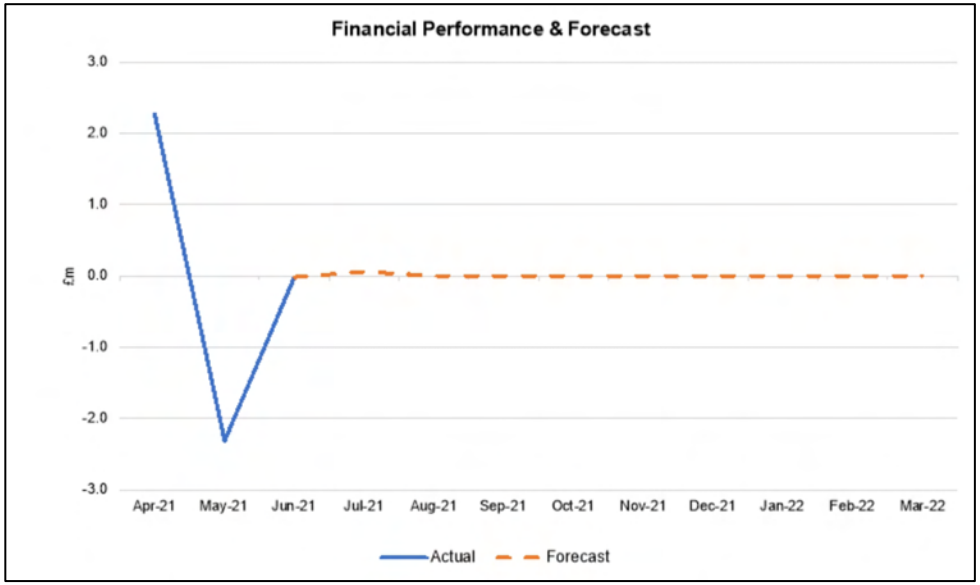
£258.2m against budget of £257.9m

£0.3m adverse (0.1%)

Revenue Position

- The in-month position is balanced, which gives a small surplus (£0.06m) cumulative position.
- There is a balanced position forecast for the year, reflecting the revised financial plan that was submitted at the end of June.

	Actual			Cumulative				Forecast
	M01	M02	M03	Budget	Actual	Variance	Variance	Actual
	£m	£m	£m	£m	£m	£m	%	£m
Revenue Resource Limit	(136.7)	(147.2)	(147.1)	(431.0)	(431.0)	0.0	0.0%	(1,807.6)
Miscellaneous Income	(12.1)	(11.6)	(11.7)	(34.5)	(35.4)	0.9	-2.6%	(136.2)
Health Board Pay Expenditure	68.2	70.2	69.7	207.6	208.1	(0.5)	-0.2%	857.7
Non-Pay Expenditure	82.8	86.3	89.1	257.9	258.2	(0.3)	-0.1%	1,086.1
Total	**2.2**	**(2.3)**	**0.0**	**0.0**	**(0.1)**	**0.1**		**0.0**



Movement in Underlying deficit	£m
Underlying Deficit b/fwd from 2019/20	75.2
Savings schemes not finalised at start of year	3.1
Additional in year savings identified	(0.2)
Red pipeline svaings schemes	(1.4)
Additional savings to be identified	(1.5)
Underlying Deficit c/fwd to 2020/21	**75.2**

Analysis of Underlying deficit	£m
Undelivered savings in 2020/21 - due to COVID-19	32.7
Non-recurrent strategic support funding	40.0
Other pressures	2.5
Underlying Deficit c/fwd to 2020/21	**75.2**

- The refreshed financial plan for 2021/22 was submitted to Welsh Government at the end of June. This provided the latest forecasts and assessments for the year, including the impact of COVID-19. It also incorporated the additional funding notified to the Health Board in Quarter 1, to offset the impact of the undelivered savings from 2020/21.
- The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m for performance and transformation) and the £19.9m COVID-19 Recovery Plan funding.
- All of this additional funding is non-recurrent, but some of the £42.0m performance and transformation monies has been committed recurrently as it relates to staff posts. This needs to be recognised in future planning.
- BCU's underlying deficit is £75.2m. Recurrent savings schemes need to be identified to reduce this deficit, so that the Health Board can continue to balance its position from 2024/25 onwards, when Welsh Government strategic support is reduced.

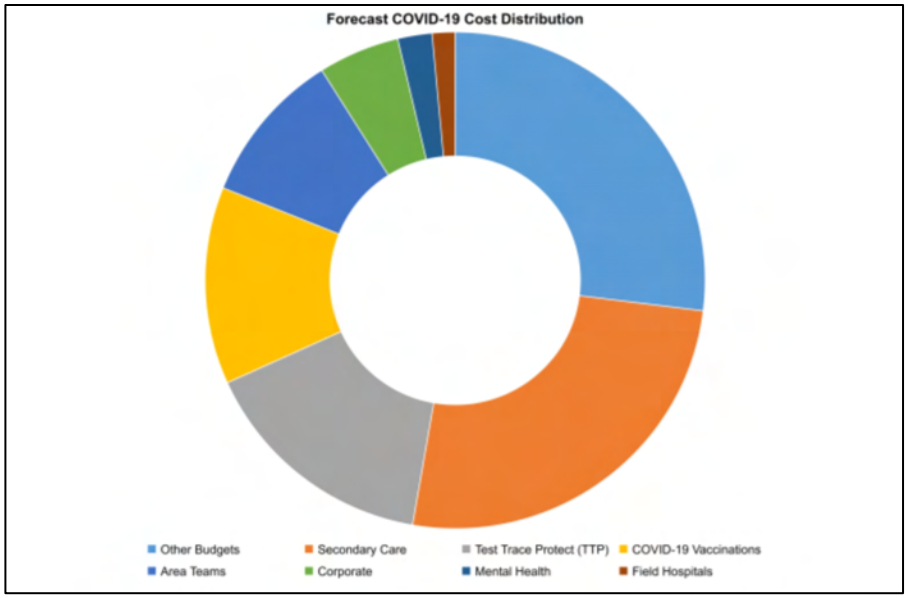
Divisional Positions

	In Month				Cumulative				Forecast Variance to Plan at M3
	Budget	Actual	Variance to Plan	Variance to Plan	Budget	Actual	Variance to Plan	Variance to Plan	
	£000	£000	£000	%	£000	£000	£000	%	£000
WG RESOURCE ALLOCATION	(147,123)	(147,123)	0	0%	(431,035)	(431,035)	0	0%	0
AREA TEAMS									
West Area	14,050	13,765	285	2%	40,871	40,804	67	0%	(2,574)
Central Area	18,640	18,224	415	2%	53,891	53,446	445	1%	0
East Area	21,824	21,299	525	2%	63,642	62,967	675	1%	(1,000)
Other North Wales	3,560	3,408	152	4%	10,706	10,454	252	2%	(84)
Field Hospitals	160	160	(0)	0%	1,179	1,179	0	0%	0
Track, Trace and Protect	2,049	2,049	0	0%	5,326	5,326	0	0%	0
Commissioner Contracts	18,235	18,546	(312)	-2%	54,279	54,621	(342)	-1%	(2,684)
Provider Income	(1,704)	(1,674)	(31)	2%	(5,113)	(4,977)	(136)	3%	(835)
Total Area Teams	76,813	75,778	1,034	1%	224,781	223,820	961	0%	(7,177)
SECONDARY CARE									
Ysbyty Gwynedd	9,026	9,048	(22)	0%	26,530	26,872	(342)	-1%	(3,135)
Ysbyty Glan Clwyd	11,628	11,309	319	3%	32,784	33,068	(284)	-1%	(3,071)
Ysbyty Maelor Wrexham	9,365	9,891	(527)	-6%	27,778	29,143	(1,365)	-5%	(7,219)
North Wales Hospital Services	9,754	9,881	(128)	-1%	27,940	28,596	(656)	-2%	(2,982)
Womens	3,579	3,428	151	4%	10,304	10,059	244	2%	683
Total Secondary Care	43,351	43,558	(207)	0%	125,335	127,738	(2,402)	-2%	(15,724)
Total Mental Health & LDS	11,016	11,094	(78)	-1%	32,854	33,024	(171)	-1%	(1,207)
Total Corporate	12,753	12,587	166	1%	36,973	38,512	(1,540)	-4%	(2,405)
Total Other Budgets incl. Reserves	3,190	4,087	(897)	-28%	11,093	7,883	3,210	29%	26,513
TOTAL	0	(18)	18		0	(58)	58		0

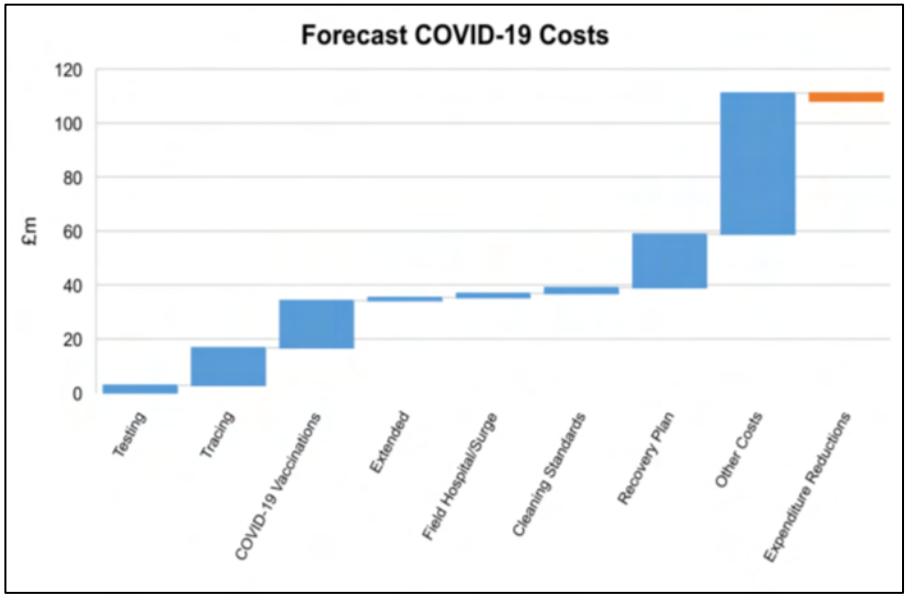
- Divisional forecasts have been prepared at Month 3. Movements in these forecasts will be tracked over the rest of the year.
- During Month 3, £17.0m of the Welsh Government funding to offset the impact of the undelivered savings from 2020/21 was allocated to divisions from Reserves. This has improved the position of all divisions in month and reduced the value of Reserves.
- Other Budgets & Reserves include Performance Fund and Strategic Support monies for schemes that have not yet been approved, as well as future months' COVID-19 funding, which is drawn down as incurred.

Impact of COVID-19

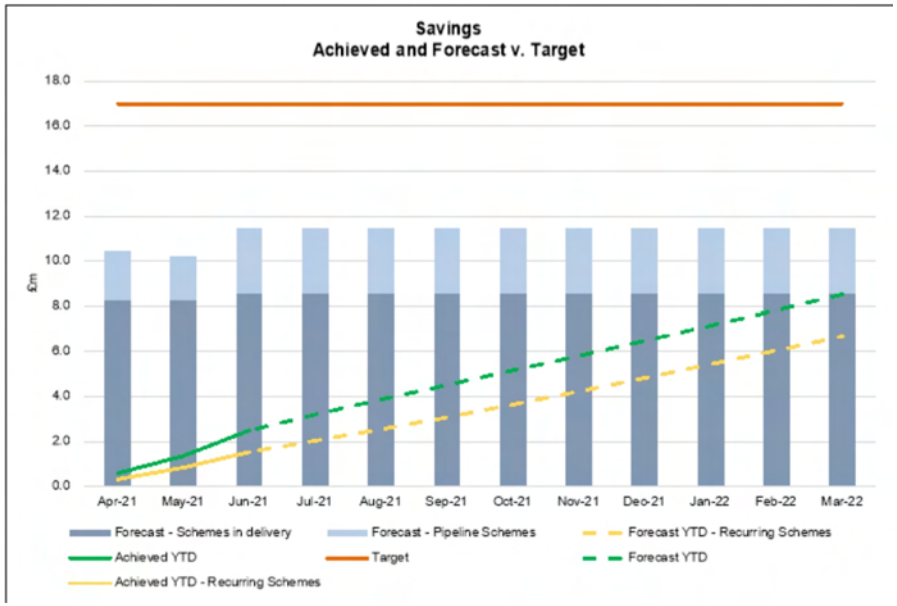
	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.3	0.6	2.8
Tracing	1.1	1.0	1.0	3.1	13.9
Mass COVID-19 Vaccinations	1.7	1.5	2.1	5.3	17.5
Extended Flu Vaccinations	0.0	0.0	0.0	0.0	1.1
Field Hospital/Surge	0.3	0.7	0.2	1.2	1.5
Cleaning Standards	0.0	0.0	0.0	0.0	2.2
Recovery Plan	0.5	0.3	1.1	1.9	19.9
Other Costs	4.0	3.3	3.4	10.7	52.2
Total COVID-19 costs	**7.7**	**7.0**	**8.1**	**22.8**	**111.1**
Non Delivery of Savings	0.8	(0.8)	0.0	0.0	0.0
Expenditure Reductions	(0.2)	(0.7)	(0.9)	(1.8)	(2.9)
Slippage on Planned Investments	0.0	0.0	0.0	0.0	0.0
Total Impact of COVID-19	**8.3**	**5.5**	**7.2**	**21.0**	**108.2**



- The total impact of COVID-19 in June, including all costs offset by expenditure reductions, is £7.2m. Welsh Government funding has fully offset this impact. The forecast total impact of COVID-19 is currently £108.2m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to cover this cost.
- The main change in the forecast spend is a £4.8m increase in mass COVID-19 vaccination costs. This reflects the continued high level of spend in this area, along with a booster programme later in the year.
- As additional modelling data for COVID-19 is received, forecasts will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospitalisations.



Savings



- Savings in Month 3 totalled £1.1m, an increase of £0.3m over the delivery in Month 2. This gives cumulative savings delivered of £2.5m for the year to date.
- Savings of £8.5m are forecast for delivery in 2021/22 against identified amber and green schemes, an increase of £0.2m compared to Month 2.
- Red schemes in development are expected to deliver a further £3.0m by year end, an increase of £1.0m against Month 2. Work is ongoing to convert these schemes to amber and green by the deadline dates identified in the tracker.
- Further opportunities are being identified both within Divisions and across BCU to ensure delivery of the savings included within the financial plan.

		SCHEMES IN DELIVERY									PIPELINE SCHEMES				TOTAL PROGRAMME	
		Year to Date				Forecast										
	Savings Target	Savings Target	Recurring Savings Delivered	Variance in Recurring Savings	Non-Recurring Savings Delivered	Recurring Forecast	Variance	Non-Recurring Forecast	Total Forecast	Forecast FYE	Recurring Plan	Non-Recurring Plan	Total Plan	Plan FYE	Total Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Ysbyty Gwynedd	1,833	458	103	(356)	0	350	(1,483)	29	378	456	64	0	64	71	442	(1,391)
Ysbyty Glan Clwyd	2,155	539	42	(497)	0	175	(1,980)	33	208	325	433	0	433	554	641	(1,514)
Ysbyty Wrexham Maelor	1,922	481	76	(404)	50	300	(1,622)	163	463	433	67	477	544	120	1,007	(915)
North Wales Managed Services	1,399	350	42	(308)	134	378	(1,021)	163	542	670	19	0	19	33	561	(838)
Womens Services	584	118	62	(56)	0	361	(223)	3	364	475	13	206	219	25	582	(2)
Secondary Care	**7,893**	**1,945**	**324**	**(1,621)**	**185**	**1,564**	**(6,329)**	**390**	**1,954**	**2,359**	**596**	**683**	**1,279**	**803**	**3,234**	**(4,659)**
Area - West	1,387	347	176	(171)	95	918	(469)	264	1,183	1,049	0	0	0	0	1,183	(204)
Area - Centre	1,900	475	363	(112)	5	1,730	(170)	36	1,766	2,260	100	0	100	100	1,866	(34)
Area - East	1,861	465	261	(204)	677	990	(871)	1,125	2,116	1,047	140	120	260	140	2,376	515
Area - Other	234	59	0	(59)	0	0	(234)	0	0	0	0	0	0	0	0	(234)
Contracts	980	245	0	(245)	0	0	(980)	0	0	0	0	0	0	0	0	(980)
Area Teams	**6,362**	**1,591**	**799**	**(791)**	**777**	**3,638**	**(2,724)**	**1,426**	**5,064**	**4,357**	**240**	**120**	**360**	**240**	**5,424**	**(938)**
MHLD	840	210	374	164	0	1,252	412	5	1,257	1,266	98	0	98	98	1,355	515
Corporate	1,910	478	40	(437)	2	235	(1,675)	18	253	325	219	1,000	1,219	268	1,472	(438)
Total Programme	**17,005**	**4,223**	**1,538**	**(2,685)**	**964**	**6,689**	**(10,316)**	**1,840**	**8,529**	**8,307**	**1,153**	**1,803**	**2,956**	**1,409**	**11,485**	**(5,520)**

Income

Description	£m
Allocations Received	
Opening allocation	1,637.9
COVID-19 funding	64.2
ED Wellbeing and Home Safe Service	0.5
Other allocations	0.5
Total Allocations Received	**1,703.1**

Description	£m
Allocations Anticipated	
COVID-19 funding	79.6
Substance Misuse	5.8
Mental Health Service Improvement Fund	3.3
ICF Allocations - Anticipated Dementia Fund	2.2
IM&T Refresh Programme	1.9
CAMHS School In-Reach Service	1.4
Prevention and Early Years Funding	1.3
MSK Orthopaedic Services	1.2
Obesity Pathways	0.6
Welsh Risk Pool - contribution share	-3.1
Capital	8.2
Other allocations	2.1
Total Allocations Anticipated	**104.5**

	£m
Total Allocations Received	**1,703.1**
Total Allocations Anticipated	**104.5**
Total Welsh Government Income	**1,807.6**

COVID-19 Funding

Total COVID-19 costs in 2021/22	111.1
Impact of non delivery of savings in 2020/21	32.7
Total COVID-19 funding required	143.8

COVID-19 funding received	64.2
COVID-19 funding anticipated	79.6
Total COVID-19 funding	143.8

- The majority of the Health Board's funding is from the Welsh Government allocation through the Revenue Resource Limit (RRL). The RRL is £1,807.6m for the year. £431.0m of the RRL has been profiled into the position cumulatively, which is £20.9m less than three equal twelfths, primarily due to the profile of COVID-19 and performance funding.
- The RRL includes confirmed allocations to date of £1,703.1m, with further anticipated allocations in year of £104.5m.
- Miscellaneous income totals £11.7m in Month 3, £35.4m cumulatively, which is a favourable variance of £0.9m against the budget.
- The impact of COVID-19 has resulted in lost income of £0.4m in June (£1.1m year to date) relating to General Dental Services (GDS) patient income. This is included as a cost of COVID-19.

Expenditure

Pay Costs	Actual			Forecast									Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	9.5	9.7	9.5	9.7	9.7	9.8	10.0	10.0	10.1	10.2	10.1	10.1	29.7	28.7	1.0	118.4
Medical & Dental	15.9	16.3	16.3	16.7	17.0	17.0	17.4	17.4	17.4	17.6	17.5	17.5	47.0	48.5	(1.5)	204.0
Nursing & Midwifery Registered	21.5	22.2	22.1	21.9	22.1	22.2	22.7	22.7	22.7	22.9	23.0	22.9	68.1	65.8	2.3	268.9
Additional Clinical Services	9.7	10.3	10.1	3.2	3.2	3.1	3.3	3.3	3.3	3.3	3.3	3.3	27.2	30.1	(2.9)	59.4
Add Prof Scientific & Technical	3.1	3.1	3.1	9.8	9.9	9.9	10.2	10.2	10.2	10.3	10.3	10.2	10.0	9.3	0.7	100.3
Allied Health Professionals	4.0	4.0	4.0	4.0	4.0	4.1	4.2	4.2	4.2	4.2	4.2	4.2	11.8	12.0	(0.2)	49.3
Healthcare Scientists	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.3	1.3	3.6	3.6	0.0	15.0
Estates & Ancillary	3.3	3.4	3.4	3.4	3.4	3.5	3.5	3.5	3.6	3.6	3.6	3.6	10.1	10.1	0.0	41.8
Students	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.6
Health Board Total	**68.2**	**70.2**	**69.7**	**69.9**	**70.5**	**70.8**	**72.7**	**72.7**	**72.9**	**73.5**	**73.4**	**73.2**	**207.6**	**208.1**	**(0.5)**	**857.7**
Primary care	1.4	2.3	1.8	1.4	1.4	1.4	1.4	1.4	1.5	1.5	1.5	1.5	5.0	5.5	(0.5)	18.5
Total Pay	**69.6**	**72.5**	**71.5**	**71.3**	**71.9**	**72.2**	**74.1**	**74.1**	**74.4**	**75.0**	**74.9**	**74.7**	**212.6**	**213.6**	**(1.0)**	**876.2**

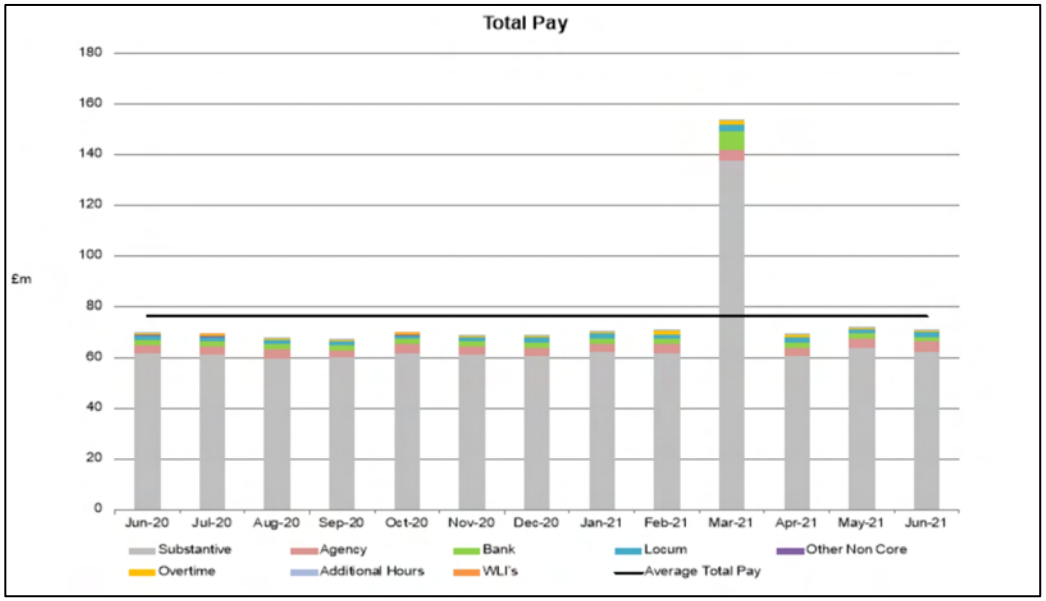
WTE	17,687	17,396	17,396

Variable Pay	M01	M02	M03	Total
	£m	£m	£m	£m
Agency	3.1	3.5	3.7	10.3
Overtime	1.1	0.7	0.7	2.5
Locum	1.9	1.8	1.8	5.5
WLIs	0.1	0.2	0.2	0.5
Bank	2.0	2.0	2.1	6.1
Other Non Core	0.1	(0.1)	0.1	0.1
Additional Hours	0.5	0.4	0.4	1.3
Total	**8.8**	**8.5**	**8.9**	**26.2**

- Health Board pay costs total £69.7m in Month 3. Variable pay is £8.9m of this cost, equivalent to 12.7%. Non-pay costs total £89.1m in Month 3. Pay costs are further analysed on page 10 and non-pay costs on page 11.

Non-Pay Costs	Actual			Forecast									Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care	18.3	18.9	19.1	18.3	18.1	18.2	17.9	18.3	18.0	17.9	18.0	19.2	56.6	56.3	0.3	220.2
Primary Care Drugs	9.2	7.9	9.3	9.0	9.0	9.0	9.0	9.1	9.1	9.1	9.1	9.1	26.1	26.4	(0.3)	107.9
Secondary Care Drugs	5.6	6.0	6.8	6.8	7.1	7.6	7.6	7.5	8.0	7.5	7.5	8.0	17.2	18.4	(1.2)	86.0
Healthcare Services Provided by Other NHS Bodies	22.8	22.8	23.4	23.4	23.4	23.4	23.4	23.4	23.4	23.4	23.4	23.4	68.9	69.0	(0.1)	279.6
Continuing Care and Funded Nursing Care	8.2	9.2	8.5	9.1	9.1	9.0	8.9	8.8	8.8	9.1	8.7	9.1	25.8	25.9	(0.1)	106.5
Other Non-Pay (incl. General & Clinical Supplies)	16.3	19.1	17.4	21.0	21.0	21.5	22.1	22.0	22.0	22.1	22.0	22.0	54.0	52.8	1.2	248.5
Non-pay costs	**80.4**	**83.9**	**84.5**	**87.6**	**87.7**	**88.7**	**88.9**	**89.1**	**89.3**	**89.1**	**88.7**	**90.8**	**248.6**	**248.8**	**(0.2)**	**1,048.7**
Cost of Capital	2.4	2.4	4.6	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.2	9.3	9.4	(0.1)	37.4
Total non-pay including cost of capital	**82.8**	**86.3**	**89.1**	**90.7**	**90.8**	**91.8**	**92.0**	**92.2**	**92.4**	**92.2**	**91.8**	**94.0**	**257.9**	**258.2**	**(0.3)**	**1,086.1**

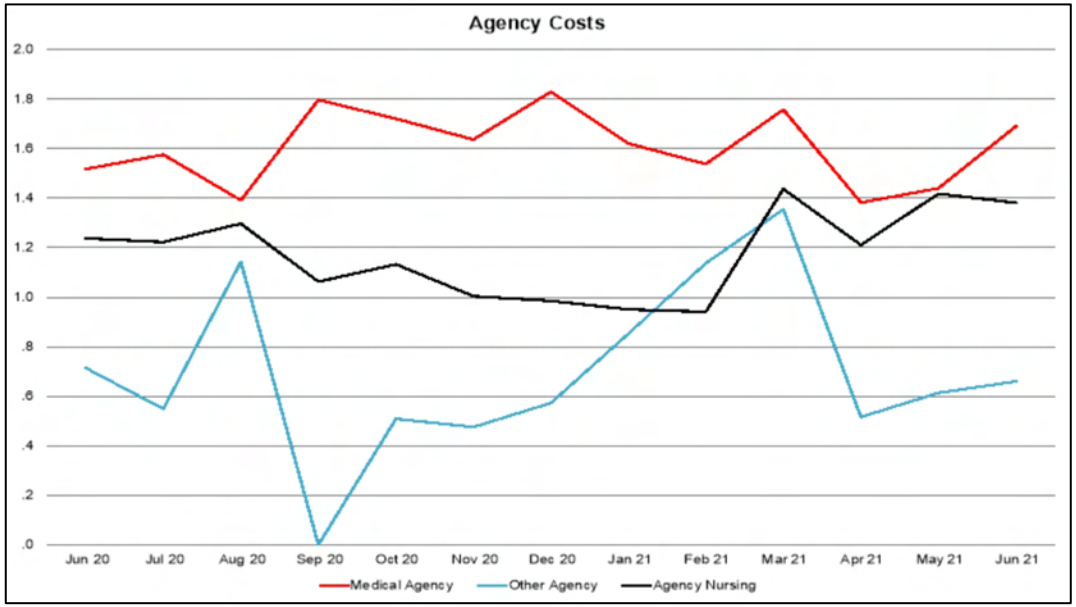
Pay Costs



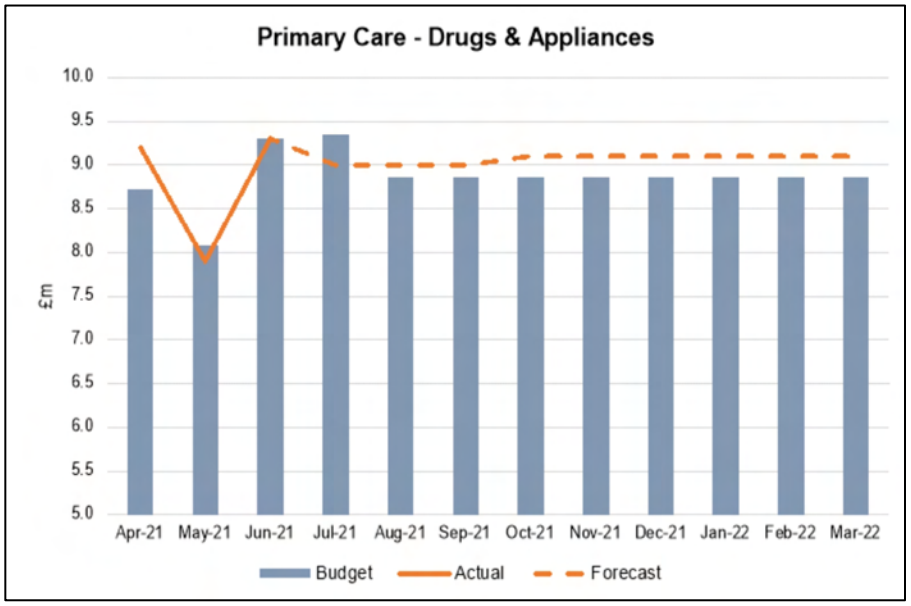
- **Total pay costs** in June are £71.5m. Provided Services pay costs are £69.7m, which is £0.6m (1%) less than in Month 2.
- Pay costs last month included two months' worth of estimated costs for the 2021/22 pay award, to also account for Month 1. Costs and funding have been profiled equally across the rest of the year. Therefore, the impact of the additional month in May was £0.7m, which accounts for the fall in spend this month.
- A total of £2.8m of pay costs were directly related to COVID-19 in June, which is £0.3m higher than in May. .

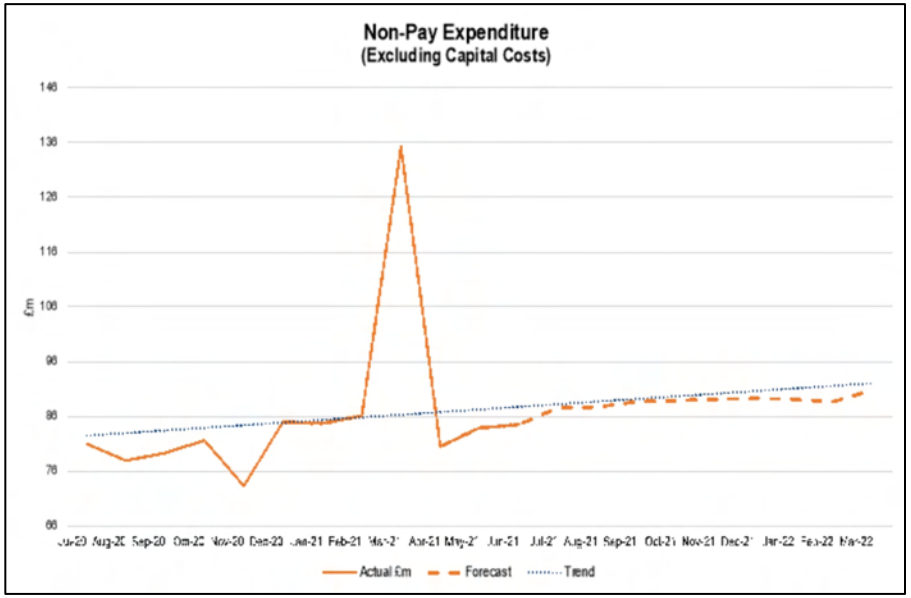
- There has been slippage of £0.8m in pay costs from the £42.0m Performance Fund and Strategic Support monies, due to delays in recruitment for schemes. It has been forecast that this slippage will be recovered in the second half of the year.

- **Agency costs** for Month 3 are £3.7m, representing 5.2% of total pay. This is an increase of £0.2m on Month 2, with the increase relating to medical agency spend. Monthly agency spend for June included £0.4m that related to COVID-19, £0.1m less than last month.



Non-Pay Costs





- **Primary Care Drugs**: Expenditure for Month 3 is £1.3m (17%) more than in Month 2. However, Month 3 had three more prescribing days than the previous month and based on an average cost per prescribing day of £0.48m, this increase is expected. Following receipt of the April prescribing data, the average cost per prescribing day has increased by 2.9%. The average cost per item has remained stable (a small reduction of 0.3%), but the number of items has increased by 3.5%. Therefore, the increase in the average cost per prescribing day is driven by volume not price, suggesting a return to business as usual. The cumulative overspend is £0.3m, with a forecast adverse variance of £1.5m for the year.
- **Other Non-Pay:** Spend in June is £1.7m (10%) less than in May, primarily due to anticipated spend of Intermediate Care Fund (ICF) monies that were included in Month 2 (total of £1.9m). Offsetting this is an increase in activity across the three acute sites, leading to an rise in non-pay costs. Scheduled Care activity is up by circa 18% across sites, which is driven by increases in Theatres activity. All three sites have also seen significant increases in Emergency Department activity, which is above equivalent 2019/20 levels. These indicate that there is a return to business as usual and this is happening sooner than had been anticipated.
- **Cost of Capital**: Costs have increased in month due to the June non-cash submission to Welsh Government. This included a request for additional strategic depreciation and baseline support of £7.4m. This increased resource requirement has been phased over 12 months, resulting in the increase in costs in Month 3.

Risks and Opportunities (not included in position)

	Issue	Description	£m	Likelihood	Key Decision Point & Summary Mitigation	Risk Owner
1	Risk: Savings Programme – Red Pipeline Schemes	There is a risk that the savings programme will not deliver the £17.0m target, as per the financial plan. Savings of £10.2m are forecast for delivery in 2021/22, which includes £3.0m of red-rated schemes in the pipeline.	3.0	Medium	Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.	Sue Hill, Executive Director of Finance
2	Risk: Savings Programme – Schemes to be Identified	There is a risk that the savings schemes still be to identified, which total £2.3m, will not deliver in the current financial year.	2.3	Medium	As per above, the stretch target should ensure required savings delivery is achieved.	Sue Hill, Executive Director of Finance

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Finance Report Month 4 2021/22**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tom Stanford, Interim Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Finance
Atodiadau **Appendices:**	Appendix 1: Finance Report Pack Appendix 2: Tracker Performance Fund and COVID-19 Recovery Plan Forecast

Argymhelliad / Recommendation:

It is asked that the report is noted.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad/cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable.

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the draft unaudited financial performance of the Health Board as at July (month 4) 2021.

Cefndir / Background:

In line with all NHS organisations in Wales, the draft plan was revised in Quarter 1 to refine and develop the triangulation of activity, workforce and financial plans, while maintaining the focus on the six key objectives described in the draft plan. The revised financial plan submitted to Welsh Government in June anticipates ensuring the Health Board achieves a balanced position at the year end.

We are testing our assumptions in the original plans and if required will refresh our forecasts with the divisional teams, by month 6, to ensure that the overall forecast outturn is robust and achieved. This may include additional outsourcing, interims or consultancy, to progress some of the larger schemes.

The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications

This paper aligns to the strategic goal of attaining financial balance and is linked to the well-being objective of targeting our resources to those with the greatest need.

Opsiynau a ystyriwyd / Options considered

Not applicable – report is for assurance only

Goblygiadau Ariannol / Financial Implications

	Month4 £m	YTD £m	Forecast £m
Actual Position	0.06	0.00	0.00
Planned Position	0.00	0.00	0.00
Variance	(0.06)	0.00	0.00

The in-month position is a £58k deficit, which gives a cumulative break even position. This reflects the additional funding received in May which is to cover the impact of the undelivered savings from 2020/21, means that there is now also a balanced position forecast for the year.

The total cost of COVID-19 in July is £8.9m (£29.7m for the year to date). Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

Dadansoddiad Risk / Risk Analysis

There are four risks to the financial position, two with a combined total of £3.0m and two being yet to be determined. One of these risks is in relation to the pay award which has not been agreed with the unions. Risks are detailed in the report pack.

BCU risks are reported separately via the Risk Register.
There is one opportunity in relation to potential future one off accountancy gains.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Not applicable.

Asesiad Effaith / Impact Assessment

Not applicable.

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Finance Report
July 2021: M04-22

Sue Hill

Executive Director of Finance

Executive Summary

Objective

To provide assurance on financial performance and delivery against Health Board financial plans and objectives and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.

Positives & Key Assurances

- ✓ Current month £58k deficit to bring to cumulative break even position reported.
- ✓ Balanced position forecast for the year.
- ✓ Key financial targets for cash, capital and PSPP all being met.

Issues & Actions

- ➢ Quarter 1 refresh of the financial plan was finalised and submitted. This included the latest assumptions around the impact of COVID-19, as well as plans for the strategic support and planned care recovery funding.
- ➢ This will be further tested and if required will be refreshed by month 6

Key Messages

- ❖ The cumulative financial position and forecast position for 2021/22 remain balanced.
- ❖ The Health Board has been notified of additional funding totalling £32.6m to cover the impact of the undelivered savings from 2020/21. This additional funding is anticipated to cover the financial risk for the year that was identified in the draft financial plan.
- ❖ Expenditure related to the £42.0m funding for the Performance Fund and Strategic Support, plus the £19.9m COVID-19 Recovery Plan funding is included in forecasts based on submitted plans. The full utilisation of this funding to improve performance, reduce waiting lists and drive a programme of transformation is dependent on operational teams implementing approved plans at pace. See appendix 2 for further detail.

Summary of Key Numbers

Month 04 Position

£58k deficit position in month.
Deficit

Cumulative position is break even.
Balanced

Forecast

Reflects additional funding to cover the impact of the undelivered savings from 2020/21

Balanced

Divisional Performance

Area Teams	£0.1m adverse
Secondary Care	£0.7m adverse
Mental Health	£0.2m adverse
Corporate	£0.1m favourable
Other	£0.9m favourable

Savings

In-month: £2.6m against plan of £2.3m
£0.3 favourable

YTD: £5.1m against plan of £5.6m
£0.5m adverse

Savings Forecast

£11.4m against plan of £17.0m

£5.6m adverse

COVID-19 Impact

£29.7m cost YTD
£108.8m forecast cost
Funded by Welsh Government

£nil impact

Income

£46.1m against budget of £46.0m

£0.1m favourable

Pay

£277.1m against budget of £277.2m

£0.1m adverse

Non-Pay

£348.4m against budget of £348.2m

£0.2m adverse

Revenue Position

- The in-month position is a £58k deficit bringing a break even cumulative position. This reflects the additional £32.6m funding notified to the Health Board in May, to cover the impact of the undelivered savings from 2020/21.
- The total cost of COVID-19 in July is £8.9m (£29.7m for the year to date). Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

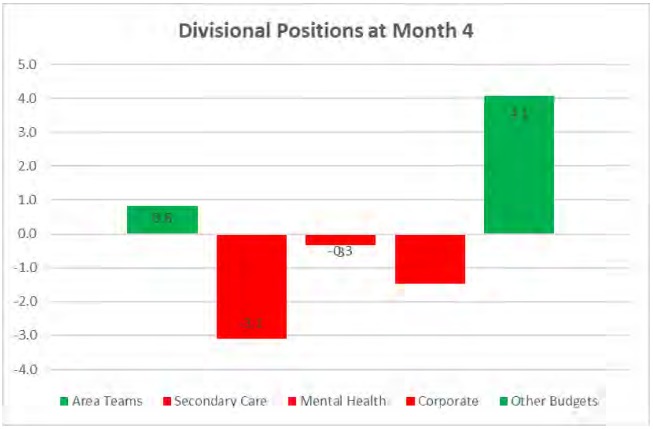
	Actual				Cumulative				Forecast
	M01	M02	M03	M04	Budget	Actual	Variance	Variance	Actual
	£m	£m	£m	£m	£m	£m	£m	%	£m
Revenue Resource Limit	(136.7)	(147.2)	(147.1)	(148.3)	(579.3)	(579.3)	0.0	0.0%	(1,808.6)
Miscellaneous Income	(12.1)	(11.6)	(11.7)	(10.7)	(46.0)	(46.1)	0.1	-0.2%	(136.7)
Health Board Pay Expenditure	68.2	70.2	69.7	69.0	277.2	277.1	0.1	0.0%	852.5
Non-Pay Expenditure	82.8	86.3	89.1	90.0	348.2	348.2	0.0	0.0%	1,092.8
Total	**2.2**	**(2.3)**	**0.0**	**0.0**	**0.1**	**(0.1)**	**0.2**		**0.0**

- The forecast position has been updated to recognise the additional funding, meaning that there is now a balanced position forecast for the year.
- The Health Board's plans for 2021/22 include the £82m strategic support funding notified by Welsh Government last year (£40m to cover the deficit and £42m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.
- In line with all NHS organisations in Wales, the plan was revised during Quarter 1 to refine and develop the triangulation of activity, workforce and financial plans, while maintaining the focus on the six key objectives described in the draft plan. Further work will be undertaken to test our assumptions and refresh if required the plan by Month 6.

Divisional Positions

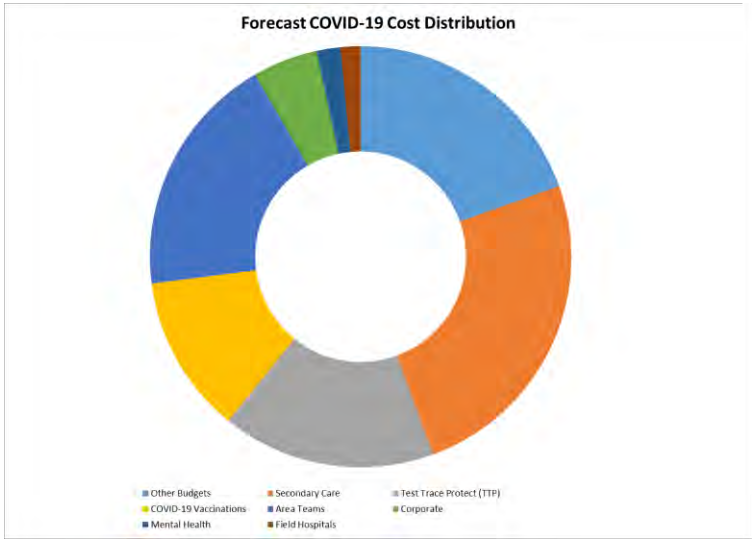
	In Month			Cumulative		
	Budget	Actual	Variance to Plan	Budget	Actual	Variance to Plan
	£000	£000	£000	£000	£000	£000
WG RESOURCE ALLOCATION	(148,308)	(148,308)	0	(579,342)	(579,342)	0
AREA TEAMS						
West Area	14,352	14,631	279	55,223	55,435	212
Central Area	18,903	18,852	(51)	72,794	72,298	(496)
East Area	22,745	22,559	(186)	86,386	85,526	(861)
Other North Wales	3,915	3,774	(141)	14,621	14,228	(393)
Field Hospitals	488	488	0	1,667	1,667	0
Track,Trace,Protect & Vaccination	1,972	1,972	0	7,298	7,298	0
Commissioner Contracts	19,462	19,648	186	73,741	74,269	528
Provider Income	(2,067)	(2,021)	46	(7,180)	(6,998)	182
Total Area Teams	79,770	79,903	134	304,550	303,723	(827)
SECONDARY CARE						
Ysbyty Gwynedd	8,730	8,897	168	35,259	35,769	510
Ysbyty Glan Clwyd	11,118	11,205	87	43,902	44,273	371
Ysbyty Maelor Wrexham	9,397	9,756	360	37,174	38,899	1,724
North Wales Hospital Services	9,422	9,637	215	37,361	38,233	871
Womens	3,436	3,303	(133)	13,739	13,362	(377)
Total Secondary Care	42,101	42,797	696	167,437	170,535	3,099
Total Mental Health & LDS	11,627	11,792	164	44,481	44,816	335
Total Corporate	11,347	11,268	(78)	48,319	49,781	1,461
Total Other Budgets incl. Reserves	3,463	2,605	(858)	14,556	10,488	(4,068)
TOTAL	0	58	58	0	0	0

- Divisional forecasts have been completed as part of the Quarter 1 refresh. The assumptions on the forecasts will be tested and if required the plan will be refreshed by Month 6.
- Corporate is showing a cumulative underspend due to a one off rate rebate in-month and cumulative underspend.

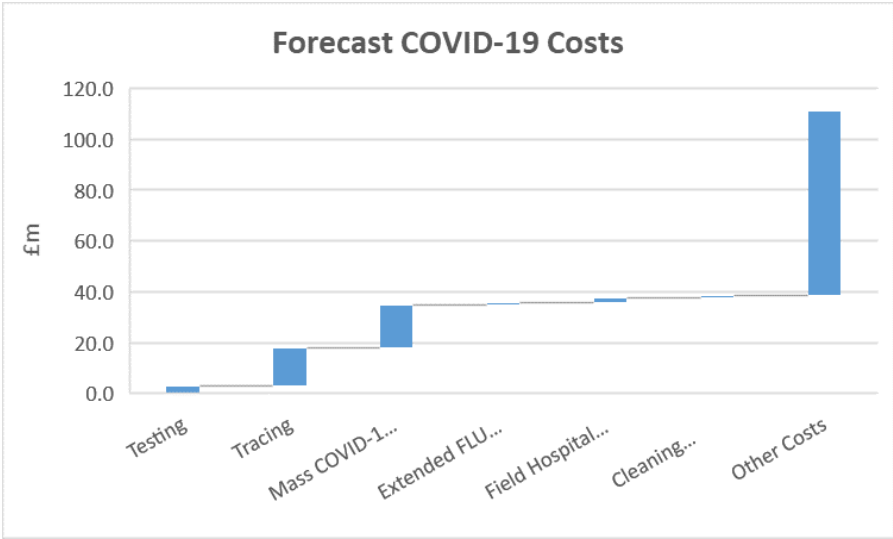


Impact of COVID-19

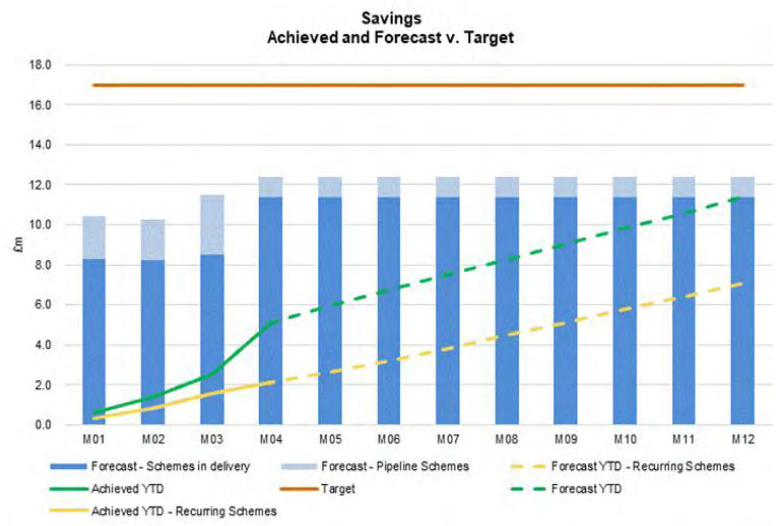
	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.2	0.3	0.8	3.0
Tracing	1.1	1.0	1.0	0.9	4.0	14.8
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	6.0	16.8
Extended FLU Vaccinations	0.0	0.0	0.0	0.0	0.0	1.2
Field Hospital/Surge	0.3	0.7	0.2	0.5	1.7	1.7
Cleaning Standards	0.0	0.0	0.0	0.0	0.0	0.9
Other Costs	4.5	3.6	4.5	6.3	18.9	72.7
Total COVID-19 costs	**7.7**	**7.0**	**7.9**	**8.8**	**31.4**	**111.1**
Non Delivery of Savings	0.8	(0.8)	0.0	0.0	0.0	0.0
Expenditure Reductions	(0.2)	(0.7)	(0.8)	0.1	(1.7)	(2.3)
Slippage on Planned Investments	0.0	0.0	0.0	0.0	0.0	0.0
Total Impact of COVID-19	**8.3**	**5.5**	**7.1**	**8.9**	**29.7**	**108.8**
Welsh Government Funding	(8.3)	(11.9)	(10.6)	(11.5)	(42.3)	(143.8)
Impact of COVID-19 on Position	**0.0**	**(6.4)**	**(3.5)**	**(2.6)**	**(12.6)**	**(35.0)**



- The forecast total impact of COVID-19 is currently £108.8m. This is based on existing Welsh Government guidance and the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to fully cover this cost, so there is no impact on the overall Health Board position.
- As additional modelling data for COVID-19 is received, and in line with the refresh of the financial plan, this forecast will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospital activity.



Savings



- Savings in Month 4 totalled £2.6m, which is £1.5m more than in Month 3. This gives cumulative savings of £5.1m for the year, which is £0.5m below the year to date target of £5.6m.
- Savings of £12.4m are forecast for delivery in 2021/22. This is against a target of £17.0m, giving a £4.6m shortfall.
- Forecast savings in primary care medicines have reduced this month, offsetting growth in other areas. The medicines programme will be reviewed to recover the reduction.
- The savings forecast includes £1.0m of red rated risk schemes. These schemes need to be moved to green and amber rated risks over the next month.
- Further opportunities are being identified both within Divisions and across BCU to ensure delivery of the savings included within the financial plan.

		SCHEMES IN DELIVERY									PIPELINE SCHEMES				TOTAL PROGRAMME	
		Year to Date				Forecast										
	Savings Target	Savings Target	Recurring Savings Delivered	Variance in Recurring Savings	Non-Recurring Savings Delivered	Recurring Forecast	Variance	Non-Recurring Forecast	Total Forecast	Forecast FYE	Recurring Plan	Non-Recurring Plan	Total Plan	Plan FYE	Total Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Ysbyty Gwynedd	1,833	611	145	(466)	6	374	**(1,459)**	29	403	441	64	0	64	71	467	(1,366)
Ysbyty Glan Clwyd	2,155	718	42	(676)	1	136	**(2,019)**	33	169	234	433	0	433	554	603	(1,552)
Ysbyty Wrexham Maelor	1,922	641	85	(556)	226	272	**(1,650)**	645	916	363	57	0	57	106	973	(949)
North Wales Managed Services	1,399	466	88	(378)	134	490	**(909)**	163	654	610	19	0	19	33	673	(726)
Womens Services	584	158	83	(75)	161	372	**(212)**	197	569	495	0	15	15	0	584	(0)
Secondary Care	**7,893**	**2,594**	**442**	**(2,152)**	**527**	**1,644**	**(6,249)**	**1,067**	**2,711**	**2,145**	**573**	**15**	**588**	**764**	**3,299**	**(4,594)**
Area - West	1,387	462	237	(226)	120	936	**(451)**	304	1,240	1,035	0	0	0	0	1,240	(147)
Area - Centre	1,900	633	501	(133)	7	1,908	**8**	36	1,944	2,381	100	0	100	100	2,044	144
Area - East	1,861	620	369	(251)	911	1,046	**(815)**	1,381	2,427	1,078	80	60	140	80	2,567	706
Area - Other	234	78	0	(78)	0	0	**(234)**	0	0	0	0	0	0	0	0	(234)
Contracts	980	327	0	(327)	0	0	**(980)**	0	0	0	0	0	0	0	0	(980)
Area Teams	**6,362**	**2,121**	**1,107**	**(1,014)**	**1,038**	**3,890**	**(2,472)**	**1,721**	**5,611**	**4,494**	**180**	**60**	**240**	**180**	**5,851**	**(511)**
MHLD	840	280	517	237	27	1,364	524	97	1,461	1,383	0	0	0	0	1,461	621
Corporate	1,910	637	41	(596)	1,390	196	**(1,714)**	1,418	1,614	323	184	0	184	184	1,798	(112)
Divisional Total	**17,005**	**5,631**	**2,106**	**(3,525)**	**2,981**	**7,094**	**(9,911)**	**4,303**	**11,397**	**8,345**	**937**	**75**	**1,012**	**1,128**	**12,409**	**(4,596)**
											0	0	0	0	0	0
											0	0	0	0	0	0
											0	0	0	0	0	0
											0	0	0	0	0	0
Improvement Group Total											**0**	**0**	**0**	**0**	**0**	**0**
Total Programme	**17,005**	**5,631**	**2,106**	**(3,525)**	**2,981**	**7,094**	**(9,911)**	**4,303**	**11,397**	**8,345**	**937**	**75**	**1,012**	**1,128**	**12,409**	**(4,596)**

Income

Description	£m
Allocations Received	1,713.2
Total Allocations Received	**1,713.2**

Description	£m
Allocations anticipated	
Capital	6.6
Removal of Donated Assets / Government Grant Receipts	-0.8
Total COVID-19 (see below analysis)	75.1
Substance Misuse	5.8
IM&T Refresh Programme (in line with 11-12)	1.9
Prevention and Early Years Funding	1.3
SpRs for the year	0.4
MSK Orthopaedic Services - Secondary Care funding	0.8
Mental Health Service Improvement Fund	3.3
2022 ICF Allocations - Anticipated Dementia Fund	2.2
Welsh Risk Pool	-3.1
Planned care recovery on English Contracts	1.3
Other	2.6
Total Allocations Anticpated	**97.4**

	£m
Total Allocations Received	**1,713.2**
Total Allocations Anticpated	**97.4**
Total Welsh Government Income	**1,810.6**

COVID -19 Funding	£m
Total COVID-19 costs in 2021/22	111.1
Impact of non delivery of savings in 2020/21	32.7
Total Covid -19 funding	**143.8**

Received	68.7
Anticpated	75.1

- The majority of the Health Board's funding is from the Welsh Government allocation through the Revenue Resource Limit (RRL). The RRL is currently £1,806.6m for the year. £579.0m of the RRL has been profiled into the position cumulatively, which is £24.3m less than two equal twelfths, primarily due to the profile of COVID-19 and performance funding.
- The RRL includes confirmed allocations to date of £1,713.2m, with further anticipated allocations in year of £97.4m.
- Miscellaneous income totals £10.7m in Month 4, £46.1m cumulatively, which is a favourable variance of £0.1m against the budget.
- The impact of COVID-19 has resulted in lost income of £0.3m in July (£1.4m year to date) relating to General Dental Services (GDS) patient income. This is included as a cost of COVID-19.

Expenditure

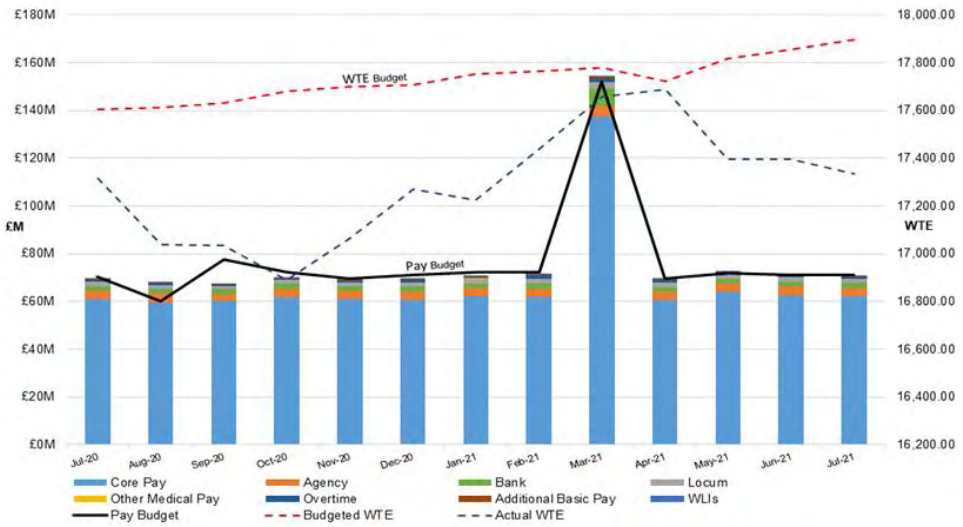
Pay Costs	Actual				Forecast								Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	9.5	9.7	9.5	9.5	9.7	9.8	9.9	9.9	9.9	10.1	10.1	10.1	39.6	38.2	1.4	117.7
Medical & Dental	15.9	16.3	16.3	16.5	16.9	16.9	17.1	17.1	17.2	17.4	17.4	17.5	62.9	65.0	(2.1)	202.5
Nursing & Midwifery Registered	21.5	22.2	22.1	21.6	21.9	22.2	22.2	22.3	22.4	22.7	22.8	22.9	90.6	87.4	3.2	266.8
Additional Clinical Services	9.7	10.3	10.1	9.7	9.8	9.9	10.0	10.0	10.1	10.2	10.2	10.2	36.4	39.8	(3.4)	120.2
Add Prof Scientific & Technical	3.1	3.1	3.1	3.1	3.2	3.2	3.2	3.3	3.3	3.3	3.3	3.3	13.3	12.4	0.9	38.5
Allied Health Professionals	4.0	4.0	4.0	4.0	4.0	4.1	4.1	4.1	4.1	4.2	4.2	4.2	16.0	16.0	(0.0)	49.0
Healthcare Scientists	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.3	1.3	1.3	4.7	4.8	(0.1)	14.7
Estates & Ancillary	3.3	3.4	3.4	3.4	3.4	3.5	3.5	3.5	3.5	3.6	3.6	3.6	13.4	13.5	(0.1)	41.7
Students	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.5	0.2	0.0	0.2	0.7
Health Board Total	**68.2**	**70.2**	**69.7**	**69.0**	**70.1**	**70.8**	**71.2**	**71.4**	**71.7**	**72.9**	**73.0**	**73.6**	**277.2**	**277.1**	**0.1**	**851.8**
Primary care	1.4	2.3	1.8	1.9	1.4	1.4	1.4	1.4	1.5	1.5	1.5	1.4	6.7	7.4	(0.7)	18.9
Total Pay	**69.6**	**72.5**	**71.5**	**70.9**	**71.5**	**72.2**	**72.6**	**72.8**	**73.2**	**74.4**	**74.5**	**75.0**	**283.9**	**284.5**	**(0.6)**	**870.7**

Variable Pay	M01	M02	M03	M04	Total
	£m	£m	£m	£m	£m
Agency	3.1	3.5	3.7	3.5	13.8
Overtime	1.1	0.7	0.7	0.7	3.2
Locum	1.9	1.8	1.8	1.7	7.2
WLIs	0.1	0.2	0.2	0.4	0.9
Bank	2.0	2.0	2.1	2.0	8.1
Other Non Core	0.1	(0.1)	0.1	0.1	0.2
Additional Hours	0.5	0.4	0.4	0.4	1.6
Total	**8.8**	**8.5**	**8.9**	**8.7**	**34.9**

- Health Board pay costs total £69.0m in Month 4. Variable pay is £8.7m of this cost, equivalent to 12.6%. Non-pay costs total £90.0m in Month 4. Pay costs are further analysed on page 10 and non-pay costs on page 11.
- **Forecast expenditure** related to the £30m funding for the Performance Fund, £12m Strategic Support and £19.9m COVID-19 Recovery Plan is based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend each month for the first seven months of the year and a continued high level of spend for the remaining five months. This cost profile is dependent on operational teams implementing approved plans at pace. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts

Non-Pay Costs	Actual				Forecast								Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care	18.3	18.9	19.1	19.7	18.8	18.9	18.9	18.5	18.6	18.5	18.3	18.5	76.5	76.0	0.5	225.0
Primary Care Drugs	9.2	7.9	9.3	10.4	9.6	9.6	9.8	10.0	10.1	9.9	9.1	10.1	36.0	36.8	(0.8)	115.0
Secondary Care Drugs	5.6	6.0	6.8	6.9	7.1	7.3	7.2	7.1	7.5	7.2	7.0	7.5	23.4	25.3	(1.9)	83.2
Healthcare Services Provided by Other NHS Bodies	22.8	22.8	23.4	24.4	23.1	23.1	23.0	23.0	23.0	23.0	23.0	23.0	93.2	93.4	(0.2)	277.6
Continuing Care and Funded Nursing Care	8.2	9.2	8.5	10.2	8.7	8.5	8.7	8.6	8.6	8.7	8.2	9.2	35.1	36.1	(1.0)	105.3
Other Non-Pay (incl. General & Clinical Supplies)	16.3	19.1	17.4	15.3	20.7	22.3	23.6	23.5	23.3	23.6	24.0	24.7	71.5	68.1	3.4	253.8
Non-pay costs	**80.4**	**83.9**	**84.5**	**86.9**	**88.0**	**89.7**	**91.2**	**90.7**	**91.1**	**90.9**	**89.6**	**93.0**	**335.7**	**335.7**	**(0.0)**	**1,059.9**
Cost of Capital	2.4	2.4	4.6	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	0.8	12.5	12.5	0.0	35.0
Total non-pay including cost of capital	**82.8**	**86.3**	**89.1**	**90.0**	**91.1**	**92.8**	**94.3**	**93.8**	**94.2**	**94.0**	**92.7**	**93.8**	**348.2**	**348.2**	**(0.0)**	**1,094.9**

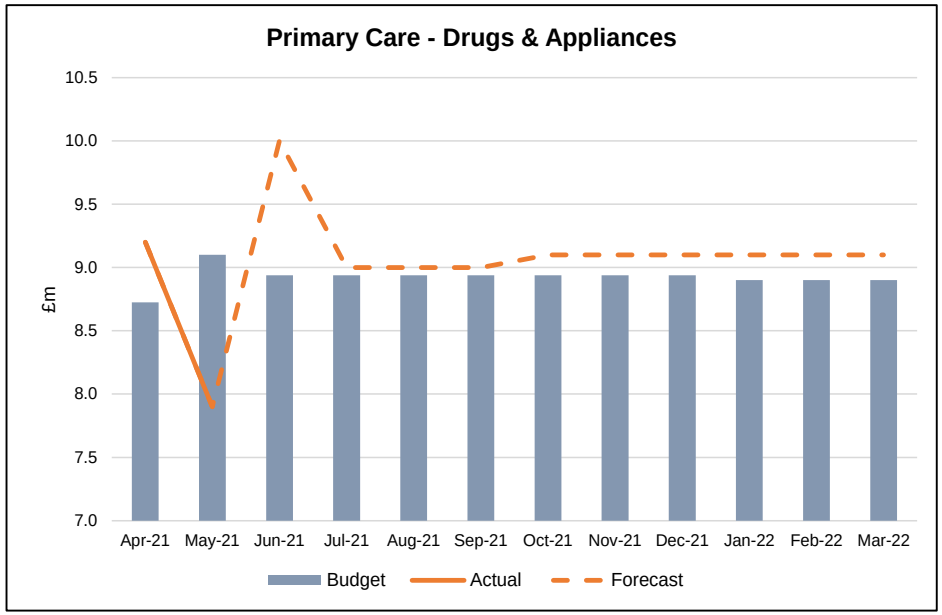
Pay Costs



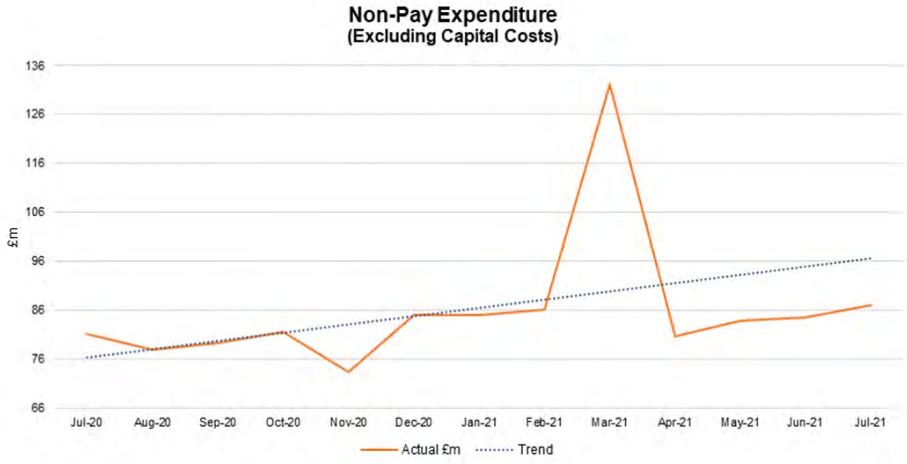
- **Total pay costs** in July are £70.9m. Provided Services pay costs are £69.0m, which is £0.6m (1.0%) less than last month.
- Pay costs and funding are currently profiled across the year, for the 1% pay award back dated to April.
- A total of £2.6m of pay costs were directly related to COVID-19, which is £0.1m lower than in June.

- **Agency costs** for Month 4 are £3.5m, representing 4.9% of total pay, which is the average monthly expenditure in 2020/21. Monthly agency spend for July included £0.6m that related to COVID-19, £0.1m more than last month.

Non-Pay Costs



Primary Care Drugs: The expenditure for Month 4 is £1.2m (15%) more than in Month 3 and is higher than any other month. This is mainly being driven by the volume of drugs being prescribed. Following receipt of the May prescribing data, the average cost per Prescribing Day has shown a material increase; May was £502k compared to April at £477k, representing an overall increase of 5.4%. The average cost per item has shown a small increase of 1.0%, but the number of items prescribed has increased by 4.7%. Once again this month, the increase in the average cost per Prescribing Day appears to be driven by volume not price, suggesting a return to business as usual. The expenditure in Month 4 was £1.4m more than had been forecast. This is because up to the May Comparative Analysis System for Prescribing Audit (CASPA) data, although we had been seeing an upwards trend for the average cost per prescribing day, which was factored into forecasts the subsequent volume of prescribing had not been factored in. Also, May is the only the second month of actual data and costs for 2021/22, and so may not be indicative (for the remaining 10 months of the financial year. The cumulative overspend is £0.8m, with a forecast adverse variance of £1.4m for the year.



Other Non-Pay: Spend in July is £5.3m (15%) less than in June. This decrease is for technical reasons and mainly relates to the transfer of COVID-19 costs to Joint Financing £2.6m) in respect of payments to Local Authorities for COVID-19 Tracing. The other reductions compared to Month 3 relates to Intermediate Care Fund (ICF) (£0.7m), Radiography/RMS (£0.6m) and COVID -19 (£1.0m). Offsetting this, activity has increased further across the three acute sites, leading to an increase in non-pay costs. Scheduled Care activity is up by circa 18% across sites, in line with last month, which is driven by increases in Theatres activity. In one site the Theatre activity was down slightly but this was offset by an increase in trauma activity. All three sites have also seen significant increases in Emergency Department activity, which is above equivalent 2019/20 levels. These all indicate that there is a return to business as usual and this is happening sooner than had been anticipated.

Risks and Opportunities (not included in position)

	£m	Level	Explanation
Risks			
Savings Programme – Red Risk Pipeline Schemes	1.0		There is a risk that the savings programme will not deliver the £17.0m target, as per the financial plan. Savings of £12.4m are forecast for delivery in 2021/22, which includes £1.0m of red-rated schemes in the pipeline. Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.
Savings Programme - Planning Assumptions	2.0		There is a risk that the planning assumptions still be to identified, which total £2.3m, will not deliver in the current financial year. Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.
Additional funding – Risk of not being to utilise additional funding provided by WG	TBC		There is a risk that the Health Board will not be able to utilise the additional funding provided by Welsh Government, for example, performance fund monies, due to plans not being identified and approved.
Pay award – Risk of no additional funding to cover settlements over 1%	TBC		The financial plan assumes a 1% pay award. There is a risk that there will be no additional funding to cover settlements over the 1% that has been budgeted.

	£m	Level	Explanation
Opportunity			
Accountancy gains	TBC		There is a potential for future one off accountancy gains.

Appendix 2 – Performance Monies Tracker

EXEC SUMMARY

Performance Monies & WG Bid Tracker at Month 4

	Funds Available £000	Plan Spend £000	Plan Slippage £000	Plan YTD £000	Actual YTD £000	Slippage YTD £000	Plan M5 - M12 £000	Forecast M5 - M12 £000	Slippage M5 - M12 YTD £000	Forecast Slippage 2021/22 £000	2022/23 Funds Available £000	2022/23 Plan Spend £000	2022/23 Slippage / Shortfall £000	2023/24 Funds Available £000	2023/24 Plan Spend £000	2023/24 Slippage / Shortfall £000
PERFORMANCE - OTHER (£15m)	15,268	15,010	(258)	2,098	1,233	(866)	12,911	13,777	865	(259)	*15,000*	*24,913*	*9,913*	*15,000*	*25,733*	*10,733*
PERFORMANCE - PLANNED CARE (£15m)	12,546	12,550	5	2,025	499	(1,526)	10,526	12,052	1,526	5	*15,000*	*0*	*(15,000)*	*15,000*	*0*	*(15,000)*
PERFORMANCE - PLANNED CARE SLIPPAGE	2,187	436	(1,751)	0	122	122	436	2,065	1,629	0	*0*	*436*	*436*	*0*	*436*	*436*
TRANSFORMATION (£12m)	12,000	10,551	(1,449)	1,370	352	(1,018)	9,180	10,145	964	(1,503)	*12,000*	*14,306*	*2,306*	*12,000*	*21,443*	*9,443*
WG BID (£20m)	19,942	14,965	(4,977)	2,592	2,197	(395)	12,373	17,350	4,977	(395)	*0*	*2,281*	*2,281*	*0*	*2,081*	*2,081*
Total	**61,942**	**53,512**	**(8,430)**	**8,085**	**4,402**	**(3,683)**	**45,427**	**55,389**	**9,962**	**(2,152)**	*42,000*	*41,937*	*(63)*	*42,000*	*49,694*	*7,694*

Slippage:	**£000**
Initial Plan Slippage against funding	(8,430)
YTD Slippage on actual M1 - M4 spend	(3,683)
Forecast on M5 - M12 spend	9,962
Total Slippage	**(2,152)**

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Savings Programme Update**
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Finance
Awdur yr Adroddiad Report Author:	Head of Value and Savings Programme
Craffu blaenorol: Prior Scrutiny:	Review by Executive Director of Finance
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

That the Committee note the current savings plans and forecast delivery, along with the opportunities identified to address the recurring savings deficit.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	**X**	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
If this report relates to a 'strategic* decision'*, i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.						**Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

This report presents an update on savings delivery as at Month 4 2021/22.

Cefndir / Background:

The Health Board's Annual Plan identified the need to secure £17m of recurring savings in 2021/22. This savings requirement was set at a reduced level from previous years, due to the anticipated impact of COVID-19, particularly in quarters 1 and 2 of the financial year.

Asesiad / Assessment & Analysis

Strategy Implications

Delivery of the savings programme is critical in supporting the Health Board to return to a sustainable financial position. Securing financial improvement during 2021/22 and beyond is a key component of the targeted Intervention framework.

Financial Implications

Distribution of the Savings Target

In previous years the Health Board has adopted a uniform distribution of the savings target across service areas based upon operating budgets. For some time there has been a recognition that savings opportunities, identified from benchmarking and other data sources, are not uniformly distributed across services. Recognising this, the Executive Team agreed a distribution of savings for 2021/22 based on the following components and weightings –

Underachievement of 20/21savings requirement – 50%
Baseline budget – 25%
Benchmark opportunities – 25%

This distribution signals the first step in a movement to a distribution based increasingly upon benchmark opportunities in future years.

Divisional Plans – Overall Forecast

The overall forecast delivery for each Division as at month 4 is summarised in the table below, include percentage achievement of target –

Division	Cash Releasing Target £'000	Amber / Green Forecast £'000	Red Forecast £'000	Gross Forecast £'000	% Delivery of Target
Ysbyty Gwynedd	1,833	403	64	467	25%
Ysbyty Glan Clwyd	2,155	169	433	603	28%
Ysbyty Wrexham Maelor	1,922	916	57	973	51%
North Wales Managed Services	1,399	654	19	673	48%
Womens Services	584	569	15	584	100%
Secondary Care	**7,893**	**2,711**	588	3,299	42%
Area - West	1,387	1,240	-	1,240	89%
Area - Centre	1,900	1,944	100	2,044	108%
Area - East	1,861	2,427	140	2,567	138%
Area - Other	234	-	-	-	0%
Contracts	980	-	-	-	0%
Area Teams	**6,362**	**5,611**	240	5,851	92%
MHLD	840	1,461	-	1,461	174%
Corporate	1,910	1,614	184	1,798	94%
Divisional Total	**17,005**	**11,397**	1,012	12,409	73%

Forecast delivery across Divisions is variable with significant shortfalls across secondary care, noting the exception of Women's services. This pattern is consistent with previous years and points to a need for a refreshed approach and focus to savings delivery in acute care settings.

Savings delivery for contracts has been impeded by national contracting principles applied during the pandemic, which tie the Health Board into block contracts.

Programme Delivery

The year to date position for schemes in delivery (amber and green risk) against the savings requirement and the forecast year end position is set out in the table below –

Schemes In delivery (Amber or Green)		Savings Delivered YTD				Forecast				
Includes savings delivered by schemes awaiting PIDs	Cash Releasing Target £'000	YTD Target £'000	Recurring Savings Delivered £'000	Variance in Recurring Savings £'000	Non-Recurring Savings £'000	Recurring Forecast £'000	Variance in Recurring Savings £'000	Non-Recurring Forecast £'000	Total Forecast £'000	Forecast FYE £'000
Ysbyty Gwynedd	1,833	611	145	(466)	6	374	(1,459)	29	403	441
Ysbyty Glan Clwyd	2,155	718	42	(676)	1	136	(2,019)	33	169	234
Ysbyty Wrexham Maelor	1,922	641	85	(556)	226	272	(1,650)	645	916	363
Sub-total Hospital Sites	**5,910**	**1,970**	**272**	**(1,698)**	**233**	**782**	**(5,128)**	**706**	**1,488**	**1,039**
North Wales Managed Services	1,399	466	88	(378)	134	490	(909)	163	654	610
Womens Services	584	158	83	(75)	161	372	(212)	197	569	495
Secondary Care	**7,893**	**2,594**	**442**	**(2,152)**	**527**	**1,644**	**(6,249)**	**1,067**	**2,711**	**2,145**
Area - West	1,387	462	237	(226)	120	936	(451)	304	1,240	1,035
Area - Centre	1,900	633	501	(133)	7	1,908	8	36	1,944	2,381
Area - East	1,861	620	369	(251)	911	1,046	(815)	1,381	2,427	1,078
Area - Other	234	78	0	(78)	0	0	(234)	0	0	0
Contracts	980	327	0	(327)	0	0	(980)	0	0	0
Area Teams	**6,362**	**2,121**	**1,107**	**(1,014)**	**1,038**	**3,890**	**(2,472)**	**1,721**	**5,611**	**4,494**
MHLD	840	280	517	237	27	1,364	524	97	1,461	1,383
Corporate	1,910	637	41	(596)	1,390	196	(1,714)	1,418	1,614	323
Divisional Total	**17,005**	**5,631**	**2,106**	**(3,525)**	**2,981**	**7,094**	**(9,911)**	**4,303**	**11,397**	**8,345**

Recurrent savings for schemes in delivery are forecast to be £7.1m, which leaves a shortfall of £9.9m against the £17m requirement. The full year effect of recurrent schemes is £8.3m. Non recurrent savings of £4.3m are forecast which gives an in year total expected delivery of £11.4m. This is an increase of £2.8m against the expected out-turn position reported in month 3.

In addition to the schemes in delivery, the following schemes are currently under development (red risk) –

Red Risk Schemes	Planned			
	Recurring Plan £'000	Non-Recurring Plan £'000	Total Planned £'000	Planned FYE £'000
Ysbyty Gwynedd	64	0	64	71
Ysbyty Glan Clwyd	433	0	433	554
Ysbyty Wrexham Maelor	57	0	57	106
North Wales Managed Services	19	0	19	33
Womens Services	0	15	15	0
Secondary Care	**573**	**15**	**588**	**764**
Area - West	0	0	0	0
Area - Centre	100	0	100	100
Area - East	80	60	140	80
Area - Other	0	0	0	0
Contracts	0	0	0	0
Area Teams	**180**	**60**	**240**	**180**
MHLD	0	0	0	0
Corporate	184	0	184	184
Divisional Total	**937**	**75**	**1,012**	**1,128**

Schemes under development will add a further £1m to delivery by year end. This will bring the recurring shortfall down to £9m and the in year gap to £4.5m. This is an increase in overall programme delivery of £0.9m against month 3.

Identifying Additional Schemes

Experience in previous years is that there is a continued increase in savings identification as the year progresses. A similar pattern is expected to emerge in 2021/22 and therefore with continued focus the balance of £4.5m in total savings required in year should be achieved. The critical issue is the balance between recurrent and non-recurrent schemes, as experience from previous years suggests that non-recurrent schemes will form a significant part of the overall delivery. This does not address the need to demonstrate progress in reducing the underlying deficit.

The Health Board is currently developing its approach to transformation of services in order to improve quality of care, outcomes for patients, performance and value. This transformation programme is the key driver that will enable a movement towards financial sustainability. It is critical that this programme is clinically led. Therefore, focussing primarily on improved quality and outcomes is key to securing engagement and commitment. Using this approach to identify and adopt consistent ways of delivering services, linked to clinical pathways and evidence of best practice, will also enhance efficiency and thereby enable the required savings to be generated.

The requirement for a focus on recurrent savings delivery, in the context of the need to deliver £17m in 2021/22, with the target rising to £35m in 2022/23, has been discussed with the Executive Management Group (EMG). The EMG discussion recognised the need to align the savings programme with the overall transformation programme so that actions are primarily focussed on patient experience and quality with financial savings being achieved as a result of this approach, rather than being positioned as a primary driver. This is critical to securing engagement from clinical teams to drive the substantial change that will be required.

Benchmarking data points to a series of areas where recurrent opportunities exist and importantly, where the potential for improvements in quality, outcomes and performance is recognised. Discussions at EMG recognised the need for a more structured approach, addressing a small number of key areas.

The following have been identified as potential opportunities -

Planned Care

- Outpatient Follow up rates – there is an opportunity to review and amend practise in relation to follow up outpatient appointments. This will allow clinic slots to be released to enable more patients to be seen from the current waiting list backlog within core capacity. This will reduce the expenditure required on premium cost additional activity.

- Theatres – there is an opportunity to increase productivity within theatres which will enable more patients to be operated upon within core capacity. This will create slots for patients who are currently waiting whilst also reducing reliance upon premium cost additional activity

Unscheduled Care

- Length of stay – there is an opportunity to reduce length of stay for patients, thereby improving their experience of care and releasing capacity to support improvements in flow through hospitals. This, along with other changes being implemented, such as Home First, will

contribute to improved performance in unscheduled care and reduce expenditure upon surge capacity.

- Ambulatory Care Sensitive Conditions – across BCU there is evidence of comparably higher admission rates per 1000 population for specific ambulatory care conditions than in other areas. Securing improvement may require some investment in primary and community services, but will improve quality of care for patients, avoiding unnecessary admissions and thereby reduce pressure on Emergency Departments. This will assist in reducing premium costs associated with emergency care provision.

Workforce

- The challenge of recruitment and retention of staff to ensure that use of agency and bank resources are reduced remains significant. This impacts upon quality of care for patients and the working experience and wellbeing or our permanent workforce. Action to improve permanent staffing levels and transition from agency to bank will address the above and bring associated financial benefits.

Adopting a more structured approach to addressing the priorities above will assist in addressing the current shortfalls in savings identified within the secondary care sector.

Implementation of Transformation agenda and associated team structure

The Transformation team will be critical to the delivery of revised patient pathways aligned to Value Based Health Care (VBHC) principles and there will be be a financial improvement team embedded within this structure. In order to maintain an effective focus on both the transformation and savings programmes, a Transformation and Finance Group will be established with the remit to ensure that savings delivery and transformation are complimentary activities, aligned within the change programme.

To enhance support to Divisions and accountability for delivery, monthly review meetings will take place with each Director to support the development of the programme and ensure timely delivery. These meetings will be led by the Executive Director leads.

Confirmation of priorities and the connection with the transformation programme will be established in September, building on the discussions with EMG.

Risk Analysis
There is a risk that operational pressures related to COVID-19 and recovery impact upon management capacity to focus on delivery of the required savings improvements.

Legal and Compliance
There are no specific issues associated with this report

Impact Assessment
As savings proposals are developed they are subject to impact assessments which are reviewed by Executive Directors to give assurance that there are no adverse impacts.

Recommendation
That the Committee note the current savings plans and forecast delivery, along with the opportunities identified to address the recurring savings deficit.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Workforce Performance Report**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Sue Green, Executive Director of Workforce & Organisational Development (OD)
Awdur yr Adroddiad **Report Author:**	Mr Nick Graham, Associate Director Workforce Planning & Performance
Craffu blaenorol: **Prior Scrutiny:**	Executive Director of Workforce & Organisational Development (OD)
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to **note** the report and planned improvements to reporting.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	✓	**Er gwybodaeth** **For Information**	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**							**N**

Sefyllfa / Situation:

This report sets out the overall position in relation to workforce performance up to 31st July 2021. It brings together the position in terms of:

1) Organisation Wide Workforce Composition
   a) Workforce Dashboard Indicators
   b) Budgeted Establishment versus Actuals
   c) Current Vacancy Rates
   d) Non-Core/Flexible Workforce
   e) Attendance & Availability
   f) Pay Spend across all areas

2) Workforce Systems & Processes Performance
   a) Recruitment
   b) Resourcing
   c) Presentation: Tools and dashboards utilised to support recruitment & resourcing across BCUHB

Asesiad / Assessment & Analysis

1) Organisation Wide Workforce Composition

a) Workforce Indicators Dashboard

Vacancy Rates

	Rate	Vs Target of 8%
All Staff Groups	7.5%	-0.5%
N&M	11.9%	+3.6%
M&D (non-training)	8.8%	+0.8%

Sickness Absence

Rolling 12 month rate = 5.34%

Adverse; 1.14% above target, an increase of 0.07% on previous month

Turnover

Monthly turnover rate 8.6%

Adverse; highest turnover rates in previous 12 months but still within range

Registered Nurse Bank Performance

Bank fill rate 18%
Agency fill rate 39%

Favourable; 2% reduction in agency usage on previous month

Time to Hire (vacancy approval to offer letter)

74 days average

Adverse; 12 days more than previous month but still within range

Medical Bank Fill

Bank fill rate 53%
Agency fill rate 46%

Favourable; 8% reduction in agency usage

b) Budgeted Establishment vs Actuals

Table 1 below sets out the total budgeted establishment and actual whole time equivalent (wte) in post for July 2021 with Table 2 providing the position for August 2020.

The current gap between budget and actual as of July 21 is 1,338 wte, which is an increase of 223 wte on the comparative position at this time in 2020.

The budgeted establishment has increased overall by 438 wte during this period with an actual increase in wte in post of 661. This reflects the investment made using the 20/21 winter pressures funding and the performance funding for 21/22. It also reflects the new services established in response to the Covid19 Pandemic such as the Test Trace Protect (TTP) service and the Vaccination programme.

The year on year increase in actual wte and improvement of 223 wte positive vacancy position reflects the ongoing development and mobilisation of successful programmes such as the overseas nursing campaigns which has seen over 60 new nurses recruited to the Health Board and moving forward, circa. 120 nurses over the next 12 months from places such as India and other overseas countries.

Within medical staffing the gap across the GP workforce is still a concern and work is ongoing to identify short and long-term solutions to address this, acknowledging this is a national challenge.

Short-term work is underway to develop a primary care recruitment campaign in conjunction with Medacs to attract more GPs to the medical bank to increase temporary support. A level of temporary staffing support is already in place across this cohort and currently stands at 23.5 wte supplied through agency, which leaves the true workforce gap at 10.2 wte.
Medium term we are working actively to recruit more GPs to the Health Board whilst long-term solutions are progressed eg commissioning and skill mix plans. This is an area of significant opportunity as we move closer to the development of an Inter-professional Medical & Health Sciences School in North Wales. We are also progressing work with Doctors Direct, to supply junior doctors who have British nationality but qualified as a doctor overseas within the European Union. Current estimates are between 10 and 20 junior doctors joining over the coming year.

Table 1 Budget V Actual WTE as at July 2021

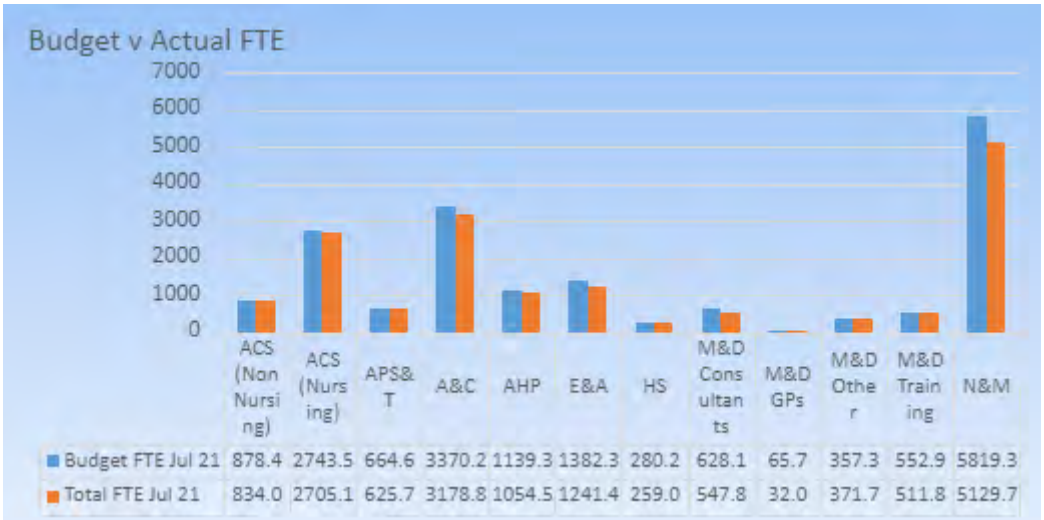
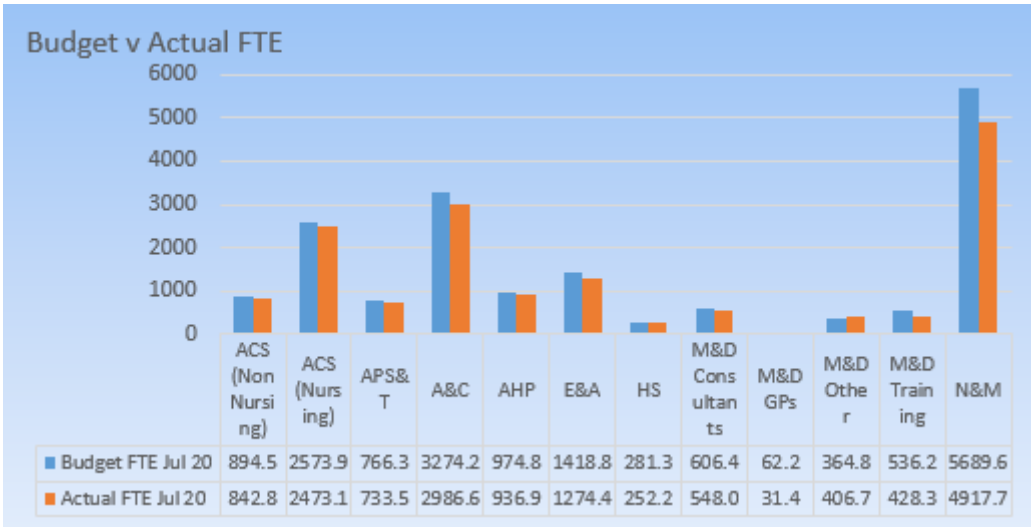


Table 2 Budget V Actual WTE as at August 2020



The work to progress the Clinically led Service/Workforce Reviews supported by Kendall Bluck is progressing and below is a more detailed outline of the work with a specific update around the

Unscheduled Care programme as requested at the last Committee meeting. We expect this work realise benefits across Q3 and into Q4 of 2021.

The work across Unscheduled Care (USC) has been significant to date with analysis having been conducted with feedback given to the team. Extensive work has been undertaken regarding the USC business case, including numerous meetings with the project team, Health Board management and clinical teams. The business case has been aligned with the Same Day Emergency Care (SDEC) work also being carried out across USC. Alongside this Kendall Bluck are working with the ED team to formalise the ED pathways and are collaboratively developing pathway models to ensure the workforce is aligned to these going forward. Specifically, pathways are also being developed in relation to frailty, acute medicine, and GP services.

The six areas each have a lead executive as Senior Responsible Officer (SRO) and there is a robust programme structure in place around each review work stream. A project update is provided in Table 3 below:

Table 3 Clinical Workforce Service Review Programme Outline

Service Review	Project Update
Emergency Care Pathway SRO – Deputy Chief Executive/Director Nursing & Midwifery	Business case developed, ED pathways being reviewed and workforce models aligned accordingly
Colorectal Services SRO – Executive Medical Director	Data analysis commenced with project group being pulled together for start-up meeting
Stroke Services SRO – Executive Director Primary Care & Community Services	Data analysis completed, meeting with the stroke services team scheduled for 25/8 to align findings with existing stroke services business case
Women's Services SRO – Executive Director Public Health	Data analysis commence with project group meeting scheduled for 14/9, building on existing work carried out prior to the pandemic
Mental Health SRO – Executive Director Public Health	Data analysis ongoing with first project group meeting having taken place on 09/08 and initial pathways identified with clinical lead
Urology Services SRO - Executive Medical Director	Data analysis commenced with project group being pulled together for start-up meeting

The outputs are anticipated to be improved patient outcomes, improved efficiency, improved employee morale, recruitment and retention, and increased patient satisfaction. The implementation of the reviews is scheduled to be towards the end of Q2 and into Q3 of 2021. Some of the likely benefits will be more balanced clinical rotas across the identified areas and better training opportunities for our trainees. The monitoring arrangements will be through the monthly overarching programme group for each service review with regular update reports going through the Executive Delivery group – People & Culture, Executive Team and being reported through this report to the F&P committee.

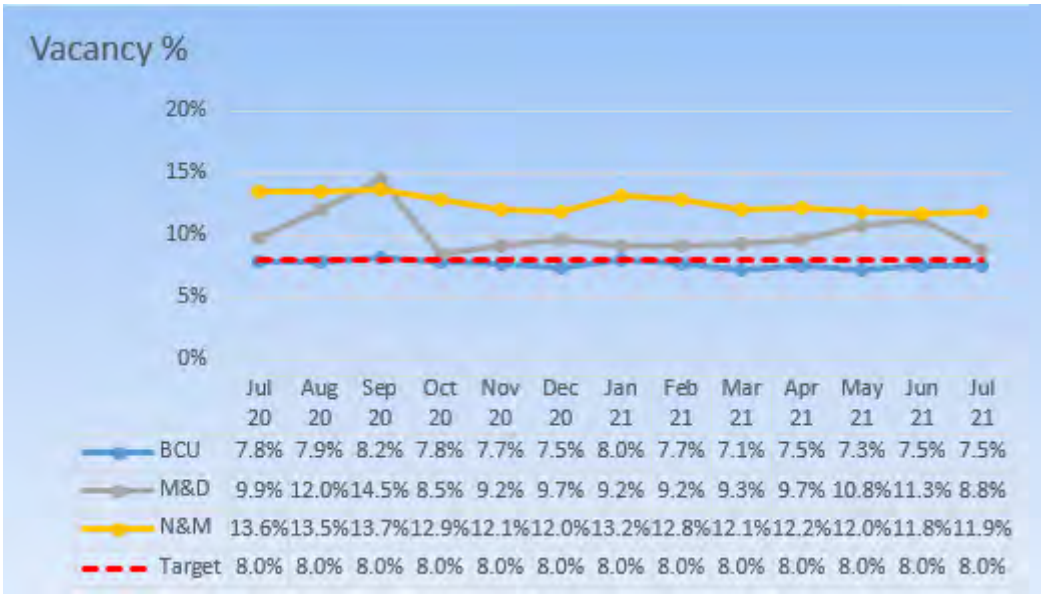
All of this work will be undertaken to the standards laid down by the relevant Royal Colleges, professional organisations, and the relevant education and training requirements linked to the service.

c) Current Vacancy Rates

Table 4 sets out the current overall vacancy rate for the Health Board; alongside this is the Medical and Dental, and Nursing and Midwifery vacancy rates as percentages. Whilst clearly there are other professional groups critical in the delivery of care and services, these two groups are fundamental in delivery of clinical services.

