Bundle Performance, Finance & Information Governance Committee 12 May 2023

1 GOVERNANCE

2 PF23/56 Apologies

Jason Brannan for whom Nick Graham Associate Director Workforce Planning and Performance will deputise
Nick Lyons for whom his deputy Medical Director will deputise
Angela Woods for whom Mandy Jones Deputy Nurse Director will deputise

3 PF23/57 Declarations of Interest

4 PF23/58 Draft minutes of the previous meeting held on 23.2.23 - for approval

- for approval

PF23.58 PFIGC minutes 23.2.23 v.02 draft Public session.docx

5 PF23/59 Matters arising and table of actions

PF23.59 Table of actions public.docx

6 PF23/60 Notification of matters referred from other Board Committees on this or future agendas

*Phil Meakin Interim Board Secretary
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7 DEVELOPING NEW STRATEGIES OR PLANS

8 PF23/61 Planning, Performance and Accountability

Steve Webster Interim Executive Director of Finance
*Recommendation
*
The Committee is asked to note the planned approach and draft timelines.

PF23.61a 23-24 planning performance and accountability.docx

PF23.61b App 1 PFIG May 2023 Proposed budgeting and local planning arrangements 23-24 v3.pptx

PF12.61c App 2 PFIG May 2023 Planning performance and accountability action plan.pdf

9 MONITORING EXISTING STRATEGIES OR PLANS

10 PF23/62 Finance report

*Steve Webster Interim Executive Director Finance
*
Recommendation
The Committee is asked to note the report

PF23.62a Finance report Month 12.docx

PF23.62b App Ai Finance Report M12 updated 2.5.23.pptx

PF23.62c App Aii WG Monitoring report M12.pdf

PF23.62d App B M12 Savings v6.pptx

PF23.62e App C Capital Report - Month 12.docx

11 PF23/63 No item

12 PF23/64 People (Workforce) Performance report

*Nick Graham Associate Director Workforce Optimisation in attendance
*
*Recommendation
*
The Committee is asked to NOTE the current performance position provided and feedback any improvements on the content of this report for future reporting.

PF23.64a Workforce Performance Report.docx

PF23.64b Workforce Performance Report v1_Final.pptx

13 PF23/65 Performance report

Steve Webster Interim Executive Director Finance
*Barbara Cummings Interim Performance Director in attendance
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*Recommendation
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*The Committee is asked to:
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Review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.

PF23.65a Performance Report PFIG - Month 12 performance 2023.docx

PF23.65b Appendix 1 PFIG - Quality and Performance Report - Final.pptx

14 PF23/66 Business Case for a Community Complex Conditions Service (Long Covid Business Case)

*Gareth Evans Acting Executive Director Therapies and Health Sciences
*
*Recommendation
*
The committee is asked to support
Option 4 - This option will establish a Community Complex Conditions Service in BCUHB, integrating Long COVID, Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Breathing Pattern Disorders, Persistent Physical Symptoms (PPS), and Frequent Attenders (FA) in order to improve patient outcomes, provide sustainability and address current and future demand for services and gaps in service provision

PF23.66a Long Covid Business Case.docx

PF23.66b Long COVID Business Case V1.6.4.docx

PF23.66c Appendix 1 Building Community Capacity.pdf

PF23.66d Appendix 2 WEDFAN IA Covid 19.pdf

PF23.66e Appendix 3 WEDFAN YGC Data.pdf

PF23.66f Appendix 4 Patient Feedback.pdf

PF23.66g Appendix 5 EqIA Screening Long COVID recovery v0.03.pdf

15 CLOSING BUSINESS

16 PF23/67 Questions submitted by the public 7 working days before the meeting

17 PF23/68 Agree items for Chairs Assurance report

Committee Chair
including
*Items for referral to Board / Other Committees
*
Review of risks highlighted in the meeting for referral to Risk Management Group

18 PF23/69 Review of meeting effectiveness

Committee Chair

19 PF23/70 Summary of private business to be reported in public

For information

PF23.70 Items previously discussed in private session.docx

20 PF23/71 Date of next meeting 29.6.23

21 Exclusion of 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 Performance, Finance and Information Governance Committee held in public on 23.2.23 via Teams

Present:	
John Cunliffe	Independent Member / Committee Chair
Richard Micklewright	Independent Member
Linda Tomos	Independent Member
Neil Bradshaw	Assistant Director – Capital (Items PF23/30,31,32)
Jason Brannan	Deputy Director People
Barbara Cummings	Interim Performance Director (Items PF23/35&37)
Geraint Farr	Acting Associate Director for Emergency Care (Item PF23/39)
Nikki Ffoulkes	Interim Outsourcing and Insourcing Manager (Item PF23/38)
Nick Graham	Associate Director Workforce - Planning and Performance (part meeting)
Ian Howard	Assistant Director Strategic and Business Analysis (Items PF23/32&33)
Carole Johnstone	Head of Information Governance (Item PF23/40)
Mandy Jones	Deputy Director Nursing and Midwifery
Nick Lyons	Executive Medical Director (part meeting)
Phil Meakin	Director of Governance
Hugh Mullen	Interim RTC Programme Director (Item PF23/38.1)
Phil Orwin	Interim Regional Delivery Director (part meeting)
Andy Oxby	Interim Outpatient Programme Support Manager (Item PF23/38)
Dylan Roberts	Chief Digital and Information Officer (part meeting)
David Seabrooke	Interim Assistant Director Governance (Items PF23/19 and PF23/41)
Chris Stockport	Executive Director Planning and Transformation
Steve Webster	Interim Executive Director Finance
Diane Davies	Corporate Governance Manager / Committee Secretariat
Observing	
Fflur Evans	Wales Audit

Agenda Item Discussed	Action By
PF23/18 Apologies and Declarations of Interest Apologies were received on behalf of Sue Green for whom Jason Brannan and Nick Graham deputised, Justine Parry for whom Carole Johnstone deputised for item PF23/40, Angela Wood for whom Mandy Jones deputised, Dave Harries Internal Audit, Andrew Doughton Finance Lead, Wales Audit and Michelle Phoenix Performance Lead, Wales Audit. No declarations of interest were received.	
PF23/19 Review of Performance, Finance and Information Governance Committee Terms of Reference and delegated authority **PF23/19.1** The Interim Assistant Director of Corporate Governance joined the meeting to present this tabled item. It was noted that the Health Board had agreed	

a change to BCUHB Scheme of Reservation and Delegation (SORD) at its meeting on 30 March 2022 which delegated authority to approve business cases to the value of up to £1million to the Performance, Finance and Information Governance Committee. He advised insertion of an additional row in the SORD referencing PFIGC delegated approval ceiling of up to £1m for Business Cases. **PF23/19.2** In the discussion which followed the Interim Executive Director of Finance pointed out that a higher and lower figure should be incorporated within the PFIGC SORD insertion for clarity ie £0.5m to £1m as his role was delegated approval up to £0.5m. **PF23/19.3** The Associate Workforce Director questioned whether the figure related to business cases only. **PF23/19.4** The Committee directed that the references to 'evidence based' be retained within the Terms of Reference, however the remaining amendments were agreed as outlined. **It was resolved that the Committee** agreed to • recommend to the Audit Committee that actions are undertaken to amend the latest version of the SORD and Standing orders as delegated by the Board • approve the TOR for submission to the Audit Committee subject to the amendments outlined within the discussion	DS for MM
PF23/20 Draft minutes of the previous PFIG Committee meeting held on 19.1.23 The minutes of the meeting were approved.	
PF23/21 Matters arising and table of actions The table of actions was updated and closed actions agreed.	
PF23/22 Report of the Chair None reported	
PF23/23 Report of the Lead Executive **PF23/23.1** The Committee welcomed the written report. The Interim Executive Director Finance advised that further information would be shared with the Committee in due course in regard to the review work which had been undertaken which had significant implications. **PF23/23.2** In response to the Committee's questioning of whether the previous 'modus operandi' was flawed, he advised that there were issues in processes	

involving commitment to new expenditure. However, this had been rectified going forward and he was now fully sighted on 95% of the historical commitments.. **PF23/23.3** In response to the Committee, the Interim Executive Director Finance advised that whilst an interim appointment had been made of a suitably qualified applicant to fill the combined role of the departing Director of Estates and Assistant Director Capital, the permanent position was in the process of being recruited. **It was resolved that the Committee** noted the report	
PF23/24 Notification of matters referred from other Board Committees on this or future agendas None advised	
PF23/25 Finance reports Months 9 and 10 **PF23/25.1** The Interim Executive Director Finance highlighted the recovery plan, advising that current recurrent spending rates were not reducing materially; and that instead more slippage was being experienced along with some release from the balance sheet. He drew attention to potential issues with the forecast and WG resource. He stated that it could be possible to meet the 3 year breakeven position however this could affect the finances in the next year. WG would be setting out the position in regard to potential more in year allocation. Therefore a decision would be considered shortly on whether to reduce the forecast deficit and potentially change to a breakeven forecast. **PF23/25.2** The Committee questioned the consistency of Covid/Unscheduled care funding from WG in comparison with other health boards. The Interim Executive Director of Finance advised that the costs attributable to Covid/USC would be reported more consistently in line with other Health Boards in presenting the recurrent 2022/23 deficit, but this would not change the 2022/23 WG Covid funding other than in relation to the £4.3m additional funding agreed by WG. **PF23/25.3** In response to the Committee, the Interim Executive Director of Finance agreed to provide the rationale on why key risks had been de-escalated between month 8 and 9, as the Committee Chair perceived these to have been those which required most attention. Following a point made by the Committee Chair, the Director of Governance undertook to clarify whether properties were increasing or decreasing in respect of data provided on page 15 and to also confirm that an overarching risk was on the current Corporate Risk Register (CRR). **PF23/25.4** The Committee questioned how Pay Vs Vacancy work was being progressed, with particular concern on the reliance of agency staffing and what approach was being undertaken to resolve the issue. The Interim Executive Director of Finance reflected that a large driver to appoint staff was the impact on safety as well as cost, he also cited the need for executive sponsorship to work through divisional issues, need for disinvestment discusssions and Nurse Staffing Act requirements. The Deputy Director of People stated that the newly introduced	SW PM

operating model provided greater local decision making and accountability. He also cited optimisation work, additional interim controls and referred the Committee to the supporting paper of PF23/29 Agency Controls report. The Executive Medical Director emphasised the importance of addressing quality and finance hand in hand, emphasisng the importance of local accountability given that medical agency was now high cost and high volume useage. **PF23/25.5** In response to the Committee, the Interim Executive Director of Finance advised that anticipated WG support had not been factored into the cash flow forecasts presenting in the Month 8 report as it has not been agreed at that stage by WG, resulting in the large cash shortfall shown in the M8 report. This ought to have been made clearer in the report. **PF23/25.6** In response to the Committee, the Interim Executive Director of Finance advised that the Savings pipeline needed to be resurrected to focus on longer term strategic programmes and away from short term non-recurrent schemes. **PF23/25.7** It was agreed that the plan to schedule Divisional officers reporting on their progress would be resurrected and included in the 2023/24 Cycle of Business at each meeting. **It was resolved that the Committee** noted the reports	SW (DD)
PF23/26 Savings Delivery report **PF23/26.1** The Interim Executive Director of Finance advised current savings delivery was static and that, following further discussion with the Deputy Director People, the position would be clarified on when VERS savings would be included in the report. The Committee was very concerned with the lack of process. The Interim Executive Director of Finance emphasised the requirement to make improvements moving forward into the next financial year. **PF23/26.2** Following concerns raised by the Committee a discussion ensued on the effectiveness of the Savings programme, especially in regard to the level of specivity provided. The Interim Executive Director of Finance undertook to address the feedback provided including validation and benefits realisation moving forward. The Executive Medical Director added that, along with managerially led finances it would be important to ensure clinical teams were contributing and accountable to ensure sustainability, albeit this would be challenging. **PF23/26.3** The Interim Regional Delivery Director commented on the need to also support BCU managers with an appropriate level of financial training, as holding to financial account would be challenging. **It was resolved that the Committee** noted the report	

PF23/27 Delivery of Health Board Savings Internal Audit Report **PF23/27.1** The Committee was very concerned with the Internal Audit report which was rated as providing 'no assurance'. The Interim Executive Director of Finance reflected other Health Boards in Wales were in a similar position regarding total savings delivery, however transformational change at BCU would be key. **PF23/27.2** The Committee questioned whether another Performance and Accountability (P&A) Framework would provide a solution, as previously introduced frameworks had been ineffective. The Interim Executive Director of Finance advised that the newly appointed Interim Performance Director and the approach to properly implementing the performance and accountability framework would be an important enabler to improving processes. **PF23/27.3** The Committee again raised concern as to whether a continuous pipeline of savings delivery was planned in year or, as in previous years, whether plans were scheduled to be delivered towards the end of the financial year. In addition, the deliverability of the management report response in regard to governance and assurance processes was questioned (P13). **PF23/27.4** A discussion ensued on strengthening the P&A Framework, delivery support, skills support, budgetory financial consequences of non-delivery and an acknowledgement that transformational schemes had not contained a sufficient level of granularity in order to be deliverable, which had been an important learning point. **It was resolved that the Committee** noted the report	
PF23/28 Financial control report **PF23/28.1** The Interim Executive Director of Finance advised that the recommendations of the End Year report along with those of Internal and External Audit needed to be incorporated within the Financial Control report. Decision making where there are financial consequences also needed to be better understood. A review of decision-making processes around cost pressures or investments resulting in increased expenditure needed to also be incorporated in the plan. The Committee stated that the table within the report could improve assurance through the inclusion of milestones and delivery updates. **PF23/28.2** The Interim Executive Director of Finance took onboard the feedback provided and undertook to amend the format of future reports. The Committee requested that the amended report be referred to Audit Committee **It was resolved that the Committee** noted the report	SW SW/ MM
PF23/29 Agency Controls report	

PF23/29.1 The Associate Workforce Director presented this report, he highlighted the controls process in place, need for improvements in compliance, support required to assist staff and improvement required in unit costs. **PF23/29.2** The Committee acknowledged that the report provided assurance on the process however it questioned whether the report provided sufficient compliance detail. It was noted that the Deputy Director People undertook to provide the necessary information, which also aligned with the new operating model, within 3 months. **PF23/9.3** In the discussion on modernising the workforce it was noted that potential savings and improved sustainability would result following the introduction of alternative appropriately trained roles. **It was resolved that the Committee** noted • the current controls outlined in the report • the intention to review and amend future reports as outlined within the discussion	JB
PF23/30 Capital Programme Monitoring reports Months 8 and 9 **PF23/30.1** The Assistant Director – Capital presented the report. He advised confidence in meeting the Capital Resource Limit (CRL), all orders had been placed with appropriate delivery times. It was noted that there remained the ability to manage slippage. **It was resolved that the Committee** • noted and scrutinised the report • supported the proposed adjustments to the capital programme	
PF23/31 Draft Capital Programme 2023 - 2028 **PF23/31.1** The Assistant Director – Capital presented the report, highlighting that WG had confirmed that there would be a separate funding allocation in support of "Targeted Improvements in the NHS Estate in Wales" (Estates and Facilities Advisory Board (EFAB) Programme) in 2023/24 and 2024/25. BCU had approved £4.324m funding for 2023/24. Health Boards were required to provide 30% support from their discretionary allocation, for BCU this equated to £1.297m for 2023/24. **PF23/31.2** He also drew attention to the 25% overcommittment made and that there were 'ready to go' schemes available to slot into the final quarter which the Capital Improvement Group had prioritised based on risk and need. **PF23/31.3** The Committee raised concern regarding fire compliance in BCU's estate. The Assistant Director - Capital stated that the report provided further detail however prioritisation had taken place. It was acknowledged that BCU's	

resources were not sufficient, however the organisation manage its capital expenditure within the available resources overall.. **It was resolved that the Committee** supported the draft programme for submission to the Health Board for formal approval	
PF23/32 Wrexham Maelor Hospital Continuity Programme Full Business Case (FBC) **PF23/32.1** The Assistant Director –Capital advised the business case to be a priority of BCU's recently agreed Estate Strategy which would be funded by WG at a cost of £54.2m plus inflation, albeit that volatilities in the energy market might impact. He also drew attention to the report statement that any provision for additional inflation risk should be held within the client contingency not the Supply Chain Partner in order to avoid unwarranted gain share. **PF23/32.2** In response to the Committee, the Assistant Director – Planning stated that no adverse impact was anticipated with the same company providing the services of Project Manager and Cost Advisor, as the company had provided the best tenders and this situation was also reflected in others across Wales. **PF23/32.3** The Committee acknowledged the long service and contribution that the Assistant Director –Capital had provided with BCUHB and predecessors and wished him well in retirement. **It was resolved that the Committee** supported the business case for subsequent approval by the Health Board.	
PF23/33 Business Case Tracker **PF23/33.1** The Committee pointed out that the progress of the Long Covid Business Case would need to be updated on the tracker. The Committee Chair requested a meeting with the Interim Executive Director of Finance to discuss a more effective format that the Committee required. **PF23/33.2** The Interim Executive Director of Finance also undertook to discuss prior scrutiny of future report submissions via the Executive Team with the Assistant Director Strategic and Business Analysis following the meeting. **It was resolved that the Committee** noted the update	SW SW
PF23/34 Transformation and Improvement update **PF23/34.1** The Executive Director of Transformation and Planning drew attention to the stepped activity taking place with Improvement Wales, and that prioritisation was taking place to deal with those which would deliver most quickly. The 6 goal process was highlighted including improved engagement and methodology.	

PF23/34.2 The Committee questioned how the new reporting formats would be linked with financial reports, which the Executive Director of Transformation and Planning advised was being explored with the Interim Executive Director of Finance. It was suggested that the beneficial impacts on finance would be useful to be included within future updates. **PF23/34.3** The Committee Chair stated it would be important demonstrate that public monies were being utilised in an effective manner in regard to project management tools. The Interim Executive Director of Finance concurred that investments in programme management should be demonstrated alongside the benefits delivered. It was noted that the Executive Medical Director advised that executives were considering how to demonstate consistency in regard to Targetted Intervention and the Corporate Risk Register. **It was resolved that the Committee** received the report and noted the areas of progress	
PF23/35 Operational Plan Monitoring report (OPMR) **PF23/35.1** The Executive Director of Transformation and Planning introduced the item. It was noted that a meeting had taken place with the Committee Chair to inform future report formatting to be introduced in the new financial year. He advised the development to be ontrack for delivery. **PF23/35.2** The Interim Director of Performance was welcomed to her first meeting. In response to the Committee's concern with 50% lack of data submission, she perceived that there was a systemic lack of engagement with the process. Following discussion, the Executive Director of Transformation and Planning advised an updated report would be provided to the next meeting. **It was resolved that the Committee** noted the report	
PF23/36 People Performance report **PF23/36.1** The Associate Workforce Director Performance and Planning introduced the report**.** He highlighted no significant additional use of agency staffing, recruitment improvements with the exception of medical and nursing, improved grip on recruitment and progression with optimisation work. **PF23/36.2** The Committee welcomed the increased level of detail provided however, narrative was needed regarding the 3 year plan moving forward to ensure a more strategic view. The Associate Workforce Director Performance and Planning undertook to take the feedback provided forward including provision of community nurse staffing detail and age profiling, which could assist in recruitment forecasting. The Interim Executive Finance Director was concerned with the potential £10m cost of compliance with the nurse staffing levels (NSLs), he stressed the importance of ensuring alignment with BCU's finances – the	

Committee Chair pointed out that this issue had prevoiusly been raised by the Committee when NSLs were introduced. **PF23/36.3** The Deputy People Director advised that the next Partnerships, People and Population Health Committee was scheduled to receive an update on BCUHB's People Strategy. **PF23/36.4** The Executive Medical Director requested that the covering template be amended to indicate that the report did not provide detail on Dentistry, Community Pharmacy or Independent Contractors. **PF23/36.5** The Interim Regional Delivery Director reflected on the utilisation of interims for 'difficult to fill' roles, especially senior operational managers, a discussion ensued on the use of substantive and temporary appointments. **It was resolved that the Committee** • noted the current performance position • considered and provided feedback on content for future reporting	NG
PF23/37 Integrated Quality and Performance report **PF23/37.1** The Interim Performance Director presented the report highlighting performance in planned, unscheduled care and also cancer services. It was noted that Primary Care performance would be included within the next report. **PF23/37.2** A discussion ensued on the importance of providing clarity on issues arising and mitigations that were in place to address them, especially in regard to scale. **PF23/37.3** It was agreed that Committee members would discuss the Committee's reporting needs in regard to Planned and Unscheduled Care outside the meeting **It was resolved that the Committee** scrutinised the report	JC/RM/LT
This item was taken out of sequence to assist operational need **PF23/39 Unscheduled Care report** **PF23/39.1** The Executive Medical Director highlighted the improvements which had taken place whilst industrial action had taken place, including 15 minute ambulance handovers of patients. The Acting Associate Director Emergency Care (ED) reported that BCU had maintained the WG performance target during the winter period, he highlighted the advantages gained through the inclusivity of Primary Care colleagues. He also reported on a reflective learning event that had taken place.	

PF23/39.2 The Committee welcomed the improved reporting provided. In response to the Committee, the Acting Associate Director ED provided further detail on the Airdale model introduction on goal 2 – Signposting. **It was resolved that the Committee** noted the update on Unscheduled Care performance and partial assurance provided from actions to deliver to national targets	
PF23/38 Planned Care (PC) update The Interim Outsourcing and Insourcing Manager and Interim Outpatient Programme Support Manager joined the Interim Regional Delivery Delivery Director in supporting this item. A brief summary was provided on the report provided. It was noted that had industrial action not taken place the outpatient programme would have overdelivered on the target set. **It was resolved that the Committee** noted the partial assurance of the PC programme	
PF23/38.1 Planned Care : Regional Treatment Centre (RTC) update **PF23/38.1.1** The Interim RTC Programme Director joined the meeting to present this item, he advised that a key workshop would be taking place the following week on how to demonstrate how planned care recovery would take place, which could significantly change RTC plans. The Interim RTC Programme Director drew particular attention to the level of WG financial support required within the report. **PF23/38.1.2** The Committee raised a number of questions. The Interim RTC Programme Director advised that should the developing standalone Orthopaedic Hub Business Case based at Llandudno be taken forward this would affect the size of the RTC build. The Interim Executive Director of Finance acknowledged Committee concerns and reported that the Strategic Outline Case had not been approved by WG. BCU's committed spending in relation to design costs to date had been significant and potentially a cost burden given other issues that had arisen. The logic of the development was acknowledged however it was potentially undeliverable within available budgets. The Executive Medical Director also acknowledged that existing theatre utilisation and workforce needed to be considered further and addressed in the upcoming workshop. **PF23/38.1.3** The Interim RTC Programme Director advised that the Orthopaedic BC could progress with or without the RTC, as it was his belief that 2 sites would be needed due to workforce requirements and potential evening and weekend working. **PF23/38.1.4** The Director of Governance highlighted the financial risk to the organisation and the need to clarify the current RTC risk with potential alternative solutions. **It was resolved that the Committee**	

• noted the content of the report as evidence of work being undertaken to progress the RTC programme • noted work on programme risk reporting • agreed the proposal for a quarterly report to PFIGC on programme progress, finances and risks	
PF23/40 Information Governance Quarter 2 2022/23 Key Performance Indicators (KPI) Report. **PF23/40.1** The Head of Information Governance joined the meeting to present the report. She highlighted the positive news that BCU's overall compliance of mandatory Information Governance training across BCUHB had remained at 83% during quarter 2. The paper had been deferred from the December meeting due to shortening the PFIGC agenda to accommodate operational needs, she advised that progress had since been made on the information governance asset register, compliance, access to health records and the complaints had been closed. **PF23/40.2** The Committee questioned the mail box confidentiality issue and reporting controls. It was noted that whilst under reporting was impossible to quantify, all reported incidents were acted upon. She undertook to provide more detail within the next report and was pleased to advise that since the IG department had merged within the DDAT division there had been increased collaborative working in this area. **It was resolved that the Committee** noted the report, including assurance provided on compliance with the Data Protection and Freedom of Information legislation	
PF23/41 Board Assurance Framework The Interim Assistant Director Corporate Governance presented this item. He agreed to consult with the Interim Board Secretary on whether the Internal Audit Savings report addressed the gaps in CRR 2.7 and, following a query raised by the Interim Executive Director of Finance, to clarify whether the version presented was the most up to date. **It was resolved that the Committee** noted • the BAF risks and their associated mitigations • the three risks that were now outside the risk appetite of the Health Board in relation to unscheduled care, planned care and the delivery of the savings plan	DS
PF23/42 Corporate Risk Register **PF23/42.1** The Committee Chair was disappointed not to receive the CRR. It was noted that plans were in hand to agree submission of the CRR at each meeting based on the proposal that the Risk Management Group would be consolidated within the Health Board Leadership Team. At the HLT meeting held on 15.2.23 it was noted that no new risks had been identified.	