The organisational vacancy rate has been maintained below or on 8% across the last 12-month period, with a blip in September 2020. A comparative measure as to how well we perform across Wales is the advertised posts metrics, to date BCU have advertised 1890 posts in the first 4 months of this year within the All Wales total of 7715. This means that BCU accounts for 25% of all roles advertised across NHS Wales year to date. The recruitment team are working hard with managers to close the vacancy gap as shown in the figures above. In addition, we would expect to see an improvement across the recruiting manager KPIs shown in table 16 further in this report. This will be monitored through our regular workforce performance meetings and presented back to the committee in this report going forward.

Table 4. Vacancy Rate at 31 July 2021



	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
BCU	7.8%	7.9%	8.2%	7.8%	7.7%	7.5%	8.0%	7.7%	7.1%	7.5%	7.3%	7.5%	7.5%
M&D	9.9%	12.0%	14.5%	8.5%	9.2%	9.7%	9.2%	9.2%	9.3%	9.7%	10.8%	11.3%	8.8%
N&M	13.6%	13.5%	13.7%	12.9%	12.1%	12.0%	13.2%	12.8%	12.1%	12.2%	12.0%	11.8%	11.9%
Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

The vacancy rate for medical and dental staff shown in Table 4, has been averaging 9.75% across 2021 but currently sits at 8.8% (this includes all grades i.e. training vacancies) which is the best position since October 2020.

Medical and Dental
General consultant recruitment remains positive with appointments made to the majority of roles advertised, with work continuing with a number of partner organisations as well as with teams across Acute, Community and Mental Health and Learning Disabilities to deliver against recruitment plans in place.

The hard to recruit specialities remain Children and Adolescent Mental Health services (CAMHS), Care of the Elderly (COTE) and Rheumatology with Mental Health. There is specific work underway across these 4 areas. In respect of CAMHS Health Education and Improvement Wales (HEIW) have been approached to work towards improving trainee take up which is a national issue. Recruitment from wider professional groups (such as teachers) is being considered and to that end there is a workforce task and finish group in place to support the development and recruitment to targeted intervention teams for young adults in crisis.

With COTE where there have been long-term vacancies since 2016, we have redesigned their adverting campaign and have placed a greater focus on flexible working opportunities to attract a different target audience. In addition targeted recruitment campaigns working with a specialist digital recruitment company are underway to support the new business case for Stroke and the longstanding issues in Rheumatology.

In relation to Mental Health, work (in collaboration with Kendall Bluck) is underway to review staffing models for the memory clinics, to ensure development in addition to recruitment to a sustainable workforce model going forward. Alongside this, the work with Doctors Direct as mentioned previously will enable the Health Board to generate a steady flow of Junior Doctors to supplement existing gaps and build a succession pipeline going forward.

As previously reported, as there are a number of factors influencing recruitment of medical and dental staff that all require attention if we are to succeed in attracting and retaining high calibre individuals at a level required for the demand we have across our communities. This requires not only effective workforce planning and commissioning, efficient recruitment processes but also clarity in respect of the importance of and accountability for each step in these processes. As we move forward, the focus needs to be upon empowerment to act within a clear framework of accountability and authority supported by fit for purpose workforce and education services.

As one part of the movement towards this model, recognising the need to improve at a time when there are significant pressures to recruit high volumes (both vacancies and additional roles to support planned care recovery), the Medical recruitment Panel in place pre Covid19 has been refreshed, refocussed and re-established. The first meeting of Medical Resourcing Delivery Group, has been set for Monday 6 September. This purpose of this group is:

- to ensure that all vacancies are being progressed at pace and to address any blockages/delays, agreeing exceptions and escalation e.g. gaps in availability and membership of Consultant Recruitment Panels (Advisory Appointments Committee (AAC);
- to ensure plans are in place to mobilise recruitment for additional roles coming through as part of clinical pathways development/planned care recovery/Diagnostic & Treatment Centre development, to reduce the lag between approval and deployment;
- to ensure that there are robust plans in place to reduce reliance on long term temporary cover, either through recruitment or skill mix changes; and
- to identify and report themes for improvement and learning through to People and Culture Executive Delivery group to ensure multi professional solutions are optimised.

The group will be Executive led and meet weekly to begin with until the improvements in process and local ownership of responsibilities are secured.

In the intervening period, the Group has been focussed upon ensuring that recruitment to key roles e.g. Vascular services and Urology are being progressed at pace both by the clinical services and by the resourcing team. Appointment to Clinical Director and Consultants positions for Urology is on track for completion by mid-October at the latest (AAC set for September with a fall back panel in October for additional roles if possible). Appointment to Vascular consultant positions is being

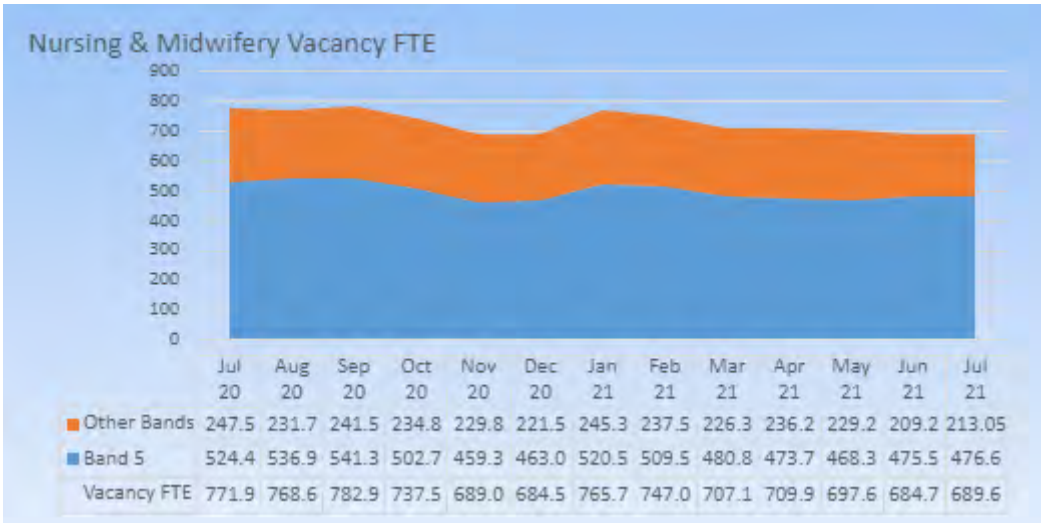
expedited to bring forward from the current December timeline to October. Interim Regional Delivery Director, Secondary Care Medical Director and Associate Director of Workforce Planning & Performance are working together to ensure no slippage in these timelines.

Nursing & Midwifery

There has been a steady improvement in nursing vacancies from January 2021, which stood at 13.2%. Table 4 shows the rate in Nursing and Midwifery down to 11.9% in July 2021 and Table 5 shows this in wte. In July, there were 689.6 wte vacancies across the nursing workforce down from 697.6 in May. This is a small decrease month on month but is a significant improvement on the figures reported for January (765.7wte). The difference in the main is due to steady recruitment across nursing and the addition of 24 international nurses per month as part of the international nurse recruitment programme commissioned by the Health Board in 2020 which is now extended through to May 2022.

This is positive news but whilst the model of delivery remains predominantly inpatient bed based across multiple locations, sustaining this increase in nursing staff is likely to continue to be a challenge. The current service reviews underway across the six specialities will provide opportunities to look at the way we deliver our services and the introduction of Clinical Fellowships will support ongoing recruitment and retention. Alongside this, we are currently reviewing training numbers and types and are working with HEIW to look at commissioning numbers and roles and the funding associated with them across North Wales. This work is aligned with the work that is ongoing with Bangor University around the North Wales Medical and Health Sciences School.

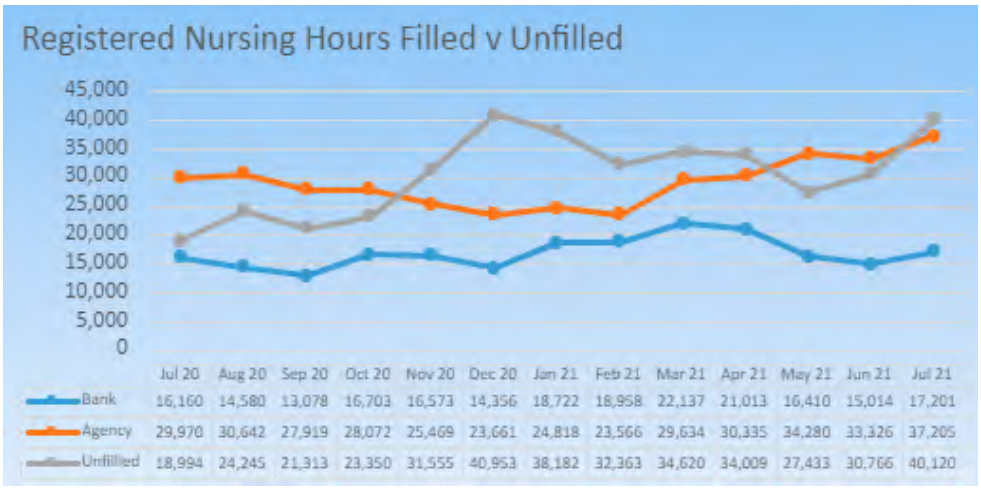
Table 5. – Nursing and Midwifery Vacancy Rate



	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Other Bands	247.5	231.7	241.5	234.8	229.8	221.5	245.3	237.5	226.3	236.2	229.2	209.2	213.05
Band 5	524.4	536.9	541.3	502.7	459.3	463.0	520.5	509.5	480.8	473.7	468.3	475.5	476.6
Vacancy FTE	771.9	768.6	782.9	737.5	689.0	684.5	765.7	747.0	707.1	709.9	697.6	684.7	689.6

d) Non-Core/Flexible Workforce

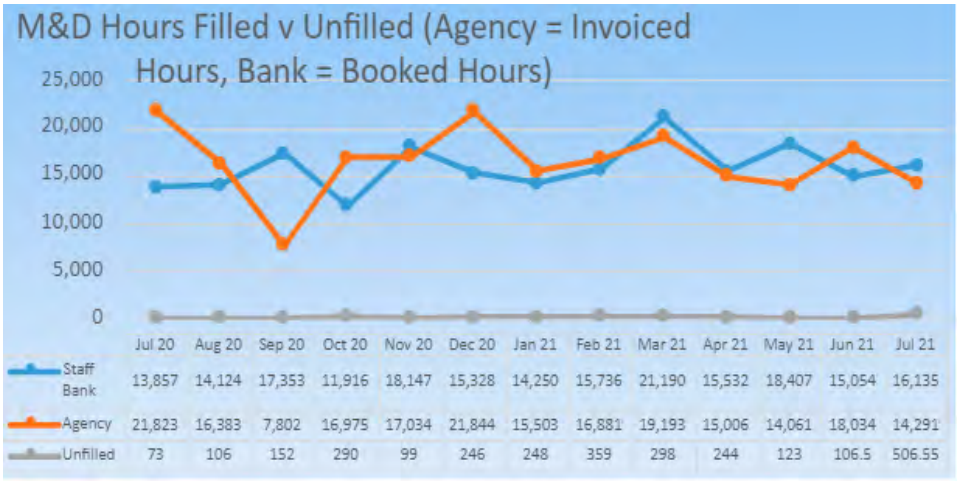
Table 6. Register Nursing Hours Filled vs Unfilled



	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Bank	16,160	14,580	13,078	16,703	16,573	14,356	18,722	18,958	22,137	21,013	16,410	15,014	17,201
Agency	29,970	30,642	27,919	28,072	25,469	23,661	24,818	23,566	29,634	30,335	34,280	33,326	37,205
Unfilled	18,994	24,245	21,313	23,350	31,555	40,953	38,182	32,363	34,620	34,009	27,433	30,766	40,120

Table 6 shows the number of hours filled by bank and agency nurses and unfilled hours remaining each month across BCU. The figures for July 2021 show an increase in the hours filled by both agency and bank nurses. Some of the intelligence behind this indicates that whilst usage has gone up demand has increased with the gap in unfilled hours increasing also. This is monitored closely as fatigue across our substantive staff from supporting Covid19 starts to take an effect. Workforce are working to drive further recruitment to the bank which has seen an increase in numbers but these have been initially absorbed by the vaccination programme. As part of the planning for the vaccination workforce, we are moving from a register vaccinator led programme to an unregistered vaccinator led programme, which should release some register nurse capacity back into the system.

Table 7. Medical & Dental Hours Filled vs Unfilled



	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Staff Bank	13,857	14,124	17,353	11,916	18,147	15,328	14,250	15,736	21,190	15,532	18,407	15,054	16,135
Agency	21,823	16,383	7,802	16,975	17,034	21,844	15,503	16,881	19,193	15,006	14,061	18,034	14,291
Unfilled	73	106	152	290	99	246	248	359	298	244	123	106.5	506.55

Table 7 shows the number of hours filled by bank and agency doctors and unfilled hours remaining each month across BCU. As can be seen there has been an overall decrease in hours requested.

The balance in July saw hours filled by bank significantly outstrip hours filled by agency - this is being monitored and with the support of ongoing initiatives such as the work with the Doctors in Training Bank which will supply additional junior doctors to support our existing bank, we aim to keep increasing the bank fill in comparison to the agency fill going forward.

e) Attendance & Availability

At the last Finance and Performance Committee meeting it was requested that information around how carried forward annual leave pressures for 21/22 were impacting across the Health Board. As shown in table 8 below for the current position for the different staff groups. The average position across the whole of the Health Board stands at 27% of scheduled leave expected to be utilised in the period has either already been taken. This leaves a gap of 6%. Workforce teams are monitoring this closely and are working with areas to ensure leave is taken both from a wellbeing and service delivery perspective. Given the pressure seen across the Health Board through the first 4 months of the 2021 and the expected pressures as we move into the autumn/winter period, the workforce teams in collaboration with operational teams and Trade Unions will be looking at what initiatives can be put in place support staff and services to keep a balance between leave taken and service delivery to ensure the wellbeing of both patients and staff.

Table 8. - Staff Annual Leave to end of July 21

Staff Group	% of Annual Leave Taken	1st Apr - 31 Jul Proportion	Difference
Add Prof Scientific and Technic	24.25%	33.33%	-9.08%
Additional Clinical Services	27.20%	33.33%	-6.13%
Administrative and Clerical	26.07%	33.33%	-7.26%
Allied Health Professionals	28.28%	33.33%	-5.06%
Estates and Ancillary	26.69%	33.33%	-6.65%
Healthcare Scientists	15.91%	33.33%	-17.42%
Nursing and Midwifery Registered	28.32%	33.33%	-5.02%
Students	1.59%	33.33%	-31.75%
Grand Total	**26.97%**	**33.33%**	**-6.36%**

Table 9 shows the sickness absence rate for the Health Board split by Non Covid19 related and Covid19 related as at 31 May 2021.

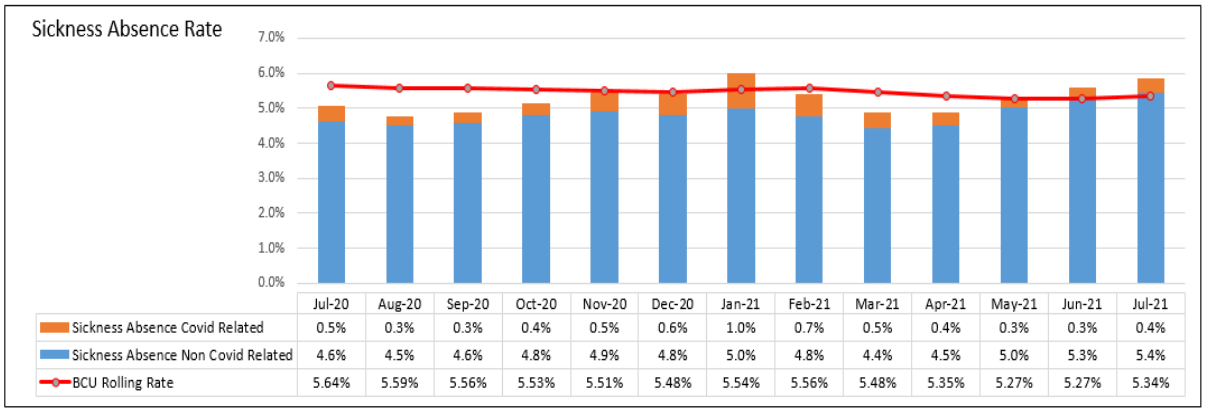
Covid19 related absence decreased steadily over 2021 from 1% in January to 0.3% in June but has seen a slight increase to 0.4% in July. In addition, Non Covid19 related absence also increased from May to July. Whilst the Non Covid rate decreased across the first quarter of 2021 (Average 4.6%) it

has started to increase again across the second quarter. (Average 5.2%) and is now higher than the same period in 2020 by 0.8%, this is now an ongoing rise as the impact of the sustained pressure over 2020/21 starts to be felt. Work is underway both nationally and locally to put measures and further plans in place to address this and mitigate the risks associated with increased physical and mental ill health as well as the potential increase in turnover and subsequent pressure on remaining staff.

The capacity of managers, workforce and occupational health teams to support “regular” sickness management has continued to be impacted by the continued pressure of the pandemic and vaccination programme. Cases are being prioritised to ensure that those long-term cases requiring resolution and the highest risk cases continue to be covered.

The commencement of the Strategic Organisational Development Route map is a key element to maintaining resilience and wellbeing of our staff. The discovery phase of ‘Stronger Together’ started in March and is progressing well.

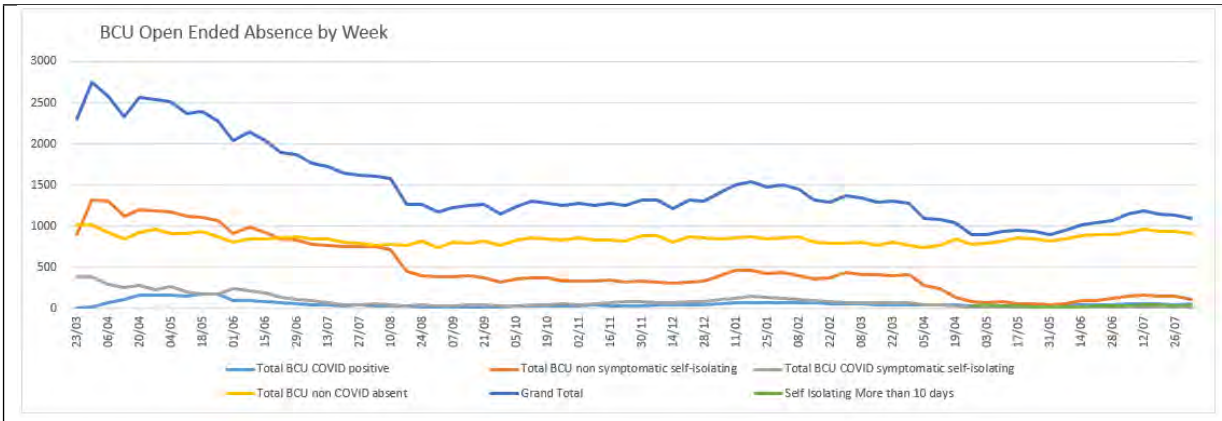
Table 9. – Sickness absence rate



	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Sickness Absence Covid Related	0.5%	0.3%	0.3%	0.4%	0.5%	0.6%	1.0%	0.7%	0.5%	0.4%	0.3%	0.3%	0.4%
Sickness Absence Non Covid Related	4.6%	4.5%	4.6%	4.8%	4.9%	4.8%	5.0%	4.8%	4.4%	4.5%	5.0%	5.3%	5.4%
BCU Rolling Rate	5.64%	5.59%	5.56%	5.53%	5.51%	5.48%	5.54%	5.56%	5.48%	5.35%	5.27%	5.27%	5.34%

Table 10 below shows both Covid19 and non-Covid19 related absence by week since w/c 23 March 2020. This information, was used as part of the modelling being undertaken to underpin the plan for 2021/22 and ongoing as part of the plan refresh at the end of May 21 and will be used to inform delivery throughout 21/22. It is also used to inform the forward modelling work carried out across the operational teams and is utilised with the Intelligence Cell to support projections around Covid19 and its potential impact on the Health Board.

Table 10. – Total Covid19 and Non Covid19 Open absence by week



Since the last report in May, we have seen a steady rise in staff positive cases with a slight dip in the last week of July. As we move through the summer months and into autumn this is something that is high on workforce's radar. Whilst the positive impact of the vaccination programme is being seen, we are actively monitoring all areas and sites closely with the advent of the Delta variant across the Northwest of England and the relaxation of mask wearing and social distancing across North Wales.

Table 11 shows the profile of testing and all results and Table 12 shows positive cases split by geographical Area in terms of acute, primary, and other BCU units. This information allows workforce to better understand the availability of staff and is being used to inform the modelling for planning purposes.

Table 11. – Covid19 Testing and case profile for BCU Staff

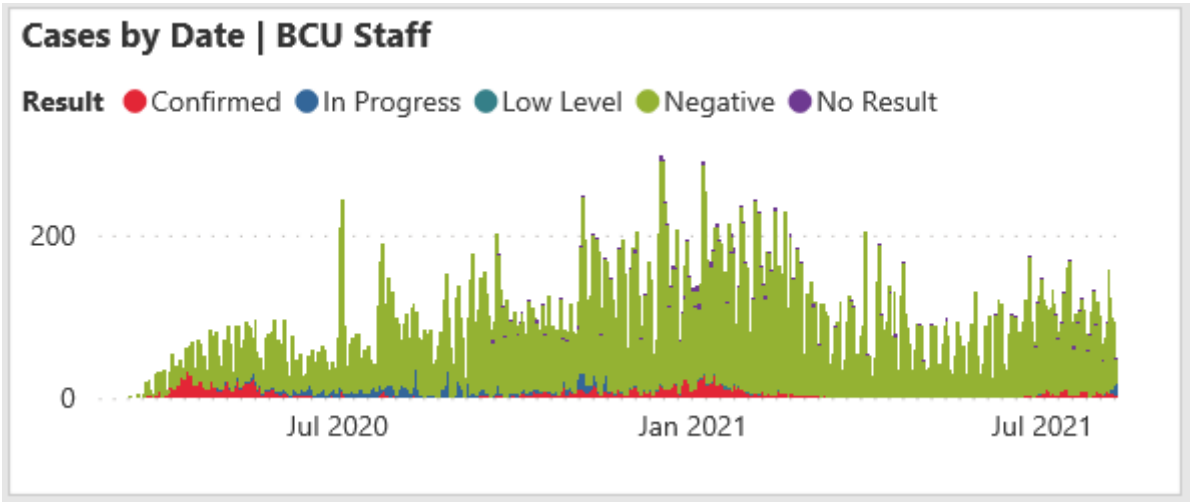
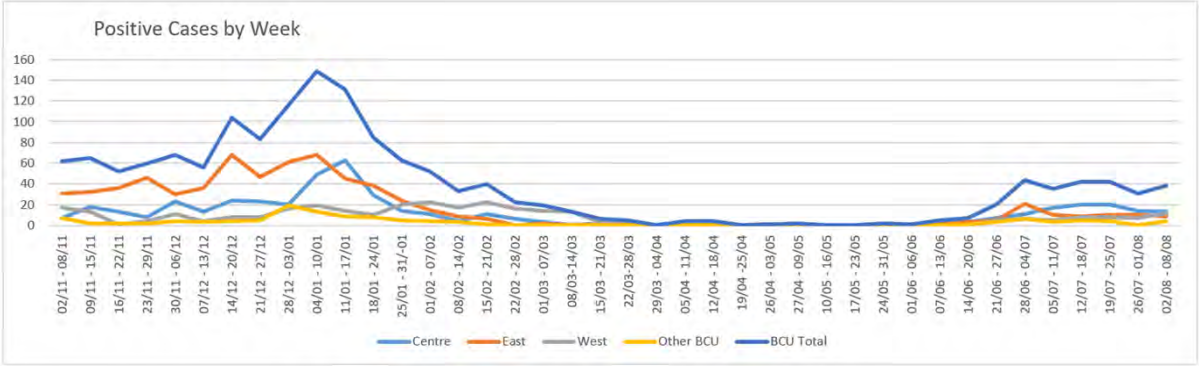


Table 12. – Covid19 Positive Cases by week for BCU Staff



A key element to ensure attendance of staff and provide protection for themselves and their patients is the staff Covid19 vaccination programme. For the Health Board staff, we have applied the Clinical Guidelines based on the Green Book and in line with national policy.

The Health Board has:

Offered vaccinations to 100%:

- Group 2 BCU frontline workers
- Group 3 BCU non Direct Patient Care (DPC) staff 75 years and over
- Group 4 BCU non DPC staff 70 years and over and clinically extremely vulnerable

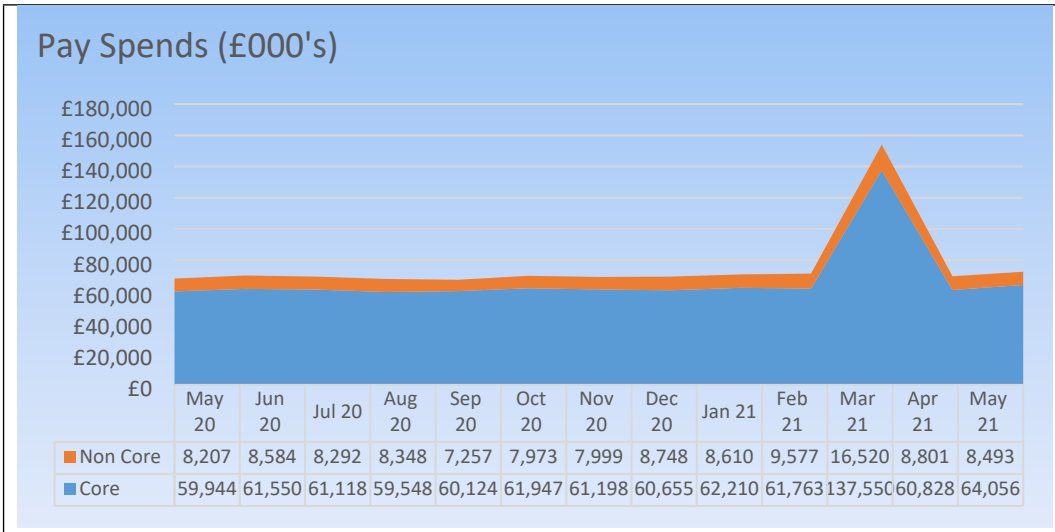
As of end of July 2021, the following position in terms of first and second dose vaccinations for staff can be seen in table 13 below. In total, 20584 staff have received first and second dose vaccinations of which 2982 are bank or locum workers. The percentages of permanent and fixed term temporary staff receiving their 2nd dose has increased from 83.4% in May to 88.7% by the end of July. For bank and locum staff this has increased from 62.1% to 71.4% across the same period.

Table 13: Staff Vaccination Position in numbers and as a % total of staff and bank workers

Assignment Category	Vaccinated 1 Dose		Vaccinated 2 doses	
Permanent, Fixed Term Temp, Non Execs	767	4.0%	16835	88.7%
Bank, Locum, Honorary	230	6.0%	2752	71.4%
Grand Total	**997**	**4.4%**	**19587**	**85.8%**

f) Pay Spend across all areas

Table 14. Pay Spend across BCU – Core & Non-Core



	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Non Core	8,207	8,584	8,292	8,348	7,257	7,973	7,999	8,748	8,610	9,577	16,520	8,801	8,493
Core	59,944	61,550	61,118	59,548	60,124	61,947	61,198	60,655	62,210	61,763	137,550	60,828	64,056

Table 14 shows the total pay spend across BCU and the proportion of core spend against non-core spend. This has remained reasonably static across the last 12 months with the sharp rise in March attributed to pay increases and bonuses, which were funded directly by Welsh Government.

The position in July 2021 was that non-core pay spend accounted for 12.2% of the overall pay spend across BCU, this is a slight increase from May (11.7%). The current high level of additional hours worked by existing staff as a result of Covid19 can account for a large part of this high proportion, and ongoing the planned care recovery programme will see additional hours worked by planned care teams to reduce the backlog. This is something that Workforce is aware of and is working with teams to look at ways to ensure the impact on staff working non-core hours can be balanced where possible.

2) Workforce Systems & Processes Performance

a) Recruitment

The scope of the Organisational Recruitment Improvement Review is being finalised in conjunction with an independent Improvement Practitioner. The review will cover the end to end process and will involve key leads for each of the stages as well as enabling teams, i.e.:

- ✓ Local and recruiting managers;
- ✓ Senior clinical and operational leaders;
- ✓ Workforce planning and recruitment;
- ✓ Workforce information;
- ✓ Clinical education leads e.g. medical, nursing, therapies and health sciences;
- ✓ NNHS Shared Service Partnership;
- ✓ Finance
- ✓ New recruits

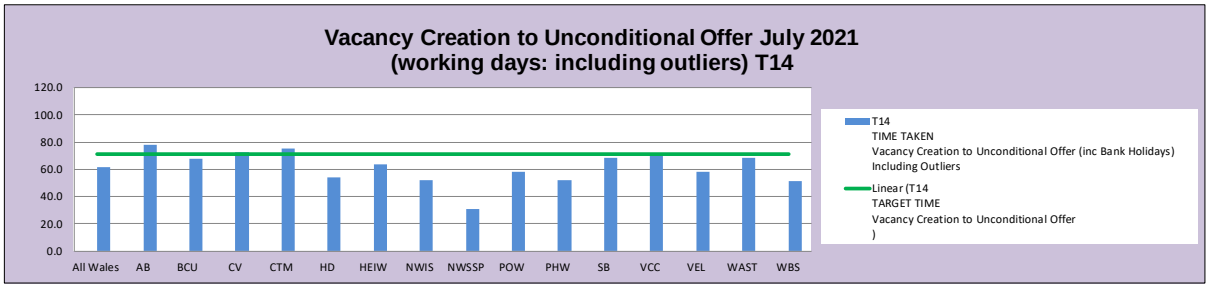
The Improvement Review will initially be overseen by a subset of the Executive Team with the “kick off” session planned for week commencing 13 September. Stage 1 will be current state mapping and immediate improvements (quick wins). Each stage will be undertaken within a 30-day block, with 30/60 and 90-day improvements identified at each stage.
The importance of collaborative current state mapping and co design of organisational wide improvements and local tests of change cannot be underestimated. Clarity of accountability for improvement, identify, delivery metrics and outcome measures will be essential in ensuring the design principles of the organisation, most importantly making it easier for people to do the right thing

and empowering decision making at the right place, time are embedded within the processes moving forward.
Progress against this Improvement Review will be reported to future committee meetings.

Alongside this review, the workforce recruitment team has been working with the Assistant Director for Nursing Workforce and other senior clinical colleagues to develop the Workforce Recruitment Business Intelligence (BI) dashboard seen below in Table 18. This new tool provides visual metrics, which outline vacancies and recruitment activity across the Health Board. A more in depth presentation of this work will presented at the November committee meeting.

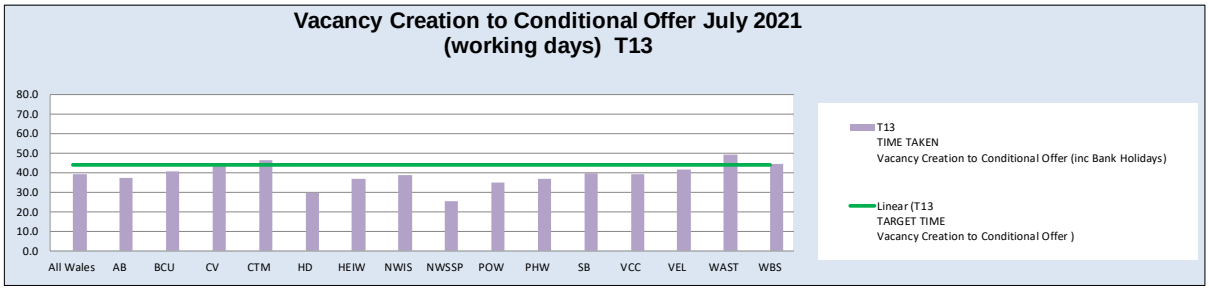
The recruitment data included within the report is presented for the Committee to understand where BCU sits in comparison to other Health Boards. The NHS Wales Shared Service Partnership provides this information.

Table 15. - Vacancy Creation to Unconditional Offer



As can be seen in Table 15 BCU is below the target time in terms of vacancy being created to an unconditional offer being made to a candidate. This is an improvement from May where we were on the target time. We also outperform or are on par with a number of Health Boards across Wales. We are starting to work internally to improve our performance as outlined below in Table 17. Ongoing we the Improvement Review outlined above will enable the Health Board in demonstrating best practice.

Table 16. Vacancy Creation to Conditional Offer



As can be seen in Table 16 BCU is below the target time in terms of vacancy being created to a conditional offer being made to a candidate. This is still in line with May's performance and we are still outperforming or are on par with a number of Health Boards of comparative size across Wales.

Whilst overall performance against key performance indicators (KPIs) is positive compared to other Health Boards, We are clear that there are still critical improvements required. Table 17 below shows the internal performance indicators split by steps in the process. This shows through external validation of the need for the Health Board to secure significant improvement in the first step Time from Notice to authorisation start date. This, we have started to do with the figure in July down to

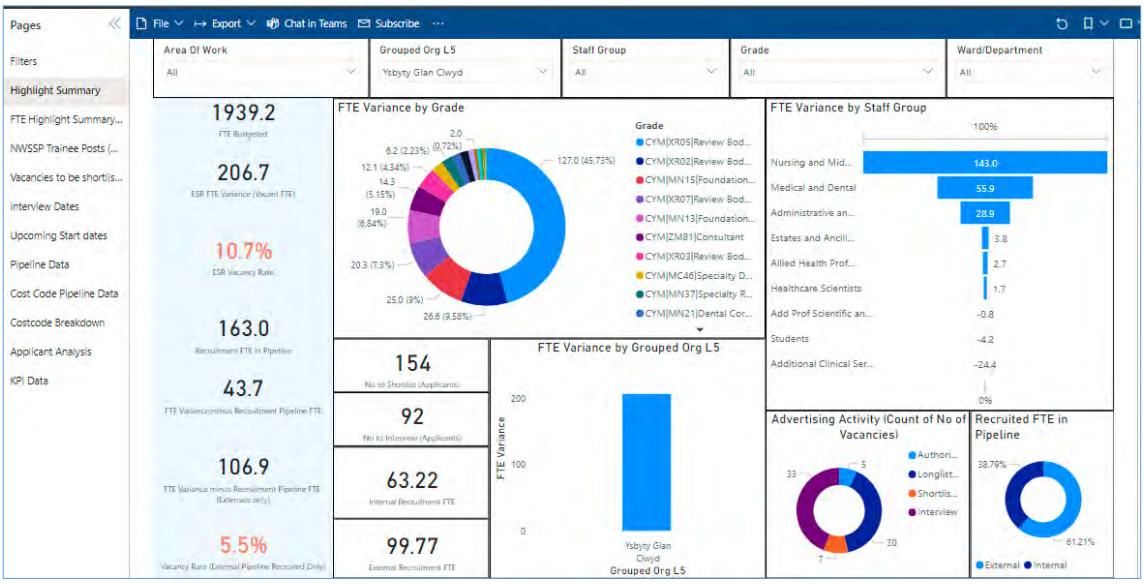
48.4 days as compared to 52.7 days in May. We know there is still a long way to go in the scope for improvement as well as working to improve across the end-to-end process.

Table 17. Recruiting Managers Key performance Indicators

Recruiting Managers Key Performance Indicators

		Average Time in Working Days	
Trac Report Code	**Trac Recruitment Health Check**	**Target**	**Jul-21**
T0a	**Time from Notice to Authorisation Start Date**	**5**	48.4
T1a	**Time to Approve Vacancies**	**10**	4.0
T4	**Time to Shortlist**	**3**	6.7
T5b	**Time to notify Recruitment of Interview Outcome**	**3**	4.8
T7	**Conditional offer to ID appointment Booked**	**3**	1.7
T7c	**ID appointment attended to DBS form submitted**	**1**	5.6
T9b	**Time to approve references**	**2**	2.1
T9c	**Time to obtain all References**	**4**	4.8
T13	**Time from Vacancy Requested to Conditional Offer Letter Issued**	**44**	41.1

Table 18. Workforce Recruitment BI Dashboard



b) Resourcing

The Enhanced Contract Management process is now embedded to ensure the Health Board only uses interim appointments for the minimum amount of time required and ensures that the link between interims and vacancies is monitored. This information is triangulated with the recruitment dashboard and going forward this gap will be minimised to ensure interims are only used when absolutely required across the Health Board for the least amount of time.

As the vaccination booster programme progresses the resourcing team together with area vaccination teams have carried out a rolling recruitment programme and have specially organised a one stop recruitment shop programme that will allow the Health Board to fast track non-registered vaccinators into the programme to support the booster programme and deliver a workforce ready to be mobilised to allow registered vaccinators to return to other roles within the Health Board. These events are scheduled for August to ensure there is a team in place to start delivering the booster programme from mid-September onwards if required. To date the rolling programme has 17 applicants at offer stage, 93 at interview stage and 45 at shortlisting stage across a range of roles to support the booster programme. In addition to this, there are currently 51 applicants for the initial recruitment event being held on Monday 23/08.

Strategy Implications

The effective management and deployment of our workforce is a critical enabler (as well as a driver) in the delivery of our strategic priorities. The alignment of our workforce with the core purpose of the Health Board is a foundation of the Workforce Strategy 2019-2022 and the Strategic Organisational Development Route Map referenced in the body of this report.

Financial Implications

The financial implications associated with the content of this report are reported within the Finance Report.

Risk Analysis

Workforce risks are set out within the Board Assurance Framework and Corporate Risk Register. There are no additional risks arising from the content of this report.

Legal and Compliance

The processes in place supporting the elements described in the body of this report are compliant with both legal and regulatory requirements.

Impact Assessment

Each element described in the body of this report is subject to review to identify and address the implications and opportunities to promote equality across staff with protected characteristics.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Residential Accommodation – proposal to move to a managed services model**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson - Executive Director of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Rod Taylor – Director of Estates and Facilities
Craffu blaenorol: **Prior Scrutiny:**	The Health Board previously approved the development of a strategic outline case for residential accommodation in support of delivering affordable and fit for purpose staff accommodation on all three acute hospital sites. The Health Board approved the strategic outline case at its meeting on the 21st of January 2021 for submission to Welsh Government for approval. Following formal feedback from Welsh Government in a letter dated the 29th of April 2021, Welsh Government confirmed that the Health Board would need to re-consider "alternative ways of funding non-core developments" due to significant pressures on the All Wales capital over the next five years. A Board development session was held on the 3rd of June 2021 to debate further options for the management and redevelopment of residential accommodation. Recommendations contained within this report are aligned with the approach agreed at the Board development session in regards to progressing a new delivery model for residential accommodation.
Atodiadau **Appendices:**	Appendix 1 Letter from Welsh Government dated 29 April 2021.

Argymhelliad / Recommendation:

The Finance and Performance Committee is asked to approve the following recommendations :

1. To **approve** the procurement proposal for a residential accommodation managed service model as detailed within this report.

2. To **note** the continued opportunities to work collaboratively with local social housing providers in developing the service specification.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	**x**	**Ar gyfer Trafodaeth For Discussion**	**x**	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**Y**	

The overall aim of the duty is to deliver better outcomes for those who experience socio-economic disadvantage, so this will need to be factored into any decision around future models for the residential accommodation.

Sefyllfa / Situation:

The purpose of this report is to seek approval to progress a managed service accommodation model for Health Board provided residential accommodation.

This new proposal is being considered following discussions with Welsh Government in regards to considering "alternative ways of funding non-core developments" due to significant pressures on the All Wales capital over the next five years.

Recommendations contained within this report were debated at a recent board development session to deliver improved Health Board provided residential accommodation through a revenue funded managed services model.

Cefndir / Background:

This report presents recommendations to move to a revenue funded managed service accommodation model to improve Health Board provided accommodation.

The scope of the accommodation model includes doctors in training, medical students, on-call doctors and locums as well as allied-to-medicine staff and students.

The Health Board's existing portfolio of residential accommodation is in a poor state of repair and requires significant levels of investment to redevelop the estate to make it fit-for-purpose and compliant.

There are five key strategic drivers for change:

1) The residential estate is not compliant with national standards for residential accommodation. Furthermore, the building configuration of some of the existing stock means that required ratios of occupants to toilet, shower, living and dining room facilities will not be met.

2) The estate is failing to deliver modern, energy efficient and fit-for-purpose facilities and backlog maintenance is high. The accommodation has therefore been identified as a key area of risk for the Health Board and is one of its priority areas for investment over the coming three years.

3) The estate is failing to support the Health Board's objectives in relation to attracting and retaining high quality staff. A residential accommodation user survey at the Health Board has

confirmed that the accommodation is viewed in a very poor light, and that this is a potential disincentive in staff coming to work in the area.

4) Current capacity is not well aligned to demand, in terms of both the amount and type of capacity.

5) Welsh Government has confirmed that All Wales capital is fully committed and therefore to address improvements within the Health Board's accommodation will require an alternative funding solution.

Given the strategic drivers outlined above, the Health Board has concluded that the current condition of residential accommodation is unsustainable, and that business as usual is not an option going forward.

The preferred way forward is a procurement process to appoint a preferred partner to deliver a managed services accommodation model that will manage, maintain and modernise the Health Board's residential accommodation over a five-year period.

The procurement timeline to deliver the preferred option is detailed as follows:-

- Specification and market consultation (PQQ) – three months
- OJEU notice and tender returns – two months
- Tender evaluation – two months
- Health Board and Welsh Government approvals – three months
- Contract award – one month
- Mobilisation and contract commencement – two months

Delivering the preferred way forward will not require capital funding from Welsh Government. Costs associated with a managed service model will be revenue based and summarised in the following key areas

1. Contract management fee (percentage to be determined within service specification and tender evaluation).
2. Accommodation occupancy guarantee – this is typically set at around 90% occupancy (note: the Health Board's existing accommodation generally runs at >90% occupancy).
3. The Health Board will forgo current rental income, as this will be retained by the preferred management partner.

Following approval of the recommendations contained within this report project governance arrangements will be established to deliver the programme and procurement timelines as detailed above.

The proposed management service specification will be developed in consultation with the Health Boards regional Social Housing Providers to ensure collaborative opportunities are considered.

Asesu a Dadansoddi / Assessment & Analysis

Strategy Implications

This project is one of the Board's priority areas for estates investment over the next three years and is crucial to the delivery of its Living Healthier; Staying Well strategy, particularly in relation to "recruiting and retaining of high-calibre clinical and nursing staff".

This paper seeks to highlight the importance of:

1. Meeting Welsh Government and British Medical Association (BMA) standards for residential accommodation;
2. Delivering high quality, sustainable services through attracting workers to the region, investing in them, and keeping them;
3. Planning and managing the Health Board's estate to provide fit for purpose facilities that are financially sustainable;
4. As the largest employer in the region, operating as an 'exemplar' for looking after its staff and working in partnership across the public and third sector to improve health and wellbeing, develop stronger communities, generate sustainable economic development and reduce inequalities in North Wales.

The Estates strategy sets out investment requirements over a 15+ years planning horizon and priorities and implementation plans for the next three years. The strategy sets these proposals for residential accommodation within a broader estates investment context.

The Estates strategy identifies residential accommodation as one of the Health Board's key areas of challenge/risk from an estates perspective, and as one of its investment priorities for the next three years.
Wales has a net outflow of workers and there are recruitment shortfalls in a number of professions and specialties. In response to these challenges, Welsh Government has set out clearly the strategic importance it places on recruitment and retention of high-quality NHS staff. It has also made clear that it wants medical students to be trained in Wales and become qualified doctors residing and serving the population of Wales.
High quality, affordable accommodation is one factor that can help enable the Health Board achieve these ambitions.

Financial Implications

Delivering the preferred way forward will not require All Wales capital funding from Welsh Government.

Costs associated with a managed service model will be revenue based and summarised in the following key areas :-

1. Contract management fee (percentage to be determined within service specification and tender evaluation).

2. Accommodation occupancy guarantee – this is typically around 90% occupancy.

3. The Health Board will forgo current rental incomes (£0.985m) as this will be retained by the preferred management partner.

Risk Analysis

Major risks associated with this report are summarised as follows :-

1. Residential accommodation has significant risks in regards to backlog maintenance and compliance.
2.
The Health Board's accommodation does not comply with the BMA Minimum Standards for Hospital Accommodation.

The Health Board's accommodation does not support the recruitment and retention strategy in regards to workforce planning.

The proposals contained within this report seek to lower the current risk score, which is recorded on the Health Board register.

Legal and Compliance

Failure to comply with Health and Safety legislation could leave the Health Board exposed to enforcement action and litigation.

Impact Assessment

An EIQA will be included within the development of the specification and procurement process.

Attachments

Appendix 1 – Welsh Government letter dated 29th of April 2021.

Ian Gunney
Deputy Director, Capital, Estates & Facilities
Cyfarwyddiaeth Cyllid/Finance Directorate
Y Grwp Iechyd a Gwasanaethau Cymdeithasol/Health & Social Services Group
Llywodraeth Cymru/Welsh Government

Llywodraeth Cymru
Welsh Government

Jo Whitehead
Chief Executive
Betsi Cadwaladr University Health Board
Block 5, Carlton Court
St Asaph Business Park
St Asaph
LL17 0LG

Our Ref: IG/RB2021-22
29 April 2021

Dear Jo,

Nuclear Medicine – Strategic Outline Case (SOC)
Residences – Strategic Outline Case (SOC)

I am writing to you following the submission to Welsh Government of Strategic Outline Cases for the proposed Centre for Nuclear Medicine and for Residences. I wanted to clarify the current status and need for the Health Board to consider further work in respect of these proposals.

Nuclear Medicine – Strategic Outline Case (SOC)

A paper was taken to the Infrastructure Investment Board in January where concerns were raised about the proposal. These concerns primarily related to how the scheme would align to other capital business cases and proposals being developed by the Health Board.

Whilst the SOC did not identify a preferred site (other than it either being Wrexham Maelor Hospital or Ysbyty Glan Clwyd), concerns were raised how this would fit with the wider plans being considered for Wrexham Maelor Hospital in particular should this be identified as the preferred location.

Questions were also raised around fit and potential duplication with the proposed Diagnostic and Treatment Centres (DTCs). When we met to discuss the DTCs on 22 April, the DTC SOC references all three acute hospitals continuing to provide diagnostic tests which raises a number of concerns including the ability to appropriately staff.

Residences – Strategic Outline Case (SOC)

The Residences SOC was submitted in March with the preferred option being £56m capital funding from the All Wales Capital Programme. You will be aware of the significant pressures on the capital programme going forward and as a result,

organisations will be challenged to look for alternative ways of funding non-core developments such as this.

Given continued interest by Housing and RSL partners to deliver key worker accommodation, the Health Board will need to look at alternative solutions such as these in order to make progress. I am aware that revenue options have been looked at in the past, but alternative funding routes need to be considered, potentially with other Health Boards who are facing similar difficulties.

I hope this helps to clarify the Welsh Government position with both of these business cases and I am happy to arrange a meeting to discuss if it would be helpful or to pick up through the scheduled Capital Review Meetings.

Yours sincerely

Ian Gunney

cc: Simon Dean
Mark Wilkinson
Sue Hill
Neil Bradshaw
Ian Howard
Samia Saeed-Edmonds
Olivia Shorrocks
Nicola Powell

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Welsh Community Care Information System Business Case (WCCIS)**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Chris Stockport, Executive Director Primary Care & Community Services
Awdur yr Adroddiad **Report Author:**	Bethan Jones, Project Sponsor, Area Director Central Christine Couchman, (Programme Manager) Tracey MacGillivray, Project Manager
Craffu blaenorol: **Prior Scrutiny:**	*The Full Business Case has previously been scrutinised by:* *WCCIS Project Board* *Chief Information Officer* *Chief Finance Officer* *Health Board Review Group and* *Executive Team*

Argymhelliad / Recommendation:

The Committee is asked to approve the Welsh Community Care Information System (WCCIS) updated Revenue Business case to allow a phased implementation of the system across Community Services to enable a review of its functionality.

No additional funding is requested for the current financial year; however a scale up implementation across the Health Board would require an additional £1.1m annually for the three year implementation period and an additional £700k p.a for ongoing support costs post implementation. Capital costs for devices will be requested through discretionary IT Capital bids.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

An EQIA has been completed; an SED is not required for this business case

Sefyllfa / Situation:

This paper is presented to seek support for a phased approach to the implementation of WCCIS in order to review its functionality. BCUHB had originally planned to go-live with WCCIS in April 2017, on a profession by profession basis, but this was delayed due to issues including Inpatient functionality and interfaces to other systems.

It has previously been agreed that BCUHB should explore the options for progressing implementation despite the gaps in functionality, once key prerequisites were met. These pre-requisites, including interfaces to existing systems are now planned for delivery in Q3 of 2021/22. An options appraisal in early 2021, based on legal advice, concluded that while there were some advantages to seeking alternative solutions, the benefits of a collaborative solution remain attractive. Coupled with the fact that Welsh Government could ultimately require the Health Board to take up the national solution and are providing funding to accelerate progress, the recommendation was that BCUHB should persist with WCCIS, subject to revised contractual arrangements and a full review of the business case.

To fully explore the functionality of the system to support the transformation of our Community Resource Teams a prototype has been planned in partnership with our social care colleagues. This could be achieved through a contractual variation, limiting commitment to an initial 500 users, and can be supported from within the current budget, allowing a full evaluation of the solution through a gateway review before any scale up is considered; further commitment would be subject to approval by the project board.

Given the delay, the previously agreed budget has been reduced to around £720,000 p.a. This is sufficient to support the prototype implementation of up to 500 users. A review of the business case has identified that a scale up across the Health Board would require around £1.8m annually during the three year implementation phase, with post implementation support costs of just over £1.4m recurrently. This represents an increase of approximately £200,000 p.a. over the initial allocation, which can be attributed to an increased number of end users (Approximately 1,000 more than originally identified), a greater understanding of the support requirements, and inflation.

Cefndir / Background:

WCCIS is a once-for-Wales solution to allow better-integrated working across health and local authorities. The solution is being developed to facilitate joint case management and more effective sharing of care records to optimise services for citizens across Wales.

In January 2016, the Health Board approved the full business case for the programme, including the funding required to implement and support the product over the lifetime of the contract. Since that time, delays in the delivery of key functionality have meant that BCUHB have as yet been unable to progress implementation, and the agreed funding has been largely unspent, and subsequently reduced to £720k pa.

The WCCIS solution will provide a single electronic integrated record spanning across Health, Social Care, acting as an enabler to data sharing and joined up workflow across North Wales. Following the delays to the BCUHB implementation, four of the Local Authorities (Ynys Mon, Gwynedd, Conwy and Wrexham) have now progressed to using WCCIS from their original systems.

Concerns with the lack of a community solution have been identified several times, with a Healthcare Inspectorate Wales (HIW) and Care Inspectorate Wales (CIW) joint thematic review of Community Mental Health Teams (February 2019), and the National Assembly review into Community and District Nursing Services (August 2019) recommending the need for progress.

An updated business case has been produced to provide assurance of the continued business justification for the project, and to review and re-state the funding requirements for the revised implementation plan. The updated business case has been scrutinised by the WCCIS Project Board, Finance, Health Board Review Group and the Executive Team.

Asesu a Dadansoddi / Assessment & Analysis

Strategy Implications

The Strategic Case demonstrates how the proposed investment fits within the existing business strategies of the Health Board, and establishes a compelling case for change to the existing methods for supporting the delivery of excellent patient care. The proposal aligns with a number of National, Local and Informatics Strategies: the Welsh Government's published digital strategy – Informed Health and Care – A Digital Health and Social Care Strategy for Wales (December 2015), *Living Healthier, Staying Well (LHSW) and* the BCUHB Informatics 'Our Digital Future' Strategy

Options

Following an options appraisal, the preferred Option "***To continue to work with the supplier and the National Team, seeking to implement V5 at the earliest opportunity once key interfaces are available, using a phased approach to scale-up as new functionality is released"*** has been agreed. A "Community Resource Team" contract, supporting up to 500 users, will enable the prototype, allowing an assessment of the functionality before a full contract is agreed.

Financial Implications

Ongoing delays have meant that BCUHB have incurred costs equating to just under £1.5m for the 5 years 2016-2021, with approximately half covered by grants. This was to support both the initial planning and readiness phases and ongoing engagement to address functionality issues.

The roll out of devices has been expedited over the last 12 months to support the Covid response (using both IT Capital and grant funding), but additional devices (laptops / smartphones / tablets) will be required to complete the rollout. Additional Capital funding to support these requirements will need to be supported through discretionary IT Capital bids over the periods 2022-2024, at an anticipated cost of approximately £1,612,000.

The previously approved allocation for WCCIS has been reduced due to project delays and the remaining allocation of £720,000 pa will not be sufficient to fully implement the solution as described. Approximately £1.8m will be required from 2022/23 annually for the full three year implementation period (an increase of £1.1m), with an ongoing commitment of around £1.4m pa from 2025. Capital costs for devices will be requested through discretionary IT Capital bids.

Whilst this currently represents a cost pressure to the organisation, national grants such as the Integrated Care Fund and Digital Priorities Investment Fund are being sought at every opportunity. This case is presented as an organisation cost pressure, providing an opportunity to invest in the modernisation of our community, therapies and mental health services.

Dadansoddiad Risk / Risk Analysis

The business case highlights a number of risks, including both Health Board Project risks, these include:

- The risk that patient information remains siloed resulting in a delay to the delivery of health and social care integration (Care Closer to Home)
- The risk that the supplier will fail to deliver the statement of requirements
- The risk that existing legacy systems are stand alone and managed by the individual services
- The original statement of requirements may not address business needs over future years
- The use of a mixed economy of patient records will not meet the requirements of the Informatics Digital Strategy
- Welsh Government could require that BCUHB implements WCCIS

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Delivery of Primary Care Audiology Services – business case**
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director of Primary Care
Awdur yr Adroddiad Report Author:	John Day, Clinical Director of Audiology Jane Wild, Consultant Clinical Scientist (Audiology)
Craffu blaenorol: Prior Scrutiny:	Executive Team (14th July 2021) - Approved Business Case Review Group (Nov 2020) - Approved
Atodiadau Appendices:	Appendix 1 Full business case – Ver 4.7 (6th November 2020) Appendix 2 Equality Impact Assessment August 2021 Appendix 3 Socio-Economic Disadvantage impact Assessment August 2021

Argymhelliad / Recommendation:

The Committee is asked to approve implementation of a Primary Care Audiology Service across North Wales, as described within the health board annual plan for 2021/22.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**Y**

EqIA and SED assessments are included in the appendices.

Sefyllfa / Situation:

This paper describes the proposal for extension of Primary Care Audiology services across North Wales, providing background/strategic context. It seeks approval for commitment of funding to progress the plan of implementation that has been endorsed by the Executive Team.

Cefndir / Background:

Primary Care Audiology services feature first point of contact Advanced Audiology Practitioners in Primary Care. The transformational and NHS Wales award winning service model features people presenting in primary care with hearing, tinnitus and balance conditions being assessed and managed by an Audiologist rather than a GP. This offers benefits of; releasing GP capacity, increasing accessibility, providing specialist care closer to home and providing a more integrated care pathway for people presenting with hearing related health conditions. The expanded pan-North Wales service will include an Audiology led, managed and delivered earwax management pathway, within primary care settings.

Implementation of this scheme will ensure that the Health Board complies with specific Welsh Government directives (Welsh Health Circulars inc WHC2020/014) relating to primary care Audiology and assuring consistent access to NHS earwax management services across North Wales.

There has been engagement with The North Wales Community Health Council and the Regional Partnership Board, who have received briefing presentations with opportunity to comment on advanced practice primary care audiology and earwax management. There is widespread stakeholder support for roll-out of the proven/tested service model across North Wales.

For further information, please refer to the business case, which describes a progressive roll out of the service across North Wales, over a 3 year period, with associated funding commitment.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

This proposal is listed (p29) as a Performance Fund scheme within the Health Board's Annual Plan 2021 to 2022. The scheme has been identified as addressing the following key priorities for the Health Board:

- Primary and Community Care
- Making effective and sustainable use of resources
- Transformation for improvement
- Strengthen our wellbeing focus
- Recovering Access to timely planned care

Establishment of Primary Care Audiology is a health board action in the Welsh Government '*Framework of Action for Wales (2017 -2020/23) – Integrated framework of care and support for people who are D/deaf or living with hearing loss'.* This framework links to the Well-being of Future Generations (Wales) Act 2015, the Social Services and Well-being (Wales) Act 2014, the Primary Care Plan, and Planned Care Ear Nose and Throat Plan

The scheme is therefore closely aligned with specific Welsh Government policy actions for these prevalent and significant health conditions and more general policy objectives, such as delivering care closer to home. For further strategic context, please refer to the business case.

Reference: https://gov.wales/sites/default/files/publications/2019-03/integrated-framework-of-care-and-support-for-people-who-are-d-deaf-or-living-with-hearing-loss.pdf

Opsiynau a ystyriwyd / Options considered

Section 3.3 of the business case describes a full option appraisal.

Goblygiadau Ariannol / Financial Implications

With approval to implement received in August, there would be some non-recurrent expenditure from September with pay cost likely incurred from November onwards, with total in year cost of 220K (see table below). Subsequent and full year costs are detailed within the business case, section 4.0. Figures provided by Finance.

Scheme costs 21-22

21-22	FYE Phase 1	August	September	October	November	December	January	February	March	Total
Existing NR Funding	-304,879	-25,407	-25,407	-25,407	-25,407	-25,407	-25,407	-25,407	-25,407	-304,884
Band 8 a	169,926	14,160	14,160	14,160	14,160	14,160	14,160	14,160	14,160	169,920
Band 7	232,984	11,180	11,180	11,180	19,415	19,415	19,415	19,415	19,415	175,336
Band 5	237,503	0	0	0	19,792	19,792	19,792	19,792	19,792	98,960
MSE & Consumables	76,800	0	0	0	6,400	6,400	6,400	6,400	6,400	32,000
Recurrent Cost	**412,333**	-67	-67	-67	34,360	34,360	34,360	34,360	34,360	171,332
Non Recurrent Set Up costs	48,733			19,493	29,240					48,733
Total 21-22 Costs - Phase 1	**461,066**	-67	-67	19,426	63,600	34,360	34,360	34,360	34,360	**220,065**

Full scheme costs and implementation timelines

	Additional recurrent funding required	Additional non recurrent funding required	Total additional investment required	Population coverage for both elements of scheme
Existing funding	304,879			25%*
21-22 Phase 1 FYE	412,333	48,733	461,066	50%
22-23 Phase 2	347,889	48,733	396,622	75%
23-24 Phase 3	347,891	48,733	396,624	100%
Total Rec Investment	1,412,992			

**current service only covers first point of contact advanced practice audiology in PC and not wax management pathway*

Dadansoddiad Risk / Risk Analysis

Please see Section 6 of business case.

Keys risks and mitigating measures:

Lack of funding for sustainable service delivery - It is critical that core funding is identified at the outset for the scheme to continue and expand according to the implementation plan. The scheme is well regarded by the public, primary care colleagues and has been commended by Welsh Government.

Implementation compromised by difficulties of recruitment - Expansion plans to extend and deliver the service across the Health Board will be phased to allow for safe and effective implementation and recruitment.

Implementation compromised by poor understanding of new service model by stakeholders - Excellent relationships with GPs, practice managers and primary care teams have been developed and have been essential to the success of the scheme to date. These specific relationships will need to be continued and developed with other key stakeholders in primary care and through communication with service users.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Key deliverables, identified for this scheme within 2021-22 Annual Plan (p 29):

- Evaluation of existing services will continue to ensure a safe, effective and high quality service is delivered.

- Key performance data will be collected, analysed and shared routinely at a whole service level and locally within each practice or and/or locality. This will include:
  - Demand and activity
  - First point of contact (enabling more than 22,000 people each year to access Audiology)
  - Referral rates to ENT and audiology
  - Appropriateness of onward referral
  - Patients experience
  - Primary Care clinician experience

Additionally, a Benefits Realisation Action Plan (BRAP) has been completed (see Business case, Appendix 4), setting out the benefits of the project, the category of each benefit (in economic terms) how they will be measured and quantified, who is responsible for their realisation and what actions need to be taken and by when to achieve delivery of the benefit. The benefits included on the plan link to the relevant sections of the business case.

Asesiad Effaith / Impact Assessment

The service model is already tested in practice within the Health Board, managed within the Pan-Health Board Audiology service. Quality, data governance and Welsh language etc are considered within existing management teams and governance structures. In light of this, additional adverse impacts in these domains have not been experienced to date, or are anticipated. Equality and SED impact assessments are included in the appendices.

Division	North Wales Managed Clinical Services
Development or Scheme	**First Point of Contact Advanced Audiology Practitioners in Primary care to release GP capacity; increase accessibility providing specialist care closer to home and develop a more integrated pathway (Part A). Including an audiology led, managed and delivered earwax management pathway within Primary Care (Part B).**
Author/s	Jane Wild, Consultant Clinical Scientist, Head of Adult Audiology John Day, Consultant Clinical Scientist & Clinical Director of Audiology
Version	Final 4.7
Date	6th November 2020

1. Executive Summary & Recommendations

1.1 Vision

Part A: All people with hearing, tinnitus and specific balance difficulties in North Wales can access an Advanced Practice Audiologist as the first point of contact in a Primary Care location, enabling them to receive more specialist care sooner and closer to home and at the same time releasing GP capacity.

Part B: All people presenting with problematic earwax can access an integrated earwax management pathway delivered and managed by Audiology in Primary Care, that uses NICE recommended (microsuction) methods for the safe and effective removal of earwax (cerumen), enables onward referral as required and provides equity of access and care.

1.2 Purpose

This business case document makes recommendations based upon an evaluation of the established Advanced Practitioner Audiologists in Primary Care service. It describes the case to roll out the successful scheme to provide equity of access and realise the same benefits across BCUHB area (Part A). The business case also includes the management and delivery of the Wales earwax management pathway within Primary Care (Part B), providing a response from the health board to the recent Welsh Health Circular WHC/2020/014 Appendix 1.

1.3 Summary

Primary Care Audiology – First Point of Contact (Part A)

- Advanced Practice Audiologists are currently in place in 36 GP Practices (c25% coverage across North Wales) and to date has been funded using Primary Care Investment Funds. These funds are reducing in real terms as staffing costs increase through annual pay awards. A decision now needs to be made as to how the service will be sustainably funded and a plan developed for extension across BCUHB.

- There is an increasing demand on GPs and other Primary Care staff. This innovative service model has been proven in practice at BCU over the last 3 years. It releases GP capacity by making the Audiologist in Primary Care the first point of contact for many people with hearing, tinnitus and certain balance conditions.

- Hearing, tinnitus and balance difficulties are important and prevalent health conditions that, if unmanaged, have a significant impact on quality of life. They are often associated with aging and the demand for these services is increasing and likely to increase further as the population ages. Cost-utility analysis has shown that management of hearing loss with hearing aids is cost effective and good value (NICE NG98 Appendix N).

- The Advanced Practice Audiology service has proven highly successful, having been well received by patients and Primary Care professionals. The service model is award winning: winning the NHS Wales award 2018 within the 'developing a sustainable workforce' category and as a finalist in the 2019 UK Advancing Healthcare Awards within the 'Innovation in Healthcare' category.

- The scheme is in line with Prudent Healthcare Principles and National and Health Board Policy. Establishment of Primary care audiology is a health board action in the Welsh Government 'Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss'. The health board has been challenged by Welsh Government to progress roll out – See Appendix 2.

Primary Care Audiology - Earwax Removal (Part B)

- Problematic earwax effects many people with an estimated 4% of the population requiring earwax removal annually. Occluding ear wax can cause a variety of symptoms some of which can have a significant impact particularly for people with pre-existing unmanaged hearing loss and for those using hearing aids. Occluding ear wax will compound any pre-existing hearing ear difficulties and will reduce the benefit of interventions such as hearing aids.
- Wax removal services across BCUHB are currently variable and uncoordinated with services currently being provided by cluster based community nursing services; practice nurse clinics and with some areas having no service and people being signposted to private providers at a cost to the individual and leading to complaints and concerns raised by the CHC and SM/MP queries.
- Current wax removal services within BCUHB largely use ear irrigation as a method of removal which has risks associated and contraindications for use for a number of people. The recent Welsh Health Circular WHC/2020/014 (Appendix 1) outlining a national earwax management pathway suggests a move away from irrigation towards manual method of removal (including microsuction). Development of a national earwax management pathway is a health board action in the Welsh Government 'Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss'. The multisector North Wales Collaborative Care Group NWCCG (which includes CHC representatives), overseeing the implementation of the Framework in North Wales, identified the development of improved wax management pathways and equitable access to wax management services as a priority for North Wales. This was supported as a priority by service users across North Wales as part of a survey of priorities undertaken by the NWCCG.
- An Audiology led earwax management pathway is currently being piloted in Conwy East using Cluster funds. This pilot is in line with the WHC/2020/014, that is, being led and managed by the first point of contact advanced practice audiology service, being delivered by Audiologists and uses manual methods of earwax removal.
- This business case proposes that Audiology oversee the management and delivery of the new Wales Earwax Management Pathway in Primary Care, ensuring equitable access across BCUHB and delivery of an integrated pathway for those with problematic earwax. This is in line with the recent Welsh Health Circular WHC/2020/014 Appendix 1.

Advanced Practice Audiologists in PC are well placed to provide the clinical management and leadership of the new national earwax management pathway in primary care, overseeing the delivery of this new pathway by Audiologists. Therefore it would not be possible for Audiology to manage or deliver the new earwax management pathway laid out in the WHC/2020/014 without the implementation of the first point of contact Advanced Practice Audiologists in Primary care. **I.e. Part B of this business case is dependent upon the implementation of Part A**

1.4 Recommendation

The option appraisal within this business case identifies the extension of the Advanced Practice scheme and implementation of an Audiology led earwax management pathway across BCUHB as the preferred option, with roll-out over 3 years. Core funding from within Primary Care budgets needs to be identified to enable this service, and the benefits it brings, to be continued and extended. These benefits are summarised below:

• Release of GP and other Primary Care staff time – **the proposal will require investment but will release capacity in PC care (GP and nursing) and community nursing and so is considered cost neutral with the potential to be cost saving to the health economy**
• Improved access to specialist Audiology advice and management sooner and closer to home
• Patient pathway is shorter for more people
• Accessibility for people with hearing, tinnitus, specific balance conditions and earwax improves
• Equity of access and services across BCUHB for people with hearing difficulties, tinnitus, specific balance conditions and problematic earwax
• Complaints related to inability to access current earwax management provision are addressed
• An innovative and NHS Wales award winning service model, enhancing reputation of the health board
• BCUHB will comply with WG specific policy and planning actions for introduction of Primary Care Audiology across Wales (Integrated Plan for Hearing Loss 2017-2020), the Wales earwax management pathway WHC/2020/014 and NICE guidance (NG98).

COVID update/context: There is no expectation that the underlying epidemiology (and therefore presentation rates in the North Wales population) relating to hearing, balance, tinnitus and cerumen will change as a consequence.

1.5 Costs

Within Year Costs £(20/21) – part year costs, with scheme to commence Jan 2021

Total additional recurrent investment required Y1 for delivery from Jan 2021 (Q4 only) (412,333/4)	103,083
Non recurrent costs Y1	48,733
Total Additional Investment in 2021	**151,816**

Recurrent Costs Summary £– see section 5.2 below for detail

Current Budget	304,879
3 year recurrent Investment	1,108,113
Total Recurrent Costs	**1,412,992**

Whilst this business case outlines the additional costs required for Audiology to deliver these services it is important to recognise that these services are currently being delivered by others within the Health Board . As such, there is no net additional cost to the organisation but rather a movement of resources to enable the delivery of more clinically and cost effective pathways.

High level calculations indicate a £3.83 saving/advanced practiced audiology pathway compared to traditional GP pathway. There are currently 700 pathways/month across approx. 25% of BCUHB GP practices. This would equate to a net annual saving across BCU of >£10,000

1.3 Approval Process

Original submission of business case in February 2020 for consideration within BCUHB future development (20/21) discussions.
Concept presented to Regional Partnership Board (RPB) January 2020.
Business case presented to and supported by Area Quartet Team 02/09/2020 and PC Senior Management Team

Business case presented to Health Board Review Team (HBRT) on 5/11/2020 and updated to reflect comments including addition of Benefits Realisation Action Plan.
Current V4.7 submitted for consideration by Executive Team 2/12/2020

The costed start date of Jan 2021 is subject to date of approval.

2. **The Strategic Case**

2.1 Overview of the Business Case

Part A: First point of Contact Advanced Practice Audiology in Primary Care is an innovative scheme removing the need for many people with hearing, tinnitus and certain balance conditions (specifically, Benign Paroxysmal Positional Vertigo (BPPV)), to see their GP.

To date the scheme has seen more than 20,000 patients with approximately 700 patients being seen each month within 36 GP practices. It is estimated that if the scheme was extended and implemented across BCUHB more than 22,000 patients would be seen by the Audiologist in Primary Care each year, thereby freeing up GPs to manage more complex conditions and cases. This number exceeds the capacity initially predicted.

This business case will demonstrate the value of extending this scheme across BCUHB and has been informed by the experience and evaluation of this new model of working over the last 3 years.

Simply, the new scheme removes the need for many people to see a GP by making the Audiologist the first point of contact for people with hearing difficulties, tinnitus and BPPV.

Implementation to date has enabled:

- Release of GP capacity
- Development of job descriptions and definition of new roles
- Recruitment of Masters level Advanced Practitioner Audiologists (including internal and external recruitment)
- Up-skilling of staff to enable wax removal using micro-suction techniques
- Agreement of pathways and referral criteria between primary care, audiology and ENT to enable more integrated care
- Building relationships with primary care colleagues
- Solving logistical and practical challenges to ensure safe and effective service delivery

It is worth noting at the beginning of this business case that this scheme does not aim to move the delivery of Secondary Care Audiology services into Primary Care locations. Secondary care Audiology Service are already delivered in 3 District General and 21 Community Hospitals across North Wales where specialist test conditions and equipment are available. Additionally the scheme does not aim to reduce actual demand for Secondary care services although it is expected that referrals may be more appropriate.

There is also strategic fit of this service with Welsh Government Policy. The Framework of Action for Wales (2017 - 2020) – Integrated Framework of Care and Support for People Who are D/deaf or Living with Hearing Loss, was published in May 2017. A letter from Karin Phillips, Deputy Director of Primary Care has been included as Appendix 2. This letter supports the implementation of the Framework and specifically mentions this scheme and its implementation at BCUHB. A National Project Board has been established, chaired by the Chief Nursing Officer.

Part B:
An audiology led, managed and delivered earwax management pathway would provide a coordinated and integrated service for wax management across BCUHB.
Currently access to earwax removal services is variable across BCUHB with provision being largely limited to irrigation techniques (no microsuction in primary and community care) and with no consistent or coordinated service delivery model or pathway. This means that in certain areas there are significant restrictions or delays to access or no wax removal services and people are sign posted to private providers.
A pilot has been underway in Conwy East Cluster using Cluster funds where an Audiology led wax removal pathway is being implemented and overseen by Advanced Practice Audiology in Primary Care services. This pilot has been interrupted by changes in service delivery due to Covid-19.

Implementation to date has enabled:

- Release of practice nursing capacity
- Development of job descriptions and definition of new roles
- Recruitment of Audiologists in wax removal roles
- Up-skilling of staff to enable wax removal using micro-suction techniques
- Implementation of more effective and efficient wax removal techniques
- Agreement of pathways and referral criteria between primary care, audiology and ENT to enable more integrated care
- Building relationships with primary care colleagues
- Solving logistical and practical challenges to ensure safe and effective service delivery

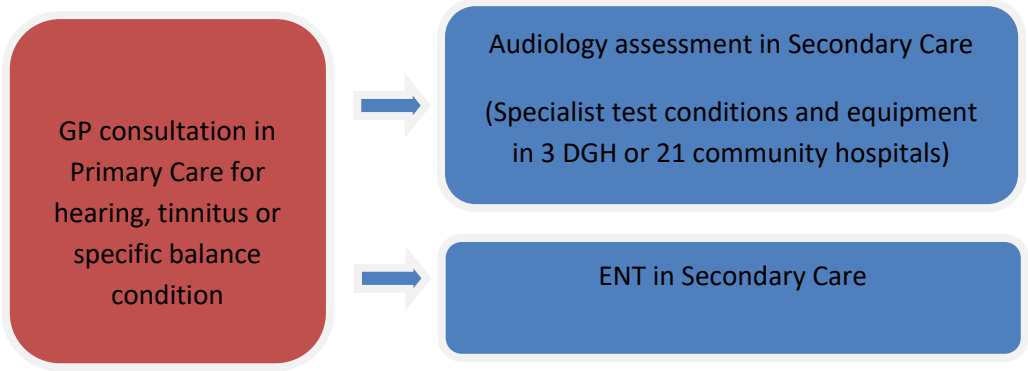
As with Part A of this business case there is a clear strategic fit of Part B with Welsh Government Policy. The Framework of Action for Wales (2017 -2020) – Integrated Framework of Care and Support for People Who are D/deaf or Living with Hearing Loss, was published in May 2017 and includes development of wax management pathways. In response to this, a multidisciplinary national task and finish group was set up and has develop the national pathway for wax management and other supporting documents. The implementation of the new national pathway has been outlined in the WHC/2020/014 (Appendix 2). Development of this pathway is further supported by the multisector North Wales Collaborative Care Group NWCCG (which includes CHC representatives), overseeing the implementation of the Framework in North Wales. They have identified the development of improved wax management pathways and equitable access to wax management services as a priority for North Wales. This was supported as a priority by service users across North Wales as part of a survey of priorities undertaken by the NWCCG.

This business case will demonstrate the value of extending the audiology led wax management pilot across BCUHB.

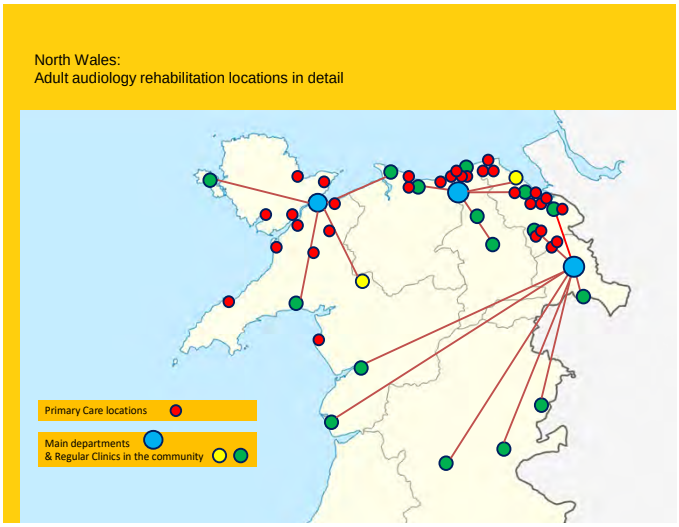
We can expect all Health Boards to be challenged further by the Welsh Government with respect to implementing the Framework for Action, and specifically the further establishment of Primary Care Audiology and provision of the Wales earwax management pathway.

2.2 The Current Service

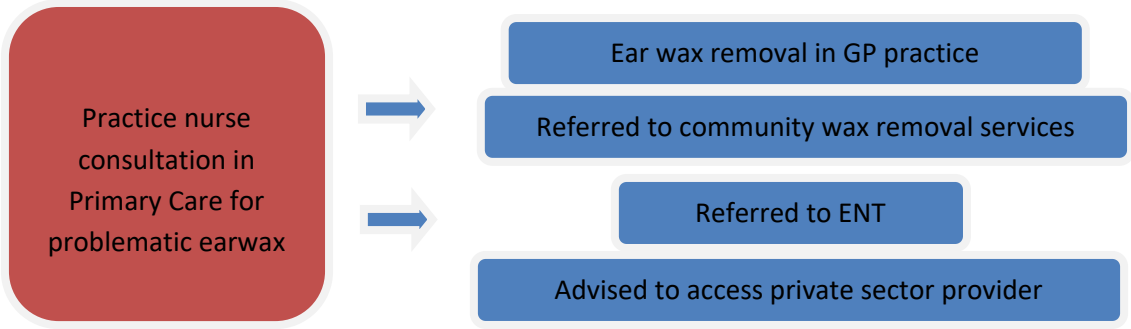
Part A: First point of Contact Advanced Practice Audiology in Primary Care
People with hearing difficulties, tinnitus and BPPV (undiagnosed) will present to their GP to seek advice and investigation. Many of these people will be referred on to Secondary Care Audiology or ENT for assessment and management.



Over the last 3 years a new and innovative scheme has been implemented and evaluated in some areas within BCUHB. The new scheme replaces the GP as the first point of contact with an Advanced Practice Audiologist. To date, this scheme has seen more than 20,000 patients in 36 GP Practices. The case for change below and other information within this business case is based on the evaluation and experience of this scheme.



Part B: Audiology led, managed and delivered earwax management pathway in Primary Care
People with problematic earwax will present to GP practices requesting wax removal. Current provision for earwax management is patchy across BCUHB with people being seen by practice nurses and support staff for ear irrigation; referred to community wax removal services for ear irrigation, referred to ENT for microsuction or in some cases advised to access services in the private sector.



A two year pilot scheme is currently underway in Conwy East, funded using Cluster funds. This pilot scheme enables people to directly access an audiology led wax management pathway where wax will be removed using manual and suction techniques. This pathway is in line with the new Wales earwax management pathway.

2.3 The Case for Change – Benefits of the scheme

Advanced Practice Audiologists in Primary Care release GP Capacity (Part A)
It is well recognised that demands on Primary Care and GPs is increasing and set to increase further. This scheme directly releases GP capacity. Evaluation data shows that only 30% of people are seeing their GP prior to the Audiologist in Primary care, making the Audiologist the first point of care in the majority of cases. In one large Practice the proportion seeing their GP first is as low as 10%.

Based on 30%, it is calculated that, with current capacity, approximately 5880 GP appointments will be released each year. If the scheme were extended to cover the whole of BCUHB this would increase to over 16,000 GP appointments being released. If the proportion of people accessing the audiologist as the first point of contact were to increase to the proportions within our current best Practice, this would increase further to over 20,000 appointments.

Advanced Practice Audiologists and Audiologist delivering wax removal pathways in Primary Care can contribute to a sustainable Primary Care workforce (Part A&B)
As outlined in 'A Planned Primary Care Workforce for Wales', the future of the primary care workforce needs to include a multi-professional and multi-disciplinary workforce. Health Care and Clinical Scientists in Audiology can be an integral and valuable part of the future Primary Care workforce across BCUHB. Workforce plans are in place to ensure that sufficient graduate audiologists are available to work in Wales.

Whilst the current scheme has been limited to adults with hearing, tinnitus and specific balance conditions, the role of the Audiologist in Primary care has the potential to be developed further, thereby increasing the value of the role and further contributing to the sustainable workforce. Role development could include children presenting with these conditions and management of outer and middle ear conditions.

This first point of contact advanced practice Audiology scheme won the NHS award 2018 within the category 'Developing a Flexible and Sustainable Workforce' and was a finalist in the 2019 UK Advancing Healthcare Awards

Advanced Practice Audiologists in Primary Care Can increase care closer to home (Part A)
Evaluation data indicates that the Audiologist in Primary Care can effectively manage the majority (>70%) of patients in Primary Care many of which may have otherwise required a referral to Secondary Care services, thereby shortening the patient pathway and providing care earlier and closer to home.
Specifically:

- Over half of people presenting with symptoms consistent with BPPV will be treated or reassured and discharged at their first appointment with the Audiologist in Primary Care
- Approximately half of these will have had a positive diagnosis of BPPV and had the condition treated within the same first appointment
- Less than 10% will require onward referral to ENT or Audiology for further assessment due to the complexity of their condition or risks associated with treatment in the Primary care setting.
- More people with hearing difficulties and tinnitus will be identified and receive the advice and management they need.
- Over 40% of people presenting with hearing difficulties were assessed, provided with information and advice and discharged in Primary Care.
- Almost 50% of people presenting with tinnitus were provided with information and advice and discharged in Primary Care.

Advanced Practice Audiologists in Primary Care and Audiologist led/delivered wax removal pathways provide a more effective and integrated patient pathway (Part A&B)

As well as managing many patients within the Primary Care setting, Audiologists in Primary Care are better able to identify those patients who require referral to Secondary Care. Additionally, for those people who require onward referral to audiology or ENT, the Audiologist in Primary Care has been able to perform some initial assessment and provide advice and information which will support this referral.

Over 90% of referrals to Secondary Care Audiology included some information about hearing levels informed by Audiometry performed in Primary Care and more than 50% of people referred to ENT had middle ear function assessed prior to referral.

An audiology led, managed and delivered wax removal pathway will contribute to an integrated pathways for people presenting with hearing/communication difficulties and ear symptoms.

Hearing, Tinnitus and BPPV are Important Health Conditions (Part A&B)

Hearing, tinnitus and Benign paroxysmal positional vertigo (BPPV) are important health conditions that, if left unmanaged, result in reduced quality of life and impact on an individual's physical and mental health.

Hearing:

- It is thought that hearing difficulties affect around 575,500 people in Wales and more than 130,000 at BCUHB, with more than 40% of people over 50 years old having hearing loss, rising to 71% of people over the age of 70. This is set to increase to 1 in 5 people in the UK by 2035.
- There is a growing body of evidence of an independent association between hearing loss and dementia. In a recent Lancet Commission 'Dementia prevention, intervention, and care', hearing loss was identified as the biggest modifiable risk factor for dementia.
- Hearing impairment is an important long term health condition and in Wales, it is ranked as the fifth highest cause of years lived with disability by the WHO Global Burden of Disease initiative. It is also the leading cause of years lived with disability for those over 70.
- Hearing loss is associated with an increase in chronic health conditions, including diabetes, stroke and sight loss; it presents a greater risk of falls and more visits to healthcare professionals. People with hearing loss are also two and a half times more likely to develop depression than their peers without hearing loss.
- Hearing impairment is often unrecognised and evidence suggests that people wait, on average, 10 years before seeking help for their hearing loss and that when they do, GPs fail to refer 30-45% to NHS audiology services. It is estimated that of the 11 million people in the UK with manageable hearing loss less than half of people who would benefit from hearing aids have them. This leaves a significant unmet need in our population.
- Cost-utility analysis has shown that management of hearing loss with hearing aids is cost effective and good value (NICE NG98 Appendix N).

Tinnitus:

- Whilst many people will experience non-bothersome tinnitus at some point in their life, about 10% of people experience persistent tinnitus. Of those people who have persistent tinnitus, around 1 in 10 will find that it has a significant impact on their quality of life.
- Tinnitus can negatively affect a person's health and well-being causing distress, depression, anxiety, sleep disturbance and poor concentration. In some cases these effects are very significant.

BPPV:

- Benign paroxysmal positional vertigo (BPPV) is thought to be the most common cause of vestibular vertigo affecting 15% of the population and accounting for approximately 25% of balance referrals to ENT.
- Unmanaged BPPV is reported to lead to depression, anxiety, diminished quality of life and result in increased medical consultations.

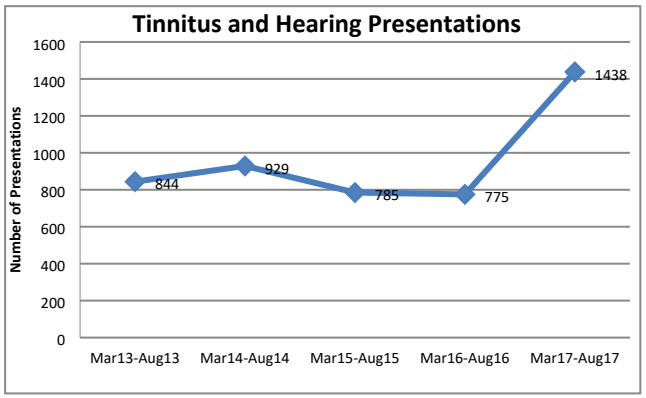
- It is suggested that most individuals first presenting with BPPV to GPs in Primary Care receive no treatment or receive medication for vertigo and it is thought that only 10% are ultimately treated with positioning manoeuvres (directly of following referral).

Problematic Earwax:

- Problematic earwax effects many people with an estimated 4% of the population requiring earwax removal annually. Occluding ear wax can cause a variety of symptoms some of which can have a significant impact particularly for people with pre-existing unmanaged hearing loss and for those using hearing aids. Occluding ear wax will compound any pre-existing hearing ear difficulties and will reduce the benefit of interventions such as hearing aids.

Advanced Practice Audiologists in Primary Care and Audiologist led/delivered wax removal pathways can improve accessibility for people with these important health conditions (Part A & B)

It is well evidenced that many people with these conditions do not present in Primary Care, or if they do present are often not referred on for specialist assessment, advice and management. Early evaluation data shows that the presence of the Audiologist in Primary Care resulted in an increase in presentations of these important health conditions (see graph below). Unmanaged, these conditions result in reduced quality of life and impact on an individual's physical and mental health.



Current wax removal services across BCUHB are variable and uncoordinated with services currently being provided by cluster based community nursing services; practice nurse clinics and with some areas having no service and people being signposted to private providers. An audiology led integrated wax management pathway managed by one service across North Wales and available and accessible within all clusters would ensure equitable access to this service for all citizens of North Wales. Additionally, the integrated management or onward referral of any remaining communication difficulties or ear problems following wax removal would be effectively implemented.

Audiologists in Primary Care and Audiologist led/delivered wax removal pathways are in line with prudent healthcare principles and national strategy and policy (part A&B)

'A Planned Primary Care Workforce for Wales' identifies the need for a multi-disciplinary and multi-professional workforce in Primary Care. Audiologists are identified as an integral and valuable part of this future Primary Care workforce.

The Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss was published in May 2017 (see 2.1 above). This framework highlights the importance of early intervention; states that people will be able to self-refer to audiology services and that in order to ensure ease of access, many Audiology services should be delivered in the local community. This scheme fulfils all the requirements within this WG Policy. A recent letter from Karin Phillips, Deputy Director of Primary

Care has been included as Appendix 1. This letter supports the implementation of the Framework and specifically acknowledges this scheme and its implementation at BCUHB.

This scheme is in line with overarching Healthcare in Wales Strategy, particularly in relation to Effective and Timely Care which promotes timely access and care closer to home.

Prudent Healthcare principles include making the most effective use of all skills and resources ensuring that we 'only do, what only we can do'. Making the Audiologist in Primary care the first point of contact fits well with this and other Prudent Healthcare Principles.

Audiology in Primary Care can provide a Management and Governance Structure for Earwax Management Pathways (part A)

Earwax management is a growing challenge as an increasing number of GP practices are reducing or stopping services. This is resulting in an increased number of patient complaints to the organisation. Advanced Practice Audiologists in Primary Care offer a management and governance structure that will enable the introduction of the new all Wales earwax management pathway. They will be able to oversee the delivery (by more junior audiology staff) of the pathway providing the clinical supervision and opportunity for onward referral if required. This new all Wales pathway and delivery model is expected to be safer, more effective and reduce the need to refer people to ENT for wax removal.

An Audiology led, managed and delivered wax management pathway can provide equitable access to an improved and effective wax management in a coordinated way across North Wales (Part B)

Current models of delivery and pathways for wax removal across North wales are variable and uncoordinated. Services vary and include being non-existent and sign posting to private providers; inappropriate referral of otherwise healthy ears to ENT; practice nurse led or community nurse led ear irrigation clinics; and an audiololgy led cluster based pathway. None of the existing primary care based services, with the exception of the audiology led pilot, have implemented the pathway outlined in the WHC and are currently using ear irrigation for wax removal. Implementation of an Audiology led wax removal service across North Wales, as outlined in this business case, would enable the coordinated implementation and ongoing management and development of the new national pathway and methods of wax removal.

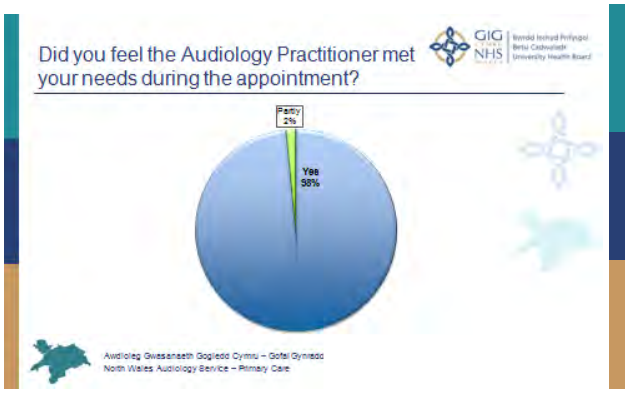
Advanced Practice Audiologists in Primary Care and Audiologist led/delivered wax removal pathways is a Tested Model (Part A&B)

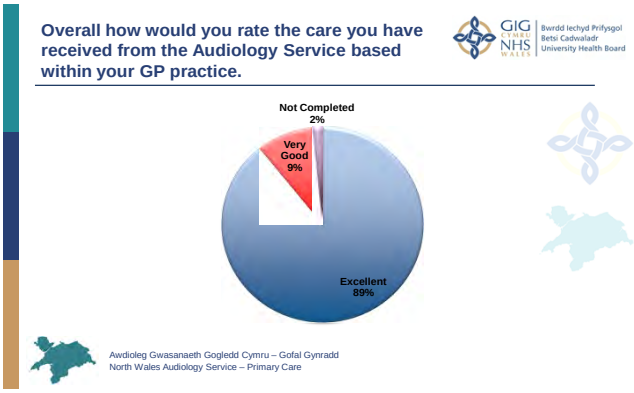
First point of contact advanced practice audiology in Primary Care is an innovative model of service delivery but has been in place within a number of BCUHB GP Practices and Clusters for 3 years. The service is also in place within some GP Practices in Swansea Bay University Health Board and Aneurin Bevan University Health Board. Evaluation and feedback has shown that this is a safe and clinically effective model which can be replicated within other Health Boards in Wales. The BCUHB service is award winning: winning an NHS Award in 2018 within the category 'developing a flexible and sustainable workforce'; and was a finalist in the 2019 Advancing Healthcare Awards within the category of 'innovation in Healthcare Science'.

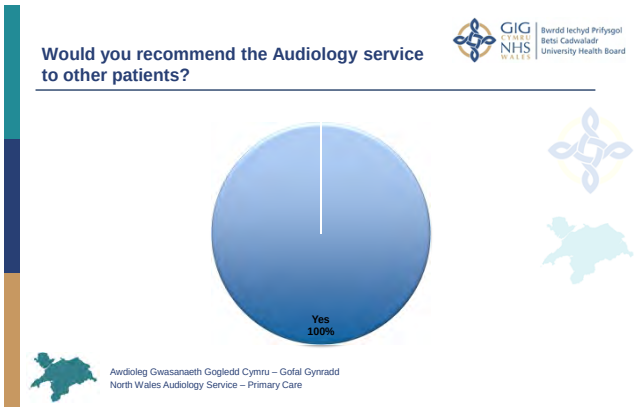
Additionally, an audiology led and delivered wax management pathway, in line with the WHC is being piloted in Conwy East Cluster. Whilst this has been more recently set up and delivery has been disrupted by Covid-19, the service was successfully implemented and well received by PC clinicians and service users.

Advanced Practice Audiologists in Primary Care have Resulted in Positive Patient Feedback:

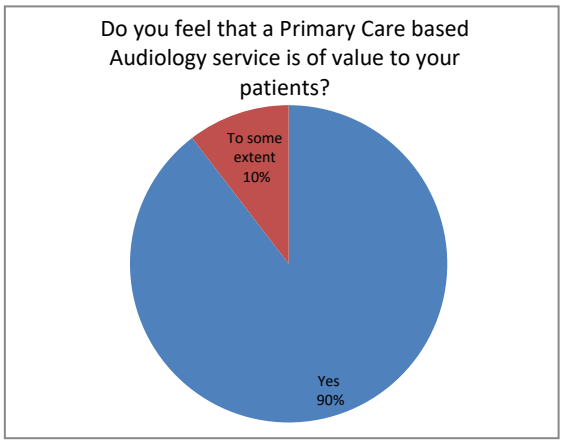
Service user feedback is collected regularly and is overwhelmingly positive. The latest survey of one hundred and thirteen service users in May 2019 show a high level of effectiveness and acceptance of the Audiology service in Primary Care, with 98% of people reporting that their needs had been met by the Audiologist in Primary Care, 98% rating the service as either very good or excellent and 100% of people saying they would recommend the Audiology service to others.