PF23/42.2 The Director of Governance summarised the following risks which had been raised during the meeting: • A risk that is on the operational risk register that reflects the Finance paper • A risk that financial overview and performance management may not be optimal which if not addressed will have the impact of worsening the BCUHB financial position • There is a potential risk that Recovery Programmes and other Programmes and Performance related issues are not optimised and this would have an impact on the key objectives of the Health Board due to a potential misunderstanding of clear understanding of accountability • There is a risk that a sub-optimal triangulation of performance information-Transformation-Financial information could have an impact on the ability to provide evidence that we are improving our Targeted Intervention Position and other important Corporate objectives • There is a risk that performance reports are not aligned to requirements of BCUHB. Including the need to align to the TI Performance Maturity Matrix • RTC -There is a risk of revenue pressure as a result of "double running" as we transform and the ability of the workforce to support these requirements. The impact of this could be to destabilise existing services. **PF23/42.3** The Director of Governance stated that BCUHB had volunteered to pilot a Risk Management system for potential rollout across Wales. In discussion which followed the need for a risk probability and impact discussion was highlighted along with the need for briefer documentation which also included Health & Safety risks and clinical risks. **It was resolved that the Committee** noted • the verbal update on future CRR reporting • the summary of risks highlighted during the meeting	
Chair Assurance reports : Executive Delivery Groups and Groups **It was resolved that the Committee** noted • the following Chair assurance reports **PF23/43.1 Chair Assurance report : Transformation EDG** **PF23/43.4 Information Governance Group** • the intention of the Interim Executive Director of Finance to discuss with the Interim Chief Executive the purpose and requirement of the following Executive Delivery Groups which had not met: **PF23/43.2 Finance EDG** **PF23/43.3 Performance EDG**	SW

PF23/44 Agree items for referral to Board / Other Committees Audit Committee - PF23/19 SORD/ToRs and PF23/28 Financial control report	
PF23/45 Review of risks highlighted in the meeting for referral to Risk Management Group See PF23/42 above.	
PF23/46 Agree items for Chairs Assurance report To be agreed outside the meeting	
PF23/47 Review of meeting effectiveness No feedback was provided.	
PF23/48 Summary of private business to be reported in public The Committee noted the report	
PF23/49 Date of next meeting 23.3.23	
Exclusion of 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."	

PEFORMANCE, FINANCE AND INFORMATION GOVERNANCE COMMITTEE
TABLE OF ACTIONS LOG – ARISING FROM MEETINGS HELD IN PUBLIC

	Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Revised timescale/ Action status (O/C)	RAG status
	Actions from PFIGC 30.6.22					
Actions from 27 October PFIGC						
8	PO see below	**PF22/151 Planned Care** **PF22/151.2** The Deputy CEO requested that the Team lock down early what capacity opportunity existed in order to ensure going forward that clear and owned trajectories were in each of the IHC systems.	11.11.22	The Interim CEO agreed to reassess and provide within the Planned Care update to the January meeting 12.1.23 PO advises There are weekly capacity meetings now by site and for HB which look at capacity and demand and the gap, and also impact on waiting times and long wait patients. The team are also now commencing that work with diagnostics colleagues too. The March update to PFIG will update on this work 15.2.23 NF advises **Clinics** are locked down until year end for West & Centre, with	April 2023	

	Nick Lyons			East completing this task by the end February **Theatres**, are in the process of being aligned with 642 principles. 23.2.23 Committee requested update via P Orwin 5.5.23 SW advises It has been agreed that an updated 23/24 Planned Care Plan will be brought to the Board by end June. It is suggested that this will address outstanding planned care issues.	Suggest action to be closed	
Actions from 19.1.23 PFIGC						
3	GE/NL	**PF23/7 Business Case for a Long Covid Service/Community Complex Conditions Service** **PF23/7.4** Executive Team to consider feedback provided and revise business case to include a balance of clinical and financial risk for consideration by the Committee and lobby WG for early clarification of financial committment.	31.1.23	14.2.23 A response is awaited from WG. 23.2.23 SW advised positive feedback had been received from WG, the BC would be prepared in due course. The Committee gave an undertaking to consider the matter between meetings if necessary. 15.3.23 GE advises: Funding confirmed by WG, updated business case approved by Executive Team, awaiting PFIGC sign off but committee stood down.	March meeting Agenda item 12.5.23 Suggest action to be closed	

4	GE/ Members	**PF23/7 Business Case for a Long Covid Service/Community Complex Conditions Service** Consider, at the earliest opportunity, a revised paper including non-recurrent funding and clarity on WG financial support.	31.1.23	14.2.23 See **PF23/7.4 above**		
7	JC NL>PO (NF) Nick Lyons	**PF23/9 Planned care (PC) report** Chair's Assurance report would highlight the slippage of the development of the Planned Care Strategy and advise it would be submitted for consideration in March.	For March Board meeting 15.3.23	16.2.23 OMD advises: On plan to submit in March as part of the ongoing work being undertaken re action 5 above	Planned care item was stood down at agenda setting Suggest action to be closed – see action 8 above	
Actions from 23.2.23 PFIGC						
1	DSeabrooke for MM PM	**PF23/19 PFIGC ToR and SORD** Arrange to submit changes agreed to Audit Committee to update SORD and TOR	14.3.23	To be addressed at Audit Committee. Action has been transferred.	Suggest action to be closed	
2a	SW	**PF23/25.3 Finance reports 9&10** Provide rationale for key risks being de-escalated between months 8 and 9	16.3.23	This rationale has been circulated to PFIG officers on 20.3.23	Complete	
2b	SW	**PF23/25.3 Finance reports 9&10** Arrange for divisional reports to be scheduled at each future meeting on COB	1.4.23	It is proposed a rolling programme is agreed to start from June 2023.	June 2023	
3	PM	**PF23/25.3 Finance reports 9&10** P15 Clarify whether properties were increasing or decreasing and advise if an overarching risk addressed this on the CRR	16.3.23	The amount of risk relating to property has reduced from 5 to 3 after April Risk Management Group review. There was a deep dive into Property risks on the	Suggest action to be closed	

				CRR at the last QSE Committee and the outcome was that the remaining three risks should not be consolidated.		
4	SW	**PF23/23 Financial Control report** • Include milestones and delivery updates within future reports • Work with Interim Board Secretary to reformat future reports and refer to Audit Committee	14.3.23	The Financial Control Action Plan is being updated to include actions in response to the EY report. By agreement of the respective Chairs this will now be reported to the Audit meeting.	April 2023 Suggest action to be closed	
5	JB	**PF23/29.2 Agency Controls report** Arrange for future reporting to align with the new operating model within 3 months	31.5.23	Update 27.04.23 - all dashboards and reports now align to the new operating model.	Suggest action to be closed	
6	SW	**PF23/33 Business Tracker** • Meet with Committee Chair to discuss format requirements • Arrange process of prior scrutiny via ET ahead of future submissions to PFIGC	18.4.23	A meeting will be held with the new PFIG Chair to discuss the format of this report.	April 2023 May 2023	
7	JC/RM/LT	**PF23/37 IQPR** Meet to discuss Planned Care and USC reporting needs to PFIGC	16.3.23		Suggest action to be closed	
8	DSeabrooke PM	**PF23/41 BAF** Clarify with Interim Board Secretary if Internal Audit Savings report addressed gaps in 2.7 and whether version submitted was the most up to date.	16.3.23	To be addressed at PFIGC meeting 12.5.23	12.5.23	

9	PM	**PF23/42.4 CRR** Arrange to include Performance and Accountability meetings within CRR.	16.3.23	14.3.23 PM advises: HBLT has now received 2 reports summarising Accountability Review Risks The latest was on 15th March for reviews in February. P Meakin coordinated this and authors report for HBLT and Risk Management Group.	Suggest action to be closed	
10	SW	**PF23/43 EDG meetings** Discuss purpose and requirement of EDG meetings to be held with CEO	16.3.23	It is proposed that a Financial Scrutiny Group will be created in place of an EDG. The will have financial and operational membership and will oversee and scrutinise financial performance and planning.	April 2023	

Teitl adroddiad: ***Report title:***	Planning, Performance and Accountability			
Adrodd i: ***Report to:***	Performance, Finance & Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide a briefing on the planned approach to divisional planning, performance and accountability. Previously, divisions have drawn up relatively simple "plans on a page" reflecting key service changes and other actions during the year. The plan is to move to IHC's producing full integrated plans, including activity plans, performance improvement trajectories, workforce plans and financial plans/budgets, with a defined framework. At the same time, we are aiming to refresh and sharpen up performance management and accountability arrangements, based on delivery against agreed local plans. The planned approach is set out on the attached slides (Appendix 1) and associated action plan (Appendix 2). The timescales and scope of actions in a short period is consciously ambitious and some level of slippage/delay is likely. The deadline for submission of Integrated Healthcare Community/Senior Leadership Team IHC/SLT plans has already been slipped to 19 May to reflect delays in provision of the planning framework and templates.			
Argymhellion: ***Recommendations:***	The Committee is asked to note the planned approach and draft timelines.			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster Interim Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***				
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	High level of confidence/evidence in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Risks of failing to deliver on a range of performance objectives.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	None directly
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	BAF 1.3, 1.4, and 1,5 regarding risks around delivery of USC, planned care and other performance improvement objectives. Also

Links to BAF risks: *(or links to the Corporate Risk Register)*	BAF 2.3 - Risk of the Health Board's failure to progressively reduce the recurrent deficit.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** See action plan in Appendix 2.	
Rhestr o Atodiadau: ***List of Appendices:*** 1. Slide pack - planning, performance and accountability 2. Action plan - planning, performance and accountability	

Planning, performance and accountability

Previous papers on the 2023/24 financial planning process have referred to the introduction of local Senior Leadership Team (SLTs) integrated planning

The intent around this was also touched on in the February accountability review meetings and will form part of the Stabilisation stage of Special Measures. It is to implement a simple, easy to understand, service planning and quarterly reporting framework that:

- Enables SLT's to develop plans, through a process of co-production with corporate, that they will have ownership of;
- Enables all to be clear who is responsible for delivering what, by when and what the desired outcomes may be and may include measures such as local or national KPIs;
- Ensure that there is a golden thread from SLT's and hopefully individual's appraisals through to our Health Board's mission and strategic goals;
- Ensures that there is continual monitoring and feedback of learning to adapt quarter by quarter.

This slide pack outlines proposals for:

- How this could operate
- How it could then be linked into the performance management process

Components of the process

- Corporate framework for local planning
- SLT plans developed in line with the corporate framework
- Review and sign off of SLT's plans (with amendments as necessary)
- Alignment of corporate support with delivery of the SLT plans
- Tracking of delivery of local plans through the year – with performance management and support of SLT's

As a consequence of delayed submission of the Health Board Annual Plan (now 30 June), there is an opportunity for local integrated plans to inform the June Health Board plan.

And for the numerical aspects of divisional plans to be summed to create the overall Health Board plan - provided they were collectively delivering on the Health Board requirements and objectives

Corporate framework for local planning

Corporate objectives

- These would come from the initial draft annual plan sent to WG

Performance, quality, and outcome improvement expectations/targets

- Suggest that initially we only do this for the c 20 key measures included in the draft performance dashboard
- Any others would need to be defined with each SLT with each SLT lead having consulted with their teams in terms of ensuring they are specific, measurable, achievable, relevant, and time-bound (SMART), and consistent with national targets for the Health Board and national data definitions etc.

SLT budgets

- Plans need to align with the budgets
- Budgets to be calculated from devolving the agreed Health Board budget – see Appendix 1
- Need provision to be able to re-align budgets for agreed cross-BCU changes (e.g. impact of pooled waiting lists)

Develop and agree a new performance and accountability and performance framework – see slide 5

Review scheme of delegation

- Needs to define the limits to SLT decision making (see next slide)

Scheme of delegation/operating rules

Essentially this needs to define the limits to SLT decision making and the process for getting decisions outside those limits

- This is around use of resources
- But also clinical models and policies etc
- And changes to planned improvement/performance trajectories etc

Need to check and update as necessary the current scheme of delegation to

- Ensure its content is wide enough to fulfil this purpose
- Ensure it is clear and practical - pick up and address the issues being identified with lack of clarity or practicality

We need to check whether the process for decision-making outside local delegations is sufficiently clear – what needs to get decided where etc

Development of a Performance & Accountability Framework for 23/24

	Element of work	Lead	RACI model to be added	Timescale
1	Agree performance targets/expectations and associated trajectories for 23/24 - for health board overall and contribution of each SLT	Barbara Cummings, David Coyle		End April
2	Update for the new operating structure			End April
3	Agree and reflect planned corporate oversight groups and associated reporting lines			End April
4	Agree and reflect revised escalation process			End April
5	Agree mechanism and approval process for any change to performance improvement trajectories			End April
6	Include defined purpose and role of performance team			End April
7	Socialise & consult with SLTs			End April

Divisional input would be sought to the above process, and HBLT agreement to the proposals brought forward. We also discuss with WG in the context of special measures.

SLT plans - content

- **Key actions/programmes of work to achieve objectives, and corporate support requested (see example on next slide)**
- **Activity plans, bed plans and demand and capacity plans**
  - Makes clear for these measures the individual divisional contributions to the HB's overall activity/D&C plans
- **Improvement trajectories for the defined priority measures within the balanced scorecard**
  - Makes clear for these measures the individual divisional contributions to the HB's overall trajectory
- **Key enablers for delivery of the plan**
  - E.g. Digital, Data and Technology enablers
- **Workforce plan (aligned with budget-setting)**
- **Budget-setting within the overall financial envelope set**
  - Further savings identification and attribution to cost centres
  - Alignment of budgets with updated review of recurrent costs (with judgement applied)
  - Attribution of non-recurring budget reductions
  - Allocation of funding from central reserves for specific schemes funded
  - SLT reserves can be held but these should be kept as small as possible

The format for submission of these elements to be defined corporately to ensure plans are presented consistently, and can be summarised to a Health Board wide total – so that we can easily sum them up to inform the Health Board wide plan submitted at the end of June.

Possible example of actions to achieve objectives

	Objective	Delivery Milestones	Lead	Budget Allocated for this work	High Level Outcomes	KPIs	Risks if we don't do it
1	Establish a new open and transparent Digital, Data and Technology Portfolio Project and Programme Management Office method, governance and function.	May – June Research & Learning Organisational consultation & workshops Draft proposals for SLT away day for interations. Prioritisation Matrix, minimum viable process and operating model. JDs sorted for key roles. Nov 22 - Basic PMO and tools ready and presented to HBLY, IHC Jan 23 MS Project for the web configured and live Mar 23 Minimum Viable PPMO live	Andrea Williams	£ ZERO	• Everyone in BCU knowing where each piece of work is across the whole project lifecycle – idea to benefits realization (soup to nuts) • Simple & clear commissioning process with clear sign off from individuals in the business • Clear prioritised portfolio of work against clear criteria • Pieces of work impact assessed – so we know what will be done, when it will be done, who will need to be involved so it can be scheduled in and costs open and transparent with contingency • Projets properly funded and resourced or not commenced. • Appropriate rigour for the right level of project to ensure delivery to time, quality and cost • Good simple and easily consumable management information as to the status of the portfolio against desired outcomes • Good practice resource management • Clear escalaton processes and governance where the "business" makes a decision on something new they know and sign up to the impact on a whole. Overall for portfolio assurance that the portfolio fo work is best aligned to the delivery of the overall outcomes.	Number of live projects reduced by 50% Number of pipeline projects reduced by 70% 30% increase in projects delivered to time, quality and cost	• Wasting money • Not delivering to time, budget or cost • Not meeting expectations • Sub optimal use of resources • He who shouts the loudest

Review and sign off of SLT plans- process

- **Corporate review of plans**
  - Objectives and plan for change and improvement - by Operations and Planning
  - Performance improvement/targets – by Performance team
  - Quality improvement - by Director of Nursing, Director of Therapies and Health Sciences and Medical Director teams
  - Digital, Data and Technology – by DDaT
  - Workforce plans - by Workforce and Organisational Development
  - Finance plans - by Finance team
  - Brought into an overall assessment by Planning or Operations – potentially with RAG ratings?

  NB SLTs would be working with these functions in the development of their plans and this should minimise issues arising at the review stage.
- **Review meetings to discuss the feedback and agree amendments/improvements needed**
- **Sign off of the final plan by the relevant SLT and the CE/EDIC. SLTs would then be accountable for the delivery of the plan.**

Alignment of corporate support with delivery of divisional plans

This would include:-

- SLT and directorate objectives - workforce, finance, performance, DDaT etc
- Use of transformation team and other supporting resources

There would still be corporate cross health board projects outside SLT plans supported by corporate resources

But there would be alignment

Tracking of delivery of local plans through the year – draft to be refined with SLT input

		Element of work	Lead	RACI model to be added	Timescale
1	**Arrangements for performance reporting during 2023/24**		Barbara Cummings, David Coyle		End April
	a	Finalise performance dashboard			
		- Confirm selected measures for IHCs			
		- Agree weights and scoring algorithms			
		- Test and confirm technical delivery of reporting			
		- Extend to other divisions			
	b	Agree approach to reporting on variances between planned and actual performance - including understanding of drivers, explanation of underlying causes, actions to address etc			
	c	Develop and design required reports at within and across divisions aligned to the governance structure defined in (1)			
2	**Refresh roles, responsibilities and accountability with regards to data and information management supported by a strong, assured data quality programme**		Dylan Roberts, Kathryn Lang, Barbara Cummings		End June
	a	Identify current issues or problems that need to be addressed with data quality and apparently conflicting reports or analyses			
	b	Identify current individuals/teams responsible for reporting information and data			
	c	Develop proposals for removing duplication, ensuring consistency and improving efficiency			

SLT input would be sought to the above process, and HBLT agreement to the proposals brought forward

Proposed outline timetable

Corporate objectives defined	mid April?
Performance, quality, outcome improvement expectations defined	mid April?
Budget envelope calculated for each SLT	early April
for the health board overall and the contribution of each SLT	
Cross cutting theme and other cross HB action plans agreed	end April
Performance and accountability framework agreed	end April
Initial SLT plans completed	end April ?
Corporate review of plans and resulting updates to achieve final agreed plans	end May
Alignment of cross-cutting themes etc with SLT plans	end May
Annual reflects local plans to the greatest possible extent	end June
In year tracking and reporting against SLT and cross-cutting plans	from June
(applying the performance and accountability framework)	

Feedback - some specific questions

- Are we committed to the work needed to make a success of local integrated planning?
- Is this a coherent process for doing that?
- Are the timescales realistic?
- Do we need a longer timetable for some specific aspects ? (e.g. planned care)
- What involvement in the development of these arrangements would SLTs want to have and how can we best facilitate that?

Appendix 1
Budgets delegated to SLTs based on £134m initial deficit plan

SLT/directorate total budget envelopes calculated from

- Recurrent spend/deficit
- Plus agreed use of perf and transformation funds, and unavoidable cost pressures
- Plus agreed use of Sustainability, Covid, VBHC funds on a ring fenced basis
- Plus share of inflation and growth uplifts
- Less mandated non-recurring underspend
- Less savings targets

Budgets held centrally (very small)

- Funding for P&I, Covid, Unavoidable cost pressures, VBHC, Sustainability, Covid not yet agreed
- New investment reserve
- Contingency reserve

Budgeting for financial improvement

Non-recurring budget reduction for continuance of 23/24 NR underspends will be removed from initial SLT budgets (non-recurrently)

Savings targets deducted from SLT budgets(held on divisional CRES reserve). Identified savings removed from relevant cost centre budgets to clear the reserve. Balance on SLT CRES reserves reported as unachieved savings. The normal savings pipeline and associated reporting process will apply.

All savings should be budget savings as the recurrent deficit will be funded

Focus should be on recurrent savings, but any non-recurrent savings can only be declared once the initial non-recurring underspend is being achieved

Impact of 2023/24 financial performance on 2024/25 budgets

In 2023/24 the starting point for SLT budgets proposed in the process outlined in these slides is their recurrent financial positions at the end of 2022/23

This does not provide the right incentives, as recurrent overspends are then funded in the following financial year. So an SLT with a higher overspend will be “rewarded” with a higher starting budget than an SLT which has underspent or overspent by less. It has been used for 2023/24 for reasons of pragmatism only.

For 2024/25 this methodology will NOT be used

Instead IF there is an overall 2023/24 recurrent overspend against plan which is agreed to be reflected as the start point for 2024/25 financial planning, then this will be applied proportionately across all SLTs. And if information is available on differences on budget relative to population need, then this will also be taken into account.