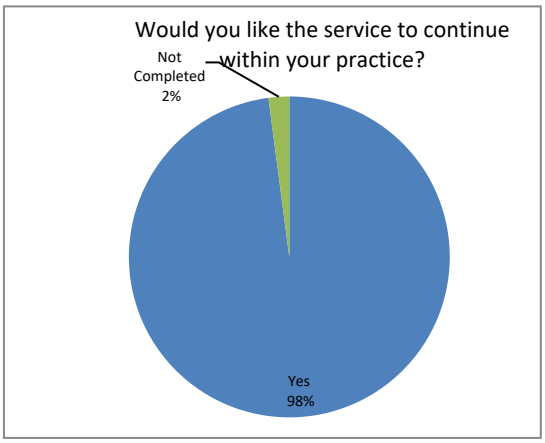






Advanced Practice Audiologists in Primary Care have Resulted in Positive Primary Care Clinician Feedback
The Audiology in Primary Care service is held in high regard. The views of Primary Care staff have been collected. The data below shows that 100% of PC clinicians responding feel that the service is of value to their patients at least to some extent and 98% reporting that they would like the service to continue in their practice.
In addition to this survey, a strong positive regard for the service has been communicated to audiology by many GPs verbally and in writing (see Appendix 3 – support letters from GPs).





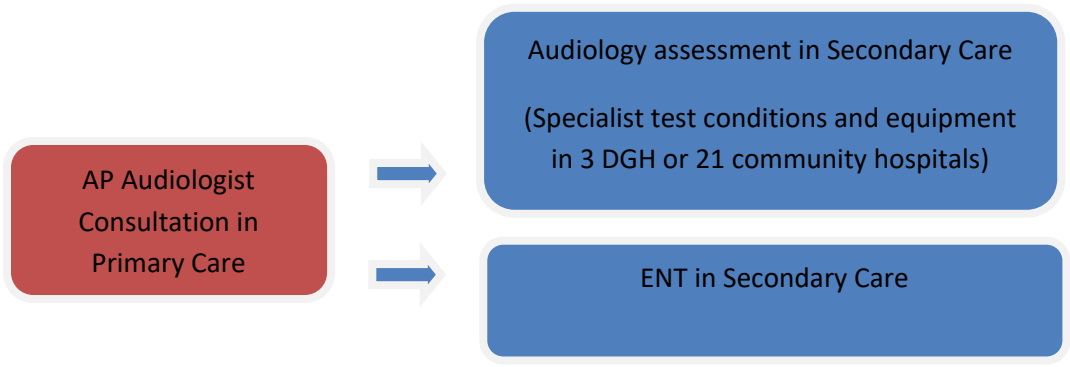
Extending the Audiology in Primary Care Scheme and Audiologist led/delivered wax removal pathways (part A&B) is essential to ensure equity of access and to realise the benefits across BCUHB
Currently, not all people are able to access an Audiologist as their first point of contact in Primary Care and delivery of wax removal service is uncoordinated and patchy. In order for equity of access to be achieved and for

the benefits realised during the schemes to date, further investment is required. See Benefits Realisation Action Plan (appendix 4) for further detail of benefits.

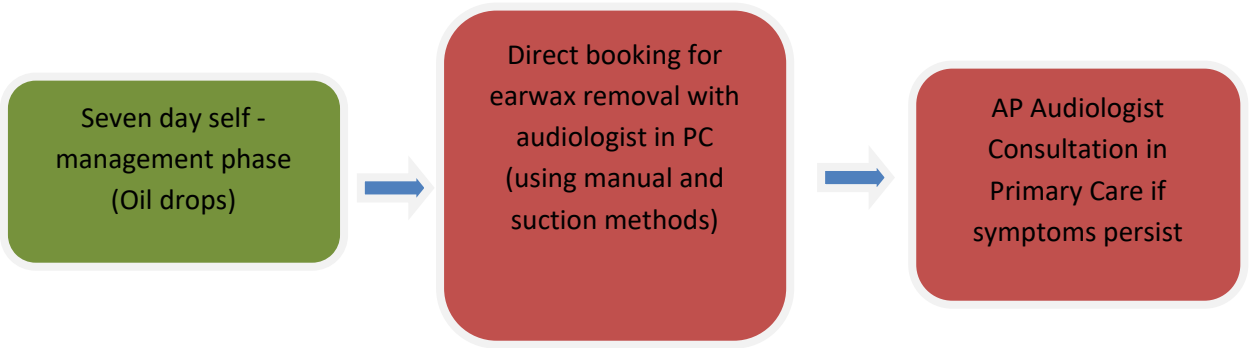
2.4 Proposed Service Development

Part A: Maintain and extend the first point of contact advanced practice audiologist in Primary Care scheme to provide equity of access across BCUHB and realise the same benefits across BCUHB. Increase the delivery of service from 36 Practices within 9 Clusters to all Practices within all 14 Clusters

Change the first point of contact from GP to Advanced Practitioner Audiologist for people with hearing, tinnitus and specific balance symptoms. Audiologists will deliver sessions within GP practices releasing GP capacity. As well as replacing the initial consultation and freeing up GP capacity, this new model will enable people to get specialist information, advice and management sooner and closer to home.



Part B Additionally, implement Audiology led, managed and delivered earwax management pathway providing manual and suction removal in line with the new Wales earwax management pathway and WHC/2020/014. Audiologists will be managed by the advanced practice audiologists in Primary Care and will manage all patents presenting with problematic ear wax, subsequently referring on the advanced practice audiologist or others as required. This will free up Practice and Community Nursing capacity across North Wales and will offer an integrated pathway for those with communication difficulties or ear symptoms and will enable people to get specialist information, advice and management sooner and closer to home.



2.5 Areas Affected by the Proposal, Inter-dependencies

The success of this scheme has depended on the development of good relationships between the Audiologists in Primary care and Primary Care clinical and non-clinical staff. These relationships have led to appropriate signposting of patients to the Audiologist and to more integrated pathways between Primary and Secondary Care.

It is expected that similar relationship would be developed between Audiology and Primary Care teams within the Practice and Clusters where the service has not yet been implemented.
Where wax removal services currently exist (i.e. those delivered by Practice or Community nurses), there will need to be a coordinated hand over and transition of services. This will be detailed in subsequent implementation plans and developed in collaboration with those services. This was achieved without incident in Conwy East where some practices were delivering wax removal prior to implementation of the Audiology led service.

The service will continue to enable a more integrated pathway between primary care and Secondary Care Audiology services and ENT.

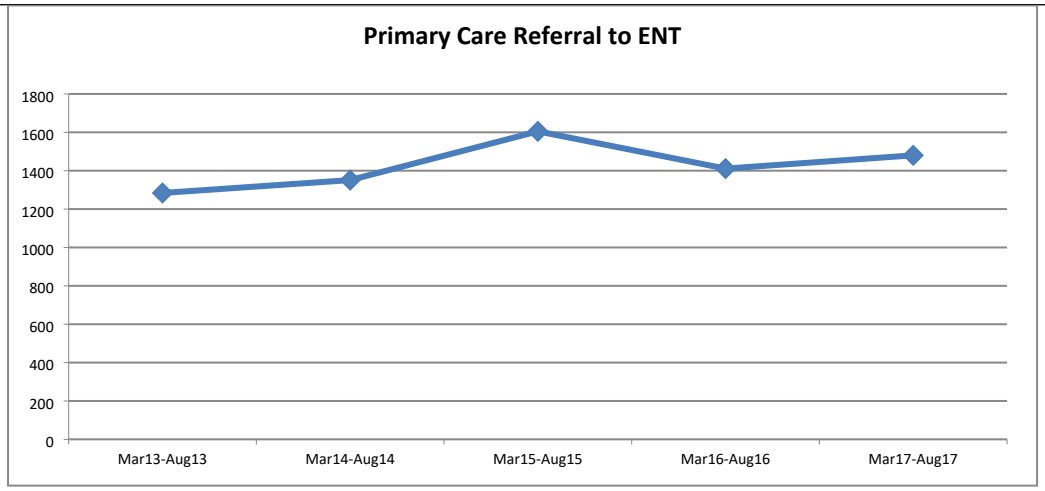
2.6 Performance, Activity and Contracting

Advanced Practice Audiology (Part A)
Continuing with the existing capacity within the 36 Practices will enable >8,000 people each year to access an Audiologist in Primary Care as the first point of contact. Extending the service with additional resources will enable more than 22,000 people each year to access an Audiologist in Primary Care as the first point of contact.

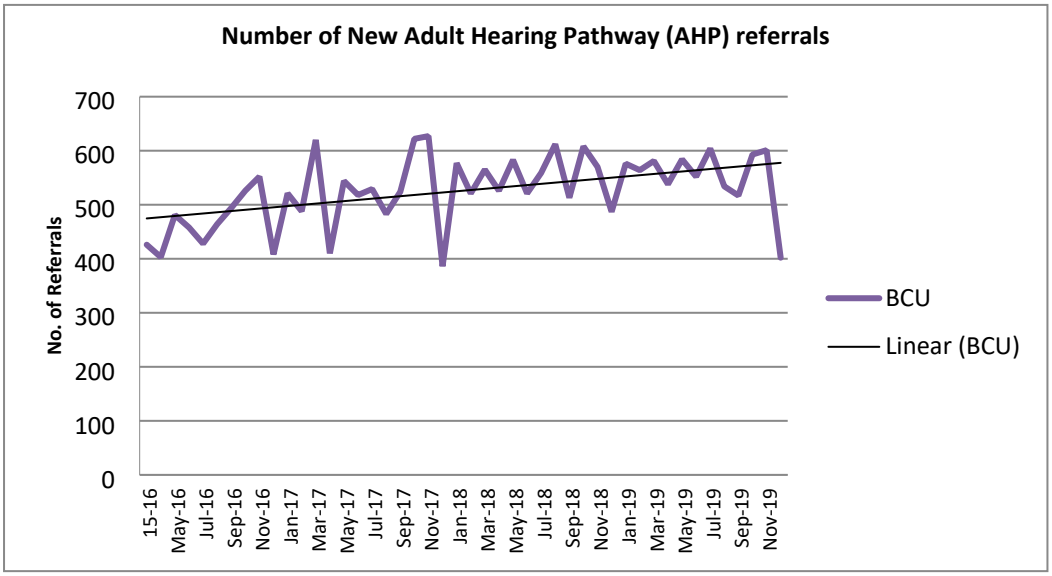
Evaluation data to date indicates that 55% of patients seen have been effectively managed by the Audiologist in Primary Care, with the majority (78%) of these being managed at the initial appointment. These patients did not require any onward referral or to see another clinician within the Primary Care team.

Only 7% of patients are referred to the GP; 19% referred to Secondary Care Audiology and 9% referred to ENT.

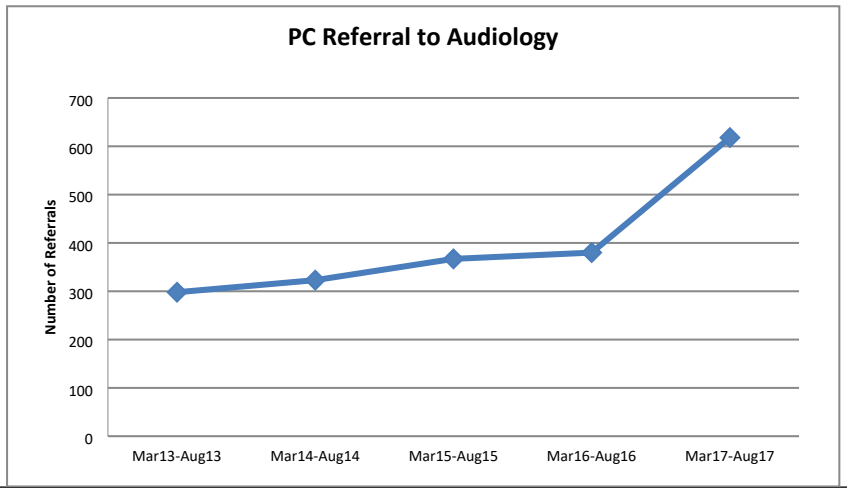
This referral rate to ENT is consistent with the referral rate seen prior to the Audiology in Primary Care scheme being implemented. Data in the graph below was collected for presentation rates over 6 month periods spanning the last 5 years, specifically 1st March to 31st August of the years 2013, 2014, 2015, 2016 and 2017. Searches were conducted using the Population Reporting function of the EMIS patient management system to find the number of patients coded with specific conditions referred in each sampling period. This data was only collected from practices where the Audiologist is currently delivering a service in Primary Care, however it is expected that this would be representative of other practices across BCUHB.
Evaluation supported the proposal that Audiologists would be as effective as GPs at identifying those people who required onward referral to ENT for specialist medical assessment.



The number of referrals received by the Secondary Care Audiology Service from Primary Care, for full Audiological assessment and rehabilitation, has been slowly increasing over a number of years.



However, additional evaluation of Primary Care data shows that there is an additional significant increase in numbers referred since the Primary Care Audiology service has been in place. Although the numbers of referrals have increased, this reflects the increased number of presentations of hearing, tinnitus and BPPV in Primary Care.



Increased presentation rates for hearing and tinnitus is thought to be due to i) an underlying unmet need ii) a backlog of people willing to take this opportunity to resolve their difficulties through this new route. On this basis, it is speculated that this higher presentation rate, since the service commenced, may in time lower to a sustained level (although still greater than historic demand).

Audiologists in Primary Care are managed professionally and clinically by the BCUHB Audiology Service. Currently this is 5.5WTE staff including 3.0WTE Area leads.

Audiology Led Earwax Management Pathways (Part B)
Problematic earwax effects many people with an estimated 4% of the population requiring earwax removal annually. This equates to over 28,000 presentations within BCUHB each year.
The current pilot underway in Conwy East Cluster (pop 54,030) is being delivered by 1.0WTE band 4/5, providing 9 clinical sessions/week and is overseen by the Advanced Practice Audiologist. It is expected that 14.0WTE Band 4/5 will be required to deliver the earwax management pathway for all patients across BCUHB.

2.7 Milestones and Quantified Benefits

Achieved Milestones and Quantifiable Benefits
The initial scheme milestones for the first point of contact Advanced Practice Audiology scheme (Part A) have been achieved:
The recruitment of 2.9 WTE advanced practitioners taking on the roles of Area leads and a further 2.62 WTE advanced practitioners delivering highly regarded and clinically effective services in 36 GP practices.

6 staff have successfully completed the M-module training in micro-suction and ear care.

More than 20,000 patients have been seen resulting in approximately :

- 14,000 saved GP appointments
- 11,000 patients successfully managed in PC closer to home

Current capacity enables approximately 700 advanced practice consultations each month.

Additionally, an integrated wax management pathway, in line with the new national pathway has been successfully implemented in Conwy East with successful recruitment of 1.0WTE audiologist.

Future Milestones and Quantifiable Benefits – see benefits realisation action plan (appendix 4) for further detail

- Provide equity of access and care by making first point of contact advanced practice audiology and access to the new national wax management pathway available in all GP practices/Clusters
    - Increase resources and recruit additional Advanced Practice Audiologist and wax removal audiologists
    - Build relationships with all Primary Care Clusters and Practices
    - Deliver both services in all GP Practices/Clusters across BCU
- Release GP capacity
    - Achieve first point of contact at least comparable to current scheme (only 30% people seeing GP prior to Audiologist)
    - Move towards fort point of contact for current best practice (only 10% seeing GP prior to Audiologist)
- Release Practice/Community Nurse capacity

    - Implement an audiology led earwax management pathway providing manual and suction earwax removal in line with Wales earwax management pathway.
    - Ensure smooth and effective hand over from those service currently delivering wax removal thereby releasing Practice and Community nursing capacity
- Manage as many people as close to home as possible, reducing need for ENT/Audiology referrals
    - Identify opportunities to purchase suitable clinical couches to increase number of people with BPPV who can be treated in PC
    - Extend scope of practice to include younger paediatrics and management of outer ear conditions
    - Provision of sound treated booths (to improve quality and value of hearing assessment measurements)
    - Wax removal equipment/facilities
- Maintain high levels of patient satisfaction
- Maintain high levels of perceived value by GPs and other Practice staff

3. Formulation and Short-listing of Options

3.1 Overview of Options – Main Business case Options

Option 1: No nothing
Option 2: Continue to deliver the first point of contact Advanced Practice Audiology in Primary Care Scheme in the existing 36 Practices
Option 3: Expand scheme to deliver the first point of contact Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB
Option 4: Expand the scheme to deliver the first point of contact Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB and extend the scheme to include the Audiology management and delivery of the national earwax management pathway

3.1.1. Options appraisal to inform Option 4 above

It is acknowledged that there are alternative options for the delivery of the national wax removal pathway which forms part of option 4 above. However those options wouldn't fulfil the recommendation in the WHC that the pathway should be led, managed and delivered by Audiology. As such, Option 4 within the business case is limited to an audiology led wax removal service.

Audiology are aware that a separate options appraisal had been started early in 2020 for the East Area and outlined the options for wax management pathway. These options included an Audiology led service:

- Option A. Community Services team to deliver the Flintshire Ear care service across the East area (Irrigation)
- Option B. A LES to be developed to incentivise practices to deliver the service on behalf of their patients (irrigation)
- Option C. Commission the service privately on behalf of the East area team (Irrigation)
- Option D. Commission Audiology service to undertake procedure (Microsuction)
- Option E. Do nothing

Whilst the review was not completed we have included below the costings from that appraisal along with additional criteria for review that will provide context and support for inclusion of Audiology as the provider of this pathway within option 4 of this business case. It is noted that this relates to an East area review but that scores are unlikely to change significantly if at all if considered across BCUHB

	Option A: Community Services team to deliver the Flintshire Ear care service across the East area (Irrigation)	Option B. A LES to be developed to incentivise practices to deliver the service on behalf of their patients (irrigation)	Option C. Commission the service privately on behalf of the East area team (Irrigation)	Option D. Commission Audiology service to undertake procedure (Microsuction)	Option E. Do nothing
Cost (£/pathway) – recurrent costs	£15.45	£18.46	£50.00	£16.02	
PC/community nursing capacity/skills released	2	2	4	4	0
Ease of implementation	3	2	0	3	4
Integrated ear care pathway	1	1	0	4	0
Access to specialist care closer to home	0	0	2	4	0
Compliant with WHC and national ear wax pathway	2	2	0	4	0
Likelihood of coordination, management and development across BCU	2	1	0	4	0
Quality assurance and evaluation of outcomes	4	2	0	4	0
Total Score	14	10	6	27	4

Relative Strengths and Weaknesses (indicative scoring, 0= weakness 4=strength).

NB Acknowledgement to James Duckers, Planning and Commissioning Manager for Primary Care who was completing the options appraisal for ear care in East area and whose costings are included in the above table.

3.2 Benefits of the Options - Main Business case Options

Option 1: Do nothing

- No requirement to identify additional funding

Option 2: Identify core funding and continue to deliver the Audiology in Primary Care Scheme in the existing 36 Practices (mix of GMS and HB managed Practices)

- GP capacity continues to be released
- People get specialist Audiology advice and management sooner and closer to home
- Patient pathway is shorter for many
- Audiology continue to contribute to the development and delivery of wax management pathways
- Accessibility for people with hearing, tinnitus and specific balance conditions improves
- No withdrawal of services required
- BCUHB leading the way – reputation for innovative service provision persists

Option 3: Expand scheme to deliver the Audiology in Primary Care Scheme to all Practices across BCUHB

- More GP capacity is released
- More people get specialist Audiology advice and management sooner and closer to home
- Patient pathway is shorter for more people
- Audiology continue to contribute to the development and delivery of wax management pathways
- Accessibility for people with hearing, tinnitus and specific balance conditions improves
- Equity of access and services across BCUHB
- BCUHB leading the way – reputation for innovative service provision is enhanced

Option 4: Expand the scheme to deliver the Advanced Audiology in Primary Care Scheme to all Practices across BCUHB and extend the scheme to include the Audiology management and delivery of the national earwax management pathway

- More GP and Practice/Community nursing capacity is released
- More people get specialist Audiology advice and management sooner and closer to home
- Patient pathway is shorter for more people
- Advanced Practice Audiology provide a management and governance framework for the delivery of the national earwax management pathway
- Accessibility for people with hearing difficulties tinnitus, specific balance conditions and problematic earwax improves
- Equity of access and services across BCUHB
- Hearing pathways are fully integrated from ear wax removal in PC to tertiary services delivered in the DGH
- BCUHB leading the way – reputation for innovative service provision is enhanced

3.3 Cost & Resource information for the Options

Option		WTE	Recurrent Cost £	Existing Budget £	Set Up Costs (NR)	Total Investment Required £	Recurrent Investment Required £	Recurrent Activity GP consultations released
1: Do nothing.	Existing Budget			-304,879		-304,879	-	-6000
2: Continue to deliver the Advanced Practice Audiology in Primary Care Scheme in the existing 36 Practices (mix of GMS and HB managed Practices) identifying and allocating Core funding	Band 8 a	2.90	169,926					6000
	Band 7	2.62	134,157					
	MSE & Consumables		32,016					
		5.52	336,099	-304,879		31,220	31,220	
3: Expand scheme to deliver the Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB	Band 8 a	2.90	169,926					22000
	Band 7	12.00	614,460					
	MSE & Consumables		86,420					
		14.90	870,806	-304,879	72,000	637,927	565,927	
4: Expand scheme to deliver the Advanced Audiology in Primary Care Scheme to all Practices across BCUHB and extend the scheme to include the Audiology management and delivery of the national earwax management pathway	Band 8 a	2.90	169,926					22,000 plus 28,000 Practice or community nurse appts
	Band 7	12.00	614,460					
	Band 5	14.00	475,006					
	MSE & Consumables		153,600					
		28.90	1,412,992	-304,879	146,200	1,254,313	1,108,113	

3.4 Key Assumptions and Dependencies of the Option

Option	Key assumptions and dependencies
1: Do nothing	• Existing services funded by WG Investment funds would continue
2: Continue to deliver the Advanced Practice Audiology in Primary Care Scheme in the existing 36 Practices (mix of GMS and HB managed Practices) identifying and allocating Core funding	• Core funding is identified
4: Expand scheme to deliver the Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB	• Core funding is identified • There is sufficient and comparable (based on populations) demand within areas we don't currently deliver the service. • Successful development of relationships with PC colleagues within area we don't currently deliver the service • Successful permanent recruitment of additional Audiology capacity identified previously. • Confirmed access to physical resources and patient records to enable safe and effective assessment and management of patients in PC.
4: Expand scheme to deliver the Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB and extend the scheme to include the Audiology management and delivery of the national earwax management pathway	• Core funding is identified • There is sufficient and comparable (based on populations) demand within areas we don't currently deliver the service. • Successful development of relationships with PC colleagues within area we don't currently deliver the service • Successful permanent recruitment of additional Audiology capacity identified previously. • Confirmed access to physical resources and patient records to enable safe and effective assessment and management of patients in PC.

3.5 Options Appraisal

3.5.1 Criteria for Assessing the Option

- Additional Cost
- GP capacity released
- PN/community nursing capacity released
- Secondary care capacity released (Audiology & ENT)
- Improved accessibility for important health conditions
- More appropriate secondary care referrals
- Patient Experience
- Specialist care closer to come (shorter care pathways)
- Equity of access
- Alignment with WG & HB strategic policy

3.5.2 Scoring framework for Assessing the Option

Relative Strengths and Weaknesses (indicative scoring, 0= weakness 4=strength).

3.5.3 Selection of Preferred Option

	Option 1: Do nothing	**Option 2: Continue to deliver the Advanced Practice Audiology in Primary Care Scheme in the existing 31 Practices (mix of GMS and HB managed Practices) identifying and allocating Core funding**	**Option 3: Expand scheme to deliver the Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB**	**Option 4: Expand scheme to deliver the Advanced Practice Audiology in Primary Care Scheme to all Practices across BCUHB and extend the scheme to include the Audiology management and delivery of the national earwax management pathway**
Cost (£/year)	£304K Costs will continue medium term as Audiologists in PC are recruited on recurrent basis	£366K	£943K including some non-recurrent set up costs (£871K recurrently)	£1,559K including some non-recurrent set up costs (1,413K recurrently)
GP capacity released	0	2	4	4
PC/community nursing capacity released	0	0	0	4
Secondary care capacity released (Audiology & ENT)	0	0	0	1
Improved accessibility for important health conditions	0	2	4	4
More appropriate secondary care referrals	0	2	4	4
Patient Experience	2	2	2	2
Specialist care closer to home	0	2	4	4
Equity of access	4	0	4	4
Alignment with WG & HB strategic policy	0	2	4	4
Total	**6**	**12**	**26**	**31**

Recommendation for Option 4: Expand scheme to deliver the Audiology in Primary Care Scheme to all Practices across BCUHB and extend the scheme to include the Audiology management and delivery of the national earwax management pathway.

4. The Financial Case

4.1 Costs

It's envisaged that roll-out of both Part A and Part B of this business case would take place in three phases over three years to ensure effective engagement, safe implementation and successful recruitment of advanced practitioners. The following funds would be required over Y1-3 and onwards. N.B. costs are based on midpoint of 20/21 salaries. Pay awards and incremental paypoints would affect final figures.

	Phase 1 Y1	Phase 2 Y2	Phase 3 Y3
Population Coverage Across N.Wales for advanced practice first point of contact and routine wax removal (Part A & B)	50%	75%	100%
Recurrent costs (PA)	402,909 (Adv Prac pay) 237,503 (wax removal pay) 76,800 (MSE & Cons) 717,212 (Total)	593,647 (Adv Prac pay) 356,254 (wax removal pay) 115,200 (MSE & Cons) 1,065,101 (Total)	784,386 (Adv Prac pay) 475,006 (wax removal pay) 153,600 (MSE & Cons) 1,412,992 (Total)
Current funding (assumes previous year investment approved)	304,879	304,879 + 412,333 717,212	717,212 + 347,889 1,065,101
Total additional recurrent investment required year on year	**412,333**	**347,889**	**347,891**
Non recurrent costs	48,733	48,733	48,733
Total Additional Investment in year	461,066	396,622	396,624

Recurrent Summary *	
Current Budget	304,879
3 year recurrent Investment	1,108,113
Total Recurrent Costs	**1,412,992**

4.2 Value for money

First Point of Contact Advanced Practice Audiology in Primary Care (Part A)

Costs comparing the old and new models have been prepared with support from finance colleagues. The old model includes one GP consultation plus a Practice Nurse consultation for a proportion of patients (where earwax removal would have been required). The new model includes one consultation with the Audiologist in Primary Care (where earwax removal would be performed as part of that initial consultation). This data indicates a £3.83/pathway saving. This is based on a 25 minute consultation with the Audiologist.

Whilst it is recognised that this scheme will require investment and will not be cash releasing it is important to recognise that these services are currently being delivered by others within the Health Board and that, if implemented, GP capacity will be released as consultations move from GPs to advanced practice audiologists. This released capacity can be utilised to improve access to GPs for other more complex health conditions. As such, there is no net additional cost to the organisation but rather a movement of resources to enable the delivery of more clinically and cost effective pathways.

It is also worth noting that further evaluation is required looking in more detail at the average pathways of people with balance (specifically BPPV) in Primary Care and at the general Primary Care presentation rates for those people with hearing and communication difficulties.
It is reported that only 10% of people presenting with BPPV in conventional primary care services are managed using positioning manoeuvres and that most receive no treatment or receive medication. It's expected that many of these people will present to see their GP a number of times where as they could be treated successfully at their initial appointment with the Audiologist.
Similarly it is reported that people with unmanaged hearing and communication difficulties access their GP and Primary Care Services more than people without hearing and communication difficulties.

Extending the scheme across BCUHB will result in additional efficiencies through economies of scale, e.g. as travel time and expenses are reduced (these have been considered within future costs).
Predications based on current demand and capacity indicate that 22,000 GP consultations will be released across BCUHB each year.

Audiology led, managed and delivered wax management pathway (Part B)
Current models of delivery and pathways for wax removal across North wales are variable, uncoordinated and often non-existent. In order to deliver a service, and the benefits that brings outlined earlier in the business case, and in order to comply with WHC/2020/014 investment and change is required.

An audiology delivered BCU wide wax removal service, led and managed by advanced Practice audiologists in Primary Care would offer a cost effective option . Whilst it is recognised that this scheme will require investment and will not be cash releasing it is important to recognise that these services are currently being delivered by others within the Health Board and that, if this service is implemented, Practice and Community nursing capacity will be released as wax removal moves from Practice and Community nurses to audiologists. This released capacity can be utilised to improve access to Practice and Community nursing for other health conditions.

Predications based on current demand and capacity indicate that 28,000 Practice or Community Nursing consultations will be released across BCUHB each year.

4.2 Financial risk

Negligible financial risk.
This innovative model of service delivery was previously untested. However, evaluation demonstrates that that this is an effective scheme that delivers within the costs initially calculated.

5. Service Management

5.1 Governance

The Primary Care Audiology Service (including first point of contact advanced practice and audiology delivered routine wax removal services) and staff will continue to be managed across BCU as one team by the Audiology Service. Clinical, professional and managerial leadership will continue to be provided by Consultant Clinical Scientists as part of Audiology Leadership team. All aspects of governance will be covered within Audiology governance structures with close liaison and collaborations with Practices and Primary Care teams. Whilst the Audiology service sits within the North Wales Managed Clinical Services Directorate they will continue to work in close engagement with Primary Care teams. This model has worked well in practice – an example of effective working across management teams/structures, with audiologists benefitting from professional support and leadership within the Audiology service, yet fully engaged with PC colleagues at cluster and practice level.
As with other Audiology teams, effective team based working principles will be employed to maximise team effectiveness.

5.2 Scheme Plan – Implementation Timeline

Delivery of existing first point of contact advanced practice audiology services would continue in the 36 practices currently engaged.

Roll-out of both Part A and Part B of this business case would take place in three phases over three years to ensure effective engagement, safe implementation and successful recruitment of advanced practitioners. As detailed in the Benefits Realisation Action Plan the aim will be to have both services fully operational within 50% of Practices by the end of Y1, 75% of Practices by end of Y2, and 100% of Practices by end of Y3. Depending of start time, these three phases may span four financial years.

Depending on approval time:
Within Year Costs £(20/21) – part year costs, with scheme to commence Jan 2021

Full year Cost Y1	412,333
Total additional recurrent investment required Y1 for delivery from Jan 2021 (Q4 only) (412,333/4)	103,083
Non recurrent costs Y1	48,733
Total Additional Investment in 2021	**151,816**

Once this business case is approved, detailed implementation plans will be developed.
Location for rollout during the three phases (Y1, Y2 an Y3) will be based on a number of factors and will be decided in collaboration with Practices, Cluster and Primary/Community Care leads.
Engagement with PC Clusters as part of existing services has been ongoing and some Practices have already registered their interest in working with audiology to implement Audiology services in primary care.
Additionally, analysis has been undertaken to understand the prevalence of hearing loss in each cluster and the rate of referral from each Practice for hearing, tinnitus and balance into secondary care services. All of this information will be used with Cluster and PC leads to agree roll out plans.

5.3 Monitoring Progress

A detailed roll out and implementation plan will be developed including KPIs and timescales and progress against this plan will be monitored by Audiology and reported back to HB as required.

5.4 Evaluation

Evaluation of existing services will continue to ensure a safe, effective and high quality service is delivered.
Key performance data will be collected, analysed and shared routinely at a whole service level and locally within each practice or and/or cluster. This will include:

- Demand and activity
- First point of contact proportions
- Referral rates to ENT and Audiology
- Appropriateness of onward referral
- Patients experience
- PC clinician experience

An annual evaluation report will be produced containing the key information listed above, including the evaluation of existing delivery and progress against rollout plans.

In addition, service evaluation will feed into ongoing service development plans to ensure that clinical and cost effectiveness is maximised both within the pathways and services themselves but also within the wider HB. This will include, in particular, consideration of potential expansion or extension of the scheme to extend scope of practice further to release further GP or ENT capacity as opportunities arise (e.g. extending to younger children, management of more complex ears within PC).

6. Critical Assumptions, Risk and Issues

- It is critical that core funding is identified for the scheme to continue and expand. Evaluation demonstrates that the scheme releases GP and Practice/Community nursing capacity and so core funding should be identified from within Primary Care funding.
- The scheme is well regarded by the public, primary care colleagues and has been commended by WG. If the decision is made to not to implement there is a risk of significant negative public and political attention.
- Expansion plans to extend and deliver the service across BCUHB need to be phased to allow for safe and effective implementation and recruitment.
- Excellent relationships with GPs, practice managers and PC teams have been developed and have been essential to the success of the scheme to date. These specific relationships will need to be developed with other key stakeholders in PC.

7. Conclusions and Recommendations

First Point of Contact Advanced Practice Audiology in Primary Care (part A of this business case) is an innovative scheme, removing the need for many people with hearing, tinnitus and certain balance conditions, to see their GP.

The scheme has been implemented within 36 practices over the last three years and evaluation shows that Audiologist can safely and effectively take this work from GPs, thereby releasing them to see more complex conditions. It is estimated that if the scheme was extended and implemented across BCUHB more than 22,000 patients would be seen by the Audiologist in Primary Care.

An audiology led, managed and delivered earwax management pathway would provide a coordinated and integrated service for wax management across BCUHB.
Currently access to earwax removal services is variable across BCUHB with provision being largely limited to irrigation techniques (no microsuction in primary and community care) and with no consistent or coordinated service delivery model or pathway. This means that in certain areas there are significant restrictions or delays to access or no wax removal services and people are sign posted to private providers at a personal cost to the individual and leading to complaints, concerns raised by the CHC and AM queries
Hearing, tinnitus and BPPV are important and prevalent health conditions and this scheme enables more people to get specialist advice and management sooner and closer to home. Additionally, problematic earwax causes patients distress and prevents effective assessment and management of hearing loss and provision for earwax removal is currently patchy across BCUHB.

The option appraisal within this business case identifies expansion of the Advanced Practice Audiology scheme across BCUHB and the extension of the scheme to include the implementation of the national earwax management pathway, as the preferred option. Core funding from within Primary Care budgets needs to be identified to enable this service, and the benefits it brings, to be continued, expanded and extended.

Appendix 1 - WHC/2020/014

WHC/2020/014

WELSH HEALTH CIRCULAR

Issue Date: (29/09/2020)

Llywodraeth Cymru
Welsh Government

STATUS: COMPLIANCE & ACTION

CATEGORY: POLICY

Title: Ear Wax Management Primary Care and Community Pathway

Date of Expiry / Review
Ongoing

For Action by:
Health Boards and NHS trusts

Action required by:
01 October 2021

Sender:
Welsh Government

HSSG Welsh Government Contact(s):
Sarah O'Sullivan-Adams
Head of Sensory Policy
Primary Care Directorate
Sarah.o'sullivan-adams@gov.wales

Enclosure(s): None

Situation: Ear wax (cerumen) is a common and significant health complaint, specifically significant for people with pre-existing hearing loss as it compounds their communication difficulties. Unresolved and troublesome ear wax is a relatively easy health condition to address through removal by trained professionals; however, NHS Wales currently has no consistent national pathway for ear wax management in line with NICE guidance (NICE 2018).

A Task and Finish Group was established to ensure all citizens across Wales can access the most appropriate treatment and support for ear wax problems, in line with the Welsh Government's *'A Healthier Wales'* plan, the *'Hearing Framework of Action'* and the new *Primary Care Model*, underpinned by the principles of prudent healthcare. The group completed its remit and the following objectives have been met:

1. Determine and report on current service provision across Wales.
2. Develop a national integrated pathway for the safe and effective management of ear wax to provide consistent patient outcomes across Wales and ensure:

    - Equitable access;
    - Efficient and effective use of NHS resources; cost effective and prudent;
    - Consistent seamless management across primary, community and secondary care settings;
    - Self-management where clinically appropriate, empowering people to better manage their own care;
    - Compliance with NICE guidance and Audiology Quality Standards. https://gov.wales/sites/default/files/publications/2019-10/quality-standards-for-adults-hearing-services-the-assessment-and-audit-tool.pdf

Background: The Welsh Government launched the *Framework of Action for People who are Dd/eaf or living with Hearing Loss* in May 2017. The Framework commits all stakeholders to work together to improve services and provide high-quality care and support for citizens across Wales. The Hearing Project Board was established to oversee implementation of the recommendations, including development of a national pathway for ear wax management.

Historical treatment: Health boards are responsible for providing ear wax management services. Wax management is not explicitly part of the GP contract - some GP practices have traditionally provided services while others have simply referred all patients with ear wax symptoms to hospital ENT departments.

In recent years, concern has been raised about the procedure used to treat ear wax problems and patient safety. Also, the number of referrals to hospital ENT departments and/or secondary care audiology departments has increased considerably and is not in line with the prudent health care principles underpinning our national plans (*'A Healthier Wales'*, *'Framework of Action'* and new Primary Care Model).

The number of referrals has been increasing year on year, resulting in extended waiting times, which has meant patients with the greatest need are not being seen in the right place, at the right time by the right health professional. In addition, some patients have reported being told by GPs that there is no NHS Wales ear wax management service available and that they should seek private treatment.

Assessment: Ear wax is produced by the ear as part of its natural process of cleaning and protection and in the majority of cases it does not need to be removed.

Sometimes wax can build up in the ear canal and softening agents can be used as part of self-management and then as part of regular maintenance to help prevent further wax. Experts suggest weekly using two drops of fresh, unused olive oil at room temperature, sodium chloride (salt water) or sodium bicarbonate drops [1](NICE 2018). Sometimes wax can become impacted and cause difficulties. Prevalence of impacted wax increases with age with some studies reporting a prevalence of as high as 34% in those over 65 years of age. Impacted and/or occluding wax can cause symptoms such as:

- Hearing loss – a decrease in hearing sensitivity of typically 20-30dBHL (mild level of hearing loss) if wax is occluding the ear canal;
- Discomfort;
- Earache;
- Feeling of blocked ear;
- Tinnitus.

Often these symptoms and their impact can be significant, particularly for those with pre-existing unmanaged hearing loss where it can compound hearing difficulties. For those using hearing aids, occluding ear wax will impede the passage of amplified sound in the ear canal; often precluding any benefit provided by the device. Also, ear wax can block the hearing aid ear mould or tubing, it can cause acoustic feedback (whistling) and prevent impressions being taken when new ear moulds are needed.

As children's ear canals are much smaller, wax build up becomes a problem more quickly and they require new ear moulds several times a year as they grow out of them. Occluding earwax also prevents the proper examination of the ear canal and the accurate completion of some diagnostic tests.

In some cases, management of earwax will be more complex (e.g. those with mastoid cavities) and referral to secondary care services may be required. However, this should be a small number of people, with the majority being able to self-manage or have their ear wax managed in primary and community care.

There is consensus that certain removal/maintenance methods should not be used (cotton buds, matches etc.) should not be used to try to clear wax from an ear canal. Wax is normally only produced in the outer third of the ear canal, so using these tools forces the wax further down the canal and forms a hard plug against the ear drum. They can also cause trauma to the ear canal and even perforation of the ear drum, thereby also increasing the risk of infection. Ear candling should not be used.

Task and Finish Group findings show patients need and appreciate direct and clear language in the advice they receive on management (including self-management) of medical conditions. Information leaflets and promotional material to support people to make the right choices related to ear wax self -management and direct them to access the correct services is important.

[1] Advice from Andrew Evans, Chief Pharmaceutical Officer, is that there is little evidence to suggest which type of oil is more effective, or whether salt water is better than a solution of bicarbonate of soda. His comments on self-management: 'We have found that using ear drops may help to remove the ear wax. It is not clear whether one type of drop is any better than another, or whether drops containing active ingredients are any better than plain water or saline.' His comments on ear drops that may be obtained on prescription, should ear wax management be added to the Common Ailments Scheme: 'When determining the choice of ear drop to prescribe, prescribers should choose the product with the lowest NHS acquisition cost unless there are compelling patient reasons'.

Provision of ear wax management services across Wales is patchy; with no clear pathway, training requirements or service specification. There are areas of good practice in ear wax management already being delivered in some health board cluster areas in line with the principles of prudent healthcare that could be rolled out across Wales in line with our national plans.

Incidence of Ear Wax in the Population of Wales: Scoping studies found as part of the development of the Advanced Practice Audiology in primary care that 3% of the population present with ear wax each year. This equates to approximately 96,000 patient appointments in primary care across Wales each year.

Recommendations: The Wax Management Task and Finish Group agreed:

1. Ear wax management to be delivered in a primary and community care setting, in line with the nationally agreed service specification, standard operating procedures and training standards, led by Advanced Audiology Practitioners and delivered by trained healthcare professionals.
2. The Audiology Heads of Service Group to agree and lead on discussion and implementation of points 3-9 below.
3. Roll out of a national wax management patient pathway.
4. Commission a national wax management training programme; to include microsuction and/or manual removal using a probe.
5. The new wax management pathway will complement roll out of 'first point of contact' access to audiology services in primary care, for patients presenting with hearing problems, tinnitus, and specific balance problems.
6. Develop national advice for ear wax self-management.
7. Health boards will now implement, monitor and review the new pathway and service models in their respective cluster areas.
8. Continue discussion with health professionals to raise awareness e.g. give pharmacists access to training and promotion of wax self-management.
9. Progress centralised national procurement of equipment in one health board.

The recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the Guideline Committee's experience and opinion of what constitutes good practice. The NICE pathway for hearing loss in adults recommends that primary or community care services should offer to remove ear wax if the ear wax is contributing to hearing loss or other symptoms, or needs to be removed in order to examine the ear to take an impression of the ear canal.

The final pathway is shown below:


SELF MANAGEMENT
Patients of all ages with complex ear conditions
Ear wax symptoms resolved. Patients provided with ongoing self-management advice.

Patients presenting **with** ear wax symptoms may experience:

- Discomfort / ear ache
- Blocked ear (self-reported or clinician observed)
- Hearing loss
- Tinnitus

Patients **without** the above ear symptoms but who report problematic earwax are to be provided with info on self-management, including ongoing self-management. Advice is from:

- Leaflets/ website
- Choose Well advice at pharmacies
- NHS Direct 0845 4647
- Public health information to include advice NOT to use cotton buds or similar inside ear

The exclusions for self-management are:

- Have sudden onset or rapid worsening of hearing (NICE Guidance NG98)
- Patients with significant pain and/or discharge from ear
- Patients with known ear drum perforations and/or discharge from the ear.

➢ **These groups of patients should contact their general practice.**

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* With the exception of counter-indications eg patients with complex ear conditions

**Referral may also be made by GP practice staff (triage) or GP if picked up in course of appointment for other condition

† Patients with complex needs(e.g. learning disability, dementia, anxiety) may require onward referral to ear wax management service with specialist/advanced skills appropriate for the management of people with complex needs

†† with specialist skills appropriate for the management of children.

Appendix 2 – Correspondence from WG

Karin M Phillips
Dirprwy Gyfarwyddwr- Gofal Sylfaenol
Deputy Director – Primary Care Division
Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

To: Directors of Primary Care; Directors of Therapy

Llywodraeth Cymru
Welsh Government

9 August 2017

Dear Directors

Framework of Action for people who are D/deaf or living with hearing loss 2017-2020

I have now officially taken up my role as Deputy Director – Primary Care and I am conscious that this is my first letter in my new role.

I met most of the Directors of Primary Care in my recent 'tour of Wales'. The remaining meetings are scheduled over the next few weeks. I am grateful to Grant for arranging these meetings and to you for providing me with a lot of information and context. I met most of the Directors of Therapies in my previous role and I look forward to continuing to work with you in my new role.

I am writing to raise awareness and seek greater engagement and dissemination of the 'Framework of Action for people who are D/deaf or living with hearing loss 2017-2020', launched by the Cabinet Secretary for Health, Well Being and Sport, in May 2017.

A multi-disciplinary project board, chaired by Andrew Goodall, has been established to oversee the implementation of the recommendations. The board held its first meeting in July 2017 to agree terms of reference and will meet again in November 2017 to agree the priorities. Further details of the board's membership and terms of reference is attached at annex 1. .

This work supports the overall policy of developing more new models of care closer to home. For example Abertawe Bro Morgannwg University Health Board and Betsi Cadwaladr University Health Board are leading in the delivery of audiology services in the community, working with local clusters to test new service models. The Cabinet Secretary has visited both projects to learn how the audiology practitioners provide an open access service to patients with a variety of ear and hearing problems. He was extremely impressed to see how the new models are improving patient outcomes, access and experiences. Similar to the pacesetter projects, he expects to see all health boards, working with clusters, to develop and move similar models of care into the community, on an all-Wales basis.

For ease of reference, the Framework can be accessed via the links below:

http://gov.wales/topics/health/publications/health/reports/audiology/?lang=en
http://gov.wales/topics/health/publications/health/reports/audiology/?skip=1&lang=cy

BUDDSODDWYR MEWN POBL | INVESTORS IN PEOPLE

Grŵp Iechyd a Gwasanaethau Cymdeithasol • Health and Social Services Group
Parc Cathays • Cathays Park
Caerdydd • Cardiff • CF10 3NQ

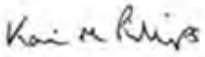
E-bost • E-mail: Grant.duncan@wales.gsi.gov.uk
Ffôn • Tel: 03000 256576

In the first instance the ask is for you to:

- disseminate the framework to your teams and clusters;
- ask clusters to reflect in their planning considerations of the key priorities for this community once agreed.

The project board looks forward to working with you. Please contact the project board secretariat to get involved with this work Philip.Reardon-Smith@gov.wales

Yours sincerely



KARIN M PHILLIPS MBE
Dirprwy Gyfarwyddwr- Gofal Sylfaenol
Deputy Director – Primary Care

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Primary Care
Cc to Directors of Therapies and Healthcare Scientists

December 2019

Dear colleagues,

I continue to receive letters from members of the public reporting that GPs are advising them that there is no NHS wax management service available and they must seek private treatment. This is not the case. The provision of earwax management services is an NHS responsibility and nobody should expect to have to pay for this service.

There has been a variety of provision for ear wax management; some GPs have traditionally provided services, whilst others have referred patients to hospital ear, nose and throat departments. In cluster areas where the new primary care audiology service model is in effect, wax management is delivered there. If a practice does not provide ear wax management services, they should refer the patient for treatment elsewhere through the NHS.

It remains the responsibility of the Health Boards to plan how services will be delivered within their area, as close as possible to people's homes whenever clinically safe and practical.

It is important for primary care providers to relay the correct message and for patients to receive the right information. Please take the appropriate action in the health board to ensure GPs are aware of the NHS Wales ear wax management pathway in their local area.

Following on, in line with *'A Healthier Wales'* it is our aim to move services out of hospitals and into primary care where appropriate. A Welsh Government task and finish group is due to report at the end of the year on a national integrated pathway for the safe and effective management of ear wax that provides for consistent patient outcomes across Wales. The key aims are to make sure patients of all ages are provided with the most appropriate treatment for the management of problematic ear wax. In the meantime, health boards should work with clusters to consider how to introduce or upscale the new primary care audiology service model, where wax management can be delivered locally.

Yours Sincerely

Alex Slade
Dirprwy Gyfarwyddwr, Gofal Sylfaenol
Deputy Director, Primary Care

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Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AC/AM
Y Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol
Deputy Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Vice Chairs of Health Boards and NHS Trusts

19 November 2019

Dear Colleagues,

Unfortunately our Q4 NHS Vice Chairs meeting on 09 December is now cancelled. However, we would like to receive a written update on the following areas which we would have discussed at the meeting.

Primary Care –

1. *Progress with promoting the Primary Care Model for Wales across the whole board*
   The Primary Care Model for Wales is one of the 5 Ministerial priorities in the NHS Planning Framework for 2020-23. As discussed in August, the Model is a matter for the whole health board, not just for the director of primary and community care. Your role is vital in continuously promoting this and monitoring progress with its implementation. I would welcome a note on the action you have taken, how effective this has been and planned further action.

2. *Progress with national standards for access to in hours general medical services*
   We discussed the access standards at our meeting in August and guidance was issued in September to support both health boards and GP practices to implement the standards. I would welcome an update on progress.

3. *Reform of Primary Care Contracts*
   Please provide an update on what the health board is doing to promote integration between primary care contractors and implementation of the changes negotiated for the national contracts. Regarding optometry, I would also like an update on the health board interaction with the Wales Eye Care Service Joint Committee, set up through Ministerial Legislative Directions to monitor service delivery.

4. *Access to Eye Care and Audiology Services*
   Moving services out of hospitals is a fundamental aim of *A Healthier Wales,* the *Primary Care Model for Wales,* the *Eye Care Delivery Plan* and the *Framework of Action Hearing Loss Plan*. Re-providing more preventative care in the community to improve access and make effective use of funding and workforce resources, underpins the agreed plans. However, the nationally agreed pathways for cataract, glaucoma, wet-Age Related Macular Degeneration and unscheduled care are not yet rolled out across health boards.

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Canolfan Cyswllt Cyntaf / First Point of Contact Centre
0300 0604400
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Correspondence.Vaughan.Gething@gov.wales

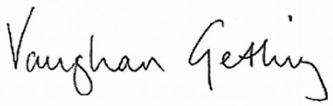
Full implementation of the pathways will help to drive forward the aims of the agreed national plans. I would welcome your assessment of the barriers and the action you are taking to progress this at pace and scale. With audiology, the new service models set up in cluster areas, using some of the transformational funding, are not being moved into mainstream service delivery. The new service models will help to drive forward the aims of the nationally agreed plans. I would welcome you assessment of the barriers and the action you are taking to progress this at pace and scale.

5. *Access Issues in Relation to Dental Services*
   Can you detail what plans you have to increase access to general dental services in your area.

We would be grateful if you could sent a copy of your written update to HSSBriefingsandMeeting@gov.wales by 29 November at the latest.

Thank you for your co-operation on this matter.

Yours sincerely,



Vaughan Gething AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Julie Morgan AC/AM
Y Dirprwy Weinidog Iechyd a Gwasanaethau Cymdeithasol
Deputy Minister for Health and Social Services

Appendix 3 – Support letters from GPs

Dr Steven Jones
Dr Rose Penson
☎ (01352) 712029

Dr Jon Potter
☎ (01352) 713289

VAT Registration
No 879 0982 60

Pendre Surgery
Coleshill Street
Holywell, Flintshire
CH8 7UP
Fax (01352) 712751

Dr Chris Wallace
☎ (01352) 710211

☎ (01352) 712133

Betsi Cadwaladr
University Health Board

12th December 2017

Our Ref: CW/LM

Jane Wild
Audiology Service
Wrexham Maelor Hospital

Dear Jane,

I believe that you are the lead for primary care audiology. I am writing to give you some feedback about the experience we have had with in-house audiology.

This has been provided by Sarah Canton over the last 12 months. We have found the whole provision very valuable. We have been able to develop a working team and provided a high level of patient care. This has been particularly useful with Sarah being on site. We think that it is a service that we would like to continue. The patients have been able to receive prompt clinical service in an environment with which they are familiar. We have been able to provide a reasonable level of administrative support. Our patients and the staff have become familiar with the service, there has been an ability to direct patients to the audiologist without having to make appointments with GPs. This has allowed us to be able to concentrate on patients with more complex needs.

We wonder whether the service could be broadened to allow us to refer paediatric patients, possibly over the age of 12 with similar hearing problems.

In summary, we have had a very good service that fits with our working ethos of near patient provision of care and we as a result have been able to free up more time for ourselves to provide care to more complex patients.

Yours sincerely

Dr C Wallace

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KINGS HOUSE SURGERY
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4 January 2018

FOR THE ATTENTION OF: Jane Wilds

I am writing this letter in support of the excellent Audiological service that has been provided at Kings House Surgery over the past year. Because of this service, there have been multiple benefits to us as a GP surgery, which I detail below.

1. It has improved patient access to GP, by freeing up GP appointments
2. It provides more appropriate referrals and signposting
3. Provision of better, evidence based, intervention for our patients
4. Specialist assessment and treatment for BPPV
5. Reduced waiting times overall for all related services

This service has become invaluable to us, as a practice already short of clinicians. To lose it would be extremely detrimental to our patients and us; with the loss of it having a significantly negative effect on our delivery of routine GMS.

Yours sincerely

Dr G S Arora

Appendix 4 – Benefits Realisation Action Plan V1.2

Benefits Realisation Action Plan for Audiology in Primary including the First Point of Contact Advanced Practice Audiologists and the Audiology Led, Managed and Delivered Earwax Management Pathway

This Benefits Realisation Action Plan sets out the benefits of the project, the category of each benefit (in economic terms) how they will be measured and quantified, who is responsible for their realisation and what actions need to be taken and by when to achieve delivery of the benefit. The benefits included on the plan were outlined in the relevant sections of the business case and the previously circulated plan.

This Action Plan is intended to be a management tool which will be reviewed at the monthly meetings of the project workstream.

Benefit 1.0	**Provide equity of access and care by making first point of contact advanced practice audiology service available in all GP practices/Clusters**						
Type of benefit	**Qualitative**						
	Specific Measurables	**Timetable for achievement**	**Method to Review**	**Lead Responsibility**	**Agreed actions**	**By when**	**Status (RAG)**
1.1	All first point of contact advanced practice audiology services currently provided are continued.	On approval of the scheme	Audiology PC team to validate	Audiology PC leads	Confirmation with all current Practices that services can continue and confirmation of sessions available and timetabled	End of M1	
1.2	Access to advanced practice audiology in Primary care in 50% of Practices across BCUHB.	50% coverage by end of Y1M6	Audiology PC team to validate	Head of Service and Audiology PC leads	Finalise and confirm detailed Y1 roll out plans. Developed in collaboration with PC clusters and PC leads. Recruit staff. Purchase equipment. Implement service delivery based on current service delivery model	End of Y1M1 End of Y1M4 End of Y1M2 End of Y1M5	
1.3	Access to advanced practice audiology in Primary care in 75% of Practices across BCUHB.	75% coverage by end of Y2M6	Audiology PC team to validate	Head of Service and Audiology PC leads	Finalise and confirm detailed Y2 roll out plans. Developed in collaboration with PC clusters and PC leads. Recruit staff. Purchase equipment. Implement service delivery based on current service delivery model	End of Y2M1 End of Y2M4 End of Y2M2 End of Y2M5	

1.4	Access to advanced practice audiology in Primary care in 100% of Practices across BCUHB.	100% coverage by end of Y3M6	Audiology PC team to validate	Head of Service and Audiology PC leads	Finalise and confirm detailed Y3 roll out plans. Developed in collaboration with PC clusters and PC leads. Recruit staff. Purchase equipment. Implement service delivery based on current service delivery model	End of Y3M1 End of Y3M4 End of Y3M2 End of Y3M5	
Benefit 2.0	**Provide equity of access and care by implementing the new national wax management pathway service in all GP practices/Clusters**						
Type of benefit	**Qualitative**						
	Specific Measurables	**Timetable for achievement**	**Method to Review**	**Lead Responsibility**	**Agreed actions**	**By when**	**Status (RAG)**
2.1	Access to Audiology led wax removal service in Primary care in 50% of Practices across BCUHB.	50% coverage by end of Y1M9	Audiology PC team to validate	Head of Service and Audiology PC leads	Finalise and confirm detailed Y1 roll out plans. Developed in collaboration with PC clusters and PC leads. Recruit staff – Phase 1 Recruit Staff – Phase 2 Purchase equipment. Implement service delivery based all Wales service specification developed as part of national pathway	End of Y1M1 End of Y1M4 End of Y1M8 End of Y1M2 End of Y1M5/9	
2.2	Access to Audiology led wax removal service in Primary care in 75% of Practices across BCUHB.	75% coverage by end of Y2M6	Audiology PC team to validate	Head of Service and Audiology PC leads	Finalise and confirm detailed Y2 roll out plans. Developed in collaboration with PC clusters and PC leads. Recruit staff. Purchase equipment. Implement service delivery based all Wales service specification developed as part of national pathway	End of Y2M1 End of Y2M4 End of Y2M2 End of Y2M5	
2.3	Access to Audiology led wax removal service in Primary care in 100% of Practices across BCUHB.	100% coverage by end of Y3M6	Audiology PC team to validate	Head of Service and Audiology PC leads	Finalise and confirm detailed Y3 roll out plans. Developed in collaboration with PC clusters and PC leads.	End of Y3M1	

					Recruit staff. Purchase equipment. Implement service delivery based all Wales service specification developed as part of national pathway	End of Y3M4 End of Y3M2 End of Y3M5	
Benefit 3.0	**Release GP capacity**						
Type of benefit	**Quantitative and non-cash releasing**						
	Specific Measurables	**Timetable for achievement**	**Method to Review**	**Lead Responsibility**	**Agreed actions**	**By when**	**Status (RAG)**
3.1	Advanced Practice audiologist is the first point of contact for >70% of people (aged 7 years and above) presenting with hearing, tinnitus or for adults with balance symptoms consistent with BPPV	6/12 following implementation at each Practice	Routine data collection and evaluation	Audiology PC leads	Engagement and promotion of first point of contact adv practice audiology with PC/Practice staff and local population Monitor referral source and include in regular activity and evaluation reports	Variable and ongoing to end of phased roll out Quarterly	
3.2	Number of GP appts released increased and then maintained as adv practice audiology service rolled out. Expected number of consultations to exceed >16,000/year when fully rolled out	Full achievement end of roll out	Ongoing monitoring of activity at each practice and monthly reporting to audiology leadership team	Audiology PC leads	Monitor activity levels for each practice and include in monthly Audiology balanced scorecard Address local variations or low activity rates (compared to expected) locally with GP practices	Monthly from M1 As required and through regular comms with each practice	
3.2	Ongoing development of the service to increase the scope of the advanced practice role as opportunities present and capacity allows	Following full roll out	Ongoing monitoring of activity and capacity	Head of Service and Audiology PC leads	As part of continued development agree plans to explore extended scope. To include consideration of younger children, outer and middle ear management including use of PGDs	Following full roll out and ongoing	

Benefit 4.0	**Release Practice/Community Nurse capacity**						
Type of benefit	**Quantitative and non-cash releasing**						
	Specific Measurables	**Timetable for achievement**	**Method to Review**	**Lead Responsibility**	**Agreed actions**	**By when**	**Status (RAG)**
4.1	Number of Practice/Community Nursing appts released increases as audiology led wax management pathway implemented and rolled out. Expected number of consultations to exceed >28,000/year when fully rolled out	Full achievement end of roll out	Ongoing monitoring of activity at each practice and monthly reporting to audiology leadership team	Audiology PC leads	Monitor activity levels for each practice and include in monthly Audiology balanced scorecard Address local variations or low activity rates (compared to expected) locally	Monthly from M1 As required and through regular comms with each practice	
4.2	Ensure smooth and effective hand over from those service currently delivering wax removal thereby avoiding duplication of service delivery and releasing Practice and Community nursing capacity	As services implemented and rolled out	Records of engagement with Practices, Clusters and community teams and development of agreed plans for transition of services	Audiology PC leads	Engage with Practices, Clusters and community teams and agree plans for transition of services to avoid overlap and duplication of service delivery	Plans for roll out in Y2 and 3 agreed by end of Y1 Plans for roll out Y1 agreed end of M3	
Benefit 5.0	**Deliver specialist care closer to home and reducing need for ENT/Audiology referrals. Where referrals do occur these will be of high quality.**						
Type of benefit	**Quantitative**						
	Specific Measurables	**Timetable for achievement**	**Method to Review**	**Lead Responsibility**	**Agreed actions**	**By when**	**Status (RAG)**
5.1	Numbers and proportion of people being assessed and managed in PC (i.e. not requiring onward referral) remains at expected levels or increases as opportunities for service improvements arise. Expected proportion of people managed in PC is >70%.	Ongoing and as services implemented and rolled out. Within 3/12 of implementation at each practice	Routine data collection and evaluation Development and review of improvement plans	Audiology PC leads	Monitor outcomes including number and proportion of people being assessed, managed and discharged in PC. Include in regular activity and evaluation reports. Develop improvement plans that include exploring opportunities to increase number and	Quarterly ongoing	

					proportion of people being assessed, managed and discharged in PC (e.g. through additional diagnostic capability/equipment, facilities (couches with arms); additional management option (PGDs)		
5.2	Rate of referral to secondary care audiology and ENT to not in exceed previous rates and appropriateness of referral monitored.	Ongoing and as services implemented and rolled out. Within 3/12 of implementation at each practice	Routine data collection and evaluation Development and review of improvement plans	Audiology PC leads	Monitor outcomes including need and reason for onward referral and include in regular activity and evaluation reports. Develop plans to address any issues around appropriateness of referral	Quarterly ongoing	
5.3	Referrals to secondary care audiology and ENT are high quality	Ongoing and as services implemented and rolled out. At least annual audit of quality of referrals	Annual audit	Audiology PC leads	Audit quality of referrals including outcomes following referral and consultation in Sec care. Develop plans based on audit findings to include consideration of impact of any diagnostic info from PC and potential changes in service to improve quality and appropriateness.	annual	
5.4	Ongoing development of the service to increase the scope of the advanced practice role as opportunities present and capacity allows thereby reducing need for onward referral	Following full roll out	Ongoing monitoring of activity and capacity	Head of Service and Audiology PC leads	As part of continued development agree plans to explore extended scope. To include consideration of younger children, outer and middle ear management including use of PGDs	Following full roll out and ongoing	
Benefit 6.0	**Provide a more effective and integrated patient pathway**						

Type of benefit	**Qualitative**						
6.1	Onward referrals to Audiology for instrumental intervention are based on individual need, confirmation of HL and assessment of readiness for intervention	Ongoing and as services implemented and rolled out	Audit of uptake of intervention following referral	Audiology PC leads	Work with secondary care audiology leads to audit outcome of referrals to audiology for instrumental intervention including uptake, identification of needs and outcomes (IMP-OS)		
6.2	Pathways are adapted and developed to best meet the needs of individuals	Ongoing	Development and review of improvement plans base on audit and service user experience	Head of service and Audiology PC leads	Use information from audit above and service user experience questionnaires to identify need for changes in pathway. Develop plans with secondary care audiology leads to improve pathway to best meet individual needs	Annually Following full roll out and ongoing	
Benefit 7.0	**High service user satisfaction**						
Type of benefit	**Qualitative**						
	Specific Measurables	**Timetable for achievement**	**Method to Review**	**Lead Responsibility**	**Agreed actions**	**By when**	**Status (RAG)**
7.1	Service users report high levels of service satisfaction. Maintain overall satisfaction levels of >90%.	Ongoing and as services implemented and rolled out. At least quarterly survey of service user experience	Service user satisfaction/experience questionnaire	Audiology PC leads	Measure service user experience and satisfaction using agreed questionnaire. Evaluate and use outcomes to develop and improve services	Quarterly ongoing	
7.2	Number of patient complaints, AM queries or issues raised by CHC related to access to and provision of wax removal services decreases	As roll out progresses	Monitor complaints to HB, AM queries and comments from CHC	Head of Service	Monitor complaints to HB, AM queries and comments from CHC related to access to and provision of wax removal services	As baseline and then quarterly	
Benefit 8.0	**Advanced Practice Audiologists and Audiologist delivering wax removal pathways in Primary Care Can Contribute to a Sustainable Primary Care Workforce**						

Type of benefit	Quantitative						
8.1	PC audiology staff successfully recruited and retained within PC audiology services.	Y1: 2.9WTE B8a retained 2.62WTE B7 retained 3.38WTE B7 recruited 7.0WTE B5 recruited Y2: above retained 3.0WTE B7 recruited 3.5WTE B5 recruited Y3: above retained 3.0WTE B7 recruited 3.5WTE B5 recruited	Review of recruitment and WF data	Head of service and Audiology PC leads	Gain EC approval and posts on TRAC Maintain CPD and PADR to support retention	As soon as possible following approvals ongoing	
Benefit 9.0	**Audiologists in Primary Care and Audiologist led/delivered wax removal pathways are in line with prudent healthcare principles and national strategy and policy**						
Type of benefit	Qualitative						
9.1	Compliance with WHC/2020/014 achieved	Plans agreed and approved within stated 12/12 (i.e. by Oct 2021) Full delivery by end of 2024	Progress against roll out plans including recruitment and implementation	Head of service and Audiology PC leads	Develop implementation/roll out plans plan Monitor progress against recommendations within WHC	End M3 for Y1 End of Y1 for Y2/3 Full compliance by end of 2024	
9.2	Delivery of WG 'Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss'	Plans agreed and approved by end of Y1 Full delivery by end of 2024	Progress against roll out plans including recruitment and implementation	Head of service and Audiology PC leads	Develop implementation/roll out plans plan	End M3 for Y1 End of Y1 for Y2/3	

					Monitor progress against HB action within Framework of Action for Wales	Full compliance by end of 2024	

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	Business case and proposal to Exec team First Point of Contact Advanced Audiology Practitioners in Primary care to release GP capacity; increase accessibility providing specialist care closer to home and develop a more integrated pathway. Including an audiology led, managed and delivered earwax management pathway within Primary Care.
Date form completed:	9th August 2021

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	A proposal and business case for: First Point of Contact Advanced Audiology Practitioners in Primary care to release GP capacity; increase accessibility providing specialist care closer to home and develop a more integrated pathway. Including an audiology led, managed and delivered earwax management pathway within Primary Care.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Purpose: This business case document makes recommendations based upon an evaluation of the established Advanced Practitioner Audiologists in Primary Care service. It describes the case to roll out the successful scheme to provide equity of access and realise the same benefits across BCUHB area. The business case also includes the management and delivery of the Wales earwax management pathway within Primary Care, providing a response from the health board to the recent Welsh Health Circular WHC/2020/014.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Being submitted to Executive team for consideration and approval. Responsible Director: Dr Chris Stockport
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Business case aligned to HB actions within the WG The Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss was published in May 2017 and the recent WHC/2020/014 (Sept 2020)
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Service users and staff. Proposal based on existing scheme that has been in place and evaluated for 3 years. There has been ongoing engagement with audiology and PC staff and the proposal has been reviewed by a number of groups (Area

Part A Form 1: Preparation

Please answer all questions

		Quartet team, PC senior management team, HBRT). Additionally the concept of advanced practice audiology and an audiology led wax removal pathway has been presented to the RPB and the latter to the LMC. Service users will be people with sensory impairment (hearing loss) or with tinnitus, specific balance problems. Both elements of this proposal feature within the WG The Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss was published in May 2017. This was developed in partnership with third sector orgs. Development of this pathway is further supported by the multisector North Wales Collaborative Care Group NWCCG (which includes CHC representatives), overseeing the implementation of the Framework in North Wales. They have identified the development of improved wax management pathways and equitable access to wax management services as a priority for North Wales. This was supported as a priority by service users across North Wales as part of a survey of priorities undertaken by the NWCCG
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	This proposal is based on a tried and tested (award winning) service model that has been in implemented and in place at BCUHB for the last three years. Key requirements to achieve benefits are well understood and are detailed within the benefits realisation action plan. The proposal requires funding/investment and this is detailed within the business case. To mitigate any risks associated with recruitment and implementation the plan proposes a three year phased roll out.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	This proposal will improve equity of access by rolling out a service that is only currently offered to approx. 25% of people in North Wales. Additionally the proposal will improve access to specialist advice and care closer to home. Many people accessing this service will be older due to the increased prevalence of hearing loss in older age groups.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below) *for further direction on how to complete this section please click here training vid p13-18)*	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** Hint/tip: do not say: "not applicable", "no impact" or "regardless of...". If you have identified 'no impact' please explain clearly how you came to this decision.		

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. For the definitions of each characteristic please click here					
	Yes	No	(+ve)	(-ve)		
Age	x		x		Positive: The advanced practice first point of contact audiology service will be limited to people aged 7 years and above. This is based on likely presenting condition and ensuring the person sees the right clinician first time. The profile of presenting symptoms is different in young children who require GP rather than audiology consultation. Work has been ongoing and will continue to re-evaluate the minimum age for accessing advanced practice audiology in PC to ensure any pts regardless of age are able to access the most safe and effective care available. Exploring opportunities to extend the minimum age is included within the business case and the benefits realisation action plan Part B of the business case (audiology led, managed and delivered wax management pathway) is in line with the national wax management pathway which is for all ages. Positive: Prevalence and severity of hearing loss increases with age. Providing first point of contact audiology services in PC will increase the accessibility for assessment, advice and support for older people.	.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Disability	x		x		Positive: This proposal will increase accessibility for people with hearing loss. Communication needs of people with hearing loss will be identified at the earliest opportunity. Hearing, tinnitus and Benign paroxysmal positional vertigo (BPPV) are important health conditions that, if left unmanaged, result in reduced quality of life and impact on an individual's physical and mental health. Hearing impairment is an important long term health condition and in Wales, it is ranked as the fifth highest cause of years lived with disability by the WHO Global Burden of Disease initiative. It is also the leading cause of years lived with disability for those over 70. Any promotional and service user materials will be developed considering appropriate language and terminology to ensure accessibility.	
Gender Reassignment		x			Service provision will be equitable across BCUHB and accessible to all those self-identifying hearing difficulties, tinnitus or specific balance symptoms All services will be delivered from within existing health board clinical premises or GP practice facilities. Any promotional and service user materials will be developed considering appropriate language and terminology.	
Pregnancy and maternity		x			Service provision will be equitable across BCUHB and accessible to all those self-identifying hearing difficulties, tinnitus or specific balance symptoms	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					All services will be delivered from within existing health board clinical premises or GP practice facilities	
Race		x			Service provision will be equitable across BCUHB and accessible to all those self-identifying hearing difficulties, tinnitus or specific balance symptoms	.
Religion, belief and non-belief		x			Service provision will be equitable across BCUHB and accessible to all those self- identifying hearing difficulties, tinnitus or specific balance symptoms	.
Sex		x			Service provision will be equitable across BCUHB and accessible to all those self-identifying hearing difficulties, tinnitus or specific balance symptoms	.
Sexual orientation		x			Service provision will be equitable across BCUHB and accessible to all those self-identifying hearing difficulties, tinnitus or specific balance symptoms	.
Marriage and civil Partnership (Marital status)		x			Service provision will be equitable across BCUHB and accessible to all those self-identifying hearing difficulties, tinnitus or specific balance symptoms. Existing patient management systems will be used to hold and record information	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Socio Economic Disadvantage	x		x		This proposal will deliver specialist care closer to home and thereby reducing the inequalities associated with rurality and social deprivation. Prevalence of hearing loss is increased in areas of social deprivation. Providing care closer to home and increasing accessibility to specialist services sooner and nearer will help to reduce this inequality.	.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166 and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	x			*none*	This service will be provided to all people within their communities.	*Please explain how you intend to remove or reduce any negative impacts you have identified.* **Be specific.**

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		x			Recruitment of specialist clinical staff will include consideration of the recruitment of Welsh speakers. Existing audiology primary care staff have developed their Welsh language skills and will continue to do so.	
Treating the Welsh language no less favourably than the English language		x			All materials and service user information has been developed bilingually and will be provided to service users in their preferred language.	

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	The Framework of Action for Wales (2017 -2020) – Integrated framework of care and support for people who are D/deaf or living with hearing loss was published in May 2017. This Framework was developed by professionals, service users, community health councils, third sector and other organisations working together Services in Wales. This framework highlights the importance of early intervention; states that people will be able to self-refer to audiology services and that in order to ensure ease of access, many Audiology services should be delivered in the local community. This proposal fulfils all the requirements within this WG Policy that was developed in collaboration with service users. The multisector North Wales Collaborative Care Group NWCCG (which includes CHC representatives), has been set up and is in place to set the priorities and oversee the implementation of the Framework in North Wales. They have identified the development of access to improved wax management pathways and equitable access to wax management services as a priority for North Wales. This was supported as a priority by service users across North Wales as part of a survey of priorities undertaken by the NWCCG. Service users feedback has been gathered where these services are already in place and the feedback is overwhelmingly positive with 98% of people reporting that their needs had been met by the Audiologist in Primary Care, 98% rating the service as either very good or excellent and 100% of people saying they would recommend the Audiology service to others. Similarly engagement with stakeholders (GP and other PC professionals) has been very positive with 100% of PC clinicians responding that the service is of value to their patients at least to some extent and 98% reporting that they would like the service to continue in their practice.

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Have any themes emerged? Describe them here.	Overwhelming support for the services proposed within this business case
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	A proposal and business case for: First Point of Contact Advanced Audiology Practitioners in Primary care to release GP capacity; increase accessibility providing specialist care closer to home and develop a more integrated pathway. Including an audiology led, managed and delivered earwax management pathway within Primary Care.

2. Brief Aims and Objectives: (Copy from Form 1)	Purpose: This business case document makes recommendations based upon an evaluation of the established Advanced Practitioner Audiologists in Primary Care service. It describes the case to roll out the successful scheme to provide equity of access and realise the same benefits across BCUHB area. The business case also includes the management and delivery of the Wales earwax management pathway within Primary Care, providing a response from the health board to the recent Welsh Health Circular WHC/2020/014.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: **This is as indicated on form 2 and 3**	Yes	No x

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, y**ou should be able to answer 'No' to this question.**	Yes	No x
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area? High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x	
	No negative impacts identified		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x	
	No negative impacts identified although recognised that current minimum age of 7 years for first point of contact access to advanced practice audiologist. Current minimal age limitations are based on clinical need and most appropriate clinical pathways. Whilst these will be reconsidered as part of ongoing service development no immediate actions are required or are appropriate.		
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes x	No	
	How is it being monitored?	Ongoing service evaluation including service user feedback	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

implement your policy or proposal?	Who is responsible?	Leads for audiology in primary care and head of adult audiology service
	What information is being used?	Access/activity data and outcomes (PROMs) plus service user feedback based on existing approved patient experience surveys (PREMs)
	When will the EqIA be reviewed?	Annually following implementation

7. Where will your policy or proposal be forwarded for approval?	Executive Director/ Board

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity	Name	Title/Role
	Jane Wild	Consultant Clinical Scientist and Head of Adult Audiology Service
	John Day	Consultant Clinical Scientist and Clinical Director of Audiology

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Senior sign off prior to committee approval:	John Day	Consultant Clinical Scientist and Clinical Director of Audiology
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	*Please detail any changes you have made as a result of negative impacts identified. ,*		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	*As indicated above, minor negative impact on one or two groups may well be an acceptable outcome. There may also be significant cost implications involved in removing minor impact for small groups but bear in mind that this minor impact could be 'disproportionate' to the group(s) involved.*		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	*We have a specific legal duty to 'advance equality of opportunity' so record here anything you have discovered during your assessment that might contribute towards meeting this duty.*		

SOCIO ECONOMIC IMPACT ASSESSMENT TEMPLATE

For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see https://gov.wales/more-equal-wales-socio-economic-duty

Public health data is available here North Wales Population Health Directory. If you require support with interpreting public health data please contact the Betsi Cadwaladr Public Health Team.

Further support in applying this process is available from Strategy and Planning colleagues, the Equality Team and your Equality Delivery Group representative. An intranet resource page to guide you through the process has been set up here Betsi Cadwaladr University Health Board | Socio-economic Duty (wales.nhs.uk)

This SEIA procedure should be commenced at the outset and inform the development of both new strategic decisions and when reviewing previous strategic decisions. It provides a clear audit trail for all decisions made under the 2010 Act.

Policy / Strategy / Proposal/Procedure Title	Business Case: Delivery of Primary Care Audiology Services.
Lead Manager	John Day, Clinical Director Audiology & Jane Wild, Head of Adult Audiology
Approval Committee	Finance and Performance Committee
Date form completed	9th August 2021
What are the aims and objectives of the policy/strategy/proposal?	All people with hearing, tinnitus and specific balance difficulties in North Wales can access an Advanced Practice Audiologist as the first point of contact in a Primary Care location, enabling them to receive more specialist care sooner and closer to home and at the same time releasing GP capacity. Additionally all people presenting with problematic earwax can access an integrated earwax management pathway delivered and managed by Audiology in Primary Care, that uses NICE recommended (microsuction) methods for the safe and effective removal of earwax (cerumen), enables onward referral as required and provides equity of access and care.

STAGE 1: PLANNING						
Is the decision a strategic decision? See definition	YES	Please provide a brief explanation for your answer	Proposal aims to fulfil requirements of Welsh Health Circular and includes investment in new pathways being delivered across North Wales			
Have you identified key stakeholders groups? Please detail below	Yes	**Can you identify relevant communities of interest?** See guidance Please detail below	Yes	**Can you identify relevant communities of place?** See guidance Please detail below	No	
Clinical colleagues in PC, North Wales Collaborative care group for Hearing loss (include SRG and CHC reps)		People with sensory loss and associated disabilities. Prevalence of hearing loss is increased in areas of social deprivation and in older people.				
STAGE 2: EVIDENCE						
What evidence have you considered about socio-economic disadvantage and inequalities of outcome in relation to this decision?	Prevalence of hearing loss is increased in areas of social deprivation and in older people. Implementation of this proposal will decrease inequalities associated with sensory loss and social deprivation by improving access and delivering specialist care closer to home.					
Have you engaged with those affected by the Policy / Strategy Proposal / Policy?	We have engaged with those accessing the service in pilot areas and feedback has been overwhelmingly positive with 100% of people surveyed saying they would recommend the service to others. The multiagency North Wales Collaborative Care Group NWCCG (which includes Community Health Council (CHC) and Stakeholder Reference Group (SRG) representatives), overseeing the implementation of the Welsh Government 'Framework of Action for Wales (2017 -2020) – Integrated					

	framework of care and support for people who are D/deaf or living with hearing loss'.in North Wales, identified the development of improved wax management pathways and equitable access to wax management services as a priority for North Wales. This was supported as a priority by service users across North Wales as part of a survey of priorities undertaken by the NWCCG. Presentation of the proposal to Regional Partnership Board (RPB) and CHC.
What engagement with people living with socio economic disadvantage will be / has been undertaken?	Engagement with pilot service users, NWCCG and CHC which will continue as we implement the service. This will include engagement with people living with socio-economic disadvantage to ensure that the service model continues to meet their specific needs.
How has / will this influence your work/guided your policy/proposal, or changed your recommendations?	The proposal will deliver services across BCU in PC locations ensuring improved access and increased specialist care closer to home thereby reducing inequalities. Communication plans and materials will be developed with CHC to ensure all people are aware of how to access the service.

Stage 3: ASSESSMENT AND IMPROVEMENT

What are the main socio economic impacts of the proposal?
Consider evidence from both research and any engagement already carried out.
Who is being affected? Refer to the North Wales Population Health Directory
Are some communities of interest or communities of place more affected by disadvantage than others?

The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain these areas include:

- Education
- Work

- Living standards
- Health
- Justice and personal security
- Participation

It is helpful to consider where action can be taken to reduce inequality of outcome resulting from socio-economic disadvantage in regards to each of these areas, evidence is provided below and issues for consideration suggested.

Education	**In Practice**	**This Proposal**
A literature review by the Centre for Research in Early Childhood (CREC) finds that evidence they examined indicates that in the UK, especially, parents' socio-economic status continues to be the primary predictor of which children prosper in adult life. They report that the magnitude of early childhood inequality in the UK is well-documented; some estimates suggest that half the attainment gaps for pupils are already present at the start of primary school. Using Millennium Cohort study data, this research shows large gaps exist in the UK for vocabulary tests between children aged 4 and 5 from families with middle incomes and those from families with lowest fifth of incomes. Data for Wales also shows pupils eligible for free school meals and children in care have	Overall school children in Wales attain scores in reading, science and mathematics below those in England, Scotland and most other developed countries. Since schools closed during lockdown, children from better-off families have been spending 30 per cent more time on home learning than poorer children How does your proposal take account of the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have or have had access to training opportunities and qualifications? Think about how careers support at BCUHB and with partners, including apprenticeships and volunteer work placements can be	This proposal could reduce inequality of outcome for children with unidentified or unmanaged hearing loss. First point of contact access to specialist practitioners closer to home will improve access and appropriateness of onward referral. Accessible communication materials will be developed to ensure awareness of the service for all. .

poorer educational outcomes in schools on average with the gap widening as pupils get older.	promoted to support young people furthest from the job market.	
Health There is a clear social gradient in terms of health outcomes as documented by the Marmot Review (2010 and 2020 update). It makes it clear that health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources (i.e. the social determinants of health). Indeed, data for Wales shows that adults and children living in the poorest areas are having poorer health outcomes. Adults living in the most deprived areas of Wales have lower life expectancies than those living in the least deprived areas. There is reasonable evidence that people in poverty or living in deprived neighbourhoods have a higher risk of addiction and mental illness and it's also known that many patients struggle financially and socially.	**In Practice** How does your proposal take account of the expected health outcomes of the local population? What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors. What are the opportunities for collaboration, have local third sector organisations been engaged and opportunities to promote access to financial wellbeing, social and other support maximised?	Hearing loss is an important health condition which if left unmanaged will have a negative impact on other health conditions . • There is a growing body of evidence of an independent association between hearing loss and dementia. In a recent Lancet Commission 'Dementia prevention, intervention, and care', hearing loss was identified as the biggest modifiable risk factor for dementia. • Hearing impairment is an important long term health condition and in Wales, it is ranked as the fifth highest cause of years lived with disability by the WHO Global Burden of Disease initiative. It is also the leading cause of years lived with disability for those over 70. • Hearing loss is associated with an increase in chronic health conditions, including diabetes, stroke and sight loss; it presents a greater risk of falls and more visits to healthcare professionals. People

		with hearing loss are also two and a half times more likely to develop depression than their peers without hearing loss. • Hearing impairment is often unrecognised and evidence suggests that people wait, on average, 10 years before seeking help for their hearing loss and that when they do, GPs fail to refer 30-45% to NHS audiology services. It is estimated that of the 11 million people in the UK with manageable hearing loss less than half of people who would benefit from hearing aids have them. This leaves a significant unmet need in our population. This proposal aims to deliver specialist care closer to home improving access and thereby reducing the inequalities related to socio-economic disadvantage. Additionally prevalence of hearing loss increases with social deprivation so increased management of hearing loss will impact positively.
Living standards 3% of all people in Wales were living in relative income poverty between 2016-17	**In Practice** How does your proposal take account of the impact of poverty and deprivation?	This proposal aims to deliver specialist care closer to home improving access

and 2018-19. This figure has remained relatively stable for the past 16 time periods. At 23%, the figure is slightly lower than last year's. Children were the age group most likely to be in relative income poverty (at 28%) and this has been true for some time. 11% of children living in Wales between 2016-17 and 2018-19 were in material deprivation and low income households.	Can you identify which groups are disproportionately impacted by poverty e.g. disabled people? Think about the UK-wide reforms to social security and the impact on the poorest in society, particularly women, disabled people, ethnic minorities and lone parents in Wales.How have the needs of people with caring responsibilities been considered? What is the incidence of rough sleeping and levels of homelessness? Twice as many people expect their financial situation to get worse as those who expect it to get better, with this rising to three times in the bottom income quintile, and more than three times for single parents. Think about the availability and accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces. As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?	and thereby reducing the inequalities related to socio-economic disadvantage
Work	**In Practice**	.

When considering all children in Wales, the likelihood of being in relative income poverty is much greater, and the gap is increasing for those living in a workless household compared to living in a working household (where at least one of the adults was in work).	As one of the largest employers in Wales BCUHB provides numerous opportunities for people to access work, the Step into Work programme is a great example. Think about how careers support including apprenticeships and volunteer work placements can be promoted to support those who are furthest from the job market, those who are in households where no one is in employment, young people who are not in employment or training and other seldom-heard groups. Think about people in terms of their income and employment status, consider the impact on the availability and accessibility of work, paid and unpaid employment, wage levels, job security and working conditions. What are the implications of the proposal for people on low income, those who are economically inactive, unemployed, workless, and people who are unable to work due to ill-health. Consider people living in work poverty. During the pandemic lower earners are three times as likely to have lost their job or been furloughed as high earners. How can procurement and commissioning arrangements be optimised to reduce inequalities of outcome caused by socio-economic disadvantage? As part of your proposal what are the opportunities to	Unemployment is higher for those with unmanaged hearing loss compared to general population. This proposal aims to improve access and deliver specialist care closer to home and thereby reducing the inequalities related to socio-economic disadvantage.

	increase employment opportunities for people who experience socio-economic disadvantage?	
Justice and personal security The National Survey for Wales (2018-19) shows that people who were not in material deprivation were found to be more likely to feel safe in their local area, compared with those who were in material deprivation. Research by the University of Bristol shows that, notwithstanding some significant methodological limitations, existing analyses in the UK and internationally have consistently found vulnerability to domestic violence and abuse to be associated with low income, economic strain, and benefit receipt. This association is underpinned by a complex set of relationships and interdependencies.	**In Practice** How does your proposal take account of local crime rates and exposure to crime? What are the hate crime statistics? Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control. How can your proposal promote and protect people's rights and increase their access to justice and personal security?	Effective communication is essential for wellbeing and independence. Communication difficulties often relate to awareness of environmental sounds and feelings of safety. This proposal will improve access and provide care closer to home for people with hearing loss who are at increased risk due to unawareness of environmental cues and reduce communication abilities.
Participation The National Survey for Wales (NSW) shows that in 2018-19, 87% of households had access to the internet. Household internet access varies by WIMD levels of	**In Practice** How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal?	Service delivery will not rely on digital inclusion. We will work with the CHC to develop a variety of communication materials and plans to ensure all people

area deprivation. In 2018-19, 92% of households in the least deprived areas had internet access, compared to 83% of households in the most deprived areas. The NSW also shows households in social housing were less likely to have internet access (75% of such households) than those in private rented (90%) or owner occupied (89%) accommodation. Those in employment were more likely to have internet access at home (96%) than those who were unemployed (84%) or economically inactive (78%).	Covid-19 has shone a spotlight on a digital divide and highlights the effects of digital exclusion on those in poverty, with some feeling isolated and forgotten about. Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities. How can your proposal increase participation for people who experience socio-economic disadvantage?	are aware of the service and how to access.

What actions will you undertake to minimise any adverse impacts identified during this Socio Economic Duty Impact Assessment?			
Impacts Identified	**Mitigating Action to be Taken**	**Action Owner**	**Monitoring Arrangements**
No adverse impacts identified			

STAGE 4: STRATEGIC DECISION MAKERS		
Who signed-off this SED Impact Assessment	**Signatory** As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.	
	Board or Sub Committee:	Finance and Performance Committee
Approval and Review	**Approval Date:**	
	Review Date:	

Appendix 3

Type of Decision Includes but is not limited to:	**Equality Impact Assessment Required**	**Socio Economic Duty Impact Assessment Required**
Strategic policy development.Strategic directive and intent, including those developed at Regional Partnership Boards and Public Service Boards which impact on a public bodies functions	x	x
Health Board Wide Plans.Medium to long term plans (for example, corporate plans, development plans, service delivery and improvement plans)	x	x
Business Case/Capital Involvement/Options Appraisal required	x	x
Setting objectives (for example, well-being objectives, equality objectives, Welsh language strategy)	x	x
Changes to and development of public services Closure of Services	x	x
Decisions affecting service users, employees or the wider community including (de)commissioning or revised services	x	x
Efficiency or saving proposals, e.g., resulting in a change in community facilities, activities, support or employment opportunities	x	x
Directorate Financial Planning	x	x
Divisional policies and procedures affecting staff	x	
New policies, procedures or practices that affect service delivery	x	
Large Scale Public Events	x	
Major procurement and commissioning decisions	x	x
Local implementation of National Strategy/Plans/Legislation (e.g. vaccination programme)	x	x

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Adult and Older Person's Mental Health Unit Glan Clwyd Hospital Outline Business Case (OBC)**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson, Executive Director of Planning & Performance Teresa Owen, Executive Director of Public Health & Lead for Mental Health Services
Awdur yr Adroddiad **Report Author:**	Ian Howard, Assistant Director – Strategic & Business Analysis Jill Timmins, Programme Director for Ablett Unit Redevelopment
Craffu blaenorol: **Prior Scrutiny:**	In line with the organisation's Procedure for Managing Capital Projects the business case has been endorsed by: • The Adult and Older Person's Mental Health Unit Project Board • The Capital Investment Group • The Executive Team
Atodiadau **Appendices:**	Appendix 1 Outline Business Case Appendix 2 Financial Analysis Appendix 3 Equality Impact Assessment Appendix 4 Socio Economic Duty Assessment Further appendices supporting the business case are available to Committee members on request – see list below

Argymhelliad / Recommendation:

The Committee is asked to approve the Business Case for submission to the Board. Subject to Board approval the case will then be submitted to Welsh Government.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision /Approval**	✓	**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**Y**

This is a strategic decision. The socio-economic impact assessment is included as an appendix to the business case.

Sefyllfa / Situation:

Major capital business case have three stages – the Strategic Outline Case (SOC), the OBC and the Full Business Case (FBC). The primary purposes of a SOC are to outline the case for change, and to indicate a potential way forward and estimated cost, rather than a definitive costed option. The SOC for this project was agreed by the Board in 2018, and approved by Welsh Government in February 2019.

This OBC is the point at which there is a clear decision about the preferred option, and robust costs are produced. The preferred option is now a new build on the Glan Clwyd site at a cost of £67.7 million.

Subject to approval by the Finance and Performance Committee and the Board, the business case will be submitted to Welsh Government for scrutiny. Welsh Government have been kept informed about the progress of the case, including the costs, throughout its development. Approval of an OBC by Welsh Government results in detailed design work being undertaken on the preferred option to produce the final capital costs for the FBC.

Cefndir / Background:

This case aims to improve the quality of patient care, and support service transformation, through the development of a new Adult and Older Person's Mental Health Unit at Glan Clwyd Hospital. The unit will replace the existing Ablett Unit at Glan Clwyd Hospital, and the Older People's Mental Health inpatient facility at Bryn Hesketh, at a capital cost of £67.7 million.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

As outlined in the Strategic section of the case, the development is fully aligned to Together for Mental Health - Welsh Government's ten year cross-governmental strategy to improve mental health and well-being – and to BCUHB's Together for Mental Health in North Wales.

Opsiynau a ystyriwyd / Options considered

The Economic section of the case contains a full option appraisal.

Goblygiadau Ariannol / Financial Implications

The Financial section of the case outlines the capital and revenue implications. The capital cost is £67.7 million. This figure includes an estimate for inflation, and excludes Optimism Bias (estimated at 2%). The capital cost has been derived in accordance with the national Design for Life; Building for Wales frameworks. This entails working with the Supply Chain Partner (construction contractor), as well as an independent Cost Advisor and Construction Project Manager. The Cost Advisor has reviewed the cost against similar projects within Wales and the UK and have provided professional assurance that that the capital costs are reasonable and compare favourably with the benchmark data.

In terms of revenue, the preferred option is projected to be revenue-neutral.

Dadansoddiad Risk / Risk Analysis

The Strategic and Economic sections of the case summarise the risks. A full risk register for the project is included as an appendix.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Subject to approval of the case by the Board and Welsh Government, the project will be managed in line with the Health Board's Procedure for Managing Capital Projects.

Asesiad Effaith / Impact Assessment

The preferred option has been assessed in terms of:

- Equality Impact
- Socio-Economic Duty
- Community Benefits
- Health Impact

The Equality Impact Assessment indicates that the preferred option has a positive impact for many of the protected characteristics (notably age, due to the improvements in OPMH provision) and no negative impacts. The Socio-Economic Duty and Community Benefits highlight in particular the employment opportunities (both paid and voluntary) of the scheme. The Health Impact is very positive, reflecting the core purpose of the project – to improve the quality of care for patients. The full impact assessments are included as Appendices to the case.