Planning, Performance and Accountability in 2023/24 - Action Plan

		Exec	Lead	Timescale
Section A - Define the corporate framework for local planning				
1	Draft summary guidance regarding the local planning process and the expected content of local plans	Chris Stockport	Sally Baxter	14-Apr
2	Define key Health Board objectives to reflect in local plans. This needs to be aligned with expectations arising from Special Measures	Chris Stockport	Sally Baxter	14-Apr
3	Agree performance targets/expectations and associated trajectories for 23/24 - for the health board overall and the contribution of each SLT. These are agreed to be aligned with the limited set of measures (circa 20) included in the balanced scorecard	Chris Stockport	Barbara Cummings, Sally Baxter, David Coyle	14-Apr
4	Updated Performance Management & Accountability Framework - see section F	Steve Webster	Barbara Cummings, Sally Baxter, David Coyle	03-May
5	Define budgets allocated each SLT within which plans need to be based and residual budgets held centrally pending allocation, and financial management principles	Steve Webster	Finance Team	14-Apr
6	Draft the templates for SLTs to submit their plans on			
	a) Section headings of written plan	Chris Stockport	Sally Baxter	14-Apr
	b) Format for setting out actions to achieve planned objectives	Chris Stockport	Sally Baxter, Barbara Cummings, David Coyle	14-Apr
	c) Format for setting out demand and capacity and activity plans (presume this will need to include bed plans aligned with projected inpatient admissions, length of stay and bed occupancy)	EDIC? Steve Webster?	Barbara Cummings, Kathryn Lang, Andrew Kent (for planned care), Geraint Farr (for USC)	14-Apr
	d) Format for setting out performance improvement trajectories	Steve Webster	Barbara Cummings	14-Apr
	e) Format for setting out workforce plans	Jason Brannan	Nick Graham	14-Apr
	f) Format for setting out financial plans	Steve Webster	Rob Nolan	14-Apr

		Exec	Lead	Timescale
7	Summary of local planning guidance & templates to HBLT on 19 Apr	Chris Stockport & Steve Webster	Sally Baxter, Barbara Cummings, David Coyle	17-Apr
8	Review and update of scheme of delegation - financial aspects (subject to agreement by Audit Committee)	Steve Webster	Tony Uttley	29-Apr
9	Define the limits of autonomy of SLTs regarding clinical/service model changes	CE	Geoff Lang	17-May
Section B - Define the Framework for Planned Care & Cancer				
1	Provide communications on the financial investment included in the 2023/24 plan above core budgets into planned care and cancer (by IHC/SLT), and the decisions made at Health Board in response to the initial plan.	EDIC/Chris Stockport?	Andrew Kent	15-Apr
2	Set out the initial activity plans and resulting projected waiting times resulting from the initial plan, by IHC and specialty	EDIC/Chris Stockport?	Andrew Kent	15-Apr
3	Set out by IHC and specialty expectations of feasible but challenging improvements to the initial plans in (2), and the increased activity/reduced waiting times resulting from them. This will be based on a range of opportunities around productivity and waiting list management.	EDIC/Chris Stockport?	Andrew Kent, Nikki Foulkes, Barbara Cummings, Kamala Williams	26-Apr
4	Seek SLT and other proposals for submission to WG against the £50m planned care funding held back by WG, within the WG identified criteria. These need to be consistent/aligned with the expectations for improvement in (3).	EDIC/Chris Stockport?	Andrew Kent	12-May
5	SLT's to set out within their local plans (by specialty) their assessment of what they can deliver against the expectations set out in (3) above, enabled where relevant by investment proposed in (4) above	EDIC	SLTs	12-May

		Exec	Lead	Timescale
6	Review the planned care plans of each SLT in (5) above, and provide feedback to the SLTs for the wider plan review process outlined below	EDIC	Andrew Kent	19-May
7	Undertake EQIA review of updated planned care plans	EDIC	Andrew Kent	19-May
Section C - SLTs draw up integrated local plans				
1	Draw up plans in line with the planning guidance	EDIC	SLTs	12-May
Section D - Review and sign-off of SLT plans				
1	Review of plan aspects by corporate functions with written feedback for SLTs			
	a) Clarity of plan and alignment with Health Board objectives	Chris Stockport	Sally Baxter	19-May
	b) Review actions to achieve objectives	EDIC? Chris Stockport?	Sally Baxter	19-May
	c) Review demand & capacity and activity plans	EDIC? Steve Webster?	Barbara Cummings, Kathryn Lang, Andrew Kent, Geraint Farr	19-May
	d) Review performance improvement trajectories	Steve Webster	Barbara Cummings, Kathryn Lang, Andrew Kent, Geraint Farr	19-May
	e) Review workforce plans	Jason Brannan	Nick Graham	19-May
	f) Review finance plans	Steve Webster	Rob Nolan	19-May
	g) Summarise feedback for each SLT	Chris Stockport	Sally Baxter	19-May
3	Run feedback meetings with each SLT with Exec attendance	Chris Stockport	Sally Baxter	26-May
4	SLT's to update plans as necessary to address feedback	EDIC	SLTs	02-Jun
5	Review and sign-off final plans	EDIC with Execs	Sally Baxter, Barbara Cummings, David Coyle	16-Jun

		Exec	Lead	Timescale
Section E - Summarise and sum plans to inform the updated Health Board plan				
1	Regarding the non-numeric aspects of SLT plans, the planning team to review the content of consider where and how to reflect in the overall BCU Health Board plan. Both descriptive content and action plans.	Chris Stockport	Sally Baxter	23-Jun
2	Individual corporate functions sum the SLT plans to identify a draft overall BCU Health Board plan, and consider any necessary adjustments to reflect in the HB plan. Adjustments or overrides to the sum of local plans may be needed, but at least they wil be known.			
	a) Demand and capacity and activity plans	EDIC? Steve Webster?	Barbara Cummings, Kathryn Lang, Andrew Kent, Geraint Farr	23-Jun
	b) Performance improvement trajectories	Steve Webster	Barbara Cummings, Kathryn Lang, Andrew Kent, Geraint Farr	23-Jun
	c) Workforce plans	Jason Brannan	Nick Graham	23-Jun
	d) Financial plans	Steve Webster	Rob Nolan	23-Jun
3	Work across corporate functions to check that activity, workforce and financial plans are consistent with each other	Steve Webster		23-Jun
4	Review and sign-off of BCU Health Plan for 2023/24	Chris Stockport	Sally Baxter	30-Jun
Section F - Develope an updated Performance and Accountability Framework for 23/24				
1	Update the framework to reflect the new operating structure	Steve Webster	Barbara Cummings	18-Apr
2	Identify proposed corporate oversight groups and associated reporting lines	Steve Webster	Barbara Cummings, David Coyle	18-Apr
3	Agree and reflect revised escalation process	Steve Webster	Barbara Cummings, David Coyle	18-Apr
4	Agree mechanism and approval process for any change to performance improvement trajectories	Steve Webster	Barbara Cummings, David Coyle	18-Apr

		Exec	Lead	Timescale
5	Include defined purpose and role of performance team	Steve Webster	Barbara Cummings	18-Apr
6	Finalise document and socialise & consult with Execs and SLTs	Steve Webster	Barbara Cummings, Sally Baxter, David Coyle	20 April to 3 May
7	Get sign off at Execs	Steve Webster	Barbara Cummings, Sally Baxter, David Coyle	26-Apr
8	Get sign-off at HBLT	Steve Webster	Barbara Cummings, Sally Baxter, David Coyle	03-May
Section G - Put in place arrangements for performance reporting during 2023/24				
1	Finalise performance dashboard			
	- Confirm selected measures for IHCs	EDIC? Steve Webster?	Barbara Cummings, Dylan Roberts, Kathryn Lang	18-Apr
	- Agree weights and scoring algorithms	EDIC? Steve Webster?	Barbara Cummings, Dylan Roberts, Kathryn Lang	18-Apr
	- Technical delivery and testing of reporting	Dylan Roberts	Dylan Roberts & Kathryn Lang	25-Apr
	- Agree timescales for extension to other divisions	Dylan Roberts	Barbara Cummings, Dylan Roberts, Kathryn Lang	
2	Agree format and content of reporting on variances between planned and actual performance - including understanding of drivers, explanation of underlying causes, actions to address etc	Steve Webster	Barbara Cummings	18-Apr
3	Develop and design required reports both within and across SLTs aligned to the governance structure defined in the P&AF - in terms of both data content and textual content, reflecting the agreed approach in (2)	Steve Webster	Barbara Cummings and Kathryn Lang	25-Apr
4	Finalise reporting format and schedules and socialise & consult with Execs and SLTs	Steve Webster	Barbara Cummings and Kathryn Lang	25 April to 2 May
5	Get sign off on performance reporting arrangements for 23/24 (including balanced scorecard) at HBLT	Steve Webster	Barbara Cummings, Dylan Roberts, Kathryn Lang	03-May

		Exec	Lead	Timescale
6	Implement from Month 1 reporting	Steve Webster	Barbara Cummings, Dylan Roberts, Kathryn Lang	Ongoing
Section H - Refresh roles, responsibilities and accountability with regards to data and information management supported by a strong, assured data quality programme			To be prioritised after initial reporting arrangements have been put in place	
1	Identify current issues or problems that need to be addressed with data quality and apparently conflicting reports or analyses	Dylan Roberts	Barbara Cummings, Kathryn Lang	19-May
2	Identify current individuals/teams responsible for reporting information and data	Dylan Roberts	Barbara Cummings, Kathryn Lang	19-May
3	Develop proposals for removing duplication, ensuring consistency and improving efficiency	Dylan Roberts	Barbara Cummings, Kathryn Lang	02-Jun

Teitl adroddiad: ***Report title:***	**Month 12 Finance report**
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 May 2023
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to provide a briefing on the draft un-audited financial performance of the Health Board for the twelve months from 1st April 2022 to 31st March 2023. The draft unaudited year end position for 2022/23 achieved a surplus of £0.4m. At Month 11, the Health Board's forecast was revised to report a balanced forecast outturn position to reflect additional unexpected income allocations and other gains. The allocations are as follows: • £1.7m Queen's funeral bank holiday funding • £4.3m COVID-19 Discharge support funding • £1.7m Dispensing Fees • £1.1m fortuitous gain on VAT recovery • Retention of funding for Performance and Transformation Strategic, Planned Care Sustainability, Value Based Healthcare and other ring-fenced funding. An Accountable Officer (AO) Letter was submitted to Welsh Government on the 12th April providing details of these areas. Total savings delivered is £31.2m against a full year plan of £25.9m and a total target of £35.0m. Accountancy Gains totalled £9.7m at Month 12 and there were no red schemes. Appendix C includes details on the delivery of the approved capital programme. It provides an update, by exception, on the status and progress of the major capital projects and the agreed capital programmes. It is confirmed that we have met the Capital Resource Limit target for 22/23 of £24.761m, subject to audit, with a remaining balance of £29,000.

Argymhellion: ***Recommendations:***	It is recommended that the report is noted			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster, Interim Executive Director of Finance,			
Awdur yr Adroddiad: ***Report Author:***				
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	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. The capital programme is in accordance with the Integrated Medium Term Plan (IMTP). The planned projects and discretionary programme assist the Health Board in meeting its' statutory and mandatory requirements.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not Applicable			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable. The health board continues to assess the requirement for carrying out Equality Impact Assessments on a capital project by project basis			

Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Naddo N Equality Impact (EqIA) and a socio-economic (SED) impact assessments not applicable. The health board continues to assess the requirement for carrying out Social-economic and Impact Assessments on a capital project by project basis.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	There is a risk that the Health Board does not meet its statutory financial duty for 2022-23. BAF 2.3. The Health Board continues to experience occasions were capital tenders are exceeding budget estimates due to the volatility within the construction market and general inflationary pressures. The programme is monitored monthly to ensure that financial commitments align to available funding.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable Appendix C. 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.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Appendix A & B. BAF 2.3 Risk of the Health Board's failure to meet the break-even duty. Appendix C. BAF 21-14 Pandemic exposure BAF 21-09, Infection prevention control BAF 21-12, Security services BAF 21-13, Health and safety BAF 21-03, Primary Care BAF 21-04, Timely access to planned care

	BAF 21-01, Safe and effective management of unscheduled care BAF 21-06, Safe and effective mental health service delivery BAF 21-16, Digital estate and assets BAF 21-17, Estates and assets development BAF 21-20, Development of IMTP BAF 21-21, Estates and assets Corporate Risk Register: 20-01, Asbestos management and control 20-03, Legionella management and control 20-04, Noncompliance of fire safety systems 20-06, Informatics – patient records pan BCU 20-07, Informatics – capacity, resource and demand 20-11, Informatics – cyber security
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Ai Finance report month 12 Aii WG Monitoring report month 12 B Savings report month 12 C Capital Programme month 12	

Appendix Ai

Finance Report
March 2023 – M12

Steve Webster

Interim Executive Finance Director

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

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

- Unaudited year end revenue position achieved a surplus of £0.4m.
- To achieve a break-even position in 22/23 will ensure that the Health Board meet its statutory financial duty to breakeven over the 3-year period and all historic debts prior to achieving the breakeven duty will be cancelled. This was announced by the Minister for Health and Social Services in June 2020.
- Key financial targets for cash and capital were all met. The Health Board achieved the cumulative PSPP target to pay 95% of valid invoices within 30 days of receipt in three of the four measures of compliance.

Issues & Actions

- 2022/23 Draft annual accounts are currently being completed and will be submitted to Welsh Government and Audit Wales on 5th May. Audit Wales will file the audited accounts with Welsh Government on 31st July.
- All figures reported throughout this report are subject to the closure and submission of the final accounts for 2022/23 and audit by Audit Wales.
- As per the Accountable Officer letter, a potential concern considered by the Health Board is the risk of a prior year adjustment to the 2022/23 accounts (in respect of the 2021/22 financial year).

Key Messages

- The draft unaudited year end position for 2022/23 achieved a surplus of £0.4m.
- At Month 11, the Health Board's forecast was revised to report a balanced forecast outturn position to reflect additional unexpected income allocations of £1.7m Queen's funeral bank holiday funding, £4.3m COVID-19 Discharge support funding, £1.7m Dispensing Fees, £1.1m fortuitous gain on VAT recovery and the retention of funding for Performance and Transformation Strategic, Planned Care Sustainability, Value Based Healthcare and other ring-fenced funding, when costs to the full level of funding could not be directly identified and attributed to this funding. An Accountable Officer (AO) Letter was submitted to Welsh Government on the 12th April providing details of these areas.
- Total savings delivered is £31.2m against a full year plan of £25.9m and a total target of £35.0m. Accountancy Gains totalled £9.7m at Month 12 and there were no red schemes.

Summary of Key Numbers – Month 12

Month 12 Position

In Month:

In Month - £8.5m Surplus

(Pending Audit)

2022/23 Position

Year to Date:

Year End - £0.4m surplus

(Pending Audit)

Divisional Performance Month 12

West IHC	£13.4m adverse
Central IHC	£13.5m adverse
East IHC	£13.7m adverse
Womens	£1.1m adverse
MH & LD	£5m adverse
Commissioning Contracts	£5.9m favourable
ICD PrimaryCare	£1.9m favourable
ICD Regional Services	£2.3m adverse
Support Functions & Other Budgets	£41.7m favourable

Savings

In-month: £5.2m against target of £7.9m

£2.7m adverse

YTD: £31.2m against target of £35.0m

£3.8m adverse

Balance Sheet

Cash: Achieved

Capital: Achieved CRL

PSPP: Non NHS invoice Target achieved

COVID-19 Impact

£44.8m cost YTD

£45.3m forecast cost.
£45.7m Funded by Welsh Government

£0.9m Surplus

Income

£152.1m against budget of £142.2m

£9.9m Favourable

Pay

£1011.8m against budget of £1006.3m

£5.5m Adverse

Non-Pay

£1,133.4m against budget of £1,129.4m

£4.0m Adverse

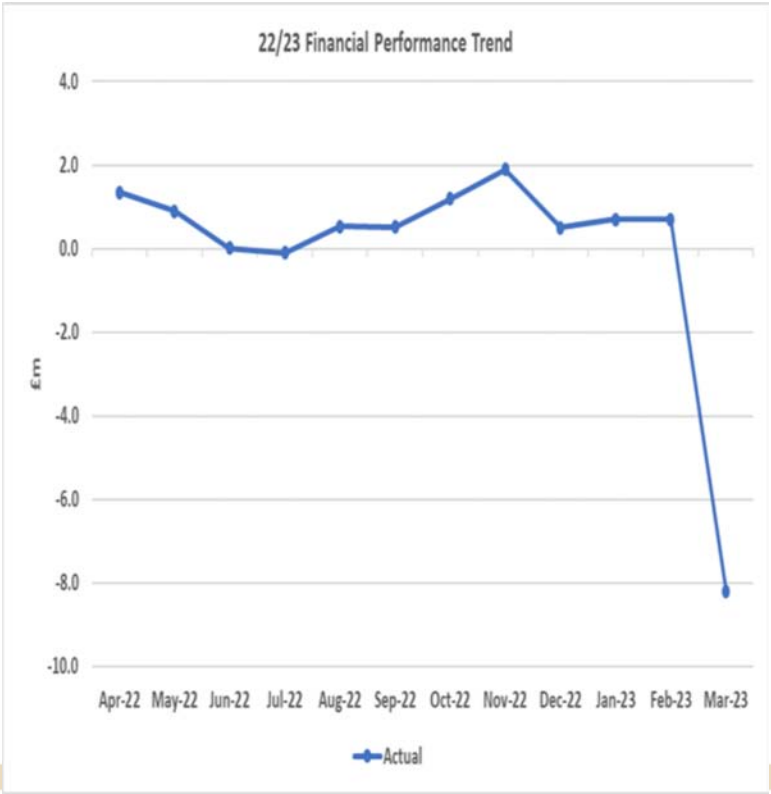
Revenue Position

	Actual M7 £m	Actual M8 £m	Actual M9 £m	Actual M10 £m	Actual M11 £m	Actual M12 £m	2022/23 Cumulative Budget £m	Actual £m	Variance £m	Variance %
Revenue Resource Limit	(158.9)	(158.9)	(160.1)	(160.8)	(164.7)	(239.7)	(1,993.5)	(1,993.5)	**0.0**	0.0%
Miscellaneous Income	(12.0)	(12.4)	(12.2)	(13.0)	(14.6)	(15.7)	(142.1)	(152.1)	-9.9	7.0%
Health Board Pay Expenditure	79.4	79.7	75.1	80.8	81.5	142.6	1,006.3	1,011.8	**5.5**	0.5%
Non-Pay Expenditure	92.7	93.5	97.7	93.7	98.6	104.2	1,129.4	1,133.4	**4.0**	0.4%
Total Deficit / (Surplus)	**1.2**	**1.9**	**0.5**	**0.7**	**0.7**	**(8.5)**	**0.0**	**(0.4)**	**-0.4**	

- The Health Board's financial plan for 2022/23 was to deliver a balanced position which includes the £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition, £38.4m Sustainability funding has been received to support planned and unscheduled care.

- At Month 11, the Health Board revised its forecast deficit of £10.0m to report a balanced forecast outturn position to reflect additional unexpected income allocations to cover retrospective costs for £1.7m Queen's funeral bank holiday, £4.3m COVID-19 Discharge support funding and £1.7m Dispensing Fees funding. In addition, the Month 12 position includes a £1.1m fortuitous gain on VAT recovery and the retention of funding for Performance and Transformation Strategic, Planned Care Sustainability, Value Based Healthcare and other ring-fenced funding when costs to the full level of funding could not be directly identified and attributed to this funding. An Accountable Officer (AO) Letter was submitted to Welsh Government on the 12th April providing details of these areas.

- The full year, draft unaudited position of the Health Board is a surplus of £0.4m and the draft in-month position is a surplus of £8.5m. The end of year financial position is subject to the closure and submission of the final accounts for 2022/23 and the subsequent audit by Audit Wales.



Revenue Position

A number of exceptional items have been included in the Month 12 position, which include:

- £10.3m - 1.5% non-consolidated pay award paid in March
- £13.6m - 1.5% Consolidated Pay Award year end adjustment.
- £37.4m - Year end adjustment in respect of the notional 6.3% employers' superannuation adjustment.

Offsetting the above increases in expenditure are the following gains in Month 12:

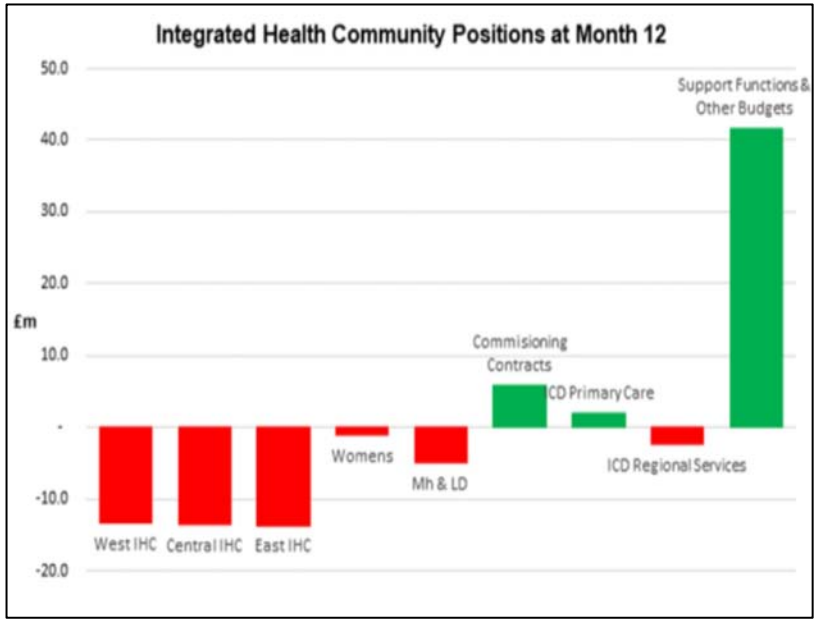
- An additional £3.2m of the Annual Leave accrual was released in month. Of the total, £2.0m was released to cover backfill costs and £1.2m was an accountancy gain.
- The review and data cleanse of purchase order accruals resulted in reduced accruals of £7.8m, of which £1.5m is an Accountancy Gain.
- £1.1m total fortuitous gain on VAT recovery for Home Oxygen Therapy Services, of which £0.9m relates to previous years

The table also shows the in-month movement compared to forecast:

	Forecast £'m	M12 Actual Income £'m	M12 Actual Spend £'m	Variance £'m
February reported position (Deficit)	**-8.1**	**1,888.6**	**-1,896.8**	**-8.2**
Month 12 movements				
Operational outturn	2.5	190.2	-192.0	-1.8
Exceptional items & Technical adjustments				
Increase in Study leave accrual	-2.0		-1.9	-1.9
Retaining balance of Value Based Healthcare	1.2	1.2		1.2
Additional accrual for No Purchase Order No pay	-1.0		-0.6	-0.6
Additional exceptional costs relating to legal cases	-1.9	4.1	-4.1	0.0
Release of Annual leave - accountancy gain			1.2	1.2
Release of Annual leave - covering backfill costs	0.5		2.0	2.0
Release due to Purchase Order review - accountancy gain			1.5	1.5
Release due to Purchase Order review - in year release	7.3		6.3	6.3
VAT Rebate - Home Oxygen Therapy Services	0.8		0.9	0.9
VAT on Lease Cars	0.4		0.4	0.4
IFRS income adjustment	0.3			0.0
Increased Surplus due to reduction in COVID spend			0.5	0.5
Increased surplus in Energy funding			0.5	0.5
6.3% superannuation		37.4	-37.4	0.0
Pay award - Non consolidated 1.5% (Paid)		10.2	-10.3	-0.1
Pay award - Consolidated 1.5% (Accrued)		12.1	-13.6	-1.5
Total March	**8.1**	**255.2**	**-246.6**	**8.6**
Total 22/23 Surplus Outturn Position	**0.0**	**2143.8**	**-2143.4**	**0.4**

Divisional Positions

	In Month			Cumulative		
	Budget	Actual	Variance to Plan	Budget	Actual	Variance to Plan
	£000	£000	£000	£000	£000	£000
WG RESOURCE ALLOCATION	(239,734)	(239,734)	0	(1,993,514)	(1,993,514)	0
WEST INTEGRATED HEALTH COMMUNITY						
Management	64	208	(144)	445	524	(80)
West Area	15,427	17,242	(1,815)	177,176	182,778	(5,602)
Ysbyty Gwynedd	10,609	11,683	(1,074)	117,211	124,316	(7,105)
Facilities	1,104	1,123	(19)	11,894	12,476	(582)
Total West	27,205	30,256	(3,052)	306,726	320,094	(13,368)
CENTRAL INTEGRATED HEALTH COMMUNITY						
Management	62	178	(116)	444	494	(50)
Central Area	20,458	19,215	1,242	234,922	233,414	1,509
Ysbyty Glan Clwyd	12,841	14,461	(1,620)	144,269	158,093	(13,824)
Facilities	1,266	1,322	(56)	13,880	15,042	(1,162)
Total Central	34,627	35,177	(550)	393,516	407,043	(13,527)
EAST INTEGRATED HEALTH COMMUNITY						
Management	75	91	(17)	551	448	103
East Area	22,750	24,937	(2,187)	266,488	272,481	(5,992)
Ysbyty Wrexham Maelor	10,713	11,549	(836)	123,393	130,474	(7,082)
Facilities	1,159	1,172	(14)	12,541	13,290	(750)
Total East	34,697	37,749	(3,053)	402,973	416,694	(13,721)
Total Midwifery and Women's Services	3,833	4,203	(369)	43,349	44,479	(1,130)
Total Mental Health and LDS	13,150	15,759	(2,609)	150,134	155,124	(4,990)
Total Commisioning Contracts	22,346	22,064	283	263,536	257,679	5,857
INTEGRATED CLINICAL DELIVERY PRIMARY CARE						
Covid Programmes	1,236	1,236	0	17,838	17,838	0
Dental North Wales	2,947	1,772	1,174	34,430	33,207	1,223
Community Dental Services	563	534	29	6,125	5,391	734
ICD Primary Care Management	13	0	13	103	47	56
Other Primary Care	(526)	(594)	68	(2,038)	(1,944)	(94)
Total Integrated Clinical Delivery Primary care	4,233	2,948	1,285	56,458	54,538	1,919
INTEGRATED CLINICAL DELIVERY REGIONAL SERVICES						
Provider Income	(1,821)	(1,990)	169	(21,330)	(21,707)	376
Diagnostic and Specialist Clinical Support	5,674	6,620	(946)	70,487	72,315	(1,829)
Cancer Services	5,653	5,626	27	55,563	56,455	(892)
Total Integrated Clinical Delivery	9,505	10,255	(750)	104,719	107,063	(2,344)
Total Service Support Functions and Other Budgets	90,138	72,784	17,354	272,104	230,411	41,693
Total	0	(8,539)	8,539	0	(389)	389



- The unaudited year end position is a surplus of £0.4m.
- Key impacts affecting divisional cumulative positions include additional pay costs due to variable pay costs, particularly Agency costs.
- Non Pay pressures continue within CHC, due to more complex packages driving an increase in costs and increasing out of area packages, prescribing costs and a number of general non pay inflationary pressures.
- Non delivery of CRES impact.