Appendices available for Committee members on request

App A Together for Mental Health in North Wales
App B Mental Health Plan 2021/2 v5
App C Benefits Realisation v9
App D Engagement Feedback report
App E Engagement Calendar
App F Bed ModellingAblett updated 27.7.21
App G CHC Letter of support
App H Ablett OA report v.07
App I Benefits Criterai Sensitivity Analysis
App J Economic Mode

App K Optimism Bias
App L Risk Workshop notes 13.7.21
App M EQIA revised July 2021 (See appendix 4 above)
App N SED v05 3.7.21 (See appendix 3 above)
App O Health Impact Assessment July 2021
App P Community Benefits
App Q Financial Analysis August 21 (See Appendix 2 above)
App R i OBC Forms14.7.21 Option 1
App R ii OBC Forms14.7.21 Option 2
App R iii OBC Forms14.7.21 Option 3
App R iv OBC Forms14.7.21 Option 4
App S TORS Governance April 2021
App T Risk Register v16 5.8.21

Adult and Older Person's Mental Health Unit Glan Clwyd Hospital

Outline Business Case (OBC)

August 2021
Draft 0.5

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Draft 0.1	27.07.21	First Draft	Ian Howard, Jill Timmins
Draft 0.2	29.07.21	Division amendments	Ian Howard, Jill Timmins
Draft 0.3	02.08.21	Amendments following review by Project Board and Capital Investment Group	Ian Howard, Jill Timmins
Draft 0.4	05.08.21	Project Team amendments	Ian Howard, Jill Timmins
Draft 0.5	12.08.21	Amendments following review by Executive Team	Darren Smith, Joanna Garrigan

Contents

1. Executive Summary

2.1 Introduction

This case aims to improve the quality of care, and support service transformation, through the development of a new Adult and Older Person's Mental Health Unit at Glan Clwyd Hospital. The unit will replace the existing Ablett Unit at Glan Clwyd Hospital, and the Older People's Mental Health inpatient facility at Bryn Hesketh, at a capital cost of £67.7 million[1].

2.2 Strategic Case

Strategically, the case is driven by Together for Mental Health, Welsh Government's ten year cross-governmental strategy to improve mental health and well-being. The key local strategy is BCUHB's Together for Mental Health in North Wales, which has a strong focus on: health promotion; early intervention; providing services which are community-based wherever possible; and supporting recovery. In terms of the acute and urgent care system, there is a commitment to three inpatient units across North Wales, on the District General Hospital sites at Bangor, Bodelwyddan and Wrexham, to ensure the effective delivery of person centred, locality-based acute care. The intention is to manage acute and serious episodes of mental illness safely, compassionately, and effectively through a service within which:

- No-one waits more than 4 hours for mental health assessment in crisis;
- Once assessed, people are placed immediately in accommodation suitable for their needs. For most people, this should be their own home, with sufficiently intensive home treatment support. For some, it could mean a short-stay crisis house. For a minority, it will mean acute inpatient care;
- No-one stays longer than they need to in acute inpatient care. There are no "delayed transfers of care" due to lack of step-down support;
- No-one is admitted to an acute mental health bed outside North Wales.

This case addresses two inter-related issues: the physical limitations of the Estate in the Central Area in delivering both the current and future models of care; and a shortage of inpatient beds to meet current and projected needs. It has been informed by various external reports and investigations - including HASCAS, Ockenden and Health Inspectorate Wales - and produced through an extensive process of engagement.

In terms of Bryn Hesketh, there is a risk to managing patients with high levels of acuity along with co-occurring physical health needs so far away from the acute general hospital. In addition the Bryn Hesketh Unit cannot be regarded as a sustainable facility in terms of national environmental and clinical quality standards.

[1] At PUBSEC 250. This figure includes an assessment of potential inflation, and excludes optimism bias (estimated at 2%).

As regards the Ablett Unit, there are a range of issues: the mixing of older people with mental illness alongside young adults, which is not appropriate and does not deliver good patient experience; ward environments that are not fit for purpose; privacy and dignity standards that not being met; an electroconvulsive therapy (ECT) facility that is not fit for purpose; a pharmacy that is too small and cannot support individual consultations; very limited therapeutic areas and opportunities for exercise; insufficient provision for patient assessment; the absence of a de-stimulation area; poor staff facilities; and traditional single office accommodation for administration which does not support co- location of specialist teams and agile working.

Patients from Conwy and Denbighshire are frequently admitted to either Bangor or Wrexham because of a lack of beds. Current and future bed requirements have been evaluated, taking into account both service transformation and demographic changes, and the conclusion is that there are insufficient beds for both Adult and Older Person's services. Also the Ablett Unit currently has a bed-based rehabilitation facility which is no longer part of the rehabilitation model of care.

The specific objectives of this case are:

1	To provide services which meet the Strategic Direction outlined within *Together for Mental Health* (T4MH) in North Wales and deliver the model of care developed through the quality and workforce groups.
2	To create a quality clinical environment that is fit for purpose, safe and humane.
3	To improve workforce recruitment and retention and absenteeism through providing an environment that supports staff to deliver safe, effective care to patients, carers and families.
4	To improve the quality of the estate by reducing backlog maintenance, reducing running costs, and achieving environmental sustainability
5	Flexibility: to deliver the flexibly to respond to future need – the solution should be designed to respond to future changes in service delivery.

The scope of the case proposes:

- Providing a 14 bed Older Person's Mental Health functional ward that incorporates bedrooms with ensuite facilities, improved circulation and recreational spaces and improved observation.
- A 13 bed new fit for purpose dementia care assessment unit with an end of life bedroom. This will include provision for families and carers to stay with their loved ones overnight, to support the implementation of John's campaign. This ward will have clear circulations routes, with no dead ends, a secure courtyard that will bring light into the ward, ensuite facilities to all bedrooms, recreational and therapy spaces and improved visibility.
- Two purpose-built 16 bedded adult wards, which will be designed flexibly to respond to gender split and future models of care. There will be an age appropriate bed included in the adult ward as required in Welsh Government's admission guidance.

- A de- stimulation area on each ward which will provide a safe nursing environment for high acuity patients. This will support the reduction of transfers to other facilities, in and out of North Wales, and provide teams with more options to manage patients differently and reduce restraints.
- An assessment suite to enable suitable patients to be moved from the Emergency Department (ED) in a timely manner to be assessed by the Psychiatric Liaison Team.
- A small gym and increased use of outdoor space for therapeutic interventions.
- A new 136 suite with an additional assessment room for all admissions to be triaged in a timely manner.
- Increased therapeutic space indoors and outdoors.
- Provision of a modern accredited regional ECT suite.
- Removal of the locked rehabilitation ward.
- Staff change and rest facilities.
- A café and bright reception area.

2.3 Economic Case

A long list of potential options have been evaluated, to establish the most cost-effective way of delivering the project. The conclusion is that the best option is to build a new unit on the Glan Clwyd site. This option addresses the full service scope outlined in the Strategic Case, and carries the least risk in terms of implementation. The socio-economic, equality and health impacts of the proposal have been assessed and found to be positive. The current service at the Ablett and Bryn Hesketh will be maintained while the new unit is constructed. Once the new build is complete, the Ablett Unit and the relevant elements of the Bryn Hesketh service move to the new build. The current Ablett Unit is retained for alternative use. The future use of the Bryn Hesketh site will be the subject of a review with stakeholders to assess whether it should be used to relocate services from other sites or if it is surplus to requirements. Car parking space is created at Glan Clwyd Hospital to replace the spaces lost, and to take account of the increased activity associated with the transfer of services from Bryn Hesketh.

2.4 Commercial Case

The project will be procured via the Building for Wales framework for Projects with a construction value in excess of £10 million.

The following appointments have been made:

▪ Construction Project Manager	Gleeds Management Services
▪ Cost Advisor	Gleeds Cost Management
▪ Supply Chain Partner (construction contractor)	BAM Construction Ltd

2.5 Financial Case

The capital cost of the preferred option is £67.7 million, at PUBSEC 250. This includes an estimate of inflation. It does not include Optimism Bias, which is estimated at 2%.

In terms of revenue, the preferred option is projected to be revenue-neutral. There is an increase in costs of £1.73 million compared to existing arrangements. Of this, £1.48 million relates to an increase in capital charges (i.e. depreciation), which is funded by Welsh Government. The net figure after capital charges is therefore £0.25 million. This gap will be fully mitigated by a corresponding reduction in out of area placements, facilitated by the increase in inpatient beds in the unit.

2.6 Management Case

The project will be managed in accordance with the Procedure Manual for Managing Capital Projects, which was adopted by the Health Board in 2018.

The key milestones for the project are as follows:

Milestones	Target Date
BCUHB approval and submission of Outline Business Case to Welsh Government	September 2021
Full Business Case Completed	January 2023
Construction Completed	December 2025

2. Structure and Contents of the Document

There are three key stages in the development of a project business case. These are: the Strategic Outline Case (SOC); the Outline Business Case (OBC); and the Full Business Case (FBC).

The SOC for this scheme established the strategic context, made a robust case for change and provided a suggested way forward, rather than a definitive preferred option. The SOC was approved by Welsh Government in 2019.

This OBC:

- Reviews and refreshes the strategic context and the case for change;
- Identifies the option which optimises value for money; and
- Outlines the funding and management arrangements for the successful delivery of the scheme.

Approval of the OBC gives consent to the procurement phase of the project. Subject to OBC approval, the FBC will: set out the negotiated commercial and contractual arrangements for the deal; demonstrate that it is 'unequivocally' affordable; and put in place the detailed management arrangements for the successful delivery of the scheme. The intention is to produce the FBC for the scheme in January 2023, and for the scheme to be complete in December 2025.

This OBC has been prepared using the agreed standards and format for business cases, as set out in the NHS Wales Infrastructure Investment Guidance. This approved format is the *Five Case Model,* and comprises the following:

- The **Strategic Case** - this sets out the strategic fit and case for change, together with the supporting investment objectives for the scheme;
- The **Economic Case** - this demonstrates that the organisation has selected a preferred option which optimizes public value for money;
- The **Commercial Case** - this outlines that the preferred option will result in a viable procurement and well-structured deal;
- The **Financial Case** - this demonstrates that the preferred option will result in a fundable and affordable deal;
- The **Management Case** - this demonstrates that the scheme is achievable and can be delivered successfully in accordance with accepted best practice.

3. The Strategic Case

3.0 Introduction

The purposes of the Strategic Case are: to explain how the scope of the project fits within the existing business strategies of the organisation; and to provide a compelling case for change, in terms of existing and future service needs.

The Strategic Case is split into three sections:

1. A brief summary of key strategic changes since the production of the SOC;
2. The strategic context: this contains a brief overview of BCUHB. It also confirms that there is a strategic fit between this project and both national and local policies and objectives;
3. The case for change: this section summarises the investment objectives; highlights the challenges with the status quo; outlines the scope of the project; and summarises the benefits, risks, constraints and dependencies of the project.

3.1 Section A: Strategic Changes since the Production of the SOC

There have been various developments in the strategic context of the project since the SOC was developed in 2018. Taken together they have resulted in a significant change to the proposed scope of the project, and to the nature of the preferred option. The changes cover the following areas:

1. The continued evolution of the national and local strategies for Mental Health Services, which have reinforced the case for change.
2. The ongoing implementation of those strategies, including through new investments. The learning from this has altered some elements of the proposed service model and the design.
3. The impact of Covid-19 on how services should be delivered, which has also altered some elements of the service model and the design.
4. A review of the scope of the project as a result of the first three points outlined above, combined with an extensive process of stakeholder engagement. This has resulted in a significantly increased scope for the project.
5. Judgements about the Older Person's Mental Health (OPMH) inpatient services at Bryn Hesketh: the future of this unit was still under discussion when the SOC was produced. A clear conclusion has now been reached, supported by the CHC, that this service should transfer to Glan Clwyd Hospital. This has changed the range of options considered at the shortlisting stage.

The full analysis of all of these changes is outlined in sections B and C, below.

3.2 Section B: The Strategic Context

3.2.1 Organisational overview

BCUHB was established on 1st October 2009 and is the largest health organisation in Wales. It provides primary, community, acute and mental health services for a population of approximately 700,000. BCUHB is responsible for the operation of over 90 health centres, clinics, community health team bases and mental health units, 19 community hospitals and three Acute Hospitals.

BCUHB employs approximately 16,500 staff and has an annual revenue budget of approximately £1.6 billion.

3.2.2 Strategy for Mental Health

3.2.2.1 National Mental Health Strategy – Together for Mental Health

Together for Mental Health was published in October 2012 and is Welsh Government's ten year cross-governmental strategy to improve mental health and well-being across all ages. The strategy sets out a number of high-level outcomes aimed at achieving a significant improvement to both the quality and accessibility of mental health services for all ages. It recognises that the causes and effects of poor mental health are complex, challenging and multi-faceted and therefore require an integrated, cross-government and cross-sector partnership approach. There are six high level outcomes underpinning the 10 year strategy:

- The mental health and well-being of the whole population is improved.
- The impact of mental health problems and/or mental illness is better recognised and reduced.
- Inequalities, stigma and discrimination are reduced.
- Individuals have a better experience of the support and treatment they receive and feel in control of decisions.
- Improved quality and access to preventative measures and early intervention to promote recovery.
- Improved values, attitudes and skills of those supporting individuals of all ages with mental health problem.

The strategy has since been supported by a series of detailed delivery plans. The third and final delivery plan was published in 2019 and whilst the delivery plan outlines a number of new priority areas for 3 years, they all contribute to achieving the high-level outcomes set out originally in Together for Mental Health.

The key priorities in the 2019-2022 delivery plan are:

- Improving mental health and well-being and reducing inequalities – through a focus on strengthening protective factors.

- Improving access to support for the emotional and mental well-being of children and young people – improving access and ensuring sustainable improvements to timeliness of interventions, as well as supporting the new curriculum and whole school approach, extending the reach of NHS services into schools and filling gaps in services within both primary and secondary care through Child and Adolescent Mental Health Services (CAMHS).
- Further improvements to crisis and out-of-hours provision for children, working age and older adults – moving to a common, multiagency offer across Wales improving the access, quality and range of psychological therapies for children, working age and older adults – to deliver a significant reduction in waiting times by the end of this Government, to increase the range of therapies offered and to support the workforce - ultimately improving service user experience.
- Improving access to and the quality of perinatal mental health services – further development of perinatal mental health services in line with quality standards and care pathways and the provision of in-patient care.
- Improving quality and service transformation – including a focus on improvements to areas such as eating disorders support, people in contact with the criminal justice system and co-occurring mental health and substance misuse issues.
- Positive change will also be achieved by responding to Healthcare Inspectorate Wales/Care Inspectorate Wales thematic reviews, reviews by NHS Delivery Unit and receiving assurance that recommendations have been delivered.

Together for Mental Health is being refreshed for the period 2022-2025. It is anticipated that it will continue to support the acute care inpatient pathway with further crisis and community services complementing our ambition that people will be in hospital for the shortest duration required.

3.2.2.2 BCUHB Mental Health Strategy – Together for Mental Health in North Wales

Overview

The key strategy that drives this business case is Together for Mental Health in North Wales (T4MHNW), which was adopted by the Health Board in 2017 and is enclosed as Appendix A. This is an all-age mental health strategy developed in partnership to support the delivery of the objectives outlined in the National Mental Health Strategy. T4MHNW is being refreshed with stakeholders via the North Wales Partnership Board, concurrently with the national strategy. As with the national strategy, it anticipated that the key strategic drivers that inform this business case will remain in place.

Together for Mental Health in North Wales is also an integral part of the Health Board's overall clinical strategy, Living Healthier, Staying Well, which was published in 2018. This overarching strategy sets out the vision for the Health Board over the next ten years, with a particular focus on: the shift of resources to community settings; the movement of care closer to home; the development of seamless multi-agency services; and the emphasis on a well-being system.

Together for Mental Health in North Wales commits the Health Board to six key principles in everything it does:

- We will treat people who use our services, and their carers and families, as equal partners – all of us must be seen as essential assets in improving the mental health and wellbeing of the communities of North Wales;
- We will ensure everything we do is as integrated as possible – across disciplines, across agencies, across services – in both planning services, and delivering services. Fragmented care must be replaced by joined-up and continuous care;
- We will work to ensure everyone feels valued and respected;
- We will support and promote the best quality of life for everyone living with mental health problems;
- We will promote local innovation and local evaluation in how we provide services;
- We will continually measure our impact on outcomes, within both national and local quality and outcomes frameworks – whether we have improved the lives of people for and with whom we provide services.

The mental health strategy confirms the Health Board's intention to offer a comprehensive range of services which:

- Promote health and wellbeing for everyone, focussing on prevention of mental ill health, and early intervention when required;
- Treat common mental health conditions in the community as early as possible;
- Are community-based wherever possible, reducing our reliance on inpatient care;
- Identify and treat serious mental illness as early as possible;
- Manage acute and serious episodes of mental illness safely, compassionately, and effectively;
- Support people to recovery, to regain and learn the skills they need after mental illness;
- Assess and treat the full range of mental health problems, working alongside services for people with physical health needs.

Urgent Care

In terms of the acute and urgent care system Together for Mental Health in North Wales envisages a service within which:

- No-one waits more than 4 hours for mental health assessment in crisis;
- Once assessed, people are placed immediately in accommodation suitable for their needs. For most people, this should be their own home, with sufficiently intensive home treatment support. For some, it could mean a short-stay crisis house. For a minority, it will mean acute inpatient care;

- No-one stays longer than they need to in acute inpatient care. There are no “delayed transfers of care” due to lack of step-down support;
- No-one is admitted to an acute mental health bed outside North Wales.

Specific Actions and Ambitions

The strategy commits the Health Board to a range of specific actions and ambitions. Significant amongst those are:

- New services and approaches will be available to promote good mental health: promotion of the five ways to wellbeing; schools-based programmes; employer-based approaches; welfare rights and money advice;
- Peer support services will be available as a step-down option from statutory community care;
- Social prescribing will be more widely available, promoting access to education, exercise, personal and creative development;
- There will be new integrated teams to manage very common co-morbidities between physical and mental health, for example anxiety and COPD;
- We will improve the availability of a range of psychological therapies, including online therapeutic interventions;
- People experiencing first episode psychosis will have access to the full range of NICE-approved interventions;
- There will be alternatives available to inpatient admission for those able to manage safely in more intensive community situations;
- All ward environments will be fit for purpose, safe and humane;
- Information about patients’ history, and care and treatment plans, will be available in real-time to all staff working with them;
- There will be a realistic and sustainable fit between our service commitments, and the numbers and skills of staff to deliver them;
- We will ensure full and effective governance of both our commissioned services, and those we directly provide.

The Estate

In terms of the Estate, the strategy contains an analysis of the significant problems with the existing inpatient facilities. In particular:

- All of the wards at the Ablett Unit at Glan Clwyd Hospital are out-of-date in design, with cramped facilities, lack of ensuite provision and narrow corridors;
- Bryn Hesketh has limited bathroom facilities, no ensuite facilities, and significant backlog maintenance problems. It is also isolated from other services;
- The Hergest Unit in Bangor is not designed to modern standards, and is of an age where upgrade to elements of the fabric and services are required;

- Coed Celyn rehabilitation unit is dated and cramped in its design;
- Cefni requires improvement to internal and external facilities.

The strategy commits the organisation to an approach which "will …generate new ward/unit designs that support future service requirements. We would expect to close more remote and isolated units, and incorporate their services in larger hubs." To deliver the ambition laid out in the strategy, there is a clear requirement for a substantial programme of investment in the estate across North Wales. Within that context there is a particular priority to address the issues related to the Ablett Unit and Bryn Hesketh in the Central Area, which are summarised above and outlined in depth in the section below on issues with current service provision.

Three Acute Mental Health Units Co-located with the Three Major General Hospitals

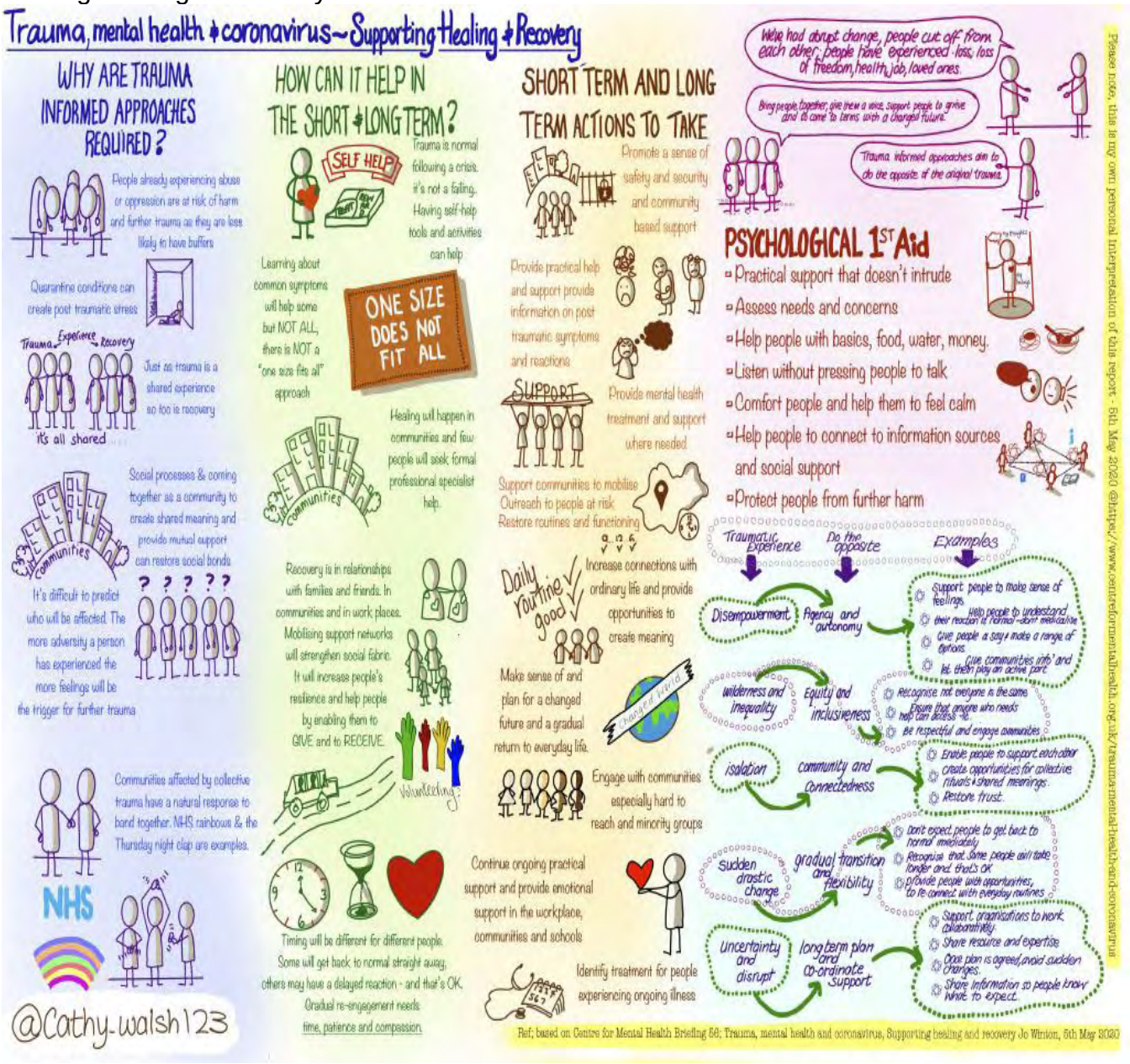
As outlined in the SOC, a central tenet of both Living Healthy Staying Well and Together for Mental Health is the delivery of care closer to home. The commitment given in Living Healthy Staying Well is that in order to deliver services to meet future needs the three main hospitals at Ysbyty Gwynedd in Bangor, Glan Clwyd Hospital in Bodelwyddan and Wrexham Maelor Hospital will provide core services to meet the needs of the population. It is important to ensure parity of esteem across physical and mental health provision. Parity of esteem means equal access to effective care and treatment; equal efforts to improve the quality of care; equal status within health care education and practice; equally high aspirations for service users; and equal status in the measurement of health outcomes. This is a key objective within the mental health strategy for North Wales. Also addressing mental and physical health needs together is better for patients' outcomes and can be more cost-effective. The Health Board will continue to operate acute admissions on all three sites to ensure that patients admitted under the Mental Health Act in an acute phase will remain closer to home in relation to their treating team and families which will impact positively on length of stay and enable timely discharge to Home treatment. The three site model will ensure that all acutely ill patients will not be travelling for extended periods of time and also takes into account operational pressures of partners such as the six Local Authorities in relation to Adult Mental Health provision, and North Wales Police in terms of crisis response.

The practical impact of this analysis is that there is a need for three inpatient units across North Wales, on the District General Hospital sites at Bangor, Bodelwyddan and Wrexham, to ensure the effective delivery of person centred, locality-based Acute care.

The implementation of Together for Mental Health in North Wales – ICAN and Service Transformation

Since the publication of the strategy in 2017 work has been ongoing on both continuing to develop the models of care via the quality and workforce groups and the Local Implementation Teams (LITs) and progressing the implementation of new services. This work has been co-produced with service user and staff involvement, undertaken in close collaboration with partners across North Wales via the Together for Mental Health Partnership Board.

As part of the engagement work, local people with lived experience said that they wanted a focus on mental health throughout their lives, from birth (and planning pregnancy) until death. Our plans build on these discussions and take an 'all-age' approach to mental health, removing potential barriers and building resilience as early as possible. In addition people with lived experience have told us that they would welcome increased accessibility and trauma informed care at the primary care level, provided in their communities, with a shared vision of moving towards recovery and utilising existing community assets.



The development of ICAN is a key element of the approach to implementing BCUHB's Mental Health Strategy. The vision is that people who use our services will lead the way in driving the cultural change required in Mental Health Services across North Wales, equipping our workforce (staff, volunteers and partners) with the skills and confidence to work in a trauma informed way across the whole continuum of care, encouraging open conversations about Mental health and reducing the stigma that exists in our Communities.

ICAN will be leaders in Mental Health Support Services, with the focus on connecting people to the right support at the right time, making the right connection at the first contact, but also connecting the wider system to itself. Creating a more organised, coordinated response to supporting people.

We will continually measure the impact of our services and will commission services based on evidence of demand and need and on the whole system outcomes we want to achieve.

ICAN Aims:

- Give a voice to people with lived experience
- Shift the focus of Care to prevention and early intervention
- Empower people to maintain their mental health and well being
- Encourage open and informed conversations about Mental Health
- Co-produce a framework to deliver a trauma informed service

The ICAN Offer will continue to be developed. However there are 4 key components to ICAN service offer aimed to support Primary Care and the whole system at a Community level:

- **ICAN Hubs** – Multi Agency community spaces offering wide ranging support.
- **ICAN Primary Care – Enhanced Mental Health offer at a GP surgery**. A first point of contact appointment as an alternative to a GP appointment and connection to the wider ICAN Offer of support.
- **ICAN Work** – Access to time unlimited intensive employment support – supporting people into competitive employment but also empowering employers to support individuals to remain in work.
- **ICAN Crisis**–services. A Twilight service. A safe space during the twilight hours when people are in crisis delivered by a third sector provider. Agreed pathways into the service from the 111 crisis team, WAST and NW police.

The ICAN approach is summarised in the following diagram:

ICAN Primary

- First contact appointment with a MH professional at the GP surgery
- Access to physical and mental health advice and support
- Access to self-management information and techniques
- Book a physio or nurse appointment
- Discuss medication
- Access to ICAN Hub & ICAN Work
- Information on local groups and services

ICAN Community Hubs

- Instant access to support within the local community
- Face to face, telephone and virtually delivered service
- Access to information
- Access to local groups and activities
- Referral to ICAN Primary Care
- Referral to ICAN Work
- Referral to specialist 3rd sector organisations

Advice and support

Putting the individual first **Close to home**

Early intervention

Accessible No wrong door

Mental Health & Wellbeing

Tailored Support

ICAN

- It aims to get people into paid employment
- Open to all those who want to work and are receiving support from a health professional for mild to moderate mental health problems.
- Provides support to people at risk of losing employment due to their condition
- The aim is to find jobs consistent with people's preferences
- It works quickly – we start job searches within 30 days
- It brings I CAN Work teams and health professionals together so that employment becomes a core part of recovery and wellbeing
- I CAN Work teams develop relationships with employers so they can match a person to a job based on their work preferences, not based on who happens to have jobs available
- It provides ongoing individualised support for the person and their employer, helping people to keep their job at difficult times
- Benefits counselling is included, because nobody should be worse off

ICAN Crisis

- Provides an alternative to A&E for Mental Health only conditions via walk in assessment unit.
- Eventual 24/7 Telephone Support
- Referral to ICAN Primary Care
- Referral to ICAN Community Hub
- Referral to ICAN Sanctuary

The recent increased provision of Welsh Government transformation funds for Mental Health has enabled the vision of investment in wider mental health community teams, primary care, specialist services and crisis support all which will complement the inpatient element of the acute care pathway. By providing more multi-disciplinary specialist advice and interventions earlier in the patient pathway, as close to home as possible, we will ensure that each acute inpatient admission is meaningful and for the shortest time required.

Prioritising investments in additional roles to support the new inpatient environment such as Occupational Therapy, Psychology, Advanced Nurse Practitioners and Pharmacists will ensure that a holistic approach to care is taken. Care will be delivered by a well-trained, highly skilled, trauma informed inpatient multi-disciplinary team providing evidenced based interventions in a modern, fit for purpose, mental health unit. This will ensure that any acute in-patient with stay is as short as possible with a seamless transition for treatment continuation in the community, close to home.

A summary of the Division's Transformation Plans is included as Appendix B.

3.3 Section C: The case for change

This section: outlines the investment objectives; highlights the challenges with the status quo; outlines the scope of the project; and summarises the benefits, risks, constraints and dependencies of the project.

3.3.1 Investment objectives

The investment objectives have been refined - for example investment objective 3 has been broadened to include the goal of improving workforce recruitment, retention and absenteeism – but cover the same territory as in the SOC. They are as follows:

Investment Objective 1	To provide services which meet the Strategic Direction outlined within *Together for Mental Health* (T4MH) in North Wales and deliver the model of care developed through the quality and workforce groups.
Investment Objective 2	To create a quality clinical environment that is fit for purpose, safe and humane.
Investment Objective 3	To improve workforce recruitment and retention and absenteeism through providing an environment that supports staff to deliver safe, effective care to patients, carers and families.
Investment Objective 4	To improve the quality of the estate by reducing backlog maintenance, reducing running costs, and achieving environmental sustainability.
Investment Objective 5	Flexibility: Deliver the flexibly to respond to future need – the solution should be designed to respond to future changes in service delivery.

A set of specific measurables that contribute to the delivery of each of these high level objectives, including baseline measurements, are included as Appendix C.

3.3.2 Existing arrangements

This section briefly describes the existing service arrangements for Mental Health services.

All of the Health Board's services, not only the specialist mental health services, play a part in maintaining and improving the mental health and wellbeing of communities in North Wales. This includes the "universal" services available across the community, such as primary care, health visiting and school nursing. It also includes the roles that other specialist and acute services take in supporting the wellbeing of people who use them, particularly services which have long-term relationships with their patients and clients.

The role of the specialist mental health services is therefore to work with the smaller number of people who have more serious and complex mental health problems.

Mental health services include primary, community and therapy services within localities across North Wales, and from inpatient services from four hospital sites. As such we make an important contribution to improving the health and wellbeing to a population of around 700,000 people. This encompasses prevention of mental ill health as well as treating illness and providing healthcare services.

The Health Board currently provides the following services for adults and older persons, based across North Wales:

- Community mental health teams for adults based in each County
- Home treatment teams based in each county
- A regional Specialist Eating Disorder service
- Mental health nurses in North Wales Police call centre undertaking triage & training of police staff
- A regional Criminal Justice and community based forensic team
- Community rehabilitation teams
- Community mental health teams for older people in each County
- Memory clinics for older people with dementia in each County
- Day hospitals for older people
- Specialist community based substance misuse services in each County
- Specialist community based learning disability services in each County
- A regional acquired brain injury service
- A range of specialist psychological therapy services in hospitals and community.
- Liaison teams working across mental health and physical health with the acute hospitals
- A regional Perinatal Team
- Primary Care Mental Health teams in each cluster

- A regional Early Intervention in Psychosis Team
- Complex Case work (for people with trauma and attachment problems)
- Inpatient services for:
    - Adults
    - Older people with functional mental health problems (a range of serious mental health problems, such as schizophrenia, bipolar disorder, or severe depression)
    - Older people with organic mental health problems (dementia and related conditions)
    - Rehabilitation
    - Learning Disabilities
    - A medium secure unit (a service for people with serious mental health problems and a history of criminal offences)
    - Detoxification unit (commissioned service via CAIS)

The main inpatient facilities are currently located in the Ablett Unit on the Glan Clwyd hospital site at Bodelwyddan, close to Rhyl; the Heddfan Unit adjacent to the Wrexham Maelor Hospital Site in Wrexham; the Hergest Unit on the Ysbyty Gwynedd hospital site on the outskirts of Bangor, and the Bryn y Neuadd site in Llanfairfechan.

In terms of the two units that are the subject of this business case, the specific services provided are as follows:

Ablett Unit	10 bedded functional older persons ward 10 bedded female acute ward 10 bedded male acute ward 8 bedded Rehabilitation ward (currently being used to cohort acute admissions due to covid isolation requirements) Regional ECT department Psychiatric Liaison Service Regional Peri-Natal Team Home Treatment Team Administration Hub
Bryn Hesketh	13 bedded organic ward (plus a family room) Memory Clinic

3.3.3 Business needs

Introduction

This section describes the problems associated with the existing service in relation to current and future needs. It focuses on the Central Area, which is the subject of this business case, and addresses two inter-related elements: the limitations of the Estate in delivering both the current model of care and the changing models of care set out

in *Together for Mental Health*; and a shortage of inpatient beds in the Central area to meet current and projected future needs.

Approach to Engagement

It is important to emphasise that the analysis of issues outlined below, and the proposed solutions, have been developed through a wide range of engagement exercises prior to and during the OBC development. In October 2016 CANIAD - which is a local service user-led organisation who supports people who want to have their voices heard, influence decisions and help shape the services they use - participated in five open events for adult service users across North Wales. 153 people attended the workshop events or gave one to one feedback, and 71 people responded to an on-line survey issued as part of the same process.

Across the patient journey, the CANIAD engagement process reported there was a strong view that both the physical and therapeutic environment of hospital wards needed to be improved. Many people spoke about there being a lack of privacy on the ward, and that some psychiatric wards felt more like a prison than a hospital. Many people also spoke about a lack of meaningful activities, having nothing to do, and feeling bored.

A Patient Flow Programme was also undertaken in response to a number of challenges such as the Division being placed in Special Measures. A Rapid Improvement Event was held on the 17th March 2016 attended by members from across Older People and Adult Services from all functions and professional groups with one of the outcomes being that people need to be treated and cared for in a safe environment and protected from avoidable harm. A multi-agency mental health summit was held in January 2017, to stimulate and draw together leaders of a wide range of local agencies which concluded that we must work together to create recovery-focused services.

Stakeholder engagement has continued to inform the development of the OBC, and has had a significant impact on the change in scope and the preferred option. A series of engagement events were held between October 2019 and January 2020. The purpose of these informal events was to gather feedback from a range of stakeholders about the options set out in our Strategic Outline Case (SOC) surrounding the future of older persons and adult mental health inpatient care in Conwy and Denbighshire. BCUHB has attended or hosted 21 meetings and events and spoken with 267 people. This included people with lived experience of older person's mental health care, their carers and loved ones, our own staff, and staff from partner organisations from across the statutory, voluntary and third sector. Our paid social media adverts also reached 5,585 Facebook users resident in Conwy & Denbighshire. Feedback from the engagement events held and engagement calendar are enclosed at Appendix D and E.

The limitations of the Estate in supporting current and future service models

A number of external reviews and inspections of the current facilities have been undertaken by the Community Health Council (CHC), Health Inspectorate Wales

(HIW) and Welsh Government (WG) as part of the review of services over a number of years, all of which have reached similar conclusions, including:

- The remote older people's mental health unit at Bryn Hesketh: although significant improvements have been made in relation to environment and staffing there is still a risk to managing patients with high levels of acuity along with co-occurring physical health needs so far away from the acute general hospital. In addition the Bryn Hesketh Unit cannot be regarded as a sustainable facility in terms of national quality standards for environment (Kings Fund 2013) or the Royal College of Psychiatrists' criteria for Older Adult Psychiatry Services in the UK for units to be based on a District General Hospital campus. (Royal College of Psychiatrists 2011)
- The mixing of older people with mental illness alongside young adults is not appropriate and does not deliver good patient experience, as well as causing significant challenges for staff to manage the differing dynamics within the ward;
- The ward environments are not fit for purpose, including lack of space (indoor and outdoor) to undertake meaningful recreation. There is a lack of space to undertake therapeutic work. Some areas are not Equality Act compliant. Mixed sex accommodation is common and the line of sight in ward areas is not to the standard it should be which leads to the increased constant levels of observation (to maintain safety) but which may compromise psychological well- being as well as increasing revenue costs.
- Privacy and dignity standards are not being met across the inpatient environments including the use of dormitory style wards, the lack of ensuite facilities and the availability of separate lounge facilities.

To give more detail in relation to the ward facilities at the Ablett Unit:

- **Tegid Ward** which hosts older people with functional illness, is not fit for purpose; the ward is very short of space with a small day room and dining area and very narrow corridors. Access is particularly challenging for those with mobility issues particularly into the bedrooms and bathrooms. There are limited sanitary and

bathing facilities; the lounge and dining area are small, cramped and used for multiple functions. HIW comment that in the longer term, the suitability of this environment for the patient group must be addressed.

- **Dinas Ward**, which hosts Adult services, has 14 single bedrooms and 3 twin rooms, none of which are ensuite. Corridors are narrow, the circulation/lounge areas are too small and it lacks dedicated recreational and therapeutic space.
- **Cynydd Ward** is an 8 bedded rehabilitation ward, which has sufficient space for the patient group. There is a large communal area in the centre of the ward, two separate lounges and a games/recreational area. The bedrooms are all single occupancy but do not have ensuite facilities. The model of providing locked rehabilitation on a district general hospital site does not link with the overall direction of travel for our future rehabilitation services which has been supported by the National Collaborative Commissioning Unit.
- **Tawel Fan** (an Adult inpatient ward) is currently closed. The ward has 14 bedrooms and 20 bed spaces, none of which are ensuite.

In addition to these issues, which were explored fully in the SOC, there are a range of other problems with the Ablett Unit which makes it not fit for purpose. These have been explored fully through a number of stakeholder events that were held between October 2019 and January 2020, as outlined above, and can be summarised as follows:

Electro Convulsive Therapy (ECT): The Ablett Unit is now the single regional ECT provision for the whole division, including the provision of outpatient ECT for the whole of North Wales. There has been an increased use of ECT as a treatment across the UK in recent years, and locally activity has increased from 300 treatments in 2017 to 500 in 2019. In order to maintain their Electroconvulsive Therapy Accreditation Service (ECTAS) update is required to the department in relation to both the flow of the patients and the modernisation of anaesthetics in relation to piped oxygen and other issues. This means the department needs to be fully upgraded to deliver safe clinical care for the increasing numbers of patients that they are treating. Between 2017 and 2019 200 more treatments were delivered and whilst the Covid pandemic impacted in 2020 the clinical leads expect the rise to be sustained as ECT is utilised as an increasing treatment of choice for both inpatients and outpatients.

Pharmacy: The existing pharmacy facility in the unit is small and has no provision for individual consultations or a waiting area. This results in limited opportunity for Pharmacists to have one to one discussions in relation to medication, concordance, side effects and providing discharge advice to patients and their carers.

Therapeutic Areas: Investment in allied health professionals and activity workers across inpatient units, as a result of a number of HIW recommendations, has led to a limitation of therapy spaces and consequently the inability to separate specific groups of patients based on their clinical presentation and treatment needs. In addition the current assisted daily living kitchen does not enable disabled access to these with mobility issues as it is too small and the worktops are not adjustable. Both these issues have been highlighted by lead Psychologists and Occupational Therapists in terms of

the ability to offer evidence based treatment, therapy and assessment for all patients which they see as key to reducing length of stay and undertaking robust discharge preparation.

Stakeholders with lived experience and their carers identified that the provision of a welcoming reception area with a café would reduce their anxieties on entering the unit and also enable other hospital staff and visitors to utilise the facility, thus reducing stigma as has been experienced in other modern mental health units. In addition they identified this as a key part of recovery where it could be an opportunity for current inpatients and those who've been discharged to gain valuable experience as part of the journey back into paid employment via a social enterprise arrangement with the third sector. This partnership approach is already in operation with KIM in the Heddfan Unit Wrexham with many positive outcomes and at no revenue cost to BCUHB.

Introduction to physical exercise via the addition of a small gym and larger space for yoga and pilates as well as enabling the therapeutic use of outside space, as opposed to just gardens, was identified as being a key element by those with lived experience and staff. This important aspect links to the five ways of wellbeing and bridges an important gap between mental and physical health. It will also provide an opportunity for staff to utilise the facilities which supports the aims identified in our Wellness Work and You Strategy MHLD (2020).

Increased Assessment Provision: The original SOC included a 4 bedded area for a clinical decision unit (CDU). During the OBC development clinicians have visited a number of these facilities and reviewed their impact. During COVID19 changes were also made to the psychiatric liaison pathway. This saw the creation of a liaison assessment hub where suitable patients were assessed on the Ablett site to minimise the footfall through the emergency department. During COVID19 the liaison hub was located in the ECT suite which did not operate during the pandemic. The experience for patients, psychiatric liaison and emergency department staff has been positive in terms of this shift to a new location for assessment and it is recommended that this continues and is included in the new development. This will be a small bespoke area situated close to the S136 suite with 4 recliner chairs with access to beverages and snacks, and both areas will be staffed by psychiatric liaison staff. Undoubtedly continuation of this approach, post the initial covid phase, will not only provide qualitative benefits to both MHLD patients and their carers but also impact on the Emergency Department in terms of patent flow and other operational pressures.

De-stimulation Area: Stakeholders have identified the requirement for de-stimulation area to be present on each ward so that acutely ill patients can be nursed in a more conducive environment to meet their needs. The aspiration of the clinical team is that this will enable patients to remain in their local unit as they will not require a transfer to psychiatric intensive care unit (PICU) which is currently only provided in East and West. Provision of this area will further support the significant reductions in restrictive practice that has been progressed within BCUHB over the last few years making the health board the second lowest across the UK in relation to restraint (NHS Benchmarking report 2019). In addition this development will support a reduction in patient on staff assaults and patient on patient assaults in the Central area as there will be de-stimulation areas on site. These bedrooms will form part of the overall adult ward numbers.

Staff Facilities: A range of staff groups identified the need for suitable staff changing and rest facilities on site which has also been previously raised by HIW. This element has become more urgent in terms of the impact of COVID19 and associated transmission risks. In addition the provision of Junior doctor/on call doctor rest rooms was highlighted as a key requirement in terms of both attracting junior doctors and retaining them. This is a key factor highlighted by a Royal College of Psychiatry review of fatigue in psychiatry in 2016 (Supported and Valued Staying Safe RCPsych 2016). The provision of onsite training facilities was identified across all disciplines as another key requirement in terms of attendance at mandatory training and maintaining continuous professional development for inpatient staff.

Acute Care Campus: More efficient use of administration resources and office space was identified by a number of stakeholders, especially in relation to enabling reconfiguration of the overall footprint to prioritise therapeutic space to improve the patient experience. The vision of creating an "acute care campus" incorporating specialist teams such as the new perinatal service where they can link with the Sub Regional Neonatal Intensive Care Unit (SURNICC), liaison psychiatry and home treatment who can work more collaboratively was seen an opportunity to work across specialisms and be more efficient in relation to sharing knowledge and expertise. In addition hot desk space for in reach provision from third sector organisations, partners and community staff was identified as a key requirement to enable the unit to be a continuum of care rather than a distinct episode of care, as it is often currently viewed.

Issues highlighted by external investigations

There have been two investigations related to care on Tawel Fan: the Ockenden Review relating to the care of patients on Tawel Fan ward prior to its closure on 20th December 2013; and the Independent Investigation into the Care and Treatment Provided on Tawel Fan Ward: a Lessons for Learning Report undertaken by Health and Social Care Advisory Service Consultancy Limited (HASCAS).

This OBC will support the delivery of a number of recommendations contained within both the HASCAS and Ockenden investigations, namely:

- HASCAS recommendation 13: Restrictive Practice Guidance

The potential alignment of Organic services onto one acute site will increase the pool of trained Restrictive Practice Intervention staff to ensure that all older adults are in receipt of lawful and safe interventions throughout a 24 hour period.

- HASCAS recommendation 15: End of Life Care Environments

The potential alignment of Organic services onto one acute site linked to a DGH will enable timely access to diagnostics and more suitable environments for end of life care.

- Ockenden recommendation 10: A review of all external reviews in relation to older people.

HIW have raised concerns in relation to the environment of Tegid ward not being fit for purpose for older persons. Redevelopment of the Ablett site would enable the environmental concerns to be addressed for both organic and functional patients.

- Ockenden recommendation 11: Outstanding estates issues

Re-provision of older person's services in Ablett would enable the creation of wards that fit the Kings fund Enhancing Healing Environments standards specific to Dementia care.

It is also worthy of note that the focus on the Ablett unit over a number of years in relation to the HASCAS investigation into standards of care has resulted in very negative perceptions of the unit with the public and partners. The development of a new unit provides a real opportunity to continue to rebuild public confidence and the reputation of psychiatric services provided on the Glan Clwyd Hospital site.

Physical Capacity

As outlined above, the national and local strategic intent is to shift the balance of care from Acute to Community settings. However even within this strategic context, the bed capacity for Adults and Older People's Mental Health in the Central Area is insufficient to meet current needs, and is also projected to be insufficient in the future. The overall analysis that has led to this conclusion is summarised below, with supporting information included in Appendix F.

The SOC utilised the "Inpatient and Community Mental Health Benchmarking 2017/18" published in October 2018 with other supporting data such as length of stay, occupancy levels and population. It identified that a high number of Conwy and Denbighshire residents were receiving their inpatient care in the West (Hergest) and the East (Heddfan), which is not in line with the strategic intention to treat patients closer to home. The conclusion reached in the SOC analysis was that the estimated numbers of beds required was 36 Adult beds and 24 OPMH beds and stated that further work would be undertaken as part of the development of the OBC to reach firm conclusions on the bed numbers and bed configuration.

During the OBC development the practice of sending Conwy and Denbighshire patients out of area (but within North Wales) was highlighted strongly as a significant issue by patients, carers and staff (including community staff) in terms of care closer to home and continuity of care often impacting negatively on length of stay and recovery.

Further analysis was also undertaken in terms of patient admissions, identified by postcode, to the other two acute units which confirmed the current capacity in central area remains insufficient to meet the needs of patients treating them closer to home.

The updated benchmarking data published in October 2019 was reviewed. For Inpatient Adult Mental Health BCUHB is essentially in line with the national average in terms of beds per 100,000 (BCUHB 22.2, benchmark mean 20.6). Average length of stay including leave is lower than the national average (BCUHB 22.8, benchmark mean 34.8). Admissions per 100,000 are well above the national average (377 admissions per 100,000 population, compared to a mean of 232). Average bed

occupancy (including leave) at midnight is also above the national average (BCUHB 104%, benchmark mean 101%). 104% is also substantially higher than the national target for mental health of 85% occupancy.

A system running at above 85% occupancy on average at midnight will frequently have insufficient beds to cope with normal variations in demand, and in a Mental Health service this is likely to lead to home leave being used as *a pragmatic response to scarce bed capacity as well as a tool for managing patient discharge*.[2] The issue of occupancy has been a key factor in considering the required number of beds for the OBC, as has the delivery of care closer to home for Central patients and future demographic changes.

The Royal College of Psychiatrists indicates that 85% bed occupancy should be optimal, but a paper published in the American Psychiatric Association suggest an even lower figure for smaller units (Rodney P Jones 2013). Whilst a target of 85% occupancy in many specialities is no longer considered a realistic goal, within Mental Health the target is still a key aspiration. The impact of running acute and older persons inpatient units at over the 85% occupancy is well documented to have a negative impact on a range of metrics, including staff sickness and retention, serious incidents and patients' experience e.g. in terms of home leave relapse and Mental Health Act (MHA) detention when no local bed is available.

A recent study exploring inpatient capacity in mental health commissioned by the Royal College of Psychiatrists highlights the same risks for high occupancy units and concluded that too many beds have been taken out of the system across the UK. The review also found that the threshold for admission has risen and patients are often discharged too early presenting risks in the community at both interfaces with bed based provision (The Strategy Unit 2019)[3].

For Older People's Mental Health BCUHB is a little below the national average in terms of beds per 100,000 (BCUHB 40.0, benchmark mean 42.9). As with Adults, admissions per 100,000 are well above the national average (230 admissions per 100,000 population, compared to a mean of 175). Average length of stay (including leave) is below the national average (BCUHB 62.0, benchmark mean 76.0). Average bed occupancy (including leave) at midnight is also well above the national average (BCUHB 101%: with the benchmark mean at 90%).

In November 2020 the annual NHS Benchmarking Network "Inpatient and Community Mental Health Benchmarking 2019/20 was published. The data and a range of relevant metrics have been reviewed by clinicians and it has been agreed that the benchmarking supports the conclusions reached in this OBC.

In terms of demography, for Adults future population projections do not indicate a change in levels of demand, however to ensure people receive care closer to home

[2] Optimum Bed Occupancy in Psychiatric Hospitals, Rodney P Jones 2013

[3] Exploring Mental Health Inpatient Capacity, The strategy Unit 2019. Commissioned by the Royal College of Psychiatrists.

and to address some of the risks posed by current occupancy levels across the system increasing the adults beds by 12 and 4 for the older persons functional ward is considered to be clinically appropriate. Whilst OPMH demand is set to rise in Central, during the stakeholder sessions Senior OPMH clinicians advised against a bed increase for organic patients in terms of risk. They strongly recommended that the preferred direction of travel should be investment in community home treatment and nursing home in reach which is identified within the current MHLD transformation delivery plan as priority areas of development, as unnecessary admissions for older persons with an organic presentation can increase their individual risk.

In relation to Rehabilitation beds, the existing locked rehabilitation ward on the Ablett unit does not deliver against the proposed future model. It is proposed that this facility is closed, as per the SOC submission, and patients are treated in other BCUHB facilities as part of the developing model of rehabilitation also outlined within the T4MH delivery plan. This direction of travel will also ensure that rehabilitation patients will be treated closer to the community ensuring the full range of community assets are utilised to aide their recovery and fully integrate those patients back into the community.

In terms of the CDU described in the SOC, stakeholder engagement during the OBC and learning form COVID19 has concluded that this area will be an assessment area with chairs and access to fluids and nutrition. It will be staffed by the Psychiatric Liaison Team who will pull medically fit patients presenting to Emergency Department to enable a full assessment of patients presenting in crisis and support plans to be agreed with partners and other stakeholders.

To conclude: the number of beds and configuration described in the SOC have been revisited and amendments have been made for both adults and older persons based on the following criteria:

- Occupancy levels
- Future population predictions
- Updated benchmarking data
- Learning from COVID19
- The Rehabilitation transformation plan
- Providing care closer to home

Therefore the future beds required are as follows:

	Adult	OPMH	Rehab	Vacant [Tawel Fan]	Total Physical Beds	Total Open Beds
Current Beds	20	23	8	20	71	51
Future Beds	32	27	0	0	59	59
Change	12	4	-8	-20	-12	8

This proposal will reduce bed pressures in Hergest and Heddfan. Given the current high levels of occupancy in these hospitals this may result in a qualitative benefit, rather than a cash-releasing reduction in the number of beds on those sites, and there is no assumption about cash-releasing savings in the Financial Case. This will be reviewed further at FBC stage.

Conclusion: Summary of the Case of Need

In summary, the current configurations of both the Ablett Unit and Bryn Hesketh do not provide the right environment to deliver high quality services. In addition the limitations of the current units do not allow any flexibility for changing the size and the gender configuration of each ward or support the implementation of new pathways, which will improve the flow of patients within the system and result in better outcomes for patients. There is also insufficient capacity to meet current and projected future need for the local population.

3.3.4 Potential Business Scope and Key Service Requirements

Given the specific issues related to service provision and the estate, the project focuses on the provision of inpatient Adult and Older People's Mental Health services in the Central Area of BCUHB. In Estates terms, the case therefore addresses all the current issues at the Ablett Unit and at Bryn Hesketh.

In summary it proposes:

- Providing a 14 bed OPMH Functional ward that incorporates bedrooms with ensuite facilities, improved circulation and recreational spaces and improved observation.
- A 13 bed new fit for purpose dementia care assessment unit with an end of life bedroom. This will include provision for families and carers to stay with their loved ones overnight, to support the implementation of John's campaign (Johns Campaign 2014). This ward will have clear circulations routes, with no dead ends, a secure courtyard that will bring light into the ward, ensuite facilities to all bedrooms, recreational and therapy spaces and improved visibility.
- Two purpose built 16 bedded adult wards, which will be designed flexibly to respond to gender split and future models of care. There will be an age appropriate bed included in the adult ward as required in Welsh Governments admission guidance.
- A de- stimulation area on each ward which will provide a safe nursing environment for high acuity patients. This will support the reduction of transfers to other facilities, in and out of North Wales, and provide teams with more options to manage patients differently and reduce restraints.
- An assessment suite to enable suitable patients to be moved from the Emergency Department in a timely manner to be assessed by the Psychiatric Liaison Team.
- A small gym and increased use of outdoor space for therapeutic interventions.

- A new 136 suite with an additional assessment room for all admissions to be triaged in a timely manner.
- Increased therapeutic space indoors and outdoors.
- Provision of a modern accredited regional ECT suite.
- Removal of the locked rehabilitation ward.
- Staff change and rest facilities.
- A café and bright reception area.

3.3.5 Main risks

The main business and service risks associated with the scope for this project are:

- Unexpected changes in service capacity/demand
- Failure to deliver the model of care
- Capital affordability

These issues are included in the risk register and will be addressed systematically as the project develops. Demand risk, service and design risk and service continuity risk are addressed as part of the option appraisal in the economic case.

3.3.6 Constraints

The requirement to co-locate services on an Acute site means that there are space constraints, which limit design options.

3.3.7 Dependencies

The project is dependent on capital funding from Welsh Government.

4. The Economic Case

4.1 Introduction

This section of the business case focuses on the main options available for delivering the required services. These options are evaluated, and the option which gives the best Value for Money (VfM) is established.

4.2 Changes from the Strategic Outline Case

The shortlisted options at SOC stage were as follows:

Option 1 – business as usual: i.e. continue with current arrangements for service provision, with incremental investment to prevent further deterioration of the estate. This was included as a baseline to compare the value for money of other options.

Option 2 – A combination of refurbishment and new build at Glan Clwyd. This entails the full implementation of the proposed service model, except for retaining the existing services at Bryn Hesketh. In summary:

- Demolish Tawel Fan
- Create new adult / OPMH functional ward(s)
- Create a clinical decisions unit
- Form a 136 suite fit for purpose
- Create a de-stimulation area
- Significantly improved environment with ensuite facilities for all service users at the Ablett Unit.

Option 3 – A combination of refurbishment and new build at Glan Clwyd in line with the proposed service model, including transferring services from Bryn Hesketh. In summary:

- Demolish Tawel Fan
- Create new adult / OPMH functional ward(s)
- Create a clinical decisions unit
- Form a 136 suite fit for purpose
- Create a de-stimulation area
- Significantly improved environment with ensuite facilities for all service users
- Transfer OPMH Organic patients from Bryn Hesketh to the Ablett site.

This was the suggested way forward.

Option 4 – Introduce the service model outlined in option 3, through an entirely new build on the Glan Clwyd site.

There have been significant changes since the development of the SOC in 2019, which have resulted in a fundamental re-appraisal of the options. Firstly, as outlined in full in the Strategic Case, there are a range of issues with the existing facilities at Glan Clwyd Hospital which need to be addressed, but which were not included in the scope of the SOC. These include: issues with the ECT facilities; the need for more therapeutic areas (including more appropriate space for group sessions, improved Occupational Health kitchen facilities, and the provision of a gym and outdoor exercise space); the requirement for increased assessment provision; the need for a de-stimulation area; improved staff facilities; and administrative accommodation that facilitates integrated working. Secondly, there is now a clear view that the issues and risks at Bryn Hesketh are sufficiently serious to rule out shortlisting any options that do not transfer the service to Glan Clwyd Hospital. This view is supported by the Community Health Council, whose letter of support is enclosed as Appendix G. In light of these changes to the strategic context the process of long-listing, short-listing and selecting the preferred option has been fully re-run, and is outlined in the remainder of this section of the business case. This has led to a change in the preferred option.

4.3 Critical Success Factors

The critical success factors (CSFs) are the attributes which are essential to the successful delivery of the scheme, against which the options are assessed. Alongside the assessment of the CSFs is the assessment of how well the options meet the scheme's spending objectives and benefits criteria. The CSFs are unchanged since the SOC, and are as follows:

- **CSF 1: Business Needs**: how well the option satisfies the existing and future business needs of the organisation.
- **CSF 2: Strategic Fit**: how well the option provides holistic fit and synergy with other key elements of national, regional and local strategies.
- **CSF 3: Benefits Optimisation**: how well the option optimises the potential return on expenditure, business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation), and assists in improving overall VFM (economy, efficiency and effectiveness).
- **CSF 4**: **Potential Achievability**: the organisation's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks and the need for supporting skills (capacity and capability). Also the organisation's ability to engender acceptance by staff.
- **CSF 5**: **Supply-side Capacity and Capability**: the ability of the market place and potential suppliers to deliver the required services and deliverables.
- **CSF 6**: **Potential Affordability**: the organisation's ability to fund the required level of expenditure namely, the capital and revenue consequences associated with the proposed investment.

4.4 The Long Listed Options

As recommended in Welsh Government and HM Treasury's Guide to Developing the Project Business Case, the Options Framework has been used to systematically

identify and evaluate a wide range of options, and to derive the shortlist for more in-depth evaluation. The Options Framework considers five categories of choice, which are:

- The scope of the service
- Service solution options
- Service delivery options
- Implementation options
- Funding options

The following table describes the options considered and the findings.

Options	Finding
1.0 Scope	
1.1 **Business as usual / Do nothing**: No change to the Ablett Unit or Bryn Hesketh, aside from incremental investment to prevent further deterioration of the estate	**Discounted**: it would not address the service and estates issues outlined in the strategic case, but is retained as a comparator against which to assess whether other options offer VfM.
1.2 **Minimum**: Resolve the issues at the Ablett Unit, retain the existing service model at Bryn Hesketh	**Discounted:** it would resolve the issues at the Ablett Unit, but all of the risks and issues associated with Bryn Hesketh would remain.
1.3 **Intermediate:** Resolve the issues at the Ablett Unit and Bryn Hesketh that were identified in the original SOC	**Possible:** it would address the service and estates issues at Bryn Hesketh, and those at the Ablett Unit that were identified in the SOC. The additional issues that have been identified since the SOC would remain, and the service model could not be implemented in full. The inclusion of this option in the shortlist means that the additional value for money delivered by increasing the scope of the project can be tested.
1.4 **Intermediate**: Resolve in full the issues at the Ablett Unit and Bryn Hesketh, as outlined in the Strategic section of this OBC	**Preferred:** this option fully addresses the scope of the project, and is the preferred option.
1.5 **Maximum:** Expand the catchment area served by the Central Area to include all Acute admissions	**Discounted:** greater centralisation of services is not in line with the Health Board's strategy.
2.0 Service Solution	
2.1 **Business as usual / Do nothing**: No change to the Unit or Bryn Hesketh, aside from incremental investment to prevent further deterioration of the estate	**Discounted**: it would not address the service and estates issues outlined in the strategic case, but retained as a comparator against which to assess whether other options offer VfM.

2.2 **Full remodelling of the current unit:** Address the full service scope outlined in the Strategic Case through a combination of refurbishment and extension of the new unit	**Possible**: this would meet the full scope requirements, but has the disadvantage that the current unit would need to be decanted to allow demolition and phased refurbishment.
2.3 **Full demolition of the existing unit to provide space for a new build on the existing site**	**Discounted**: this is not practical due to the level of decant required, and the operational impact on two other units (East and West) if patients are transferred to those facilities. There is a need to continue to provide local services for Conwy and Denbighshire residents in line with care closer to home.
2.4 **New build unit located elsewhere on the YGC site**: The current service at the Ablett and Bryn Hesketh is maintained while a new unit is constructed. Car parking lost as a result of the construction is re-provided and the existing Ablett Unit is retained for alternative use.	**Preferred**: this option provides a purpose-built facility on the Glan Clwyd site and minimises service disruption.
2.5 **Remodelling of the existing unit to support the service scope outlined in the SOC:** This would be achieved through a combination of new build and refurbishment.	**Possible:** however this option offers very limited opportunity for future development and does not address the full scope of the project, with no works to reception, ECT, staff rest areas or administration areas.
3.0 Service delivery	
3.1 **In house**	**Preferred:** in line with Welsh Government Policy
3.2 **Outsource**	**Discounted:** not in line with Welsh Government Policy
3.3 **Strategic partnership**	**Discounted:** not in line with Welsh Government policy
4.0 Implementation	
4.2 **Big Bang**: Implement the proposal as a single project	**Preferred:** the service & estates issues are interlinked and need to be resolved as a single project
4.3 **Phased**: Implement the proposal as a series of discrete projects	**Discounted:** for the reason given above.
5.0 Funding	
5.1 **Private funding**	**Discounted:** as unaffordable
5.2 **Public funding**	**Preferred**

4.5 Short-listed Options

The preferred and possible options identified above have been carried forward into the short list for further appraisal and evaluation. All the options that were discounted have been excluded at this stage. On the basis of this analysis, all the shortlisted options propose a single project (aside from business as usual) with the service delivered in-house and funded by public monies.

In terms of the Options Framework the shortlisted options are:

	Option 1	Option 2	Option 3	Option 4
Scope	Business as usual (1.1)	Preferred – full scope (1.4)	Preferred – full scope (1.4)	Minimum – SOC scope (1.3)
Service Solution	Business as usual	Full remodel of the existing Ablett Unit (2.2)	New build on the Glan Clwyd Site (2.4)	Partial remodel of the existing Ablett Unit (2.5)
Service Delivery	In house	In house	In house	In house
Implementation	Not applicable	Big bang	Big bang	Big bang
Funding	Public	Public	Public	Public

A brief narrative description of the shortlisted options is as follows:

1. **Business As Usual**: no change to the service model or the physical units at Glan Clwyd or Bryn Hesketh, aside from incremental investment to prevent further deterioration of the estate (included as a comparator).

2. **Full remodelling of the current Ablett Unit**: this option addresses the full service scope outlined in the Strategic Case, through a combination of refurbishment and extension of the existing Ablett Unit. The current unit would be decanted a phase at a time, and the relevant elements of the Bryn Hesketh service would be transferred into the remodelled unit.

3. **A new build unit located on the YGC site**: this option addresses the full service scope outlined in the Strategic Case. The current service at the Ablett and Bryn Hesketh would be maintained while the new unit is constructed. Once the new build is complete, the Ablett Unit and the relevant elements of the Bryn Hesketh service move to the new build. The current Ablett Unit is retained for alternative use. The use of the Bryn Hesketh site will be the subject of a review with stakeholders to assess whether to relocate services from other sites that are of an inferior standard. This review may result in the capital receipt of Bryn Hesketh or an alternative service. Car parking space is created at YGC to replace the spaces lost, and to take account of the increased activity associated with the transfer of services from Bryn Hesketh.

4. **Partial re-modelling of the current Ablett Unit**: the service scope and the building works are as outlined in the SOC preferred option with works to ward areas only and adding Bryn Hesketh. No other works to reception, ECT, staff rest areas or administrative areas. Given that the building works are unchanged since the SOC, this option also does not meet the requirements of the recently published NHS Wales Decarbonisation Strategy Delivery Plan.

4.6 Economic Appraisal of the Shortlisted Options

4.6.1 Introduction

This section provides a detailed analysis of the main costs and benefits associated with each of the shortlisted options. The benefits are evaluated in terms of:

- A qualitative benefits analysis
- An analysis of the monetised costs and benefits – cash releasing and non-cash releasing
- A risk analysis

4.6.2 Qualitative Benefits Appraisal

A workshop was held to evaluate the qualitative benefits associated with each option. There were sixteen attendees in total and included patient representation, senior doctors, nurses and managers from the relevant disciplines, and representatives from finance and capital planning. A full report of the workshop, including a list of attendees, is included as Appendix H. Given the passage of time since the workshop was held, the Project Team has reviewed the analysis and confirmed that it remains robust.

4.6.2.1 Methodology

The appraisal of the qualitative benefits associated with each option was undertaken by:

- identifying the benefits criteria relating to each of the investment objectives
- weighting the relative importance (in %s) of each benefit criterion in relation to each investment objective
- scoring each of the short-listed options against the benefit criteria on a scale of 0 to 10
- deriving a weighted benefits score for each option.

It is important to note that weighting and scoring has been used to give a framework to the analysis, and an approximate quantification to the differences between the four options. However the primary focus is on the analysis undertaken, rather than the score.

4.6.2.2 Qualitative Benefits Criteria

The benefits criteria were weighted as follows:

Benefits Criteria	Outcomes & Sub Benefits Criteria	Weighting
Model of care	▪ Ability to flex gender separation / specialist areas for wards dependent on need. ▪ Flexible option in terms of future demand e.g. Psychiatric Intensive Care Unit (PICU) and ability to add future service developments. ▪ Ability to change functions as strategy progresses e.g. reduce beds/ change use. ▪ Reduce/eliminate use of out of area beds. ▪ Ensure there are sufficient beds to meet current demand. ▪ Provision of a facility which enables and supports effective patient flow ▪ Closure of isolated units. ▪ Provide effective evidence-based interventions, working alongside services for people with physical health needs. ▪ Improve the availability of a range of psychological therapies, including online therapeutic interventions. ▪ Flexibly deploy our workforce to deliver appropriate levels of activity and reduce the need for overtime, bank and agency staff. ▪ In line with the rehabilitation clinical strategy.	25 %
Clinical environment	▪ Enables gender separation-and links to sexual safety work. ▪ Provision of ensuite rooms. ▪ Layout will enable good observation opportunities to reduce use of 1:1. ▪ Therapeutic use of outside space. ▪ Anti-ligature compliant. ▪ Provides least restrictive environment. ▪ Reduce inequalities, stigma and discrimination. ▪ Enables introduction of John's campaign. ▪ Includes an end of life suite with family room ensuite. ▪ Provision of children's visiting room away from ward. ▪ Includes de-stimulation areas. ▪ Meets Kings Fund Standards for dementia care wards. ▪ Meets WHBN 03-01 for acute adult wards. ▪ Meets Electroconvulsive Therapy Accreditation Service (ECTAS) Standards to maintain accreditation. ▪ Meets Royal College of Psychiatrists (RCP) Section 136 Standards. ▪ Addresses Health Inspectorate Wales (HIW) concerns re Bryn Hesketh and Tegid. ▪ Provision of a facility which enhances patient experience through improved dignity, confidentiality and comfort.	25 %

Workforce	▪ Improved staff rest and change facilities onsite. ▪ Improved access to rooms for on-site training. ▪ Improved Junior Doctor rest facilities. ▪ Improved Doctor on call rest facilities. ▪ Improved opportunities for staff exercise. ▪ Consolidation of inpatient services on one site. ▪ Improved on site study facilities for students. ▪ Bright, well ventilated areas of work. ▪ Availability of de brief rooms. ▪ Ability to provide on-site training and teaching.	10 %
Quality of the estate	▪ Provision of a modern mental health facility in accordance with the Ysbyty Glan Clwyd Services and Estates Strategy. ▪ Provision of purpose built facility which meets modern building regulations. ▪ Providing a safe and fit for purpose environment which meets current guidance on infection control and health and safety standards. ▪ Reduce running costs and backlog maintenance. ▪ Meet statutory requirements e.g.: The Health & Safety at Work etc. Act (1974), The Management of Health & Safety at Work Regulations (1999) etc.	15 %
Deliverability	▪ Impact on patients and visitors from noise and contractors presence. ▪ Risk to operating in live acute areas. ▪ Disruption for staff on duty. ▪ Additional requirement for nursing staff oversight of contractor's required. ▪ Reduced access to parts of the building for staff and patients. ▪ Reduced parking for staff, visitors and community staff. ▪ Impact on delivery of therapeutic interventions due to noise and reduction of space available. ▪ Risk to red route from reduced parking and deliveries. ▪ Decant options may not be fit for purpose for the patient / staff group. ▪ Impact on two other acute units in terms of flow and occupancy during decant and re build phase. ▪ Impact on patient length of stay.	25 %

Weighting of Criteria

The weighting of the main benefits criteria was agreed as follows:

Main Benefits Criteria	Weighting (%)
Model of Care	25
Clinical Environment	25
Workforce	10
Quality of Estates	15
Deliverability	25

4.6.2.3 Qualitative Benefits Scoring

Benefits scores were allocated on a range of 0-10 for each option and agreed by discussion by the workshop participants to confirm that the scores were fair and reasonable. The scoring exercise was held without knowledge of the weightings, in order to prevent any bias in the scores allocated. Scores of between 0 and 10 were allocated to each option against each criterion. A score of zero indicated that the option failed to satisfy the criteria in any respect.

Score	Evaluation
10	Could Hardly Be Better
9	Excellently
8	Very Well
7	Well
6	Quite Well
5	Adequately
4	Somewhat Inadequately
3	Badly
2	Very Badly
1	Extremely Badly
0	Could Hardly Be Worse

The key considerations that influenced the scores achieved by the various options were as follows:

Investment Objective/Main Benefits Criteria: To provide services which meet the Strategic Direction outlined within *Together for Mental Health* (T4MH) in North Wales and deliver the **model of care** developed through the quality and workforce groups.

Option 1: Business As Usual: The status quo could not achieve the core standards as detailed within *Together for Mental Health* e.g. numbers of beds, gender separation, flexibility and future ability to meet new requirements under the strategy. Whilst there were no concerns in relation to service quality currently provided, the existing environment/estate makes it difficult to meet many of the sub benefits e.g. unit configuration/structure and WHBN. This option was scored as 2.

Option 2: Full remodelling of the current Ablett Unit: This option was judged to be an improvement on the status quo in that it delivered all the requirements identified by the design user group in relation to areas other than wards being developed e.g.: ECT, therapies, and administration areas. In addition it provides increased bed numbers and flexibility of ward space for gender separation. However it was also noted that the flexibility of future demand and other provisions being added was limited with option 2 due to the current footprint and uncertainty in relation to the stability/future opportunity of the existing buildings i.e.: if additional levels are required for future development there is an identified lack of opportunity to increase the current boundary. Option 2 was judged to be an improvement on option 1 and subsequently scored 8.

Option 3: A new build unit located on the YGC site: Similar discussion took place in relation to option 2. This option was seen as superior in relation to future flexibility and development, in that it enables additional levels to be built to accommodate and meet the needs of future service requirements (clinical or non-clinical areas). Furthermore, the boundary issues identified in option 2, were not as constraining. This option was given a slightly higher score of 9.

Option 4: Partial re-modelling of the current Ablett Unit: Option 5 was viewed as having very limited opportunity for future development, including a lack of flexibility in relation to gender separation and specialism. There would be no increase to existing therapeutic space, which is a key element of the *Together for Mental Health* Strategy. However this option would provide increased acute and older persons mental health functional beds. This option was assessed as slightly better than the status quo option in relation to links with the *Together for Mental Health* strategic intent and was therefore scored at 5.

Investment Objective/Main Benefits Criteria: To create a quality **clinical environment** that is fit for purpose, safe and humane

Option 1: Business As Usual: Whilst acknowledging the quality of service provided, this option would fail to deliver on many of the current clinical standards as nothing will change aside from incremental maintenance work, as and when required - WHBN standards would not be achieved. The group acknowledged the upkeep work to date but concluded there would be little privacy or dignity due to the continuation of some dormitory rooms and shared bathroom facilities. For those reasons the consensus opinion was that this option would be scored at 2.

Option 2: Full remodelling of the current Ablett Unit: The plenary debate reached consensus quickly in relation to the benefits criteria for option 2 as it was felt that the option met all the requirements and would be fully compliant. This option was given a score of 9.

Option 3: A new build unit located on the YGC site: Similar to the discussions in relation to option 2 consensus scoring was quickly reached for this benefit criteria for the same rationale as above. In additional, this option provides the opportunity to achieve *BREAMM Excellent* - construction standards used to assess the design, construction, intended use and future-proofing of new build developments. This option was given also given a score of 9.

Option 4: Partial re-modelling of the current Ablett Unit: It was acknowledged that this option does not meet all requirements and current standards as there would be little change in the current configuration aside from the bedroom areas. The WHBN would only apply to the new build sections and ECT would not be upgraded risking future proofing that regional facility from a flow and clinical standards accreditation perspective. In addition it was noted that there would be limited impact on stigma related in particular to previous issues for the unit, however the bedroom areas would be upgraded in terms of privacy and dignity. Therefore this option was scored a 6.

Investment Objective/Main Benefits Criteria: To improve **workforce** recruitment and retention and absenteeism through providing an environment that supports staff to deliver safe, effective care to patients, carers and families.

Option 1: Business As Usual: The status quo option would not address the issues with additional training facilities; staff rest rooms and Junior Doctor or Doctor on call rest facilities. In addition Bryn Hesketh would remain where it is with nursing and allied health professional staff spread across two sites. This option was given a low score of 1 to reflect the issues that would remain with the status quo.

Option 2: Full remodelling of the current Ablett Unit: Participants concluded that given the level of demolition and rebuild related to option two it would meet most of the benefits criteria e.g.: shows a commitment that the service is moving in the right direction including with a potential to review staffing profiles etc. This option was given a score of 8.

Option 3: A new build unit located on the YGC site: Similarly as with option two participants concluded that given this is a complete new build it would meet most of the benefits criteria and as a new build would be attractive to new recruits across the multi- disciplinary team. Therefore this was given a slightly higher score of 9.

Option 4: Partial re-modelling of the current Ablett Unit: The level of work in relation to option 5 means that only the ward areas would be refurbished. There would be no additional rest of training facilities and indeed much of the facade of the building would remain. In relation to on call Doctors and Junior Doctors rest facilities there would be no improvements therefore this criteria scored a 4.

Investment Objective/Main Benefits Criteria: To improve the **quality of the Estate** by reducing backlog maintenance, reducing running costs, and achieving environmental sustainability

Option 1: Business As Usual: The current facilities in the unit infrastructure do not adhere currently to efficient use of energy or carbon targets. It is difficult to maintain health and safety standards and funding for routine maintenance is often being cut too maintain clinical services. There was consensus that the quality of the current estate is not of a high standard and will only

deteriorate further as time progresses. Plenary discussion subsequently awarded this criteria a score of 1 for that reason.

Option 2: Full remodelling of the current Ablett Unit: Discussion related to the improvements to many areas of the unit, however a there was acknowledgement that some elements of the build would be retained and some uncertainty how the old would function alongside the new in terms of infrastructure. Therefore the consensus score for this criteria was a 6.

Option 3: A new build unit located on the YGC site: Option 4 was considered to be the best in relation to this criteria, in that given it's a complete new build it will be able to have the most energy efficient systems from the outset, the build would meet BREAMM excellence standards. There would be opportunity to utilise the most energy efficient materials in the build and even an opportunity to generate power to give back to the grid meeting improved environmental standards. Option 4 was subsequently given a 9 for those reasons.

Option 4: Partial re-modelling of the current Ablett Unit: Option 5 has some limited works undertaken in the ward areas only and the rest of the unit would remain as is. Whilst the discussion considered the improvements made to ward areas, it was clearly highlighted that many of the other areas in the unit would not be upgraded and will still be reliant on unpredictable heating and ventilation sources. In addition the requirements for ongoing maintenance to the retained parts of the building would not alter. Therefore this was given a score of 4 to reflect the partial building works undertaken and the ongoing risks.

Investment Objective/Main Benefits Criteria: Deliverability: how straightforward is it to deliver the option in terms of disruption to patients and staff both within the Unit and on the Glan Clwyd site.

Option 1: Business As Usual: Participants discussed that given the status quo option entails just the ongoing maintenance work as and when required this was awarded a high score in relation to deliverability. Therefore the consensus score for this criteria was 9.

Option 2: Full remodelling of the current Ablett Unit: Participants felt that whilst this option is deliverable would be significant impact as the total refurbishment is much larger than the original SOC submitted, following wider engagement through the design user groups. More areas would be required to decant, and concerns were discussed in relation to the potential length or works in terms of lessons learned from the anti- ligature programme i.e.: delays and incidents. Concern was raised in relation to the noise and disruption to service users and potential impact on individuals' recovery and length of stay, which was also raised as an issue in recent engagement events. Capacity of the unit was discussed and the potential impact on the two other inpatient units East and West dependent on areas requiring closure or reduction in beds. Maintaining the health and safety of patients' staff and contractors was seen as an issue and risk during the demolition and rebuild and the potential impact on increased works to the red route which runs just in front. Due to all of the issues highlighted this option was given a score of 3.

Option 3: A new build unit located on the YGC site: Discussion took place in terms of the new build and that it would only require disruption in terms of one move for both staff and patients. There would be no decant requirements and flow would be maintained fully in Central avoiding impact on the other two units or on out of area placements. In terms of parking there's a planned

solution and there would be no impact on the red route as the build is planned for the back of the building, so disruption to the YGC site was not viewed as an issue, other than deliveries which would need to be carefully planned. The score for this option was 8.

Option 4: Partial re-modelling of the current Ablett Unit: This option was considered in terms of the impact. Discussion took place in relation to the deliverability and that the impact would be less than option 2 but there would still be disruption to staff and patients as some demolition would take place whilst operating a live environment. Similarly to option 2 there may be an impact on other units dependent on maintenance of flow in Central and length of the works. This criteria scored a 5.

4.6.2.4 Summary of Results

The results of the benefits appraisal are shown in the following table:

Benefit Criteria and Weight	**Weight %**	**Option 1 Business as usual**		**Option 2 Full remodel**		**Option 3 New build**		**Option 4 Partial remodel**	
Raw (R) & Weighted (W) scores		**R**	**W**	**R**	**W**	**R**	**W**	**R**	**W**
Model of Care	25	2	50	8	200	9	225	5	125
Clinical Environment	25	2	50	9	225	9	225	6	150
Workforce	10	1	10	8	80	9	90	4	40
Quality of the Estate	15	1	15	6	90	9	135	4	60
Deliverability	25	9	225	3	75	8	200	5	125
Total	**100**	[redacted]	**350**	[redacted]	**670**	[redacted]	**875**	[redacted]	**500**
Rank		**4**		**2**		**1**		**3**	

4.6.2.5 Sensitivity Analysis

A sensitivity analysis has been undertaken to test the robustness of the ranking of the options. The methods used were:

- Equal weighting
- Exclusion top ranked criteria
- Switching values

Undertaking the sensitivity analysis shows that the preferred option would not be different under any of the alternative methods (the full sensitivity analysis is included in Appendix I).

4.6.2.6 Conclusion of the Qualitative Option Appraisal

In summary, the benefits appraisal exercise demonstrates that the full implementation of the new service model is clearly superior when compared to both continuing business as usual and implementing the more limited scope outlined in the SOC. The option for a new build scores substantially higher than the refurbishment option in both the raw and weighted scores.

4.6.3 Monetised Benefits Appraisal

The detailed economic appraisals for each option are attached in the supporting Appendix J. The tables have been completed using the Generic Economic Model for OBCs and show the summary output tables from the model.

Output tables

	Undiscounted (£000s)	**Net Present Cost (Value) (£000s)**
Option 1: Business as Usual / Do Nothing		
Capital Costs (net VAT)	**5,500**	
Lifecycle Costs	2,560	
Optimism Bias (included under capital)	806	
Capital Cost Sub-total	**8,866**	7,071
Opportunity Costs	0	0
Revenue Costs		215,751
Total Costs		**222,822**
Less: cash releasing benefits		0
Costs net cash savings		222,822
Non-cash releasing benefits		0
Total NPC		**222,822**
Equivalent Annual Cost		**7,427**

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 2: SOC + Full remodelling of the current unit		
Capital Costs (net VAT)	**65,086**	
Lifecycle Costs	5,736	
Optimism Bias (included under capital)	2,833	
Capital Cost Sub-total	**73,655**	62,729
Opportunity Costs	0	0
Revenue Costs		219,677
Total Costs		**282,407**
Less: cash releasing benefits		(4,627)
Costs net cash savings		277,779
Non-cash releasing benefits		0
Total NPC		**277,779**
Equivalent Annual Cost		**9,259**

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 3: New Build on YGC site		
Capital Costs (net VAT)	**67,676**	
Lifecycle Costs	5,736	
Optimism Bias (included under capital)	1,468	
Capital Cost Sub-total	**74,880**	63,720
Opportunity Costs	0	0
Revenue Costs		220,378
Total Costs		**284,098**
Less: cash releasing benefits		(4,627)
Costs net cash savings		279,470
Non-cash releasing benefits		0
Total NPC		**279,470**
Equivalent Annual Cost		**9,316**

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 4: SOC ward areas inc. Bryn Hesketh		
Capital Costs (net VAT)	**24,861**	
Lifecycle Costs	2,708	
Optimism Bias (included under capital)	1,103	
Capital Cost Sub-total	**28,673**	24,873
Opportunity Costs	0	0
Revenue Costs		215,911
Total Costs		**240,783**
Less: cash releasing benefits		(4,627)
Costs net cash savings		236,156
Non-cash releasing benefits		0
Total NPC		**236,156**
Equivalent Annual Cost		**7,872**

As summarised in the table above, the options have been assessed in terms of optimism bias, and the following percentages have been applied: option one 10%; option two 4%; option three 2%; option four 4%. The analysis of optimism bias is included in Appendix K.

A sensitivity analysis made no significant difference to the scores and therefore did not affect the ranking.

Conclusion of the Monetised Benefits Appraisal

The business as usual option is obviously ranked first for monetised benefits, as the other options entail investment to improve service quality and meet clinical standards. It should be noted that following discussions with Welsh Government a proportionate approach has been adopted to monetisation with, for example, no attempt to monetise the benefits of improved patient outcomes or reduced travel times for families.

4.6.4 Risk Assessment

A risk assessment workshop was held in July 2021. The full report of the workshop, including the attendees, is included as Appendix L. Workshop participants reviewed the risk register, and considered the types of risks generally faced by projects – as outlined in HM Treasury and Welsh Government's Guide to Developing the Project Business Case.

The following risks are the material ones that are applicable to this project, and therefore form the basis of the option appraisal:

- Service and Design Risk
- Service Continuity Risk
- Demand Risk

A summary of the discussion and conclusions from the workshop is as follows:

Service Risk: The risk that the service is not fit for purpose

Design Risk: The risk that design cannot deliver the services to the required quality standards

Option	Risk
Option 1: Business As Usual / Do Nothing: No change to the unit at Glan Clwyd or Bryn Hesketh, aside from minor maintenance	- Continuation of risks associated with treating patients out of area, as there will be insufficient beds to treat all Conwy and Denbighshire residents at Glan Clwyd - Risk to the provision of a quality service, as unable to maintain ECT accreditation - Risk to the quality of care, as unable to fully implement service transformation – including: unable to provide required therapeutic space to meet ongoing service transformation; does not support future provision of a multi-disciplinary / multi-therapeutic service as part service transformation e.g.: pharmacy provision - Privacy / dignity issues including sexual safety risks and concerns as a result of the current building layout e.g.: mixed wards - Risk of not supporting the implementation of external reports / recommendations as outlined in the strategic case i.e.: ▪ Community Health Council Reports ▪ Health Inspectorate Wales Reports ▪ Welsh Government Reports ▪ The Ockenden Report ▪ Health and Social Care Advisory Service Consultancy Limited (HASCAS) - Does not address the risks at Bryn Hesketh as outlined in the Division's risk register.

Option 2: Full remodelling of the current unit: the current Strategic Outline Case (SOC) scope plus additional works to provide the same footprint and space as a new build. The current unit would need to be predominantly decanted to allow large amount of demolition and phased reconstruction of all wards	- Reduces many of the risks - Risk to the continued evolution of the service as there will be constrained / limited scope for future development as a result of retaining the current footprint and site - Risk to the full implementation of the service model: adjacencies may not be ideal as refurbishment constrains the design, and there are limited external areas
Option 3: A new build unit located on the YGC site: the current service at the Ablett and Bryn Hesketh is maintained whilst a fully designed new build unit is constructed. Once the new build is complete, Ablett Unit and the relevant elements of the Bryn Hesketh service move to the new build. The current Ablett unit is retained for alternative use. Car parking space is created at YGC to replace the spaces lost, and to take account of the increased activity associated with the transfer of services from Bryn Hesketh.	- Addresses all identified risks
Option 4: The proposal as outlined in the SOC with works to ward areas only and adding Bryn Hesketh: no other works to reception, ECT, staff rest areas or admin areas	- Risk to ECT service as unable to maintain ECT accreditation - Risk to the quality of care, as unable to fully implement service transformation – including: unable to provide required therapeutic space to meet ongoing service transformation; does not support future provision of a multi-disciplinary / multi-therapeutic service as part service transformation e.g.: pharmacy provision

Service Continuity Risk: The risk arising in accommodation projects relating to the need to decant staff/clients from one site to another.

Option	Risk
Option 1: Business As Usual / Do Nothing: No change to the unit at Glan Clwyd or Bryn Hesketh, aside from minor maintenance	- There are no decantation risks as there is no project.

Option 2: Full remodelling of the current unit: the current Strategic Outline Case (SOC) scope plus additional works to provide the same footprint and space as a new build. The current unit would need to be predominantly decanted to allow large amount of demolition and phased reconstruction of all wards	- There is a significant risk to the quality of care as a result of noise / contractor access to an operational building when patients are acutely ill. - There is a significant risk of disruption to patient care in having to decant. - This would be a phased work programme so the risk of disruption will be for a prolonged period. - There are risks associated with the interface between clinical / service delivery areas and building works – these risks cannot be fully mitigated against unless a full decant of the current site is undertaken.
Option 3: A new build unit located on the YGC site: the current service at the Ablett and Bryn Hesketh is maintained whilst a fully designed new build unit is constructed. Once the new build is complete, Ablett Unit and the relevant elements of the Bryn Hesketh service move to the new build. The current Ablett unit is retained for alternative use. Car parking space is created at YGC to replace the spaces lost, and to take account of the increased activity associated with the transfer of services from Bryn Hesketh.	- The only risk will be when the services are transferred to the new unit. This will need careful managing but is not regarded as a substantial risk.
Option 4: The proposal as outlined in the SOC with works to ward areas only and adding Bryn Hesketh: no other works to reception, ECT, staff rest areas or admin areas	- The scale of work is reduced, however the risks are the same as are outlined in Option 2.

Demand Risk: The risk that the demand for a service does not match the levels planned, projected or assumed

Option	**Risk**
Option 1: Business As Usual / Do Nothing: No change to the unit at Glan Clwyd or Bryn Hesketh, aside from minor maintenance	- This option will not deliver the level of service required to meet current or projected demand, as outlined in the Strategic Case. - The need to isolate new admissions until their COVID-19 status us clear is further reducing the effective bed capacity in the Unit

Option 2: Full remodelling of the current unit: the current Strategic Outline Case (SOC) scope plus additional works to provide the same footprint and space as a new build. The current unit would need to be predominantly decanted to allow large amount of demolition and phased reconstruction of all wards	- This option meets current and projected demand, as outlined in the Strategic Case. However there is a risk of failure to meet future demand as the limitations of the location reduce flexibility for future developments.
Option 3: A new build unit located on the YGC site: the current service at the Ablett and Bryn Hesketh is maintained whilst a fully designed new build unit is constructed. Once the new build is complete, Ablett Unit and the relevant elements of the Bryn Hesketh service move to the new build. The current Ablett unit is retained for alternative use. Car parking space is created at YGC to replace the spaces lost, and to take account of the increased activity associated with the transfer of services from Bryn Hesketh.	- This option meets current and projected demand, as outlined in the Strategic Case.
Option 4: The proposal as outlined in the SOC with works to ward areas only and adding Bryn Hesketh: no other works to reception, ECT, staff rest areas or admin areas	- This option does not meet all elements of demand as it does not support the full service model. - The need to isolate new admissions until their COVID-19 status us clear is reducing the effective bed capacity in the Unit. This limited refurbishment does not address this risk.

In summary, the new build option (option 3) is the lowest risk option. In terms of service and design, it addresses all identified risks. The only risk in terms of service continuity comes at the point of transferring services to the new building, which will require careful managing but is not regarded as a substantial risk. The option meets current and projected demand, and the location and design are sufficiently flexible to allow adaptation to meet unanticipated future changes. Option 2 (full remodelling of the current Ablett Unit) carries a significant risk to service continuity during an extended period of refurbishment and decantation in a building where acutely ill patients are receiving treatment. It is a relatively low risk in terms of service, design and meeting demand, though it lacks the flexibility of option 3. Option 4 (partial remodelling of the current Ablett Unit) also entails a significant risk to service continuity during an extended period of refurbishment and decantation, and only partially mitigates the risks to service, design and meeting demand. Option 1 (business as usual) is the poorest option from a risk perspective, as service and design risks remain unmitigated, and current and future demand is not met.

The risks associated with planning permission for the new build option have also been considered, and are regarded as relatively low. As is outlined fully in the Estates Annex, outline planning permission was sought for a different location on the site. The application was recommended for approval by the Local Authority's planning officials, but rejected by the planning committee on the basis of the impact on residential amenity. The new site location has been selected to address these concerns. BCU have appointed Tetra Tech to provide specialist planning advice and support. Their report (section 4 of the Estates Annex) notes that the revised location is some 160 metres from the nearest residential neighbour and considers that this addresses the previous concerns with respect to residential amenity. The Health Board has continued to engage with the local community and no adverse comments have been received to date. Dialogue has also continued with the planning authority whose officers are supportive of the location.

4.7 The Preferred Option

The table below summarises the key outcomes and rankings of the qualitative benefits, the monetised benefits and the risk appraisals of the shortlisted options.

Appraisal	Business as Usual	Full Refurbishment	New Build	Partial Refurbishment
Qualitative benefits	4	2	1	3
Monetised benefits	1	3	4	2
Risk appraisal	4	2	1	3
Overall ranking	4	2	1	3

The preferred option is Option 3, the new build option. This option addresses the full service scope outlined in the Strategic Case, delivers the greatest qualitative benefit and carries the least risk. The service quality benefits of the scheme justify the higher capital costs.

4.8 Impact Assessments of the Preferred Option

The preferred option has been assessed in terms of:

- Equality Impact
- Socio-Economic Duty
- Community Benefits
- Health Impact

The Equality Impact Assessment indicates that the preferred option has a positive impact for many of the protected characteristics (notably age, due to the improvements in OPMH provision) and no negative impacts. The Socio-Economic Duty and Community Benefits highlight in particular the employment opportunities (both paid and voluntary) of the scheme. The Health Impact is very positive, reflecting the core purpose of the project – to improve the quality of care for patients. The full impact assessments are included as Appendices M to P.

4.9 Decarbonisation

In developing the design of the preferred option the Health Board has responded to the Welsh Government's declaration of a climate emergency and the recently published NHS Wales Decarbonisation Strategy Delivery Plan. A number of proposals have been incorporated within the design. These have sought to provide the optimum balance between the benefits in diminishing carbon emissions and the associated capital cost to ensure value for the public money invested. The design proposals include:

- A minimum of 10% of additional parking spaces to have electric vehicle charging provision. The proposed multi-storey car park will be future proofed to increase this amount when capacity allows.
- Sustainable energy generation through photo voltaic panels located at roof level
- Heating provision through air source heat pumps and air-cooled chillers
- Selection of external cladding materials that maximise thermal and solar efficiency
- Green space and green wall/roofing provision
- Permeable paving and sustainable drainage considerations
- Natural ventilation to non-clinical areas
- Incorporation of materials that have lower embodied carbon in their composition and manufacture
- Utilisation of Modern Methods of Construction (MMC) and off-site fabrication to minimise carbon emissions during the construction process
- BREEAM Excellent accreditation.

Full details are included in the Estates Annex.

5. The Commercial Case

5.1 Introduction

This section of the OBC outlines the proposed contract strategy in relation to the preferred option outlined in section 4: The Economic Case. The aim of the Commercial Case is to secure the optimal deal for the preferred option. In accordance with national guidance the contract will be the National Engineering Contract 3 with target cost.

5.2 Required Services

5.2.1 The expected cost of the works requires that BCU utilise the national Design for Life; Building for Wales third generation frameworks and procure the following support:

- NEC 3 Project Manager
- Supply Chain Partner (construction contractor).

The national Frameworks comprise companies with proven experience and resources to deliver complex health capital projects. All companies are subject to regular performance review by a Framework Board that comprises members from NWSSP, Welsh Health Boards, Welsh Government and industry bodies. Selection from the Framework therefore provides the Health Board and Welsh Government with assurance of the selected organisation's ability to successfully deliver the project.

NWSSP Specialist Estate Services (NWSSP – SES) supported and advised the Board on the appropriate procurement processes.

Currently there is no national framework for cost advisors. As a consequence BCU utilised the Crown Commercial Services framework, and NWSSP-Procurement Services (NWSSP-PS) supported and advised the Board on the appropriate procurement processes.

5.2.2 In accordance with the appropriate framework invitations to tender were sought from the companies identified within the appropriate national framework. Tender submissions where evaluated on the basis of cost and quality and each company was invited to attend an interview in support of their tender. The interviews, together with the company's written submissions, sought to assess their proposed team, their experience of similar commissions and their approach to the project. Tenders were evaluated by a small team comprising the Project Director, Service Leads and the leads for Capital Development and Operational Estates together with support from NWSSP – SES.

Following these processes BCUHB has confirmed the following appointments:

▪ Construction Project Manager	Gleeds Management Services
▪ Cost Advisor	Gleeds Cost Management
▪ Supply Chain Partner (construction contractor)	BAM Construction Ltd

5.3 Potential for Risk Transfer

The general principle is that risks should be passed to the party best able to manage them, subject to Value for Money (VfM).

This section provides an assessment of how the associated risks might be apportioned between the BCUHB and the appointed Supply Chain Partner (SCP) and Project Manager (PM).

The risk register details how the risks have been apportioned between the BCUHB and the SCP. The risk register was generated by following the NWSSP-SES Standard Risk Register Template, adding scheme specific risks and the apportionment of the risks between the BCUHB and SCP agreed at a risk workshop.

Risk Category	Potential Allocation		
	BCUHB	SCP	Shared
Design Risk			X
Construction Risk		X	
Transition & Implementation Risk	X		
Availability & Performance Risk	X		
Operating Risk	X		
Revenue Risks	X		
Termination Risks			X
Technological Risks			X
Control Risks			X
Residual Value Risks	X		
Financial Risks			X
Legislative Risks	X		
Other Project Risks			X

5.4 Proposed Charging Mechanisms

The *Building for Wales Framework* ensures that a *collaborative working model* will be adopted. It is therefore expected that the charging mechanisms in respect of this project will be covered within the framework agreement. The framework will require a Not To Be Exceed Price (NTBE) and will also stipulate the requirement for a staged payment mechanism, which would normally be monthly via valuation. Once approved by *open book* the BCUHB would issue an interim certificate for payment.

5.5 Proposed Contract Lengths

The proposed contract length for the project is 35 months from Strategic Outline Case approval to handover (timescales are summarised in paragraph 5.8.2 below and outlined in full in the Estates Annex).

Partnership between the SCP and the BCUHB will continue twelve months after project completion and handover, ensuring any defects have been made good.

5.6 Proposed Key Contractual Clauses

The form of contract will be the *NEC 3 Option C* with Target Cost that is utilised within the *Designed for Life: Building for Wales 3 Framework*.

5.6.1 Contractual Arrangements

The contractual relationships between the various parties are subject to the rules and regulations of the framework.

5.6.2 Contract Type

The NEC contract has been chosen as the contract type to be utilised under the framework. The NEC contract will be applicable the appointment of both the Supply Chain Partners and Support Consultants. The Support Consultants will enter into the NEC Professional Services Contracts (PSC) with the BCUHB.

5.7 Personnel Implications (including TUPE)

It is anticipated that the TUPE – Transfer of Undertakings (Protection of Employment) Regulations (1981) will not apply to this project.

5.8 Procurement Strategy and Implementation Timescales

5.8.1 Procurement Strategy

The project will be procured via the *Building for Wales framework* for Projects with a construction value in excess of £10 million.

The framework supports the objectives of the Welsh Government, the core objectives of the framework are as follows:

- Obtain Best Value for Money in procuring major health capital developments.
- Implement the Welsh Government's construction policy to ensure that the NHS in Wales complies with best practice models of procurement based on long-term strategic partnerships.
- Ensure that NHS Wales becomes an exemplar client for all major construction procurement projects.
- Create an environment of collaborative working and continuous improvement that utilises strategic partnerships with integrated supply chains.

Through the attainment of these objectives the framework will ensure that construction projects are delivered with improved success factors in terms of:

- Lower design and construction costs
- Reduced programme of design and construction
- Higher quality of design and construction and less defects
- Greater predictability in relation to cost and programme
- Reduced accident rate on site
- Higher sustainability ratings
- Community benefits

5.8.2 Implementation Timescales

It is anticipated that the implementation milestones will be as follows:

Milestones	Target Date
BCUHB approval and submission of Outline Business Case to Welsh Government	September 2021
Full Business Case Completed	January 2023
Construction Completed	December 2025

The full project timetable is outlined in the Estates Annex.

6. Financial Case

6.1 Introduction

The purpose of this section is to set out the indicative financial implications of the preferred option (as set out in the economic case section) and the proposed deal (as described in the commercial case section).

Detailed financial workings are provided in Appendix Q to support the summary information provided in the financial case and the economic case.

6.2 Impact on the Organisation's Income and Expenditure Account

The revenue projection for the preferred option is detailed below:

Category	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6 Onwards	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Capital Expenditure	1,310	1,441	1,990	10,815	31,267	21,596	208	73,412
Revenue Costs	-	-	-	-	-	-	-	-
Recurrent	13,549	13,549	13,549	13,549	13,549	13,549	13,549	406,457
Non Recurrent	-	-	-	-	-	-	-	-
Total	13,549	13,549	13,549	13,549	13,549	13,549	13,549	406,457
Funded by:	-	-	-	-	-	-	-	-
WG Capital	1,231	1,346	1,911	10,715	31,176	21,298	-	67,676
Revenue Streams	11,334	11,334	11,334	11,334	11,334	11,334	11,334	340,019
Cash Releasing Savings	243	243	243	243	243	243	243	7,292
WG Funding (depreciation)	1,972	1,972	1,972	1,972	1,972	1,972	1,972	59,146
Capital Expenditure	79	95	79	100	91	299	208	5,736
Operating Expenditure	-	-	-	-	-	-	-	-

6.3 Overall Affordability

The preferred option is revenue neutral.

There is a projected increase in annual revenue costs of £1,725,925 compared to existing arrangements. The total expected capital charge (i.e. depreciation) is £1,971,523; this is an increase of £1,482,895 over the current charge. As capital charges are funded by Welsh Government the increase in capital charge is deemed to be revenue neutral for the purpose of financial affordability.

The net additional impact after the capital charges is therefore £243,081. This increased cost will be mitigated by a sustained reduction in out of area placement costs due to the creation of 12 more adult beds and 4 more older person's beds in the central area. The reduction of £243,081 will require a the use of 316 less bed days per annum at an average cost per day of £767. In 2021/21 the number of out of area bed days utilised (excluding the impact of covid) was 931. In 2019/20 the equivalent figure was 783.

6.4 Summary Revenue Costs

The financial case sets out the forecast financial implications of the preferred option. Detailed financial workings are provided in the financial appendices to support the summary information provided in the financial case and the economic case.

The costs are priced at 2020/21 price base. Staffing costs are based on the compliant standards and are costed at NHS pay scales.

The summary position from a recurrent revenue perspective for the preferred option is as follows:

Revenue Impact of Preferred Model	£000's
Inpatient Service Costs	-161
Estates and Facilities Costs	404
Net Increase in Running Costs	243
Less: Reduction in Out of Area Placements	-243
Net Position	0

There is an overall reduction in staffing costs of £161k despite the increase in the number of inpatient beds, due to the greater efficiency of the new ward layouts. While the proposed new building is more efficient than the current accommodation, there is a net increase in estates and facilities costs due to the size of the footprint of the building.

6.5 Summary Capital Costs

The summary position from a capital perspective of the preferred option (excluding optimism bias) is as follows:

Category	£000's
Works Costs	38,653
Fees	7,058
Non Works Costs	1,485
Contingency	5,233
Equipment Costs	5,143
Project Costs (before inflation)	**57,573**
Vat	11,515
Less Recoverable VAT	-1,412
Total	**67,676**

Detailed Capital Cost Forms are provided in Appendix R i to R iv.

6.6 Impact on the Balance Sheet

The business case assumes that funding will come via the conventional route and not through the Private Finance Initiative (PFI). It is anticipated there will be an impairment adjustment against the capital cost once the District Valuer (DV) values the site. The impairment is estimated to be £17.029m and is subject to final assessment by the DV. It is anticipated this impairment will need to be actioned through the Income & Expenditure account as opposed to the revaluation reserve in the balance sheet. It is assumed this will be funded by the Welsh Government as a funding flow adjustment in line with current policy.

7 Management Case

7.1 Introduction

This section of the Business Case addresses the achievability of the scheme. It sets out the actions that will be undertaken to ensure its successful delivery.

7.2 Programme and Project Management Arrangements

The project management arrangements for capital projects are outlined in the Procedure Manual for Managing Capital Projects, which was adopted by the Health Board in 2018.

7.3 Project framework

The Senior Responsible Owner for the project is Teresa Owen, the Executive Director of Public Health.

The Project Director is Jill Timmins.

The project governance arrangements are outlined in full in Appendix S.

7.4 Project Plan

It is anticipated that the implementation milestones will be as follows:

Milestones	Target Date
BCUHB approval and submission of Outline Business Case to Welsh Government	September 2021
Full Business Case Completed	January 2023
Construction Completed	December 2025

7.5 Arrangements for Change and Contract Management

The approach to change management is as follows:

- Based on the principle of involvement and inclusion: service managers and user representation have been fully involved in the process of achieving short-listed options and the design development.
- Any HR implications that are a result of preferred options will be managed in accordance with the BCUHB's' Organisational Change policy.
- A detailed change management plan will form part of the strategy for implementing any service changes. This will be documented in the Full Business Case.
- The arrangements for contract management are as set out within the *Designed for Life: Building for Wales Framework* agreement and these arrangements are as per *the JCT Design & Build Contract (2011).*

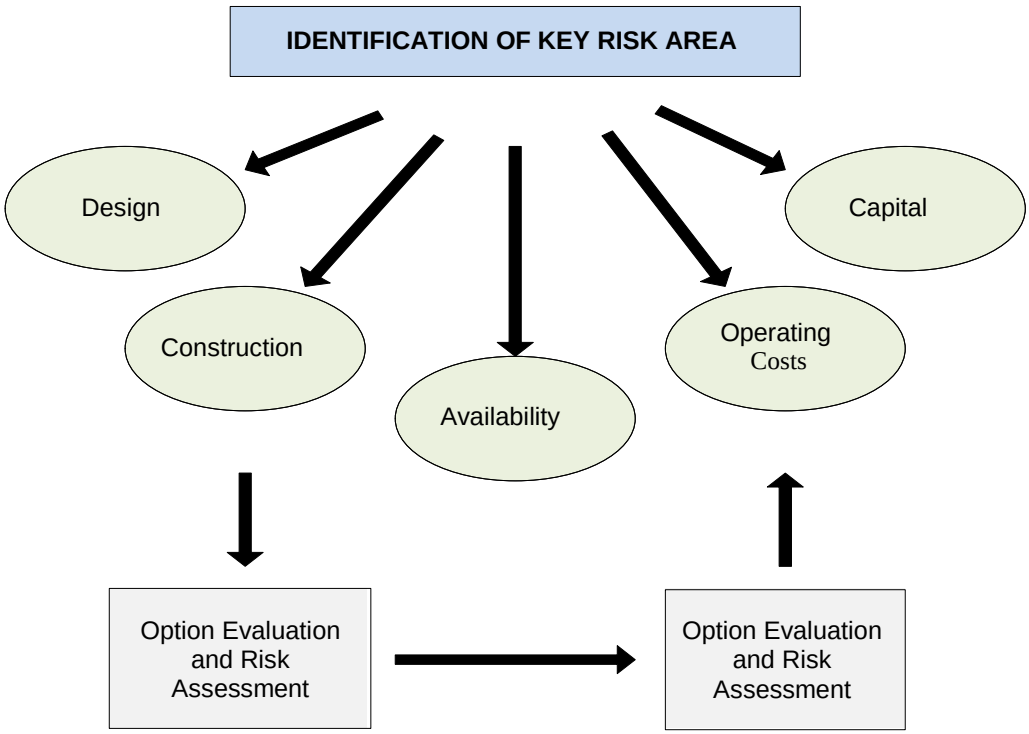
The procurement process is described within Section 5: The Commercial Case.

7.6 Arrangements for Benefits Realisation

The approach to dealing with the management and delivery of the project benefits is detailed within the Benefits Realisation Plan, which is enclosed as Appendix C. The plan provides details of who is responsible for delivery of the specific benefits, how and when they will be delivered and what activity needs to be undertaken to deliver them.

7.7 Arrangements for Risk Management

The Health Board is required to undertake a comprehensive assessment of the risks associated with the Preferred Option. The approach is shown in the diagram below:



The risk management strategy is based upon the following principles:

- Identifying the possible risk in advance, putting in place mechanisms to minimise the likelihood of risks occurring and their associated adverse effects
- Having processes in place to ensure up to date, reliable information about risks is available, and establishing an ability to effectively monitor risks
- Establishing the right balance of control is in place to mitigate the adverse consequences of risks, should they materialise
- Setting up decision-making processes, supported by a framework of risk analysis and evaluation

The Project Board has identified and quantified the key risks associated with the preferred option. All identified risks have been apportioned to either the Health Board or SCP and mitigating strategies identified in the risk register. This will be monitored on a monthly basis by the Project Board for the life of the project. It is the project manager's responsibility to manage the risk register.

A copy of the Project Risk Register is attached at Appendix T.

7.8 Arrangements for Post Project Evaluation

The outline arrangements for Post Implementation Review and Project Evaluation Review have been established in accordance with best practice guidelines.

All NHS organisations have a duty to evaluate Capital projects where they cost more than £1m, to duly learn from them and to report the findings of the evaluation to the Welsh Government. Guidance has been produced for undertaking Post Project Evaluation (PPE) as part of the Capital Investment Manual, and subsequent to that, a toolkit for evaluating design proposals has been produced.

The project will be evaluated by undertaking the following investigations:

- Review of the strategic case made for the project to confirm that it is still relevant
- Review of the benefits detailed in the Benefits Realisation Plan and confirmation that they have been met
- Review of the Business Case capital costs to confirm that the capital costs were robust
- Review of the Project Programme and adherence to it throughout the life of the project

A full post-project evaluation of the scheme will be produced and submitted to the Finance and Performance Committee of the Board 15 months after the completion of the scheme.

<u>Gateway Review Arrangements</u>

The OGC Gateway Process examines programmes and projects at key decision points in their lifecycle. It looks ahead to provide assurance that the programme and projects can progress successfully to the next stage; the Process is seen as best practice by public sector bodies. The value of the OGC Gateway Review is recognised by Health Board and we intend to utilise the peer reviews in which independent practitioners from outside the project use their experience and expertise to examine the project post commissioning. This will include a Gateway 5 to support the post-project evaluation.

8.0 Conclusion and Recommendation

This Business Case is recommended for approval.

Appendices

Appendix A	Together for Mental Health in North Wales
Appendix B	Division's Transformation Plans
Appendix C	Benefits Realisation Plan
Appendix D	Feedback from engagement events October 2019– Jan 2020
Appendix E	Series of engagement events / calendar
Appendix F	Bed capacity / model
Appendix G	CHC Letter of Support for the Business Case 15.07.2021
Appendix H	Qualitative Benefits Appraisal: Workshop Friday 17th January 2020 Attendance List
Appendix I	Qualitative Benefits Appraisal: Sensitivity Analysis
Appendix J	Financial Economical Benefits Appraisal
Appendix K	Optimism Bias
Appendix L	Risk Assessment: Workshop Report and Attendance List July 2021
Appendix M	Equality Impact Assessment
Appendix N	Socio-Economic Duty
Appendix O	Health Impact Assessment
Appendix P	Community Benefits
Appendix Q	Financial Analysis August 2021
Appendix R i - iv	Capital Cost Forms
Appendix S	Project Governance Arrangements
Appendix T	Project Risk Register

Preferred Option - Option 3

	Lifespan	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6 Onwards	Total
	Capital Expenditure								
1	Fixed assets	1,230,564	1,345,786	1,910,672	10,715,495	31,176,151	21,297,768		67,676,435
2	Software								
3	Other Capital Item	79,398	95,237	79,398	99,840	90,769	298,583	208,024	5,735,798
4	**Total Capital costs**	**1,309,962**	**1,441,023**	**1,990,070**	**10,815,335**	**31,266,920**	**21,596,351**	**208,024**	**73,412,233**
	Operating Expenditure								
5	Inpatient and ECT Staffing	4,926,581	4,926,581	4,926,581	4,926,581	4,926,581	4,926,581	4,926,581	**147,797,418**
6	Other Community Staffing	2,432,934	2,432,934	2,432,934	2,432,934	2,432,934	2,432,934	2,432,934	72,988,020
7	Medical	2,825,778	2,825,778	2,825,778	2,825,778	2,825,778	2,825,778	2,825,778	84,773,340
8	Clinical Support	219,335	219,335	219,335	219,335	219,335	219,335	219,335	6,580,050
9	Non Pay	292,189	292,189	292,189	292,189	292,189	292,189	292,189	8,765,670
10	Income	-112,627	-112,627	-112,627	-112,627	-112,627	-112,627	-112,627	3,378,810
11	Estates and Facilties	992,847	992,847	992,847	992,847	992,847	992,847	992,847	**29,785,418**
12	Depreciation	1,971,523	1,971,523	1,971,523	1,971,523	1,971,523	1,971,523	1,971,523	**59,145,677**
13	**Total Revenue costs (OPEX)**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**406,456,783**
	Total Expenditure								
14	**Total Project Costs (CAPITAL + REVENUE)**	**14,858,521**	**14,989,582**	**15,538,629**	**24,363,894**	**44,815,480**	**35,144,910**	**13,756,583**	**479,869,016**
	Funding								
15	CAPITAL	1,309,962	1,441,023	1,990,070	10,815,335	31,266,920	21,596,351	208,024	73,412,233
16	REVENUE	13,305,479	13,305,479	13,305,479	13,305,479	13,305,479	13,305,479	13,305,479	399,164,355
17	**Total funding**	**14,615,441**	**14,746,501**	**15,295,548**	**24,120,813**	**44,572,399**	**34,901,829**	**13,513,502**	**472,576,589**
				Affordability Assessment					
18	**Shortfall/Overage CAPITAL**	-	-	-	-	-	-	-	-
19	**Shortfall/Overage REVENUE**	243,081	243,081	243,081	243,081	243,081	243,081	243,081	7,292,428

Preferred Option - Option 3

Lifespan	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6 Onwards	Total
Capital Expenditure	**1,309,962**	**1,441,023**	**1,990,070**	**10,815,335**	**31,266,920**	**21,596,351**	**208,024**	**73,412,233**
Revenue Costs								
Recurrent	13,548,559	13,548,559	13,548,559	13,548,559	13,548,559	13,548,559	13,548,559	406,456,783
Non Recurrent	-	-	-	-	-	-	-	-
Total	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**13,548,559**	**406,456,783**
Funded by:								
WG Capital	1,230,564	1,345,786	1,910,672	10,715,495	31,176,151	21,297,768	-	67,676,435
Revenue Streams	11,333,956	11,333,956	11,333,956	11,333,956	11,333,956	11,333,956	11,333,956	340,018,679
Cash Releasing Savings	243,081	243,081	243,081	243,081	243,081	243,081	243,081	7,292,428
WG Funding (depreciation)	1,971,523	1,971,523	1,971,523	1,971,523	1,971,523	1,971,523	1,971,523	59,145,677
Capital Expenditure	**79,398**	**95,237**	**79,398**	**99,840**	**90,769**	**298,583**	**208,024**	**5,735,798**
Operating Expenditure	-	-	-	-	-	-	-	-

Preferred Option - Option 3

Category	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6 Onwards	Total
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
Capital Expenditure	1,310	1,441	1,990	10,815	31,267	21,596	208	73,412
Revenue Costs	-	-	-	-	-	-	-	-
Recurrent	13,549	13,549	13,549	13,549	13,549	13,549	13,549	406,457
Non Recurrent	-	-	-	-	-	-	-	-
Total	13,549	13,549	13,549	13,549	13,549	13,549	13,549	406,457
Funded by:	-	-	-	-	-	-	-	-
WG Capital	1,231	1,346	1,911	10,715	31,176	21,298	-	67,676
Revenue Streams	11,334	11,334	11,334	11,334	11,334	11,334	11,334	340,019
Cash Releasing Savings	243	243	243	243	243	243	243	7,292
WG Funding (depreciation)	1,972	1,972	1,972	1,972	1,972	1,972	1,972	59,146
Capital Expenditure	79	95	79	100	91	299	208	5,736
Operating Expenditure	-	-	-	-	-	-	-	-

Ablett Revenue Costings

	Option 1 - BAU (Do nothing) 4078 m2		Option 2 - SOC + Remodel and Bryn Hesketh 9136 m2		Variance	Option 3 - New Build (preferred option) 9136 m2 Preferred Option		Variance	Option 4 - Refurb / New Build as increased scope 9070 m2		Variance	Original Scope - SOC 4314 m2		Variance	
	wte	£	wte	£	£	wte	£	£	wte	£	£	wte	£	£	
Pay															
Inpatient Wards	132.94	4,964,765	136.94	4,926,581	-38,184	136.94	4,926,581	-38,184	136.94	4,926,581	-38,184	136.94	4,926,581	-38,184	
ECT (Included in Inpatient Nursing model)	1.60	70,825			-70,825			-70,825			-70,825			-70,825	
Liaison Team	24.50	1,141,910	24.50	1,141,910	0	24.50	1,141,910	0	24.50	1,141,910	0	24.50	1,141,910	0	
Home Treatment Teams	16.80	702,914	16.80	702,914	0	16.80	702,914	0	16.80	702,914	0	16.80	702,914	0	
Perinatal	13.00	588,110	13.00	588,110	0	13.00	588,110	0	13.00	588,110	0	13.00	588,110	0	
								0			0				
Medical	20.10	2,825,778	20.10	2,825,778	0	20.10	2,825,778	0	20.10	2,825,778	0	20.10	2,825,778	0	assume no change from Nov 20
Administration (Ward Clerks) (Included in Inpatient Nursing	2.00	52,302			-52,302	0.00	0	-52,302		0	-52,302	0.00	0	-52,302	
								0			0			0	
Total Pay	**210.94**	**10,346,604**	**211.34**	**10,185,293**	**-161,311**	**211.34**	**10,185,293**	**-161,311**	**211.34**	**10,185,293**	**-161,311**	**211.34**	**10,185,293**	**-161,311**	
											0			0	
Non Pay															
Inpatient Wards		214,863		214,863	0		214,863	0		214,863	0	0.00	214,863	0	
ECT (Included in Inpatient Nursing model)		15,215		15,215	0		15,215	0		15,215	0	0.00	15,215	0	
Liaison Team		7,718		7,718	0		7,718	0		7,718	0	0.00	7,718	0	
Home Treatment Teams		40,845		40,845	0		40,845	0		40,845	0	0.00	40,845	0	
Perinatal		13,548		13,548	0		13,548	0		13,548	0	0.00	13,548	0	
Total Non Pay	**0.00**	**292,189**	**0.00**	**292,189**	**0**	**0.00**	**292,189**	**0**	**0.00**	**292,189**	**0**	**0.00**	**292,189**	**0**	
Income		0		0	0		0	0		0	0	0.00	0	0	
Inpatient Wards		-2,000		-2,000	0		-2,000	0		-2,000	0	0.00	-2,000	0	
ECT (Included in Inpatient Nursing model)		0		0	0		0	0		0	0	0.00	0	0	
Liaison Team		-80,377		-80,377	0		-80,377	0		-80,377	0	0.00	-80,377	0	
Home Treatment Teams		-28,710		-28,710	0		-28,710	0		-28,710	0	0.00	-28,710	0	
Perinatal		-1,540		-1,540	0		-1,540	0		-1,540	0	0.00	-1,540	0	
Total Income	**0.00**	**-112,627**	**0.00**	**-112,627**	**0**	**0.00**	**-112,627**	**0**	**0.00**	**-112,627**	**0**	**0.00**	**-112,627**	**0**	
											0				
Clinical Support:-											0				
Pharmacy	4.00	219,335	4.00	219,335	0	4.00	219,335	0	4.00	219,335	0	14.00	219,335	0	
Occupational Therapy (needs sep business case)	0.00										0				
Physiotherapy (needs sep business case)	0										0				
Clinical Psychology (needs sep business case)	0										0				
Total Clinical Support Costs	**4.00**	**219,335**	**4**	**219,335**	**0**	**4**	**219,335**	**0**	**4**	**219,335**	**0**	**14**	**219,335**	**0**	
											0				
Estates and Facilities - Other Costs:-											0				
Catering		140,120		186,570	46,450		187,928	47,807		186,570	46,450		186,570	46,450	
Cleaning		168,421		190,017	21,595		191,399	22,978		190,017	21,595		190,017	21,595	
Portering		31,197		30,838	-359		31,062	-134		30,838	-359		30,838	-359	
Other facilities (eg, laundry & linen, security)		8,727		10,703	1,976		10,780	2,054		10,780	2,054		10,780	2,054	
Energy, Rates and Water		120,913		271,156	150,244		284,656	163,744		284,656	163,744		171,194	50,281	
Estate Maintenance		119,078 52		266,771 63	147,694		287,021 63	167,944		287,021	167,944		168,781 63	49,703	
Estates and Facilities Total	**0**	**588,455 52**	**0**	**956,055 63**	**367,599**	**0**	**992,847 63**	**404,392**	**0**	**989,883 0**	**401,427**	**0**	**758,180 63**	**169,724**	
											0				
Sub Total	**214.9**	**11,333,956 52**	**215.3**	**11,540,244 63**	**206,288**	**215.3**	**11,577,037 63**	**243,081**	**215.3**	**11,574,072 0**	**240,116**	**225.3**	**11,342,369 63**	**8,413**	
Depreciation / Capital charges		488,628					1,971,523	1,482,895			0			0	
					0			0			0			0	
Total	**214.9**	**11,822,584**	**215.3**	**11,540,244**	**206,288**	**215.3**	**13,548,559**	**1,725,975**	**215.3**	**11,574,072**	**240,116**	**225.3**	**11,342,369**	**8,413**	

Affordability Assessment		
		1,725,975
Total Additional Costs	1,725,975	
WG Depreciation Charge	1,971,523	
Existing Depreciation	488,628	
Shortfall in funding	243,081	
Funded By:		
Source of Funding / Savings:		
Out of Area placements	-243,081	Cost Avoidance
Agency Premium		Cost Avoidance / Cash Releasing Partly *
Reduced variable pay staffing costs		Cost Avoidance
Total Proposed Solutions	**-243,081**	
Current Gap - Preferred Model	**0**	

Additional Costs of Preferred Model	
Inpatient Service Costs	-161,311
Estates and Facilities Costs	404,392
	243,081

Revenue Impact of Preferred Model	**£000's**
Inpatient Service Costs	-161
Estates and Facilities Costs	404
	243
Reduction in Out of Area Placements	-243
	0

No assumptions for any reduced bed numbers in areas outside of Centre
Out of Area bed numbers will be managed and contained and provide cost avoidance of £243k, the equivalent of the revenue gap
Medical Substantive costs assumed unchanged but any development in medical staffing would be funded by cost avoidance on medical agency costs

No assumption of variable pay costs but these could reducte by 25% in variable pay costs due to environment and estate configuration
Pharmacy has identified the additional costs split between historical under resourcing and increased beds / acuity. These are not included at this stage and will be subject to a revenue business case for transformation
Pharmacy - There may be some Strategic Assistance Funding which may allow us to implement stage 2 of pharmacy investment
There are no efficiencies identified for campus working for admin & clerical
Additional investment in community services / primary care are not included in this case, funding will be provided via WG transformational / Strategic Assistance
Pharmacy, psychology, OT , ANPs, Physicians assistants, medicines management - none of these included at this stage, will be subject to support from strategic assistance funding.

Nov-18 **Budget figures use establishment review budgets (To be reported to DD on 13th November)** **Confidential**

Ablett Case - Initial Estimated Revenue Consequences

Bed Numbers assumed for High Level Costing at this stage

	Nursing								Estates and Facilities							Total Impact
	Classification	Beds	£ Establishment Review Budget	Current Budgeted Nursing Cost Per Bed	Classification	Beds	Expected Nursing Cost Per Bed	Estimated Cost	Net Revenue Impact	Current SqM	Cost per Sqm	Current Cost	Proposed Sq M	£ per Sqm	Total Estates	Estates Impact	Net Revenue Impact
Tegid	OPMH	10	823,887	82,389	Functional	10	82,389	823,887				0			0		
Dinas (F)	Adult	10	1,305,892	65,295		0	-	-				0			0		
Dinas (M)	Adult	10				0		-				0			0		
Bryn Hesketh	OPMH	14	1,390,346	99,310		0	-	-				0			0		
Cynydd	Rehab	8	856,453	107,057	Organic	14	99,310	1,390,346				0			0		
Adult	Adult				Adult	18	48,333	869,987				0			0		
Adult	Adult				Adult	18	48,333	869,987				0			0		
ECT	No change				No change			-				0			0		
Clinical Decision Unit					(assume Adult)	4	48,333	193,330				0			0		
		52	4,376,578	84,165		64	64,805	4,147,537	- 229,041			0			0	208,000	- 21,041
							saving per bed	16,962									

Adult Budgets from Establishment review	Classification	Beds	£ Establishment Review Budget	Budgeted Nursing Cost Per Bed	Outturn 2017/18	2017-18 Actual Nursing Cost Per Bed
Clywedog	Adult	19	872,119	45,901	1,001,171	52,693
Aneruin	Adult	17	862,991	50,764	1,073,999	63,176
Cynan	Adult	17	862,991	50,764	1,020,724	60,043
Dinas	Adult	20	1,305,892	65,295	1,941,461	97,073
Dyfrdwy	Adult	19	872,119	45,901	954,592	50,242
Average				51,725	1,037,585	57,935

Adult Average excluding Dinas **48,333** **56,538**

OPMH Budgets from Establishment Review	Classification	Beds	£ Establishment Review Budget	Budgeted Nursing Cost Per Bed	Outturn 2017/18	2017-18 Actual Nursing Cost Per Bed
Bryn Hesketh	OPMH	14	1,390,346	99,310	1,660,690	118,621
Cemlyn	OPMH	14	1,390,346	99,310	1,597,347	114,096
Gwanwyn	OPMH	13	1,411,787	108,599	1,886,451	145,112
Hydref	OPMH	14	1,354,749	96,768	1,375,588	98,256
Tegid	OPMH	10	823,887	82,389	1,034,187	103,419
Average		65		97,275	1,510,853	115,901

Rehab Budgets from Establishment Review	Classification	Beds	£ Establishment Review Budget	Budgeted Nursing Cost Per Bed	Outturn 2017/18	2017-18 Actual Nursing Cost Per Bed
Carreg Fawr	Rehab	8	704,883	88,110	708,607	88,576
Coed Celyn	Rehab	10	704,883	70,488	693,226	69,323
Cynnydd	Rehab	8	856,453	107,057	797,158	99,645
Average		26		88,552	732,997	85,848

Assumptions

Medical costs unchanged
Non pay costs unchanged
Support services. Therapies, pharmacy etc unchanged
Budgeted Figures (from establishment review) used for comparator: rationale, current budgeted levels are incorrect pending agreement of establishment review
Figures exclude unit wide resource of £299,691 which would be consistent in both comparators

Budgeted establishment have been used based on the "inpatient establishment review" which is being approved at Divisional Directors meeting on 13 November 2018. This is on the basis that the current budgets are not representative of the safe staffing needed for the wards and would have presented an inaccurate comparison, similarly we concluded that outturn figures would have been an inappropriate measure.

Dinas and Bryn Hesketh have been taken out of any average calculations to avoid skew to the figures as there is an assumption the inefficiencies will disappear under the new configuration. (Split ward and isolated unit)

Estates impact provided by Rod Taylor, based on increase in sqm. Confirmed by I Howard

SUMMARY BY FUNCTION

	£ current	proposed	var	beds current	proposed	var
adult	1,305,892	1,739,973	434,081	20	36	16
opmh	2,214,233	2,214,233	-	24	24	-
Rehab	856,453	0	- 856,453	8	0	- 8
CDU	0	193,330	193,330		4	4
Estates increase		208,000				
total	4,376,578	4,355,537	- 21,041	52	64	12

Nov-18
Ablett Case - Initial Estimated Revenue Consequences

Bed Numbers assumed for High Level Costing at this stage

	Nursing										Total Impact
	Classification	Beds	£ Establishment Review Budget	Current Budgeted Nursing Cost Per Bed	Classification	Beds	Expected Nursing Cost Per Bed	Estimated Cost	Net Nursing Revenue Impact	Estates Impact	Net Revenue Impact
Tegid	OPMH	10	823,887	82,389	Functional	10	82,389	823,887			
Dinas (F)	Adult	10	1,305,892	65,295		0	-	-			
Dinas (M)	Adult	10				0		-			
Bryn Hesketh	OPMH	14	1,390,346	99,310		0	-	-			
Cynydd	Rehab	8	856,453	107,057	Organic	14	99,310	1,390,346			
Adult	Adult				Adult	18	48,333	869,987			
Adult	Adult				Adult	18	48,333	869,987			
ECT	No change				No change			-			
Clinical Decision Unit					(assume Adult)	4	48,333	193,330			
		52	4,376,578	84,165		64	64,805	4,147,537	- 229,041	208,000	- 21,041

Area	(All)

Row Labels	Sum of WTE Budget	Sum of WTE Actual	Sum of YTD Budget	Sum of YTD Actual	Sum of YTD Variance
D143-C-Dinas (Male) Ward Ablett					
Non Pay					
30000-Drugs	0.00	0.00	36,679	44,587	7,908
30030-FP10's	0.00	0.00	710	-318	-1,028
30100-Dressings	0.00	0.00	550	22	-528
30210-M&SE : Disposable	0.00	0.00	1,520	434	-1,086
30250-Surgical Instruments : Disposable	0.00	0.00	840	5	-835
31300-Laboratory Equipment	0.00	0.00	460	9	-451
31360-Laboratory Test Kits	0.00	0.00	480	127	-353
31380-Laboratory External Tests	0.00	0.00	9,940	2,588	-7,352
32000-Provisions	0.00	0.00	2,810	349	-2,461
32040-Hardware & Crockery	0.00	0.00	1,240	178	-1,062
32400-Staff Uniforms & Clothing	0.00	0.00	1,070	363	-707
32510-Cleaning Materials	0.00	0.00	790	49	-741
32810-Other General Supplies & Services	0.00	0.00	1,620	146	-1,474
33010-Stationery	0.00	0.00	620	144	-476
33030-Medical Records Folders	0.00	0.00	350	0	-350
33610-Travel & Subsistence	0.00	0.00	946	32	-914
33620-Excess Mileage	0.00	0.00	640	0	-640
33800-Leased Cars : Contract	0.00	0.00	1,850	1,523	-327
34010-Vehicle Running Costs : Other	0.00	0.00	470	177	-293
34040-Vehicle Insurance	0.00	0.00	480	239	-241
34050-Taxi & Other Vehicle Hire	0.00	0.00	990	4,806	3,816
34080-Other Transport Costs	0.00	0.00	3,230	5,699	2,469
34220-Conferences And Seminars	0.00	0.00	720	0	-720
35300-Contract : Photocopying Rental & Charges	0.00	0.00	270	19	-251
35500-Furniture & Fittings	0.00	0.00	6,600	1,626	-4,974
35510-Office Equipment & Materials : Purchase	0.00	0.00	560	0	-560
35560-Computer Network Costs	0.00	0.00	260	85	-175
37470-Miscellaneous Expenditure	0.00	0.00	400	825	425
Pay					
2A451-Registered Nurse Band 5	4.75	1.00	184,056	152,615	-31,441
2A461-Registered Nurse Band 6	5.00	5.28	247,744	202,919	-44,825
2A471-Registered Nurse Band 7	1.00	2.08	56,662	102,478	45,816
2AA31-Nursing HCA/HCSW Band 3	11.07	10.32	345,456	329,983	-15,473
D143-C-Dinas (Male) Ward Ablett Total	**21.82**	**18.68**	**911,013**	**851,711**	**-59,302**
D144-C-Central Liaison Team					
Income					
01900-Local Authorities Income	0.00	0.00	-80,377	-79,517	860
Non Pay					
30030-FP10's	0.00	0.00	673	6	-667
32810-Other General Supplies & Services	0.00	0.00	570	0	-570
33610-Travel & Subsistence	0.00	0.00	2,475	365	-2,110
35510-Office Equipment & Materials : Purchase	0.00	0.00	4,000	4,000	0
Pay					
2A461-Registered Nurse Band 6	16.00	15.72	824,063	820,313	-3,750
2A471-Registered Nurse Band 7	1.00	1.00	52,542	52,624	82
2AA31-Nursing HCA/HCSW Band 3	6.00	6.42	190,353	149,847	-40,506
2C361-Occupational Therapist Band 6	1.00	1.00	47,376	47,599	223
2E471-Pharmacist Band 7	0.50	0.00	27,576	8,837	-18,739
D144-C-Central Liaison Team Total	**24.50**	**24.14**	**1,069,251**	**1,004,073**	**-65,178**
D145-C - North Wales E.C.T					
Non Pay					
30000-Drugs	0.00	0.00	1,285	945	-340
30200-M&SE : General	0.00	0.00	420	0	-420
30210-M&SE : Disposable	0.00	0.00	2,100	126	-1,974
30350-Anaes : Accessories & Equipment	0.00	0.00	560	-60	-620
32510-Cleaning Materials	0.00	0.00	380	27	-353
33800-Leased Cars : Contract	0.00	0.00	7,830	7,372	-458
34000-Vehicle Running Costs : Fuel	0.00	0.00	1,910	883	-1,027
34040-Vehicle Insurance	0.00	0.00	730	478	-252
Pay					
2A461-Registered Nurse Band 6	1.60	1.60	70,825	71,249	424
D145-C - North Wales E.C.T Total	**1.60**	**1.60**	**86,040**	**81,019**	**-5,021**
D146-C-Central Home Treatment Team					
Income					
01900-Local Authorities Income	0.00	0.00	-25,000	-25,000	0
08100-Leased Car : Private Deductions Income	0.00	0.00	-3,710	-6,293	-2,583
Non Pay					
30000-Drugs	0.00	0.00	3,682	7,450	3,768
32810-Other General Supplies & Services	0.00	0.00	2,150	0	-2,150
33610-Travel & Subsistence	0.00	0.00	11,043	9,022	-2,021
33800-Leased Cars : Contract	0.00	0.00	13,100	13,905	805
34000-Vehicle Running Costs : Fuel	0.00	0.00	2,890	2,227	-663
34010-Vehicle Running Costs : Other	0.00	0.00	1,290	1,366	76
34040-Vehicle Insurance	0.00	0.00	2,750	2,042	-708
34045-Vehicle Insurance Excess	0.00	0.00	750	0	-750
37460-National QC & Accreditation Fees	0.00	0.00	3,190	0	-3,190
Pay					
2A451-Registered Nurse Band 5	0.00	0.00	-856	0	856
2A461-Registered Nurse Band 6	9.80	9.48	467,975	454,976	-12,999
2A471-Registered Nurse Band 7	1.00	0.00	49,146	35,473	-13,673
2AA31-Nursing HCA/HCSW Band 3	4.00	4.00	114,441	113,867	-574
2AA41-Nursing HCA/HCSW Band 4	1.00	1.00	30,219	32,247	2,028
2F461-Social Worker Band 6	1.00	1.00	41,989	51,879	9,890
D146-C-Central Home Treatment Team Total	**16.80**	**15.48**	**715,049**	**693,162**	**-21,887**

D149-C-North Wales Perinatal Team					
Income					
08100-Leased Car : Private Deductions Income	0.00	0.00	-1,540	-758	782
Non Pay					
33010-Stationery	0.00	0.00	780	0	-737
33610-Travel & Subsistence	0.00	0.00	7,329	6,037	-1,292
33800-Leased Cars : Contract	0.00	0.00	1,720	495	-1,225
34010-Vehicle Running Costs : Other	0.00	0.00	490	0	-490
34200-Training Expenses	0.00	0.00	2,893	0	-2,893
34220-Conferences And Seminars	0.00	0.00	270	0	-270
35540-Computer Hardware Purchases	0.00	0.00	66	0	-66
Pay					
0.5 wte non-consultant Psychiatrist	0.50	0.00	30,000	0	-30,000
0.5wte Clinical Psychologist (B8a)	0.50	0.00	33,490	0	-33,490
1wte Occupational Therapist (B6)	1.00	0.00	49,384	0	-49,384
2A461-Registered Nurse Band 6	6.00	3.00	276,617	160,549	-116,068
2A471-Registered Nurse Band 7	2.00	2.00	100,091	96,078	-4,013
2AF41-Nursery Nurse Band 4	1.00	1.00	27,596	26,089	-1,507
2wte PNMH Nursery Nurse (B4)	2.00	0.00	58,924	0	-58,924
D149-C-North Wales Perinatal Team Total	**13.00**	**6.00**	**588,110**	**288,490**	**-299,577**
D150-C-Dinas (Female) Ward Ablett					
Pay					
2A451-Registered Nurse Band 5	6.00	5.51	250,417	206,665	-43,752
2A461-Registered Nurse Band 6	4.00	3.07	192,998	166,788	-26,210
2AA31-Nursing HCA/HCSW Band 3	10.75	9.75	336,524	282,213	-54,311
D150-C-Dinas (Female) Ward Ablett Total	**20.75**	**18.33**	**779,939**	**655,667**	**-124,272**
D260-C-Tegid Ward Ablett					
Non Pay					
30000-Drugs	0.00	0.00	18,011	18,930	919
30050-Medical Gases	0.00	0.00	1,080	0	-1,080
30100-Dressings	0.00	0.00	190	0	-190
30200-M&SE : General	0.00	0.00	210	0	-210
30210-M&SE : Disposable	0.00	0.00	1,500	59	-1,441
30230-M&SE : Hire Of Equipment	0.00	0.00	730	0	-730
30250-Surgical Instruments : Disposable	0.00	0.00	250	37	-213
30260-General Materials (eg EBME,OT,etc)	0.00	0.00	430	492	62
30270-CONTINENCE PRODUCTS.CONTINENCE PANTS & PADS	0.00	0.00	730	103	-627
31300-Laboratory Equipment	0.00	0.00	640	9	-631
32000-Provisions	0.00	0.00	820	0	-820
32040-Hardware & Crockery	0.00	0.00	830	30	-800
32400-Staff Uniforms & Clothing	0.00	0.00	520	0	-520
32510-Cleaning Materials	0.00	0.00	900	97	-803
32810-Other General Supplies & Services	0.00	0.00	760	70	-690
33030-Medical Records Folders	0.00	0.00	610	0	-610
33610-Travel & Subsistence	0.00	0.00	707	1,074	367
35500-Furniture & Fittings	0.00	0.00	410	684	274
35820-Materials - Electrical	0.00	0.00	350	0	-350
Pay					
2A451-Registered Nurse Band 5	8.50	5.39	338,680	268,706	-69,974
2A461-Registered Nurse Band 6	2.00	1.00	85,962	74,985	-10,977
2A471-Registered Nurse Band 7	1.00	1.00	55,917	46,896	-9,021
2AA31-Nursing HCA/HCSW Band 3	15.34	12.00	474,509	385,041	-89,468
D260-C-Tegid Ward Ablett Total	**26.84**	**19.39**	**984,746**	**797,212**	**-187,534**
D270-C-Bryn Hesketh					
Non Pay					
30000-Drugs	0.00	0.00	14,621	24,072	9,451
30030-FP10's	0.00	0.00	9,740	20,180	10,440
30100-Dressings	0.00	0.00	490	74	-416
30210-M&SE : Disposable	0.00	0.00	2,580	1,403	-1,177
30250-Surgical Instruments : Disposable	0.00	0.00	490	114	-376
30270-CONTINENCE PRODUCTS.CONTINENCE PANTS & PADS	0.00	0.00	2,820	417	-2,403
30500-M&SE Maintenance / Repairs & Components	0.00	0.00	520	51	-469
31030-ALAC: Disabled Living Aids	0.00	0.00	1,720	1,103	-617
32000-Provisions	0.00	0.00	2,690	341	-2,349
32040-Hardware & Crockery	0.00	0.00	440	44	-396
32400-Staff Uniforms & Clothing	0.00	0.00	560	760	200
32510-Cleaning Materials	0.00	0.00	1,860	647	-1,213
32810-Other General Supplies & Services	0.00	0.00	1,680	-163	-1,843
33010-Stationery	0.00	0.00	930	499	-431
33020-Books, Journals & Subscriptions	0.00	0.00	2,950	0	-2,950
33030-Medical Records Folders	0.00	0.00	320	230	-90
33610-Travel & Subsistence	0.00	0.00	3,632	79	-3,553
33620-Excess Mileage	0.00	0.00	460	0	-460
33800-Leased Cars : Contract	0.00	0.00	3,470	3,554	84
34000-Vehicle Running Costs : Fuel	0.00	0.00	1,240	1,075	-165
34040-Vehicle Insurance	0.00	0.00	840	438	-402
34045-Vehicle Insurance Excess	0.00	0.00	250	0	-250
34080-Other Transport Costs	0.00	0.00	670	0	-670
35300-Contract : Photocopying Rental & Charges	0.00	0.00	1,700	0	-1,700
35510-Office Equipment & Materials : Purchase	0.00	0.00	2,300	295	-2,005
36500-External Consultancy Fees	0.00	0.00	1,670	0	-1,670
Pay					
2A451-Registered Nurse Band 5	12.25	6.50	493,455	304,571	-188,884
2A461-Registered Nurse Band 6	4.00	4.07	198,701	185,326	-13,375
2A471-Registered Nurse Band 7	1.00	1.00	51,564	61,214	9,650
2AA31-Nursing HCA/HCSW Band 3	19.48	22.54	595,206	685,515	90,309
D270-C-Bryn Hesketh Total	**36.73**	**34.11**	**1,399,569**	**1,291,839**	**-107,730**

D481-C - Cynnydd Ward (I.R.R.U)					
Income					
08100-Leased Car : Private Deductions Income	0.00	0.00	-2,000	-2,664	-664
Non Pay					
30000-Drugs	0.00	0.00	29,341	15,335	-14,006
30210-M&SE : Disposable	0.00	0.00	0	41	41
31360-Laboratory Test Kits	0.00	0.00	270	94	-176
32000-Provisions	0.00	0.00	960	306	-654
32400-Staff Uniforms & Clothing	0.00	0.00	2,180	2,669	489
32510-Cleaning Materials	0.00	0.00	680	146	-534
32810-Other General Supplies & Services	0.00	0.00	270	100	-170
33610-Travel & Subsistence	0.00	0.00	920	60	-860
33800-Leased Cars : Contract	0.00	0.00	4,570	4,625	55
34000-Vehicle Running Costs : Fuel	0.00	0.00	3,380	1,074	-2,306
34010-Vehicle Running Costs : Other	0.00	0.00	0	112	112
34040-Vehicle Insurance	0.00	0.00	900	908	8
34080-Other Transport Costs	0.00	0.00	0	1,475	1,475
35510-Office Equipment & Materials : Purchase	0.00	0.00	790	0	-790
37470-Miscellaneous Expenditure	0.00	0.00	910	144	-766
32520-Laundry Equipment	0.00	0.00	1,390	0	-1,390
Pay					
2A451-Registered Nurse Band 5	8.60	8.28	368,810	312,865	-55,945
2A461-Registered Nurse Band 6	1.00	2.09	50,802	81,897	31,095
2A471-Registered Nurse Band 7	1.00	1.00	55,853	57,934	2,081
2AA31-Nursing HCA/HCSW Band 3	12.20	11.80	385,623	354,312	-31,311
D481-C - Cynnydd Ward (I.R.R.U) Total	**22.80**	**23.17**	**905,649**	**831,433**	**-74,216**
D276-C-Tawel Fan Ward Ablett					
Non Pay					
30260-General Materials (eg EBME,OT,etc)	0.00	0.00	300	211	-89
33610-Travel & Subsistence	0.00	0.00	296	0	-296
33620-Excess Mileage	0.00	0.00	290	0	-290
30510-M&SE Maintenance Contracts	0.00	0.00	0	2	2
Pay					
2A451-Registered Nurse Band 5	2.00	0.00	88,378	0	-88,378
2A461-Registered Nurse Band 6	1.00	0.00	48,420	0	-48,420
2A471-Registered Nurse Band 7	1.00	0.00	52,663	0	-52,663
2AA31-Nursing HCA/HCSW Band 3	0.00	0.00	6,365	0	-6,365
D276-C-Tawel Fan Ward Ablett Total	**4.00**	**0.00**	**196,712**	**213**	**-196,499**
Grand Total	**188.84**	**160.90**	**7,636,078**	**6,494,820**	**-1,141,215**

File uses 20/21 average scale points of staff in post on these wards as at July 2020
The extract from main model uses same costing methodology but staff requirements taken from original model

		2018/19			2019/20			2020/21		*Extract from Main*	
Cost Centre and Desc	**Subjective and Desc**	**Annual Budget**	**WTE Budget**	**YTD Actual**	**Annual Budget**	**WTE Budget**	**Annual Spend**	**Annual Budget**	**WTE Budget**	*Annual Budget*	*WTE Budget*
D143-C-Dinas Ward Ablett (20 Beds)	2A451-Registered Nurse Band 5	410,615	10.75	331,166	406,620	10.75	371,369	434,473	10.75	*458,916*	*10.90*
	2A461-Registered Nurse Band 6	389,907	9.00	445,967	429,409	9.00	400,841	440,742	9.00	*258,971*	*5.45*
	2A471-Registered Nurse Band 7	50,880	1.00	101,161	53,602	1.00	105,621	56,662	1.00	*52,372*	*1.00*
	2A600-Registered Nurse - Bank	0	0.00	54,651	0	0.00	80,768				
	2A700-Agency - Registered Nurse	0	0.00	15,008							
	2AA21-Nursing HCA/HCSW Band 2	0	0.00	2,653							
	2AA31-Nursing HCA/HCSW Band 3	648,376	21.82	614,590	643,645	21.82	637,608	681,980	21.82	*617,871*	*19.07*
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	273,196	0	0.00	322,816				
D143-C-Dinas Ward Ablett Total		1,499,778	42.57	1,838,392	1,533,276	42.57	1,919,023	1,613,857	42.57	*1,388,130*	*36.41*
D260-C-Tegid Ward Ablett (10 Beds)	2A451-Registered Nurse Band 5	327,272	8.50	240,062	317,109	8.50	239,941	338,680	8.50	*334,621*	*8.17*
	2A461-Registered Nurse Band 6	86,674	2.00	105,690	93,269	2.00	78,219	85,962	2.00	*84,447*	*1.78*
	2A471-Registered Nurse Band 7	53,848	1.00	61,720	55,588	1.00	55,551	55,917	1.00	*52,372*	*1.00*
	2A600-Registered Nurse - Bank	0	0.00	21,322	0	0.00	33,783				
	2A700-Agency - Registered Nurse	0	0.00	18,138	0	0.00	-4,206				
	2AA31-Nursing HCA/HCSW Band 3	434,679	15.34	362,182	445,206	15.34	375,660	474,509	15.34	*357,890*	*10.90*
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	53,835	0	0.00	104,219				
	2AC00-Agency - Nursing HCA/HCSW	0	0.00	1,345	0	0.00	-1,345				
	2H131-ACS Tech Officer band 3	0	0.00	0			904				
D260-C-Tegid Ward Ablett Total		902,473	26.84	864,295	911,172	26.84	882,726	955,068	26.84	*829,330*	*21.85*
D270-C-Bryn Hesketh Ward (13 Beds)	2A451-Registered Nurse Band 5	407,510	12.25	190,846	422,441	12.25	332,100	493,455	12.25	*458,916*	*10.90*
	2A461-Registered Nurse Band 6	169,673	4.00	223,365	177,298	4.00	179,741	198,701	4.00	*129,486*	*2.72*
	2A471-Registered Nurse Band 7	42,082	1.00	46,386	47,038	1.00	47,989	51,564	1.00	*52,372*	*1.00*
	2A600-Registered Nurse - Bank	0	0.00	30,044	0	0.00	15,839				
	2A700-Agency - Registered Nurse	0	0.00	54,815							
	2AA21-Nursing HCA/HCSW Band 2	0	0.00	12,515							
	2AA31-Nursing HCA/HCSW Band 3	559,344	19.48	597,502	579,300	19.48	635,448	595,206	19.48	*751,755*	*23.57*
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	337,310	0	0.00	421,391				
	2C351-Occupational Therapist Band 5	0	0.00	28,308							
	2M531-Domestic Band 3	0	0.00	16,997							
D270-C-Bryn Hesketh Ward Total		1,178,609	36.73	1,538,087	1,226,077	36.73	1,632,507	1,338,926	36.73	*1,392,529*	*38.19*
D481-C - Cynnydd Ward (8 Beds)	2A451-Registered Nurse Band 5	365,438	8.60	321,812	366,504	8.60	324,166	368,810	8.60	*458,916*	*10.90*
	2A461-Registered Nurse Band 6	47,424	1.00	47,743	47,089	1.00	49,497	50,802	1.00	*53,805*	*1.27*
	2A471-Registered Nurse Band 7	49,418	1.00	51,678	54,169	1.00	54,167	55,853	1.00	*52,372*	*1.00*
	2A600-Registered Nurse - Bank						70				
	2AA31-Nursing HCA/HCSW Band 3	367,904	12.00	351,489	374,627	12.00	348,593	385,623	12.20	*259,980*	*8.17*
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	7,486	0	0.00	15,272				
	2K121-Admin & Clerical Band 2				0	0.00	589				
D481-C - Cynnydd Ward (I.R.R.U) Total		830,184	22.60	780,208	842,389	22.60	792,353	861,088	22.80	*825,073*	*21.34*
Unit Wide Resource	2A451-Registered Nurse Band 5									*0*	*0.00*
	2A461-Registered Nurse Band 6									*282,528*	*5.45*
	2A471-Registered Nurse Band 7										*0.00*
	2K131-Admin & Clerical Band 3							52,302	2.00		
	2AA31-Nursing HCA/HCSW Band 3									*105,698*	*3.55*
Total Unit Wide Resource										*388,226*	*9.00*
D276-C - Tawel Fan Ward	2A451-Registered Nurse Band 5	2,746	0.00	27	88,738	2.00	47,173	88,378	2.00		
	2A461-Registered Nurse Band 6	46,713	1.00	-656	48,420	1.00	17,409	48,420	1.00	*Not in new model*	
	2A471-Registered Nurse Band 7	96,192	1.80	18,083	52,663	1.00	20,114	52,663	1.00		
	2AA31-Nursing HCA/HCSW Band 3	4,273	0.00	38,426	6,365		1,895	6,365	0.00		
D276-C - Tawel Fan Ward Total		149,924	2.80	55,880	196,186	4.00	86,591	195,826	4.00	*196,186*	*4.00*
D145-C - North Wales E.C.T	2A451-Registered Nurse Band 5	29,193	1.00	18,275	0	0.00					
	2A461-Registered Nurse Band 6	36,318	0.80	39,438	70,886	1.60	69,560	70,825	1.60	*Not in new model*	
	2A600-Registered Nurse - Bank	0	0.00	1,924	0	0.00	1,570				
D145-C - North Wales E.C.T Total		65,511	1.80	59,637	70,886	1.60	71,129	70,825	1.60	*70,886*	*1.60*
Grand Total (51 Beds)		4,626,479	133.34	5,136,501	4,779,986	134.34	5,384,330	5,035,590	134.54	*5,090,360*	*132.39*
							604,344				

Proposed Wards					
New Wards		**WTE Budget**		**Annual Budget**	
16 bed acute 1	2A451-Registered Nurse Band 5	8.17	£	334,621	
	2A461-Registered Nurse Band 6	2.72	£	129,486	
	2A471-Registered Nurse Band 7	1.00	£	52,372	
	2AA31-Nursing HCA/HCSW Band 3	16.34	£	536,835	
16 bed acute 1		28.24	£	1,053,314	
16 bed acute 2	2A451-Registered Nurse Band 5	8.17	£	334,621	
	2A461-Registered Nurse Band 6	2.72	£	129,486	
	2A471-Registered Nurse Band 7	1.00	£	52,372	
	2AA31-Nursing HCA/HCSW Band 3	16.34	£	536,835	
16 bed acute 2		28.24	£	1,053,314	
13 bed organic	2A451-Registered Nurse Band 5	10.90	£	458,916	
	2A461-Registered Nurse Band 6	2.72	£	129,486	
	2A471-Registered Nurse Band 7	1.00	£	52,372	
	2AA31-Nursing HCA/HCSW Band 3	24.52	£	796,816	
13 bed organic		39.14	£	1,437,590	
14 bed functional	2A451-Registered Nurse Band 5	8.17	£	334,621	
	2A461-Registered Nurse Band 6	2.72	£	129,486	
	2A471-Registered Nurse Band 7	1.00	£	52,372	
	2AA31-Nursing HCA/HCSW Band 3	16.34	£	536,835	
14 bed functional		28.24	£	1,053,314	
4 bed clinical assessment	2A451-Registered Nurse Band 5				To be managed by liaison remove from model
	2A461-Registered Nurse Band 6				
	2A471-Registered Nurse Band 7				
	2AA31-Nursing HCA/HCSW Band 3				
4 bed clinical assessment		0.00	£	-	
Unit wide resource	2A451-Registered Nurse Band 5	0.00	£	-	
	2A461-Registered Nurse Band 6	0.00	£	-	*Take out - this is an investment with no business case*
	2A471-Registered Nurse Band 7	0.00	£	-	
	2AA31-Nursing HCA/HCSW Band 3	0.00	£	-	*Take out - this is a new post without clear business case*
	Ward Clerk	4.00	£	94,294	2 ward clerks under D123 Admin
	Activities Coordinator	5.08	£	132,504	4 already in Bryn Hesketh and Tegid total 8.88
	Housekeeper	4.00	£	102,251	2 already in BH and Tegid
Unit wide resource		13.08	£	329,049	
D145-C - North Wales E.C.T	2A451-Registered Nurse Band 5				
	2A461-Registered Nurse Band 6	1.60		70,886	
	2A600-Registered Nurse - Bank				
Grand Total (63 Beds)		136.94	£	4,926,581	

Additional Budget required compared with current budget 20/21 -£ 109,009

Additional Budget required compared with Inpatient establishment review (not implemented) 20/21 -£ 163,780

£ 54,770

Source:	
Extract Provided by:	Karen Nolan - Qlikview download
Date of Extract:	07/02/2020
Reference Period:	Ledger Budgets at P12-19 and P09-20

97913.39063

		2018/19			2019/20			
Cost Centre and Desc	**Subjective and Desc**	**Annual Budget**	**WTE Budget**	**YTD Actual**	**Annual Budget**	**WTE Budget**	**YTD Actual**	**forecast spend 19/20**
D143-C-Dinas Ward Ablett (20 Beds)	2A451-Registered Nurse Band 5	410,615	10.75	331,166	406,620	10.75	277,103	369,471
	2A461-Registered Nurse Band 6	389,907	9.00	445,967	429,409	9.00	294,362	392,482
	2A471-Registered Nurse Band 7	50,880	1.00	101,161	53,602	1.00	78,159	104,211
	2A600-Registered Nurse - Bank	0	0.00	54,651	0	0.00	64,909	86,546
	2A700-Agency - Registered Nurse	0	0.00	15,008				0
	2AA21-Nursing HCA/HCSW Band 2	0	0.00	2,653				0
	2AA31-Nursing HCA/HCSW Band 3	648,376	21.82	614,590	643,645	21.82	484,071	645,428
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	273,196	0	0.00	257,796	343,728
D143-C-Dinas Ward Ablett Total		1,499,778	42.57	1,838,392	1,533,276	42.57	1,456,400	1,941,867
D260-C-Tegid Ward Ablett (10 Beds)	2A451-Registered Nurse Band 5	327,272	8.50	240,062	317,109	8.50	196,527	262,036
	2A461-Registered Nurse Band 6	86,674	2.00	105,690	93,269	2.00	55,877	74,503
	2A471-Registered Nurse Band 7	53,848	1.00	61,720	55,588	1.00	41,802	55,735
	2A600-Registered Nurse - Bank	0	0.00	21,322	0	0.00	22,227	29,636
	2A700-Agency - Registered Nurse	0	0.00	18,138	0	0.00	-4,206	-5,608
	2AA31-Nursing HCA/HCSW Band 3	434,679	15.34	362,182	445,206	15.34	291,267	388,356
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	53,835	0	0.00	75,041	100,055
	2AC00-Agency - Nursing HCA/HCSW	0	0.00	1,345	0	0.00	-1,345	-1,793
	2H131-ACS Tech Officer band 3	0	0.00	0				0
D260-C-Tegid Ward Ablett Total		902,473	26.84	864,295	911,172	26.84	677,190	902,920
D270-C-Bryn Hesketh Ward (13 Beds)	2A451-Registered Nurse Band 5	407,510	12.25	190,846	422,441	12.25	237,743	316,991
	2A461-Registered Nurse Band 6	169,673	4.00	223,365	177,298	4.00	142,771	190,361
	2A471-Registered Nurse Band 7	42,082	1.00	46,386	47,038	1.00	34,996	46,661
	2A600-Registered Nurse - Bank	0	0.00	30,044	0	0.00	14,938	19,918
	2A700-Agency - Registered Nurse	0	0.00	54,815				0
	2AA21-Nursing HCA/HCSW Band 2	0	0.00	12,515				0
	2AA31-Nursing HCA/HCSW Band 3	559,344	19.48	597,502	579,300	19.48	467,180	622,907
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	337,310	0	0.00	325,421	433,895
	2C351-Occupational Therapist Band 5	0	0.00	28,308				0
	2M531-Domestic Band 3	0	0.00	16,997				0
D270-C-Bryn Hesketh Ward Total		1,178,609	36.73	1,538,087	1,226,077	36.73	1,223,049	1,630,732
D481-C - Cynnydd Ward (8 Beds)	2A451-Registered Nurse Band 5	365,438	8.60	321,812	366,504	8.60	239,566	319,422
	2A461-Registered Nurse Band 6	47,424	1.00	47,743	47,089	1.00	37,043	49,391
	2A471-Registered Nurse Band 7	49,418	1.00	51,678	54,169	1.00	40,780	54,373
	2AA31-Nursing HCA/HCSW Band 3	367,904	12.00	351,489	374,627	12.00	260,770	347,694
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	7,486	0	0.00	12,479	16,639
	2K121-Admin & Clerical Band 2				0	0.00	589	785
D481-C - Cynnydd Ward (I.R.R.U) Total		830,184	22.60	780,208	842,389	22.60	591,227	788,302
D276-C - Tawel Fan Ward	2A451-Registered Nurse Band 5	2,746	0.00	27	88,738	2.00	47,173	47,173
	2A461-Registered Nurse Band 6	46,713	1.00	-656	48,420	1.00	17,409	17,409
	2A471-Registered Nurse Band 7	96,192	1.80	18,083	52,663	1.00	20,114	20,114
	2AA31-Nursing HCA/HCSW Band 3	4,273	0.00	38,426	6,365		1,895	1,895
D276-C - Tawel Fan Ward Total		149,924	2.80	55,880	196,186	4.00	86,591	86,591
D145-C - North Wales E.C.T	2A451-Registered Nurse Band 5	29,193	1.00	18,275	0	0.00	0	0
	2A461-Registered Nurse Band 6	36,318	0.80	39,438	70,886	1.60	52,263	69,684
	2A600-Registered Nurse - Bank	0	0.00	1,924	0	0.00	916	1,221
D145-C - North Wales E.C.T Total		65,511	1.80	59,637	70,886	1.60	53,179	70,905
Grand Total (51 Beds)		4,626,479	133.34	5,136,501	4,779,986	134.34	4,087,635	5,421,317

Proposed Wards					
New Wards		**WTE Budget**		**Annual Budget**	
16 bed acute 1	2A451-Registered Nurse Band 5	10.90	£	450,962	
	2A461-Registered Nurse Band 6	2.72	£	125,203	
	2A471-Registered Nurse Band 7	1.00	£	51,290	
	2AA31-Nursing HCA/HCSW Band 3	12.67	£	394,344	
16 bed acute 1		27.29	£	1,021,799	
16 bed acute 2	2A451-Registered Nurse Band 5	10.90	£	450,962	
	2A461-Registered Nurse Band 6	2.72	£	125,203	
	2A471-Registered Nurse Band 7	1.00	£	51,290	
	2AA31-Nursing HCA/HCSW Band 3	12.67	£	394,344	
16 bed acute 2		27.29	£	1,021,799	
13 bed organic	2A451-Registered Nurse Band 5	13.62	£	554,303	
	2A461-Registered Nurse Band 6	2.72	£	125,203	
	2A471-Registered Nurse Band 7	1.00	£	51,290	
	2AA31-Nursing HCA/HCSW Band 3	19.07	£	593,204	
13 bed organic		36.41	£	1,323,999	
14 bed functional	2A451-Registered Nurse Band 5	10.90	£	450,962	
	2A461-Registered Nurse Band 6	2.72	£	125,203	
	2A471-Registered Nurse Band 7	1.00	£	51,290	
	2AA31-Nursing HCA/HCSW Band 3	13.62	£	421,354	
14 bed functional		28.24	£	1,048,809	
4 bed clinical assessment	2A451-Registered Nurse Band 5	5.45	£	225,481	
	2A461-Registered Nurse Band 6	5.45	£	273,184	
	2A471-Registered Nurse Band 7	1.00	£	51,290	
	2AA31-Nursing HCA/HCSW Band 3	16.34	£	515,550	
4 bed clinical assessment		28.24	£	1,065,505	
Unit wide resource	2A451-Registered Nurse Band 5	0.00	£	-	
	2A461-Registered Nurse Band 6	5.26	£	252,031	*Includes ECT Staff*
	2A471-Registered Nurse Band 7	0.00	£	-	
	2AA31-Nursing HCA/HCSW Band 3	0.51	£	12,879	*ECT Staff*
	Ward Clerk	3.00	£	69,566	
	Activities Coordinator	8.88	£	253,219	
	Housekeeper	7.00	£	196,851	
Unit wide resource		24.65	£	784,546	
Grand Total (63 Beds)		172.14	£	6,266,457	

Additional Budget required compared with current budget 19/20 £ 1,486,471

4,512,914

Additional Budget required compared with forecast spend 19/21 £ 845,140

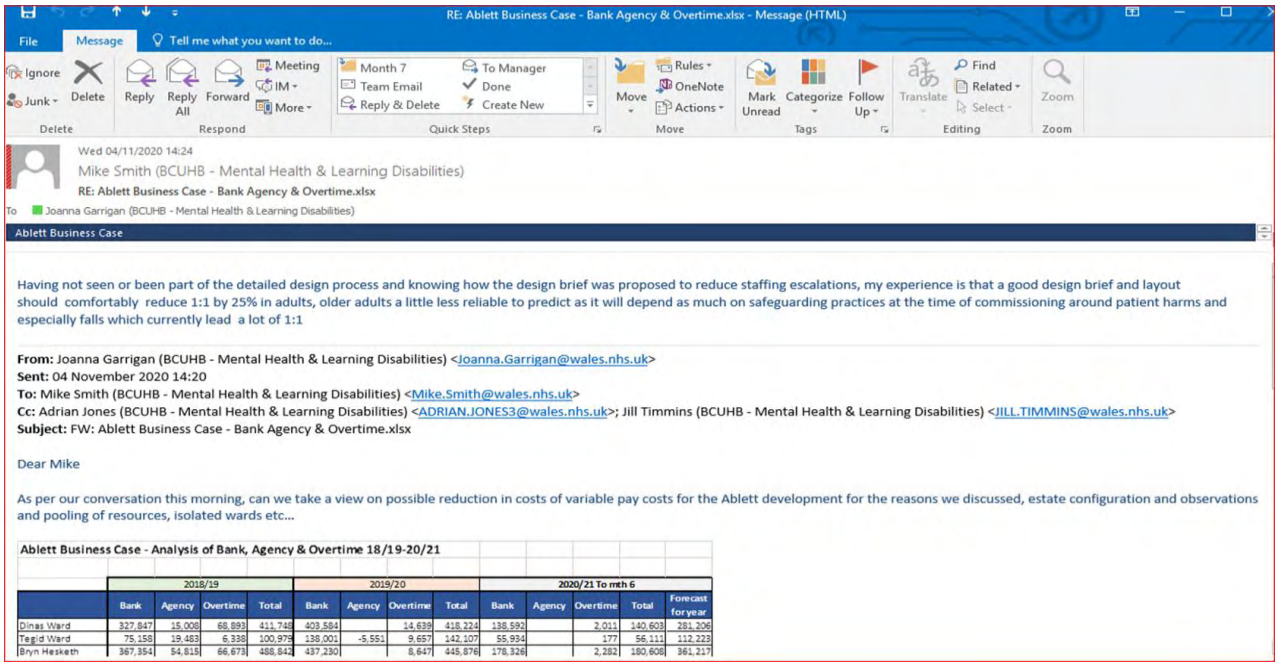
Dinas, Tegid, Bryn Hesketh, Tawel Fan, Cynnydd and ECT		2018/19			2019/20			
Cost Centre and Desc	**Subjective and Desc**	**Annual Budget**	**WTE Budget**	**YTD Actual**	**Annual Budget**	**WTE Budget**	**YTD Actual**	**forecast spend 19/20**
TOTALS BY BAND (51 Beds)								
	2A451-Registered Nurse Band 5	1,542,774	41.10	1,102,188	1,601,412	42.10	998,112	1,315,093
	2A461-Registered Nurse Band 6	776,709	17.80	861,547	866,371	18.60	599,724	793,830
	2A471-Registered Nurse Band 7	292,420	5.80	279,027	263,060	5.00	215,850	281,094
	2A600-Registered Nurse - Bank	0	0.00	107,941	0	0.00	102,991	137,321
	2A700-Agency - Registered Nurse	0	0.00	87,961	0	0.00	-4,206	-5,608
	2AA21-Nursing HCA/HCSW Band 2	0	0.00	15,168	0	0.00	0	0
	2AA31-Nursing HCA/HCSW Band 3	2,014,576	68.64	1,964,190	2,049,143	68.64	1,505,184	2,006,280
	2AB00-Nursing HCA/HCSW - Bank	0	0.00	671,827	0	0.00	670,738	894,317
	2AC00-Agency - Nursing HCA/HCSW	0	0.00	1,345	0	0.00	-1,345	-1,793
	2C351-Occupational Therapist Band 5	0	0.00	28,308	0	0.00	0	0
	2M531-Domestic Band 3	0	0.00	16,997	0	0.00	0	0
	2K121-Admin & Clerical Band 2	0	0.00	0	0	0.00	589	785
Grand Total		4,626,479	133.34	5,136,501	4,779,986	134.34	4,087,635	5,421,319

Proposed Wards					Difference compared with 19/20 Budget	
New Wards		**WTE Budget**		**Annual Budget**	**WTE Budget**	**Annual Budget**
TOTALS BY BAND (63 Beds)						
	2A451-Registered Nurse Band 5	51.76		2,132,671	9.66	531,259
	2A461-Registered Nurse Band 6	21.61		1,026,028	3.01	159,657
	2A471-Registered Nurse Band 7	5.00		256,448	0.00	-6,612
	2AA31-Nursing HCA/HCSW Band 3	74.89		2,331,674	6.25	282,531
	Activities Coordinator	8.88		253,219	8.88	253,219
	Housekeeper	7.00		196,851	7.00	196,851
	Ward Clerk	3.00		69,566	3.00	69,566
Grand Total		172.14		6,266,457	37.80	1,486,471

Ablett Business Case - Analysis of Bank, Agency & Overtime 18/19-20/21

	2018/19				2019/20				2020/21 To mth 6				
	Bank	Agency	Overtime	Total	Bank	Agency	Overtime	Total	Bank	Agency	Overtime	Total	Forecast for year
Dinas Ward	327,847	15,008	68,893	411,748	403,584		14,639	418,224	138,592		2,011	140,603	281,206
Tegid Ward	75,158	19,483	6,338	100,979	138,001	-5,551	9,657	142,107	55,934		177	56,111	112,223
Bryn Hesketh	367,354	54,815	66,673	488,842	437,230		8,647	445,876	178,326		2,282	180,608	361,217
Cynnyd	7,486	89,306	2,198	98,990	14,244		1,543	15,787	7,537		1,139	8,676	17,352
Total	**777,845**	**178,611**	**144,103**	**1,100,559**	**993,059**	**-5,551**	**34,485**	**1,021,993**	**380,390**	**0**	**5,609**	**385,999**	**771,998**

Total for 2 years	2,122,552
Average	1,061,276
Potential reduction @ 25%	265,319



Estimated Cost Sickness Absence

Cost Centre	2018	2019	2020	Grand Total
D143	£81,029.66	£96,147.32	£87,706.09	£264,883.06
D145	£6,267.39			£6,267.39
D260	£57,758.06	£38,770.60	£28,561.32	£125,089.97
D270	£61,808.39	£73,053.04	£58,881.33	£193,742.76
D276	£16,014.92	£5,353.40	£506.83	£21,875.16
D481	£40,439.95	£65,354.19	£61,997.64	£167,791.78
Grand Total	**£263,318.36**	**£278,678.55**	**£237,653.20**	**£779,650.12**

D143-C-Dinas Ward Ablett (20 Beds)
D145-C - North Wales E.C.T
D260-C-Tegid Ward Ablett (10 Beds)
D270-C-Bryn Hesketh Ward (13 Beds)
D276-C - Tawel Fan Ward
D481-C - Cynnydd Ward (8 Beds)

BETSI CADWALADR UNIVERSITY LHB
STAFF COST PROFORMA FOR 2020/21

ANNUAL FORECAST COST Staff Number	Staff Name	Grade	Inc Pt	Contract WTE	Super Y/N	Gross Pay	2020/21 NI rates 14.38% Super	NI Cost	NI Rebate	TOTAL COST
										0
Current Team										
- Lead Pharmacist – 8b, 1wte	Band 8 b	XR09	6	1.00	Y	62,001	8,916	7,343	0.00	**78,260**
- Senior Pharmacist – 8a, 1 wte	Band 8 a	XR08	6	1.00	Y	51,668	7,430	5,917	0.00	**65,015**
- Medicines Management Technician – Band 5, 1 wte	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
- Medicines Management Technician – Band 5, (0.2wte Ablett, 0.8wte Home Treatment Team).	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
				4.00						**219,335**
Current Shortfall										
- Band 7 pharmacist – 1wte	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
- Medicines Management Technician – Band 5, 0.8wte	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
- Band 4 technician – 1wte	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
- Band 2 ATO – 2wte.	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
				5.00						**170,759**
TOTAL				**9.00**						**390,094**
Proposed Workforce										
- Lead Pharmacist – 8b, 1wte	Band 8 b	XR09	6	1.00	Y	62,001	8,916	7,343	0.00	**78,260**
- Senior Pharmacist – 8a, 1 wte	Band 8 a	XR08	6	1.00	Y	51,668	7,430	5,917	0.00	**65,015**
- Band 7 pharmacist – 4wte	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
- Medicines Management Technician – Band 5, 3wte	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
- Pharmacy technician Band 4 – 3wte	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
- 2 ATOs Band 2 – 2wte	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
TOTAL				**14.00**						**617,091**

397,756

BETSI CADWALADR UNIVERSITY LHB
STAFF COST PROFORMA FOR 2020/21

ANNUAL FORECAST COST Staff Number	Staff Name	Grade	Inc Pt	Contract WTE	Super Y/N	Gross Pay	2020/21 NI rates 14.38% Super	NI Cost	NI Rebate	TOTAL COST
										0
Current Team										
- Lead Pharmacist – 8b, 1wte	Band 8 b	XR09	6	1.00	Y	62,001	8,916	7,343	0.00	**78,260**
- Senior Pharmacist – 8a, 1 wte	Band 8 a	XR08	6	1.00	Y	51,668	7,430	5,917	0.00	**65,015**
- Medicines Management Technician – Band 5, 1 wte	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
- Medicines Management Technician – Band 5, (0.2wte Ablett, 0.8wte Home Treatment Team).	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
				4.00						**219,335**
Current Shortfall										
- Band 7 pharmacist – 1wte	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
- Medicines Management Technician – Band 5, 0.8wte	Band 5	XR05	8	0.80	Y	24,492	3,522	2,167	0.00	**30,181**
- Band 4 technician – 1wte	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
- Band 2 ATO – 2wte.	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
				4.80						**162,911**
TOTAL				**8.80**						**382,245**
Proposed Workforce										
- Lead Pharmacist – 8b, 1wte	Band 8 b	XR09	6	1.00	Y	62,001	8,916	7,343	0.00	**78,260**
- Senior Pharmacist – 8a, 1 wte	Band 8 a	XR08	6	1.00	Y	51,668	7,430	5,917	0.00	**65,015**
- Band 7 pharmacist – 4wte	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
	Band 7	XR07	9	1.00	Y	44,503	6,400	4,929	0.00	**55,831**
- Medicines Management Technician – Band 5, 3wte	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
	Band 5	XR05	8	1.00	Y	30,615	4,402	3,012	0.00	**38,030**
- Pharmacy technician Band 4 – 3wte	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
	Band 4	XR04	7	1.00	Y	24,157	3,474	2,121	0.00	**29,752**
- 2 ATOs Band 2 – 2wte	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
	Band 2	XR02	8	1.00	Y	19,337	2,781	1,456	0.00	**23,573**
TOTAL				**14.00**						**617,091**

397,756

BETSI CADWALADR UNIVERSITY LHB
ESTIMATED STAFF COST PROFORMA FOR 2019/20

ANNUAL FORECAST COST			Inc	Contract	Super	Total	Gross	14.38%	NI	NI	TOTAL
Staff Number	Staff Name	Grade	Pt	WTE	Y/N	Pay	Pay	Super	Cost	Rebate	COST
Current Team											
- Lead Pharmacist – 8b, 1wte	Band 8 b	XR09	6	1.00	Y	60,983	60,983	8,769	7,224	0.00	**76,977**
- Senior Pharmacist – 8a, 1 wte	Band 8 a	XR08	6	1.00	Y	50,819	50,819	7,308	5,822	0.00	**63,949**
- Medicines Management Technician – Band 5, 1 wte	Band 5	XR05	8	1.00	Y	30,112	30,112	4,330	2,964	0.00	**37,406**
- Medicines Management Technician – Band 5, (0.2wte Ablett, 0.8wte Home Treatment Team).	Band 5	XR05	8	1.00	Y	30,112	30,112	4,330	2,964	0.00	**37,406**
				4.00							**215,738**
Current Shortfall											
- Band 7 pharmacist – 1wte	Band 7	XR07	9	1.00	Y	43,772	43,772	6,294	4,849	0.00	**54,916**
- Medicines Management Technician – Band 5, 0.8wte	Band 5	XR05	8	0.80	Y	24,090	24,090	3,464	2,133	0.00	**29,687**
- Band 4 technician – 1wte	Band 4	XR04	7	1.00	Y	23,157	23,157	3,330	2,004	0.00	**28,491**
- Band 2 ATO – 2wte.	Band 2	XR02	8	1.00	Y	19,020	19,020	2,735	1,434	0.00	**23,189**
	Band 2	XR02	8	1.00	Y	19,020	19,020	2,735	1,434	0.00	**23,189**
				4.80							159,471
TOTAL				**8.80**							**375,209**
Proposed Workforce											
- Lead Pharmacist – 8b, 1wte	Band 8 b	XR09	6	1.00	Y	60,983	60,983	8,769	7,224	0.00	**76,977**
- Senior Pharmacist – 8a, 1 wte	Band 8 a	XR08	6	1.00	Y	50,819	50,819	7,308	5,822	0.00	**63,949**
- Band 7 pharmacist – 4wte	Band 7	XR07	9	1.00	Y	43,772	43,772	6,294	4,849	0.00	**54,916**
	Band 7	XR07	9	1.00	Y	43,772	43,772	6,294	4,849	0.00	**54,916**
	Band 7	XR07	9	1.00	Y	43,772	43,772	6,294	4,849	0.00	**54,916**
	Band 7	XR07	9	1.00	Y	43,772	43,772	6,294	4,849	0.00	**54,916**
- Medicines Management Technician – Band 5, 3wte	Band 5	XR05	8	1.00	Y	30,112	30,112	4,330	2,964	0.00	**37,406**
	Band 5	XR05	8	1.00	Y	30,112	30,112	4,330	2,964	0.00	**37,406**
	Band 5	XR05	8	1.00	Y	30,112	30,112	4,330	2,964	0.00	**37,406**
- Pharmacy technician Band 4 – 3wte	Band 4	XR04	7	1.00	Y	23,157	23,157	3,330	2,004	0.00	**28,491**
	Band 4	XR04	7	1.00	Y	23,157	23,157	3,330	2,004	0.00	**28,491**
	Band 4	XR04	7	1.00	Y	23,157	23,157	3,330	2,004	0.00	**28,491**
- 2 ATOs Band 2 – 2wte	Band 2	XR02	8	1.00	Y	19,020	19,020	2,735	1,434	0.00	**23,189**
	Band 2	XR02	8	1.00	Y	19,020	19,020	2,735	1,434	0.00	**23,189**
TOTAL				**14.00**							**604,659**

388,921

J:\Financial Management\CPG Data\Mental Health

20/21

Sum of Cur Month Actual	Column Labels					
Row Labels	P01	P02	P03	P04	P05	Grand Total
MX13-West Area	4,058	-2,799	3,528	-887	-21,786	-17,885
MX14-Centre Area	109	-2,546	4,846	3,216	-26,424	-20,799
MX15-East Area	-1,608	48,964	51,552	1,488	-14,702	85,694
Grand Total	**2,560**	**43,620**	**59,925**	**3,818**	**-62,912**	**47,010**

19/20

Sum of Cur Month Actual	Column Labels											
Row Labels	P02	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12	Grand Total
MX13-West Area	11,915	11,296	-1,385	30,719	14,436	15,762	12,192	-5,600	37,750	29,957	34,571	191,613
MX14-Centre Area		18,903	17,901	26,028	-19,047	29,198	17,618	10,986	35,712	22,732	24,996	185,028
MX15-East Area				6,542	15,360	73,340	-15,687	9,877	22,351	17,233	13,059	142,075
Grand Total	**11,915**	**30,199**	**16,516**	**63,288**	**10,749**	**118,299**	**14,124**	**15,264**	**95,813**	**69,922**	**72,627**	**518,716**

This figure differs from file reported by Chelsie:-

18/19

Sum of Cur Month Actual	Column Labels										
Row Labels	P03	P04	P05	P06	P07	P08	P09	P10	P11	P12	Grand Total
MX13-West Area	3,606	317	5,828	-9,679	354	2,380	2,135	3,438	-640	5,114	12,852
MX14-Centre Area	-5,769	23,626	28,143	25,419	15,857	2,265	1,074	-1,106	-321		89,188
MX15-East Area	695	350		3,163	735	9,380	-1,420	3,217	760		16,880
Grand Total	**-1,468**	**24,293**	**33,971**	**18,903**	**16,946**	**14,025**	**1,789**	**5,548**	**-201**	**5,114**	**118,920**

From	Subject	Size	Categorie	Received
Joanna Garrigan (BC	Ablett B	534 KB	Ablett Bu	27/08/2020

EBB57491.msg

Reported by Chelsie on File

OOA INFORMATION 2019/2020

Cost	April	May	June	July	August	September	October	Novembe	Decembe	January	February	March	Total
Central	£ -		£ 15,000	£ 21,250	£ 19,097	£ 15,720	£ 31,360	£ 8,250	£ 9,410	£ 34,140	£ 29,134	£ 9,006	**£ 192,367**
East	£ -				£ 6,218	£ 11,790	£ 63,280	£ 2,250		£ 18,750	£ 25,742	£ 10,447	**£ 138,477**
West	£ -	£ 5,246	£ 2,183		£ 25,870	£ 17,250	£ 10,640			£ 33,750	£ 27,605	£ 3,073	**£ 125,616**
Regional													**£ -**
Total	**£ -**	**£ 5,246**	**£ 17,183**	**£ 21,250**	**£ 51,185**	**£ 44,760**	**£ 105,280**	**£ 10,500**	**£ 9,410**	**£ 86,640**	**£ 82,480**	**£ 22,525**	**£456,459**

20/21

Days	April	May	June	July	August	September	October	November	December	January	February	March	Total
Central	-	-	-	3									**3**
East	30	31	47	8									**116**
West	-	-	-	-									**-**
Regional	-	-	-	-									**-**
Total	**30**	**31**	**47**	**11**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**119**

19/20

Days	April	May	June	July	August	September	October	November	December	January	February	March	Total
Central	-	-	25	40	32	24	56	17	23	50	52	19	**338**
East	-	-	-	-	13	18	113	3		25	40	17	**229**
West	-	7	3		35	23	19	-	-	45	42	5	**179**
Regional	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Total	**-**	**7**	**28**	**40**	**80**	**65**	**188**	**20**	**23**	**120**	**134**	**41**	**746**

18/19

Days	April	May	June	July	August	September	October	November	December	January	February	March	Total
Central	4	2	-	42	27	22	-	-	-	-	-	-	**97**
East	-	-	-	-	-	-	-	-	-	-	-	-	**-**
West	1	-	-	-	-	-	-	-	3	-	-	-	**4**
Regional	-	-	-	-	-	4	31	-	-	-	-	-	**35**
Total	**5**	**2**	**-**	**42**	**27**	**26**	**31**	**-**	**3**	**-**	**-**	**-**	**101**

Year	Area	Cost Centr	Patient na	Provider	Ward	Hospital A	Daily rate (estimate)	PICU	1:1	1:1 costs	Period of	Admission date	Discharge date	Total bed		Estimated cos	PO	Invoice	Paid	Amount	Variance	Reasons for variance
19/20 & 20	East	D187-E - H	CR	The Priory			£ 727.50				February	17/02/2020	06/07/2020	140	£	101,850						
2019/20	East	D187-E - H	KSJ	The Priory			£ 757.00				February	01/02/2020	03/03/2020	31	£	23,467						
2019/20	East	D187-E - H	BM	The Priory			£ 757.00				February	02/02/2020	04/02/2020	2	£	1,514						
2019/20	East	D187-E - H	JN				£ 614.50				February	10/02/2020	26/02/2020	16	£	9,832						
2020/21	East	D187-E - H	EW				£ 614.50				June	27/06/2020	29/06/2020	2	£	1,229						
2020/21	East	D187-E - H	LC				£ 614.50				June	27/06/2020	01/07/2020	4	£	2,458						
2020/21	East	D187-E - H	OH				£ 614.50				June	14/06/2020	25/06/2020	11	£	6,760						
2020/21	Central		AB	The Priory		Woking					July	28/07/2020	31/07/2020	3	£	-						
2020/21	East	D187-E - H	MA	The Priory		Lakeside					July	28/07/2020	31/07/2020	3	£	-						

Cost Centre	Area	Class	Account	YTD Actual	%
D010-A - SMS - I	RSS	Pay	21800-Agen	42,773	1.25%
D012-W - West M	West	Pay	21800-Agen	1,462,455	42.83%
D012-W - West M	West	Pay	23000-Agen	44,265	1.30%
D013-E - East MI	East	Pay	21800-Agen	554,104	16.23%
D013-E - East MI	East	Pay	23000-Agen	828	0.02%
D048-C - Centre	Centre	Pay	21800-Agen	886,817	25.97%
D048-C - Centre	Centre	Pay	23000-Agen	123,768	3.62%
D048-C - Centre	Centre	Pay	26200-Agen	25,241	0.74%
D051-A - Forensi	RSS	Pay	21800-Agen	43,346	1.27%
D051-A - Forensi	RSS	Pay	23000-Agen	0	0.00%
D052-A - LDS - M	RSS	Pay	21800-Agen	200,225	5.86%
D055-A - MHLD ,	MHLD	Pay	26200-Agen	30,747	0.90%
Grand Total				**3,414,569**	100.00%

	Data	
Area	Sum of YTD Actual	Sum of %
Centre	1035826.27	30.34%
East	554931.98	16.25%
MHLD	30747.15	0.90%
RSS	286344.16	8.39%
West	1506719.23	44.13%
Grand Total	3414568.79	100.00%

		2018/19			2019/20			to P04/20		
		Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Consultant	WTE	15.30	11.49	-3.81	16.50	7.50	-9.00	16.50	8.31	-8.19
	Budget & Spend	£2,142,331	£1,424,730	- 717,601	£2,474,173	£1,680,357	- 793,816	£835,672	£480,005	- 355,667
	NHS & Internal Locums		£189,267			£184,101			£52,724	
SAS		4.70	3.60	-1.10	3.60	2.87	-0.73	3.60	2.00	-1.60
	Budget & Spend	£383,395	£317,079	- 66,316	£351,605	£308,459	- 43,146	£120,376	£70,238	- 50,138
	NHS & Internal Locums									
Agency Costs			£403,236			£1,035,826			£410,950	

Subjective and Desc	Analysis Description	Annual Budget	WTE Budget	WTE Actual	YTD Budget	YTD Actual	YTD Variance
01200-Medical Staff Income	Default	0	0.00	0.00	0	(6,521)	(6,521)
21000-Consultant (M&D)	Add Prog Activity	0	0.00	0.00	0	44,962	44,962
21000-Consultant (M&D)	Adptn Pay	0	0.00	0.00	0	24,990	24,990
21000-Consultant (M&D)	AfC Arrears	0	0.00	0.00	0	1,789	1,789
21000-Consultant (M&D)	AfC Non-Consolidated Pay (NP)	0	0.00	0.00	0	783	783
21000-Consultant (M&D)	Assistant Clinical Director	0	0.00	0.00	0	59	59
21000-Consultant (M&D)	Clinical Director Fees	0	0.00	0.00	0	12,489	12,489
21000-Consultant (M&D)	Commitment Awards	0	0.00	0.00	0	28,024	28,024
21000-Consultant (M&D)	Default	2,507,024	16.50	7.35	835,672	359,612	(476,060)
21000-Consultant (M&D)	Out of Hours	0	0.00	0.00	0	7,018	7,018
21000-Consultant (M&D)	Standby	0	0.00	0.00	0	277	277
21100-Locum Consultant (M&D)	Default	0	0.00	0.96	0	(49,721)	(49,721)
21100-Locum Consultant (M&D)	Locums	0	0.00	0.00	0	101,764	101,764
21100-Locum Consultant (M&D)	Pay in Lieu of A/L	0	0.00	0.00	0	681	681
21800-Agency - Consultant (M&D)	Default	0	0.00	0.00	0	335,294	335,294
21800-Agency - Consultant (M&D)	Locums	0	0.00	0.00	0	12,630	12,630
21800-Agency - Consultant (M&D)	Pay in Lieu of A/L	0	0.00	0.00	0	11,687	11,687
22110-Associate Specialist (M&D)	Default	187,008	1.60	1.00	62,332	39,268	(23,064)
22310-Speciality Doctor (M&D)	Default	174,134	2.00	1.00	58,044	30,969	(27,075)
23000-Agency - Other Career Grade (M&D)	Default	0	0.00	0.00	0	49,011	49,011
23000-Agency - Other Career Grade (M&D)	Pay in Lieu of A/L	0	0.00	0.00	0	1,411	1,411
23120-Locum Specialty Registrar (M&D)	Default	0	0.00	0.00	0	(18,372)	(18,372)
23120-Locum Specialty Registrar (M&D)	Locums	0	0.00	0.00	0	525	525
23120-Locum Specialty Registrar (M&D)	Pay in Lieu of A/L	0	0.00	0.00	0	80	80
24100-F2 foundation year 2 (M&D)	Default	0	0.00	0.00	0	3,131	3,131
24100-F2 foundation year 2 (M&D)	Jnr Dr Band Supplements	0	0.00	0.00	0	1,386	1,386
26200-Agency - Drs/Dentist in Training (M&D)	Default	0	0.00	0.00	0	918	918
37710-Recharge : SIFT	Default	(20,000)	0.00	0.00	(6,664)	(6,664)	0

TOTAL Agency	410,950
Consultant NHS & Internal locums	52,724

Subjective and Desc	Analysis Description	Annual Budget	WTE Budget	WTE Actual	YTD Budget	YTD Actual	YTD Variance
01200-Medical Staff Income	Default	0	0	0	0	(12,945)	(12,945)
21000-Consultant (M&D)	Add Prog Activity	0	0	0	0	186,147	186,147
21000-Consultant (M&D)	Adptn Pay	0	0	0	0	12,849	12,849
21000-Consultant (M&D)	AfC Arrears	0	0	0	0	758	758
21000-Consultant (M&D)	AfC Non-Consolidated Pay (NP)	0	0	0	0	1,397	1,397
21000-Consultant (M&D)	Assistant Clinical Director	0	0	0	0	0	0
21000-Consultant (M&D)	Clinical Director Fees	0	0	0	0	36,089	36,089
21000-Consultant (M&D)	Commitment Awards	0	0	0	0	67,441	67,441
21000-Consultant (M&D)	Default	2,474,173	16.5	7.5	2,474,173	1,361,521	(1,112,652)
21000-Consultant (M&D)	Locums	0	0	0	0	125,959	125,959
21000-Consultant (M&D)	Out of Hours	0	0	0	0	24,830	24,830
21000-Consultant (M&D)	Sick Pay	0	0	0	0	1,215	1,215
21000-Consultant (M&D)	Standby	0	0	0	0	1,055	1,055
21100-Locum Consultant (M&D)	Default	0	0	1	0	(10,022)	(10,022)
21100-Locum Consultant (M&D)	Locums	0	0	0	0	52,656	52,656
21100-Locum Consultant (M&D)	Pay in Lieu of A/L	0	0	0	0	15,508	15,508
21800-Agency - Consultant (M&D)	Default	0	0	4.02	0	886,817	886,817
22110-Associate Specialist (M&D)	Add Prog Activity	0	0	0	0	2,950	2,950
22110-Associate Specialist (M&D)	Default	182,681	1.6	1	182,681	166,008	(16,673)
22310-Speciality Doctor (M&D)	AfC Arrears	0	0	0	0	2,329	2,329
22310-Speciality Doctor (M&D)	Default	168,924	2	1.87	168,924	136,469	(32,455)
22310-Speciality Doctor (M&D)	Sick Pay	0	0	0	0	703	703
23000-Agency - Other Career Grade (M&D)	Default	0	0	1.01	0	122,524	122,524
23000-Agency - Other Career Grade (M&D)	Pay in Lieu of A/L	0	0	0	0	1,244	1,244
23120-Locum Specialty Registrar (M&D)	Default	0	0	0	0	(1,178)	(1,178)
23120-Locum Specialty Registrar (M&D)	Locums	0	0	0	0	1,433	1,433
23120-Locum Specialty Registrar (M&D)	Pay in Lieu of A/L	0	0	0	0	127	127
24100-F2 foundation year 2 (M&D)	AfC Arrears	0	0	0	0	0	0
24100-F2 foundation year 2 (M&D)	Default	0	0	0	0	9,447	9,447
24100-F2 foundation year 2 (M&D)	Jnr Dr Band Supplements	0	0	0	0	4,051	4,051
26200-Agency - Drs/Dentist in Training (M&D)	Default	0	0	0	0	25,241	25,241
37710-Recharge : Miscellaneous	Default	(20,000)	0	0	(20,000)	(19,994)	6

Agency	1,035,826
Consultant NHS & Internal locums	184,101

Subjective and Desc	Analysis Description	Annual Budget	WTE Budget	WTE Actual	YTD Budget	YTD Actual	YTD Variance
21000-Consultant (M&D)	Add Prog Activity	0	0	0	0	119,465	119,465
21000-Consultant (M&D)	AfC Arrears	0	0	0	0	(163)	(163)
21000-Consultant (M&D)	Assistant Clinical Director	0	0	0	0	(1,531)	(1,531)
21000-Consultant (M&D)	Clinical Director Fees	0	0	0	0	45,817	45,817
21000-Consultant (M&D)	Commitment Awards	0	0	0	0	64,761	64,761
21000-Consultant (M&D)	Default	2,142,331	15.3	11.49	2,142,331	1,176,200	(966,131)
21000-Consultant (M&D)	Locums	0	0	0	0	143,273	143,273
21000-Consultant (M&D)	Out of Hours	0	0	0	0	20,182	20,182
21100-Locum Consultant (M&D)	Default	0	0	0	0	45,994	45,994
21800-Agency - Consultant (M&D)	Default	0	0	4.95	0	375,059	375,059
22110-Associate Specialist (M&D)	Default	168,387	1.7	1.6	168,387	173,832	5,445
22310-Speciality Doctor (M&D)	Default	215,008	3	2	215,008	143,247	(71,761)
23000-Agency - Other Career Grade (M&D)	Default	0	0	1	0	18,521	18,521
24100-F2 foundation year 2 (M&D)	Default	0	0	0	0	290	290
24100-F2 foundation year 2 (M&D)	Locums	0	0	0	0	(284)	(284)
26200-Agency - Drs/Dentist in Training (M&D)	Default	0	0	0	0	9,656	9,656
37710-Recharge : Miscellaneous	Default	(19,992)	0	0	(19,992)	(20,000)	(8)

Agency	403,236
Consultant NHS & Internal locums	189,267

Ablett New Development (Option 3)

Floor Area	
Area	m2
Total Floor Area	9136

Associated Costs per £/m2	£/m2
Building & Engineering	£ 29.20
Energy	£ 22.43
Water	£ 2.00
Sewage	£ 2.35
Waste	£ 2.90
Rates	

Overall Associated Costs	£
Building & Engineering (Pay / Non-Pay)	£ 266,771.20
Energy	£ 204,920.48
Water	£ 18,272.00
Sewage	£ 21,469.60
Waste	£ 26,494.40
Rates	

Total Cost	**£**	**537,927.68**
Facilities	**£**	**421,169.60**
Total Estates Costs	**£**	**992,847.28**

Multi Storey Car Park

Floor Area	
Area	m2
Total Floor Area	6750

Associated Costs per £/m2	£/m2
Building & Engineering	£ 3.00
Energy	£ 2.00
Water	£ -
Sewage	£ -
Waste	£ -
Rates	

Overall Associated Costs	£
Building & Engineering (Pay / Non-Pay)	£ 20,250.00
Energy	£ 13,500.00
Water	£ -
Sewage	£ -
Waste	£ -
Rates	

Total Cost	**£**	**33,750.00**
	£	**-**

Ablett Current Expenditure (Based on Floor Area)

Floor Area	
Area	m2
Total Floor Area	4078

Associated Costs per £/m2	£/m2
Building & Engineering	£ 29.20
Energy	£ 22.40
Water	£ 2.00
Sewage	£ 2.35
Waste	£ 2.90
Rates	

Overall Associated Costs	£
Building & Engineering (Pay / Non-Pay)	£ 119,077.60
Energy	£ 91,347.20
Water	£ 8,156.00
Sewage	£ 9,583.30
Waste	£ 11,826.20
Rates	

Total Cost	**£**	**239,990.30**
Facilities	**£**	**348,465.10**
Total Estates Costs	**£**	**588,455.40**

Ablett New Development (Option 2)

Floor Area	
Area	m2
Total Floor Area	9136

Associated Costs per £/m2	£/m2
Building & Engineering	£ 29.20
Energy	£ 22.43
Water	£ 2.00
Sewage	£ 2.35
Waste	£ 2.90
Rates	

Overall Associated Costs	£
Building & Engineering (Pay / Non-Pay)	£ 266,771.20
Energy	£ 204,920.48
Water	£ 18,272.00
Sewage	£ 21,469.60
Waste	£ 26,494.40
Rates	

Total Cost	**£**	**537,927.68**
Facilities	**£**	**421,169.60**
Total Estates Costs	**£**	**959,097.28**

Ablett New Development (Option 4)

Floor Area	
Area	m2
Total Floor Area	4314

Associated Costs per £/m2	£/m2
Building & Engineering	£ 29.20
Energy	£ 22.43
Water	£ 2.00
Sewage	£ 2.35
Waste	£ 2.90
Rates	

Overall Associated Costs	£
Building & Engineering (Pay / Non-Pay)	£ 125,968.80
Energy	£ 96,763.02
Water	£ 8,628.00
Sewage	£ 10,137.90
Waste	£ 12,510.60
Rates	

Total Cost	**£**	**254,008.32**
Facilities	**£**	**421,169.60**
Total Estates Costs	**£**	**675,177.92**

Ablett New Development (SOC)

Floor Area	
Area	m2
Total Floor Area	5028

Associated Costs per £/m2	£/m2
Building & Engineering	£ 29.20
Energy	£ 22.43
Water	£ 2.00
Sewage	£ 2.35
Waste	£ 2.90
Rates	

Overall Associated Costs	£
Building & Engineering (Pay / Non-Pay)	£ 146,817.60
Energy	£ 112,778.04
Water	£ 10,056.00
Sewage	£ 11,815.80
Balance	£ 43,926.00
Waste	£ 14,581.20
Rates	

Total Cost	**£**	**339,974.64**
Facilities	**£**	**368,631.30**
Total Estates Costs	**£**	**708,605.94**

Note -

These revenue budget figures assume that future investment required for replacement of infrastructure, plant and equipment as part of the life cycle of the new development will be

** Based on EFPMS Data submitted in 2018-2019 with uplift og 15%, due to Air Source Heat Pump Design Philosophy

Note from SOC Re Estates Costs

This saving needs to be offset by the increase in Estates costs. Although the new and refurbished facilities will be more efficient, and so cost less per square metre to run, there is an overall increase in floor area of approximately 950sqm. The estimated increase in Estates running costs is £208,000.