Income

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). All allocations have been received with no further anticipated allocations expected.
- Total 22/23 COVID-19 funding allocation received is £45.7m, leaving a £0.9m surplus further to Welsh Government allowing surplus funding to be retained. Loss of dental income funding (£0.2m), COVID Enhanced Flu (£0.2m) and Nosocomial allocation (£0.4m).
- Also, within the allocations received includes £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition, £38M has also been received for Planned and Unscheduled Care Sustainability Fund.

Description	£m
Allocations Received	1,993.5
Total Allocations Anticipated	-
Total Welsh Government Income	**1,993.5**

COVID -19 Funding	£m
Total COVID-19 costs in 2022/23	44.8
Total Covid -19 funding	**44.8**
Received	45.7
Anticipated	-0.9

Expenditure

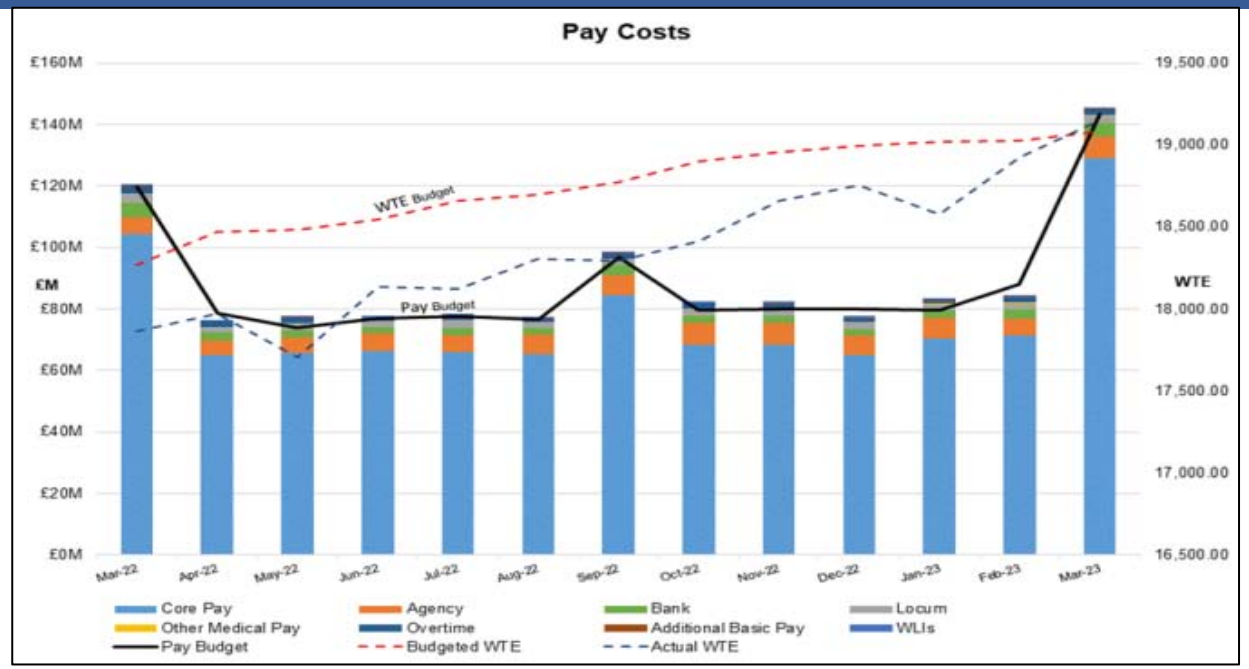
Pay Costs	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Cumulative YTD Budget	Cumulative YTD Actual	Cumulative YTD Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	11.4	10.0	11.0	10.8	11.0	14.1	11.5	9.9	11.7	12.0	11.9	21.4	149.3	146.7	(2.6)
Medical & Dental	17.6	17.3	17.9	18.2	18.0	21.7	18.6	19.7	16.7	18.6	18.6	31.6	223.1	234.0	10.9
Nursing & Midwifery Registered	23.7	22.9	23.4	23.3	22.8	28.8	24.3	25.0	22.9	24.5	24.9	42.4	317.9	309.6	(8.3)
Additional Clinical Services	11.2	10.6	10.7	11.0	10.6	15.0	11.6	11.7	10.8	11.8	12.2	6.1	138.3	149.1	10.8
Add Prof Scientific & Technical	2.9	2.9	2.9	3.0	3.0	3.5	3.1	3.2	3.0	3.1	3.1	21.5	44.9	39.9	(5.0)
Allied Health Professionals	5.0	4.7	4.7	5.0	4.9	6.1	5.3	5.4	5.2	5.4	5.4	9.8	64.6	67.2	2.5
Healthcare Scientists	1.3	1.2	1.3	1.3	1.3	1.5	1.3	1.4	1.1	1.3	1.3	2.1	17.6	16.5	(1.1)
Estates & Ancillary	3.5	3.7	3.5	3.6	3.5	5.0	3.8	3.3	3.7	3.8	3.9	6.6	49.5	48.0	(1.5)
Students	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	1.0	0.8	(0.2)
Health Board Total	**76.6**	**73.4**	**75.5**	**76.3**	**75.1**	**95.8**	**79.4**	**79.7**	**75.1**	**80.8**	**81.5**	**141.6**	**1,006.3**	**1,011.8**	**5.5**
Other Services (Incl. Primary Care)	2.0	2.4	2.2	2.3	2.5	2.8	2.9	2.8	2.6	2.6	2.9	4.1	24.7	31.0	6.3
Total Pay	**78.7**	**75.8**	**77.6**	**78.5**	**77.6**	**98.6**	**82.3**	**82.5**	**77.7**	**83.4**	**84.4**	**145.7**	**1,031.0**	**1,042.8**	**11.8**

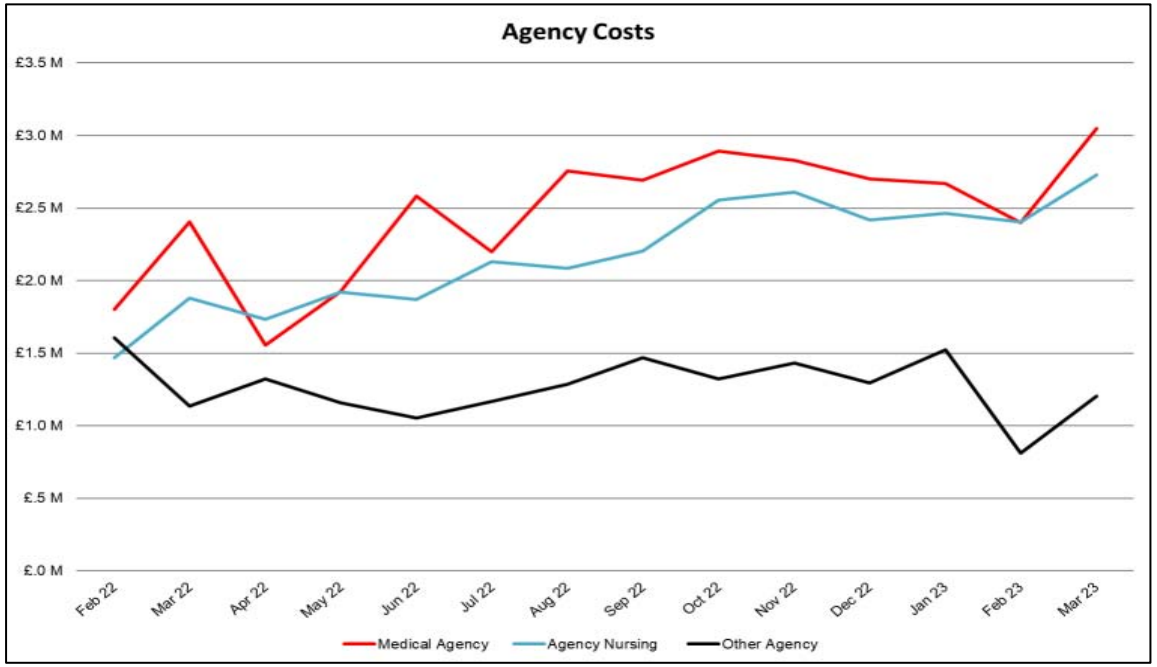
Non-Pay Costs	2022-23 M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Cumulative YTD Budget	Cumulative YTD Actual	Cumulative YTD Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care Contractors	18.1	18.1	16.8	18.2	17.6	18.3	19.1	22.3	18.9	19.7	19.0	17.6	228.0	223.7	4.3
Primary Care Drugs	8.7	8.8	9.9	10.1	10.3	10.5	9.9	9.9	10.2	10.4	10.3	11.8	106.3	120.8	(14.5)
Secondary Care Drugs	7.0	7.3	5.4	6.7	7.2	7.2	7.0	7.4	7.1	7.4	7.5	5.7	79.5	82.9	(3.3)
HC Services Provided by Other NHS	25.1	24.3	26.2	27.9	24.7	25.7	24.6	21.5	27.9	27.2	31.1	26.1	317.2	312.3	5.0
Continuing Care and FNC	9.4	9.4	9.4	10.2	9.6	5.5	8.7	8.8	8.9	7.0	6.9	10.3	97.3	104.1	(6.8)
Other Non Pay (incl Clinical & General Supplies)	18.1	19.7	18.5	15.5	25.6	21.5	20.3	22.1	21.7	19.1	20.6	24.3	258.3	246.9	11.4
Non-pay costs	**86.4**	**87.5**	**86.1**	**88.6**	**95.0**	**88.7**	**89.6**	**92.1**	**94.7**	**90.7**	**95.4**	**95.8**	**1,086.6**	**1,090.7**	**(4.0)**
Cost of Capital	2.5	2.5	2.5	5.9	3.3	3.3	3.3	1.5	3.1	3.1	3.1	8.4	42.7	42.7	0.0
Total non-pay	**88.9**	**90.0**	**88.6**	**94.5**	**98.4**	**92.1**	**92.9**	**93.6**	**97.8**	**93.8**	**98.5**	**104.2**	**1,129.4**	**1,133.4**	**(4.0)**

Variable Pay	2022-23 M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Agency	4.6	5.0	5.5	5.5	6.2	6.4	6.8	6.9	6.5	6.7	5.6	7.0	72.7
Overtime	1.8	1.8	0.9	1.3	1.1	1.6	1.5	1.3	1.2	0.9	1.5	1.7	16.5
Locum	1.7	2.1	1.8	2.5	2.0	2.0	2.2	2.5	2.2	2.1	2.3	2.6	26.0
WLIs	0.3	0.4	0.4	0.5	0.4	0.3	0.5	0.6	0.5	0.4	0.5	0.5	5.3
Bank	2.8	2.5	2.3	2.3	2.0	3.2	2.6	2.4	2.0	2.5	2.8	4.4	31.7
Other Non Core	0.1	0.1	0.0	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.9
Additional Hours	0.3	0.3	0.4	0.3	0.4	0.3	0.2	0.4	0.4	0.3	0.3	0.4	4.0
Total	**11.7**	**12.2**	**11.2**	**12.5**	**12.1**	**13.9**	**13.9**	**14.1**	**12.8**	**13.0**	**13.1**	**16.7**	**157.2**

- Total Pay costs are £145.7m in March, an increase of £61.3m from February which includes:
  - £10.3m - 1.5% non-consolidated pay award paid in March
  - £13.6m - 1.5% Consolidated Pay Award year end adjustment.
  - £36.4m - Year-end adjustment in respect of the notional 6.3% employers' superannuation adjustment.
- An additional £3.2m was of the Annual Leave accrual was released in month. Of the total, £2.0m was released to cover backfill costs and £1.2m was an accountancy gain.
- Total Variable Pay is £16.6m, an increase of £3.5m from previous month. Agency costs have increased by £1.4m. Overtime has also increased by £0.2m and Bank spend has increased by £1.6m from previous month.
- All three sites continue to experience medical and nursing staffing pressures due to vacancies, which is reflected in the increase in both overtime and Bank spend.

Pay Costs





- The 22/23 additional 3% pay award offer comprises of 1.5% is Consolidated Pay Award and 1.5% is non-Consolidated. £10.3m has been paid in March for the 1.5% non-consolidated pay award. A provision of £13.6m has also been accounted for within the Month 12 position for the 1.5% Consolidated Pay Award year which is to be paid within the new financial year. The Pay Award has been funded by Welsh Government; however the funding for the 1.5% consolidated award is £1.5m lower than projected costs.

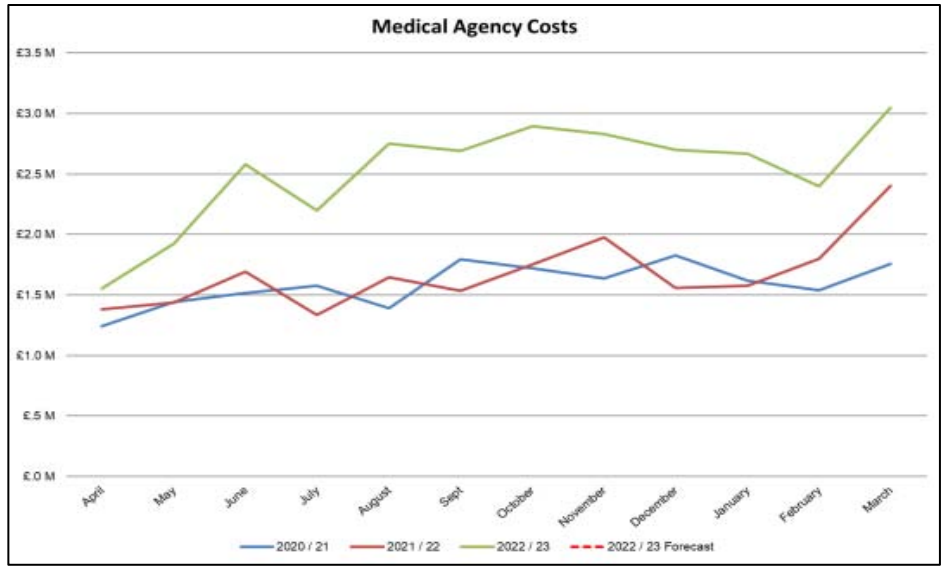
- Agency costs for March are £7.0m which is £1.4m higher than February. The increase in Month 12 Agency costs is not unusual in comparison to previous years due to increased annual leave requests in March and therefore additional cover required. In addition, there are three extra working days in March compared to February.
- Medical agency costs have increased by £0.6m to an in-month spend of £3.1m.
- Nurse Agency costs is £2.8m in March, an increase of £0.4m from February.

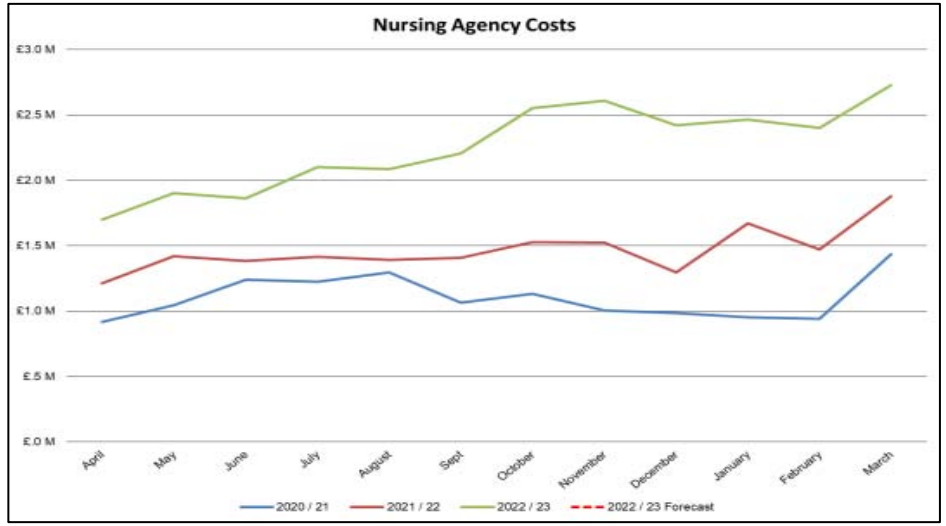
Pay Costs - Agency

- Total agency costs are £7.0m in March, having increased by £1.4m from previous month, and is £1.1m higher than the average monthly expenditure in this financial year. Of the £7.0m, the 3 hospital sites accounted for £3.9m of the costs. .
- March Agency spend is 4.8% of total pay. Total 2022/23 Agency expenditure is £72.7m (7.0% of total pay), which is £23.9m higher than in 2021/22.
- Medical agency spend is £3.1m for the month, an increase of £0.6m from February.
- Agency nursing spend is £2.8m for the month, an increase of £0.4m from February.

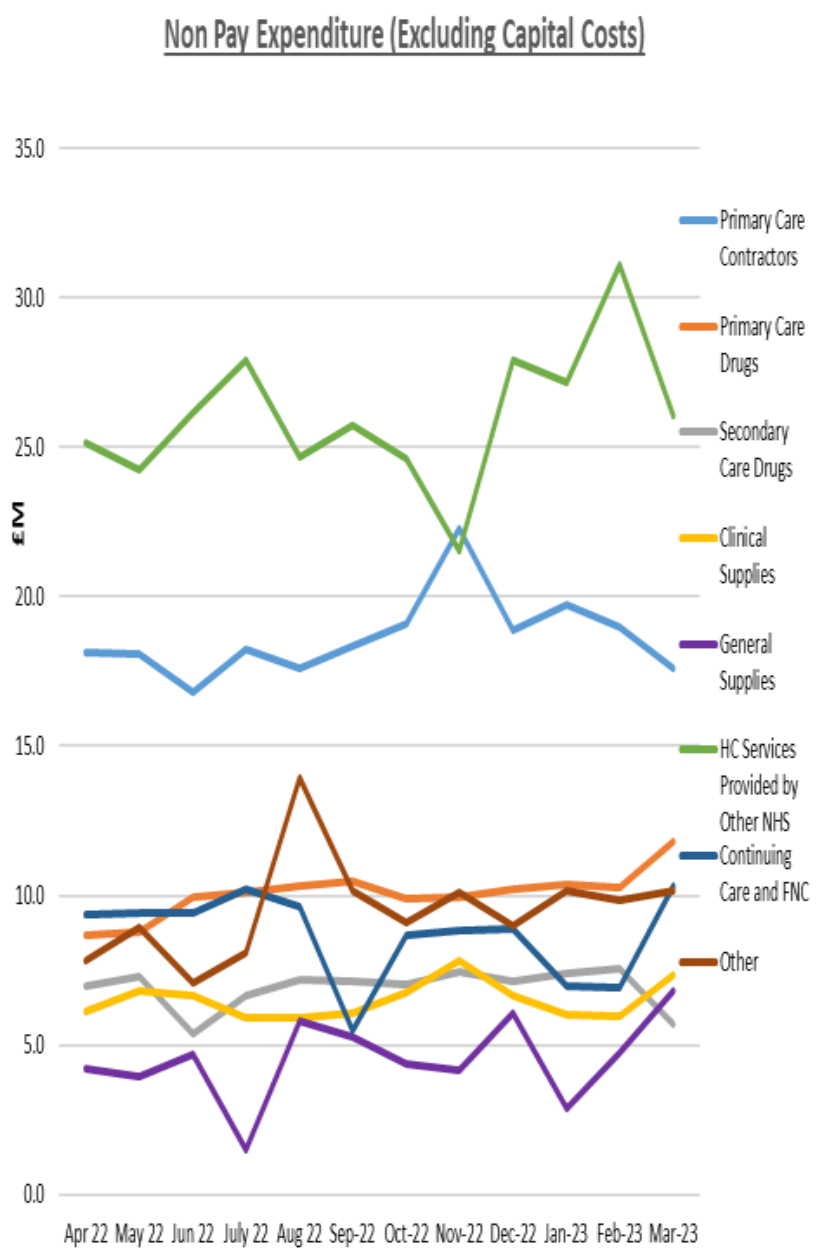
	22-23 Actual												
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total Year to Date
West Area	118	155	156	191	195	127	384	205	127	112	211	155	2,136
Ysbyty Gwynedd	570	564	565	568	651	710	779	785	776	809	844	1023	8,645
Central Area	294	379	175	380	553	487	543	420	508	561	154	638	5,092
Ysbyty Glan Clwyd	914	1,110	1,261	1,376	1,238	1,613	1,542	1,805	1,365	1552	1066	1807	16,648
East Area	576	574	1,042	357	939	758	886	975	879	814	893	733	9,425
Ysbyty Maelor Wrexham	760	812	808	1,005	923	1,062	1,084	1,072	1,000	1105	1029	1041	11,700
Mental Health & LDS	446	436	505	598	680	570	535	819	774	740	665	827	7,593
Other	931	976	989	1023	980	1068	1075	821	1067	975	780	815	11,500
Total Agency	4,609	5,004	5,502	5,497	6,159	6,394	6,828	6,901	6,495	6,669	5,642	7,038	72,740

- The below graphs shows movements in both Medical & Agency Nursing costs from 2020/21 and 2021/22.





Non-Pay Costs



Total Non-Pay Expenditure: March expenditure is £95.8m (excluding capital charges), which is £0.4m higher than previous month. Key movements include:

- **Primary Care Contractor:** Expenditure is £1.4m (7.5%) less than previous month. The reduction in Month 12 spend is primarily due to £1.3m Dental Contractors hand-backs. GMS Enhanced Services has also reported a £0.4m reduction against forecast due to lower than expected activity and £0.5m reduction in Premises costs due to actual rent costs moved from GMS to capital in line with IFRS 16 requirements.

- **Primary Care Drugs:** Expenditure has increased by £1.6m (15.1%) from February. The general upward trend in prescribing costs is due to No Cheaper Stock Obtainable (NCSO) items and is likely to remain a pressure until Antibiotics come off NCSO supply. As prescribing costs are based on a 3-month average cost (November-January), this is being impacted by the high cost over the winter period. This, together with there being 3 more prescribing days in March (23) in comparison to February (20), has led to an increase in Month 12 expenditure.