Note: JG - Estates costs for SOC are amended on utilities and maintenance to agree to £208k as quoted above.

Ablett New Development

Facilities

Floor Area	
Area	m2
Total Floor Area	9136

Associated Costs per £/m2	£/m2
Catering Pay	£ 4.77
Catering Non Pay	£ 15.80
Domestic Cleaning Pay	£ 20.23
Domestic Non Pay	£ 0.72
Portering Pay	£ 3.20
Portering Non Pay	£ 0.20
Postal Services	
Linen Services Pay	
Linen Non Pay	£ 0.72
Stores and Distribution Services Pay	£ 0.46
Laundry Services	TBC

Overall Associated Costs	£
Catering Pay	£ 43,578.72
Catering Non Pay	£ 144,348.80
Domestic Cleaning Pay	£ 184,821.28
Domestic Non Pay	£ 6,577.92
Portering Pay	£ 29,235.20
Portering Non Pay	£ 1,827.20
Postal Services	
Linen Services Pay	£ 6,577.92
Linen Non Pay	
Stores and Distribution Services Pay	£ 4,202.56
Laundry Services	TBC

Total Cost	**£ 421,169.60**

Ablett Current Expenditure (Based on Floor Area)

Facilities

Floor Area	
Area	m2
Total Floor Area	4,078

Associated Costs per £/m2	£/m2
Catering Pay	£ 5.63
Catering Non Pay	£ 28.73
Domestic Cleaning Pay	£ 40.14
Domestic Non Pay	£ 1.16
Portering Pay	£ 7.45
Portering Non Pay	£ 0.20
Postal Services	
Linen Services Pay	
Linen Non Pay	£ 1.07
Stores and Distribution Services Pay	£ 1.07
Laundry Services	TBC

Overall Associated Costs	£
Catering Pay	£ 22,959.14
Catering Non Pay	£ 117,160.94
Domestic Cleaning Pay	£ 163,690.92
Domestic Non Pay	£ 4,730.48
Portering Pay	£ 30,381.10
Portering Non Pay	£ 815.60
Postal Services	
Linen Services Pay	£ 4,363.46
Linen Non Pay	
Stores and Distribution Services Pay	£ 4,363.46
Laundry Services	TBC

Total Cost	**£ 348,465.10**

7.5 hours per day x7 based on £19337

Ablett Expenditure (SOC - Extrapolated from Facilities and Estates Costs)

Facilities

Floor Area	
Area	m2
Total Floor Area	4,314

Associated Costs per £/m2	£/m2
Catering Pay	£ 5.63
Catering Non Pay	£ 28.73
Domestic Cleaning Pay	£ 40.14
Domestic Non Pay	£ 1.16
Portering Pay	£ 7.45
Portering Non Pay	£ 0.20
Postal Services	
Linen Services Pay	
Linen Non Pay	£ 1.07
Stores and Distribution Services Pay	£ 1.07
Laundry Services	TBC

Overall Associated Costs	£
Catering Pay	£ 24,287.82
Catering Non Pay	£ 123,941.22
Domestic Cleaning Pay	£ 173,163.96
Domestic Non Pay	£ 5,004.24
Portering Pay	£ 32,139.30
Portering Non Pay	£ 862.80
Postal Services	
Linen Services Pay	£ 4,615.98
Linen Non Pay	
Stores and Distribution Services Pay	£ 4,615.98
Laundry Services	TBC

Total Cost	**£ 368,631.30**

AOPMHU REDEVELOPMENT 13/07/2021
OBC COST OPTIONS - PUBSEC 250

	Option 1 Maintain existing: Allowance for programme of minor repairs and maintenance	**Option 2** Refurb/New Build as increased scope	**Option 3** New Build + Car Park	**Option 4** Do Minimum: SOC + Upgrade Bryn Hesketh	Original SOC (incl new build Bryn Hesketh)
Works Cost	2,804,441	33,190,315	38,653,381	12,677,918	13,903,280
Fees	560,888	6,638,063	7,058,362	2,535,584	2,889,102
Non Works	280,444	3,319,032	1,484,597	1,267,792	285,000
Equipment	420,666	4,978,547	5,143,145	1,901,688	2,000,000
Contingency	609,966	7,218,894	5,233,948	2,757,447	2,861,607
Sub total	**4,676,405**	**55,344,851**	**57,573,433**	**21,140,429**	**21,938,989**
VAT	935,281	11,068,970	11,514,687	4,228,086	4,388,000
Less recoverable VAT	- 112,178	- 1,327,613	- 1,411,672	- 507,117	- 578,000
Total Project Cost	**5,499,508**	**65,086,209**	**67,676,448**	**24,861,398**	**25,748,989**

ABLETT REDEVELOPMENT
OBC COST OPTIONS

11/09/2020

	Option 1 Maintain existing: Allowance for programme of minor repairs and maintenance	**Option 2** Do Minimum: SOC + Upgrade Bryn Hesketh	**Option 3** New Build + Car Park	**Option 4** Refurb/New Build as increased scope	Original SOC (incl new build Bryn Hesketh)
Works Cost	2,588,714	11,403,935	35,650,996	29,397,035	13,903,280
Fees	517,743	2,280,787	6,316,557	5,879,407	2,889,102
Non Works	129,436	1,140,394	1,502,000	2,939,703	285,000
Equipment	388,307	1,710,590	5,392,000	4,409,555	2,000,000
Contingency	543,630	2,480,356	4,886,155	6,393,855	2,861,607
Sub total	**4,168,000**	**19,016,000**	**53,748,000**	**49,020,000**	**21,939,000**
VAT	833,600	3,803,200	10,749,600	9,804,000	4,388,000
Less recoverable VAT	- 103,549	- 456,157	- 1,263,311	- 1,175,881	- 578,000
Total Project Cost	**4,898,000**	**22,363,000**	**63,234,000**	**57,648,000**	**25,749,000**
Assumed Start on Site	Feb-22	Feb-22	Feb-22	Feb-22	
Estimated Completion	Feb-24	Jun-23	Aug-24	Nov-24	
Nr Weeks	104	72	130	146	

	Option 1	Option 2	Option 3	Option 4	SOC
Sqm Estate	3629	4314	9070	9070	3364
Car Park			13500		

Capital Analysis

1.Capital charge calculations (preferred option):

Scenario 1 on capital cost over project life per discounted cash flow

Scenario 2 impaired valuation over average asset life for health centre

					Lifespan
Scenario 1	assumed average asset life is 30 years. Equipment over 10 years				30
	capital:	£	Capital charge:	£	
	works	48,644,581			
	Land	0			
	other	8,118,957	Build	1,892,118	
	sub total	56,763,538	Equipment	647,040	
	equipment	6,470,400	**Total**	**2,539,158**	
	total	63,233,938			

Scenario 2	impairment assumes a 30% reduction in build value but final adjustment is subject to DV valuation.					
	assumed average asset life is 30 years. Equipment over 10 years.					
	Build Value	39,734,477	Capital charge:	£		
	Land Value	0	Build	1,324,483		
	Total Value	39,734,477	Equipment	647,040		
	% of total capital	70%	**Total**	**1,971,523**	Proposed deprn	1,971,523
					Current deprn	488,628
Existing capital charge:			Ablett	Bryn Hesketh	**Increase**	**1,482,895**
		Asset value £	3,995,475	1,517,943		
		Asset life yrs	11.00	12.00		
		Depreciation £	**363,326**	**125,302**		

2.Impairment Calculation:	Capital Cost	£56,763,538	
	Estimated Value of New Premises	£39,734,477	
	Projected Impairment	**£17,029,061**	*highly indicative subject to DV.*
	Potential write down @ 80% gives:	£1,214,354	

Betsi Cadwaladr University Health Board

Forecasting Report for Period Ending 31-Mar-2020

Filter : Specific Model : Real Print Date : 11-Mar-2020

Buildings Purchased

No.	Description	Depreciation Qtr1	Qtr2	Qtr3	Qtr4	Total	Opening NBV	Current NBV	Interest 3.5%	Total Charge	Life
225	EMI Unit	£17,871	£17,858	£17,858	£17,858	£71,445	£1,559,598	£1,517,943	£53,857	£125,302	£12.11
Total For:	Buildings Purchased	£17,871	£17,858	£17,858	£17,858	£71,445	£1,559,598	£1,517,943	£53,857	£125,302	
Grand Total		£17,871	£17,858	£17,858	£17,858	£71,445	£1,559,598	£1,517,943	£53,857	£125,302	

Betsi Cadwaladr University Health Board

Forecasting Report for Period Ending 31-Mar-2020

Filter : Specific Model : Real Print Date : 11-Mar-2020

Buildings Purchased

No.	Description	Depreciation Qtr1	Qtr2	Qtr3	Qtr4	Total	Opening NBV	Current NBV	Interest 3.5%	Total Charge
192	Ablett Unit	£63,912	£44,381	£44,802	£44,893	£197,988	£5,452,392	£3,995,475	£165,338	£363,326
Total For:	Buildings Purchased	£63,912	£44,381	£44,802	£44,893	£197,988	£5,452,392	£3,995,475	£165,338	£363,326
Grand Total		£63,912	£44,381	£44,802	£44,893	£197,988	£5,452,392	£3,995,475	£165,338	£363,326

£11.00

Issue	Response	Include Y/N	Action
Qualitative Isues / Non Cash Releasing			
ECT - single regional site needs to fully upgraded			
DDA compliance and increased therapy space			
Transition to paid employment - café			
Health and Wellbeing - gym, pilates, yoga etc			
Better staff facilities / changing and rest			
Acute care campus - perinatal, Liaison psychiatry, home treatment teams			
In reach from third sector services			
provision of crisis care and alternatives to admission			
Extra care facility will see reduction in contnuous observations? Factor in			
Reduction in Serious incidents			
Improved patient experience			
Transfer of Bryn Hesketh - Benefits			
Extra rest facilities			
Training facilities			
Increased recruitment - reduction in agency / bank?	Medical and Nursing		
Reduced staff sickness			
more efficient use of s136 will see benefits for partners			
Timely assessment of S136 patients			
Retrictive Practice Intervention - reduction			
Occupancy levels at suggested 85% reduces SUI			
Enhanced roles - ANP recruitment and retention			
One hospital site			
Pharmacy - quicker medicines management review and better compliance			
Medical staff - recruitment - more attractive / increased reputation / less stigma TF			
Reduction in SUI / Inquests??			
Garden Areas increased therapeutic space, less SUI / quicker recovery?			
Home leave relapses			
Detention levels - linked to higher occupancy			
Qualitative benefit - reduce bed pressures in Hergest and Heddfan - high bed occupancy in these areas as well as centre	Resulting in less OAP?		
Potential Cash Releasing			
Reduced Out of Area costs	Email sent to AP and triumvirate		
Reduced Transport costs for OOA	Email sent to AP and triumvirate		
Overhead costs - estates	Rod Taylor		
Observational costs reduced - zonal nursing			
ECT Income potential?			
Medical - any savings or additional costs - cost avoidance agency?	Email sent to AP and AS		
Admin savings from Bryn Hesketh - reduced reception costs?	deemed none		
Reduced backlog maintenance?			
Clarification			
Options - If this is SOC / Model / Phased / Do nothing / Do minimum	Staffing models for the different options?		
Increased bed stock - increased activity?? Discharges			
pharmacy, differentiate between current shortfall and increase due to increased beds			
Costs do not include ANP			
4 bed clinical assessment unit - benefits, consider staged approach?	Stage approach to Extra Care Facility		
ECT Budget shortfall - transfer from other areas?			
Nurse staffing act - becoming law will be a requirement -as with pharmacy, two staged explanation for increase	Assessed impact is £59k		
What does Extra care mean, what does this give us in cash releasing and other benefits?			
SOC - average cost per bed £84,165 reduced down to £64,805 - how does this compare now?			
Model does not allow for additional one to one costs - cannot compare with current costs			
Model does not assume ANPs in structure			
Need to know depreciation costs current	This is now provided, need to include impairment @30% of capital cost		JG - emailed DR

SOCIO ECONOMIC IMPACT ASSESSMENT TEMPLATE

For a comprehensive guide to the Socio Economic Duty in Wales and supporting resource please see https://gov.wales/more-equal-wales-socio-economic-duty

Public health data is available here North Wales Population Health Directory. If you require support with interpreting public health data please contact the Betsi Cadwaladr Public Health Team.

Further support in applying this process is available from Strategy and Planning colleagues, the Equality Team and your Equality Delivery Group representative. An intranet resource page to guide you through the process has been set up here Betsi Cadwaladr University Health Board | Socio-economic Duty (wales.nhs.uk)

This SEIA procedure should be commenced at the outset and inform the development of both new strategic decisions and when reviewing previous strategic decisions. It provides a clear audit trail for all decisions made under the 2010 Act.

Policy / Strategy / Proposal / Procedure Title	Adult & Older Persons Mental Health Unit Redevelopment
Lead Manager	Senior Responsible Officer, Teresa Owen, Executive Director Of Public Health
Approval Committee	Adult & Older Persons Mental Health Unit Redevelopment Project Board
Date form completed	5th July 2021
What are the aims and objectives of the policy / strategy / proposal?	Reconfiguration of adult mental health services to provide the right environment to deliver high quality services that meet the privacy and dignity requirements of a modern day mental health facility. Objectives of the proposal are: **Investment Objective 1**: To provide services which meet the Strategic Direction outlined within *Together for Mental Health* (T4MH) in North Wales and deliver the **model of care** developed through the quality and workforce groups. **Investment Objective 2**: To create a quality **clinical environment** that is fit for purpose, safe and humane.

	Investment Objective 3: To improve **workforce** recruitment and retention and absenteeism through providing an environment that supports staff to deliver safe, effective care to patients, carers and families. **Investment Objective 4**: To improve the **quality of the estate** by reducing backlog maintenance, reducing running costs, and achieving environmental sustainability **Investment Objective 5**: **Flexibility:** Deliver the flexibly to respond to future need – the solution should be designed to respond to future changes in service delivery.

<table>
<tr><td colspan="6">STAGE 1: PLANNING</td></tr>
<tr><td>Is the decision a strategic decision? See definition</td><td>Yes</td><td>Please provide a brief explanation for your answer</td><td colspan="3">The key strategy that drives this business case is Together for Mental Health in North Wales, adopted by the Health Board in 2017. This is an all-age mental health strategy developed in partnership to support the delivery of the objectives outlined in the Together for Mental Health Strategy Welsh Government (2012).

Together for Mental Health in North Wales is also an integral part of the Health Board's overall clinical strategy, Living Healthier, Staying Well, published in 2018. Together for Mental Health in North Wales commits the Health Board to six key principles in everything it does:
i. We will treat people who use our services, and their carers and families, as equal partners – all of us must be seen as essential assets in improving the mental health and wellbeing of the communities of North Wales;
ii. We will ensure everything we do is as integrated as possible – across disciplines, across agencies, across services – in both planning services, and delivering services. Fragmented care must be replaced by joined-up and continuous care;
iii. We will work to ensure everyone feels valued and respected;
iv. We will support and promote the best quality of life for everyone living with mental health problems;
v. We will promote local innovation and local evaluation in how we provide services;
vi. We will continually measure our impact on outcomes, within both national and local quality and outcomes frameworks – whether we have improved the lives of people for and with whom we provide services.</td></tr>
<tr><td>Have you identified key stakeholders groups?
Please detail below</td><td>Yes</td><td colspan="2">Can you identify relevant communities of interest?
See guidance / Please detail below</td><td>Yes</td><td>Can you identify relevant communities of place? See guidance / Please detail below</td><td>Yes</td></tr>
<tr><td colspan="2">▪ CANIAD
▪ Local Implementation Teams
▪ Welsh Ambulance Service
▪ North Wales Police
▪ Community Health Council
▪ Workforce Partnership Group
▪ Patients in our inpatient facilities
▪ Voluntary Service Networks
▪ Elwy Ward members
▪ TIDE and DEEP Carer Groups</td><td colspan="2">▪ Individuals who share one or more of the protected characteristics.
▪ Individuals with lived experience
▪ Carers / families
▪ Welsh speakers</td><td colspan="3">▪ Staff
▪ Patients
▪ Carers / families
▪ Local residents
▪ Local business owners</td></tr>
</table>

▪ Staff in Ysbyty Glan Clwyd ▪ Staff in Bryn Hesketh ▪ Alzheimer's Society ▪ Residents of Bodelwyddan ▪ Bryn Hesketh Carers Group ▪ Family of Tawelfan Stakeholder Group		

STAGE 2: EVIDENCE

What evidence have you considered about socio-economic disadvantage and inequalities of outcome in relation to this decision?	▪ North Wales population Health Assessment: North Wales Social Care and Wellbeing Services Improvement Collaborative April 2017 ▪ Together for Mental Health North Wales 2017 ▪ Public Health Wales Observatory (2016) 'General Practice Population Profiles'. Public Health Wales. Available at: http://www.wales.nhs.uk/sitesplus/922/page/87851 Accessed 5th July 2021 ▪ Welsh Index of multiple Deprivation (WIMD) Results Report Welsh Government 2019 ▪ Public Service Board Wellbeing Assessment: Conwy and Denbighshire Public Service Board 2018 ▪ International Horizon Scanning and Learning to Inform Wales Covid-19 Public Health Wales Response and Recovery Report 30, 01/07/2021 ▪ BCUHB Living Healthier Staying Well 2018 ▪ Welsh Government De-carbonisation Strategy 2021 ▪ Mental Health Benchmarking: Inpatient and Community Mental Health Benchmarking, November 2020
Have you engaged with those affected by the Policy / Strategy Proposal / policy?	Wide engagement was undertaken during the development of the Outline Business Case. During our engagement we attended and participated in a range of meetings with stakeholders: ▪ CANIAD Big Chats ▪ Local Implementation Teams ▪ Welsh Ambulance Service ▪ North Wales Police ▪ Community Health Council ▪ Workforce Partnership Group ▪ Patients in our inpatient facilities ▪ Voluntary Service Networks ▪ Elwy ward members ▪ TIDE and DEEP carer groups ▪ Staff in YGC ▪ Staff in Bryn Hesketh ▪ Alzheimer's society ▪ Residents of Bodelwyddan ▪ Carers group in Bryn Hesketh ▪ Family of Tawelfan stakeholder group

	In addition to the above range of face to face meetings and we also utilised social media and local press to reach groups and communities that may have been unable to attend in person.
What engagement with people living with socio economic disadvantage will be / has been undertaken?	▪ CANIAD Big Chats ▪ Local Implementation Teams ▪ Patients in our inpatient facilities ▪ TIDE and DEEP carer groups ▪ Staff in YGC ▪ Staff in Bryn Hesketh ▪ Residents of Bodelwyddan ▪ Carers group in Bryn Hesketh ▪ Today, we talked: A novel approach to overcoming barriers to sexual safety on mental health wards -2019 Page - 2020 - Journal of Psychiatric and Mental Health Nursing - Wiley Online Library
How has / will this influence your work/guided your policy/proposal, or changed your recommendations?	The engagement we have undertaken both as part of the Together for Mental Health strategy and during the outline business case development have told us that: ▪ Single, secure ensuite rooms are important for people to feel safe and secure ▪ That hearing loops are essential ▪ That the provision of assessments in language of choice are important ▪ That residents of Conwy & Denbighshire want to be treated closer to home ▪ That space for third sector services to be part of the redevelopment are important such as CAB/ CANIAD/ KIM/ HAFAL ▪ That people detained under s136 of the Mental Health Act want to be seen quickly in a pleasant environment with access to fluids and nutrition ▪ That introduction to exercise and nutrition should be part of the inpatient offer ▪ That individuals undergoing gender reassignment should be able to choose the ward they reside on ▪ That an age appropriate bed should be available for young people ▪ That disability access to all areas is key ▪ That the provision of a welcoming reception and café will assist to reduce stigma ▪ That introduction to volunteering and paid employment should be part of the café via a social enterprise approach ▪ Staff rest and change facilities need to be onsite ▪ That there should be a separate visiting room for children ▪ Therapeutic use of the inside and outside space is important ▪ Introduction to exercise and five ways to well-being is key in terms of the holistic offer.
Stage 3: ASSESSMENT AND IMPROVEMENT	
What are the main socio economic impacts of the proposal? Consider evidence from both research and any engagement already carried out. Who is being affected? Refer to the North Wales Population Health Directory	

Are some communities of interest or communities of place more affected by disadvantage than others?

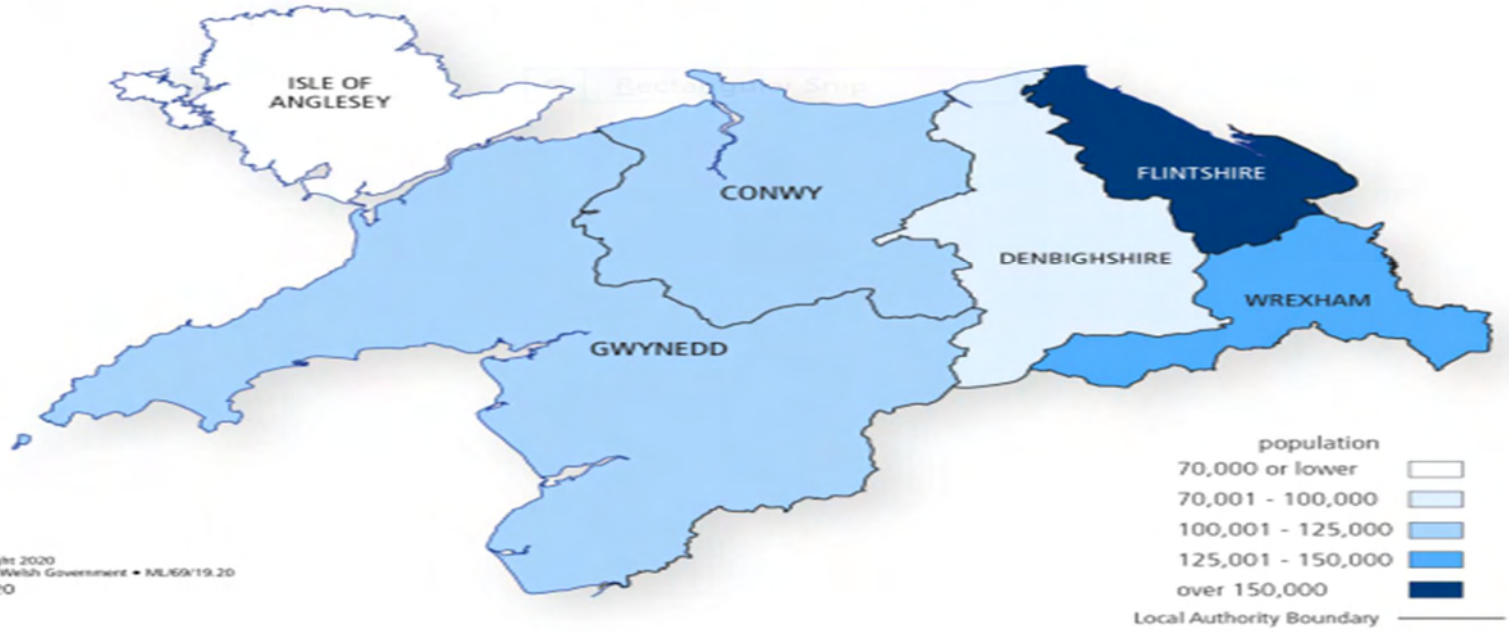
The Equality and Human Rights Commission monitor progress on equality and human rights across a range of areas of life in Great Britain these areas include:

- Education
- Work
- Living standards
- Health
- Justice and personal security
- Participation

It is helpful to consider where action can be taken to reduce inequality of outcome resulting from socio-economic disadvantage in regards to each of these areas, evidence is provided below and issues for consideration suggested.

Population

Figure 1: Population in North Wales, by local authority, 2018



Demography of Conwy & Denbighshire

1.1 Population estimates, 2020

Conwy and Denbighshire have a combined population of almost 214,850 residents (Table 1). Conwy has the largest population and an older population compared to Denbighshire (Table 2). In Conwy, 28% of residents are aged 65 years and over compared to 24% in Denbighshire. Conwy also has a higher proportion of residents aged 85 years and over (4%) compared to Denbighshire (3%) (Table 3).

Table 1: Population estimates, all persons, all ages, Conwy and Denbighshire, 2020

Conwy	118,184
Denbighshire	96,664
Central Area	214,848

Source: StatsWales (WG); MYE 2020 (ONS)

Table 2: Population estimates, all persons by age group, Conwy and Denbighshire, 2020

	Aged 0 to 15	Aged 16 to 64	Aged 65 & over	Aged 85 & over
Conwy	18,855	66,391	32,938	5,172
Denbighshire	17,399	55,748	23,517	2,670
Central Area	36,254	122,139	56,455	7,842

Source: StatsWales (WG); MYE 2020 (ONS)

Table 3: Percentage Population estimates, all persons by age group, Conwy and Denbighshire, 2020

	Aged 0 to 15	Aged 16 to 64	Aged 65 & over	Aged 85 & over
Conwy	16	56	28	4
Denbighshire	18	58	24	3
Central Area	17	57	26	4

Source: StatsWales (WG); MYE 2020 (ONS)

Table 5: Denbighshire, Welsh Index of Multiple Deprivation overall rank, 2019

	WIMD Rank*
Rhyl West 2	1
Rhyl West 1	2
Rhyl West 3	11
Rhyl South West 2	19
Glyn (Conwy) 2	20
Rhyl South West 1	57
Abergele Pensarn 2	70
Tudno 2	78
Rhyl East 3	133
Denbigh Upper/Henllan 1	170
Colwyn 2	190
Rhyl South East 4	192
Llysfaen 1	193
Rhiw 3	202
Kinmel Bay 1	296
Pentre Mawr 1	313
Rhyl East 1	351
Tudno 1	364
Prestatyn East 1	389
Prestatyn Central 2	400
Towyn	439
Glyn (Conwy) 1	477
Pant-yr-afon Penmaenan 2	516
Denbigh Upper/Henllan 2	519

Source: WIMD; (WG)

* A lower number indicates higher deprivation

Table 6: Conwy, Welsh Index of Multiple Deprivation overall rank, 2019

LSOA Name	WIMD 2019 Rank
Glyn (Conwy) 2	20
Tudno 2	78
Colwyn 2	190
Llysfaen 1	193
Rhiw 3	202
Kinmel Bay 1	296
Pentre Mawr 1	313
Tudno 1	364
Towyn	439
Glyn (Conwy) 1	477
Pant-yr-afon/Penmaenan 2	516
Mostyn (Conwy) 2	521
Kinmel Bay 3	540
Mostyn (Conwy) 1	590
Llandrillo yn Rhos 4	610
Mochdre	615
Eirias 1	616
Gogarth 1	623
Gele 1	647
Kinmel Bay 4	681
Conwy 1	711
Craig-y-Don 1	726
Pensarn 1	759
Kinmel Bay 2	781
Glyn (Conwy) 3	792
Bryn	902
Uwch Conwy	914
Llangernyw	968
Pant-yr-afon/Penmaenan 1	969
Crwst	1,000
Llansannan	1,001
Marl 2	1,084
Gogarth 2	1,107
Betws yn Rhos	1,126
Colwyn 3	1,159
Betws-y-Coed	1,165
Uwchaled	1,168
Eglwysbach	1,178
Trefriw	1,195
Pensarn 2	1,197
Caerhun	1,251
Gower (Conwy)	1,267
Llanddulas	1,277
Capelulo	1,293
Rhiw 4	1,310
Llysfaen 2	1,328
Pandy	1,408
Tudno 3	1,457
Colwyn 1	1,466
Llandrillo yn Rhos 3	1,482
Llandrillo yn Rhos 5	1,506
Eirias 2	1,550
Pentre Mawr 2	1,584
Llandrillo yn Rhos 2	1,596
Gele 2	1,598
Penrhyn 1	1,599
Deganwy 2	1,610
Conwy 3	1,632
Conwy 2	1,688
Craig-y-Don 2	1,694
Gele 3	1,739
Llandrillo yn Rhos 1	1,742
Rhiw 1	1,769
Marl 1	1,830
Rhiw 2	1,841
Deganwy 1	1,856
Penrhyn 2	1,859
Penrhyn 3	1,861

Source: Welsh Government, WIMD 2019

2.1 Children living in poverty

In Denbighshire, 25% of children aged 0 to 18 years live in poverty compared to 22% in Conwy (Table 7). Denbighshire has the highest proportion across North Wales and is just above the average for Wales (24).

Table 7: Percentage of children aged 0 to 18 years living in poverty, Wales and North Wales unitary authorities, 2017

	%
Wales	24
Isle of Anglesey	22
Gwynedd	18
Conwy	22
Denbighshire	25
Flintshire	19
Wrexham	22

Source: Public Health Wales, PHOF

2.2 Houses in multiple occupancy (HMOs)

Houses in multiple occupancy (HMO) are often occupied by residents on low income and/or from vulnerable groups (Welsh Government, 2017).

Denbighshire has the highest estimated number of HMOs despite having among the lowest known HMOs. Many of these HMOs are situated in Rhyl.

Conwy UA has the second highest number of estimated number of HMOs and the third highest estimated number of HMOs in North Wales.

To derive this data, local authorities were asked to provide data on both the number of known HMOs in their area and an overall estimate of the total number of HMOs they believe are present within the area.

Table 8: Number of known HMOs and estimates, North Wales unitary authorities, 2018-19

	Known HMOs	Estimate of all HMOs
Isle of Anglesey	93	250
Gwynedd	950	1200
Conwy	791	1099
Denbighshire	235	1336
Flintshire	40	900
Wrexham	289	962

Source: StatsWales (WG)

3. Health & Wellbeing

In the Central Area, 81% of working aged adults in Conwy report being in good health, compared to 72% in Denbighshire. A higher percentage of working aged adults in Conwy also report being free from a long term limiting illness, 74% compared to 72% in Denbighshire. It is a similar picture for older adults in Conwy who report better health than older residents of Denbighshire.

Tables 8 and 9 show that residents of Denbighshire experience poorest mental health and wellbeing in the Central Area.

The percentages of patients registered as having a mental health condition in North Denbighshire and Central & South Denbighshire Clusters are just above the averages for BCUHB and Wales (Table 9).

This data is taken from the QOF and is likely to underestimate the true prevalence because it relies on the patient presenting to a General Practitioner (GP) for treatment, receiving a diagnosis from the GP, and being entered onto a disease register. There will be many patients in the community with symptoms of a psychological disorder who do not have an encounter with their GP; therefore, it is important to interpret these estimates with caution.

Table 9: Percentage of patients registered as having a mental health condition, Wales, Betsi Cadwaladr UHB & Central Area Primary Care Clusters, 2019

Wales	1.0
Betsi Cadwaladr UHB	0.9
North Denbighshire	1.2
Central & South Denbighshire	1.1
Conwy East	1.1
Conwy West	0.9

Source: QOF

Conwy has a higher average mental wellbeing score than Denbighshire, BCUHB and Wales, which suggests stronger mental wellbeing.

Table 10: Mental well-being among adults, age-standardised average*, Wales, Betsi Cadwaladr UHB & Central Area unitary authorities, 2018/19

	%
Wales	51.4
Betsi Cadwaladr UHB	52.4
Conwy	53.3
Denbighshire	51.6

Source: Public Health Wales, PHOF

* Scores range from 14 to 70, a higher score suggests stronger mental wellbeing.

Table 11 shows the rate of premature deaths from key non-communicable diseases in persons aged 30 to 70 years. The indicator includes the following diseases:

- Diseases of the circulatory system
- Malignant neoplasms (excluding other and unspecified malignant neoplasm of skin)
- Diabetes mellitus
- Diseases of the respiratory system except infections

Denbighshire has a higher rate of deaths from key non-communicable diseases than Conwy, 351.4 compared to 296.4 poer 100,000 persons aged 30 to 70 years. Denbighshire's rate is the highest across BCUHB and is statistically significantly higher than the average for Wales (315.5).

Table 11: Premature deaths from key non-communicable diseases, EASR per 100,000 population, all persons aged 30 to 70 years, Wales, Betsi Cadwaladr UHB & Central Area unitary authorities, 2016-2018

Wales	315.5
Betsi Cadwaladr UHB	311.6
Conwy	296.4
Denbighshire	351.4

Source: Public Health Wales (PHOF)

Education A literature review by the Centre for Research in Early Childhood (CREC) finds that evidence they examined indicates that in the UK, especially, parents' socio-economic status continues to be the primary predictor of which children prosper in adult life. They report that the magnitude of early childhood inequality in the UK is well-documented; some estimates suggest that half the attainment gaps for pupils are already present at the start of primary school. Using Millennium Cohort study data, this research shows large gaps exist in the UK for vocabulary tests between children aged 4 and 5 from families with middle incomes and those from families with lowest fifth of incomes. Data for Wales also shows pupils eligible for free school meals and children in care have poorer educational outcomes in schools on average with the gap widening as pupils get older.	**In Practice** Overall school children in Wales attain scores in reading, science and mathematics below those in England, Scotland and most other developed countries. Since schools closed during lockdown, children from better-off families have been spending 30 per cent more time on home learning than poorer children How does your proposal take account of the impact of education on the local population, children and adults with additional learning needs, basic literacy levels and those less likely to have or have had access to training opportunities and qualifications?	As per the Mental Health Measure Legislation all admissions to the unit will have a care and treatment plan which is holistic in its approach. This includes any parental or caring responsibilities for children and areas that require additional support. Identification of numeracy and literacy skills will be included as part of the assessment and relevant interventions and referrals to other third sector service will be made to support individuals in these areas which in term will impact positively on children and young people in the family. The redevelopment will include jobs for local tradespeople and an apprenticeship. In reach and outreach form local schools will be part of the redevelopment as will prevention education provided by qualified practitioners.

	Think about how careers support at BCUHB and with partners, including apprenticeships and volunteer work placements can be promoted to support young people furthest from the job market.	Volunteering opportunities for people with lived experience will be provided via the ICAN hubs in Conwy and Denbighshire. The addition of CAFÉ to the redevelopment will also provide volunteering and paid employment opportunities Welsh Government transformation monies is enabling the creation of new roles and jobs additional therapies and pharmacy posts for the unit. The specialist perinatal team will be based at the unit working across the pre and post-natal period with children and families.
Health There is a clear social gradient in terms of health outcomes as documented by the Marmot Review (2010 and 2020 update). It makes it clear that health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources (i.e. the social determinants of health). Indeed, data for Wales shows that adults and children living in the poorest areas are having poorer health outcomes. Adults living in the most deprived areas of Wales have lower life expectancies than those living in the least deprived areas. There is reasonable evidence that people in poverty or living in deprived neighbourhoods have a higher risk of addiction and mental illness and it's also known that many patients struggle financially and socially.	**In Practice** How does your proposal take account of the expected health outcomes of the local population? What are the current health needs and what action can be taken to increase access to healthcare for those who experience socio-economic disadvantage? Have the costs of transport and travel been taken into account? Think about the design of the built environment on the physical and mental health of patients, staff and visitors. What are the opportunities for collaboration, have local third sector organisations been engaged and opportunities to promote access to financial wellbeing, social and other support maximised?	The bed modeling for the unit has been reviewed the beds required to treat Conwy & Denbighshire residents closer to home therefore reducing the need to travel to more. Space for third sector colleagues to provide input into the unit is in the plan. The introduction to exercise and healthy nutrition will be part of the inpatient programme. Working with local Authorities this will continue this will continue to be offered on discharge through the exercise on prescription scheme. Both the inside and outside therapeutic space will be increased and utilised for relevant interventions to support positive mental health and well-being. Physical health checks and covid and flu vaccinations will be provided for all admissions.

		Substance misuse assessment and treatment services will in reach into the new unit. Rest and change facilities are provided for staff as part of the new development. Some staff may have to travel further to work but will be reimbursed as per Health Board relocation arrangements Transport links are already well established for the hospital the redevelopment will increase the provision of cycling routes as part of the YGC transport strategy. Re-establishing the park and ride is being explored by BCUHB.
Living standards 3% of all people in Wales were living in relative income poverty between 2016-17 and 2018-19. This figure has remained relatively stable for the past 16 time periods. At 23%, the figure is slightly lower than last year's. Children were the age group most likely to be in relative income poverty (at 28%) and this has been true for some time. 11% of children living in Wales between 2016-17 and 2018-19 were in material deprivation and low income households.	**In Practice** How does your proposal take account of the impact of poverty and deprivation? Can you identify which groups are disproportionately impacted by poverty e.g. disabled people? Think about the UK-wide reforms to social security and the impact on the poorest in society, particularly women, disabled people, ethnic minorities and lone parents in Wales.How have the needs of people with caring responsibilities been considered? What is the incidence of rough sleeping and levels of homelessness? Twice as many people expect their financial situation to get worse as those who expect it to get better, with this rising to three times in the bottom income quintile, and more than three times for single parents.	All care and treatment plans include reviewing any financial issues and parenting or caring responsibilities Third sector agencies will be present as part of the redevelopment to offer advice and assistance in relation to benefits and debt. The therapies team is being expanded and their programme includes healthy eating, cooking skills, nutrition and budgeting. Local Authority Housing officers are a key part of the unit's current multi - disciplinary functioning and will continue to do so in the new unit. BCUHB MHLD division fund a housing development officer who post who links with housing associations strategically to identify MHLD future needs and support any individuals who are NFA / roofless.

	Think about the availability and accessibility of transport, healthy food, leisure activities, road safety and the quality and safety of play areas and open spaces. As part of your proposal what are the opportunities to reduce the impact of poverty on living standards?	Access to exercise and therapeutic outside space is significantly improved in the new unit. The wider BCUHB MHLD transformation plan includes community hubs offering 24/7 support. The new development has an increased assessment area with access to fluids and nutrition and a place of safety.
Work When considering all children in Wales, the likelihood of being in relative income poverty is much greater, and the gap is increasing for those living in a workless household compared to living in a working household (where at least one of the adults was in work).	**In Practice** As one of the largest employers in Wales BCUHB provides numerous opportunities for people to access work, the Step into Work programme is a great example. Think about how careers support including apprenticeships and volunteer work placements can be promoted to support those who are furthest from the job market, those who are in households where no one is in employment, young people who are not in employment or training and other seldom-heard groups. Think about people in terms of their income and employment status, consider the impact on the availability and accessibility of work, paid and unpaid employment, wage levels, job security and working conditions. What are the implications of the proposal for people on low income, those who are economically inactive, unemployed, workless, and people who are unable to work due to ill-health. Consider people living in work poverty. During the pandemic lower earners are three times as likely to have lost their job or been furloughed as high earners.	Under the terms of the *NHS Building for Wales Framework* there are specific requirements which the appointed Supply Chain Partner will be committed to achieve and will be measured against on a quarterly basis. Proactive engagement with local schools, training and employment agencies, community groups and our supply chain to maximise added value. Opportunity to link with Bangor and Wrexham Universities to initiate collections allowing graduating students to donate any unwanted household items to community groups, low income families and charities in an attempt to reduce waste and fly tipping whilst supporting those in need of essential goods. Provide educational activities to local primary and secondary schools, colleges and universities e.g.: STEM engagement, world of work days, hoarding art work competition, mock interviews, masterclasses, work experience, site visits and dissertation support. The redevelopment will include jobs for local tradespeople and an apprenticeship. In reach and outreach form local schools will be part of the

	How can procurement and commissioning arrangements be optimised to reduce inequalities of outcome caused by socio-economic disadvantage? As part of your proposal what are the opportunities to increase employment opportunities for people who experience socio-economic disadvantage?	redevelopment as will prevention education provided by qualified practitioners. Volunteering opportunities for people with lived experience will be provided via the ICAN hubs in Conwy and Denbighshire. The addition of CAFÉ to the redevelopment will also provide volunteering and paid employment opportunities Welsh Government transformation monies is enabling the creation of new roles and jobs additional therapies and pharmacy posts for the unit.
Justice and personal security The National Survey for Wales (2018-19) shows that people who were not in material deprivation were found to be more likely to feel safe in their local area, compared with those who were in material deprivation. Research by the University of Bristol shows that, notwithstanding some significant methodological limitations, existing analyses in the UK and internationally have consistently found vulnerability to domestic violence and abuse to be associated with low income, economic strain, and benefit receipt. This association is underpinned by a complex set of relationships and interdependencies.	**In Practice** How does your proposal take account of local crime rates and exposure to crime? What are the hate crime statistics? Think about people who live in less safe areas and those more likely to be victims of domestic violence and abuse. Evidence suggests that domestic violence incidents are becoming more complex and serious, with higher levels of physical violence and coercive control. How can your proposal promote and protect people's rights and increase their access to justice and personal security?	The unit will have a s136 place of safety. All bedrooms are single ensuite which are lockable. Gender separation and flexible use of space is part of the design. There is mandatory training for all staff in relation to domestic abuse, safeguarding, MCA and POVA. The building will be secure inside and out and deploy the most up to date systems to maintain staff and patient safety. All patients who are detained under the Mental Health Act are informed of their rights on admission and of their rights to appeal. Advocates are present on the inpatient unit.

Participation The National Survey for Wales (NSW) shows that in 2018-19, 87% of households had access to the internet. Household internet access varies by WIMD levels of area deprivation. In 2018-19, 92% of households in the least deprived areas had internet access, compared to 83% of households in the most deprived areas. The NSW also shows households in social housing were less likely to have internet access (75% of such households) than those in private rented (90%) or owner occupied (89%) accommodation. Those in employment were more likely to have internet access at home (96%) than those who were unemployed (84%) or economically inactive (78%).	**In Practice** How is participation enabled, how is engagement sustained with people with lived experience of socio-economic disadvantage and how has this informed your proposal? Covid-19 has shone a spotlight on a digital divide and highlights the effects of digital exclusion on those in poverty, with some feeling isolated and forgotten about. Think about digital exclusion and digital poverty, people living in rural areas and those unable to access services and facilities. How can your proposal increase participation for people who experience socio-economic disadvantage?	CANIAD and CHC have a seat on the project board. The governance of the project has an ongoing communication strategy and a number of working groups that incudes staff and other stakeholders. The project team continue to attend CANIAD big chats ion person where covid restrictions enable. Local media and Facebook will continue to be a vehicle for enabling engagement as the project progresses. A range of sessions will be delivered over August / September to share the revised plans post engagement with the local community and a range of stakeholders as we undertook in phase 1.

What actions will you undertake to minimise any adverse impacts identified during this Socio Economic Duty Impact Assessment?			
Impacts Identified	**Mitigating Action to be Taken**	**Action Owner**	**Monitoring Arrangements**
Carers travelling further to YGC from Bryn Hesketh			
Staff travelling further from Bryn Hesketh			

STAGE 4: STRATEGIC DECISION MAKERS		
Who signed-off this SED Impact Assessment	**Signatory** As per the Health Board's Standing Orders, the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board', to Committees and others. These functions may be carried out by a prescribed Committee, sub-Committee or officer of the Health Board as per the Standing Orders Schedule 1, in accordance with their delegated limits. Strategic decisions must have appropriate sign off. If you are in any doubt as to the correct approving body for a strategic decision, please contact the Office of the Board Secretary.	
	Board or Sub Committee:	
Approval and Review	**Approval Date:**	
	Review Date:	

Type of Decision Includes but is not limited to:	**Equality Impact Assessment Required**	**Socio Economic Duty Impact Assessment Required**
Strategic policy development.Strategic directive and intent, including those developed at Regional Partnership Boards and Public Service Boards which impact on a public bodies functions	X	x
Health Board Wide Plans. Medium to long term plans (for example, corporate plans, development plans, service delivery and improvement plans)	x	x
Business Case / Capital Involvement / Options Appraisal required	x	x
Setting objectives (for example, well-being objectives, equality objectives, Welsh language strategy)		
Changes to and development of public services Closure of Services	x	x
Decisions affecting service users, employees or the wider community including (de)commissioning or revised services	x	x
Efficiency or saving proposals, e.g., resulting in a change in community facilities, activities, support or employment opportunities	x	x
Directorate Financial Planning	x	x
Divisional policies and procedures affecting staff	x	
New policies, procedures or practices that affect service delivery	x	
Large Scale Public Events	x	
Major procurement and commissioning decisions	x	x
Local implementation of National Strategy / Plans / Legislation (e.g. vaccination programme)	x	x

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT

PARTS A and B

SCREENING

Redevelopment of the Mental Health Inpatient Unit at Glan Clwyd Hospital

Reviewed July 2021

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A and B: SCREENING AND OUTCOME REPORT

Introduction:
These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

This is not optional: Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

The Forms:
You must complete:

- **Part A:** this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B**: this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown "due regard" to the duties.

You may also need to complete **Part C** (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

To enter text, click on the grey box in the part of the form you are completing. Help text will appear in the status bar at the foot of the page. Some boxes have drop-down lists from which you can select options. Others may simply be a box to answer a question. Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

Part A Form 1: Preparation

1.	What are you equality impact assessing? What is the title of the document you are writing or the service review you are undertaking?	Redevelopment of the Adult and Older Persons Mental Health Inpatient Unit at Glan Clwyd Hospital	
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Strategic outline Case is seeking funding form Welsh Government to redevelop the Mental Health Inpatient Unit in Ysbyty Glan Clwyd. The project has the following investment objectives: Our plan is set within the BCU strategic context and our refreshed well-being objectives are: ▪ To improve physical, emotional and mental health and well-being for all ▪ To target our resources to those with the greatest needs and reduce inequalities ▪ To work in partnership to support people – individuals, families, carers, communities - to achieve their own well-being ▪ To improve the safety and quality of all services ▪ To respect people and their dignity ▪ To listen to people and learn from their experiences	
3.	Who is responsible for the document /work you are assessing i.e.: who has the authority to agree /approve any changes you identify are necessary?	Project Board Chaired by Teresa Owen Executive Director	
4.	Who is Involved in undertaking this EqIA? Include the names of all the people in your sub-group.	**Name:**	**Title/Role:**
		Lea Marsden, Director of Transformation Keeley Twigg, Head of Planning, Mental Health Lisa Hughes, Capital and Systems Planning Manager Liz Williams, Specialist Information Analyst Dr Alberto Salmoiraghi, Medical Director Anita Pierce, Clinical Director, Central Area Sharmi Bhattacharyya, Clinical Lead OPMH Services Steve Forsyth, Director of Nursing Jill Timmins, Director of Operations and Service Delivery Ian Howard, Assistant Director - Strategic and Business Analysis Denise Charles, CANIAD (Service user carer rep) Tesni Hadwin, Conwy Local Authority Mike Smith, Interim Director Of Nursing	

5.	Is the Policy related to, or influenced by, other Policies/areas of work?	The Outline Business Case has been developed in the context of the new statutory duties under the Social Services and Well-being (Wales) Act 2014 (SSWB) and the Well-being of Future Generations (Wales) Act 2015. Both Acts came into force in April 2016 and have major implications for the Health Board and the way that we carry out our functions. The Health Board's system-wide strategy for health, well-being and healthcare, 'Living Healthier, Staying Well', was shaped by the national and local polices above. This strategy sets out the strategic vision for delivery of services in Primary and Community care, including Mental Health services, to support good healthcare for the medium to longer term. The Mental Health & Learning Disabilities (MHLD) Division have developed the Together for Mental Health in North Wales, this was developed and shaped by numerous policies, action plans and drivers: The plan has also been developed in the context of the wider legislative duties of the Health Board, national policy and guidance and local policy frameworks: ▪ Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 ▪ BCU Strategic Equality and Human Rights Plan 2016-2020 ▪ Special Measures Improvement Framework ▪ NHS Wales Planning Framework 2018/19 ▪ Together for Mental Health in North Wales (April 2017) ▪ Human Rights Act 1998 ▪ QIGP ~ Quality Improvement & Governance Plan We have also worked with colleagues in the Local Authorities and other partner organisations. Supporting Strategies and action plans: ▪ Area Planning for Substance Misuse & Mental Health ▪ Crisis Concordat ▪ Talk to Me 2 ▪ North Wales Learning Disabilities Partnership Integration Project ▪ MHLD 2017/2018 Operational Plan ▪ Mental Health Strategy ~ Together 4 Mental Health (T4MH) ▪ Integrated Winter Resilience Plan ▪ Interdependencies / Living Health & Staying Well ▪ BCU Quality Improvement Strategy ▪ Dementia Action Plan for Wales 2018-21
6.	Who are the key Stakeholders i.e who will be affected by your document or proposals?	A stakeholder analysis has been undertaken. In summary, the stakeholder groups are: ▪ People, their families, carers and communities ▪ BCUHB Staff ▪ The Health Board's statutory advisory forums: - The Stakeholder Reference Group - The Healthcare Professional Forum - The Local Partnership Forum

		- Community Health Council ▪ Partnership organisations including Local Authorities, third sector and existing networks ▪ Mid Wales Collaborative ▪ Public Health Wales ▪ Welsh Government ▪ Special interest groups in the area
7.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	The engagement of the staff of the Mental Health Division in responding to the redevelopment described and committing to the change required to fulfil this. Strong leadership, organisational, cultural and behavioural change will be required to deliver the transformation required. Ongoing communication, engagement and co-production with partners and stakeholders will be essential to the successful implementation of the priorities within the plan. A clear accountability structure for transformational change will be essential to ensure performance management and remedial action where needed. There are potential barriers to change which may hinder the plan. These may include: ▪ Lack of resource / capacity during the redevelopment ▪ Current pressures on the service leading to the inability to focus attention on the longer term changes required. ▪ Managing the environmental changes and demand on services with the least impact on patient care whilst the development is ongoing ▪ Funding constraints, both revenue and capital, which may hinder the pace of change.

Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:- Positive (+) Negative (-) Neutral (N) No Impact / Not Applicable (N/a)	Scale (see Table A on next page)	Please detail here, for each characteristic listed on the left:- (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or (3) any other information that has informed your assessment of Potential Impact.
Age	Positive	High	**Ageing Well: Dementia patients / Older Person Mental Health** The estimated 2016 mid-year population of people in North Wales aged 65 and over was nearly 157,000 and the population aged 85 and over was 20,289. By 2036 the older population will have experienced a greater percentage increase than Wales as a whole, with an increase of around 34% in those aged 65 and over and an increase of 23% in those aged 85 or over. About 1 in 4 people aged 85 or over are likely to have significant or complex needs. The local area has a relatively high proportion of people in this age group[1] and this is set to rise within the next decade. People aged 65 and over living in Denbighshire and Conwy – where the majority of service users reside make up a significant proportion of the population (20% in Denbighshire and 24% in Conwy[2]). The service model being proposed needs to understand and respond to a change in future demography.
Disability	Positive	Low	The design of the proposed redevelopment will ensure that requirements for accessibility from the Changing Places campaign in relation to toilets and public spaces are followed[3]. All toilet areas will have access to a fully accessible toilet. The building itself will be designed to comply with regulatory guidelines for public building and will be fully accessible and dementia-friendly throughout. Colour coding signage will be dementia friendly. The rooms within the ward will have en-suite facilities and DDA compliant. The UN Convention on the Rights of Disabled Persons is designed to promote and protect the human rights of disabled people and ensure full and equal enjoyment. The 8 principles of the convention are set the framework for the approach and the strategy programmes will seek to adopt the principles. Whilst article 25 relates specifically to health and healthcare, the Health Board has a broader responsibility in relation to the overall articles.

[1] **Public Health Wales Observatory (2013) GP Clusters Profiles: Betsi Cadwaladr University Health Board**
[2] **North Wales population assessment Draft 0.1 24 November 2016**
[3] **http//ww.changing-places.org/**

			Around 1 in 4 people will experience mental health issues each year; and around 13% of respondents in the Welsh Health Survey reported receiving treatment for mental health needs. The number of adults with a common mental health need in North Wales is expected to increase from around 93,000 in 2015 to 99,000 in 2035. This may increase due to risk factors such as unemployment, lower income, debt and stressful life events. It is recognised that there is a need for continued strengthening of strategic and operational/commissioning relationships with Local Authorities around meeting the needs of disabled people. Together for Mental Health in North Wales, a partnership approach to improving mental health and well-being for all agrees focusses on six broad outcomes through the promotion of health and well-being for everyone; prevention of mental ill-health and early intervention when needed; and delivery of joined-up and recovery-focused care.
Gender Reassignment	Positive	Medium	Data on gender reassignment is not routinely collected. The Gender Identity Research and Education Society estimates of the trans* community in the UK range from 65,000 to 300,000. This includes people who have transitioned to a new gender role via medical intervention, and the broader trans* community. We will make every attempt to provide a gender sensitive environment. The absence of official estimates makes it difficult to ascertain the level of discrimination, inequality or social exclusion faced by the trans community. **Is** Wales Fairer identifies there is still the need to eliminate violence, abuse and harassment against LGBT people. This is supported by Stonewalls new research, based on research with 871 trans and non-binary people by *YouGov*, it highlights the profound levels of discrimination and hate crime faced by trans people in Britain today. All inpatient wards will be en-suite therefore providing each patient with their own facility and will not be sharing a toilet/bathroom.
Pregnancy & Maternity	Positive	Low	The move to individual bedroom space would provide privacy for these patients. **Additional Evidence Considered:** ▪ Perinatal Mental Health Mental health problems affect more than one in ten women during pregnancy and the first year after childbirth, and can have a devastating impact on them and their families. Early detection and timely intervention can significantly reduce or prevent the lasting effects of perinatal mental health problems. Perinatal mental health problems are diverse and complex, present in a variety of health settings and are currently

			managed by many different services within BCU. National statistics show that the majority of women (over 90%) with perinatal mental health problems are treated in primary care. The remainder receive care from specialist mental health services. BCU has a dedicated perinatal services to support women. The specialist team has dedicated staff working across North Wales including: ▪ Community Psychiatric Nurses ▪ Occupational Therapists ▪ Specialist Midwife (Linking into Specialist Midwife for Substance Misuse Services) ▪ Nursery Nurses / Project Workers ▪ Administrative Support
Race / Ethnicity	Neutral	-	We recognise that, within this characteristic, there needs careful assessment and appropriate mitigating actions for any detailed project where negative impacts are identified.
Religion or Belief	Positive	Low	The move to individual bedroom space would provide privacy for patients to practice their religion if they so with.
Sex	Positive	Low	Improved separation of facilities
Sexual Orientation	Positive	Low	The 2015 Annual population survey found that 1.7% of the UK population identified themselves as lesbian, gay or bisexual, with Wales having a lower percentage than the UK overall. The population aged 16 to 24 years is the age group with the largest percentage identifying themselves as LGB. Government figures estimate 6% of the population is lesbian, gay or bisexual. National reports highlight the barriers experienced by Lesbian, Gay and Bisexual (LGB) people accessing and using services. Each inpatient will have access to their own room which will have an en-suite facility.
Welsh Language	Positive	Low	All signage will be bilingual and every service user will have the opportunity to speak with a Welsh speaker, in line with BCU policy.
Human Rights	Positive	Medium	The individual bedrooms will facilitate maintaining the dignity and privacy of our service users. A crucial change will be the development of a person-centred approach to working with service users which facilitates the independence, strengths and assets of the individual. Each person accessing our services will have a strong voice and sense of control in determining their health and well-being outcomes and how these can best be met, not just through hospital intervention, but through accessing a range of community services and maximising the assets already at their disposal. Pathways will be clearly explained and accessible.

Summary of Impact

	Positive	**Negative**	**Neutral**
Number	**9**	**0**	**1**

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use the table below to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

Table A

High negative	Note: It is important to understand that we will be required to demonstrate what we have considered and/or done in order to mitigate or eliminate any negative impact on protected groups identified within the assessment. Details should be recorded in sections 3a/3b in the Action Plan in Form 4.
Medium negative	
Low negative	
Neutral	
Low positive	
Medium positive	
High positive	
No impact/Not applicable	

Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the "General Duty". This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to: ▪ Eliminate unlawful discrimination, harassment and victimisation; ▪ Advance equality of opportunity; and ▪ Foster good relations between different groups	
1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise	There are no aspects of the proposed changes which discriminate, harass or victimise unlawfully.
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	Removing physical barriers including the provision of gender-neutral toilets, will help to advance equality of opportunity.
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Not applicable

Part B:
Form 4 (i): Outcome Report

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD

1. What is being assessed?	Mental Health Services and Ablett Redevelopment

2. Brief Aims and Objectives:	The remit of the Project is to: ▪ To provide services that are both clinically effective and safe, and allow for the provision of individualised therapeutic care ▪ To ensure compliance with the requirements for gender separation within inpatient facilities and ensure patient dignity, privacy and safety is maintained at all time through 100% single ensuite rooms up to modern standards ▪ To provide appropriate space whereby the solution will meet the national guidance for the best practice in the delivery of acute mental health inpatient facilities ▪ Develop the flexibility to respond to future need whereby the solution will need be designed to respond to any changes in service delivery that may be required as a result of the strategic review of acute services ▪ To provide a centre of excellence in patient care ▪ To support/facilitate appropriate adjacencies/integration with other services through the building design ▪ To provide services which meet the strategic direction outlined within Together for Mental Health in North Wales and the delivery of the model of care developed through the Quality & Workforce groups ▪ To provide an environment that supports staff to deliver safe, effective care to patients, carers and families

3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes	No √
3b. Could any of the protected groups be negatively affected?	Yes	No √
3c. Is your decision or policy of high significance – consider the scale and potential impact across BCUHB including costs/savings, the numbers of people affected and any other factors?	Yes √	No

4. Did the assessment of potential impact on Form 2, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No √	
	Yes ☐	No	**Not applicable** ☒

5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Yes √	No ☐
	How is it being monitored?	Sub committees of the Board along with the Capital Programme Team
	Who is responsible?	Teresa Owen Executive Director
	What information is being used?	National benchmarking and bed and capacity modelling
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	The EqIA will be subject to ongoing review and further supporting EqIA work as detailed proposals are developed for the priority areas. The overall EqIA will be reviewed as the project progresses

7. Where will your decision or policy be forwarded for approval?	F&P Committee and BCU Health Board

8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	**Engagement events**: Since 2015, we have conducted a wide range of engagement exercises, to ensure that the views of a wide range of people inform and influence our thinking. In October 2016 CANIAD which is a local service user-led organisation who supports people who want to have their voices heard, influence decisions and help shape the services they use, participated in five open events for adult service users across North Wales. 153 people attended the workshop events or gave one to one feedback, and 71 people responded to an on-line survey issued as part of the same process. Across the patient journey, the CANIAD engagement process reported there was a strong view that both the physical and therapeutic environment of hospital wards needed to be improved. Many people spoke about there being a lack of privacy on the ward, and that some psychiatric wards felt more like a prison than a hospital. Many people also spoke about a lack of meaningful activities, having nothing to do, and feeling bored.

	A Patient Flow Programme was also undertaken in response to a number of challenges such as the Division being placed in Special Measures. A Rapid Improvement Event was held on the 17th March 2016 attended by members from across Older People and Adult Services from all functions and professional groups with one of the outcomes being that people need to be treated and cared for in a safe environment and protected from avoidable harm. Further a multi-agency mental health summit was held in January 2017, to stimulate and draw together leaders of a wide range of local agencies.

	Name	Title/Role
9. Name / role of person responsible for this Impact Assessment	Ian Wilkie	Director of Mental Health and Learning Disabilities
10. Name/ role of person approving this Impact Assessment	Ian Wilkie	Director of Mental Health and Learning Disabilities
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Form 4 (ii): Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Not applicable		
2. What changes are you proposing to make (or have already made) to your document or proposal as a result of the EqIA?	Not applicable		
3a. Where negative impact(s) on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	Overall positive impact		
3b. Where negative impact(s) on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	Not applicable		

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Not applicable		

NOTE: If your decision recorded above is that you will need to proceed to a Full Equality Impact Assessment, then you should refer to the Full Impact Assessment Forms (Part C)

Note: For detailed guidance on the completion of these forms, please refer to Chapter 3 of the Toolkit that is available on the Equality pages of the BCUHB Intranet site.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**North Wales Endoscopy Service** **Insourcing of Endoscopy Services**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Adrian Thomas - Executive Director of Therapies and Health Science Clive Walsh – Director of Regional Delivery
Awdur yr Adroddiad **Report Author:**	Ian Donnelly – Acute Care Director Wrexham Helen O'Connell – Endoscopy Network Manager (Interim)
Craffu blaenorol: **Prior Scrutiny:**	Executive Team
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

Finance and Performance Committee is asked to approve funding to continue insourcing of Endoscopy Services across the 3 hospital sites for 4 months from August to December 2021 to maintain capacity, address increasing demand, reduce the backlog and ensure safe clinical services for patients.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	√	**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The North Wales Endoscopy Project has a business case to build a sustainable service and workforce to meet the increasing demand and backlog from both COVID and pre-COVID times. BCUHB have the longest waiting lists for endoscopy nationally and the Bowel Screening Wales service has the longest waiting times to first appointment across Wales. This is a significant risk to the HB and as a result there is a clinical decision to reduce significantly or eliminate the backlog in 2021/22. As we are now in Quarter 2 of 2021/22, this paper requests continued funding of insourcing to maintain capacity as we address the challenges of substantive recruitment and procurement.

Cefndir / Background:

The North Wales Endoscopy business case has been developed and is in the process of approval which includes the elements being requested in this paper. It is a complex case and has been delayed longer than anticipated and this paper is submitted to approve aspects of the case required to maintain activity and support the project implementation. The project is also fully supported by the National Endoscopy Programme.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

Insourcing has helped to mitigate some long waiting times that have resulted from a historical backlog pre-COVID and the further impacts of COVID. Insourcing has provided a substantial increase to current capacity and needs to continue while the alternative actions of increased procedure rooms and a sustainable workforce are taken forwards.

Urgent cancer waits have reduced and insourcing has also provided additional capacity for urgent treatments to be undertaken. The significant backlog, in addition to urgent cancer referrals, includes patients on routine and urgent Referral to Treatment (RTT) pathways and surveillance patients. The incidence of cancer in the endoscopy waiting lists is 1.9%, 4% and 10%, translating to 34, 114 and 33 patients respectively having a delayed cancer diagnosis. The longer these patients wait the worse their health outcome will be.

Insourcing is providing a further 33% increase in capacity, and is an integral part of the recovery plans.

Opsiynau a ystyriwyd / Options considered

The option of doing nothing in this case risks increasing the waiting lists for patients and increases potential harm.

Goblygiadau Ariannol / Financial Implications

BCU has been granted a national allocation of £8.2M for 2021/2022 to address the backlog and the shortfall in capacity. The table below shows expenditure to date against the allocation of £882K.

Expenditure	YGC C897	YG C547	WXM T612	Corporate	April to June 2021
Insourcing Contracts	£229,872	£357,234	£124,632		**£711,738**
Insourcing Drugs/Consumables/Nursing support	£45,268	£17,835	£69,786		**£132,889**
Interim Manager Costs				£37,723	**£37,723**
	£275,140	**£375,069**	**£194,418**	**£37,723**	**£882,350**

Insourcing for the next 4 months to December 2021 is requested to allow the business case to proceed through the approval process. The table below demonstrates the lists covered and costs for insourcing for 2 months. For the increased period, the request is for 4 months and therefore is £2.086452M.

Cost per session		No of sessions/weekend			No of sessions/weekday			Cost (000)		
Weekend	Weekday	East	West	Central	East	West	Central	Weekend	weekday	Total
2,857	2,449	12	12	8	10	0	0	£822,816	£220,410	£1,043,226

Dadansoddiad Risk / Risk Analysis

The Endoscopy business case is complex and has both long and short plans for reducing the backlog and building the capacity to cope with demand.

Lack of capacity in the service is mitigated by insourcing as further longer term solutions are implemented.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Asesiad Effaith / Impact Assessment

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Financial Procedure F02 - Lease Car Policy and Procedure**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tom Stanford, Interim Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	Financial Procedure F02 – Lease Car Policy and Procedure has been updated following consultation. The procedure has been scrutinised and approved by the following groups: • Finance Department Senior Management Team; • NHS Wales Shared Services; • Local Counter Fraud Services; • BCUHB Workforce Policies and Procedure Group The procedure was subject to a two week consultation period on the Health Board's intranet site between 31st May and 11th June 2021, which was open to all members of staff. It was also included on the Weekly Bulletin each week during that period. The relatively short consultation period was agreed as it is already an established policy and procedure with only minor changes. Once approved by Committee, the policy will be formally implemented and communicated through the Weekly Bulletin, updated on the intranet and internet but also published on the BCUHB microsite maintained by the Fleet Management company. A dedicated mailbox is also in place for any additional questions or queries.
Atodiadau **Appendices:**	Appendix 1: Financial Procedure F02 - Lease Car Policy and Procedure Appendix 2: Equality Impact Assessment Form Appendix 3: Policy Checklist

Argymhelliad / Recommendation:
The Finance and Performance Committee is asked to approve the updated version of Financial Procedure F02 – Lease Car Policy and Procedure.

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad/cymeradwyaeth **For Decision/**	✓	**Ar gyfer Trafodaeth**		**Ar gyfer sicrwydd**		**Er gwybodaeth**	

Approval		For Discussion		For Assurance		For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**						**Y**	

Equality Impact (EqIA) assessments applicable as per Appendix 2.

Sefyllfa / Situation:

Financial Procedure F02 – Lease Car Policy and Procedure provide guidance on the Health Board's arrangements for the provision of lease cars to eligible staff and budget managers.

The updated policy and procedure is to designed to:

- Clarify for managers and staff the eligibility for a lease car, the process of application and roles and responsibilities;
- Provide fair and equal access to all staff eligible for the scheme;
- Provide clarity on the financial implications in order to provide an economical, efficient and effective scheme;
- Create a policy that reduces the environmental impact of its carbon footprint, by encouraging the selection of cleaner and more fuel-efficient vehicles.

Cefndir / Background:

Financial Procedure F02 – Lease Car Policy and Procedure has recently been updated by the Finance Department and in accordance with OBS1 – Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents and now requires approval by the Finance and Performance Committee.

Financial Procedure F02 – Lease Car Policy promotes a fair and transparent process that will allow health board employees access to a reliable means of transport that will enable the efficient delivery of services via the Lease Car Scheme. This scheme is open to all employees with a permanent or fixed term (more than 3 years) contract of employment and is available to all such employees whether they do business travel or not.

The revised financial policy and procedure has been subject to consultation and approval as detailed in the "Prior Scrutiny" section above.

A number of comments were received from Counter Fraud, employees and members of the Workforce Policies and Procedure Group (that includes union representation). There were 7 comments received in total, which were considered and incorporated within the revised policy and procedure. An Equality Impact Assessment Form (Appendix 2) has been completed and changes included within the new procedure detailed in Part 4 page 12.

The key changes from the previous version of this financial policy and procedure are as follows:

- The policy and procedure included a mitigation that will review all applications to ensure that the reduction to an employees' salary through salary sacrifice must not take them within 3% per annum of the national minimum wage or below the National Insurance lower earnings limit for national insurance contributions.
- Clarity with the health board's requirement to be compliant with HMRC guidance regarding the early termination of the salary sacrifice lease car.
- Additional narrative on the HMRC fuel rate being applicable and the inclusion of the CO2 incentives.

It will offer the Health Board a means to work towards achieving the goal of becoming carbon neutral before 2030 by offering employees a green incentive to encourage the uptake of electric and low emission cars that may not be otherwise affordable to them.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications
The Lease Car Policy and Procedure support the strategic objective to reduce carbon emissions.

Opsiynau a ystyriwyd / Options considered
Not applicable.

Oblygiadau Ariannol / Financial Implications
See Appendix 1.

Dadansoddiad Risk / Risk Analysis
Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Compliance with the NHS Terms and Conditions.

Asesiad Effaith / Impact Assessment
An Equality Impact Assessment Form (Appendix 2) has been completed as part of the process to update this procedure and changes included made will have a positive impact on protected groups listed in the Equality Act 2010 and on employees human rights.

Version: 0.3 FO2

FO2 - Lease Car Policy and Procedure

Author & Title	Financial Services				
Responsible Dept / director:	Executive Director of Finance				
Approved by:	Finance and Performance Committee				
Date approved:					
Date activated (live):					
Documents to be read alongside this document:	NHS Wales Travel and Subsistence Policy (DRAFT) Agenda for Change – Section 17 Agenda for Change – Annex 12 Driver Pack F03 – Anti – Fraud, Bribery and Corruption Policy OBS02 – Standards of Business Conduct Policy WP 6 – Code of Conduct (Disciplinary Rules and Standards of Behaviour) Policy				
Date of next review:					
Date EqIA completed:	July 2021				
First operational:	September 2010				
Previously reviewed:	**Nov 2016**	**Jan 19**	**July 21**		
Changes made yes/no:	**Yes**	**Yes**	**Yes**		

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Contents

1. Introduction

Betsi Cadwaladr University Health Board recognises the importance for employees to have access to a reliable means of transport that enable the efficient delivery of services.

The Health Board therefore facilitates and supports the provision of a lease car scheme for all permanent and fixed term (more than 3 years) employees. The Health Board wishes to be clear that whereas it facilitates the provision of a lease car scheme, the primary risk and costs associated with using a lease car as set out in this policy, remain the responsibility of the employee when entering into a Lease Car Agreement.

In addition, this policy is available to all permanent and fixed term (more than 3 years) employees who do no business mileage yet wish to take advantage of the Lease Car Scheme or the Salary Sacrifice Scheme.

2. Policy Statement

The Heath Board is committed to providing clear and concise principles to all employees on leasing a new vehicle.

The Health Board is required to ensure that the Corporate Governance arrangements which it has in place are strengthened with a view to preventing Fraud, Bribery and Corruption occurring.

The Health Board is also required under Section 7 of the Bribery Act 2010 to take reasonable and necessary steps to ensure that the Corporate Governance arrangements which it has in place are sufficient, to prevent Bribery from occurring as a result of its Policies and Procedures.

3. Purpose

This document seeks to provide guidance on the Health Board's arrangements for the provision of lease cars to eligible employees and budget managers and is intended as general guidance on the practical application of the transactions.

Participants will be required to enter into a binding agreement with the Health Board for the duration of the lease under the conditions set out in the scheme rules - Terms and Conditions of Use.

Participants will be responsible for the full cost of the vehicle including excess damage and excess mileage during the contract, any recharges not included in the contract, fines and fixed penalty notices.

The Health Board seeks to be carbon neutral before 2030 and to achieve this, employees will be actively encouraged to choose cars below 120 g/km. The Health Board contribution will include a carbon levy which will increase for high emission cars. Electric and low emission cars will qualify for a green incentive to encourage uptake. The levy and incentive is set out at Annex A.

The charge for the car will be dependent on the specification of the vehicle they have selected as well as the number of business and private miles undertaken.

- **Salary Deduction** - The Health Board provides a car scheme that allows its employees to lease a brand new vehicle that can be used for private or private/business miles. Employees who use the salary deduction lease car for business are entitled to a contribution from the Health Board that reduces the monthly payments. This is based on the business miles you travel and the contribution is capped at 10,000 miles.

- **Salary Sacrifice** - The Health Board also provides a benefit and recruitment scheme under which a car is provided as a gross sacrifice through the employee's pay. Any reduction to an employees' salary through salary sacrifice must not take them within 3% per annum of the national minimum wage or below the National Insurance lower earnings limit for national insurance contributions.

  Salary sacrifice could have an impact on pensions, maternity or adoption pay and mortgages or any other credit application that is based on an employee's basic pay, and employees should consider this when applying.

- **Pool Vehicle –** The Health Board provides business use only pool vehicles that are shared by employees for business purposes, and are normally kept on the premises overnight.

An employee using their own vehicle to perform business miles is known as 'grey fleet' and are included in this policy.

4. Objectives

The objectives of the policy are:

- To clarify for managers and employees the eligibility for a lease car, the process of application and roles and responsibilities;
- To provide fair and equal access to all employees eligible for the scheme;
- To provide clarity on the financial implications in order to provide an economical, efficient and effective scheme;
- To create a policy that reduces the environmental impact of its carbon footprint, by encouraging the selection of cleaner and more fuel-efficient vehicles.

5. Scope

- All employees with permanent and fixed term employment contracts (fixed term past the end of the lease term) will be eligible to join the Lease Car Scheme (includes employees who do not undertake any business miles).

- Employees who use a salary deduction lease car for business are entitled to a contribution from the Health Board that reduces the monthly payments. This is based on the business miles you travel.
- Employees who undertake no business mileage, are eligible to take advantage of the Lease Car Scheme, although no Health Board contribution will be payable.
- Eligible employees may join the scheme at any time but cannot opt out during the lease period without reimbursing any early termination charges incurred by the Health Board.
- As part of the application the number of business miles will need to be evidenced based on actual mileage undertaken either by the individual, previous post holder or post holders undertaking similar roles.
- Employees must be legally valid to drive i.e. hold a full UK Driving Licence (or equivalent as determined by the Driver and Vehicle Licensing Agency (DVLA)). Employees holding a provisional licence or those disqualified from driving will not be eligible to apply for a car.
- The Health Board approves each lease car application and reserves the right to decline any application taking account of the eligibility criteria and any other related circumstances.

6. Roles and Responsibilities

Responsibility of the Health Board

The responsibility for the provision the Lease Car Policy rests with the Health Board.

The Health Board will ensure that:

- A fully automated quotation, application and authorisation system is in place to facilitate an efficient and robust process for ordering a lease car.
- The Policy is implemented through the Health Board's line management structure.
- All employees are made aware of their personal responsibilities under the policy.
- All employees are informed about the policy.
- Policy provisions comply with law.

Responsibility of the Finance Department

- All mileage and appropriate authorisation for the application process will be checked and verified.
- Manage the contract with the Fleet Management Company, reviewing KPIs and dealing with those queries outside of the agreement.
- To provide ongoing support in the application of the Policy in individual cases and for all managers.
- To ensure the Policy is continually developed and updated.

Managerial Responsibility

- To ensure that employees are made aware of this policy and take a pro-active approach in promoting the lease car scheme.
- To ensure that the application in is line with verifiable business mileage.
- To ensure that efficient use of technology such as virtual meetings and other alternatives to travel are considered before approving the application of a pool car.

Employee's Responsibilities

- Inspect the vehicle on delivery/collection and check that it is a condition that would be expected for a new vehicle.
- Throughout the period of the Agreement report promptly to the Fleet Management Company, and if necessary in writing, any defects or symptoms of defects which are not rectified in the course of routine services.
- Ensure that routine servicing and maintenance are carried out within the agreed intervals recommended by the manufacturer. Failure to comply with these requirements may result in a void warranty/lease agreement.
- Permit persons authorised by the Health Board and the Leasing Company to inspect the vehicle at any reasonable time.
- Not modify or alter the vehicle or remove any parts from it, nor change any of the identification marks or numbers without proper consent in writing from the Leasing Company.
- At all times keep the vehicle parked in a way which minimises the risk of theft or damage.
- Keep the vehicle clean and as per manufacturer's recommendation check and maintain the oil, water, battery and brake fluid levels, bulbs etc. as well as tyre pressures and tyre conditions.
- Take all responsible precautions against frost damage and ensure that antifreeze in the engine coolant system is of adequate strength.
- Pay any costs arising from mechanical damage due to the employee's negligence.
- Not use the leased vehicle for hire, racing, pace making, trials, rallies, or any other form of competitive sport.
- Pay for all fuel, oil, bulbs and other fluids required for maintaining correct levels between servicing.
- Pay the cost of any repairs in respect of damage incurred during use of the vehicle and not met by the Insurers or the Leasing Company under the Group Hire Agreement.
- Employees must inform the Health Board of all penalty points or other motoring offences that may affect the driver's ability to drive the vehicle. In the event of being disqualified from driving, notify the Health Board and make arrangements for the contracted vehicle to be returned to the Health Board within 24 Hours. The employee (where appropriate) will be responsible for any resulting early termination charges involved.
- Notify the Fleet management company of any change of address or telephone number, both at work and at home. (The change of address on your driving

licence should also be notified to the DVLA within seven days of such a move).

- The employee shall not smoke or permit smoking by others in the lease vehicle.
- Pay any insurance excess in the event of a claim.
- Pay any termination costs.
- Pay for any excess mileage charges as per the Leasing Company *(if you travel more than your contracted miles).*
  a) If the leaseholder has travelled more business miles than contracted, then the Health Board will pick up the excess charges.
  b) If the leaseholder has travelled more private miles than contracted, then the lease car driver will pick up the excess charge.
  c) A combination of a) and b) will result in a split charge to both the Health Board and leaseholder the Health Board paying for the excess business miles travelled and the lease holder being billed for the private miles travelled.
- Pay any penalty fines (speeding, parking, etc.) plus associated Administrative Fees.
- Pay for the repair of tyres due to punctures. Damage caused by accidents or running over debris will be classed as accident damage and subject to insurance excess.

7. Procedure

The standard term for the lease car agreement is 36 months. There is a number of advantages of a lease car. These include a fixed payment every month that covers:

- No deposit or credit check
- Cost of the vehicle
- Road Tax
- Fully comprehensive insurance
- Servicing
- Tyres
- Roadside Assistance/ Recovery
- No risk on the sale price of the vehicle

It should be noted if the vehicle is taken abroad maintenance is not covered. The employee will be responsible for any accidental damage, including tyres, resulting from the misuse or neglect of the vehicle.

Lease Car Payment

Salary Deduction - Employees will pay for the lease car monthly out of their net pay. The Benefit in Kind (BIK) tax will be processed monthly through payroll and detailed in your payslip. The costs of which are detailed upon the automated quotation document supplied to the employee prior to agreeing to a lease.

Salary Sacrifice – Employees will sacrifice the value of the lease car monthly payment from their gross pay reducing income tax, national insurance and

pension contributions. The BIK will be processed monthly through payroll and detailed in your payslip. The costs of which are detailed upon the automated quotation document supplied to the employee prior to agreeing to a lease.

Salary Sacrifice could have an impact on pensions, maternity or adoption pay and mortgages or any other credit application that is based on an employee's basic pay, and employees should consider this when applying.

In addition, the Health Board reserves the right to invoice the employee for any costs associated with the employee whilst using their lease car i.e. Parking, Speeding, Insurance Excess etc.

Benefit in Kind

HM Revenue & Customs regards the provision of a lease car as a "benefit in kind" and therefore it is taxable as income.

Users of lease cars are liable for income tax on the taxable benefit value of private use on their car, and any excess pence per mile for fuel reimbursement. Taxable benefits depend upon the list price of the vehicle and CO^2 emissions value. In the case of a salary deduction the private monthly contributions is subtracted to give the residual taxable benefit in kind.

The information can be found on the H M Revenue & Customs (HMRC) web site. https://www.gov.uk/calculate-tax-on-company-cars

Note that travel to and from your normal place of work is classed as private use by HMRC.

Maintenance, Servicing & Mechanical Failures

Employees are responsible for ensuring that servicing is carried out in accordance with the manufacturer's requirements. You may take the vehicle to be serviced at any main dealer for the vehicle or other independent dealers as approved by the leasing company.

Most garages will provide a courtesy car/collection and pick up service, if you use the service booking line or give the garage enough notice. Any courtesy cars will need to be insured on the Health Board insurance policy and may require you to show a copy of the insurance certificate. Please ensure that cars are booked into garages well in advance and a courtesy car booked. The Health Board will not pay for hire cars during routine servicing if courtesy cars are not available.

Occasionally cars do suffer mechanical failures. If this is the case, please have the car recovered to the nearest main dealer. Where possible, attempt to secure a courtesy car whilst the vehicle is being looked at. If required, each car is covered by Breakdown Recovery for which contact details will be provided within the drivers pack.

The employee is responsible for maintaining the vehicle in accordance with the manufacturer's recommendations. This includes:-

- Tyre Pressures;
- Oil, Coolant, Brake Fluid and Windscreen Washer levels;
- Visual inspection of lights, windscreens and bodywork.

Insurance

All leased vehicles are covered by the BCUHB Fleet Motor Insurance policy as part of the lease contract.

In the case of an accident the driver will pay the policy excess if the incident occurred during private use, the excess will be deducted from the employee's salary. If it can be proved that the driver was not at fault and recovery of the costs from the third party is possible, the excess will be refunded as a net payment through the employee's salary.

If the incident occurred whilst undertaking work travel in the lease car the employee will not be liable for the excess, provided that their budget holder agrees and signs a payment authorisation form.

Any costs incurred by misuse including the incorrect use of fuel appropriate to the vehicle, will be charged in full to the employee. Such costs are not covered by the insurance policy and employees should take care to ensure that the correct fuel is used at all times. Any costs that are incurred will be deducted directly from the employee's salary.

Additional Drivers

Under the scheme an employee can add additional drivers to their contract at any time during the contract period. Any person can drive with the permission of the policy holder (the Health Board) but primarily the employee and one named driver will be free of charge. Any other person, up to the maximum of four people, can be added subject to agreement and an additional cost may be incurred depending on the age of the driver as per the Health Board's Insurance Policy.

The excess may increase from £250 depending on the age of the driver.

Use of the lease vehicle abroad

Use of the lease vehicle abroad is permitted, subject to prior written application from the fleet management company. However, maintenance costs are not covered when the vehicle is abroad, and it is the employee's responsibility to make special arrangements to cover this period. Employees will be advised of the maintenance requirement when written permission is given depending on the country of travel. You must contact the fleet management company 10 days before departure to obtain a proof of ownership certificate and insurance green card.

Mileage Claims

Mileage reimbursement will be made as per the current HMRC Fuel Rate and in accordance with the procedures outlined within the “Travel & Subsistence Allowances Policy and Procedures” document.

Claims should be submitted routinely as follows:

- Claims must be submitted on a monthly basis. If claims are submitted more than 3 months late, the Health Board reserves the right to refuse payment.

Parking Fines and Penalties

The employee remains fully responsible for any fines or penalties incurred during use of the vehicle. Any payment which becomes due will be met by the employee in all cases and may be deducted from their salary.

Termination

The Agreement will terminate immediately if:

- The Agreement between the Health Board and the Leasing Company relating to the letting of the Vehicle to the Health Board by the Leasing Company terminates;
- The Vehicle is damaged beyond economic repair or is stolen and not recoverable (in accordance with the Insurance Company confirmation);
- The employees employment with the Health Board expires or terminates (including retirement or voluntary termination), if Retire & Return the lease contract will be reviewed on a case by case basis;
- The employee becomes disqualified from holding or for any reason ceases to hold a valid UK driving licence;
- Death of the employee;
- The employee commits an act of bankruptcy.

The Health Board may give notice to the employee to terminate the agreement at any time including, but not limited to, after the occurrence of the following:

- Breach by the employee of the terms of the Agreement of these conditions or terms of Employment;
- Wilful neglect and/or reckless caretaking of vehicle;
- Absence from normal duties for an unreasonable period (i.e. long term sick, long term training, etc.) This will be discussed and agreed on an individual basis;
- When the employee’s contributions cannot be recovered from their salary;
- Any other exceptional circumstances not provided for above.

On termination the employee is responsible for the early termination (and any associated costs) and should contact the fleet management company.

Early Termination

Under a salary sacrifice arrangement employees are required to complete the full term of the agreement. HMRC will allow opting in or out in the event of lifestyle changes that significantly alters an employee's financial circumstances. HMRC Salary Sacrifice

Employees considering termination of the agreement must contact the fleet management company to discuss the resulting financial implications. It should be noted that employees are unable to order a new lease car within a 3 month period of the contract termination date.

On early termination of the lease car contract, payment is required to be made to the leasing company. The amount of the payment will vary depending on how far into the contract the employee is when it is terminated. Early termination charges are detailed within individual lease agreements and the cost will be passed on to the employee.

In the event of the employee's death in service, or on early termination of the employee's contract on the grounds of ill health redundancy or OCP (Excess Mileage), there shall be no financial penalty to the employee or their estate in the case of early termination of their lease car agreement.

Transfers to other organisations – in the event that a service or individual transfers to another organisation under a TUPE arrangement and the new organisation decline the transfer of the vehicle the employee will not be liable for an early termination penalty.

In all other cases of early termination, the employee will be required to reimburse the Health Board for any payment due because of the early termination of the contract for hire.

Once the employee has terminated their lease car agreement they must return the car and pay any outstanding contribution for private use within the current contract year. Employees will be given the opportunity to purchase the car on termination.

End of Lease/Return of Vehicles

The employee's right to use the vehicle will cease at the expiration of the period of the lease agreement unless an agreed extension has been arranged with the Health Board. The following procedures apply:

- If the employee wishes to continue his/her participation in the Scheme (and the Scheme continues to be in existence), the User will submit a new application.

- If there is to be no further Agreement, the Vehicle must be returned in accordance with the Leasing Companies instructions.

- In certain circumstances an extension to the maximum of 12 months may be possible with agreement with the leasing company and the Health Board.

At the end of the contract, all vehicles must be returned in a clean state and in line with British Vehicle Rental & Leasing Association (BVRLA) guidelines. An inspection will need to be carried out in the final month of the contract.

The employee is liable for any charges for excess private mileage. Any mileage not declared on the Expenses system during the term of the lease agreement will be considered as private use. Claims against the Health Board insurance fleet policy cannot be made once the vehicle has been returned to the leasing company.

Please note the state of the vehicle will be inspected by representatives of the leasing company.

If an existing lease car owner has decided to terminate their lease early, the Health Board could offer this vehicle to other eligible employees for the remaining period of the lease agreement. If accepted, the transfer will include the following (not an exhaustive list):-

- Previous employee will accept any excess mileage charges at the point of transfer;
- Lease will be adjusted based on the new employees' mileage;
- New employee will take on full responsibility for the vehicle as outlined in this policy;
- Vehicle will need to be transferred in the same condition as if being returned to the lease company and the employee transferring the car will be responsible for any associated costs;
- End of contract damage charge.

Absences from work

If the employee chooses to return the car there will be a financial penalty, on account of early termination of the contract and the employee will be liable for this charge.

If an employee is absent from work on sick leave, maternity leave or other authorised long term absence they may continue to use their lease car privately.

If the employee chooses to keep the car for the duration of their absence from work the payment will continue through deductions from pay. If they go into a period of no pay they must continue to make the payment directly to the Health Board. Employees should also consider where a change in work circumstances may impact their income and ability to continue to pay ongoing payments (for example, sickness, maternity leave or reduced hours).

Electrical charging points

Both electric and Hybrid cars can be leased through either of the lease car schemes. However, the Health Board does not have any electrical charging points across any of its sites and has no legal responsibility to install either free of charge or pay as you go electrical charging points on hospital grounds for either employees, patients or public.

Employees should be aware that unauthorised charging of electric vehicles using a Health Board power supply could not only be a potential safety risk but could also be considered gross misconduct.

Pool Vehicles

Pool vehicles are lease vehicles which are acquired by the health board for business use only.

The car is not ordinarily allowed to be taken home or used for any private use as this would contravene HMRC Use Of Company Pooled Car Rules .

Any unauthorised use of pool vehicles for private use, at any time without the express permission of the Line Manager may be seen as a disciplinary offence and employees may face disciplinary action.

The rental charges for the use of the lease vehicle will be based on the type of vehicle and the total estimated annual vehicle mileage. It is important to calculate mileage estimates as accurately as possible as the viability of a pool vehicles has been calculated at 10,000 miles per annum. If a department need a pool car and travel less than this they need to put together a valid business case.

To qualify as a pooled car all of the following conditions must be satisfied:

- Used by more than one employee;
- Not ordinarily used by one employee to the exclusion of others;
- Not normally kept at or near employees' homes;
- Used only for business journeys – private use is only permitted if it is merely incidental to a business journey (for example, commuting home with the car to allow an early start to a business journey the next morning).

Applications for pool vehicles shall be made by the relevant budget holder and approved by the relevant Head of Service.

Each pool vehicle will be managed by a 'Responsible Officer' within the relevant department, who will ensure that each vehicle under their control will be checked and maintained in line with the criteria as set out in this policy.

Pool vehicles may only be driven by organisation's authorised employees holding a full current UK Driving Licence (or acceptable equivalent valid in the UK) for that type of vehicle and not those holding a provisional licence or those

disqualified from driving, only authorised passengers may be carried in pool vehicles. A driver record form needs to be completed as per below:

- For an employee to drive a pool car they must complete a driver record form;
- Show their original driving licence to their line manager;
- Copy of driver record form is shared with the BCU Lease Car department;
- Original form is put in their employee file by their line manager.

Where involved in a road traffic accident the employee should ensure that he/she obtains full particulars from the other party/parties involved. Where possible they should obtain the name and address of any witness and the name and number of any police officer who attends. At no time should responsibility be admitted nor any negotiations be entered into regarding the accident. The employee should immediately notify the Responsible Officer who will report the accident using the Accident reporting link and provide any information required by the leasing company or the insurer, following their instructions with regard to repair.

All costs of the lease and running costs are met by the organisation. Fuel cards will be issued for each lease vehicle and shall be used for the purchase of fuel for that lease vehicle only. Any misuse of the card may be seen as gross misconduct and will be dealt with appropriately under the Disciplinary Policy and may also be referred to the Local Counter Fraud Specialist for a criminal investigation to be carried out, if considered appropriate.

Fuel cards and Personal Identification Numbers (PIN) for the pool vehicle fuel cards must not be left in pool vehicles overnight, nor shared in a manner for others to read, for example written on the cover of the Vehicle Log Sheets.

Fuel cards or fuel from NHS fuel tanks intended for pool vehicles, must not be used by employees for private use in any circumstances.

Whenever a pool vehicle is used the log book must be completed at the start and end of each journey. A copy of the log sheet will be kept in each vehicle and it is the drivers' responsibility to ensure it is fully completed after each journey.

It is the drivers' responsibility to ensure that at the commencement of each journey the milometer reading is confirmed against the last log entry to ensure that full account of each journey has been made. If it is found that the mileage does not tally then it must be reported to the Responsible Officer so they may track the missing journey entries.

When a driver draws fuel they must request a receipt from the providing garage and attach to the log book. These will be verified by the Responsible Officer on a regular basis, against fuel card records.

Each completed log sheet must be submitted to the Responsible Officer for review. Submission detail is shown on each log sheet. It is the responsibility of the person completing the last entry on a log sheet to ensure the completed log sheet is submitted to the Responsible Officer.

Vehicle log sheets will be reviewed, on a regular basis, by the Responsible Officer, to ensure completeness of information, that there is no gap in the milometer figures, all fuel receipts are attached and to verify journey appropriateness.

It is the responsibility of the driver to report any problems or defects to the Responsible Officer, immediately following the discovery of such problems or defects.

Grey Fleet

'Grey fleet' is the term used to describe any vehicles that do not belong to the Health Board, but which are used for business travel. All employees using their vehicles for grey fleet business mileage will require business use cover on their private insurance policies and will not be able to claim travel expenses without providing evidence of this on the e-expenses system. Proof of a current valid MOT and paid vehicle tax will also have to be provided.

The employee can use their approved privately owned car for work and be reimbursed in line with the NHS Terms and Conditions of Service (Agenda for Change) 45p per mile up to 3,500 miles, and then 28p per mile thereafter or see below table. Different arrangements apply for Medical and Dental employees – please refer to the Medical and Dental handbook.

Type of Vehicle/allowance	**Annual mileage up to £3,500 miles (Standard rate)**	**Annual mileage from 3,501 to 10,000 miles (AFC rate)**	**Annual mileage from 10,001+**	**All eligible miles travelled (see paragraph 17.15 and Table 8)**
Car (all types of fuel)	45 pence per mile	28 pence per mile	25 pence per mile	
Motor cycle				28 pence per mile
Pedal cycle				20 pence per mile
Passenger allowance				5 pence per mile
Carrying heavy or bulky equipment				3 pence per mile

8. Equality including Welsh Language

This document complies with the Health Board's Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

The Health Board is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marital status, disability, race, nationality, gender, religion, sexual orientation, gender reassignment, ethnic or national origin, beliefs, domestic circumstances, social and political affiliation or trade union membership, HIV status or any other basis not justified by law or relevant to the requirements of the post.

By committing to a policy encouraging equality of opportunity and diversity, the Health Board values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Health Board is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

The Health Board will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed- term contract or any other relevant factor.

Where there are barriers to understanding e.g. an employee has difficulty in reading or writing or where English is not their first language additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure.

9. Well-being of Future Generations

The Health Board's Well-being objectives are to improve physical, emotional and mental health and well-being for all; to target resources to those with the greatest needs and reduce inequalities; to support children to have the best start in life; to work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being; to improve the safety and quality of all services; to respect people and their dignity; to listen to people and learn from their experiences.

Application of this financial procedure will include all employees that require access to a vehicle that will facilitate personal needs and potentially those of families, patients and communities.

10. Environmental Impact

Employees are encouraged to partake of the schemes to provide a safe new modern vehicle fleet with low CO_2 emissions to support the Health Board's commitment in reducing its carbon footprint, and compliance with Health & Safety/Corporate issues. Consideration will be given to reduce future emissions to improve air quality that will feed into the Future Generations Act decarbonisation agenda.

11. Resources

There are no additional resource implications arising from this document as it replaces an existing operational financial procedure.

12. Training

The procedure is available to existing employees accessing the Health Board's intranet site.

13. Implementation

The lease car scheme will be open on a continuous basis so applications can be made at any time.

14. Audit

Internal Audit will review compliance with this procedure as required.

15. Review

The Finance Department will be responsible for monitoring the overall effectiveness of the lease car policy.

This policy will be reviewed every 3 years or more frequently if required in line with any legislative changes, by the Finance Department and Staff Side.

16. Contact Details

- Fleet Management Company – Knowles Associates 01206 252300
- BCUHB Lease Cars 03000 855115
- Pensions 02920 903908
- Payroll Services 02920 903908
  (all expenses managed through the Expenses Team in Payroll)

17. Appendices

Annex A – Contribution

1. Example of Salary Deduction contribution (values will vary upon reviews)

Annual Business Miles	Business Allowance	Annual Business Miles	Business Allowance
100	£ 25.20		
500	£ 126.00	5500	£ 1,386.00
1000	£ 252.00	6000	£ 1,512.00
1500	£ 378.00	6500	£ 1,638.00
2000	£ 504.00	7000	£ 1,764.00
2500	£ 630.00	7500	£ 1,890.00
3000	£ 756.00	8000	£ 2,016.00
3500	£ 882.00	8500	£ 2,142.00
4000	£ 1,008.00	9000	£ 2,268.00
4500	£ 1,134.00	9500	£ 2,394.00
5000	£ 1,260.00	10000	£ 2,520.00

2. Fuel for Business Use

- Fuel reimbursement will be paid at the prevailing HMRC Advisory Fuel Rate.
- The advisory electricity rate for fully electric cars is 4 pence per mile.
- Hybrid cars are treated as either petrol or diesel cars for advisory fuel rates.

3. The following CO_2 incentives apply to lease cars:

		O2 Levy = -£200
CO2 Band g/km	%	Incentive
0	100%	-£200
0 – 50	75%	-£150
51 – 75	50%	-£100
76 – 100	25%	-£50
101 – 120	0%	£0

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	F02 – Lease Car Policy and Procedure
Date form completed:	July 2021

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

IT FORMS

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Financial procedure F02 – Lease Car Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This document will provide guidance on the Health Board's arrangements for the provision of lease cars to eligible staff and budget managers. The objectives of the policy are: • To clarify for managers and staff the eligibility for a lease car, the process of application and roles and responsibilities; • To provide fair and equal access to all staff eligible for the scheme; • To provide clarity on the financial implications in order to provide an economical, efficient and effective scheme; • To create a policy that reduces the environmental impact of its carbon footprint, by encouraging the selection of cleaner and more fuel-efficient vehicles.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Executive Director of Finance and the Executive Management Team
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	No
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Key stakeholders who will be affected by this financial procedure is as follows: - Health Board Staff and Managers

Part A Form 1: Preparation

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The Health Board will need to ensure that the procedure is communicated widely and that all relevant staff/managers understand their responsibilities and the process.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The procedure will promote a fair and transparent process that will allow health board employees access to a reliable means of transport that will enable the efficient delivery of services via the Lease Car Scheme. This scheme is open to all employees with a permanent or fixed term (more than 3 years) contract of employment and is available to all such employees whether they do business travel or not. It will offer the Health Board a means to work towards achieving the goal of becoming carbon neutral before 2030 by offering employees a green incentive to encourage the uptake of electric and low emission cars that may not be otherwise affordable to them.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	✔			✔	The Health Board is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age. Retire and Return applications are considered on a case by case basis. Employees who are close to retirement age may incur a negative impact due to reduction in their pension fund (for salary sacrifice schemes) and early termination fees. All employees who are eligible to drive and meet the minimum criteria will be considered for a lease car.	The scheme is generally considered to be an overall benefit to staff, however it is recognised that there could be a negative impact on those employees approaching retirement. The policy will make express provision for this to ensure that staff are sufficiently aware to make an informed decision as to personal impact.
Disability (think about different types of impairment		✔			Only those employees that hold a full UK Driving Licence may apply under the rules of the scheme. This excludes those who are unable to drive due to a disability such as	Reasonable adjustments and support as to travel for employees with a disability, such as sight impairment,

and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)					sight impairment. This is beyond the control of the Health Board. Where required, adaptations to vehicles will be considered on a case by case basis in order to provide disabled employees with every opportunity to participate in the Lease Car Scheme.	will be made in accordance with the relevant workforce policies.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		✔			Has no bearing on the eligibility to lease a car through the scheme.	No negative impacts have been identified.
Pregnancy and maternity	✔			✔	If an employee is absent from work on sick leave, maternity leave or other authorised long term absence they may continue to use their lease car privately. If the employee chooses to keep the car for the duration of their absence from work the payment will continue through deductions from pay. If they go into a period of no pay they must continue to make the payment directly to the Health Board.	A potential negative impact has been identified where an employee is in receipt of reduced income due to maternity leave or returning to work on reduced hours afterwards. This will be mitigated by making it clear that there may be financial implications as a result of reduced income and what

						arrangements need to be made in advance of such changes taking place.
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.		✔			The Health Board will take every possible step to ensure that this procedure is applied fairly to all employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed- term contract or any other irrelevant factor.	No negative impacts have been identified.
Religion, belief and non-belief		✔			Has no bearing on the eligibility to lease a car through the scheme.	No negative impacts have been identified.
Sex (men and women)		✔			As above	No negative impacts have been identified.

Sexual orientation (Lesbian, Gay and Bisexual)		✔			As above	No negative impacts have been identified.
Marriage and civil Partnership (Marital status)	✔			✔	Single people (not married or in a partnership) reliant on a single income may struggle to continue to make payments if their income is reduced due to sickness or periods of unpaid leave.	Potential negative impact will be mitigated by making express provision informing employees that this may have an impact / employees are made aware of their personal responsibilities under the policy. Overall, it is considered that the provision of a lease car is a positive benefit for staff.
Low-income households		✔			The Health Board also provides a benefit and recruitment scheme under which a car is provided as a gross sacrifice (Salary Sacrifice) through the employee's pay. Any reduction to an employees' salary through salary sacrifice must not take them within 3% per annum of the national minimum wage or below the National Insurance lower earnings limit for national insurance contributions.	As above, in relation to mitigating potential financial implications in the event of reduced income through absence, maternity or sickness.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2 Right to life*
- *Article 3 Prohibition of inhuman or degrading treatment*
- *Article 5 Right to liberty and security*
- *Article 8 Right to respect for family & private life*
- *Article 9 Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	✔				All employees of the health board will be able to follow the same principles when applying the procedure.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	✔		✔		The document will be submitted for translation to Welsh once finalised/approved.	
Treating the Welsh language no less favourably than the English language	✔		✔		The document will be submitted for translation to Welsh once finalised/approved.	

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	Draft policy has been shared with the BCU Workforce Policy Procedure Group and was published on the public noticeboard for consultation. The Counter Fraud team were also consulted.
Have any themes emerged? Describe them here.	Individual queries were raised including questions from the Counter Fraud team.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	Minor tweaks were made and a fraud statement was included in the Policy Statement.

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	Financial procedure F02 – Lease Car Policy

2. Brief Aims and Objectives: (Copy from Form 1)	The objectives of the policy are: • To clarify for managers and staff the eligibility for a lease car, the process of application and roles and responsibilities; • To provide fair and equal access to all staff eligible for the scheme; • To provide clarity on the financial implications in order to provide an economical, efficient and effective scheme; To create a policy that reduces the environmental impact of its carbon footprint, by encouraging the selection of cleaner and more fuel-efficient vehicles.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No ✔
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No ✔
3c. Is your policy or proposal of high significance?	Yes	No ✔

Part B Form 5: Summary of Key Findings and Actions

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No ✔	
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The procedure will not have a negative impact in on Equality, Human Rights or the Welsh Language.		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes ✔		
	The procedure requires to be communicated effectively to all employees within the Health Board.		
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes ✔	No	
	How is it being monitored?	Implementation of the procedure will be monitored by the financial services team on an on-going basis.	
	Who is responsible?	Financial Services	

Part B Form 5: Summary of Key Findings and Actions

implement your policy or proposal?	What information is being used?	Performance data from our fleet management company, payroll services and other financial data related to lease car contracts.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	June 2024

7. Where will your policy or proposal be forwarded for approval?	Executive Management Team

8. Names of all parties involved in undertaking this Equality Impact Assessment – please note EqIA should be undertaken as a group activity	Name	Title/Role
	Denise Roberts	Senior Accountant
	Angela Howitt	Leased Cars Supervisor

Part B Form 5: Summary of Key Findings and Actions

Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Potential negative impacts have been identified, however it will be made clear to staff that they have personal responsibilities in terms of financial commitments.	Finance retain responsibility for the overarching policy. Managers have a duty of care towards their employees for example discussing applications that may not be financially viable for that individual. This is subject to a second check by Finance colleagues who will challenge applications that do not meet	Already in place.

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
		the criteria and/or it appears that there may be an issue of affordability.	
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	There will be express provision for instances where staff may be in receipt of reduced income, for example sickness, maternity and extended periods of unpaid absence.	Finance.	During development of the policy.
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	As above, express provision for impacted groups.	Finance.	During development of the policy.
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	Overall, the benefit of the scheme outweighs the potential for negative impact.	Finance/the Health Board. The approval of the use of the scheme is the decision of the Executive Team.	N/A

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	The policy is open to all employees (in a permanent or fixed term contract that covers the life of the lease contract).	Finance.	N/A

Checklist for the Review and Approval of all BCUHB Written Control Documents (WCDs)

*This checklist should be completed by the author and attached to the WCD along with the EqIA when submitted to Divisional/Departmental Governance Groups for approval. WCDs **must** have received the appropriate scrutiny and approval as per Policy on Policies in order to be uploaded to the Policies, Procedures and other written Control Document website / staff intranet. For queries, please contact: BCU.Policies@wales.nhs.uk*

	Details of document being reviewed: *F02 – Lease Car Policy and Procedure*	**Yes / No / Unsure**	**Comments**
1.	**Development Process**		
	Have the necessary impact assessments been completed? ***(An EqIA is mandatory for all documents. Further consideration should be given to Welsh Language, Finance, Environmental sustainability, the older person, children, carers, data protection and general resources such as staffing, IT or accommodation requirements).*** ***Note the Equality Act 2010 places a statutory requirement / duty on relevant bodies when they are taking strategic decisions to have due regard to the need to reduce the inequalities of outcome resulting from socioeconomic disadvantage. If the WCD relates to a 'strategic decision' you must conduct a socio-economic impact assessment.***	Y	
	Has the development template/process in OBS01 Policy on Policies been applied?	Y	
	Is there evidence of consultation/engagement with specialist groups, stakeholders and users? *Where possible, WCDs should be developed on a BCUHB wide basis. Always consider consultation with patients, carers, staff side, relevant services as well as external organisations (Welsh Ambulance, Local Authority etc.)*	Y	Policy was issued for consultation and has been slightly revised as a result of comments received from this consultation.

	Details of document being reviewed: *F02 – Lease Car Policy and Procedure*	Yes / No / Unsure	Comments
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used? i.e. National guidance, NICE guidance, relevant Code of Practice, Professional Guidelines etc. ***WCDs must be formulated using evidence based knowledge and best practice***	Y	Guidance taken from our fleet management company, NWSSP Expenses Team, BCUHB Counter Fraud team and Lease Car Team expertise.
2.	**Rationale**		
	Are the reasons for development of the document stated and agreed by Director sponsor [if new WCD]? *Have you conducted a thorough search of the intranet to identify whether it already exists?*	Y	
3.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a Strategy, policy, procedure or standard etc.? *A policy is a written statement of intent describing a broad overarching objective. It is not a description of standard methods for performing activities*	Y	
4.	**Content**		
	Is the statements and intended outcome of the document clear and unambiguous?	Y	
	Is the target audience clearly defined?	Y	
	Is the Document control identification correctly described?	Y	
	Is the document free from spelling and grammatical errors? *Always give the full name before using the Acronym*	Y	
	Text must all be in Arial font 12 and left aligned	Y	

	Details of document being reviewed: *F02 – Lease Car Policy and Procedure*	Yes / No / Unsure	Comments
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited correctly?	Y	
	Are supporting documents correctly referenced?	Y	
6.	**Approval**		
	Does the document identify appropriate approval committee / group? (see page 17 of Policy on Policies)	Y	
	Is it clear who will be responsible for the maintenance and review of the documentation?	Y	
7.	**Dissemination and Implementation**		
	Is there an implementation plan with timescales and leads identified?	Y	
	Does the plan include all the necessary actions e.g. training / support to ensure compliance?	Y	
8.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y	
	Is there a plan to review or audit compliance with the document?	Y	
9.	**Review**		
	Has the review date and frequency been identified? If so is it acceptable?	Y	

FOR COMPLETION BY THE APPROVING SENIOR MANAGEMENT TEAM

<table>
<tr><td colspan="2">BCUHB review / approval Group :</td><td>Date reviewed / approved:</td><td rowspan="4">Final approval required at higher level committee:

Yes [if yes state name of approval group]

No [if no state reason e.g. minor change to procedure only or local document (check page 17 of Policy on Policies]</td></tr>
<tr><td colspan="2">Executive Director Lead:</td><td></td></tr>
<tr><td colspan="2">Author:</td><td></td></tr>
<tr><td colspan="2">Which grouping does the WCG belong in: insert department or speciality</td><td></td></tr>
</table>

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**External Contracts Quarter 1 Update 2021/22**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mrs Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tracy Pope, Head of Healthcare Contracts Gillian Milne, Head of Healthcare Contracts – Finance
Craffu blaenorol: **Prior Scrutiny:**	Adrian Tomkins, Associate Director of Contracting
Atodiadau **Appendices:**	Appendix 1 – Quarterly External Healthcare Contracts -Update Quarter 1 2021/22

Argymhelliad / Recommendation:

The Committee is asked to:

note

- the financial position on the main external contracts as reported at Quarter 1 2021/22.
- the work underway in respect of stabilising wider health / patient care contracts and key risks / related activity.
- the impact of Covid-19 on external healthcare contracts.
- the impact and risk posed as a result of Covid-19 revised contracting arrangements adopted for contracts with NHS Providers and Commissioners.
- the work underway in respect of increasing planned care capacity
- the risks associated with the current contractual arrangements with independent care home and domiciliary care providers and actions being taken
- the work underway to increase capacity within the team and develop robust governance and scrutiny arrangements

approve

- the proposals in relation to third sector commissioning

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth **For Decision/ Approval**	☒	**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**	☒	**Er gwybodaeth** **For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Sefyllfa / Situation:

The purpose of this report is to provide an update on the contractual position of external 'Health Care' contracts (excluding primary care contracts) and the headline successes and challenges each quarter, this update is for Quarter 1 of 2021/22.

Cefndir / Background:

The Health Board (HB) commissions healthcare with a range of providers, via circa 517 contracts, to a value of approximately £351 million. Currently circa 92% of expenditure is covered by a formal contract.

The financial position at the end of Quarter 1 2021/22 is a reported overspend of £0.3 million for external healthcare contracts and an under recovery of £0.1 million on the healthcare income contracts. The adverse position is due to low non contracted activity (NCA) income in April due to lockdown measures being in place for part of the month. The external contracts show an overspend, this is due to delays in the allocation of additional funding for the Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) developments. Until there is greater clarity on whether the proposed schemes will be implemented in the planned timescales the funding is being held centrally by the HB.

Key issues of note can be summarised as follows:

- The issuing of the final 2021/22 Welsh standards has been delayed as these are currently with the Welsh Health Policy leads for review. The HB has been advised that the 2020/21 delivery framework will apply for the first six months of the financial year, with the intention that the 2021/22 framework will be implemented in the second half of the year.

- The Healthcare Contracting Team (HCCT) are supporting the Planned Care lead and operational teams in increasing planned care capacity. Currently three endoscopy providers are on site awarded insourcing contracts until March 2022. As part of the 2021/22 planned care recovery programme the HCCT is currently working with the operational teams on outsourcing and insourcing requirements across a range of specialties.

- The HCCT are currently undertaking a number of pieces of governance work.

- The fragility of the nursing home market remains a significant challenge and monitoring / compliance activity in this area is undertaken in partnership with HB Continuing Healthcare (CHC) and Local Authority (LA) colleagues.

- A number of historic challenges have re-emerged with a care home provider, a formal dispute process has been invoked and the HB and Provider are working jointly to reach a negotiated settlement.

- The HCCT also support the Partnership working agenda working with LA colleagues and regulators to look at care home quality assurance moving forward.

- The updated Regional contractual framework, Pre Placement Agreement (PPA) with Care Home providers, which has been under development since 2019, has failed to reach a satisfactory conclusion. Existing contractual arrangements have now been extended to facilitate further discussion between the HB, LA, Care Forum Wales (CFW), Provider representatives and legal teams.

- The HCCT have been working alongside the Health Strategy and Planning Team and Regional Programme Manager, Community Services Transformation on a programme of work to develop an integrated commissioning approach to 3rd Sector contracts with Local Authority partners.

- The Non-Emergency Patient Transport Services (NEPTS) management responsibility transferred from the HB to Welsh Ambulance Service Trust (WAST) on the 1st April 2021, monthly meeting are held with WAST to monitor the transition.

- During 2020/21 as part of the Covid-19 response 'Block' contracts were put in place with NHS Commissioners and Providers. It has been agreed that in Wales the block contracting will continue for Quarter 1. A further proposal to extend this throughout 2021/22 is currently with the All Wales Director of Finance group for consideration.

- The contracting arrangements between England and Wales as agreed between NHS-England and Welsh Government is to continue with block contracts for the first half of the year. In addition to the block payment a process has been put in place to encourage the recovery of elective work. Additional payments will be made where elective activity exceeds set thresholds, however there is no penalty for under performance. Discussions regarding the arrangement for the second half of the year are ongoing but early indications are that the modified block contracts are likely to continue.

- The HB continues to engage fully with Welsh Health Specialised Services Committee (WHSSC) and is actively involved with the development of the Plan for 2022/23.

- A review of the team structure is in progress in order to ensure the team can meet future demands particularly around the extensive planned care programme.

- A review is currently being undertaken into the effectiveness of the current healthcare contracts governance structure that provides assurances to the F&P committee.

Asesiad / Assessment & Analysis

Strategy Implications

The Contracts Update supports the delivery of the HB's annual plan and is therefore aligned to the agreed strategic and business plans of the HB.

Options considered

Not applicable – report is for assurance only.

Financial Implications

The financial position at the end of Quarter 1 2021/22 is a reported overspend of £0.3 million for external healthcare contracts and an under recovery of £0.1 million on the healthcare income contracts.

Risk Analysis

The HB manage contractual relationships which enables the HB to reduce risk, monitor and increase quality, take corrective action where required and closely monitor future costs, ensuring a cost effective approach to externally commissioned healthcare.

The report focuses on the performance of the main external healthcare contracts but also provides the Finance & Performance Committee with an overview of the contractual developments of other external healthcare contracts. It also highlights key activity undertaken towards formalising and standardising all patient care contracts across the HB.

The Regional contractual framework, Pre Placement Agreement (PPA) with Care Home providers has expired. This carries a number of risks for the HB and the LA which are currently being considered.

The implementation of the recommendations of the Section 16 Ombudsman Report has identified a number of risks associated with joint funded lead commissioner arrangements with LA's which have been escalated to the Regional Commissioning Board.

Legal and Compliance

None

Impact Assessment

None

Appendix 1

Quarterly External Healthcare Contracts – Update Quarter 1 2021/22

1. Introduction

This report provides a summary of activity by the HCCT and the headline successes and challenges in Quarter 1 of the 2021/22 financial year.

2. Analysis of current contracts position

2.1 There are currently 517 active healthcare expenditure contracts, this is a reduction of 45 contracts since last reported in April as the HCCT have completed a contracts data cleanse as part of the development of a strategic contracts register. This resulted in the archiving of a number of inactive contracts and the update of contract values to reflect 2021/22 values.

Table 1 – Analysis of Contracts @ 30th June 2021

Type of Care	Total	Anticipated Value £000's
Ambulance / transport	5	5,585
Community Care	61	16,378
Diagnostic/testing	22	9,589
Domiciliary Care	78	8,352
General Healthcare	4	56
General support / signposting	35	2,325
Learning Disability	29	641
Mental Health	70	6,951
Nursing Home	113	46,756
Other	18	998
Product / Nursing Care	4	874
Residential Home	16	1,816
Secondary Care (Acute)	9	32,787
Secure Hospital / Wards	19	5,153
Specialist Hospital / unit	16	9,644
Tertiary Care	12	202,641
Domiciliary Care & Supported Living	6	280
Grand Total	**517**	**350,826**

2.2 92% of commissioned healthcare (by value) continues to be covered by a signed contract, the remaining contracts are under development as part of a 3-year plan to ensure all commissioned healthcare is contracted effectively. The HCCT continue to work to formalise contractual arrangements for the remaining 8% of expenditure, this in the main relates to GP cover for community hospitals / minor injury units and a small number of nursing home providers.

2.3 All contracts are risk assessed annually to ensure that there is a prioritised workplan for contract stabilisation activity aimed at minimising risk for patients and the HB corporately.

2.4 The issuing of final 2021/22 Welsh standards have been delayed as these are currently with the Welsh Health Policy leads for review. The HB have been

advised that the 2020/21 delivery framework will apply for the first six months of the financial year with the intention that the 2021/22 framework will be implemented in the second half of the year.

2.5 During the quarter endoscopy insourcing activity has continued to support the delivery of planned care. The team conduct weekly telephone contract monitoring meetings for all insourcing providers after each weekend where any operational issues are identified and addressed.

2.6 The HCCT team are supporting the Planned Care lead and operational teams in a number of other service areas and looking at sourcing options and compliant routes to market with the development of detailed specifications.

Table 2 – Status of Procurements

	Stage											
Sourcing Option	Proposal/Planning	Specification	Board Approval	WG Approval	Tender	Evaluation	Award	Mobilisation	Monitoring	**Contract Start**	**Contract End**	**Issues to Note**
Insourced Endoscopy	x	x	x	NA	x	x	x	x	x	Nov-20	Mar-22	
Outsourced Orthopaedics	x	x	x	NA	x	x						Awaiting Chairs Action to approve award
Outsourced Mixed Specialties	x	x	x	NA	x							Tender to be reissued
Insourced Mixed Specialties	x	x	x	NA								Governance points under consideration prior to tender being published
Insourced Orthopaedics	x	x	x	NA								Governance points under consideration prior to tender being published
Mobile Theatres	x											
Diagnostic & Treatment Centre	x											

2.7 The HCCT are currently undertaking a number of pieces of governance work, which include:

- continue to identify key areas for development of the strategic contracts register
- enhancements to supplier due diligence processes,
- working with LA colleagues to implement agreed actions in respect of the recommendations made within the Ombudsman section 16 report.

The review of Joint funded Lead Commissioner arrangements as part of the follow up of the Ombudsman Joint and Local action plans has raised a number of concerns that have been escalated through the CHC Operational Group to the Regional Commissioning Board for consideration.

2.8 The fragility of the nursing home market remains a significant challenge and monitoring / compliance activity in this area is undertaken in partnership with HB CHC and LA colleagues. The detail on issues and associated risk and

actions for homes in increasing/escalating concerns are reported to the CHC Operational Group and the Care Home Support Cell established as part of the HB's Covid-19 response. The HCCT are actively involved in monitoring 2 nursing homes and 1 domiciliary care provider who are in increasing/escalating concerns.

2.9 A number of historic challenges have re-emerged with a care home provider, a formal dispute process has been invoked and the HB and Provider are working jointly to reach a negotiated settlement.

2.10 The HCCT also support the Partnership working agenda working with LA colleagues and regulators to look at care home quality assurance moving forward.

2.11 As previously reported the updated Regional contractual framework, PPA with Care Home providers, which has been under development since 2019, has failed to reach a satisfactory conclusion and existing contractual arrangements have expired. As part of risk mitigation measures the HB working with LA colleagues and the Regional Commissioning Board (RCB) have introduced interim contractual arrangements whilst PPA discussions are concluded and a final document agreed. Conwy Local Authority is leading on securing legal advice on behalf of the RCB and there have been a series of meetings with Care Forum Wales and their legal team to work through the terms of the PPA. It was anticipated that the new PPA would be in place after a period of provider consultation by the 1st October 2021, however due to a number of operational issues timeframes are likely to slip further and the legal implications of this are currently being considered. A further update will be provided to a future committee.

2.12 The HCCT have been working alongside the Health Strategy and Planning Team and Regional Programme Manager, Community Services Transformation on a programme of work to develop an integrated commissioning approach to 3rd Sector contracts with Local Authority partners. Proposals have been considered by the RCB and the Community Transformation Board. Whilst the principle of joint commissioning has been endorsed, further work is in progress to agree local approaches and sign-up. See Annex 5 for a detailed update of the work to date and recommendations for approval.

2.13 The transfer of the management responsibility for the NEPTS from the HB to the WAST was completed on the 1st April 2021. The HCCT continues to work with the divisions and WAST to support the development and implementation of the contract monitoring arrangements.

2.14 See Annex 1 for additional detail on Key Activity and Benefits in Quarter 1 2021/22.

3. Quarter 1 2021/22 Financial performance of the main external contracts

3.1 As outlined, the HB holds contracts with a range of English NHS Trusts, Welsh Health Boards and Welsh Trusts, to deliver care and patient services on its

behalf. The value of the English locally managed contracts is £65 million, the HCCT administers all of these contracts. However, £57.3 million of this is reported in the HB Contracting reports the remainder relates to repatriated services and is reported by the appropriate division.

3.2 Table 3 shows the financial position on the HB external healthcare contracts at the end of Quarter 1 as £0.3 million overspent.

Table 3 – 2021/22 Quarter 1 Contract position (Health Board Contracting)

	19/20 Outturn £'m	20/21 Outturn £'m	21/22 Plan £'m	21/22 Forecast £'m	21/22 Forecast Variance £'m	21/22 Q1 Plan £'m	21/22 Q1 Actual £'m	21/22 Q1 Variance £'m
Locally Managed English Contracts	54.4	55.4	57.2	56.6	(0.6)	14.3	14.1	(0.2)
Welsh Contracts	10.3	10.6	11.4	11.5	0.1	2.8	2.8	0.0
WHSSC	177.0	189.6	196.9	195.2	(1.7)	49.2	48.5	(0.7)
WHSSC Provider Contracts	(40.6)	(42.9)	(44.0)	(43.9)	0.1	(11.0)	(10.9)	0.1
BCU divisional recharges/misc.	(4.1)	(2.5)	(8.0)	(5.0)	3.0	(2.0)	(1.4)	0.6
NCAs & IPFR	4.6	4.4	5.0	5.3	0.3	1.3	1.4	0.1
Outsourcing	4.1	1.0	0.0	0.0	0.0	0.0	0.0	0.0
Savings	(0.5)	0.0	(1.5)	0.0	1.5	(0.4)	0.0	0.4
Total	**205.2**	**215.6**	**217.0**	**219.7**	**2.7**	**54.2**	**54.5**	**0.3**

3.3 Both Welsh Health Specialist Services Committee (WHSSC) and the Emergency Ambulance Services Committee (EASC) have drawn down the full funding for all the developments included in their 2021/22 Integrated Medium Term Plan (IMTP) and are reporting that it is anticipated to be spent in full during the year. However the development funding is not currently allocated to the contracts budget so is leading to the overspent position being reported. The HB is holding the funding for the new schemes centrally until there is greater clarity on whether they will be implemented in the planned timescales due to the ongoing impact of the response to Covid-19.

3.4 The block contracting arrangements in place in 2020/21 have been extended into 2021/22 for both the Welsh and English contracts.

3.5 For the Welsh contracts an All Wales task and finish group was established to consider how and when to move away from the block arrangements. It has put forward a proposal to the All Wales Directors of Finance group to maintain block contracts for the current year to focus on recovery plans and enhancing reporting arrangements.

3.6 A national agreement is currently in place for the cross border contracts to follow the contractual arrangements that have been put in place in England, for the period April – September 2021 (known as 'H1'). This effectively continues the Block Arrangements that were in place during 2020/21. Interim inflation has been agreed as 0.5%; this will be adjusted and back dated once the Pay Uplift has been confirmed.

3.7 In addition to the block payments the English model includes an elective recovery framework (ERF) to incentivise the delivery of the highest possible elective activity. Through the ERF additional payments are made for elective activity where it exceeds the nationally set thresholds. Discussions are ongoing

with local providers to fully assess the impact on the HB. Welsh Government have confirmed that additional funding will be provided to the HB to cover any ERF costs incurred. (See Annex 2 for further detail on the ERF).

3.8 Discussions relating to the arrangements for the period October – March 2022 (known as 'H2') are ongoing and therefore a further update will be provided in a future committee.

3.9 The HB continues to engage fully with Welsh Health Specialised Services Committee (WHSSC) and is actively involved with the development of the Plan for 2022/23. Quarterly SLA meetings were reinstated in June 2021 to monitor the contract for specialist services provided by the HB.

3.10 See Annex 2 for further detail on issues of note for the finance positon and the reported levels of activity delivered as at Quarter 1 in 2021/22 and Annex 3 for cross border Provider services updates

4. Income Contracts

4.1 The HB holds income contracts with a range of English NHS commissioners and Welsh HBs to deliver care and patient services to their patients. The value of the healthcare contracts managed by the income team is £20.5 million, which is reported centrally. The section also manages a range of non-healthcare contracts where the income is reported by the appropriate division.

4.2 Table 4 shows the financial position on the HB income healthcare contracts at the end of Quarter 1 as £0.1 million under recovered.

Table 4 – 2021/22 Quarter 1 Income Contract position (Healthcare Income)

	19/20 Outturn £'m	20/21 Outturn £'m	21/22 Plan £'m	21/22 Forecast £'m	21/22 Forecast Variance £'m	21/22 Q1 Plan £'m	21/22 Q1 Actual £'m	21/22 Q1 Variance £'m
English CCG Contracts	**(8.9)**	**(7.8)**	**(9.3)**	**(9.3)**	0.0	**(2.3)**	**(2.3)**	0.0
Welsh HB Contracts	**(2.8)**	**(2.8)**	**(3.1)**	**(2.9)**	0.2	**(0.7)**	**(0.7)**	0.0
NHS England - Specialist	**(0.7)**	**(1.2)**	**(1.2)**	**(1.2)**	0.0	**(0.3)**	**(0.3)**	0.0
NCAs	**(7.1)**	**(4.0)**	**(6.1)**	**(5.6)**	0.5	**(1.5)**	**(1.4)**	0.1
Other (inc RTA & Overseas visitors)	**(1.3)**	**(1.0)**	**(0.8)**	**(0.7)**	0.1	**(0.2)**	**(0.2)**	0.0
Total	**(20.8)**	**(16.8)**	**(20.5)**	**(19.7)**	**0.8**	**(5.0)**	**(4.9)**	**0.1**

4.3 The same contracting arrangements apply to the income healthcare contracts as to the expenditure contracts (reported above) in 2021/22. Fixed Block contracts are in place with the Welsh Commissioners and modified block contracts with the English commissioners.

4.4 At the end of Quarter 1 the healthcare income section is reporting an under recovery of £0.1 million. This relates to the Non Contracted Activity (NCA) income which was low in the first quarter due to UK Covid-19 travel restrictions being in place during April. This area was heavily impacted during 2020/21 however it is anticipated that in the current year as internal travel has been

restored and international travel is restricted this could return to pre Covid-19 levels.

5. Contracts Structure and Governance Review

5.1 This paper has identified a number of areas where the HCCT are supporting the wider HB agenda around planned care and the transformation programme. In order to be able to respond to this effectively and ensure capacity exists to meet future demands a review of the team structure is in progress.

5.2 As part of the review of structures, consideration is being given to the effectiveness of the current healthcare contracts governance structure that provides assurances to the F&P Committee. The membership of the contracts scrutiny group, terms of reference and key stakeholders are being refreshed which will see a greater emphasis on partnership working across HB disciplines which will be driven through the development of detailed annual work plan and cycle of business.

6. Recommendation

6.1 The HCCT continues to influence a broad and expanding spectrum of healthcare contracting issues across the HB and despite the impact of Covid-19 on current contracting arrangements continues to build on the progress to stabilise traditional contractual arrangements. Current performance on a range of issues has been outlined within this paper.

6.2 The Finance & Performance Committee is asked to:

- note the financial position on the main external contracts as reported at Quarter 1 2021/22.
- note the work underway in respect of stabilising wider health / patient care contracts and key risks / related activity.
- Note the impact of Covid-19 on external healthcare contracts
- note the impact and risk posed as a result of Covid-19 revised contracting arrangements adopted for contracts with NHS Providers and Commissioners.
- note the work underway in respect of increasing planned care capacity
- note the identification of risks associated with Joint Funded Lead Commissioner arrangements and escalation to the RCB.
- note the risks associated with the current contractual arrangements with independent care home providers and actions being taken
- note and approve the proposals in relation to third sector commissioning
- note the work underway to increase capacity within the team and develop robust governance and scrutiny arrangements

Tracy Pope, Head of Healthcare Contracting
Gillian Milne, Head of Healthcare Contracting - Finance

Annex 1

Key activity, Issues and benefits to date 2020/21

Response to Covid-19

During the year the HCCT and Finance Contracts Team have actively supported the HB response to Covid-19, which has included implementation of revised Contracting guidance and the challenge to independent providers, both Care Homes and Domiciliary Care providers.
Elements of this support is still ongoing within the independent care sector and is reinstated on a Local Authority patch basis as required. The focus generally is now on how we maintain effectively and to mutual benefit those established communication links.

Endoscopy

Insourced endoscopy diagnostic services to support the delivery of planned care is in place on all three acute sites. The HCCT conduct weekly telephone contract monitoring meetings with all three insourcing providers after each weekend of service. To date there have been operational issues raised on all sites, however the staffing of lists by the insourced provider in the East has been the most challenging issue, which is currently being addressed and assurances sought moving forward. Issues have been exacerbated by the fact that lists are only being run on one day over the weekend due to operational issues. There has been satisfactory patient feedback across all 3 sites.

Planned Care

The HCCT team are supporting the Planned Care lead and operational teams in a number of other areas, including:

- Sourcing of Modular Theatres/Wards
- Sourcing of a Mobile Ophthalmology Theatre
- Tendering for Dental cone beam computed tomography
- Re-tendering for Community Optometry Diagnostic and Treatment Centres (ODTCs)
- PET CT

Governance Processes

The HCCT are currently undertaking a number of pieces of governance work, which includes:

- Reviewing its due diligence processes and links with the Board Secretary's Office where HB employees are identified as working for companies outside of the HB, due to the potential conflict of interest.
- Developing the Contracts database to produce an overarching Contracts Register
- Updating Standard Operating Procedures

Section 16 – Ombudsman Report Recommendations

The Ombudsman report identified a number of failings relating to joint commissioning and contracting arrangements, as well as care planning and risk assessments.

The HCCT have been working with LA colleagues to review Joint funded Lead Commissioner arrangements as part of the follow up of the Ombudsman Joint and Local action plans, which has raised a number of concerns that have been escalated through the CHC Operational Group to the Regional Commissioning Board for consideration.

Quality monitoring and contract compliance

Whilst quality issues are referenced within this report for completeness, it should be noted that a summary update will also be reported through to the revised HB Quality and Safety committee structure.

Non Acute contracts

Ongoing contract monitoring is a key focus for healthcare / clinical service contracts and continues to increase, with many of the contracts well established and now in the active monitoring / compliance stage.

Nursing Home Monitoring Visits

The fragility of the nursing home market remains a significant challenge and monitoring / compliance activity in this area is undertaken in partnership with HB CHC and LA colleagues. The HCCT continue to participate in care home monitoring visits which have been significantly affected by the pandemic, visits are risk assessed and dependent on the outbreak position regionally and the status of care homes there have been a mix of onsite and remote visits. A total of 9 visits have been undertaken in Quarter 1 with findings reported through to Area teams.

Nursing Homes in Increased or Escalating Concerns

A significant amount of time is spent actively monitoring those homes that are in increased or escalating concerns, this has continued remotely throughout the pandemic and care home lockdown. The detail on issues and associated risk and actions for homes in increasing / escalating concerns is reported via the Area Teams monthly reports to Patient Quality, Safety and Experience Group, (PSQ), CHC Operational Group and the Care Home Support Cell established as part of the HB's Covid-19 response. The HCCT are actively involved in monitoring 2 Nursing homes and one Domiciliary Care provider who are in increasing/escalating concerns.

Quarterly Quality Assurance

In addition to the formal contract monitoring, the HCCT continue to monitor the quality and assurance Key Performance Indicator (KPI) returns from care homes across the 6 LA areas. Since last reporting Quarter 4 Assurance Returns (Period January – March

2021) have been received. The current graphical representation is included at Annex 4. In the quarter ending March 2021, the care home assurance return rate was 95%, a significant improvement on Quarters 1 - 3 2020/21. The return rate was 100% in four of the six LA Areas, the central area 95% with a total of 3 Homes who have not submitted the data. The HCCT continue to work with the homes in these areas to improve the return rate, through education and training support.

A number of issues picked up with Quarter 4 submissions, January to March 2021 have been subject to further scrutiny and discussion with the homes and the Area Practice Development Nurses in order to identify opportunities for corrective action. A number of areas are showing concerning trends, including increases in falls predominately in the West and a marginal deterioration in Malnutrition Universal Screening Tool (MUST) Scores and medication errors in the Centre. Whilst it was pleasing to note the reduction in the use of Agency Nursing/HCSW in the 3rd Quarter this has seen a significant increase in Q4 across all Areas. The number of safeguarding submissions has seen a significant reduction in numbers in the West after gradual increases over Quarters 1 -3, 2020/21.

Quarter 1 (period April – June 2021) returns have been issued to Nursing Homes and are currently being collated, these will be reported to a future Committee.

Given the reduced level of monitoring and access to care homes currently these returns are a significant element of current assurance and escalation processes.

Acute contracts

Within the Covid-19 pandemic national guidance it was recognised that local performance reporting requirements needed to be relaxed to focus resources on the response efforts. Consequently, normal contract monitoring was stepped down, providers entered into business continuity mode and performance is now only being reported by exception.
We have been linking with colleagues from WHSCC to obtain service updates from Cross Border Providers, which have been shared with Health Board colleagues. Relevant Service updates by Provider are shown in Annex 3

Partnership Working

The HCCT also support the Partnership working agenda, this quarter has seen a number of key pieces of work being taken forward as we work with LA colleagues and regulators to look at care home quality assurance moving forward.

These include:

Assurance Mapping – The HCCT Assurance mapping piece of work has been revisited to support the current Health / LA work stream looking at how information can be shared and assurances derived from a central depository of information to remove duplication and unnecessary bureaucracy for care home. The HB Quality Assurance KPI returns have been revisited to include an updated set of indicators, which addresses both HB and LA requirements. Under the ‘ask once’ principle the HB for Nursing Homes and LA for Residential settings will pilot this in Quarter 2 2021/22.

This marks a significant step forward in partnership working and reducing bureaucracy for care homes.

New Home Care Model in Gwynedd – the team have been supporting the development of a new home care model in Gwynedd, which will be a partnership agreement between the Health Board and Local Authority. Successful bidders providing patch based care within Gwynedd for the provision of domiciliary care for adults with the exception of people with learning disabilities and younger adults facing mental health issues. It is for the provision of 'standard' community based services excluding the skills and expertise of a qualified nurse.

The project started to gather pace in the early part of the year with the development and finalisation of the specification with the intention to commence the procurement process in May. However since last reporting a number of issues have been raised which are currently being considered by the LA legal team, which has delayed progress. Once these have been addressed proposals will go through Health Board Governance routes for approval. Updates will be provided to the Committee as the project is brought back on track.

Domiciliary Care Model – Isle of Anglesey - The Isle of Anglesey County Council in partnership with the HB undertook a formal tender for domiciliary care services in January 2018. In June 2018 a contract was awarded and commenced using a patch based approach with one domiciliary care provider per patch. The contract awarded was for 3 years with the potential for annual extensions of up to 3 years. (1year +1Year +1 Year). Despite the HCCT and Area team working with the Isle of Anglesey Council to produce an options appraisal and agreeing the continuation of existing contractual arrangements as the initial 3 year contract expired in June 2021, new contracts have not been put in place by the Local Authority. The HCCT are currently working with the Isle of Anglesey County Council to ensure that as lead commissioner this is actioned to mitigate any potential risks of providers working under implied contractual terms.

Annex 2

Financial Issues of Note for Contracts

English Elective Recovery Framework (ERF)

The contracting arrangements put in place for the first half of the year in England are based on the blocks that were in place in 2020/21 but also allow for additional payments to providers who deliver additional elective activity above nationally set thresholds. This is to encourage providers to deliver the highest possible levels of recovery activity.

Table 5 – Monthly Performance thresholds for English Contracts

Month	Lower Threshold	Upper Threshold
April 2021	70%	85%
May 2021	75%	85%
June 2021	85%	85%
July – September 2021	95%	100%

A baseline value is calculated based on the tariff prices for the 2019/20 inpatient and outpatient elective activity. The actual value for the month is calculated on the same basis. The principle of calculating on a monthly basis as opposed to cumulatively is to provide a continued incentive where providers have not been able to achieve the required levels in earlier months.

Where the lower threshold is exceeded when compared to the 2019/20 actual elective activity value the additional activity is paid for at 100% of the tariff price. Any activity above the upper threshold would attract payments @ 120% of the tariff price, this is to take into account the additional costs to the provider that are not included in the baseline plan but may arise from increases in elective activity e.g. Critical care and drugs costs.

There is no downward adjustment to the block value where activity is delivered below the lower threshold.

The actual implementation of this has been left to the HB's to agree on an individual basis with their contracted providers as the methodology will vary depending on nature of the contract and activity being commissioned.

Discussions are ongoing with local providers to fully assess the impact on the HB. Welsh Government have confirmed that additional funding will be provided to the HB to cover any ERF costs incurred.

Contract Financial Performance

The HCCT continues to monitor the actual value of the all healthcare activity undertaken for the HB costed at tariff against the cost of the block payments.

Table 6 below shows comparison by provider. Please note this includes activity that does not form part of the ERF calculation so over performance does not indicate that an ERF payment will due.

Table 6 Comparison of Block Value and Actual Performance Quarter 1 2021/22

	Block Payments Q1 £	Actual Value of Activity Q1 £	Variance £	% Value of Work done
Liverpool Womens	208,556	367,022	-158,466	176%
Countess of Chester	6,270,146	7,116,212	-846,066	113%
Clatterbridge	897,608	1,013,135	-115,527	113%
Shrewsbury & Telford	431,941	464,994	-33,053	108%
Royal Liverpool & Broadgreen	1,372,037	1,096,875	275,162	80%
Robert Jones & Agnes Hunt	3,648,974	2,868,494	780,480	79%
Manchester University Hospital	344,128	264,828	79,300	77%
Aintree Hospitals	828,413	618,683	209,730	75%
University Hospital North Midlands	1,418,870	1,010,745	408,125	71%
Wirral Hospitals	575,100	345,180	229,920	60%
Total English Contracts	**15,995,772**	**15,166,168**	**829,604**	95%

The over performance in Liverpool Women's Hospital is due to the high volume of HB neonatal activity referred there in Quarter 1 when compared to the base year of 2019/20. The neonatal beds in the North West of England are managed on a network basis, overall there is not a significant change to the HB's use of external cots so there is a corresponding underperformance in the Wirral Hospital's neonatal activity.

Elective recovery in the Countess of Chester (CoCH) has been high during the first three months this is partly due to actions taken to mitigate the anticipated impact that the implementation of their new patient administration system in July 2021 will have on activity.

The over performance in Clatterbridge is due to the high cost drug charges in Quarter 1 of 2021/22 when compared to the same period in the base year of 2019/20 this is consistent with the significant increase in elective activity that they are reporting.

Annex 3

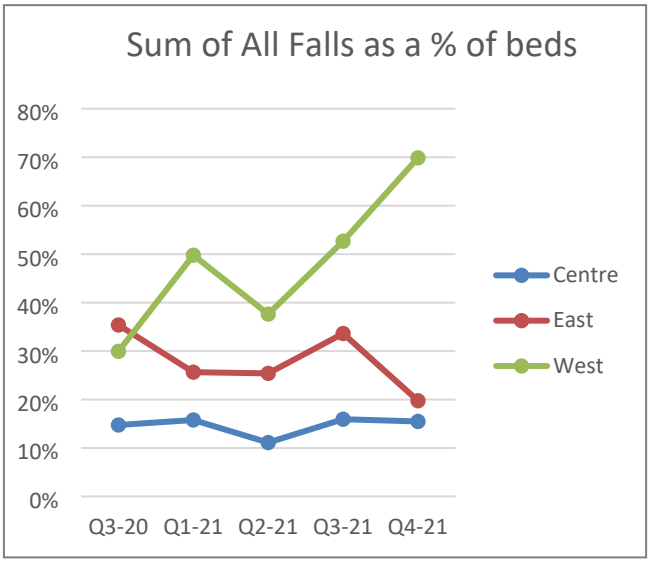
Cross Border Provider Service Updates July 21

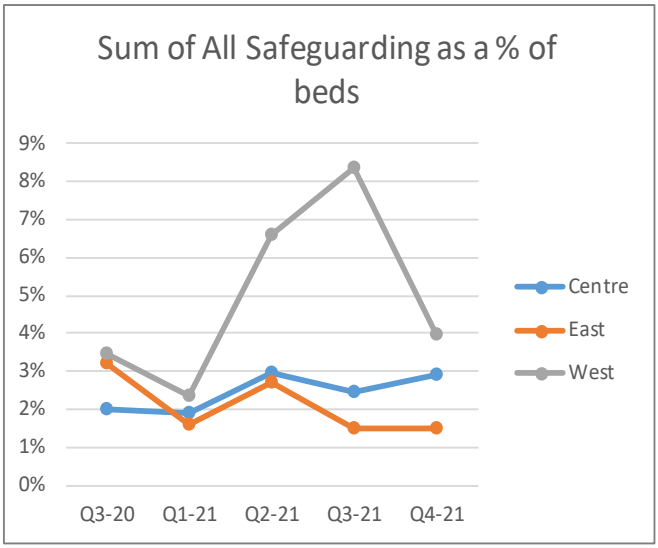
NHS England Finance and Contracting Guidance: Signed 2021/22 contracts between NHS commissioners and NHS providers (NHS trusts and NHS foundation trusts) are not required for the H1 2021/22 period.

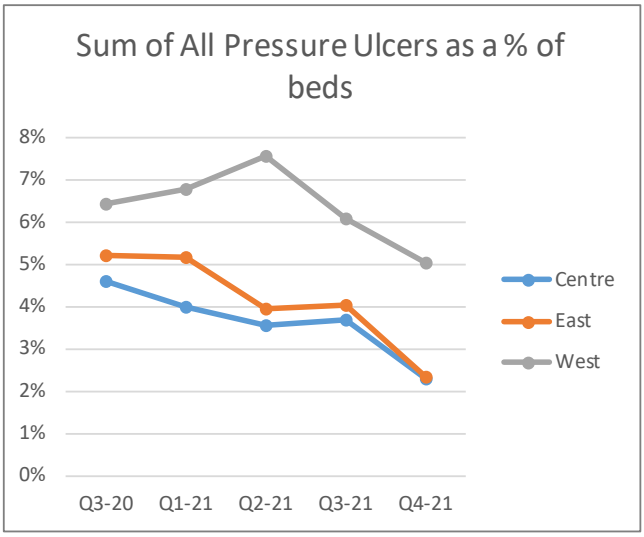
Where services continue to be provided, the nationally mandated terms of the NHS Standard Contract for 2021/222 will apply from 1 April 2021 onwards, and a contract incorporating those nationally mandated terms will be implied as being in place between the parties.

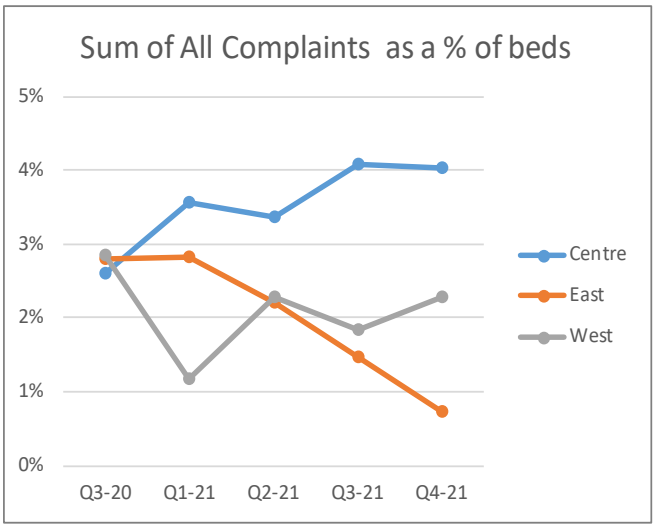
Provider	Service Update
Countess of Chester (COCH)	COCH's elective recovery is ongoing despite challenges relating to the EPR implementation which went live on 23rd/24th July. Points of Delivery targets were set nationally in Q1 and the Trust has consistently performed well against each of the four targets in April, May and June. The ED department has been under sustained pressure in recent weeks with the Trust now regularly seeing 300+ patients per day which is impacting significantly on the 4 hour target.
Robert Jones and Agnes Hunt Hospital (RJAH)	To date the Trust is delivering successfully against the Points of Delivery which are tracked nationally. Patients continue to be treated in priority order following the national prioritisation guidance (P1-P4) alongside a focus for reducing very long waits. It is expected that recovery requirements will increase in H2 and there will be much greater pressure on stabilising the financial position with Covid support being withdrawn in a phased approach.
Clatterbridge Cancer Centre (CCC)	Clatterbridge are experiencing sustained, significant increases in activity as more patients work through the GP and secondary care system. Extra measures are in place to ensure there are no delays and patients can be treated as quickly as possible.
University Hospitals of North Midlands	UHNM reported that Major Trauma is fully operational as per normal. There was an issue at the end of July with a suspicious package on the hospital site which required police involvement. This meant access to ED was re-routed but it had no effect on patients.

Annex 4

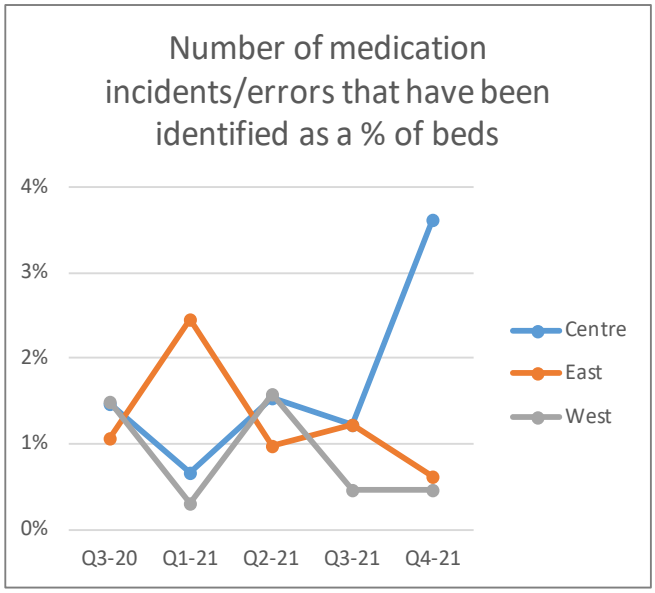


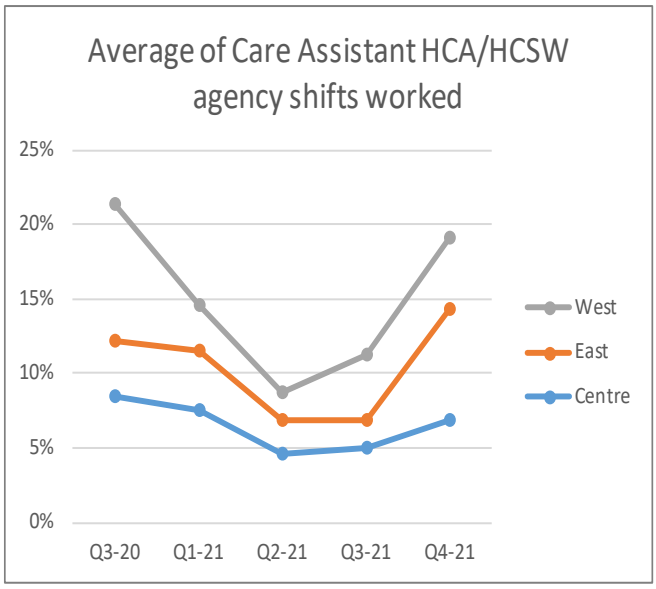


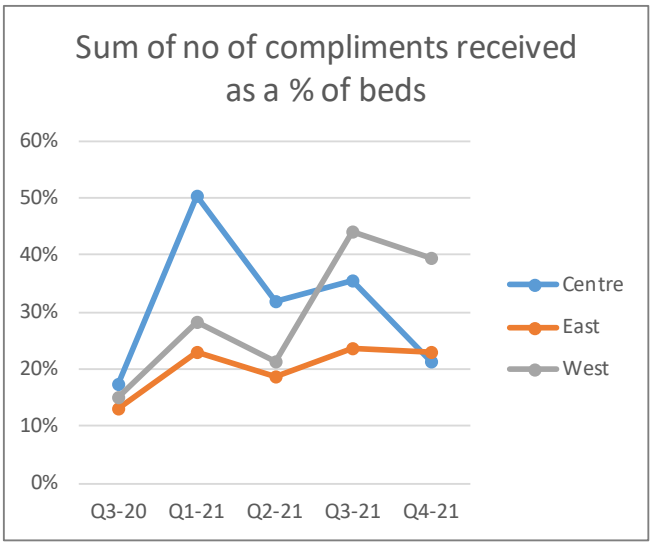


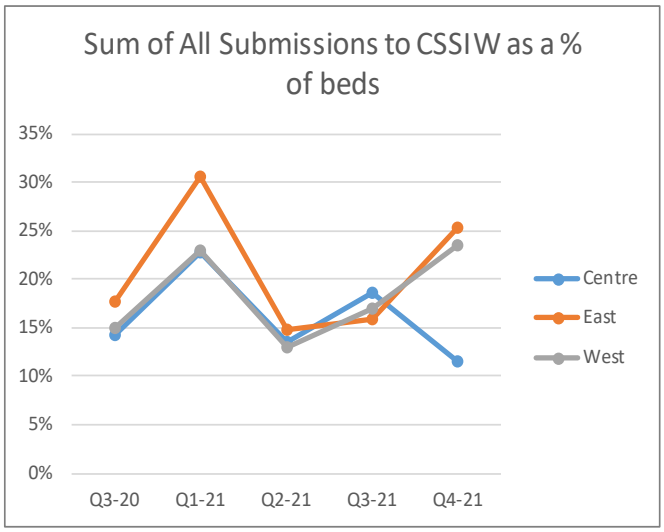


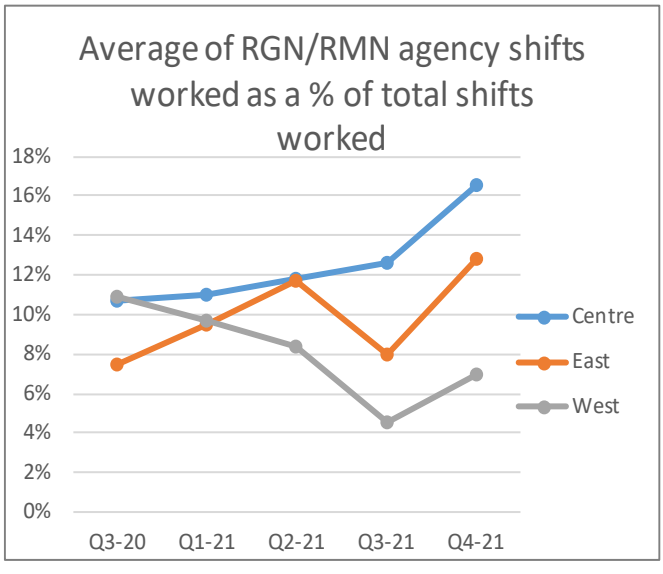
Quarter 4 2020/21 -Self-Declaration of Quality Assurance Indicators by Area – Nursing Homes – North Wales

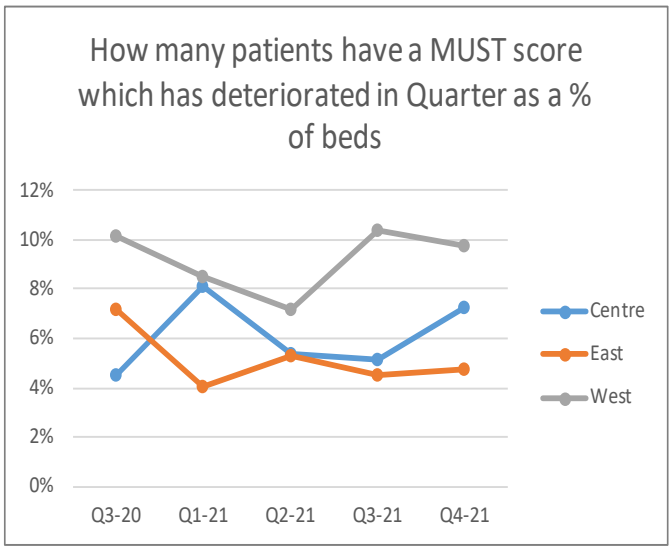

Number of medication incidents/errors that have been identified as a % of beds
4%
3%
2%
1%
0%
Q3-20
Q1-21
Q2-21
Q3-21
Q4-21
Centre
East
West


Average of Care Assistant HCA/HCSW agency shifts worked
25%
20%
15%
10%
5%
0%
Q3-20
Q1-21
Q2-21
Q3-21
Q4-21
West
East
Centre


Sum of no of compliments received as a % of beds
60%
50%
40%
30%
20%
10%
0%
Q3-20
Q1-21
Q2-21
Q3-21
Q4-21
Centre
East
West


Sum of All Submissions to CSSIW as a % of beds
35%
30%
25%
20%
15%
10%
5%
0%
Q3-20
Q1-21
Q2-21
Q3-21
Q4-21
Centre
East
West


Average of RGN/RMN agency shifts worked as a % of total shifts worked
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
Q3-20
Q1-21
Q2-21
Q3-21
Q4-21
Centre
East
West


How many patients have a MUST score which has deteriorated in Quarter as a % of beds
12%
10%
8%
6%
4%
2%
0%
Q3-20
Q1-21
Q2-21
Q3-21
Q4-21
Centre
East
West

Annex 5

3rd Sector Commissioning and Governance arrangements

Introduction

The HB has contracted expenditure with 3rd Sector organisations which totals £3.3 million in the financial year 2021/2022. There are 17 historic grant agreements which account for £0.8 million, with a further 49 that are formal contracts with a total spend of £2.5 million.

In 2019/2020 3rd Sector grant agreements and contracts were aligned to divisions and related budgets were devolved to facilitate divisional ownership and management. A number of contracts are pan North Wales and these were devolved to 'Host' divisions. Annex 6 provides the detail.

The responsibility for the performance management of contracts sits with the accountable division under delegated budget arrangements, who have responsibility for defining specifications, tendering, agreeing contracts and carrying out ongoing contract and performance management to review the effectiveness of commissioned services and inform future decisions.

Regular meetings and the use of key performance indicators to manage performance across Divisions currently varies in terms of frequency and level of detail collected. This is one of the key drivers for the review of commissioning arrangements and the development of an integrated commissioning approach with Local Authority partners, a proposal recommended within the main body of this annex.

Situation

The purpose of the third sector commissioning review is to determine the extent to which grant funded initiatives and third sector contracts are achieving the desired outcomes and remain strategically relevant to the changing needs of the North Wales population. The review will be undertaken in light of the Covid-19 pandemic and the changed environment / ways of working, and our work to review and refresh the 'Living Healthier Staying Well' strategic principles and priorities

A number of improvement actions are required to strengthen BCUHB's approach to third sector commissioning. These include:

- ensuring that all commissioned services are subject to a full and robust review
- moving away from rolling one year funding agreements and inflationary uplifts that are often applied in an ad-hoc manner – and move towards 3+2 year contract terms
- having a robust contract monitoring and reporting process in place that is outcomes focussed for all third sector services (rather than some)

In undertaking the improvement actions we are looking to align ourselves more closely with the commissioning approach adopted by Local Authorities

Background

Commissioning has been identified as a key function of integrated health and social care localities, which are being developed through the work of the Community Services Transformation programme in response to A Healthier Wales. Work is currently underway as part of the Conwy-West pacesetter to consider what integrated place-based commissioning needs to look like. To support the work of the pacesetter, a report into alternative delivery models for integrated care was commissioned by the Community Services Transformation programme. The review, undertaken by Denbighshire County Council Legal Services, highlighted integrated commissioning as an important priority underpinning integration. The recommendation came from an understanding that integrated commissioning can help to pave the way for the greater alignment of health and social care, through the development of single/ joint outcomes frameworks for integrated care at a locality level.

The work to develop an integrated response to third sector commissioning is intended to serve as a ‘test for change’ and allow partners to develop the required systems and processes, to support the integrated commissioning of a wider range of community/ locality based services, using relatively smaller sums of money, and with less risk to partner organisations.

Central to the Community Services Transformation Programme is the need to develop strong and resilient community care and support, including services provided by the third sector. The proposed work to integrate third sector contracts, and align contract terms and conditions will help to strengthen the third sector, and support the development of a more resilient and responsive marketplace.

Assessment & Analysis

A review of third sector contracts and development of an integrated commissioning approach will significantly strengthen our focus on the provision of prevention and well-being services across North Wales.

Benefits include:

- detailed contract management that allows us to understand service activity and achievement against outcomes and help to identify whether there is

capacity within commissioned services that can be flexed at times when an escalated response is required. Significantly, where a service is identified as operating below capacity, it will enable us to work with the provider to step up the service response without incurring additional costs

- commissioned activity that responds to and is aligned with our strategic priorities. It allows robust evidence based commissioning decisions to be made, as well as funding to be released and re-invested, as priorities change over time

- regular contract management that helps to facilitate sound market management, and ensures that the commissioned provider is delivering in a way that meets identified outcomes. Systems and measures will be in place to ensure providers are accountable

- collaborative and / or integrated third sector commissioning across health and social care that supports a prudent health care approach by reducing duplication and allowing partners to strengthen existing services or re-invest in new services within existing resources.

Whilst the shift towards integrated commissioning brings a number of benefits for third sector providers, it will be important to co-produce alternative commissioning models from an early stage in order to alleviate any concerns, outline intended benefits, and secure buy-in.

The role of the County Voluntary Services Council's (CVC) in supporting this work is imperative in helping to engage with the wider sector, although it should be acknowledged that the CVCs do not represent all third sector providers operating across North Wales. Consideration will need to be given to how best to include other providers and at what stage. If the approach is agreed, partners would need to be clear about the role of the CVC, and in particular, any conflicts of interest that may arise from CVCs having a provider arm. Terms and conditions in relation to this would need to be incorporated into joint Compact Agreements where appropriate.

We recognise that there is no one size fits all solution and partners should agree how best to move forward with integrated commissioning, pooled budgets and partnership agreements to reflect local difference. The review process will be underpinned by agreed outcomes frameworks that describe the outcomes to be achieved at a locality level.

A proposed timetable can be found in Annex 7. If agreed, this will be developed into a more detailed implementation plan. The timescales will need to be reviewed if delays in securing sign-up from Local Authority partners are incurred.

Financial Implications

The review of third sector contracts will provide an opportunity to release funding from those contracts that are no longer deemed strategically relevant and / or where there is significant overlap with other Local Authority funded services. The released funding can be re-invested to strengthen existing and / or support new third sector services.

Resources will be required in order to agree and align commissioning and contracting arrangements, review third sector contracts, and implement any commissioning decisions that come as a result of the review.

BCUHB has agreed that Officers from within the Contracts Team will support the review of joint Contracts. Area and Divisional Directors have agreed to assign a senior member of each of their Management Teams to support this work. Resources will need to be identified within each Local Authority if approval to proceed with joint commissioning arrangements is given.

The review is a considerable undertaking and further more dedicated resource may need to be identified to support the process.

Risk Analysis

Once the review has been completed and work undertaken to determine the services required to meet agreed outcomes, work will need to take place to implement the commissioning decisions. This will inevitably include the decommissioning of some existing contracts and the commissioning of new contracts. The review may therefore be of a sensitive nature and could incur local and regional political interest.

Recommendations

Members of the F& P Committee are asked to note the proposals and agree to:

- a review of third sector services moving away from 12 month funding agreements and ad-hoc inflationary uplifts towards 3+2 year contract terms

- a programme of work to develop integrated commissioning and contract arrangements with Local Authority partners.
  Note: Proposals to develop a phased approach to integrated commissioning were presented to the Regional Commissioning Board on the 16th June 2021 and the Community Services Transformation Board on 22nd July 2021. Whilst the principle of joint commissioning was endorsed, further work is required to agree local approaches and sign-up

- proceed with a review on a stand-alone basis in the event of being unable to secure timely approval from Local Authority partners to proceed with joint integrated commissioning arrangements. Robust contract management should be embedded within our core practice regardless of any decision to move forward with integrated commissioning arrangements.

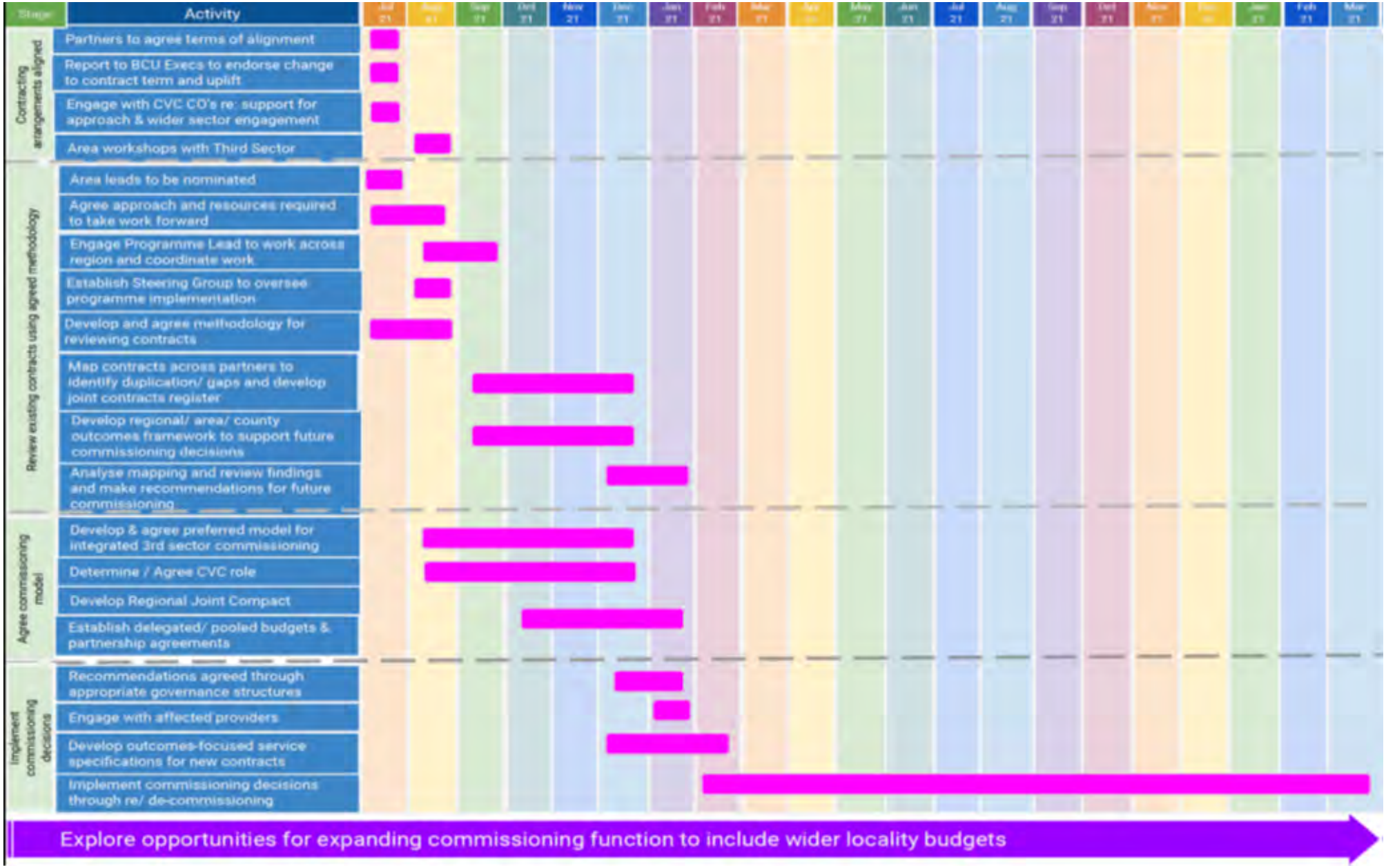
The scope of the review shall include all third sector contracts commissioned across primary and community services, and mental health and learning disabilities. If approval to proceed with joint commissioning arrangements is given by Local Authority partners, it will also include those third sector contracts that sit within Adult Social Care Departments.

Annex 6

Table 7: Analysis of Grants and Contracts between Divisions

03/08/2021					
SUPPLIER	**Division**	**TYPE**	**19/20**	**20/21**	**21/22**
Cwmni Addysg Rhyw	Centre	Contract	36,614	36,614	75,000
Conwy Voluntary sector council	Centre	Contract	38,885	38,885	39,663
Denbighshire Voluntary servs cncl	Centre	Contract	38,885	38,885	39,663
CADMHAS IMCA	Centre	Contract			23,187
North Wales Deaf Association transition support service	Centre	Contract	21,650	21,650	22,083
Care & Repair Conwy	Centre	Contract	15,000	15,000	15,300
Young carers - Conwy county council	Centre	Contract		11,500	11,500
Care & Repair Denbs	Centre	Contract	5,000	5,000	5,100
FPA Cymru	Centre	Contract	21,463		
Young carers & Stepping Stones- Conwy county council	Centre	Contract	35,500		
Rape and Sexual Abuse support Centre north wales	Centre	Grant		40,000	40,800
Cruze Bereavement	Centre	Grant	3,000	3,000	3,060
DVSC - Denbighshire forum for learning disabilities	Centre	Grant	3,349		
	Centre Total	**13**	**219,346**	**210,534**	**275,355**
Epilepsy Wales	Corporate	Contract	44,433	44,433	45,322
Neurotherapy	Corporate	Contract	20,000	20,000	20,604
ASNEW IMCA	Corporate	Contract			10,937
MHAS IMCA	Corporate	Contract			9,625
Unllais IMCA	Corporate	Contract		174,631	-
	Corporate Total	**5**	**64,433**	**239,064**	**86,488**
British Red Cross	East	Contract	100,000	100,000	135,000
British Red Cross - Centre, West and East	East	Contract	111,100	111,099	113,321
AVOW	East	Contract	41,208	41,208	42,032
Flintshire Local Voluntary council	East	Contract	41,208	41,208	42,032
Newcis - Community hospital coordinator	East	Contract	39,421	39,421	40,210
Care & Repair - enabling & adaptations response service	East	Contract		20,000	20,400
Newcis - Primary care Coordinator	East	Contract	18,672	18,672	19,045
NEWCIS Primary care Coordinator	East	Contract	13,062	13,062	13,324
Care & Repair Flintshire	East	Contract	10,000	10,000	10,200
Newcis-Barnados	East	Contract		9,000	9,180
Newcis	East	Contract	5,804	5,804	5,921
Newcis - Core funding	East	Contract	3,879	3,879	3,957
Young Carers - Barnardos	East	Contract	9,122	9,122	-
The Stroke association	East	Grant	101,435	101,435	104,363
Stepping stones	East	Grant		24,000	24,480
Systems Advocacy	East	Grant	3,998	3,998	-
	East Total	**16**	**498,910**	**551,909**	**583,464**
Parabl	MHLD	Contract	303,000	303,000	309,060
Crossroads for Dementia	MHLD	Contract	193,779	193,779	197,655
Wrexham Borough Council	MHLD	Contract	149,149	149,149	149,149
MIND Y Gelli	MHLD	Contract	145,631	145,631	148,544
Community Mental Health Advocacy Flintshire & Wrexham	MHLD	Contract	106,050	106,050	108,171
Community Mental Health Advocacy Gwynedd & Mon	MHLD	Contract	101,000	101,000	103,020
Community Mental Health Advocacy Conwy & Denbighshire	MHLD	Contract	95,950	95,950	97,869
change step (was combat stress)	MHLD	Contract	71,921	71,921	74,924
ASNEW IMHA	MHLD	Contract			70,170
CADMHAS IMHA	MHLD	Contract			70,170
MHAS IMHA	MHLD	Contract			70,170
Vale of Clwyd Mind Association	MHLD	Contract		49,979	50,979
Vale of clwyd MIND Rhyl - Mahoneys	MHLD	Contract	39,175	39,175	39,959
The KIM Project	MHLD	Contract		31,279	31,905
Delyn Women's Aid Co Ltd	MHLD	Contract		28,753	29,328
MIND Ynys Mon	MHLD	Contract	24,564	24,564	25,055
Dolgellau & Tywyn social groups	MHLD	Contract	10,000	10,000	20,400
Flintshire Mind	MHLD	Contract		6,952	7,091
Vale of clwyd MIND SOPS	MHLD	Contract	5,885	5,885	6,003
Unllais - IMHA	MHLD	Contract	421,025	421,025	-
Abbey Road Centre	MHLD	Grant	95,381	95,381	97,289
Tan Y Maen	MHLD	Grant	51,627	76,519	78,050
Canolfan Felin Fach	MHLD	Grant	67,550	67,550	68,901
Aberconwy MIND	MHLD	Grant	65,092	65,092	66,394
Hafal Denbighshire rural	MHLD	Grant	39,336	39,336	40,123
Hafal - Wrexham Community Support Service	MHLD	Grant		38,963	39,742
Advances Brighter Futures	MHLD	Grant	35,664	35,664	36,377
Hafal - Conwy Family Support Service	MHLD	Grant		31,872	32,509
Hafal Flintshire	MHLD	Grant	29,045	29,045	29,626
Hafal Arosfa	MHLD	Grant	23,839	23,839	24,316
Hafal - Wrexham Family Support Service	MHLD	Grant		10,986	15,219
Conwy Connect	MHLD	Grant	14,583	14,583	14,875
Dolgellau Towyn Group	MHLD	Grant	7,500		
Tywyn Community Wellbeing Project	MHLD	Grant	10,000		
	MHLD Total	**34**	**2,106,747**	**2,312,923**	**2,153,041**
Crossroads North wales	West	Contract	80,000	80,000	81,600
Medwrn Mon	West	Contract	41,400	41,400	42,228
Careers outreach service	West	Contract	12,458	12,458	12,707
Care & Repair Anglesey	West	Contract	5,000	5,000	5,100
Care & Repair Gwynedd	West	Contract	5,000	5,000	5,100
Young Carers Ynys Mon	West	Contract	3,871	3,871	3,948
Ynys Mon CC - Anheddau	West	Contract	15,861		
Mantell Gwynedd	West	Grant	38,885	38,885	39,663
	West Total	**8**	**202,475**	**186,614**	**190,346**
	Grand Total	**68**	**3,091,911**	**3,501,044**	**3,288,694**

Annex 7: Integrated Commissioning Roadmap


Stage
Activity
Contracting arrangements aligned
Partners to agree terms of alignment
Report to BCU Execs to endorse change to contract term and uplift
Engage with CVC CO's re: support for approach & wider sector engagement
Area workshops with Third Sector
Review existing contracts using agreed methodology
Area leads to be nominated
Agree approach and resources required to take work forward
Engage Programme Lead to work across region and coordinate work
Establish Steering Group to oversee programme implementation
Develop and agree methodology for reviewing contracts
Map contracts across partners to identify duplication/ gaps and develop joint contracts register
Develop regional/ area/ county outcomes framework to support future commissioning decisions
Analyse mapping and review findings and make recommendations for future commissioning
Agree commissioning model
Develop & agree preferred model for integrated 3rd sector commissioning
Determine / Agree CVC role
Develop Regional Joint Compact
Establish delegated/ pooled budgets & partnership agreements
Implement commissioning decisions
Recommendations agreed through appropriate governance structures
Engage with affected providers
Develop outcomes-focused service specifications for new contracts
Implement commissioning decisions through re/ de-commissioning
Explore opportunities for expanding commissioning function to include wider locality budgets

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **26.8.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Monthly Monitoring Report – Months 3 & 4**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tom Stanford, Interim Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	The submission made to Welsh Government required Chief Executive and Director of Finance sign off.
Atodiadau **Appendices:**	Appendix 1: Month 3 Monitoring Return Narrative Report Appendix 2 Month 4 Monitoring Return Narrative Report

Argymhelliad / Recommendation:

Note the contents of the report that has been made to Welsh Government about the Health Board's financial position for Months 3 & 4 of 2021/22.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad/cymeradwyaeth **For Decision/ Approval**		**Ar gyfer Trafodaeth** **For Discussion**		**Ar gyfer sicrwydd** **For Assurance**		**Er gwybodaeth** **For Information**	✓

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**	**N**

Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable.

Sefyllfa / Situation:

To report to the Committee the completion of monthly reporting to Welsh Government for Months 3 & 4 of 2021/22.

Cefndir / Background:

- The refreshed financial plan for 2021/22 was submitted to Welsh Government at the end of June. This provided the latest forecasts and assessments for the year, including the impact of COVID-19. It also incorporated the additional funding notified to the Health Board in Quarter 1, to offset the impact of the undelivered savings from 2020/21.

- The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

- The recovery from COVID-19 and the related workforce constraints are the main risk to the delivery of the schemes relating to the £42.0m this year and so the Health Board is actively identifying alternative schemes which can be mobilised in order to ensure we maximise the opportunity to improve performance.

- We are testing our assumptions in the original plans and if required will refresh our forecasts with the divisional teams, by month 6, to ensure that the overall forecast outturn is robust and achieved.

This may include additional outsourcing, interims or consultancy, to progress some of the larger schemes.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications

This paper aligns to the strategic goal of attaining financial balance and is linked to the well-being objective of targeting our resources to those with the greatest need.

Opsiynau a ystyriwyd / Options considered

Not applicable – report is for assurance only

oblygiadau Ariannol / Financial Implications

Financial position

- The in-month for month 4 position is a deficit of £58k which brings the cumulative position to breakeven. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

- The total cost of COVID-19 in July is £8.9m (£29.7m for the year to date). Welsh Government income has been anticipated which exceeds these costs. This additional COVID-19 funding (totalling £32.6m), was issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.2	0.3	0.8	3.0
Tracing	1.1	1.0	1.0	0.9	4.0	14.8
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	6.0	16.8
Extended FLU Vaccinations	0.0	0.0	0.0	0.0	0.0	1.2
Field Hospital/Surge	0.3	0.7	0.2	0.5	1.7	1.7
Cleaning Standards	0.0	0.0	0.0	0.0	0.0	0.9
Other Costs	4.5	3.6	4.5	6.3	18.9	72.7
Total COVID-19 costs	**7.7**	**7.0**	**7.9**	**8.8**	**31.4**	**111.1**
Non Delivery of Savings	0.8	(0.8)	0.0	0.0	0.0	0.0
Expenditure Reductions	(0.2)	(0.7)	(0.8)	0.1	(1.7)	(2.3)
Slippage on Planned Investments	0.0	0.0	0.0	0.0	0.0	0.0
Total Impact of COVID-19	**8.3**	**5.5**	**7.1**	**8.9**	**29.7**	**108.8**
Welsh Government Funding	(8.3)	(11.9)	(10.6)	(11.5)	(42.3)	(143.8)
Impact of COVID-19 on Position	**0.0**	**(6.4)**	**(3.5)**	**(2.6)**	**(12.6)**	**(35.0)**

Forecast

- The forecast position has been maintained at a balanced position for the year.

- The forecast assumes that the pay award will be 1% for the year but in the event that the pay award is higher than expected, the risk is that it will not be funded.

- The forecast total impact of COVID-19 is currently is £111.1m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to more than cover this cost, with £32.7m of COVID-19 funding supporting the core position. This equates to the additional funding issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

- Other costs have increased to £6.3m in July from £4.5m in June due to increase in healthcare services provided by other NHS bodies in England (£1.3m) and in primary care drugs (£0.5m).

- As additional modelling data for COVID-19 is received, and in line with the refresh of the financial plan, this forecast will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospitalisations.

Dadansoddiad Risk / Risk Analysis

Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Not applicable.

Asesiad Effaith / Impact Assessment
Not applicable.

MONITORING RETURN

MONTH 3 2021/22

Sue Hill

Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION & FORECAST

1.1 Financial Plan

- The refreshed financial plan for 2021/22 was submitted to Welsh Government at the end of June. This provided the latest forecasts and assessments for the year, including the impact of COVID-19. It also incorporated the additional funding notified to the Health Board in Quarter 1, to offset the impact of the undelivered savings from 2020/21.

- The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

- The potential of a COVID-19 3rd wave and the related workforce constraints are the main risk to the delivery of the schemes relating to the £42.0m this year and so the Health Board is actively identifying alternative schemes which can be mobilised in order to ensure we maximise the opportunity to improve performance.

1.2 Actual Year to Date Position

- The in-month position is a small surplus of £0.02m, which gives a cumulative surplus position of £0.06m. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

- The total cost of COVID-19 in June is £7.2m (£21.0m for the year to date). Welsh Government income has been anticipated which exceeds these costs, with £3.5m of COVID-19 funding used to support the core position. This additional COVID-19 funding (totalling £32.6m), was issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

1.3 Forecast Position

- The forecast position has been maintained at a balanced position for the year.