- **Provider Services Non Pay:** Expenditure has increased by £4.1m (23.0%) from previous month, of which £3.1m is increase in Month 12 Local Authority payments mainly due to RIF (Regional Integrated Fund) which is fully funded from WG. Also, additional costs of £0.6m was reported across a range of medical and surgical equipment, implant and patient appliance categories and additional Therapies equipment totalling £0.6m.

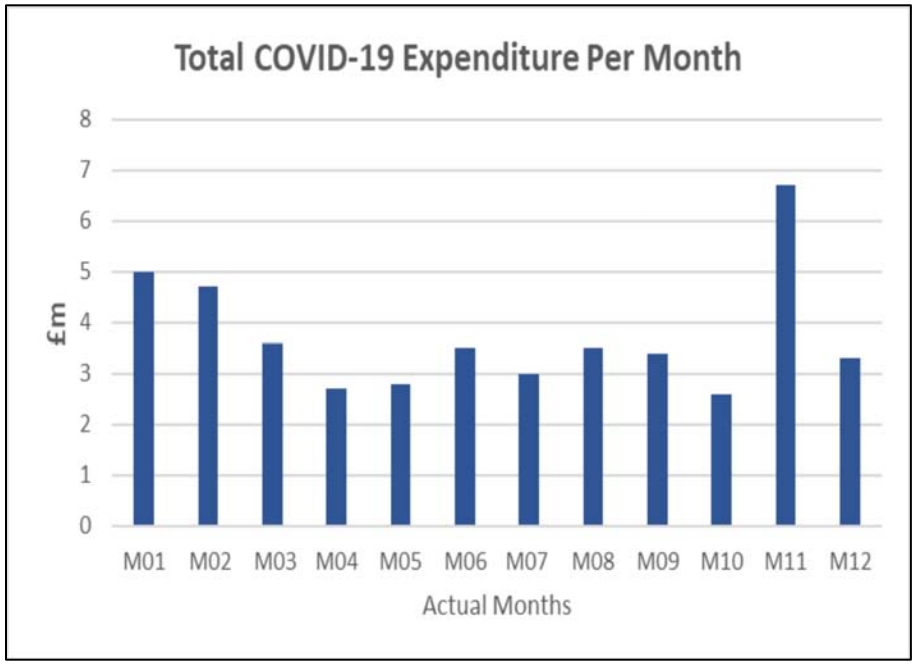
- **Secondary Care Drugs:** Expenditure has decreased by £1.8m (24.3%) of which £1.1m was VAT rebate on Home Oxygen Therapy Services and £0.6m year-end stock adjustment due to stock increase within the Pharmacy top up system.

- **Healthcare Services provided by Other NHS Bodies**: Expenditure is £5.0m (16.2%) less, of which £5.5m is reduction in WHSCC due to backdated WHSCC costs reported in Month 11. Expenditure is in line with previous months average and is £0.9m less than forecast. Movement from forecast is due to £0.4m reduction against Hywel Dda contract, £0.3m reduction in NCA's and £0.2m reduction in the WAST 6 days service contract.

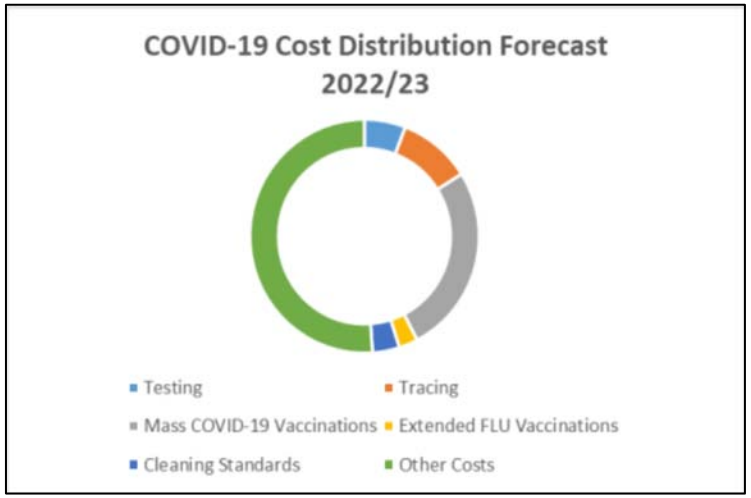
- **Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure is £3.4m (48.6%) higher than previous month. Month 12 expenditure includes £0.5m additional provisions for the impact of the NHS pay award on 22/23 CHC and FNC rates, whilst increase in MHLD dispute cases is £1.7m and local Integrated Health Communities (IHC) fees disputes/claims from providers has also increased by £0.4m. Out of Area Placements continues to be an area of high concern and increase in complexity of packages is also leading to higher costs.

Impact of COVID-19

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual M05 £m	Actual M06 £m	Actual M07 £m	Actual M08 £m	Actual M09 £m	Actual M10 £m	Actual M11 £m	Actual M12 £m	Total YTD 2022/23 £m
Testing	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.0	2.5
Tracing	1.0	0.9	0.9	0.1	0.2	0.2	0.2	0.3	0.2	0.1	0.2	0.3	4.6
Mass COVID-19 Vaccinations	0.7	1.1	0.8	0.8	0.8	1.1	1.4	1.4	1.1	0.8	0.8	1.0	11.8
Extended Flu Vaccinations	0.0	0.0	0.1	0.0	0.0	0.1	0.1	0.3	0.3	(0.1)	0.1	0.3	1.4
Cleaning Standards	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.2	0.2	1.6
Other Costs	2.9	2.3	1.4	1.5	1.5	1.7	1.0	1.1	1.5	1.4	5.1	1.5	22.9
Total COVID-19 expenditure	**5.0**	**4.7**	**3.6**	**2.7**	**2.8**	**3.5**	**3.0**	**3.5**	**3.4**	**2.6**	**6.7**	**3.3**	**44.8**
Welsh Gov COVID-19 income	(5.0)	(4.7)	(3.6)	(2.7)	(2.8)	(3.5)	(3.0)	(3.5)	(3.4)	(2.6)	(6.7)	(3.3)	(45.7)
Impact of COVID-19 on Position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.9)**



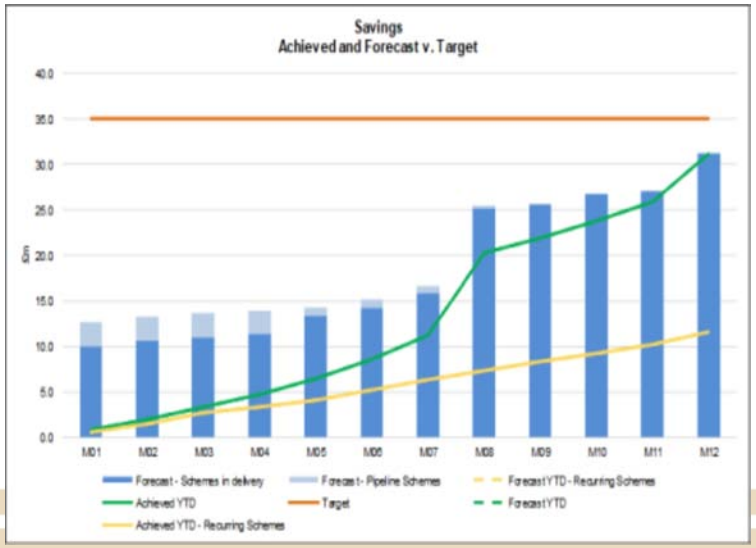
- The total impact of COVID-19 spend in March is £3.3m, a reduction of £3.4m from February, which is due to February spend being higher as a result of retrospective COVID-19 discharge support costs claimed in Month 11.
- Welsh Government income has been received to fully fund these costs, leaving a £0.9m surplus, further to Welsh Government allowing surplus funding to be retained on Loss of dental income funding (£0.2m), COVID Enhanced Flu (£0.2m) and Nosocomial allocation (£0.4m).



Savings

		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	3,124	3,124	300	(2,824)	474	300	(2,824)	474	773	340	0	0	0	0	773	(2,351)
Ysbyty Glan Clwyd	3,951	3,951	379	(3,572)	538	379	(3,572)	538	917	418	0	0	0	0	917	(3,034)
Ysbyty Wrexham Maelor	3,171	3,171	687	(2,484)	1,957	687	(2,484)	1,957	2,645	1,006	0	0	0	0	2,645	(526)
Total of hospitals	**10,246**	**10,246**	**1,366**	**(8,880)**	**2,969**	**1,366**	**(8,880)**	**2,969**	**4,335**	**1,763**	**0**	**0**	**0**	**0**	**4,335**	**(5,911)**
North Wales Managed Services	3,586	3,586	2,019	(1,567)	453	2,019	(1,567)	453	2,472	2,113	0	0	0	0	2,472	(1,114)
Womens Services	1,375	1,375	115	(1,260)	2,021	115	(1,260)	2,021	2,137	133	0	0	0	0	2,137	762
Secondary Care	**15,207**	**15,207**	**3,500**	**(11,707)**	**5,444**	**3,500**	**(11,707)**	**5,444**	**8,943**	**4,010**	**0**	**0**	**0**	**0**	**8,943**	**(6,264)**
Area - West	2,940	2,940	1,160	(1,780)	1,542	1,160	(1,780)	1,542	2,702	1,513	0	0	0	0	2,702	(238)
Area - Centre	4,942	4,942	2,287	(2,656)	2,074	2,287	(2,656)	2,074	4,361	2,502	0	0	0	0	4,361	(581)
Area - East	5,080	5,080	1,527	(3,553)	1,688	1,527	(3,553)	1,688	3,215	1,531	0	0	0	0	3,215	(1,865)
Area - Other	235	235	235	0	108	235	0	108	343	235	0	0	0	0	343	108
Contracts	1,804	1,804	0	(1,804)	3,488	0	(1,804)	3,488	3,488	0	0	0	0	0	3,488	1,684
Area Teams	**15,001**	**15,001**	**5,209**	**(9,793)**	**8,900**	**5,209**	**(9,793)**	**8,900**	**14,109**	**5,781**	**0**	**0**	**0**	**0**	**14,109**	**(893)**
MHLD	613	613	2,457	1,844	252	2,457	1,844	252	2,708	2,458	0	0	0	0	2,708	2,095
Corporate	4,179	4,179	527	(3,651)	4,869	527	(3,651)	4,869	5,396	693	0	0	0	0	5,396	1,218
Divisional Total	**35,000**	**35,000**	**11,692**	**(23,308)**	**19,464**	**11,692**	**(23,308)**	**19,464**	**31,157**	**12,942**	**0**	**0**	**0**	**0**	**31,157**	**(3,843)**

- The Health Board has set a savings target of £35m for 2022/23 to be driven equally by both transaction and transformation led plans and program of work.
- Savings delivered in month total £5.2m against a plan of £4.3m and a total target of £7.9m.
- Total savings delivered in 22/23 is £31.2m against a full year plan of £25.9m and a total target of £35m. As all schemes were transactional, the transactional savings target of £17.5m has been met in terms of total savings delivered. However, the proportion of recurring savings delivered totals only £11.7m.
- The FY Outturn of £31.2m delivered a £4.1m increase on the FY Forecast at M12. Of this, £2.7m related to non-recurring Accountancy Gains and £1.1m VAT refund, which was delivered earlier than anticipated. Consequently, the related scheme will be removed from the savings plan for 23-24. Following the implementation of a VERs scheme approved by the RaTs Committee, a related savings scheme totalling £0.2m was approved by the interim Executive Directors of Finance and Workforce for inclusion in the Monitoring Return.
- Accountancy Gains totalled £9.7m at Month 12 and there were no red schemes.



Capital

Ref:	Performance against CRL / CEL	Year To Date Plan £'000	Year To Date Actual £'000	Year To Date Variance £'000
	Gross expenditure			
	All Wales Capital Programme: Schemes:			
1	Imaging	4,483	4,749	266
2	Wrexham Redevelopment	2,399	1,184	(1,215)
3	Nuclear Medicine	425	258	(167)
4	Substance Misuse-Holyhead	0	(1)	(1)
5	Digital Medicine	10	10	0
6	Ablett Unit	1,423	1,038	(385)
7	Linacs	1,922	1,793	(129)
8	Emergency Departments	418	357	(61)
9	Energy Saving Schemes	250	220	(30)
10	Year End Funding - Enli Ward	500	812	312
11	Year End Funding - Mortuary	346	135	(211)
12	Endoscopy Training	50	39	(11)
13	Year End Funding-Medical Devices	430	418	(12)
14	Year End Funding-Local Area Network	250	0	(250)
15	Eye Care	68	68	0
16	Ambulance	130	111	(19)
17	Digital Funding	126	123	(3)
	Sub Total	**13,230**	**11,314**	**(1,916)**
	Discretionary:			
43	I.T.	1,713	1,348	(365)
44	Equipment	1,379	1,952	573
45	Statutory Compliance	0	0	0
46	Estates	7,879	9,560	1,681
47	Other	0	0	0
48	**Sub Total**	**10,971**	**12,860**	**1,889**
	Other (Including IFRS 16 Leases) Schemes:			
49	Donated	460	460	0
50	Internally Generated	0	0	0
51	IFRS16	5,051	5,051	0
69	**Sub Total**	**5,511**	**5,511**	**0**
70	**Total Expenditure**	**29,712**	**29,685**	**(27)**
	Donations:			
77	Donations:	460	460	0
78	**Sub Total**	**460**	**460**	**0**
92	**CHARGE AGAINST CRL / CEL**	**29,252**	**29,225**	**(27)**
93	**PERFORMANCE AGAINST CRL / CEL (Under)/Over**		**(27)**	

- The approved Capital Resource Limit (CRL) for 2022/23 is £29.252m.
- Actual expenditure for the year was £29.225m, giving a small surplus of £0.027m.
- £0.25m received for Local Area Network (LAN) scheme has been spent in full, but it is shown in discretionary as one scheme.

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

MONITORING RETURN

Month 12 2022/23

Steve Webster
Interim Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION

1.1 Financial plan

- The Health Board's financial plan for 2022/23 was to deliver a balanced position, which includes the £82.0m strategic support funding from Welsh Government. In addition, £38.4m Sustainability funding has been received to support planned and unscheduled care.

- The £42m Strategic Support was included as recurrent in the MDS. Prior to the submission of the financial plan for 2022-25, the Health Board started discussions with Welsh Government on the continuation of the Strategic Support. The three-year financial plan included in the BCU IMTP submission also assumed that funding for Performance and Transformation would continue beyond 2023-24. The Health Board has been clear that it is committing recurrently against this funding (as agreed with the previous NHS Chief executive Andrew Goodall) in order to be able to deliver the required outcomes. Welsh Government subsequently requested the Health Board to reflect the £42m as non-recurrent, which consequently increased the carried forward underlying deficit.

- Following the deep dive review of the forecast outturn at Month 6, the Health Board reported a forecast deficit position of £10.0m. At Month 11, the Health Board's forecast was revised to report a balanced forecast outturn position to reflect additional unexpected income allocations for Queen's funeral bank holiday funding £1.7m, COVID-19 Discharge support funding £4.3m, Dispensing Fees £1.7m, a £1.1m fortuitous gain on VAT recovery and the retention of funding for Performance and Transformation Strategic, Planned Care Sustainability, Value Based Healthcare and other ring-fenced funding, when costs to the full level of funding could not be directly identified and attributed to this funding. An Accountable Officer (AO) Letter was submitted to Welsh Government on the 12th April providing details of these areas.

1.2 Year to Date Financial Position

- The full year, draft unaudited position of the Health Board is a surplus of £0.4m and the draft in-month position is a surplus of £8.5m. The end of year financial position is subject to the closure and submission of the final accounts for 2022/23 and the subsequent audit by Audit Wales.

- The below table shows the in-month movement compared to forecast:

1. FINANCIAL POSITION

	Forecast £'m	M12 Actual Income £'m	M12 Actual Spend £'m	Variance £'m
February reported position (Deficit)	**-8.1**	**1,888.6**	**-1,896.8**	**-8.2**
Month 12 movements				
Operational outturn	2.5	190.2	-192.0	-1.8
Exceptional items & Technical adjustments				
Increase in Study leave accrual	-2.0		-1.9	-1.9
Retaining balance of Value Based Healthcare	1.2	1.2		1.2
Additional accrual for No Purchase Order No pay	-1.0		-0.6	-0.6
Additional exceptional costs relating to legal cases	-1.9	4.1	-4.1	0.0
Release of Annual leave - accountancy gain			1.2	1.2
Release of Annual leave - covering backfill costs	0.5		2.0	2.0
Release due to Purchase Order review - accountancy gain			1.5	1.5
Release due to Purchase Order review - in year release	7.3		6.3	6.3
VAT Rebate - Home Oxygen Therapy Services	0.8		0.9	0.9
VAT on Lease Cars	0.4		0.4	0.4
IFRS income adjustment	0.3			0.0
Increased Surplus due to reduction in COVID spend			0.5	0.5
Increased surplus in Energy funding			0.5	0.5
6.3% superannuation		37.4	-37.4	0.0
Pay award - Non consolidated 1.5% (Paid)		10.2	-10.3	-0.1
Pay award - Consolidated 1.5% (Accrued)		12.1	-13.6	-1.5
Total March	**8.1**	**255.2**	**-246.6**	**8.6**
Total 22/23 Surplus Outturn Position	**0.0**	**2143.8**	**-2143.4**	**0.4**

1.3 Income (Table B)

- Income totals £255.2m for March, an increase of £75.8m from February.

- Total Revenue Resource Limit (RRL) Annual allocation has increased by £75.0m from February's allocation. This includes £38.7m additional 6.3% employer's superannuation costs and £22.0m 22/23 Consolidated & Non-Consolidated Pay Award allocation. Further details on RRL allocation are included in Section 7 (Table E).

1.4 Actual Expenditure (Table B)

- Expenditure totals £246.6m for March, £66.7m higher than February expenditure which is offset by £75.8m additional income in Month 12.

- A number of exceptional items have been included in the Month 12 position, which are driving the increase in costs:

  - £10.3m - 1.5% non-consolidated pay award paid in March
  - £13.6m - 1.5% Consolidated Pay Award year end adjustment.
  - £36.4m - Year-end adjustment in respect of the notional 6.3% employers' superannuation adjustment.
  - £1.0m - 6.3% superannuation year-end adjustment in Primary Care

- Offsetting the above increases in expenditure are the following gains in Month 12:

  - An additional £3.2m was released for Annual Leave in month. Of the total, £2.0m was released to cover backfill costs and £1.2m was an accountancy gain.
  - Further to the review and data cleanse of purchase order accruals resulting in reduced accruals of £7.8m, of which £1.5m is an Accountancy Gain
  - £1.1m total fortuitous gain on VAT recovery for Home Oxygen Therapy Services, of which £0.9m relates to previous years.

- Expenditure of £3.3m is directly related to COVID-19 in March, of which £2.3m is Pay and £1.0m is across Non-Pay expenditure categories. COVID-19 Month 12 expenditure is £3.4m less than previous month due to the £4.3m of COVID Discharge support costs claimed retrospectively in Month 11.

- The areas of significant increases in Month 12 spend includes Provided Services Pay (£61.0m), of which includes one off technical adjustments in Month 12 as detailed in below table. Provider Services Non-Pay (£4.1m), Continuing Care and Funded Nursing Care (£3.4m), Losses, Special Payments and Irrecoverable Debts (£5.0m) and Other Private & Voluntary Sector (£0.3m). Offsetting these are decreases in Healthcare Services provided by Other NHS Bodies (£5.0m), Secondary Care Drugs (£1.8m), Primary Care Contractor (£1.4m) and DEL Depreciation\Accelerated Depreciation\Impairments (£1.1m).

- Further detail on key movements in spend is provided in the below table.

Primary care Contractor	• Expenditure in March is £1.4m (7.5%) less than previous month and £2.1m less than forecast. The reduction in Month 12 spend is primarily due to £1.3m Dental Contractors Handbacks.

	• In addition to the Dental Contract Handbacks, GMS (General Medical Services) Enhanced Services has also reported a £0.4m reduction against forecast due to lower than expected activity and £0.5m reduction in Premises costs due to actual rent costs moved from GMS to Capital in line with IFRS 16 requirements. • Primary Care Contractor expenditure includes £1.0m in respect of additional 6.3% employer's superannuation contributions.
Primary care – Drugs & Appliances	• Expenditure has increased by £1.6m (15.1%) from February and is £1.4m higher than forecast for the month. The general upward trend in prescribing costs due to high prescribing costs of No Cheaper Stock Obtainable (NCSO) items is likely to remain until Antibiotics come off NCSO supply. As prescribing costs are based on a 3-month average cost (November-January), this is being impacted by the high cost over the winter period. This, together with there being 3 more prescribing days in March (23) in comparison to February (20), had led to an increase in Month 12 expenditure. • Following receipt of January prescribing data, the Average Cost per Item prescribed increased in January which was £7.61 per item compared to £7.39 per item for December. • The 3-month Average Cost per Item also increased from £7.41 to £7.46 (+0.7%). • Total cost of prescribing in 2022/23 was £120.8m, which is £8.5m higher than in 2021/22.
Provided Services - Pay	• Provided Services Pay expenditure has increased by £61.0m (74.8%) from Month 11 and is £64.0m higher than forecast. The movement in pay expenditure includes: ➢ £10.3m - 1.5% non-consolidated pay award paid in March ➢ £13.6m - 1.5% Consolidated Pay Award year end adjustment. ➢ £36.4m - Year-end adjustment in respect of the notional 6.3% employers' superannuation adjustment. • Total Pay costs directly related to COVID-19 in March is £2.3m, which is £2.6m less than previous month due to the backdated COVID-19 discharge support costs claimed in Month 11. • Variable Pay has also increased by £3.7m, of which the increase is against Agency (£1.4m), Bank (£1.6m) Locum (£0.5m) and overtime (£0.2m). All three sites continue to experience Medical and Nursing staffing pressures due to vacancies, however the increase in Month 12 Bank, Agency & overtime spend is not unusual due to additional cover required for increased annual leave requests prior to year-end. • Further detail on Agency spend is included in Section 5.1.

1. FINANCIAL POSITION

Provider Services Non-Pay	• Expenditure has increased by £4.1m (23.0%) from previous month and is £5.0m higher than forecast, which is reported against a range of non-pay categories, however the key increases are: ➢ £3.1m increase in Local Authority payments mainly due to RIF (Regional Integrated Fund) which is fully funded from WG. ➢ Additional costs of £0.6m across a range of medical and surgical equipment, implant and patient appliance categories and additional Therapies equipment totalling £0.6m. • COVID-19 Provider Services Non-Pay is £0.3m, a reduction of £0.2m from previous month.
Secondary care Drugs	• Expenditure has decreased by £1.8m (24.3%) from previous month and is £1.9m less than forecast. • This movement is primarily due to the £1.1m VAT rebate on Home Oxygen Therapy Services reported in Month 12. In addition, there has been a £0.6m year-end stock adjustment due to stock increase within the Pharmacy top up system.
Healthcare Services provided by other NHS Bodies	• Month 12 expenditure is £5.0m (16.2%) less than previous month, of which £5.5m is reduction in WHSCC due to backdated WHSCC costs reported in Month 11. • Expenditure is in line with previous months' average and is £0.9m less than forecast. Movement from forecast is due to £0.4m reduction against Hywel Dda contract, £0.3m reduction in NCA's and £0.2m reduction in the WAST 6-day service contract.
Continuing Health care (CHC) and Funded Nursing care (FNC)	• Expenditure is £3.4m (48.6%) higher than previous month and is £2.0m higher than forecast. Spend is £1.8m higher than from previous months monthly average. • Month 12 expenditure includes £0.5m additional provisions for the impact of the NHS pay award on 22/23 CHC and FNC rates, whilst increase in MHLD dispute cases is £1.7m and local Integrated Health Communities (IHC) fees disputes/claims from providers has also increased by £0.4m. • Mental Health Out of Area Placements continues to be an area of high concern and significant pressures remain within patient flow due to Delayed Transfers of Care. CHC Process needs to be reviewed as lack of both placements and speed of assessments is of significant concern. An increase in complexity of packages is also leading to higher costs.
Other Private and Voluntary Sector	• Expenditure relates to a variety of providers, including hospices, Mental Health organisations and planned care activity providers.

	• Expenditure has increased by £0.3m from previous month and £0.4m higher than previous months' monthly average. However, March expenditure is £1.7m less than forecast due to Non-NHS Outsourcing not progressing as well as planned.
Joint Financing	• Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget and the Mass Vaccination Centres spend. • Expenditure is £0.2m higher than Month 11, however it is in line with forecast and previous months run rate.
Losses, Special Payments and Irrecoverable Debts	• Includes Redress, Clinical Negligence, Personal Injury and loss of property. • Expenditure has increased by £5.0m in Month 12 and is £4.8m higher than forecast, of which £4.1m relates to an exceptional funded item.
Capital	• Includes depreciation and impairment costs. • Capital costs is £0.5m less than previous month costs and is £5.9m higher than forecast. This is due to late adjustments, which were followed up with Welsh Government to agree the final non cash balances.

- The brought forward opening Annual Leave accrual value from 2021/22 was £27.2m. All staff that were due payment for selling annual leave from 2021/22 have now been paid via BCUHB Payroll, which reduced the baseline provision to £25.7m. Total Annual Leave accrual released into the position is £14.7m, of which £9.2m is the release of accrual to cover backfill costs and £4.0m is an Accountancy Gain.

- The 22/23 Annual Leave accrual is £12.5m which has been capped at 10 days (excluding A&C and Estates & Ancillary which have been capped at 50% of 10 days). Staff on long term sick and maternity leave have been excluded from this cap due to legislation.

- The 22/23 additional 3% pay award offer comprises of 1.5% is Consolidated Pay Award and 1.5% is non-Consolidated. £10.3m has been paid in March for the 1.5% non-consolidated pay award which is non-pensionable. A provision of £13.6m has also been accounted for within the Month 12 position for the 1.5% Consolidated Pay Award year which is to be paid within the new financial year. The Pay Award has been funded by Welsh Government; however the funding for the 1.5% consolidated award is £1.5m lower than projected costs.

- Energy costs are volatile and have been updated in line with WG advice and data received via NWSSP from British Gas. The energy forecast outturn at Month 11 was £25.7m, which has reduced by £0.5m to £25.2m in Month 12.

- A number of items of equipment have been identified as being transferred from the National Equipment Reserve, however as the legal title is still under discussion these have not been accounted for within the Return.

1.5 Performance and Transformation Strategic Support and Other Ring-fenced Funds

- The 3-year financial plan assumed funding for Performance and Transformation was to continue on a recurrent basis, which was also reflected in the submitted 2022/23 MDS tables. However, as requested by Welsh Government this has been reported as non-recurrent within Table A as from Month 4. The Health Board has been clear with Welsh Government that it is committing recurrently against this funding, as it relates to substantive recruitment of specific staff posts to ensure delivery of the required outcomes.

- The Performance and Transformation Strategic Support year to date total attributed spend is £33.5m against a total funding allocation of £42m, thus reporting a shortfall of £8.5m against planned expenditure. A summary of the 22/23 Performance and Transformation fund monthly spend is provided as per below table:

	Actual												
	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	0.6	2.0	1.4	1.3	1.8	1.6	1.9	0.9	1.6	1.4	3.6	5.0	**23.1**
Non-Pay	0.2	0.8	0.4	0.7	1.0	1.2	1.4	2.8	0.8	0.2	-0.1	1	**10.4**
Total	**0.8**	**2.8**	**1.8**	**2.0**	**2.8**	**2.8**	**3.3**	**3.7**	**2.4**	**1.6**	**3.5**	**6.0**	**33.5**

- The shortfall of attributed spend to these funds, together with shortfalls against other ring-fenced funding and balance sheet movements, have effectively financed the recurrent 2022/23 deficit of £114m (total £196m less £82m strategic support), which is within the build-up of the 2023/24 financial plan shared with the FDU.

- As reported within the Month 12 Ring-fenced allocations template, the total shortfall of attributed spend against the other ring-fenced funding is £9.9m, which consists of Sustainability (£6.2m), Value Based Healthcare (£2.4m), Six Goals (£0.2m) and Mental Health SIF (£1.1m) as per below table.

1. FINANCIAL POSITION

	Total Funding £m	Attributed Spend £m	Shortfall of Attributed Spend £m	% Spent
Strategic Support				
Performance Fund	30.00	23.11	-6.89	
Transformation Fund	12.00	10.38	-1.62	
Total Strategic Support	**42.00**	**33.49**	**-8.51**	**80%**
Other New Ring-fenced Funding				
Sustainability	38.39	32.17	-6.22	84%
Value Based Healthcare	3.35	0.99	-2.36	30%
Six Goals (Urgent Emergency Care)	2.96	2.74	-0.22	93%
Mental Health (SIF)	1.56	0.44	-1.12	28%
Regional Integrated Fund (RIF)	34.20	34.20	0.00	100%
Total Other New Ring-fenced Funding	**80.46**	**70.54**	**-9.92**	**88%**
TOTAL	**122.46**	**104.03**	**-18.43**	**85%**

- Total Regional Integrated Fund (RIF) allocation is £34.2m and has been spent in full. The potential sources of RIF funding may differ to other returns depending on whether the narrative mentioned RIF on the allocation letters.

- The below table includes specific items reported within the Month 12 outturn position which are similar in nature to the areas of underspend on ring-fenced funding:

Overspends Funded by Shortfall of Attributed Spend	£m
SDEC (using Six Goals funds)	0.25
Mental Health inpatient nursing costs (using SIF funds)	1.12
Primary Care Prescribing	15.04
Managed Practices	6.88
YGC Targeted Intervention	0.91
Secondary Care Medical staff costs	11.25
Total	**35.45**

- A number of actions will be taken by the Health Board to ensure ring-fenced funding is spent as planned in future years, for example:

- Review of all Performance and Transformation Fund schemes as part of the 2023/24 Financial Plan and disinvestment in schemes that have not been committed and undertake a further review.
- "Backfill" this reduced development expenditure with other areas of development which are already in the recurrent expenditure run rate and are considered priorities but are outside the recurrent budget.
- Improved accountability and oversight through a financial scrutiny group that will check and challenge financial performance (including outside financial improvement targets), including spend against ring-fenced funding.
- High level issues will be brought into performance and accountability meetings with Integrated Health Communities.

1.6 Accountancy Gains (Table B)

- The Health Board is reporting £2.7m Accountancy Gains in March.
- Year to Date Accountancy Gains reported up to end of March is £9.7m.

1.7 COVID-19 (Table B3)

- Total impact of COVID-19 spend in March is £3.3m, a reduction of £3.4m from February. The reduction is due to the review of the categorisation of COVID-19 discharge support and additional bed capacity that was reflected in the Month 11 COVID-19 Tables.
- The £44.8m COVID-19 full year expenditure includes the £4.3m COVID-19 Discharge Support costs claimed in Month 11 (£2.9m for escalation beds in Ysbyty Gwynedd & Women's Services, £1.0m for Therapies and support costs in Wrexham, and £0.4m for discharge to assess beds within private care homes).
- The below table summarises actual monthly spend by COVID-19 category.

1. FINANCIAL POSITION

	Actual M01	Actual M02	Actual M03	Actual M04	Actual M05	Actual M06	Actual M07	Actual M08	Actual M09	Actual M10	Actual M11	Actual M12	Total 2022/23
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Testing	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.0	2.5
Tracing	1.0	0.9	0.9	0.1	0.2	0.2	0.2	0.3	0.2	0.1	0.2	0.3	4.6
Mass COVID-19 Vaccinations	0.7	1.1	0.8	0.8	0.8	1.1	1.4	1.4	1.1	0.8	0.8	1.0	11.8
Extended Flu Vaccinations	0.0	0.0	0.1	0.0	0.0	0.1	0.1	0.3	0.3	(0.1)	0.1	0.3	1.4
Cleaning Standards	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.2	0.1	0.2	0.2	0.2	1.6
Other Costs	2.9	2.3	1.4	1.5	1.5	1.7	1.0	1.1	1.5	1.4	5.1	1.5	22.9
Total COVID-19 expenditure	**5.0**	**4.7**	**3.6**	**2.7**	**2.8**	**3.5**	**3.0**	**3.5**	**3.4**	**2.6**	**6.7**	**3.3**	**44.8**
Welsh Gov COVID-19 income	(5.0)	(4.7)	(3.6)	(2.7)	(2.8)	(3.5)	(3.0)	(3.5)	(3.4)	(2.6)	(6.7)	(4.3)	(45.7)
Impact of COVID-19 on Position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.9**

- The planned additional expenditure due to COVID-19 was £51.0m, however the 22/23 total annual COVID-19 expenditure is £44.8m, a reduction of £6.2m from the opening plan.

- Welsh Government income of £45.7m has been received up to Month 12 and total COVID-19 Annual spend is £44.8m, a reduction of £0.5m from previous month annual forecast. Welsh Government has fully funded these costs, but a downturn in expenditure in the latter months has left a £0.9m full year surplus. Welsh Government has agreed to allow the surplus funding to be retained, with the surplus funding being on Loss of dental income funding (£0.2m), COVID Enhanced Flu (£0.2m) and Nosocomial allocation (£0.4m).

- The outturn cost for COVID-19 is £0.5m less than forecast at Month 11. Movements from forecast are detailed in the below table:

	Forecast at Month 11 £m	Outturn at Month 12 £m	Change £m
Testing	2.5	2.5	0.0
Tracing	4.6	4.6	0.0
Mass COVID-19 Vaccinations	11.7	11.8	0.1
Extended Flu Vaccinations	1.6	1.4	(0.2)
Cleaning Standards	1.6	1.6	0.0
Other Costs	23.3	22.9	(0.4)
Total COVID-19 costs	**45.3**	**44.8**	**(0.5)**
Welsh Gov COVID-19 income	(45.7)	(45.7)	0.0
Total Impact of COVID-19	**(0.4)**	**(0.9)**	**(0.5)**

1. FINANCIAL POSITION

- Testing and Tracing expenditure are in line with previous month. COVID-19 Mass Vaccination costs have increased by £0.1m due to a large service charge fee paid in Month 12 for two of the sites used by the vaccination team backdated for 9 months of this financial year. In addition, outstanding invoices for the security company were also claimed in March.

- Extended Flu Vaccinations expenditure has decreased by £0.2m.

- Total outturn within the PPE (Personal Protective Equipment), Long COVID and Other section (A6) on Table B3 is £22.9m, having decreased by £0.4m from the forecast at Month 11 due to slippage against the Nosocomial funding allocation.

- COVID Surge annual outturn at Month 12 has decreased by £0.6m from forecast. Movements in annual COVID Surge expenditure from forecast are detailed in the below table:

COVID Surge	Month 11 Forecast £ m	Month 12 Outturn £ m	Change £ m
A2. Increased bed capacity specifically related to COVID-19	0.7	0.7	0.0
A3. Other Capacity & facilities costs (exclude contract cleaning)	1.4	1.3	(0.1)
B1. Prescribing charges directly related to COVID symptoms	0.1	0.2	0.1
C1. Increased workforce costs as a direct result of the COVID response and IP&C guidance	9.7	9.7	0.0
D1. Discharge Support	4.3	4.4	0.1
D5. Other Services that support the ongoing COVID response	2.0	1.3	(0.7)
TOTAL	**18.2**	**17.6**	**(0.6)**

2. UNDERLYING POSITION

2.1 Movement from financial plan (Table A)

- The Health Board has faced a significant underlying deficit position, which is a consequence of our historic residual infrastructure and delivery inefficiencies. The underlying position brought forward from 2021/22 was a deficit of £67.8m, with an opening plan deficit of £82.0m.

- Further to the March touch point meeting, the carried forward underlying deficit has increased from £187.6m to £196.2m as per the MDS submission.

- In year pressures included within Table A are:

    - Line 29 – £27.0m Cost pressures in Prescribing, CHC, Agency and Non-Pay pressures.
    - Line 34 – £0.1m GMS overspend.

- The outturn position is reporting a surplus of £0.4m after taking into account the following mitigations:

    - Line 27 - £18.4m Shortfall of attributed spend against planned spend
    - Line 30 - £10.7m Release of Annual Leave Accrual to support increased pay costs (Excluding Accountancy Gain)
    - Line 35 - £1.18m GDS underspend

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The reported position is subject to the closure and submission of the final accounts for 2022/23, and the subsequent audit by Audit Wales.

- As per the Accountable Officer letter, a potential concern considered by the Health Board is the risk of a prior year adjustment to the 2022/23 accounts (in respect of the 2021/22 financial year).

4. RING FENCED ALLOCATIONS

4.1 GMS (Table N)

- At Month 12, the Health Board reported a £0.1m full year overspend position against the ring-fenced GMS budget. This figure includes the year-end adjustment for GPOOH & 6.3% superannuation costs.
- Significant cost pressures remain in two main areas, Managed Practice operating expenses/Locum GP costs and costs of drugs and fees reported through GMS Dispensing (although dispensing fees cost pressures were alleviated due to recent WG funding).
- These cost pressures are offset with under-spends on some Enhanced Services and underperformance against Access Standards. The National winter pressure access scheme costs were less than anticipated, along with costs within LHB Admin, including Paternity/Maternity locum allowances. Premises spend, specifically Trade Refuse and Improvement Grants were also below forecast.
- As at 31st March the Health Board is managing 12 practices (including 4 practices in the West, 2 in Central area and the remaining 6 in East area). The reduction to 12 Managed Practices followed the merger of Rhoslan and Rysseldene Practices in December 2022 to form West End Medical Centre.
- GP Practice COVID vaccination fees now amount to £1.578m year to date, which has been funded via the WG COVID Allocation.

4.2 GDS (Table O)

- At Month 12, the Health Board reported a £1.180m full year underspend position against the ring fenced GDS budget.
- The Main GDS Contracts budget remains under-spent following contract terminations, non-recurrent (NR) contract reductions and payment withholds due to contractor under-performance. Recently applied non recurrent reductions at Month 12 has exacerbated the Main Contracts under-spend position and heavily contributing to the £1.174m in-month position movement.
- Furthermore, the under-spent position has arisen due to the Dental Academy Unit opening later than expected in the Financial Year.
- A sum of £0.5m has been applied as additional COVID funding to cover the deficit in PCR Income. Total COVID funds received amounts to £2.975m, which includes a sum of £2.475m applied non-recurrently at the start of the Financial Year. Overall PCR income

generation amounted to £4.303m, giving rise to a £0.367m under-achievement (even whilst factoring in additional funding resources).

- Whilst Sickness costs were roughly in line with last year's costs (£49k 2022/23 against £43 2021/22), Maternity/Paternity costs were notably lower (£122k 2022/23 against £287k in 2021/22).
- EDS costs have increased over the last year, these include own Commissioned EDS sessions, Dental Helpline and EDS staff costs recharges. Additional staff costs are expected due to unprocessed annual leave payments.
- Orthodontic based activity has increased this year due to in-year commissioned Access sessions.

5. AGENCY/LOCUM EXPENDITURE

5.1 Agency/Locum Expenditure (Table B2 – Sections B & C)

- Total Agency costs for Month 12 are £7.0m, representing 4.8% of total pay. The £1.4m increase reported in Month 12 Agency costs is not unusual in comparison to previous years due to increased annual leave requests in March, and therefore additional cover required. In addition, there are three extra working days in March compared to February. March Agency spend includes £0.3m that is COVID-19 related spend, which is in line with previous month.

- Medical Agency costs have increased by £0.6m to an in-month spend of £3.1m. Of this, £0.2m related to COVID-19 work which is in line with February.

- Nurse agency costs totalled £2.8m for the month, an increase of £0.4m from February. This includes £0.2m for CPVID-19 Nurse Agency costs, same as previous month. Acute sites continue to carry a high level of nursing vacancies.

- Other agency costs totalled £1.1m in March, an increase of £0.3m from previous month.

- Total 2022/23 Agency expenditure is £72.7m (7.0% of total pay), which is £23.9m higher than in 2021/22.

6. SAVINGS

6.1 Savings (including Accountancy Gains and Income Generation) (Tables C, C1, C2 and C3)

- The Health Board has set a savings target of £35m for 2022/23 to be driven equally by both transaction and transformation led plans and programmes of work.

- Savings delivered in month total £5.2m against a plan of £4.3m, and a total target of £7.9m (of which £1.4m was transactional with the remainder relating to the Transformation target which was heavily profiled into Quarter 4).

- Year to date savings delivered total £31.2m against a full year plan of £25.9m and a total target of £35.0m. As all schemes were transactional, the transactional savings target of £17.5m was met in terms of total savings delivered. However, the proportion of recurring savings delivered totalled only £11.7m and of this, only £9.8m was budget reducing.

- The full year outturn of £31.2m delivered a £4.1m increase on the full year forecast at Month 12. Of this, £2.7m related to non-recurring Accountancy Gains and £1.1m to a VAT refund, which was delivered earlier than anticipated. Consequently, the related scheme will be removed from the savings plan for 23-24. Following the implementation of a VERs scheme approved by the RaTs Committee, a related savings scheme totalling £0.2m was approved by the interim Executive Directors of Finance and Workforce for inclusion in the Monitoring Return.

- Accountancy Gains totalled £9.7m at Month 12 and there were no red schemes.

- The ongoing reliance on smaller scale savings initiatives remains a concern. Plans for major programmes have not yet been received.

7. INCOME ASSUMPTIONS

7.1 Income/Expenditure Assumptions (Table D)

- All figures included in Table D have been reviewed and amended as necessary following the Month 12 Agreement of Balances.

7.2 Resource Limits (Table E)

- The Revenue Resource Limit (RRL) for the year is £1,993.5m. All allocations have been received with no further anticipated allocations expected.

- Total COVID-19 funding allocation received for the full year is £45.7m.

8. HEALTH CARE ARGEEMENTS & MAJOR CONTRACTS

8.1 Welsh NHS Contracts

- All Welsh Healthcare agreements were agreed and signed off by the deadline of 30th June 2022.

9. STATEMENT OF FINANCIAL POSITION & AGED WELSH NHS DEBTORS

9.1 Statement of financial position (Table F)

- Details of actual material movements in the Statement of Financial Position during 2022-23 are as follows:

    - **Current assets – trade and other receivables (line 7)**
      Current trade and other receivables decreased by £28.396m during the year, the most significant element being a reduction of £26.036m in the amount that the Health Board would be able to recover from the Welsh Risk Pool in the event of litigation claims, particularly clinical negligence, being successful.

      This information is provided in the Legal and Risk Services monthly quantum reports with the potential costs of cases being reflected in the increased value of provisions reported on Table F.

    - **Current assets – Cash and cash equivalents (line 9)**
      Cash and cash equivalents decreased by £3.765m during the year made up of a decrease of £4.148m in cash available for capital schemes and an increase of £0.383m in revenue cash

    - **Current liabilities – Trade and Other Payables (line 13)**
      Trade and other payables decreased by £19.273m during the year which was largely due to a reduction of £14.631m in the accrual for untaken annual leave alongside a reduction in open purchase order balances.

    - **Current liabilities – Provisions (line 15)**
      Current provisions decreased by £17.722m during the year which was mainly made up of a decrease in provisions for on-going litigation claims of £21.060m offset by a newly created provision of £4.100m for an on-going case.

9. STATEMENT OF FINANCIAL POSITION & AGED WELSH NHS DEBTORS

9.2 Welsh NHS Debtors (Table M)

Aged Debtors (Table M)

- At the end of Month 12 2022-23 the Health Board held one outstanding NHS Wales invoice for £180.00 that was over eleven weeks old and had been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales. This invoice was paid on 11th April 2023.

10.1 Monthly Cash Flow Forecast (Table G)

- The closing cash balance as at 31st March 2023 was £2.913m, which was made up of £1.513m cash held for revenue expenditure and £1.400m for capital projects.

- Cash funding received during the year included £29.000m revenue working balance support, £1.000m general capital working balance support and £5.740m IFRS16 capital working balance support.

- No strategic cash –only support was requested from Welsh Government during the year.

- Table G is showing one validation error as the Health Board drew £1.771m less revenue resource cash than was available due to the timing of receipt of final cash allocation letters.

11.1 . Public Sector Payment Policy PSPP (Table H)

- The Health Board achieved the PSPP target to pay 95% of valid invoices within 30 days of receipt in two of the four measures of compliance during quarter 4 2022-23 with NHS invoices by number being below target at 88.2% and non-NHS invoices by number being below target at 94.6%.

- The cumulative PSPP target was achieved in three of the four measures of compliance with NHS invoices by number missing the target at 87.0% of invoices paid within thirty days (quarter 3 86.5%).

- The Health Board is continuing to work on resolving underlying reasons for the late payment of invoices including reviewing reasons for any delays in invoices being processed by NWSSP through the Optical Character Reading (OCR) process.

12. CAPITAL SCHEMES & OTHER DEVELOPMENTS

12.1 Capital Resource Limit (Table I)

- The approved Capital Resource Limit (CRL) for 2022/23 is £29.252m. Actual expenditure for the year was £29.225m, giving a small surplus of £0.027m.

- Please note £0.25m received for Local Area Network (LAN) scheme has been spent in full, but it is shown in discretionary as one scheme.

12.2 Capital Programme (Table J & K)

- The Capital Programme spend by scheme is reported in Table J.

- Disposals (Table K) is reporting a small capital disposal of £0.016m.

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 12 Monitoring Return will be received by the Health Board's Performance, Finance and Information Governance Committee members at the May meeting.

Nick Lyons
Interim Deputy Chief Executive Officer

Steve Webster
Interim Executive Director of Finance

Monitoring Return Review – Action Point 11.1

The table below shows the ring-fenced areas where there are uncommitted values in the Month 11 return.

Ring Fenced Category	Uncommitted Spend Value (£000)	BCU Supporting comments including email update provided 20th March 23.
Recovery	4,749	Month 11 Narrative: The balanced forecast outturn position also includes slippage against the Planned Care Sustainability funding allocation to be retained. **Additional Note:** ***RF Return forecasts that £10.070m recovery spend (committed plus uncommitted) will be invested in month 12***
Value Based Health Care (Opening Allocation Paper)	2,471	Month 11 Narrative: Slippage of £1.2m is reported against Value Based Healthcare funding, and the balanced forecast outturn anticipates that this slippage will be retained by the Health Board. **Update 20th March 23 email** – Projecting to underspend by £2.2m (including £1.2m previously reported slippage), with funding not forecast to be returned to WG.
UEC	709	No comment in Month 11 Narrative. **Update 20th March 23 email:** Confirm this uncommitted spend will now be incurred.
Mental Health SIF	449	No comment in Month 11 Narrative. **Update 20th March email:** Confirm projected underspend of £0.300m.

I trust that the Health Board has kept the relevant Policy Leads informed of the latest position against allocations. As we approach year-end, Health Boards can now retain any remaining underspends (spend is not being restricted within the ring-fenced area, in the hope that these funds can be utilised within the overall Operational position). We have communicated previously that Health Boards should also now manage any movements on the Covid and Energy funding positions. If slippage cannot be utilised, then it will form part of your final outturn. (Action Point 11.1)

Response

The Health Board has reported a shortfall in attributed spend against other ringfenced funding as per below table. In addition, £0.9m surplus has been reported against the COVID-19 funding allocation, both of which have contributed towards the final outturn position.