1.4 Income (Table B)

- Income totals £158.8m for June. Further details are included in Section 7.

- The impact of COVID-19 has resulted in lost income of £0.4m in June (£1.1m year to date) relating to General Dental Services (GDS) patient income. This is included as a cost of COVID-19 within the "Other" category.

1. FINANCIAL POSITION & FORECAST

1.5 Actual Expenditure (Table B)

- Expenditure totals £158.8m for Month 3. This is £2.1m more than in Month 2, with the increase being primarily attributable to increased costs for Primary Care drugs and Capital charges, offset by a decrease in Provider Services non-pay costs.

- Costs of £8.1m are directly related to COVID-19 this month (£22.8m year to date). Of this £2.8m is pay and £5.2m is non-pay.

- The expenditure forecasts in the Month 2 return were at a point in time and were not finalised until the financial plan was submitted at the end of June. Therefore, the actual spend and future forecasts in Table B may differ from the Month 2 return. Going forward, any significant deviations from the financial plan, as shown in the Minimum Data Set (MDS), will be explained in this report.

Primary Care	• Spend of £19.1m is in line with May. Primary Care pay, arising from Managed Practices, continues to be a pressure and so costs have not reduced as had been anticipated last month or in the plan. • Pressures in General Medical Services (GMS) also remain from increased costs of drugs reported through GMS Dispensing and GP Prescribing. • Further details on GMS and General Dental Services (GDS) are included in section 4.
Primary Care Drugs	• The expenditure for Month 3 is £1.3m (17%) more than in Month 2 and back to the level seen in Month 1. However, Month 1 had 21.5 prescribing days, Month 2 had 19.5 and Month 3 had 22.5 prescribing days. With three more prescribing days in Month 3 and an average cost per prescribing day of £0.48m, this increase is in line with the expected levels. • Following receipt of the April prescribing data, the average cost per prescribing day has increased; April was £477k compared to March at £462k, representing an overall increase of 2.9%. • The average cost per item has remained stable (a small reduction of 0.3%), but the number of items has increased by 3.5%. Therefore, the increase in the average cost per prescribing day is driven by volume not price, suggesting a return to business as usual. • The expenditure in Month 3 was £0.8m less than had been forecast. This is because up to the April Comparative Analysis System for Prescribing Audit (CASPA) data, we had been seeing an upwards trend for the average cost per prescribing day, which was factored

	into forecasts. However, this has not continued at anticipated rates within the April data. • Also, April is the first, and only, actual data and costs for 2021/22, and so may not be indicative for the remaining 11 months of the financial year. • The cumulative overspend is £0.3m, with a forecast adverse variance of £1.5m for the year.
Provided Services - Pay	• Provided Services pay costs are £69.7m, which is £0.6m (1%) less than in Month 2. • Month 2 included two months' worth of estimated costs for the 2021/22 pay award, to also account for Month 1. Costs and funding have been profiled equally across the rest of the year. Therefore, the impact of the additional month in May was £0.7m, which accounts for the fall in spend this month. • Agency costs have increased by £0.2m compared to last month. Further details on agency spend are included in section 5.1. • A total of £2.8m of pay costs were directly related to COVID-19, which is £0.3m higher than in May. • Spend in Month 3 is £2.3m less than had been forecast in the MDS. Reductions can be seen across all staff groups, but particularly in Nursing & Midwifery (£0.6m less) and Medical & dental (£0.5m less). There has been slippage of £0.8m on the £42.0m Performance Fund and Strategic Support monies, due to delays in recruitment for schemes. In addition, there has been slippage on the £19.9m COVID-19 Recovery Plan funding totalling £0.5m and spend that it was originally anticipated would be pay is now being incurred as non-pay costs. • The Health Board has made a further £0.3m of payments for staff bonuses against the accrual during Month 3, which leaves a remaining accrual of £2.8m. There will be a small number of further payments up to September, relating to employees who elected to receive their bonus payment in instalments. The Health Board is also aware of a group of staff that were not considered eligible to receive the bonus but who have subsequently requested for this decision to be reviewed, as they believe that they meet the criteria. • Based on the above the Health Board is anticipating a cash drawing requirement of £18.0m and this has been included in both Table E Resource Limits and Table G Monthly Cashflow Forecast in the Month 3 submission. This request will be subject to adjustment over the next few months as final payments are made.

1. FINANCIAL POSITION & FORECAST

Provider Services Non-Pay	• Spend in June is £1.7m (10%) less than in May. This decrease primarily relates to anticipated spend of Intermediate Care Fund (ICF) monies that were included in Month 2 (total of £1.9m). • Offsetting this, activity has increased further across the three acute sites, leading to an increase in non-pay costs. Scheduled Care activity is up by circa 18% across sites, which is driven by increases in Theatres activity. All three sites have also seen significant increases in Emergency Department activity, which is above equivalent 2019/20 levels. These all indicate that there is a return to business as usual and this is happening sooner than had been anticipated. • Month 3 actual spend is £0.4m lower than the forecast in the MDS. This is due to slippage of £0.8m on the £42.0m Performance Fund and Strategic Support monies, offset by more of the COVID-19 Recovery Plan spend being non-pay, rather than pay, than had originally been anticipated.
Secondary Care Drugs	• Costs are £0.8m (13%) higher than both Month 2 and the forecast for June in the MDS. • This increase in costs is across specialities and is being driven by the increase in activity for both Scheduled Care and through Emergency Departments. • Cancer drugs have increased by £0.3m from last month, which is due to patients on a double regimen, where costs are incurred every three months. • In addition, as with Primary Care Drugs, the extra three Prescribing Days in June compared to May has increased spend this month.
Healthcare Services provided by other NHS Bodies	• Spend has increased by £0.6m (2%) on last month and is £1.3m higher than anticipated in the MDS. This is due to increases in the WHSCC contract. • Block contracts with English providers remain, however there is a risk around inflation on these contracts, as well as inflation on Welsh contracts and a future pay award.
Continuing Health Care (CHC) and Funded Nursing Care (FNC)	• Expenditure in June is £0.7m (7%) lower than in May and £0.7m below the forecast for the month in the plan. • Costs have reduced for high cost Children's CHC cases and also in Mental Health, where efficiencies, as reported through savings, are over achieving. • CHC costs related to COVID-19 totalled £0.9m in June, which is £0.4m less than May and further explains the decrease in overall spend.

Other Private and Voluntary Sector	• Expenditure relates to a variety of providers, including hospices and Mental Health organisations.
Joint Financing	• Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget.
Losses, Special Payments and Irrecoverable Debts	• Includes Redress, Clinical Negligence, Personal Injury and loss of property.
Capital	• Includes depreciation and impairment costs, which are fully funded. • Capital costs have increased in month and compared to the MDS due to the June non-cash submission. The forecast submission in June included the request of additional strategic depreciation and baseline support of £7.4m. This increased resource requirement has been phased over 12 months, resulting in the increase in costs in Month 3.

1.6 Forecast Expenditure (Table B)

- Forecast costs have been revised from the Month 2 return, so that they align with the Minimum Data Set (MDS) tables that were submitted as part of the refreshed financial plan.

- Significant changes to annual expenditure have arisen between the MDS and the Month 3 return in the following categories:
  - Payments to Local Authorities for COVID-19 Tracing are shown in Provider Services Non pay in the ledger and Table B, but in Joint Financing in the MDS. This results in a £10.7m adjustment between the two expenditure lines.
  - Total pay costs have reduced by £7.4m. This reflects the reassessment of where additional costs for the COVID-19 Recovery Plan funding will arise, with 88% of these costs not forecast to be non-pay.
  - Secondary Care drugs have increased by £13.2m. This is due to the actual costs seen at the start of the year and the movement towards business as usual occurring earlier and more quickly than had been anticipated. In addition, £1.2m of the COVID-19 Recovery Plan funding is now expected to be spent on Secondary Care drugs.
  - Healthcare Services Provided by Other NHS Bodies has increased by £13.0m. This reflects increases in the WHSCC contract and an increased expectation of the use of outsourcing from NHS rather than private providers. As a result of this shift, the forecast for Other Private & Voluntary Sector spend has reduced (by £8.9m).
  - Capital charge costs have moved, in line with the June non-cash submission.

1. FINANCIAL POSITION & FORECAST

- The NHS pay award for 2021/22 has not yet been confirmed. The forecast includes an estimate of the pay award costs and funding, which have been profiled across Months 2 to 12. £0.7m, equivalent to 1/12th, has been included in Month 3. The total expenditure for the year is forecast at £8.8m. As more detail is received on the amount and timing of any award, the phasing will be adjusted accordingly.

- Expenditure related to the £30.0m funding for the Performance Fund and £12.0m Strategic Support included in the forecast, based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend over the remaining months of the year. This cost profile is dependent on operational teams implementing approved plans at pace. There may be movements between pay and non-pay as schemes progress and the ability for Health Board staff to undertake additional work is assessed. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts. The table below gives the phasing for these schemes, as included in the forecast.

	Actual			Forecast									
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.3	0.4	0.6	2.1	2.3	2.7	3.3	3.4	3.3	4.3	4.2	5.0	31.9
Non-Pay	0.0	0.0	0.3	0.2	0.3	0.5	1.6	1.6	1.6	1.6	1.6	0.8	10.1
Total	**0.3**	**0.4**	**0.9**	**2.3**	**2.6**	**3.2**	**4.9**	**5.0**	**4.9**	**5.9**	**5.8**	**5.8**	**42.0**

- As discussed with Welsh Government, some of this £42.0m non-recurrent funding has been committed recurrently as it relates to staff posts. The Health Board would welcome a further discussion around how best to show this is the in the Monitoring Return tables, to ensure there is transparency around our future commitments.

1.7 Accountancy Gains (Table B)

- The Health Board is not reporting any accountancy gains this month.

1.8 COVID-19 (Table B3)

- The total impact of COVID-19 in June, including all costs offset by expenditure reductions, is £7.2m. Welsh Government funding has fully offset the impact of COVID-19.

1. FINANCIAL POSITION & FORECAST

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.3	0.6	2.8
Tracing	1.1	1.0	1.0	3.1	13.9
Mass COVID-19 Vaccinations	1.7	1.5	2.1	5.3	17.5
Extended Flu Vaccinations	0.0	0.0	0.0	0.0	1.1
Field Hospital/Surge	0.3	0.7	0.2	1.2	1.5
Cleaning Standards	0.0	0.0	0.0	0.0	2.2
Other Costs	4.5	3.6	4.5	12.6	72.1
Total COVID-19 costs	**7.7**	**7.0**	**8.1**	**22.8**	**111.1**
Non Delivery of Savings	0.8	(0.8)	0.0	0.0	0.0
Expenditure Reductions	(0.2)	(0.7)	(0.9)	(1.8)	(2.9)
Slippage on Planned Investments	0.0	0.0	0.0	0.0	0.0
Total Impact of COVID-19	**8.3**	**5.5**	**7.2**	**21.0**	**108.2**
Welsh Government Funding	(8.3)	(11.9)	(10.6)	(30.8)	(143.8)
Impact of COVID-19 on Position	**0.0**	**(6.4)**	**(3.4)**	**(9.8)**	**(35.6)**

- The forecast total impact of COVID-19 is currently is £108.2m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to more than cover this cost, with £35.6m of COVID-19 funding supporting the core position. This equates to the additional funding issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

- Movements in the overall forecast from last month are as follows:

	Forecast at Month 2 £m	Forecast at Month 3 £m	Change £m
Testing	2.8	2.8	0.0
Tracing	13.5	13.9	0.4
Mass COVID-19 Vaccinations	12.7	17.5	4.8
Extended Flu Vaccinations	1.1	1.1	0.0
Field Hospital/Surge	1.4	1.5	0.1
Cleaning Standards	2.5	2.2	(0.3)
Other Costs	69.3	72.1	2.8
Total COVID-19 costs	**103.3**	**111.1**	**7.8**
Non Delivery of Savings	0.0	0.0	0.0
Expenditure Reductions	(2.8)	(2.9)	(0.1)
Slippage on Planned Investments	0.0	0.0	0.0
Total Impact of COVID-19	**100.5**	**108.2**	**7.7**

- The main change is a £4.8m increase in mass COVID-19 vaccination costs. This reflects the continued high level of spend in this area, along with a booster programme later in the year.

1. FINANCIAL POSITION & FORECAST

At Month 2, it was anticipated that payments to GPs for undertaking vaccinations would cease after 6 months. However it is now forecast that these will continue for the full year, which has resulted in £5.2m of additional costs. This have been slightly offset by small reductions in expected Health Board pay and non-pay costs.

- As additional modelling data for COVID-19 is received, and in line with the refresh of the financial plan, forecasts will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospitalisations.

- Included within the Other section on Table B3 is expenditure against the £19.9m COVID-19 Recovery Plan. Forecast costs have been phased in line with submitted plans as follows:

	Actual			Forecast									
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.1	0.0	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	2.5
Non-Pay	0.1	0.7	0.5	1.6	1.6	1.8	1.9	1.8	1.8	1.9	1.8	1.9	17.4
Total	**0.2**	**0.7**	**0.6**	**1.7**	**1.8**	**2.0**	**2.2**	**2.1**	**2.1**	**2.2**	**2.1**	**2.2**	**19.9**

- In addition to the above, £52.1m of COVID-19 costs are included in the Other section. Secondary Care costs are a large element of this and include all of the costs related to dealing with COVID-19 in the three acute sites, which covers expenditure on COVID-19 wards, increased staffing, drugs, PPE and critical care. In addition, there are significant costs included for Prescribing and CHC. Forecast costs are included based on estimates from divisional finance leads. These are best estimates at the current month and subject to all of the uncertainties around COVID-19 rates, the level of hospitalisations and the acuity of patients as restrictions are eased and then heading into the winter months.

2. UNDERLYING POSITION

2.1 Movement from Financial Plan (Table A)

- The Health Board continues to face a significant underlying deficit position, which is a consequence of our residual infrastructure and delivery inefficiencies from 2019/20, combined with the impact of the non-delivery of recurrent savings in 2020/21.

- The underlying position brought forward from 2020/21 is £75.2m. The carried forward underlying deficit is £75.2m. This is primarily as a result of:

    - £32.6m undelivered savings in 2020/21, due to COVID-19. These have been funded non-recurrently in 2021/22, but they will remain a pressure in future years.
    - £40.0m strategic support funding that is non-recurrent.

- The organisation is progressing establishment and resourcing of its transformation agenda, which will support the development of a rolling three year savings programme that will deliver savings to help bring the underlying position back into balance.

- It is currently forecast that red pipeline schemes will have an in-year impact of £3.0m and a recurring Full Year Effect of £1.4m (line 32). In addition, £2.3m of savings (line 33) have not been identified, due to the impact of COVID-19 on the Health Board's ability to identify and deliver savings this year. This is a reduction of £1.4m on last month, showing progress has been made in identifying savings schemes, however the Health Board recognises that there is further work to be done and detailed review are being held with Divisional Directors in July.

- There are no changes to planned non COVID-19 expenditure in Month 3.

- The operational forecast outturn for the year is a £35.6m deficit, offset by a £35.6m surplus on COVID-19. This reflects the additional funding to cover the impact of the undelivered savings from 2020/21, which has been classified as COVID-19 funding.

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The below are risks to the Health Board's financial position for 2021/22.

	£m	Level	Explanation
Risks			
Savings Programme – Red Risk Pipeline Schemes	3.0		There is a risk that the savings programme will not deliver the £17.0m target, as per the financial plan. Savings of £10.2m are forecast for delivery in 2021/22, which includes £3.0m of red-rated schemes in the pipeline. Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.
Savings Programme - Planning Assumptions	2.3		There is a risk that the planning assumptions still be to identified, which total £2.3m, will not deliver in the current financial year. Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.

4. RING FENCED ALLOCATIONS

4.1 GMS (Table N)

- Not required this month.

4.2 GDS (Table O)

- Not required this month.

5. AGENCY/LOCUM EXPENDITURE

5.1 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 3 are £3.7m, representing 5.2% of total pay. This is an increase of £0.2m on Month 2, with the increase relating to medical agency spend. Monthly agency spend for June included £0.4m that related to COVID-19, £0.1m less than last month.

- Medical agency costs have increased by £0.2m compared to last month; to an in-month spend of £1.7m. COVID-19 costs were £0.1m in June and £0.2m in May.

- Nurse agency costs totalled £1.4m for the month, the same as last month. Acute sites continue to carry a high level of nursing vacancies and the overseas nurses that have started are still not fully registered and so are above the establishment. Further investigations are taking place to understand the increased costs. COVID-19 costs were £0.1m in June, the same as in May.

- Other agency costs total £0.6m this month, the same as last month. In June, £0.2m related to COVID-19, primarily Admin and Clerical, the same as in May.

6. SAVINGS

6.1 Savings (Tables C – C3)

- Savings in Month 3 totalled £1.1m, an increase of £0.3m over the delivery in Month 2. This gives cumulative savings delivered of £2.5m for the year to date.

- Savings of £8.5m are forecast for delivery in 2021/22 against identified amber and green schemes, an increase of £0.2m compared to Month 2.

- Red schemes in development are expected to deliver a further £3.0m by year end, an increase of £1m against Month 2. Work is ongoing to convert these schemes to amber and green by the deadline dates identified in the tracker.

- Further opportunities are being identified both within Divisions and across BCU to ensure delivery of the savings included within the financial plan.

- The residual shortfall in anticipated savings delivery of £2.3m has been included on line 33 of Table A.

7. INCOME ASSUMPTIONS

7.1 Income/Expenditure Assumptions (Table D)

- Most of the figures in Table D are included based on 2020/21 outturn.

7.2 Resource Limits (Table E)

- The Revenue Resource Limit (RRL) is £1,807.6m for the year. £431.0m of the RRL has been profiled into the position cumulatively, which is £20.9m less than three equal twelfths, primarily due to the profile of COVID-19 and performance funding.

- A reconciliation between the RRL phased into the position and an equal phasing is shown in the table below.

	M03 £m
RRL (Table E)	1,807.6
Less COVID-19 funding (Table E, line 90)	(143.8)
Less funding for specific purposes, e.g. performance funding	(63.0)
Adjusted RRL	1,600.8
Equal 12ths phasing	400.2
Add YTD COVID-19 funding	30.8
Phased YTD RRL	431.0
Actual YTD RRL (Table B)	431.0
Variance	**0.0**

- Confirmed allocations to date are £1,703.1m, with further anticipated allocations in year of £104.5m. This includes £143.8m for COVID-19, of which £79.6m is included in anticipated income.

8. HEALTH CARE ARGEEMENTS & MAJOR CONTRACTS

8.1 Welsh NHS Contracts

- All Welsh healthcare agreements were agreed and signed by the deadline of the end of 11th June 2021.

9. STATEMENT OF FINANCIAL POSITION & AGED WELSH NHS DEBTORS

9.1 Statement of Financial Position (Table F)

- Key movements in the SoFP since 2020/21 are:

  - Non-current assets (Property, Plant and Equipment): decrease of £7.5m due to newly capitalised assets in year less non-cash adjustments.
  - Trade and other receivables: increase of £4.0m, which primarily relates to an increase of £25.6m in the Welsh Risk Pool debtor, offset by reductions in NHS Commissioning debtors (£4.4m), VAT debtor (£1.1m), Accounts Receivable balance (£1.4m) and RRL adjustment (£14.4m).
  - Cash: increase of £7.7m due to the timing of drawdowns and payments. Cash is forecast to end the year at the same level as in 2020/21.
  - Trade and other payables: decrease of £32.8m due £6.7m relating to HMRC, £18.0m for the bonus payment and £5.9m Accounts Payable balance reduction.
  - Provisions: increase of £27.6m primarily due to the Clinical Negligence provision.
  - General Fund: increase of £9.1m due £0.1m surplus plus £9.0m Capital Resource Limit drawn.

9.2 Welsh NHS Debtors (Table M)

- The Health Board held one outstanding NHS Wales invoice over eleven weeks old at the end of Month 3, which has been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales.

10. CASH

10.1 Cash Flow Forecast (Table G)

- The closing cash balance at the end of June was £10.9m, which included £5.5m cash held for revenue expenditure and £5.4m for capital projects.

- Further payments in respect of the NHS bonus were made during June, with the Health Board's latest forecast of total cash required to fulfil this obligation being £18.0m. This additional cash drawing requirement has been included on Tables E and G of the Month 3 return.

- The Health Board currently estimates that a further £12.0m cash relating to movements in working capital and provisions will be required during 2021/22. This relates to allocations previously provided on a resource only basis for decommissioning of Field Hospitals, consequential losses and holiday pay on overtime and additional hours. This initial estimate has been included on Tables E and G of the Month 3 return and will be updated in future submissions as actual requirements become known.

- No adjustments relating to the annual leave accrual have been included in the Month 3 Monitoring Return submission. An element of this accrual will be carried forward to 2022/23 and a view on how much will be utilised during 2021/22 will be formed in coming months based on annual leave booked on the Health Board's ESR system.

- It is currently assumed that capital payables will remain unchanged during 2021/22 and these will be updated in future months in line with progress on the capital programme.

- Table G currently forecasts a 2021/22 closing cash balance of £3.2m which is unchanged from 2020/21.

11. PUBLIC SECTOR PAYMENT COMPLIANCE

11.1 PSPP (Table H)

- The Health Board achieved the PSPP target to pay 95% of valid invoices within 30 days of receipt in three of the four measures of compliance during Quarter 1.

- NHS invoices by number remained below target at 92.0% with 82 invoices being paid later than 30 days from receipt. These invoices relate to a range of departments across the Health Board and managers have been reminded of the importance of raising purchase orders at the time that goods or services are ordered rather than waiting until invoices are received.

12. CAPITAL SCHEMES & OTHER DEVELOPMENTS

12.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2021/22 is £27.6m. There is slippage of £0.1m against the planned spend of £1.9m at Month 3. It is anticipated that this will be recovered during the rest of the year and that the CRL will be achieved.

12.2 Capital Programme (Table J)

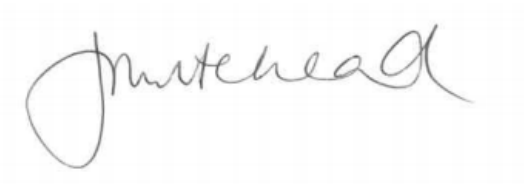
- Details of spend and forecast on a monthly basis and by scheme are included in the table. There is nothing of significance to note.

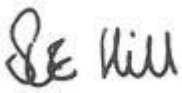
13. OTHER ISSUES

13.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.

- The Month 3 Monitoring Return will be received by the Health Board's Finance and Performance Committee members at the August meeting.





Jo Whitehead
Chief Executive

Sue Hill
Executive Director of Finance

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Month 2 Monitoring Return Responses

Other – Action Point 2.1 I note that you are reporting a revised breakeven year end position; this position includes anticipated income assumptions that remain subject to further challenge and final agreement. It is also acknowledged that this outturn is current being assisted by c. £5.700m (including c. £2.000m of red schemes) of planning assumptions still to be finalised. I trust that the required actions have been escalated as assumptions will need to be finalised in the final plans and reported as such within your Month 3 submission.
Response We have made progress in identifying the remaining savings plans and will continue to give these the highest priority.
Other – Action Point 2.2 At Month 2, generally across Wales, monthly forecast Covid-19 spend appears to reflect a rudimentary approach i.e. straight line phasing, or replicating current month actual in all future month periods etc. All organisations are therefore requested to again review the future month expenditure totals and profiles to ensure they reflect a robust assessment of future month spend.
Response The local knowledge of each Divisional management team, through the CFOs, is incorporated within the Covid-19 forecasts, and they are reviewed and updated every month to reflect changes in the uncertain landscape of Covid-19, or new knowledge and information as it arises.
Movement of Opening Financial Plan to Forecast Outturn (Table A) - Action Point 2.3 I note that the total 'new planned non covid-19 expenditure' (Line 2) has increased by £2.994m since Month 1; as we are still in the planning stage, I acknowledge the details behind this change and how this has impacted on the mitigating actions (funding/savings/assumptions still to be finalised) will form part of your final plan submission in June which will be reviewed by the FDU. Any changes after the plan has been finalised and submission will need explaining in the MMR narrative.
Response Following submission of the plan, any changes to planned non COVID-19 expenditure will be explained in the narrative.
Movement of Opening Financial Plan to Forecast Outturn (Table A) - Action Point 2.4 The year to date phasing of the Covid-19 funding is minimally higher (£0.026m) than the

corresponding phasing of the Covid-19 expenditure. Please review and correct within June and ensure that Covid-19 funding and spend aligns within all future returns.

Response

The phasing issue has been corrected for June.

Risks and Opportunities (Table A2) – Action Point 1.7

In your response to Action Point 1.7, you confirm that the risk of not delivering the red pipeline savings schemes should be included in Table A2; however this was not reported at Month 2. The opportunity of delivery of red schemes has been reported on Line 1; however, this is already part of your outturn on Table A, so is therefore double counted. In addition, please note that risks reported in Table A2 (Lines 4 – 25) should be populated as negative values. At Month 3, the expectation is that all planning assumptions should be finalised.

The risk table has been corrected, we have made good progress in reducing the value of the planning assumptions, but have not yet finalised all of them.

Monthly Positions (Table B) – Action Point 2.5

There have been material movements in annual expenditure between categories since Month 1. Again, recognising that we are still in the planning stage, I acknowledge that these amendments will form part of your final plan submission, which will be reviewed by FDU. It would be helpful however, if your MMR submission acknowledged and explained these movements.

Response

Following submission of the plan, any significant changes to annual expenditure by category will be explained in the narrative.

Monthly Positions (Table B) – Action Point 2.6

Your narrative currently provides detailed explanations for SoCNE expenditure (by SoCNE Category) movements between the current and previous month. Please enhance this section to also provide supporting assumptions for material movements in future month expenditure profiles (e.g. Primary Care contractor spend reduces by c. £1.000m in future months (similar level to month 2 increase) but then increases by £2.000m in March).

Response

The narrative has been updated to provide more detail on significant movements in forecast spend.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Pay Analysis (Table B2) – Action Point 2.7 I note that you are projecting that the agency expenditure in future months will be lower than actual costs in May. Please provide further explanation to support this assumption.
Response The Agency forecast has reduced due to a projected fall in COVID-19 costs.
Pay Analysis (Table B2) – Action Point 2.8 Thank you for providing the requested update regarding the 'Provider' bonus payment to applicable staff. Please continue to provide\include this position going forward.
Response The position will continue to be reported in the narrative.
Covid-19 Analysis (Table B3) – Action Point 2.9 Please ensure that your narrative provides sufficient detail of the Covid-19 spend areas reported within Section A7 'other' which currently equate to c£69m. We have already requested that a specific supporting narrative be included for the 'Covid Recovery', which is within 'other'; however, greater detail is also required (i.e. what is driving the spend, what methodologies sit behind the values and profiles, is spend to plan and if not, what impact has this had on future values etc) to support the balance of the c£49m in this section.
Response The narrative has been updated to provide more detail on this spend.
Covid-19 Analysis (Table B3) – Action Point 2.9 In addition to the above, please provide individual explanations to support the following assumptions: 1. Testing – A&C pay (Line 3) will materially increase from Month 3 whilst Nursing and Midwifery pay (Line 5) spend will reduce. 2. Field Hospital / Surge non pay costs (Line 128) will cease after Month 4. 3. Loss of dental income (Line 188) will remain at a material level (£0.250m+) for the remainder of the financial year.
Response 1. Testing:- The service manager has reviewed the forecast and has provided an updated position, which is now reflected in the tables.

2. Field Hospital / Surge non pay costs:-

It was originally envisaged that the field hospitals would cease around Month 4, but we will have costs for a further couple of months, and this has been reflected in the revised forecast.

3. Loss of dental income:-

The loss of Dental income is based on the assumption that current trends in the loss of Income are likely to continue until all COVID-19 restrictions are removed and access to GDS returns to normal levels. This trend assumption has been extrapolated until the end of March 2022, but will of course will be amended to reflect the actual impact and likely continued impact of the pandemic during the Financial year on our PCR Income levels.

All Covid-19 forecasts are reviewing and updating on a monthly basis to take into account any new or additional information. If you become aware that we are not reflecting the latest guidance we would be grateful if you could share that guidance with us so we can reflect and adjust accordingly.

Covid-19 Analysis (Table B3) – Action Point 1.15

I note your response that the reported 'Protect' costs of £0.077m reflect a new role to support the delivery of the Protect agenda. Having made enquiries, we are not aware of any Health Board costs that would currently fall under this policy area. Therefore please confirm which WG Policy Lead you have been liaising with on this particular area. If, however, this is a decision\development driven by the Health Board only, then this should be removed from the TTP template and shown only in section A7 of Table B3 which will need to be funded from your Stability allocation.

Response

This post does appear to be an internally agreed post and is now reflected within the Stability funding forecast.

Resource Limits (Table E) – Action Point 2.10

I understand that a revision to the 2021/22 risk sharing split has been issued by NWSSP which is to reflected in the final plan; your Health Board's updated share value is now £3.132m. Please therefore update all impacting Tables\sections, as applicable**.**

Response

All tables and sections have been updated accordingly.

Covid-19 Analysis (Table B3) – Action Point 2.11

I refer to the recently announced 'Long Covid-19' funding; the specific impact by Health Board may not be known until after the Plans have been finalised but we expect this to recorded,

when appropriate, within section A7 'other' and a specific section included within your narrative to provide supporting details. For ease, we have separately provided a spreadsheet (to all NHS organisations) which we would be grateful if you could complete and submit on Day 9. This allows us to prescribe the level of detail required so we can consistently obtain and consolidate the analysis of these 'high profile' specific spend areas, which otherwise would be lost within the Table B3 section A7 (the spreadsheet also includes Covid Recovery and replaces the narrative table that you would have provided at M2).
Response The additional table for Covid Recovery has been completed. At present the 'Long Covid-19' funding or costs are not known, but will be included in future months as and when these become available.
Covid-19 Analysis (Table B3) – Action Point 2.12 I refer to the supplementary Mass Vaccination Template; please ensure that the latest reporting period (on the Vaccination Summary Tab) is selected as this drives the formulas on the YTD calculation.
Response The latest reporting period will be selected in future.

MONITORING RETURN

MONTH 4 2021/22

Sue Hill

Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION & FORECAST

1.1 Financial Plan

- The refreshed financial plan for 2021/22 was submitted to Welsh Government at the end of June. This provided the latest forecasts and assessments for the year, including the impact of COVID-19. It also incorporated the additional funding notified to the Health Board in Quarter 1, to offset the impact of the undelivered savings from 2020/21.

- The Health Board's plans for 2021/22 include the £82m strategic support funding notified by Welsh Government last year (£40m to cover the deficit and £42m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

- The recovery from COVID-19 and the related workforce constraints are the main risk to the delivery of the schemes relating to the £42m this year and so the Health Board is actively identifying alternative schemes which can be mobilised in order to ensure we maximise the opportunity to improve patient outcomes and operational performance.

- We are testing our assumptions in the original plans and if required will refresh our forecasts with the divisional teams, by month 6, to ensure that the overall forecast outturn is robust and achieved. This may include the appropriate use of additional outsourcing / insourcing, interims or consultancy, to progress some of the larger schemes within this financial year.

1.2 Actual Year to Date Position

- The in-month position is a deficit of £58k which brings the cumulative position to breakeven. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

- The total cost of COVID-19 in July is £8.9m (£29.7m for the year to date). Welsh Government income has been anticipated which exceeds these costs. This additional COVID-19 funding (totalling £32.6m), was issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

1.3 Forecast Position

- The forecast position has been maintained at a balanced position for the year.

- The forecast assumes that the pay award will be 1% for the year but in the event that the pay award is higher than expected, the risk is that it will not be funded.

1.4 Income (Table B)

1. FINANCIAL POSITION & FORECAST

- Income totals £158.9m for July. Further details are included in Section 7.

- The impact of COVID-19 has resulted in £0.3m lost income in July (£1.4m year to date) relating to General Dental Services' (GDS) patient income. This is included as a cost of COVID-19 within the "Other" category.

- The credit on the Welsh Government non-RRL relates to ICF capital timing difference which will even out in month 5.

1.5 Actual Expenditure (Table B)

- Expenditure totals £159.0m for Month 4. This is £254k more than in Month 3, with the increase being primarily attributable to increased costs for Primary Care drugs and Continuing Care and Funded Nursing Care, offset by a decrease in Provider Services non-pay costs and Capital Charges.

- Costs of £8.8m are directly related to COVID-19 this month (£31.4m year to date). Of this £2.6m is pay and £6.2m is non-pay.

Primary Care	• Spend of £19.7m is £624k higher than in June. • Pressures in General Medical Services (GMS) also remain from increased costs of drugs reported through GMS Dispensing and GP Prescribing.
Primary Care Drugs	• The expenditure for Month 4 is £1.2m (15%) more than in Month 3 and is higher than any other month. This is mainly being driven by the volume of drugs being prescribed. • Following receipt of the May prescribing data, the average cost per Prescribing Day has shown a material increase; May was £502k compared to April at £477k, representing an overall increase of 5.4%. • The average cost per item has shown a small increase of 1.0%, but the number of items prescribed has increased by 4.7%. Once again this month, the increase in the average cost per Prescribing Day appears to be driven by volume not price, suggesting a return to business as usual. • The expenditure in Month 4 was £1.4m more than had been forecast. This is because up to the May Comparative Analysis System for Prescribing Audit (CASPA) data, although we had been seeing an upwards trend for the average cost per prescribing day, which was

	factored into forecasts the subsequent volume of prescribing had not been factored in. • Also, May is the only the second month of actual data and costs for 2021/22, and so may not be indicative for the remaining 10 months of the financial year. • The cumulative overspend is £0.8m, with a forecast adverse variance of £1.4m for the year.
Provided Services - Pay	• Provided Services pay costs are £69.0m, which is £0.6m (1%) less than in Month 3. • Pay has decreased compared to Month 3 due to reduction in agency costs and staff turnover, and annual leave taken by agency staff. • Agency costs have decreased by £0.2m compared to last month. Further details on agency spend are included in section 5.1. • A total of £2.6m of pay costs were directly related to COVID-19, which is £0.2m lower than in June. • There has been slippage of £1.7m on the £42.0m Performance Fund and Strategic Support monies, due to delays in recruitment for schemes. In addition, there has been slippage on the £19.9m COVID-19 Recovery Plan funding totalling £0.6m and spend that it was originally anticipated would be pay is now being incurred as non-pay costs. • The Health Board has some small payments for staff bonuses against the accrual during Month 4, which leaves a remaining accrual of £2.8m. There will be a small number of further payments up to September, relating to employees who elected to receive their bonus payment in instalments. The Health Board is also aware of a group of staff that were not considered eligible to receive the bonus but who have subsequently requested for this decision to be reviewed, as they believe that they meet the criteria.
Provider Services Non-Pay	• Spend in July is £5.3m (15%) less than in June. This decrease is for technical reasons and mainly relates to the transfer of COVID-19 costs to Joint Financing (£2.6m) in respect of payments to Local Authorities for COVID-19 Tracing. The other reductions compared to Month 3 relates to Intermediate Care Fund (ICF) (£0.7m), Radiography/RMS (£0.6m) and COVID -19 (£1.0m). • Offsetting this, activity has increased further across the three acute sites, leading to an increase in non-pay costs. Scheduled Care activity is up by circa 18% across sites, in line with last month, which is driven by increases in Theatres activity. In one site the Theatre activity was down slightly but this was offset by an increase in trauma activity. All three sites have also seen significant increases in

	Emergency Department activity, which is above equivalent 2019/20 levels. These all indicate that there is a return to business as usual and this is happening sooner than had been anticipated.
Secondary Care Drugs	• Costs are in line with Month 3 and is £0.1m (1%) higher than Month 3 but is £0.8m higher than the forecast for July in the MDS. • This increase in costs is across specialities and is being driven by the increase in activity for both Scheduled Care and through Emergency Departments. • In addition, as with Primary Care Drugs, the volume of drugs prescribed is the main reason for increased spend this month.
Healthcare Services provided by other NHS Bodies	• Spend has increased by £1.0m (4%) on last month and is £2.3m higher than anticipated in the MDS. This is due to increases in the WHSCC contract. • Block contracts with English providers remain, however there is a risk around inflation on these contracts, as well as inflation on Welsh contracts and a future pay award.
Continuing Health Care (CHC) and Funded Nursing Care (FNC)	• Expenditure in July is £1.7m (19%) higher than in June and £1.2m above the MDS. • Costs have increased for CHC and also in Mental Health relating to inflation adjustments and a rise Older People Mental Health (OPMH) growth and pressures. • CHC costs related to COVID-19 totalled £0.8m in July, which is £0.1m less than June.
Other Private and Voluntary Sector	• Expenditure relates to a variety of providers, including hospices and Mental Health organisations.
Joint Financing	• Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget. This has increased by £3.4m compared to June due to payments to local authorities.
Losses, Special Payments and Irrecoverable Debts	• Includes Redress, Clinical Negligence, Personal Injury and loss of property.
Capital	• Includes depreciation and impairment costs, which are fully funded. • Capital costs have decreased in month by £1.2m compared to June. This is due to the extra resource requirement recorded in June for additional strategic depreciation and baseline support of £7.4m being phased over 12 months.

1.6 Forecast Expenditure (Table B)

- The NHS pay award for 2021/22 has not yet been confirmed. The forecast includes an estimate of the pay award costs and funding based on a 1% settlement, which has been profiled across Months 2 to 12. £0.7m (equivalent to 1/12th), has been included in Month 4. The total expenditure for the year is forecast at £8.8m. As more detail is received on the amount and timing of any award, the profiling will be adjusted accordingly.

- Expenditure related to the £30m funding for the Performance Fund and £12m Strategic Support included in the forecast, based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend over the remaining months of the year. This cost profile is dependent on operational teams implementing approved plans at pace. There may be movements between pay and non-pay as schemes progress and the ability for Health Board staff to undertake additional work is assessed, given the level of brought forward annual leave to be taken in the remainder of the year. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts.

- As discussed with Welsh Government, some of this £42m non-recurrent funding has been committed recurrently as it relates to substantive recruitment of specific staff posts and the recurrent element will be confirmed in future month's MRs.

1.7 Accountancy Gains (Table B)

- The Health Board is reporting £0.2m accountancy gains in July as a year to date position with a forecast of £0.2m for the year and is awaiting guidance from Welsh Government about the status of the exceptional workforce provisions made in 2020/21 as a result of COVID-19 pandemic.

1.8 COVID-19 (Table B3)

- The total impact of COVID-19 in July, including all costs offset by expenditure reductions, is £8.9m. Welsh Government funding has fully offset the impact of COVID-19.

1. FINANCIAL POSITION & FORECAST

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.2	0.3	0.8	3.0
Tracing	1.1	1.0	1.0	0.9	4.0	14.8
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	6.0	16.8
Extended FLU Vaccinations	0.0	0.0	0.0	0.0	0.0	1.2
Field Hospital/Surge	0.3	0.7	0.2	0.5	1.7	1.7
Cleaning Standards	0.0	0.0	0.0	0.0	0.0	0.9
Other Costs	4.5	3.6	4.5	6.3	18.9	72.7
Total COVID-19 costs	**7.7**	**7.0**	**7.9**	**8.8**	**31.4**	**111.1**
Non Delivery of Savings	0.8	(0.8)	0.0	0.0	0.0	0.0
Expenditure Reductions	(0.2)	(0.7)	(0.8)	0.1	(1.7)	(2.3)
Slippage on Planned Investments	0.0	0.0	0.0	0.0	0.0	0.0
Total Impact of COVID-19	**8.3**	**5.5**	**7.1**	**8.9**	**29.7**	**108.8**
Welsh Government Funding	(8.3)	(11.9)	(10.6)	(11.5)	(42.3)	(143.8)
Impact of COVID-19 on Position	**0.0**	**(6.4)**	**(3.5)**	**(2.6)**	**(12.6)**	**(35.0)**

- The forecast total impact of COVID-19 is currently is £111.1m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to more than cover this cost, with £32.7m of COVID-19 funding supporting the core position. This equates to the additional funding issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

- Other costs have increased to £6.3m in month from £4.5m in June due to increase in healthcare services provided by other NHS bodies in England (£1.3m) and in primary care drugs (£0.5m).

1. FINANCIAL POSITION & FORECAST

- Movements in the overall forecast from last month are as follows:

	Forecast at Month 3 £m	Forecast at Month 4 £m	Change £m
Testing	2.8	3.0	0.2
Tracing	13.9	14.8	0.9
Mass COVID-19 Vaccinations	17.5	16.8	(0.7)
Extended FLU Vaccinations	1.1	1.2	0.1
Field Hospital/Surge	1.5	1.7	0.2
Cleaning Standards	2.2	0.9	(1.3)
Other Costs	72.1	72.7	0.6
Total COVID-19 costs	**111.1**	**111.1**	**0.0**
Non Delivery of Savings	0.0	0	0.0
Expenditure Reductions	(2.9)	(2.3)	0.6
Slippage on Planned Investments	0.0	0	0.0
Total Impact of COVID-19	**108.2**	**108.8**	**0.6**

- The main change is the decrease in the forecast for cleaning standards and the mass vaccinations offset by increase in other costs which is mainly due to extra pay costs for medical and nursing.

- As additional modelling data for COVID-19 is received forecasts will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospitalisations.

- Included within the Other section on Table B3 is expenditure against the £19.9m COVID-19 Recovery Plan. Forecast costs have been phased in line with submitted plans as follows:

	Actual				Forecast								
	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	M06 £m	M07 £m	M08 £m	M09 £m	M10 £m	M11 £m	M12 £m	Total £m
Pay	0.1	0.0	0.1	0.1	0.2	0.1	0.2	0.3	0.2	0.2	0.3	0.3	2.1
Non-Pay	0.1	0.7	0.5	0.6	1.4	2.1	2.1	2.0	2.0	2.1	2.1	2.1	17.8
Total	**0.2**	**0.7**	**0.6**	**0.7**	**1.6**	**2.2**	**2.3**	**2.3**	**2.2**	**2.3**	**2.4**	**2.4**	**19.9**

- In addition to the above, £52.8m of COVID-19 costs are included in the Other section.

- Secondary Care costs are a large element of this and include all of the costs related to dealing with COVID-19 in the three acute sites, which covers expenditure on COVID-19 wards, increased staffing, drugs, PPE and critical care.

- There are significant costs included for Prescribing and CHC. Forecast costs are included based on estimates from divisional finance leads. These are best estimates at the current month and subject to all of the uncertainties around COVID-19 rates, the level of hospitalisations and the acuity of patients as restrictions are eased and then heading into the winter months.

2. UNDERLYING POSITION

2.1 Movement from Financial Plan (Table A)

- The Health Board continues to face a significant underlying deficit position, which is a consequence of our residual infrastructure and delivery inefficiencies from 2019/20, combined with the impact of the non-delivery of recurrent savings in 2020/21.

- The underlying position brought forward from 2020/21 is £75.2m. The carried forward underlying deficit is £75.2m. This is primarily as a result of:

    - £32.6m undelivered savings in 2020/21, due to COVID-19. These have been funded non-recurrently in 2021/22, but they will remain a pressure in future years.

    - £40.0m strategic support deficit funding that is non-recurrent.

- The organisation is progressing establishment and resourcing of its transformation agenda, which will support the development of a rolling three year savings programme that will deliver savings to help bring the underlying position back into balance.

- It is currently forecast that red pipeline schemes will have an in-year impact of £1.0m and a recurring Full Year Effect of £1.1m (line 32). In addition, £2.0m of savings (line 33) have not been identified, due to the impact of COVID-19 on the Health Board's ability to identify and deliver savings this year. This has decreased by £0.3m compared to last month, however, the Health Board recognises that there is further work to be done and detailed review are being held with Divisional Directors in August.

- There are no changes to planned non COVID-19 expenditure in Month 4.

- The operational forecast outturn for the year is a £32.6m deficit, offset by a £32.6m surplus on COVID-19. This reflects the additional funding to cover the impact of the undelivered savings from 2020/21, which has been classified as COVID-19 funding.

- The plans for Post Covid-19 Rehabilitation Long Covid are being developed and do not currently feature in the financial plan.

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The below are risks to the Health Board's financial position for 2021/22.

	£m	Level	Explanation
Risks			
Savings Programme – Red Risk Pipeline Schemes	1.0		There is a risk that the savings programme will not deliver the £17.0m target, as per the financial plan. Savings of £12.4m are forecast for delivery in 2021/22, which includes £1.0m of red-rated schemes in the pipeline. Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.
Savings Programme - Planning Assumptions	2.0		There is a risk that the planning assumptions still be to identified, which total £2.3m, will not deliver in the current financial year. Divisions have been set a stretch savings target of £25.0m, which is £8.0m above the agreed target and should ensure that there are enough schemes within the pipeline to allow for any slippage or under delivery that may occur.
Additional funding – Risk of not being to utilise additional funding provided by WG	TBC		There is a risk that the Health Board will not be able to utilise the additional funding provided by Welsh Government, for example, performance fund monies, due to plans not being identified and approved.
Pay award – Risk of no additional funding to cover settlements over 1%	TBC		The financial plan assumes a 1% pay award. There is a risk that there will be no additional funding to cover settlements over the 1% that has been budgeted.

3. RISK MANAGEMENT

- The below is an opportunity to the Health Board's financial position for 2021/22.

	£m	Level	Explanation
Opportunity			
Accountancy gains	TBC		There is a potential for future one off accountancy gains.

4. RING FENCED ALLOCATIONS

4.1 GMS (Table N)

- Not required this month.

4.2 GDS (Table O)

- Not required this month.

5. AGENCY/LOCUM EXPENDITURE

5.1 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 4 are £3.5m, representing 4.9% of total pay. This is a decrease of £0.2m on Month 3, with the decrease mainly relating to medical agency spend. Monthly agency spend for July included £0.6m that related to COVID-19, £0.1m more than last month.

- Medical agency costs have decreased by £0.4m compared to last month; to an in-month spend of £1.3m. COVID-19 costs were £0.2m in July and £0.1m in June. This decrease is mainly due to consultants and doctors on leave.

- Nurse agency costs totalled £1.4m for the month, the same as last month. Acute sites continue to carry a high level of nursing vacancies and the overseas nurses that have started are still not fully registered and trained and so are above the establishment. COVID-19 costs were £0.2m in July and £0.1m in June.

- Other agency costs total £0.7m this month, an increase of £0.1m on last month. In July £0.1m and June, £0.2m related to COVID-19, primarily Admin and Clerical, a decrease of £0.1m.

6. SAVINGS

6.1 Savings (Tables C – C3)

- Savings in Month 4 totalled £2.6m, an increase of £1.5m over the delivery in Month 3. This gives cumulative savings delivered of £5.1m for the year to date. This is mainly due to a one-off rates rebate of £1.3m.

- Savings of £11.4m are forecast for delivery in 2021/22 against identified amber and green schemes, an increase of £2.9m compared to Month 3.

- Red schemes in development are expected to deliver a further £1.0m by year end, a decrease of £2m against Month 3 reflecting the movement from red to amber and green. Work is ongoing to convert these schemes to amber and green by the deadline dates identified in the tracker.

- Further opportunities are being identified both within Divisions and across BCU to ensure delivery of the savings included within the financial plan.

- The residual shortfall in anticipated savings delivery of £2.0m has been included on line 33 of Table A.

7. INCOME ASSUMPTIONS

7.1 Income/Expenditure Assumptions (Table D)

- Most of the figures in Table D are included based on 2020/21 outturn.

7.2 Resource Limits (Table E)

- The Revenue Resource Limit (RRL) is £1,810.6m for the year. £579.0m of the RRL has been profiled into the position cumulatively, which is £24.5m less than four equal twelfths, primarily due to the profile of COVID-19 and performance funding.

- A reconciliation between the RRL phased into the position and an equal phasing is shown in the table below.

	M04 £m
RRL (Table E)	1,810.6
Less COVID-19 funding (Table E, line 90)	(143.8)
Less funding for specific purposes, e.g. performance funding	(56.0)
Adjusted RRL	1,610.8
Equal 12ths phasing	536.9
Add YTD COVID-19 funding	42.1
Phased YTD RRL	579.0
Actual YTD RRL (Table B)	579.0
Variance	**0.0**

- Confirmed allocations to date are £1,713.1m, with further anticipated allocations in year of £97.5m. This includes £143.8m for COVID-19, of which £75.2m is included in anticipated income.

8. HEALTH CARE ARGEEMENTS & MAJOR CONTRACTS

8.1 Welsh NHS Contracts

- All Welsh healthcare agreements were agreed and signed by the deadline of the end of 11th June 2021.

9. STATEMENT OF FINANCIAL POSITION & AGED WELSH NHS DEBTORS

9.1 Statement of Financial Position (Table F)

- Key movements in the Statement of Financial Position since 2020/21 are:

  - Non-current assets (Property, Plant and Equipment): decrease of £9.6m due to newly capitalised assets in year less non-cash adjustments.

  - Trade and other receivables: decrease of £6.1m, which primarily relates to an increase of £25.9m in the Welsh Risk Pool debtor, offset by reductions in NHS Commissioning debtors (£4.4m), Accounts Receivable balance (£2.7m) and RRL phasing adjustment in month (£12.1m) and year to date of (£26.3m).

  - Cash: increase of £3.6m due to the timing of drawdowns and payments. Cash is forecast to end the year at the same level as in 2020/21.
  -
  - Trade and other payables: decrease of £47.4m due to reduction of £12.5m as two pharmaceutical feeds in month, £10.0m relating to HMRC, £18.0m for the bonus payment and £6.5m Accounts Payable balance reduction.

  - Provisions: increase of £26.9m primarily due to the Clinical Negligence provision (£27.8m).

  - General Fund: increase of £9.0m due to balanced position plus £9.0m Capital Resource Limit drawn.

9.2 Welsh NHS Debtors (Table M)

- The Health Board held four outstanding NHS Wales invoice over eleven weeks old at the end of Month 4, which has been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales. One of these invoices was paid prior to the Monitoring Return submission.

10. CASH

10.1 Cash Flow Forecast (Table G)

- The closing cash balance at the end of July was £6.9m, which included £3.1m cash held for revenue expenditure and £3.8m for capital projects.
- Further payments in respect of the NHS bonus were made during July 2021 with the Health Board's latest forecast of total cash required to fulfil this obligation being £18.0m.
- The Health Board currently estimates that a further £12.0m cash relating to movements in working capital and provisions will be required during 2021/22. This relates to allocations previously provided on a resource only basis for decommissioning of Field Hospitals, consequential losses and holiday pay on overtime and additional hours. This initial estimate of working capital requirements has been included as a cash pressure on Table G in March 2022.
- No adjustments relating to the 2020/21 annual leave accrual have been included in the Month 4 Monitoring Return submission. An element of this accrual will be carried forward to 2022/23 and a view on the level that will be utilised during 2021/22 will be formed in coming months based on annual leave booked on the Health Board's ESR system.
- The Health Board paid £2.7m to primary care contractors and received confirmation of matched resource funding in Month 4.
- It is currently assumed that both the capital payables and capital cash balances will remain unchanged during 2021/22 and these will be updated in future months in line with progress on the capital programme.
- Table G currently forecasts a 2021/22 negative closing cash balance of £26.8m which consists of a negative revenue balance of £29.3m and a positive capital balance of £2.5m.

10. CASH

Revenue cash requirements 2021-22	£m
Opening revenue balance	0.7
Forecast outturn position	0.0
Forecast movement in revenue payables	(28.0)
Forecast movement in provisions balances	(2.0)
Forecast closing revenue cash balance	**(29.3)**

Capital cash requirements 2021-22	£m
Forecast cash funding	
Opening capital balance	2.5
Approved Capital Resource limit	27.6
Donated asset income	0.8
Disposal proceeds	0.2
Forecast capital cash funding	**31.1**
Forecast cash spend	
Forecast spend on approved Capital Resource limit	(27.6)
Forecast donated asset cash spend	(0.8)
Forecast disposal proceeds cash spend	(0.2)
Total cash requirements	**(28.6)**
Forecast closing capital cash balance	**2.5**

11. PUBLIC SECTOR PAYMENT COMPLIANCE

11.1 PSPP (Table H)

- Table not required this month.

12. CAPITAL SCHEMES & OTHER DEVELOPMENTS

12.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2021/22 is £27.6m. There is slippage of £0.5m against the planned spend of £3.3m at Month 4. It is anticipated that this will be recovered during the rest of the year and that the CRL will be achieved.

12.2 Capital Programme (Table J)

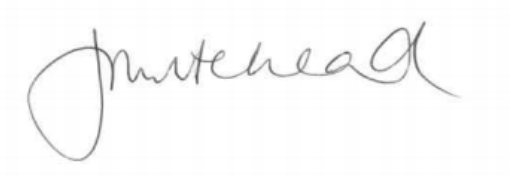
- Details of spend and forecast on a monthly basis and by scheme are included in the table. There is nothing of significance to note.

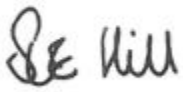
13. OTHER ISSUES

13.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.

- The Month 4 Monitoring Return will be received by the Health Board's Finance and Performance Committee members at the August meeting.





Jo Whitehead
Chief Executive

Sue Hill
Executive Director of Finance

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Month 3 Monitoring Return Responses

Other – Action Point 3.1 I note that you are continuing to forecast financial balance; this position includes anticipated income assumptions that remain subject to further challenge and final agreement. It is also acknowledged that this outturn is current being assisted by c. £5.300m of planning assumptions still to be finalised (including c. £3.000m of red schemes), which is a reduction of c. £0.400m since Month 2. You are reminded of the requirement to have finalised all assumptions by Month 3, which reflected a three month extension on the normal deadline. The current pace of finalising these planning assumptions is a concern. In order to provide assurance that the current forecast outturn will be delivered, assumptions assumed in that outturn must be finalised by Month 4.
Response Work is continuing with Divisions to identify savings to deliver the requirements set out in the financial plan. This is being escalated by Executive Directors to ensure sufficient focus across the organisation for this critical task.
Risks and Opportunities (Table A2) – Action Point 3.2 I note that your narrative does not refer to any potential opportunities and there also none reported within Table A2, which will be required to mitigate the risk to non-delivery of savings. The Health Board, as you are fully aware, is - 2 - expected to achieve financial balance this year and therefore any risks to achieving that outcome will need to be promptly mitigated. As mentioned at the start of this letter, assurance will increase once all schemes (planning assumptions) are finalised with robust a certain delivery expectations.
Response As above outstanding planning assumptions have been escalated by Executive Directors.
Monthly Positions (Table B) – Action Point 3.3 Your narrative references year to date pressures (e.g. pay in managed practices) in Primary Care Contractor expenditure, please provide details to support the assumption that costs will materially decrease in future months with the exception of March. In addition, please provide a supporting explanation for the material increase (c. £1.300m) in Month 12 spend when compared to February.
Response Primary care contractors currently play a significant role in the delivery of our Vaccination programme which is expected to tail off. The increase in month 12 relates to a specific scheme, for which further detail is being sought prior to re-profiling.
Monthly Positions (Table B) – Action Point 3.4

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Please provide details to support the projection that secondary care drug spend will increase in future months (only a minor element relates to Recovery).
Response All forecasts are continually reviewed, but the main increase in Secondary care drugs relates to the increased activity due to a return to a more normal service, together with the minor element relating to recovery.
Pay Analysis (Table B) – Action Point 3.5 I note that you are reporting that £1.600m of the £42.000m performance/strategic funding support has been incurred to date, with a stepped increase in spend being dependent on operational teams implementing approved plans at pace. Although not ring fenced per se, I trust that you will advise at the earliest opportunity in the event that this funding will not be fully utilised for the purpose it was issued.
Response The forecast is tracked on a monthly basis and where slippage is identified alternative plans, which also fall within the remit of the funding, are being developed.
Pay Analysis (Table B2) – Action Point 2.7 I note that you are continuing to project that agency expenditure in future months, will be lower than the current month actual costs. Whilst this is of course positive, please provide further explanation to support this assumption as I am aware of the increased level of staff in NHS Wales who will be taking back leave carried forward from last year, in the next few months, which may impact plans to reduce reliance on Agency; therefore your methodology behind the reduction would be helpful.
Response The Agency forecast has been updated, and is showing a slight increase. The HB has over 100 overseas nurses currently progressing through orientation, who will absorb some of the workload relating to Annual leave cover.
Covid-19 Analysis (Table B3) – Action Point 3.6 Please clarify the key expenditure areas which are attributable to the 'Other' (Section A7) Covid-19 forecast annual spend increasing by c. £2.800m.
Response Additional costs have been added to the forecast which relate to Critical Care Beds. This is being reviewed on a monthly basis and will be adjusted as and when further information is available.
Covid-19 Analysis (Table B3) – Action Point 3.7 After not reporting any cleaning standards expenditure to date, you are now projecting monthly spend of c. £0.25m from Month 4. Please provide details of your assumptions that support the year to date and future month profile.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Response

A revised profile has now been received and incorporated into the forecasts.

Covid-19 Analysis (Table B3) – Action Point 3.8

Please provide a supporting explanation for LA Tracing spend (Line 49) which materially increases in March (£1.556m).

Response

With regard to the March projection, this includes the management fee for Flintshire and a "contingency" based on 3% of overall projected staff costs. This is because there will be a pay award for NJC staff in 21/22 and although negotiations are ongoing, this will be at a minimum of 1.75% and backdated to April. As always we will refine our projections each month to reflect up to date information.

Identified Expenditure Saving Schemes (Table C) – Action Point 3.9

A year to date savings overachievement of £0.374m is reported against identified M1 plan; but you are forecasting that this will diminish with annual forecast slippage of £0.181m reported. Although these values are not excessive at this stage, I trust that the current forecast identified savings profile is feasible and supported by robust delivery assessments.

Response

The forecast reduction in savings later in the year arises from medicines management schemes. These have been reviewed and robust delivery assessments are in place to underpin the forecasts provided.

Cash Flow (Table G) – Action Point 3.9

As you are forecasting the receipt of working balances and bonus pay cash support within your projected revenue drawing limit plus have the full year approved drawing limit available, I am unsure why you are projecting cash shortfalls from November to February. Please review your reported cash flow at Month 4 ensuring that the following reporting guidance is followed.

Response

The cash flow profile in Table G has been reviewed and updated to reflect the reporting guidance in Action Point 3.9. As requested the cash impact of movements in working capital are now reflected in the March 2022 position with a breakdown provided in the narrative commentary.

Monthly Positions (Table B) – Action Point 3.10

The narrative (section 1.2) reports the year to date surplus as £6k; however, the Tables report a higher value of £58k. In future months, please ensure the narrative supports all financials reported in the Tables.

Response Narrative will support the tables in future.
Covid-19 Analysis (Table B3) – Action Point 3.11 Your narrative references that Payments to Local Authorities for Covid-19 Tracing are shown in Provider Services non pay in Table B, but in Joint Financing in the MDS (i.e. Table B3). I wish to re-affirm than items should be consistently reported across your return, therefore I trust this will be reviewed prior to your Month 4 submission.
Response The Covid costs relating to Local Authority payments have been correctly mapped to the Joint Financing row in the Month 4 tables.
Covid-19 Analysis (Table B3) – Action Point 3.12 Within the supplementary 'Other' Analysis Template (Recovery Tab), you are reporting a year to date £0.423m underspend. Unless there is a genuine year to date and forecast underspend, I would expect that funding will be phased to offset current and future month spend. I assume this is what you have done in your main MMR submission (B3). Please review the phasing of corresponding income within the supplementary template submission at Month 4. In addition, please ensure that this template is populated in round £000s going forward.
Response The phasing of the supplementary tab has been updated.
Covid-19 Analysis (Table B3) – Action Point 3.13 Also in relation to the 'Other' Analysis Template – when you come to record the costs of English Provider Recovery, please use the 'spare tab 1' and rename as "English Recovery'. This will allow to keep the first main 'Recovery' tab, for the Welch Recovery only.
Response English provider costs are now included on the separate tab as requested.
SoFP (Table F) – Action Point 3.14 Please ensure that your narrative also discusses material movements between the opening and closing SoFP.
Response An explanation of actual and forecast material movements in the SoFP, including how they relate to cash movements, will be included in future narrative submissions.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Aged Debtors (Table M) – Action Point 3.15 In respect of any outstanding invoices raised against Welsh Government which are > 11 weeks old, please list within Table M by using the 'Organisation' option (there is no Welsh Government option) from the 'Debtor' drop down list. For confirmation, please also include a statement in the comments column clarifying the invoice relates to Welsh Government.
Response Any invoices with Welsh Government which are over 11 weeks old will be reported on Table M using the "Organisation" option with additional narrative being included in the comments column.

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Business Case Tracker**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson Executive Director Planning and Performance
Awdur yr Adroddiad Report Author:	Ian Howard Assistant Director Strategic and Business Analysis
Craffu blaenorol: Prior Scrutiny:	Not Applicable
Atodiadau Appendices:	Appendix 1 Capital Business case tracker Appendix 2 Revenue Business case tracker

Argymhelliad / Recommendation:

The Committee is asked to note the contents of the business case trackers.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✔

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

The business case trackers are presented as part of the routine update on the implementation of the Health Board's plans.

Cefndir / Background:

The Health Board has introduced a business case tracker to monitor the progress of the major capital and revenue investments contained in its plans.

At the request of the Committee the major capital schemes have been RAG-rated in terms of progress.

It should be noted that the increase in revenue available this year has resulted in a significant increase in the number of revenue cases being developed.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications Not Applicable.
Opsiynau a ystyriwyd / Options considered Individual business cases will include option appraisals.
Goblygiadau Ariannol / Financial Implications The tracker includes the current estimate of the capital and/or revenue implications of the business cases that are under development.
Dadansoddiad Risk / Risk Analysis Individual business cases will contain assessments of risk.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance Not applicable
Asesiad Effaith / Impact Assessment Appropriate impact assessments will be carried out as part of the development of individual cases.

BCUHB Revenue Business Cases Tracker

2021/2022 Plan: Performance Fund Schemes

Business Case Title	Business Case Cost Estimate £000s 2021 / 2022 Full Year Effect	Business Case Cost Estimate £000s 2021 / 2022 Part Year Effect	Executive Lead & Project Director	Update August 2021
Attend Anywhere	**375**	**379**	Gavin Macdonald, Chief Operating Officer Andy Oxby, OPD Programme Support Manager	**Business Case approved at Executive Team 13 May 2021** **Following approval update requested (13 July 2021) re: impact on activity / performance following implementation - including anticipated performance trajectories**
Continuation of AccuRx - Video Consultation	**415**	**300**	Chris Stockport, Executive Director Primary & Community Care Clare Darlington, Assistant Area Director, Primary Care, Central	**Following confirmation *Licence / Order Terms & Conditions* signed by Executive Lead effective 01 June 2021, further request issued for update against performance / activity impact / trajectories / additional financial impact i.e.: IT costs / hidden costs etc.**
Planned Care Recovery Schemes	**15,000**	**14,732**	Gill Harris, Executive Director Nursing & Midwifery Clive Walsh, Director of Regional Delivery, Nursing Midwifery & Patient Services	**Schemes approved with business cases to follow**
Development of cancer specific and non-cancer elective Prehabilitation Programme and conservative management pathways / avoidance of secondary care	**900**	**450**	Gavin Macdonald, Chief Operating Officer Neil Agnew, Consultant Anaesthetist, Anaesthetics Gareth Evans, Clinical Director Therapy Services	**Business Case in the process of being refined following HBRT and Executive Team feedback.** **Amended Business Case to be reviewed by the Executive Lead prior to re-submission to the Executive Team Meeting.**
Urgent Primary Care Centres	**2,200**	**1,600**	Chris Stockport, Executive Director Primary & Community Care Rob Smith (East) Bethan Jones (Central) Wyn Thomas (West)	**Confirmation received from Welsh Government (July 2021) committing to fund East and Central Area bids - total allocated funding £1,012,207.** **West Area business case is currently being developed**
Suspected Cancer Pathway	**2,000**	**1,500**		
Reducing waits to rapid access breast clinic	**349,754**		Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Kaizen PID approved at Executive Team 23 June 2021**
Straight to test lung pathway			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Kaizen PID approved at Executive Team 28 July 2021**
Straight to test neck lump clinics			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Kaizen PID to be completed after pilot clinic held 16 August 2021**
Vague symptoms one-stop clinics			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Kaizen PID approved at Executive Team 11 August 2021**
Additional cancer nurse specialists and support posts			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**HBRT Meeting held 30 July 2021 and feedback given.** **Updated case presented to be presented to Executive Team via the Executive Lead - Wednesday 18 August 2021**

Business Case Title	Business Case Cost Estimate £000s 2021 / 2022 Full Year Effect	Business Case Cost Estimate £000s 2021 / 2022 Part Year Effect	Executive Lead & Project Director	Update August 2021
Additional treatment capacity within specialist treatment services			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Discussions continuing**
Patient tracking staff			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Kaizen PID approved at Executive Team 12 May 2021**
Service improvement posts			Adrian Thomas, Executive Director Therapies & Health Sciences Geraint Roberts, General Manager, Cancer Services	**Kaizen PID approved at Executive Team 28 July 2021**
Home First Bureau	**1,770**	**1,770**	Chris Stockport, Executive Director Primary & Community Care Rob Smith (East) Bethan Jones (Central) Ffion Johnstone (West)	**Request for update issued 5 July 2021 re: business case progression / presentation to Executive Team and implementation. Previously reviewed by HBRT 22 March 2021**
ED Workforce	**1,200**	**1,200**	Sue Green, Executive Director of Workforce Nick Graham, Workforce Optimisation Advisor	**The ED workforce business case now sits with the Unscheduled Care Programme Group. It is being finalised this week (week commencing 16 August 2021) and should be moved forward for Executuve Team submission and sign off by end August 2021.**
WOD Resource: Resourcing Establishment Control Team	**270**	**270**	Sue Green, Executive Director Workforce Nick Graham, Workforce Optimisation Advisor	**The WOD Resource business case is in final stages of production and will be going forward to Executive Team by end August 2021.**
Neurodevelopmental (Backlog waiting times) - Recovery of lost activity	**1,400**	**1,400**	Chris Stockport, Executive Director Primary & Community Care Bethan Jones Area Director (Central) Liz Fletcher, Assistant Area Director - Children (West) Christina Billingham, Operations Manager, Children & Young Peoples Services, East Area	**Executive Lead to present a recovery plan / position paper to the Executive Team.**
CAMHS Training and Recruitment	**270**	**207**	Bethan Jones Area Director (Central) Louise Bell, Operations Manager, Paediatrics	**Confirmation received PID agreed by Executive Director (June 2021). Executive lead agreed not required to be presented to Executive Team. Finance to confirm funding has been allocated.** **Waiting response from Operations Manager**
Primary Care Academy	**3,229**	**940**	Chris Stockport, Executive Director Primary & Community Care Clare Darlington, Assistant Area Director, Primary Care, Central	**HBRT Meeting held 29 July 2021.** **To be presented at Executive Team on 11 August 2021 followed by Finance & Performance Committee**
Continuing Healthcare Infrastructure	**1,138**	**1,138**	Chris Stockport, Executive Director Primary & Community Care Rob Smith (East) Bethan Jones (Central) Ffion Johnstone (West)	**Case continues to be developed**
Advanced Audiology Practitioner / Ear wax (Primary Care Audiology / Pathway Redesign)	**800**	**461**	Chris Stockport, Executive Director Primary & Community Care Consultant Clinical Scientist & Clinical Director Of Audiology	**Business Case approved at Executive Team Meeting 14 July 2021 and is to be presented to Finance and Performance Committee**

Mental Health Schemes

Business Case Title	Business Case Cost Estimate £000s 2021 / 2022 Full Year Effect	Business Case / Kaizen PID (if known)	Executive Lead & Project Director	Comments / Update August 2021
Older Persons Crisis Care	**500**	**Business Case**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Business case received and reviewed by HBRT - feedback meeting held 13 July 2021. Following HBRT case redrafted taking on board comments received and subsequently approved via Divisional governance. Executive Lead to present business case to Executive Team.**
Eating Disorders	**500**	**Business Case**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Business case received and reviewed by HBRT - feedback meeting held 13 July 2021. Following HBRT case redrafted taking on board comments received and subsequently approved via Divisional governance. Executive Lead to present business case to Executive Team.**
ICAN Primary Care	**1,700**	**Business Case**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Business case received and reviewed by HBRT - feedback meeting held 13 July 2021. Following HBRT case redrafted taking on board comments received and subsequently approved via Divisional governance. Executive Lead to present business case to Executive Team.**
Medicines Management	**600**	**Business Case**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Business case received and reviewed by HBRT - feedback meeting held 13 July 2021. Following HBRT case redrafted taking on board comments received and subsequently approved via Divisional governance. Executive Lead to present business case to Executive Team.**
Occupational Therapy	**400**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID completed and approved via Divisional governance. To be presented to Executive Team via Executive lead.**
Perinatal	**200**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID completed and approved via Divisional governance. To be presented to Executive Team via Executive lead.**
Early Intervention in Psychosis	**300**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID completed and approved via Divisional governance. To be presented to Executive Team via Executive lead.**
Psychiatric Liaison	**300**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID currently in draft and being reviewed / finalised.**
PMO Support Function	**200**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID completed and approved via Divisional governance. To be presented to Executive Team via Executive lead.**
Consultant Therapist	**100**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID completed and approved via Divisional governance. To be presented to Executive Team via Executive lead.**
CAMHS Transition and Joint Working	**800**	**Business Case**	Chris Stockport, Executive Director Primary & Community Care	**Draft Kaizen PID developed and issued to Acting Associate Director Primary Care (Strategy) for review / comment**
Integrated Autism Service	**700**	**Business Case**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Business case currently being reviewed by the Division following HBRT feedback meeting held 13 July 2021.**
Joint Commissioning POT with AISBs	**300**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Business case in draft and currently being reviewed by the Division**
Wellness, Work and Us	**200**	**Kaizen PID**	Teresa Owen, Executive Director Of Public Health Interim Deputy Director, Mental Health & Learning Disabilities	**Kaizen PID completed and approved via Divisional governance. To be presented to Executive Team via Executive lead.**

Other Schemes

Business Case Title	Business Case Cost Estimate £000s	2020/2021 Q3 / Q4 Ref	Executive Lead & Project Director	Comments / Update August 2021
3 year OHS Compliance Strategy and Security Review **- Fit Testing Programme** **- Occupational Health, Wellbeing, Health & Safety** **- Security** **- Manual Handling training Staff**	**218,796** **328,080 (3 yrs)** **457,350**	**20.20**	Sue Green, Executive Director of Workforce Rod Taylor, Director Estates & Facilities / Peter Bohan, Associate Director Of Health, Safety & Equality	**This has been broken into 4 separate business cases:** **- Fit Testing Programme** **- Occupational Health, Wellbeing, Health and Safety** **- Security** **- Manual Handling training Staff** **All cases submitted / approved at Executive Team Wednesday 4 August 2021**
Estates & Facilities: Health & Safety Statutory Compliance	**481,000 (Staffing)** **853,000 (Non pay over 3 year period**		Rod Taylor, Director Estates & Facilities / Peter Bohan, Associate Director Of Health, Safety & Equality	**Following HBRT review held July 2021 - the business case is currently being refreshed to reflect the feedback received with a proposal to resubmit for the case for consideration to the HBRT in September 2021**
Corporate Safeguarding / Deprivation of Liberty Safeguards	**471**		Gill Harris, Deputy CEO Executive Director of Nursing & Midwifery Michelle Denwood, Associate Director Safeguarding	**This remains active. Due to amendments to the expected Liberty Protection Safeguards Code of Practice, further information has supported the strengthening and development of the Business Case. Once complete, it will sent to Executive Director of Nursing & Midwifery for approval in August 2021.**
Digital Dictation / Speech Recognition		**18.10**	Adrian Thomas, Executive Director Therapies & Health Sciences Hospital Director TBC	**This relates to a national programme which is being developed**
Medicine Transcription Electronic Discharge (MTED)	**127 reducing to 75**	**18.20**	Chris Stockport, Executive Director Primary & Community Care Dylan Williams, Chief Information Officer, Informatics Berwyn Owen, Chief Pharmacist	**Business case approved and recruitment has commenced**
Cardiology Imaging **Join Business Case with Radiology**			TBC Helen Wilkinson, Strategic Manager Cardiac Services Pat Youds, Professional Lead, Radiography / Radiology	**Business Case is being progressed - with Cardiology and Radiology input. Completion date yet to be confirmed**
Critical Care: Advanced Critical Care Practitioners in line with service needs at the three Acute Hospital sites	**Circa: 250**		Arpan Guha, Acting Executive Medical Director Richard Pugh, Clinical Lead for Critical Care Glesni Driver, Head Of Tactical Control Centre,	**The draft Critical Care business case, which incorporates both the Advanced Critical Care Practitioner and Allied Health Professional and Clinical Psychology workforce elements, is currently being reviewed by stakeholders, and any feedback being incorporated. Once the feedback has been received, final updates will be made, and the business case will be appropriately reviewed, approved and progressed through the Health Board's approval process.**
Critical Care: Business Case to be developed for the shortfall in Allied Health Professional and Clinical Psychology workforce including Rehabilitation Co-ordinator and Rehabilitation Assistant posts at the three Acute Hospital sites	**Circa: 750**		Arpan Guha, Acting Executive Medical Director Richard Pugh, Clinical Lead for Critical Care Glesni Driver, Head Of Tactical Control Centre	**The draft Critical Care business case, which incorporates both the Advanced Critical Care Practitioner and Allied Health Professional and Clinical Psychology workforce elements, is currently being reviewed by stakeholders, and any feedback being incorporated. Once the feedback has been received, final updates will be made, and the business case will be appropriately reviewed, approved and progressed through the Health Board's approval process.**

Business Case Title	Business Case Cost Estimate £000s	2020/2021 Q3 / Q4 Ref	Executive Lead & Project Director	Comments / Update August 2021
Welsh Nursing Care Record			Gill Harris, Executive Director Nursing & Midwifery Jane Brady, Senior Lead Nursing Informatics Specialist	**Case reviewed by HBRT Group 29 July 2021 and recommended feedback given. Final / signed off case presented to Executive Team Wednesday 11 August 2021 - case not approved and deferred - further work required.**
Welsh Patient Administration System (WPAS) **Phase 4 Implementation**	**EST 1.6M over 3 years depending on agreed approach / options**		Chris Stockport, Executive Director Primary & Community Care Dylan Williams, Chief Information Officer, Informatics	**HBRT review and feedback held 30 April 2021** **Discussed at Executive Team meeting on 16 June 2021** **Executive Lead given approval to proceed to undertake necessary recruitment that we would expect to be supported by Welsh Government - in addition there are CEO / DOF conversations taking place to move things forward** **Case presented and approved at Executive Team Wednesday 11 August 2021.** **Scheduled for Finance & Performance Committee in August 2021**
Strategic OD Programme			Sue Green, Executive Director Workforce Nick Graham, Workforce Optimisation Advisor Ellen Greer, Acting Associate Director Of Organisational Development,	**Awaiting response from Acting Associate Director Of Organisational Development**
Results Management	**165,151 (Yr1)** **100,071 (Recurrent)**		Arpan Guha, Acting Executive Medical Director Gary Francis, Interim Secondary Care Medical Director Danielle Edwards, Head of Patient Records & Digital Integration, Informatics Glesni Driver, Head of Tactical Control Centre	**HBRT review / feedback held 15 July 2021** **Business case to be refined taking on board comments received - case to then be presented to Executive Team**
WCCIS Business Case			Chris Couchman, Programme Manager, Informatics Tracey Macgillvray, Project Manager, Informatics	**Business case received and reviewed by HBRT - feedback meeting held 4 August 2021.** **Business case to be refined taking on board comments received - case presented / approved at Executive Team Wednesday 11 August 2021.** **To be presented to August 2021 Finance & Performance Committee**
North Wales IMD **Cardiff & Vales Health Board Business Case**			Gill Harris, Executive Director Nursing & Midwifery Steve Grayston Assistant Area Director Of Therapy Services (Centre)	**Business Case led by Cardiff & Vale University Health Board and previously approved by Welsh Health Specialised Services Committee. Case to be progressed through the Health Board's governance approval process via the Revenue Business Case Group.** **Health Board financial lead to be assigned who will then complete a financial review of the case.** **Plan will be to position this for HBRT to review the case in September 2021.**
Critical Care & Anaesthetic Workforce **Wrexham Maelor Hospital**	**762,678**		Faye O'Keefe, Surgical, Anaesthetics & Critical Care Directorate Lead Manager	**Business Case received June 2021** **Case to be informally reviewed and a view taken on whether the case is to be presented to HBRT**
Urology **Wrexham Maelor Hospital**	**1,130,841**		Ian Donnelly, Acute Care Director, East	**Business Case received June 2021** **Case to be informally reviewed and a view taken on whether the case is to be presented to HBRT**
Endometriosis Business Case			Teresa Owen, Executive Director Of Public Health Maria Atkin, General Manager & Business Lead, Obstetrics & Gynaecology	**Scoping Document for business case development approved by Executive Team**

WEST

Business Case Title	Business Case Cost Estimate £000s	2020/2021 Q3 / Q4 Ref	Executive Lead & Project Director	Comments / Update August 2021
Pharmacy & Medicines Management Mental Health Staffing **Development for OPMH for HASCAS group**	**556**		Berwyn Owen, Chief Pharmacist Elizabeth Bond, Consultant Mental Health Pharmacist	**Following feedback business case is being refined / updated.** **Case to be submitted to HBRT for review by end August 2021**
Penrhos Polich Nursing Home			Chris Stockport, Executive Director Primary & Community Care Ffion Johnstone, Area Director (West)	**Public sector partnership established between Clwyd Alyn Housing Association (lead partner), Gwynedd Council and the Health Board to retain care home and housing provision on the Penrhos site with a view to assessing feasibility of new model of care. Site now acquired by Clwyd Alyn and initial concept design plans developed for consideration. Primary resource requirement (for Health / Nursing Home element) is likely to be revenue. Discussions in progress with partners and Welsh Government regarding potential for partnership capital to build new care home facilities.**

CENTRAL

Business Case Title	Business Case Cost Estimate £000s	2020/2021 Q3 / Q4 Ref	Executive Lead & Project Director	Comments / Update August 2021
Dinerth Road Project Conwy County Borough Council / BCUHB joint development	**1,800**	**14.62**	Bethan Jones, Area Director - Central Nicola Eatherington, Asst. Director Community Hospitals, Intermediate Care and Medical Specialities	**The proposed approval timeline has been delayed due to land transfer from Welsh Government to Conwy County Borough Council still not formally agreed. Business case is currently being redrafted to include broader range of cash releasing benefits.**

EAST

Business Case Title	Business Case Cost Estimate £000s	2020/2021 Q3 / Q4 Ref	Executive Lead & Project Director	Comments / Update August 2021
Former Flint Community Hospital	**339**	**14.60**	Chris Stockport, Executive Director Primary & Community Care Rob Smith, Area Director - East	**Request made 16 July 2021 for business case tracker update**

BCUHB Capital Business Cases Tracker - August 2021

Business Case	Status: FBC, OBC, SOC, BJC, PBC, Scoping Document, Under review / consideration	Cash Value (Current estimate) £ millions	Senior Responsible Officer & Project Director	Planned vs Actual	Business Case Governance				Comments / Update
					Capital Investment Group	Exec Team	Finance & Performance	Health Board	August 2021
Royal Alexandra Hospital (North Denbighshire)	Full Business Case - submitted to Welsh Government	67.3 plus inflation	Chris Stockport, Executive Director Primary & Community Care Gareth Evans, Clinical Director Therapy Services	Planned	September 2020	October 2020	October 2020	November 2020	We are finalising responses to some of the additional queries. Welsh Government have informed the Health Board that capital is unavailable at present and there will be further discussions held at Welsh Government re: prioritisation of all Wales capital schemes.
				Actual		October 2020 March 2021	October 2020	November 2020	
Adult and Older Person's Mental Health Unit Glan Clwyd Hospital	Outline Business Case stage	63.7	Teresa Owen, Executive Director Public Health Jill Timmins, Programme Director Ablett Redevelopment	Planned	August 2021	August 2021	August 2021	September 2021	Outline Business Case submitted and approved at the Capital Investment Group Tuesday 3 August 2021 and Executive Team Wednesday 11 August 2021 - in line with previously agreed timetable.
				Actual	August 2021	August 2021			
Wrexham Maelor Continuity Programme Business Case	Outline Business Case Stage	Approved PBC Cost is 50 - 60 This is likely to increase dependant on the outcome of the programme scope	Mark Wilkinson, Executive Director Planning & Performance Neil Bradshaw, Assistant Director Strategy: Capital	Planned	August 2021	August 2021	August 2021	September 2021	The risk workshops concluded that the project scope should be increased to include the additional identified risks, including enhancing ventilation, and agreed a potential preferred option for the ward design solution. The increase in scope will have a significant impact on the costs and programme to agree the business cases and deliver the project. We are currently reviewing the expected capital cost with the Supply Chain Partner and Cost Advisor. The Gateway Review supported the proposal that consideration should be given to fast tracking elements of the engineering infrastructure remedial works to mitigate the impact of this expected delay.
				Actual					
Diagnostic & Treatment Centres	Strategic Outline Case Stage	154 - 252 depending on the option	Gill Harries Deputy CEO/Executive Director Nursing And Midwifery Alyson Constantine	Planned	March 2021	March 2021	March 2021	May 2021	Discussions are continuing with Welsh Government. Verbal update to be given post the meeting with Welsh Government on 17 August 2021.
				Actual	March 2021	March 2021	March 2021	May 2021	
Nuclear Medicine Reconfiguration (including PET)	Strategic Outline Case submitted to Welsh Government	11	Adrian Thomas, Executive Director of Therapies & Health Sciences David Fletcher, Directorate General Manager, NWMCS	Planned	February 2020	August 2020	August 2020	September 2020	All Wales Pet Programme Business Case approved by the Health Board in July 2021. Welsh Government have not approved Strategic Outline Case pending further discussion re: the strategic future of the site and the strategic fit with the Diagnostic & Treatment Centre. The Project is working on a response to these issues and is currently working through the options appraisal.
				Actual	February 2020	August 2020	August 2020	September 2020	
Residential Accommodation (includes Revenue Implication)	Strategic Outline Case Stage	55.8	Mark Wilkinson, Executive Director Planning & Performance Rod Taylor, Director Estates & Facilities	Planned		November 2020	December 2020	January 2021	Following a Board Development Session on 3 June 2021 - the Board and the Executive Team supported a move, based on the limited capital available from an all Wales perspective, to progress a paper to Finance & Performance Committee on 26 August 2021, proposing a move to a residential accommodation managed service model which confirms a move from seeking capital to a revenue funded solution
				Actual		November 2020	December 2020	January 2021	
Wrexham Redevelopment Business Case	Programme Business Case stage	TBC Over 200	Mark Wilkinson, Executive Director Planning & Performance Graham Alexander, Project Director	Planned	February 2021	February 2021	February 2021	March 2021	Discussions still ongoing re: strategic fit and the relationship with the Wrexham Business Continuity Case. The Chair and CEO in discussion regarding the creation of a Board Workshop with the site to agree the next steps.
				Actual					
Ysbyty Gwynedd: Fire Safety and Infrastructure Compliance	Programme Business Case Stage	216	Sue Green, Executive Director of Workforce & Organisational Development Rod Taylor, Director Estates & Facilities	Planned	February 2021	February 2021	February 2021	March 2021	Scrutiny grid has been received from Welsh Government and responses are currently being collated.
				Actual	March 2021		March 2021		
Conwy/Llandudno Junction: Development of new integrated premises in the Conwy / Llandudno Junction area	Scoping Document stage	4 - 8	Bethan Jones, Area Director Central Alison Kemp, Assistant Area Director, Community Services	Planned	October 2021				Still waiting on the outcome of the all-Wales review of Primary Care Estate undertaken by Archus. Area continues to work on the development of the Strategic Outline Case
				Actual					

Business Case	Status: FBC, OBC, SOC, BJC, PBC, Scoping Document, Under review / consideration	Cash Value (Current estimate) £ millions	Senior Responsible Officer & Project Director	Planned vs Actual	Business Case Governance				Comments / Update
					Capital Investment Group	Exec Team	Finance & Performance	Health Board	August 2021
Neuro Rehabilitation Services: Llandudno General Hospital	**Scoping Document stage**	**5 - 8**	Chris Stockport, Executive Director Primary & Community Care Gareth Evans, Clinical Director Therapy Services	**Planned**	**December 2020 Scoping Document**	**February 2021 Scoping Document**			**Scoping document reviewed and agreed in principal by the Executive Team in July 2021. Funding options to be agreed (third party development or all-Wales capital) which will determine the approval route and timescales.**
				Actual	**December 2020**				
NWCTC Radiotherapy Software, Hardware and Linear Accelerator (Linac) Replacement	**BJC**	**4.4 - 4.7**	Adrian Thomas, Executive Director of Therapies & Health Sciences Geraint Roberts - Divisional General Manger Cancer	**Planned**	**November 2021**				**Previously included in the Programme Scoping Document.** **Business Justification Case is to be developed for the replacement of Radiotherapy software/ hardware and 1 of 4 linacs - for submission to Welsh Government**
				Actual					
Endoscopy Service. Sustainable Endoscopy services across North Wales. A capital Business Case for estates improvements that enables JAG accreditation at the three Acute Hospital sites that address clinical standardisation across pathways and meet JAG accreditation, workforce requirements and National Endoscopy programme recommendations.	**Under review**		Adrian Thomas, Executive Director of Therapies & Health Sciences Helen O'Connell, Endoscopy Network Manager (Interim)	**Planned**	**August 2021**	**August 2021**	**September 2021**	**October 2021**	**Final draft agreed with operational teams to include estates work for 3rd procedure room in Wrexham to be upgraded as insourcing continues and modular procurement progresses**
				Actual					
Hanmer Health & Well-being Centre **Model for Health & well-being centres created with partners based around a 'home first' ethos. Agree and finalise decisions on business case**	**Under Review**		Rob Smith, Area Director - East Simon Jones, Assistant Area Director, Primary Care, East	**Planned**	**August 2021**	**November 2021**	**November 2021**	**December 2021**	**Request made 16 July 2021 for business case tracker update**
				Actual					
Llay Health & Well-being Centre: CAPITAL & REVENUE **Model for Health & well-being centres created with partners based around a 'home first' ethos. Finalise business case for first stage agreement regarding funding sources**	**Under Review**		Rob Smith, Area Director - East Simon Jones, Assistant Area Director, Primary Care, East	**Planned**	**July 2021**	**August 2021**	**August 2021**	**September 2021**	**Request made 16 July 2021 for business case tracker update**
				Actual					
Cefn Mawr Health & Well-being Centre: CAPITAL & REVENUE **Feasibility study for the development of a new build**	**Under Review**		Rob Smith, Area Director - East Simon Jones, Assistant Area Director, Primary Care, East	**Planned**	**August 2021**	**November 2021**	**November 2021**	**December 2021**	**Request made 16 July 2021 for business case tracker update**
				Actual					
Feasibility study Denbigh Health and Social Care	**Under Review**		Bethan Jones, Area Director Central Alison Kemp, Assistant Area Director, Community Services	**Planned**					**ICF funding, scope and governance confirmed.** **Condition survey of Denbigh Infirmary commissioned but not completed.** **Pubic Health report requested and is in progress.** **Cataloguing of services continuing.** **Stakeholder event planned for November 2021**
				Actual					
Kinmel Bay Business Case	**Under Review**		Bethan Jones, Area Director Central Alison Kemp, Assistant Area Director, Community Services	**Planned**	**March 2021**	**March 2021**	**April 2021**	**May 2021**	**Will be initiated as the next priority for Primary Care in Central Area - once Strategic Outline Case for Llandudno Junction / Conwy is progressed. Likely to be Q3 start at earliest.**
				Actual					
Rhos / South Wrexham **Model for Health & well-being centres created with partners based around a 'home first' ethos. Continue development through programme board by drafting a business case**	**Under Review**		Rob Smith, Area Director - East Simon Jones, Assistant Area Director, Primary Care, East	**Planned**					**Request made 16 July 2021 for business case tracker update**
				Actual					
Penygroes Health & Wellbeing Hub			Ffion Johnstone, Area Director (West) Wyn Thomas, Assistant Area Director Primary & Community Care	**Planned**					**Primary resource requirement likely to be revenue but to be confirmed. Discussions regarding the potential for accessing partnership capital from Welsh Government are being explored by the partners.**
				Actual					

Business Case	Status: FBC, OBC, SOC, BJC, PBC, Scoping Document, Under review / consideration	Cash Value (Current estimate) £ millions	Senior Responsible Officer & Project Director	Planned vs Actual	Business Case Governance				Comments / Update
					Capital Investment Group	Exec Team	Finance & Performance	Health Board	August 2021
Llanfair PG Health Wellbeing Centre - Primary Care extension			Ffion Johnstone, Area Director (West) Wyn Thomas, Assistant Area Director Primary & Community Care	**Planned**					**No further update following May 2021 update: *Scheme in draft. Discretionary Capital Programme for 2022/23. Draft design for the scheme to be prepared by the Architect and business case to be submitted to Capital Investment Group in Autumn 2021 for construction in 2022/23.***
				Actual					
Clinical Research Facility - Outpatients Wrexham	**Feasibility Study - under way**		Acting Executive Medical Director Arpan Guha Graham Alexander, Project Director	**Planned**					**No further update following May 2021 update: *Feasibility study outcome still being discussed with key stakeholders. No date yet set for submission of a scoping document.***
				Actual					
Maggie's Centre Ysbyty Glan Clwyd.	**Exploratory Stage**		Project Director: TBC	**Planned**					**The Health Board's Executive Team met on Wednesday 14 July 2021 to discuss an initial proposal to have a Maggie's Centre in North Wales. Those in attendance unanimously agreed, in principle, to provide approval to host a Maggie's Centre in North Wales. A decision is awaited on who the Senior Responsible Officer will be, scoping work and a Business Case will then progress**
				Actual					
Bryn Beryl site - Final phase redevelopment	**Scoping Document stage**	**£5-10m**	Ffion Johnstone, Area Director (West) Wyn Thomas, Assistant Area Director Primary & Community Care	**Planned**					**Scoping document to be completed by September. Initial budget estimate £5-10m.**
				Actual					
Orthopaedic Modular Units	**Scoping Document stage**		Neil Windsor, North Wales Musculoskeletal Network Delivery Manager	**Planned**					**Request made 16 July 2021 for business case tracker update - further update requested 28 July 2021 and 4 August 2021**
				Actual					
Hwb Cybi (Holyhead) Primary Care Health & Wellbeing Hub	**Scoping Document stage**		Ffion Johnstone, Area Director (West) Wyn Thomas, Assistant Area Director Primary & Community Care	**Planned**					**Project Board currently being established to meet in September 2021 to scope and plan a new Primary Care Health & Wellbeing hub for Holyhead**
				Actual					

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 26.8.21**
Cyhoeddus neu Breifat: Public or Private:	Public Session
Teitl yr Adroddiad Report Title:	**Summary of business considered in private session to be reported in public**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Executive Director of Finance
Awdur yr Adroddiad Report Author:	Diane Davies Corporate Governance Manager
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to **note** the report

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**N**

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesu a Dadansoddi / Assessment & Analysis

The Finance and Performance Committee considered the following matters in private session on 24.6.21

- Contractor request for BCUHB to re-commission Dental Services following proposed incorporation
- Deeside Enfys Hospital reinstatement works tender
- Approval of acceptance of the recommended tender for the fit out of wards 6 and 10 at Ysbyty Glan Clwyd
- Approval for the Health Board to be party to a Section 106 Agreement prepared by Flintshire County Council (former Lluesty Hospital site in Holywell)
- Update on delivery against Price Waterhouse Cooper (PWC) recommendations

Goblygiadau Strategol / Strategy Implications This is addressed within the private session documentation
Opsiynau a ystyriwyd / Options considered This is addressed within the private session documentation
Goblygiadau Ariannol / Financial Implications This is addressed within the private session documentation
Dadansoddiad Risk / Risk Analysis This is addressed within the private session documentation
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance This is addressed within the private session documentation
Asesiad Effaith / Impact Assessment This is addressed within the private session documentation