	Total Funding	Attributed Spend	Shortfall of Attributed Spend	% Spent
	£m	£m	£m	
Other New Ring-fenced Funding				
Sustainability	38.39	32.17	-6.22	84%
Value Based Healthcare	3.35	0.99	-2.36	30%
Six Goals (Urgent Emergency Care)	2.96	2.74	-0.22	93%
Mental Health (SIF)	1.56	0.44	-1.12	28%
RIF	34.20	34.20	0.00	100%
Total Other New Ring-fenced Funding	**80.46**	**70.54**	**-9.92**	**88%**

Movement of Opening financial plan to Forecast Outturn (Table A) – Action Point 11.2

The balanced outturn is being supported by additional forecast Accountancy Gains (Annual Leave Accrual, VAT & PO Accruals) totalling £6.726m. Please ensure that these are reflected in the Tracker (C3) at Month 12 (ensure sufficient detail is provided on each separate area). (Action Point 11.2)

Response

The Annual Leave Accrual, VAT & PO Accrual Accountancy Gains have been reflected in the Month 12 Tracker (Table C3). However, please note that the £1.1m VAT adjustment accountancy gain is reported within the procurement savings schemes rather than a standalone scheme.

Underlying Position (Table A1) – Action Point 11.5

I note that you are continuing to report a c/f underlying deficit position of £187.600m. This was discussed at the March 'Touch Point' meeting and I acknowledge that you are working closely with colleagues in the FDU to understand the various drivers, and your future recovery plans. (Action Point 11.5)

Response

The underlying deficit position has now been increased to £196.2m as per the MDS submission.

Pay Expenditure Analysis (Table B2) - Action Point 11.9

Sine Month 10, I note that the annual forecast agency expenditure has reduced by c. £1.900m. The narrative references and explains a lower movement of c. £1.000m. Please ensure the narratives provide full explanations going forward. (Action Point 11.9)

Response

The £1.0m referred to in the Month 11 narrative was the in-month reduction in Agency spend from Month 10 to Month 11. Also, to clarify the annual forecast agency expenditure has reduced by £1.9m as noted in above Action Point 11.9 and we will ensure explanation is provided in full going forward.

MONITORING RETURN ACTION POINTS RESPONSES

Covid-19 Analysis (Table B3) - Action Point 11.10

Since your submission, I note that colleagues have confirmed to Prof. Chris Jones that there is now forecast slippage against the Nosocomial allocation totalling £0.428m. The Health Board can retain and reinvest this slippage; however, if this is not possible then it will form part of your final outturn position. (Action Point 11.10)

Response

The slippage is part of the final outturn position, due to insufficient time and capacity to reinvest elsewhere.

Ringfenced Template – Action 11.11

The return at Month 11 appears to have included forecast allocation underspends within the uncommitted expenditure section. Uncommitted expenditure is when the intended use remains within the ring-fenced area. A forecast underspend is a declaration that it will not be incurred within the ringfenced area and will be re-directed elsewhere within the wider Operation position. Supporting explanations for any over/under spends should also be explained within your commentary. (Action Point 11.11)

Response

The table has been updated to reflect the above.

Appendix B

Savings Month 12
18th April 2023

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University Health Board

Background

A savings target was set for 2022/23 and subsequent 2 years at £35m p.a.

This represents 3% of the Health Board's discretionary expenditure.

The savings must be cash releasing and recurring.

Historically, the Divisions have delivered transactional savings plans.

Financial Year	22/23 £m	23/24 £m	24/25 £m
Transactional Savings	18	12	6
Transformational Savings	17	23	29
Savings Target	35	35	35

A Transformation and Improvement team has been established with temporary Welsh Government (WG) funding to drive transformational improvement across the range of required outcomes, non-financial and financial.

The priority is the delivery of targeted patient and staff outcomes in line with the Health Board's strategy, vision and Integrated Medium Term Plan (IMTP). The challenge is to deliver on the £35m financial target at the same time.

The financial target for 2022/23 was split 50/50 between Transformation and Divisional/ Transactional plans, with the expectation that 85% of savings are delivered through transformational change by 2024/25.

The target was not reached by end March and the submission of plans to WG.

The Divisions delivered cash releasing savings plans of £12.5m. Recurring savings inc. Red schemes £8.9m; excl. Red £7.8m

The original transactional target has been met in terms of total savings delivered. However, recurring savings fall short of the target, which presents a challenge.

The purpose of this document is to provide a summary of the position at Month 12.

FY Plan and Forecast – Update Month 12

- Total target £35m
- FY Plan M1 £12.6 m
- FY Plan M12 £25.9m, up £2.9m from M11
- FY Outturn M12 £31.2m, up £4.1m from £27.1m M11 FY Forecast
- Increase includes:
  - adjustment to the existing accountancy gain relating to the annual leave provision £1.2m
  - a new accountancy gain relating to the PO accrual review £1.5m
  - a new scheme relating to VERS £0.2m
  - a new scheme for the VAT rebate on Home Oxygen Therapy £1.1m

- MHLD delivered £2.7m against target of £0.6m – £2.5m through CHC
- 3 Areas delivered a total of £10.3m
  - £3.8m favourable to Transactional target
  - £2.1m favourable to FY Plan
  - Savings driven through:
    - CHC £3.9m although East impacted by closure of 2 Care Homes
    - Meds Management £2.6m
    - Centre Pay related scheme £0.9m
- 3 Providers savings total £4.3m
  - £0.8m below transactional target
  - £0.1m below FY Plan
  - Savings driven through:
    - the VAT refund £1.1m
    - Procurement £1.8m
    - YMW pay and agency related savings £1.8m

£'000's	Target	FY Plan	Gap	FY Forecast	Gap
Transformation Savings	17,500	-	(17,500)	-	(17,500)
Divisional Savings (Amber & Green)	17,500	25,893	**8,393**	31,157	**13,657**
Total	**35,000**	**25,893**	(9,107)	**31,157**	(3,843)

	FY OUTTURN (M12)		
£'000's	Recurring	Non Recurring	Total
Amber and Green Schemes			
Cash Releasing - Budget	9,757	5,230	14,987
Cash Releasing - Run Rate	1,669	3,918	5,586
Cost Avoidance	267	98	365
Accountancy Gains	-	9,667	9,667
Income Generation - Budget	-	234	234
Income Generation - Run Rate	-	317	317
	11,692	**19,464**	**31,157**
Red Schemes			
Cash Releasing	-	-	-
Cost Avoidance	-	-	-
Income Generation	-	-	-
	-	-	-
Total - Red, Amber and Green Schemes	**11,692**	**19,464**	**31,157**

The FY Outturn includes:

- Recurring savings of £11.7m of which £9.8m are cash releasing and budget-reducing
- Non-recurring Accountancy Gains of £9.7m

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Divisional Savings – FY Plan vs FY Forecast vs Actual – Month 12

1) Transformation Savings

- FY Target 17.5m, loaded heavily in Q4
- FY Plan nil
- YTD delivered nil

£'000's	FY			YTD M12			
Total Plans	**Target**	**Plan***	**Forecast**	**Target**	**Plan***	**Actual**	**Variance to Plan**
Transformation Savings	17,500	-	-	17,500	-	-	0
Divisional Savings	17,500	25,893	31,157	17,500	25,893	31,157	5,263
	35,000	**25,893**	**31,157**	**35,000**	**25,893**	**31,157**	**5,263**
Divisional Plans	**Target**	**Plan***	**Forecast**	**Target**	**Plan***	**Actual**	**Variance to Plan**
Recurring	17,500	10,348	11,692	17,500	10,348	11,692	1,344
Non Recurring		15,546	19,464		15,546	19,464	3,919
Total	**17,500**	**25,893**	**31,157**	**17,500**	**25,893**	**31,157**	**5,263**

2) Transactional (Divisional) savings:

Green and Amber schemes:

- FY Target £17.5m Transactional Target
- FY Plan M12 £25.9m
- FY Outturn M12 £31.2m, up £4.1m on M11
- FY Outturn M12 recurring savings £11.7m – up £0.5m on M11

- YTD Actuals £31.2m:
  - £5.3m favourable variance against Plan*
    Increase on favourable variance reported last month (£1.0m)

- Month Only:
  - Achieved £5.2m vs £4.3m Plan and £1.4m Transactional Target

- Actual savings delivered total £31.2m against Plan of £25.9m, up £5.2m in month
- The proportion of cash releasing recurring savings delivered total £11.7m, of which only £9.8m is budget reducing (or £7.0m in terms of Plan figures). This contributes to the challenge for next year.
- The FY outturn includes non-recurring Accountancy Gains of £9.7m of which £2.7m was added in month 12.
- A scheme totalling £1.1m relating to a VAT rebate on Home Oxygen Therapy Services has been delivered at the end of the current year. This is earlier than anticipated; consequently the scheme will be removed from the plan for next year.
- The ongoing reliance on smaller scale savings initiatives remains a concern.
- Programme and project delivery capacity and capability issues continue to impact the delivery of larger scale savings.

Divisional Savings – FY Plan vs FY Forecast – Month 12
Movement in Recurring/ Non Recurring

	IY PLAN				FY OUTTURN (M12)				VARIANCE		
£'000's	Recurring	Non Recurring	Total	Recurring FYE Plan	Recurring	Non Recurring	Total	Recurring FYE Forecast	Recurring	Non Recurring	Total
Amber and Green Schemes											
Cash Releasing - Budget	6,988	3,317	10,306	7,218	9,757	5,230	14,987	10,553	2,769	1,913	4,681
Cash Releasing - Run Rate	3,125	2,232	5,357	3,847	1,669	3,918	5,586	2,122	(1,457)	1,686	229
Cost Avoidance	234	98	333	234	267	98	365	267	32	0	32
Accountancy Gains	-	9,347	9,347		-	9,667	9,667		0	320	320
Income Generation - Budget		234	234		-	234	234		0	0	0
Income Generation - Run Rate		317	317		-	317	317		0	0	0
	10,348	**15,546**	**25,893**	**11,299**	**11,692**	**19,464**	**31,157**	**12,942**	**1,344**	**3,919**	**5,263**
Red Schemes											
Cash Releasing			-		-	-	-		0	0	0
Cost Avoidance			-		-	-	-		0	0	0
Income Generation			-		-	-	-		0	0	0
	-	-	-		-	-	-		**0**	**0**	**0**
Total - Red, Amber and Green Schemes	**10,348**	**15,546**	**25,893**	**11,299**	**11,692**	**19,464**	**31,157**	**12,942**	**1,344**	**3,919**	**5,263**

- FY Outturn at M12 stands at £31.2m
  - Increase of £4.1m on the M11 FY Forecast of £27.1m. Movements in month summarised overleaf.
  - Favourable variance against FY Plan - £5.3m*
  - Favourable variance against FY Transactional Target - £13.7m
  - Adverse variance against total FY Target of £35m, which was split equally between Transactional and Transformation
- 3 Areas FY Outturn is £2.1m favourable against FY Plan.
- 3 Providers FY Outturn is £0.1m under FY Plan and £0.8m below transactional target – continuing impact of pressure on Agency spend

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*variance analysis provided in Appendices

FY Forecast – Summary Movements in Month 12

The table below summarises key movements in the Full Year Forecast for green and amber schemes since last month.

Figures in £'000s		
Month 11 FY Forecast		**27,105**
Existing Schemes:		
Meds Management	39	
Agency Savings (Med & Nursing)	(26)	
CHC	16	
Procurement	1,172	
Annual Leave Accrual	1,157	
Other Schemes	(9)	
Subtotal	**2,349**	
New Schemes this Month		
VERS	201	
Old PO accrual data cleanse	1,502	
Subtotal	**1,703**	
Total Movement		**4,052**
Month 12 FY Outturn		**31,156**
Notes:		
Medicines Management		
Area	(17)	
Site	10	
Cancer	46	
	39	

FY Outturn increased by £4.1m in Month 12 to **£31.2m**

Procurement

- Following CFO review, a savings scheme totalling £1.131m relating to a VAT rebate on Home Oxygen Therapy Services was delivered in Month 12. This is earlier than anticipated; consequently the corresponding amount included in Procurement's savings plan for next year will be removed.
- The total movement in month was £1.172m.
- Excluding the VAT refund, total in year savings stand at £1.6m of which £0.2m is recurring. Favourable variance to the £1.3m forecast throughout the year.

Medicines Management

- The increase in Forecast this month is largely due to a review of potential cancer drug patent savings.

Annual Leave Accrual

- An amendment to the annual leave accrual (maximum carry over changed to 10 days) resulted in an adjustment of £1.2m to an existing scheme categorised within Accountancy Gains. This brings the total adjustment to £4m.

PO Accrual data cleanse

- Following a review of POs between £1K to £20K, a number of accruals were closed, resulting in a new accountancy gain related scheme of £1.5m.

VERs

- Following the implementation of a VERs scheme approved by the RaTs Committee, a related savings scheme totalling £0.2m was approved by the interim Executive Directors of Finance and Workforce for inclusion in the Monitoring Return.

FY Outturn Reported by Category Month 12

MMR Category	Area - West	Area - Centre	Area - East	Area - Other	Provider - YG	Provider - YGC	Provider - YMW	Provider - NW	Womens	MHLD	Contracts	Corporate	Total
Savings													
Agency - Reduced usage of Agency/Locums paid at a premium	0	200	358	0	0	51	346	0	70	0		0	1,026
CHC and Funded Nursing Care	1,948	1,072	870	0	0	0	0	0	0	2,456		0	6,346
Commissioned Services	0	0	0	0	0	0	0	202	0	0		0	202
Medicines Management (Primary & Secondary Care)	491	905	1,235	0	6	150	91	1,765	0	0		0	4,644
Non Pay - Procurement	51	80	101		584	668	559	170	13	66		414	2,707
Non Pay - Other	0	342	91	235	16	0	190	317	140	156		301	1,788
Pay	169	836	0	0	88	0	1,456	0	1,889	0		339	4,777
Subtotal	**2,660**	**3,434**	**2,655**	**235**	**695**	**870**	**2,642**	**2,454**	**2,113**	**2,678**	**0**	**1,053**	**21,490**
Accountancy Gains													
Commissioned Services	0	0	0	0	0	0	0	0	0	0	3,488	0	3,488
Non Pay	37	927	560	108	78	47	2	18	24	31	0	375	2,206
Pay	0	0	0	0	0	0	0	0	0	0	0	3,973	3,973
Grand Total	**2,697**	**4,361**	**3,215**	**343**	**773**	**917**	**2,645**	**2,472**	**2,137**	**2,708**	**3,488**	**5,401**	**31,157**

Corporate	£m's
Locally driven savings	0.4
Procurement savings	0.4
VERs scheme	0.2
Accountancy Gain - PO accruals	0.4
Accountancy Gain - Annual leave accrual, held centrally at time of reporting	4
	5.4

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FY Forecast against Target - IHC View - Month 12

The full year outturn for transactional savings plans totals £31.2m. This exceeds the original transactional target of £17.5m. However, the proportion of cash recurring savings delivered totals only £11.7m, of which £9.8m is budget reducing. Furthermore, the total includes non-recurring Accountancy Gains of £9.7m. The ongoing reliance on smaller scale savings initiatives remains a concern. Plans for major programmes have not yet been received.

	Forecast				
Divisional Plans	**Amber & Green**	**Cash Releasing Target (Divisonal Transactional)**	**Transactional Variance**	**Total Target**	**Total Variance**
IHC East					
Ysbyty Wrexham Maelor	2,645	1,586	1,059	3,171	-526
Area - East	3,215	2,540	675	5,080	-1,865
	5,860	**4,126**	**1,734**	**8,251**	**-6,517**
IHC Centre					
Ysbyty Glan Clwyd	917	1,976	-1,059	3,951	-3,034
Area - Centre	4,361	2,471	1,890	4,942	-581
	5,278	**4,447**	**831**	**8,893**	**-8,062**
IHC West					
Ysbyty Gwynedd	773	1,562	-789	3,124	-2,351
Area - West	2,697	1,470	1,227	2,940	-243
	3,470	**3,032**	**438**	**6,064**	**-5,626**
North Wales Managed Services	2,472	1,793	679	3,586	-1,114
Womens Services	2,137	688	1,449	1,375	762
MHLD	2,708	307	2,402	613	2,095
Area - Other	343	118	225	235	108
Contracts & Provider Income	3,488	902	2,586	1,804	1,684
	11,148	**3,807**	**7,341**	**7,613**	**-272**
Corporate	5,401	2,089	3,312	4,179	1,222
Total	**31,157**	**17,500**	**13,657**	**35,000**	**-3,843**

Accountancy Gains	£m's
Corporate	4.4
Other	5.3
	9.7
Corporate	
Locally driven savings	0.4
Procurement savings	0.4
VERs scheme	0.2
Accountancy Gain - PO accruals	0.4
Accountancy Gain - Annual leave accrual, held centrally at time of reporting	4
	5.4
Other reported savings	
YMW conducted a deep dive review mid year yielding significant savings in pay and agency	1.8
MHLD CHC and funded nursing care	2.5
IHC West CHC savings significantly exceeded other Areas, with East IHC impacted by closure of 2 Care Homes	1.9
IHC East delivered highest level of savings in Medicines Management	1.2
IHC Centre delivered a Pay related scheme early in the year	0.8
Womens reported significant slippage against vacancies	1.7

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FY Forecast against Target - Divisional View - Month 12

The full year outturn for transactional savings plans totals £31.2m. This exceeds the original transactional target of £17.5m. However, the proportion of cash recurring savings delivered totals only £11.7m, of which £9.8m is budget reducing. Furthermore, the total includes non-recurring Accountancy Gains of £9.7m. The ongoing reliance on smaller scale savings initiatives remains a concern. Plans for major programmes have not yet been received.

		Forecast				
Total Improvement	Divisional Plans	Amber & Green	Cash Releasing Target (Divisonal Transactional)	Transactional Variance	Total Target	Total Variance
1,534	Ysbyty Gwynedd	773	1,562	-789	3,124	-2,351
918	Ysbyty Glan Clwyd	917	1,976	-1,059	3,951	-3,034
2,723	Ysbyty Wrexham Maelor	2,645	1,586	1,059	3,171	-526
5,174	**Hospital Sites**	**4,335**	**5,123**	**-788**	**10,246**	**-5,911**
1,591	North Wales Managed Services	2,472	1,793	679	3,586	-1,114
1,453	Womens Services	2,137	688	1,449	1,375	762
8,219	**Secondary Care**	**8,943**	**7,604**	**1,340**	**15,207**	**-6,264**
1,550	Area - West	2,697	1,470	1,227	2,940	-243
3,614	Area - Centre	4,361	2,471	1,890	4,942	-581
3,181	Area - East	3,215	2,540	675	5,080	-1,865
343	Area - Other	343	118	225	235	108
3,488	Contracts & Provider Income	3,488	902	2,586	1,804	1,684
12,176	**Area Teams**	**14,104**	**7,501**	**6,603**	**15,001**	**-897**
1,213	MHLD	2,708	307	2,402	613	2,095
5,272	Corporate	5,401	2,089	3,312	4,179	1,222
6,484	**Other**	**8,109**	**2,396**	**5,713**	**4,792**	**3,318**
-		-		0		0
26,880	**Total**	**31,157**	**17,500**	**13,657**	**35,000**	**-3,843**

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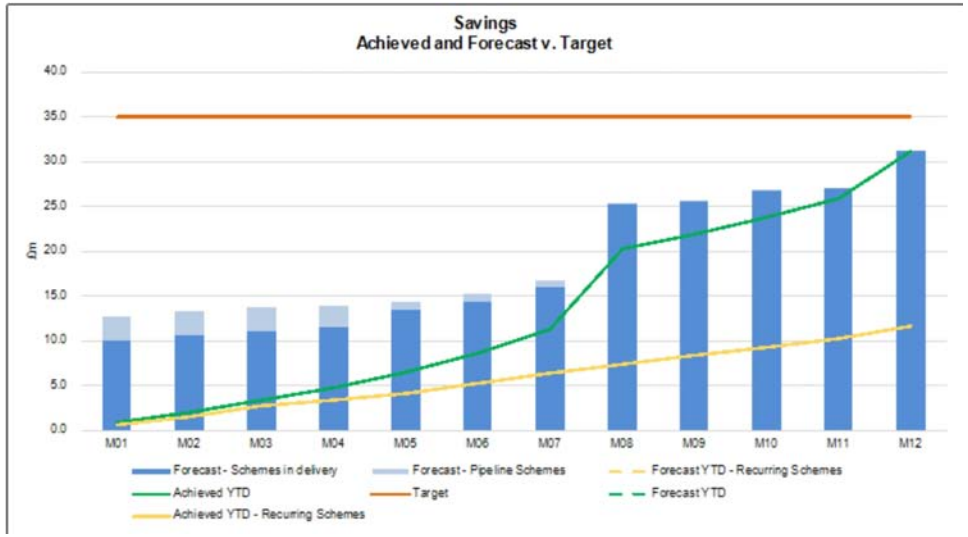
Appendices

Annex 1: Flash Report - Savings

		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	3,124	3,124	300	(2,824)	474	300	(2,824)	474	773	340	0	0	0	0	773	(2,351)
Ysbyty Glan Clwyd	3,951	3,951	379	(3,572)	538	379	(3,572)	538	917	418	0	0	0	0	917	(3,034)
Ysbyty Wrexham Maelor	3,171	3,171	687	(2,484)	1,957	687	(2,484)	1,957	2,645	1,006	0	0	0	0	2,645	(526)
Total of hospitals	**10,246**	**10,246**	**1,366**	**(8,880)**	**2,969**	**1,366**	**(8,880)**	**2,969**	**4,335**	**1,763**	**0**	**0**	**0**	**0**	**4,335**	**(5,911)**
North Wales Managed Services	3,586	3,586	2,019	(1,567)	453	2,019	(1,567)	453	2,472	2,113	0	0	0	0	2,472	(1,114)
Womens Services	1,375	1,375	115	(1,260)	2,021	115	(1,260)	2,021	2,137	133	0	0	0	0	2,137	762
Secondary Care	**15,207**	**15,207**	**3,500**	**(11,707)**	**5,444**	**3,500**	**(11,707)**	**5,444**	**8,943**	**4,010**	**0**	**0**	**0**	**0**	**8,943**	**(6,264)**
Area - West	2,940	2,940	1,160	(1,780)	1,542	1,160	(1,780)	1,542	2,702	1,513	0	0	0	0	2,702	(238)
Area - Centre	4,942	4,942	2,287	(2,656)	2,074	2,287	(2,656)	2,074	4,361	2,502	0	0	0	0	4,361	(581)
Area - East	5,080	5,080	1,527	(3,553)	1,688	1,527	(3,553)	1,688	3,215	1,531	0	0	0	0	3,215	(1,865)
Area - Other	235	235	235	0	108	235	0	108	343	235	0	0	0	0	343	108
Contracts	1,804	1,804	0	(1,804)	3,488	0	(1,804)	3,488	3,488	0	0	0	0	0	3,488	1,684
Area Teams	**15,001**	**15,001**	**5,209**	**(9,793)**	**8,900**	**5,209**	**(9,793)**	**8,900**	**14,109**	**5,781**	**0**	**0**	**0**	**0**	**14,109**	**(893)**
MHLD	613	613	2,457	1,844	252	2,457	1,844	252	2,708	2,458	0	0	0	0	2,708	2,095
Corporate	4,179	4,179	527	(3,651)	4,869	527	(3,651)	4,869	5,396	693	0	0	0	0	5,396	1,218
Divisional Total	**35,000**	**35,000**	**11,692**	**(23,308)**	**19,464**	**11,692**	**(23,308)**	**19,464**	**31,157**	**12,942**	**0**	**0**	**0**	**0**	**31,157**	**(3,843)**

Savings delivered in month total £5.2m against plans of £4.3m and a total target of £7.9m (of which £1.4m was transactional)
Total savings delivered are £31.2m against Plan of £25.9m and Target of £35.0m. The transactional target of £17.5m has been met in terms of total actual savings delivered. Total savings represent an overachievement of £13.7m against this target.
The total savings of £31.2m increased by £4.1m this month from the FY Forecast of £27.1m reported in the previous month.
The recurring element totals £11.7m of which £9.8m relates to budget reducing schemes. The total also includes non-recurring Accountancy Gains of £9.7m.
The Transformational savings target was profiled towards the final quarter and the lack of plans and delivery of transformational savings caused an under achievement in full to the total target of £17.5m.
The net of the savings against the transactional and transformation targets total £3.8m shortfall to the full £35m target for the year.



Annex 2: MR Narrative

Month	Narrative
12	Savings (including Accountancy Gains and Income Generation) (Tables C, C1, C2 and C3) The Health Board set a savings target of £35m for 2022/23 to be driven equally by both transaction and transformation led plans and programmes of work. Savings delivered in month totalled £5.2m against plans of £4.3m and a total target of £7.9m (of which £1.4m was transactional with the remainder relating to the Transformation target which was heavily profiled into Q4). Savings delivered total £31.2m against a Full Year plan of £25.9m and a total target of £35m. As all schemes were transactional, the transactional savings target of £17.5m was met in terms of total savings delivered. However, the proportion of recurring savings delivered totalled only £11.7m and of this, only £9.8m was budget reducing. The FY Outturn of £31.2m delivered a £4.1m increase on the FY Forecast at M12. Of this, £2.7m related to non-recurring Accountancy Gains and £1.1m to a VAT refund, which was delivered earlier than anticipated. Consequently, the related scheme will be removed from the savings plan for 23-24. Following the implementation of a VERs scheme approved by the RaTs Committee, a related savings scheme totalling £0.2m was approved by the interim Executive Directors of Finance and Workforce for inclusion in the Monitoring Return. Accountancy Gains totalled £9.7m at Month 12 and there were no red schemes. The ongoing reliance on smaller scale savings initiatives remains a concern. Plans for major programmes have not yet been received.

Annex 3: Variance Analysis

Divisional Savings – FY Plan vs FY Forecast at Month 12

FY Plan totals £25.9m

FY Outturn has increased from £27.1m in M11 to £31.2m in M12. £5.3m favourable variance to FY Plan shown below. £2.1m relates to Areas.

The Forecast for Providers has been reduced to reflect YTD under delivery on Medical & Nursing Agency.

Division	Scheme / Opportunity Title	Savings Scheme Number	RAG Rating	Recurrent / Non Recurrent	Sum of Current Year Annual Plan (£)	Sum of Annual Forecast Savings £	Sum of FOT Variance (£)	
Area - Centre	Procurement - Recurring	IGPROC22001-01	Green	R	66,752	4,485	-62,268	
Area - Centre	Procurement - Non Recurring	IGPROC22001-02	Green	NR	30,387	75,178	44,790	
Area - Centre	Dressings & Woundcare	IGMM22001-05	Green	R	100,000	75,000	-25,000	
Area - Centre	Community Equipment and Consumables	AC22004-01	Green	R	70,000	63,000	-7,000	
Area - Centre	Savings truxima, biktarvy and descovy	IGMM22002-07	Green	R	10,431	14,347	3,916	
Area - Centre	Non recurring financial accounting transaction – prescribing	AC22001-03	Green	NR	200,000	520,000	320,000	
Area - Centre	CHC Transactional Cost containment, including CHC Management & Tri	AC22006-01	Green	NR	600,000	1,072,430	472,430	
Area - East	Meds Management scheme - AE Primary Care	IGMM22001-07	Green	R	190,000	420,236	230,236	
Area - East	CHC Cost containment	AE22004-01	Green	NR	600,000	582,843	-17,157	
Area - East	CHC Management & Trigger Tool	AE22005-01	Green	R	300,000	287,073	-12,927	
Area - East	Procurement - Recurring	IGPROC22001-01	Green	R	70,456	4,818	-65,638	
Area - East	Procurement - Non Recurring	IGPROC22001-02	Green	NR	35,595	96,097	60,502	
Area - East	Dressings & Woundcare	IGMM22001-08	Green	R	100,000	0	-100,000	
Area - East	Grip and Control - Pay Agency Staffing	AE22006-01	Green	NR	240,000	357,992	117,992	
Area - East	Grip and Control - Non-Pay	AE22007-01	Green	NR	90,000	91,332	1,332	
Area - East	Savings truxima, biktarvy and descovy	IGMM22002-09	Green	R	10,431	37,136	26,705	
Area - West	Medicines Management - Primary Care - Reviews	IGMM22001-02	Green	R	175,000	312,323	137,323	
Area - West	Medicines Management - Primary Care - Cat M prices	IGMM22001-03	Green	R	484,000	161,333	-322,667	
Area - West	CHC Schemes	AW22003-01	Green	R	500,000	661,952	161,952	
Area - West	CHC Schemes - Backlog reviews	AW22004-01	Green	NR	150,000	1,286,530	1,136,530	
Area - West	Grip and control measures - pay	AW22006-01	Green	NR	150,000	169,080	19,080	
Area - West	Procurement - Recurring	IGPROC22001-01	Green	R	27,266	2,026	-25,240	
Area - West	Procurement - Non Recurring	IGPROC22001-02	Green	NR	15,530	49,303	33,773	
Area - West	Savings truxima, biktarvy and descovy	IGMM22002-06	Green	R	11,430	17,562	6,132	2,134,797
Corporate	Procurement - Recurring	IGPROC22001-01	Green	R	236,234	4,510	-231,724	
Corporate	Procurement - Non Recurring	IGPROC22001-02	Green	NR	28,831	409,444	380,613	
MHLD	Right Care Programme	MH22001-01	Green	R	1,000,000	2,455,583	1,455,583	
MHLD	Procurement - Recurring	IGPROC22001-01	Green	R	15,723	1,263	-14,460	
MHLD	Procurement - Non Recurring	IGPROC22001-02	Green	NR	10,084	64,848	54,764	
Provider - NW	Procurement - Recurring	IGPROC22001-01	Green	R	87,390	51,320	-36,069	
Provider - NW	Procurement - Non Recurring	IGPROC22001-02	Green	NR	53,837	118,699	64,862	
Provider - NW	Drug Patent Savings	NWP22001-01	Green	R	522,000	1,160,768	638,768	
Provider - NW	Drug Patent Savings	NWP22001-02	Green	R	391,026	604,116	213,090	2,525,426

Divisional Savings – FY Plan vs FY Forecast at Month 12 cont.

Division	Scheme / Opportunity Title	Savings Scheme Number	RAG Rating	Recurrent / Non Recurrent	Sum of Current Year Annual Plan (£)	Sum of Annual Forecast Savings £	Sum of FOT Variance (£)	
Provider - YG	Medicine - Dressings and Continence Supplies	YG22002-01	Green	R	18,750	0	-18,750	
Provider - YG	Medicine - Oxygen Therapy	YG22003-01	Green	R	18,750	3,000	-15,750	
Provider - YG	YG Management - Roster Efficiency	YG22006-01	Green	R	66,000	0	-66,000	
Provider - YG	YG Management - Redeployments	YG22007-01	Green	R	32,000	64,325	32,325	
Provider - YG	YG Management - Reduction in Sickness	YG22008-01	Green	R	24,000	0	-24,000	
Provider - YG	Procurement - Recurring	IGPROC22001-01	Green	R	139,372	189,087	49,715	
Provider - YG	Procurement - Non Recurring	IGPROC22001-02	Green	NR	52,687	395,314	342,627	
Provider - YG	Medical Agency Reduction	YG22009-01	Green	R	350,000	0	-350,000	
Provider - YG	Secondary Care Drugs savings from 21/22 - difference in fye verses rep	IGMM22002-01	Green	R	4,327	6,265	1,938	
Provider - YG	Savings truxima	IGMM22002-02	Green	R	2,943	0	-2,943	
Provider - YGC	Medical Agency	YGC22001-01	Green	NR	250,000	51,463	-198,537	
Provider - YGC	Nurse Agency	YGC22002-01	Green	NR	250,000	0	-250,000	
Provider - YGC	Admin Agency	YGC22003-01	Green	NR	50,000	0	-50,000	
Provider - YGC	Sickness Management	YGC22005-01	Green	NR	50,000	0	-50,000	
Provider - YGC	Escalation Nursing Reduction	YGC22006-01	Green	NR	30,000	0	-30,000	
Provider - YGC	Procurement - Recurring	IGPROC22001-01	Green	R	176,029	228,580	52,551	
Provider - YGC	Procurement - Non Recurring	IGPROC22001-02	Green	NR	60,917	439,634	378,716	
Provider - YGC	Savings truxima	IGMM22002-03	Green	R	3,924	150,093	146,169	
Provider - YMW	Medical staffing - agency reduction	YMW22001-01	Green	R	50,000	16,667	-33,333	
Provider - YMW	Medical staffing - agency reduction	YMW22005-01	Green	R	75,000	20,000	-55,000	
Provider - YMW	Medical staffing - agency reduction	YMW22012-01	Green	R	25,000	4,000	-21,000	
Provider - YMW	Nurse staffing - agency reduction/overseas nursing	YMW22002-01	Green	R	250,000	49,948	-200,052	
Provider - YMW	Nurse staffing - agency reduction/overseas nursing	YMW22006-01	Green	R	200,000	209,319	9,319	
Provider - YMW	Nurse staffing - agency reduction/overseas nursing	YMW22013-01	Green	R	150,000	12,500	-137,500	
Provider - YMW	Theatres performance	YMW22008-01	Green	R	40,000	34,000	-6,000	
Provider - YMW	Orthopaedic Implants	YMW22009-01	Green	R	10,000	0	-10,000	
Provider - YMW	Sterile Services - Review staffing structure and sustained change	YMW22010-01	Green	R	20,000	35,832	15,832	
Provider - YMW	Procurement - Recurring	IGPROC22001-01	Green	R	162,830	189,034	26,203	
Provider - YMW	Procurement - Non Recurring	IGPROC22001-02	Green	NR	57,600	369,675	312,075	
Provider - YMW	Savings truxima	IGMM22002-05	Green	R	10,791	81,860	71,069	-80,326
Womens	Medical Agency	WOM22002-01	Green	R	60,000	70,000	10,000	
Womens	CoCH Contract - 21/22 unachieved due to block contract	WOM22001-01	Green	R	107,496	0	-107,496	
Womens	Procurement - Recurring	IGPROC22001-01	Green	R	7,081	2,563	-4,517	
Womens	Procurement - Non Recurring	IGPROC22001-02	Green	NR	4,532	10,672	6,141	
Womens	Vacancy FactorVacancy Factor - Administration	WOM22003-01	Green	NR	38,000	165,958	127,958	
Womens	Vacancy Factor - HCA	WOM22004-01	Green	NR	47,000	263,282	216,282	
Womens	Vacancy Factor - RGN & Midwifery	WOM22005-02	Green	NR	580,000	1,003,942	423,942	
Womens	Reduced Travelling expenditure	WOM22006-01	Green	R	30,000	41,000	11,000	683,309
Grand Total					**10,077,433**	**15,340,638**	**5,263,206**	**5,263,206**

Annex 4: Comparative & Trend Analysis

FY Plan & Forecast: Comparison – Areas

	FY PLAN					FY OUTTURN (M12)			
£'000's	West	Centre	East	Total		West	Centre	East	Total
Medicines Management	670	826	978	2,475		491	830	1,235	2,557
Dressings		100	100	200			75	-	75
CHC	650	600	900	2,150		1,948	1,072	870	3,891
Procurement	43	97	106	246		51	80	101	232
Community Equipment and Consumables/ G&C non-pay		70	90	160			63	91	154
Pay Related	150	1,036	240	1,426		169	1,036	358	1,563
Other		279	184	462			279	184	462
Sub-Total	**1,513**	**3,008**	**2,598**	**7,119**		**2,660**	**3,434**	**2,839**	**8,934**
Accountancy Gains	37	607	376	1,020		37	927	376	1,340
Total	**1,550**	**3,614**	**2,974**	**8,139**		**2,697**	**4,361**	**3,215**	**10,273**
Target against £17.5m	**1,470**	**2,471**	**2,540**	**6,481**		**1,470**	**2,471**	**2,540**	**6,481**
Difference	**80**	**1,143**	**434**	**1,657**		**1,227**	**1,890**	**675**	**3,792**

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

FY Plan & Forecast : Comparison - Providers

£'000's	FY PLAN YG	FY PLAN YGC	FY PLAN YMW	FY PLAN Total	FY OUTTURN (M12) YG	FY OUTTURN (M12) YGC	FY OUTTURN (M12) YMW	FY OUTTURN (M12) Total
Medicines Management	7	4	20	31	6	150	91	247
Medicine	38			38	3			3
SACC	13			13	13			13
Procurement	192	237	220	649	584	668	559	1,811
Pay Related	496	630	2,230	3,356	88	51	1,802	1,942
Theatres			35	35			25	25
Outpatients			**	-			**	-
Other	78	47	168	293	78	47	168	293
Sub-Total	**824**	**918**	**2,673**	**4,415**	**773**	**917**	**2,645**	**4,335**
Target against £17.5m	**1,563**	**1,976**	**1,586**	**5,125**	**1,563**	**1,976**	**1,586**	**5,125**
Difference	**(739)**	**(1,058)**	**1,087**	**(710)**	**(790)**	**(1,059)**	**1,059**	**(790)**

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Divisional Savings – FY Plan vs Prior Years and Target

Notable % variances against current year (transactional) target:

- YG
- YGC
- NW Managed Services
- Corporate

Compare Area targets to prior years:

- West
- Centre
- East
- MHLD (System capacity, cost pressures, vacancies and workforce availability)

	Delivered				Plan	Target	Delivered as a % of Transactional Target				Plan
£'000's	2018-19	2019-20	2020-21	2021-22	2022-23	2022-23	2018-19	2019-20	2020-21	2021-22	2022-23*
Ysbyty Gwynedd	1,928	2,384	1,051	426	1,091	1,562	61%	81%	25%	23%	47%
Ysbyty Glan Clwyd	3,121	2,143	540	364	917	1,976	84%	56%	11%	17%	46%
Ysbyty Wrexham Maelor	2,179	1,682	847	1,155	1,115	1,586	66%	64%	19%	60%	70%
North Wales Managed Services	2,713	2,276	1,311	1,274	866	1,793	76%	87%	30%	91%	48%
Womens Services	921	1,516	249	614	514	688	77%	143%	14%	105%	75%
Secondary Care Divisional	-	-	-	-	-						
Secondary Care	**10,863**	**10,002**	**3,998**	**3,833**	**4,153**	**7,604**	**72%**	**76%**	**20%**	**49%**	**55%**
Area - West	5,661	4,704	2,298	2,615	1,502	1,470	113%	144%	52%	189%	102%
Area - Centre	5,885	4,863	3,281	4,155	2,397	2,471	108%	98%	51%	219%	97%
Area - East	6,058	5,990	4,281	4,635	2,399	2,540	95%	122%	66%	249%	94%
Area - Other	458	680	300	326	-	118	100%	211%	49%	139%	0%
Contracts	-	500	-	-	100	902					
Area Teams	**18,062**	**16,736**	**10,160**	**11,731**	**6,398**	**7,501**	**104%**	**120%**	**54%**	**184%**	**85%**
MHLD	4,123	5,865	3,240	1,784	1,026	307	54%	162%	324%	212%	335%
Corporate	5,300	2,328	993	1,812	1,436	2,089	106%	54%	18%	95%	69%
Divisional Total	**38,348**	**34,932**	**18,391**	**19,161**	**13,013**	**17,500**	**85%**	**100%**	**41%**	**113%**	**74%**
											*Reflects target of £17.5m

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Appendix C

Performance, Finance and Information Governance Committee

27th April 2023

Capital Programme Report Month 11&12 2023 and update of 2023/24 Capital Programme

1. Introduction/Background

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).

2. Approved funding 2022/23

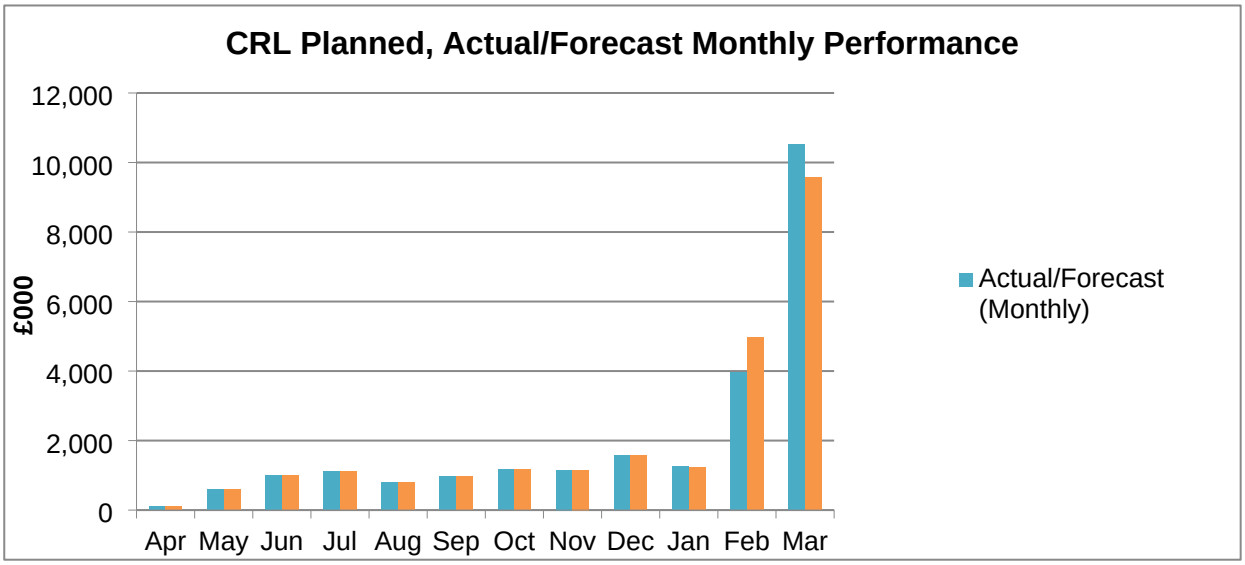
The agreed capital funding from all sources may be summarised as follows:

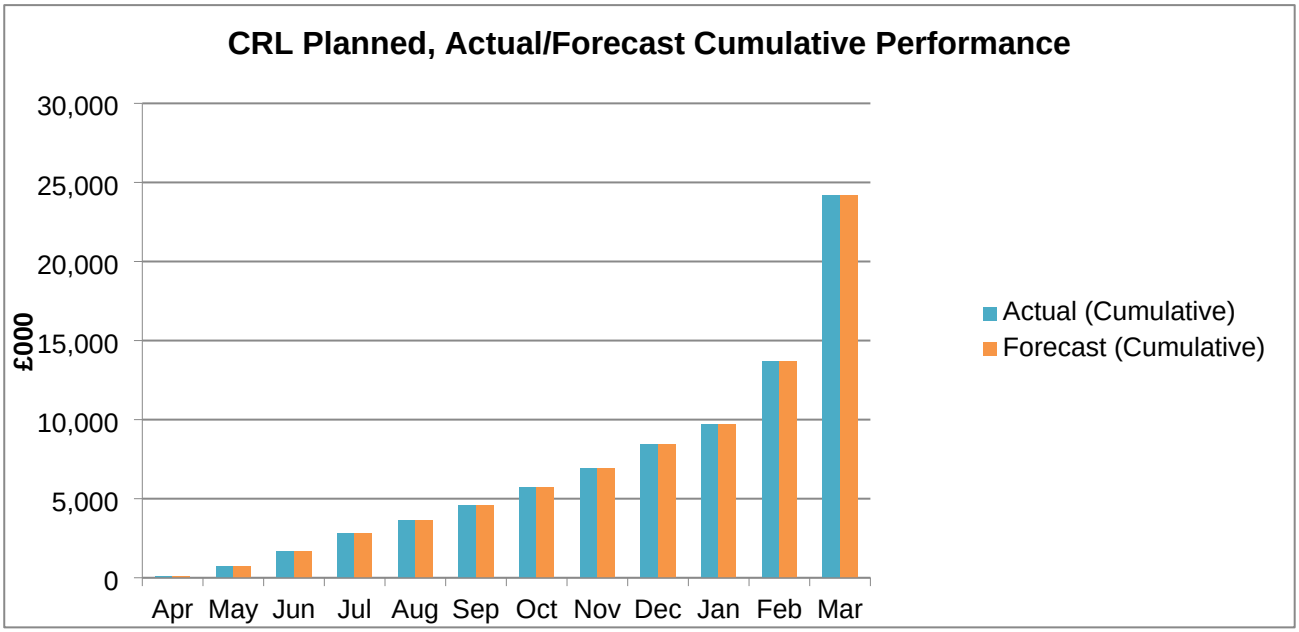
Capital Programme	**£ '000**
All Wales Capital Programme	13.230
Discretionary Capital	10.971
Total Welsh Government CRL	**24.201**
Capital Receipts	
Donated Funding	0.560
TOTAL	**24.761**

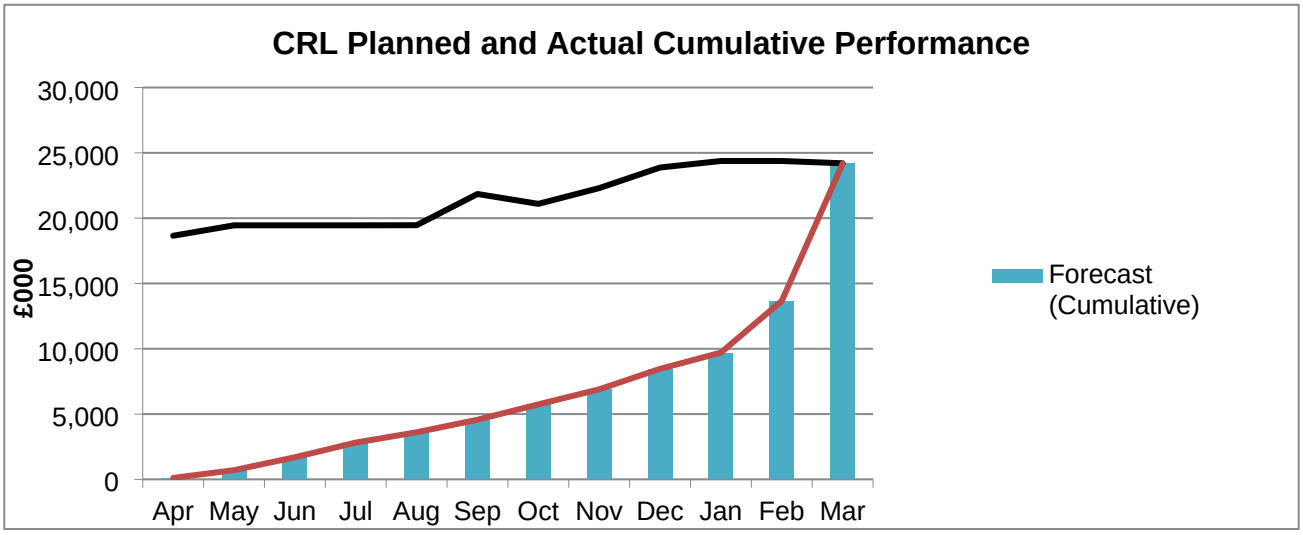
3. Expenditure Planned/Actual 2022/23

Finance colleagues have confirmed we have met the Capital Resource Limit target for 22/23, subject to audit the balance is £29K.

	CRL Revised	Planned (Monthly)	Forecast (Cumulative)	Actual/Forecast (Monthly)	Actual (Cumulative)
Apr	18,653	112	112	112	112
May	19,451	593	705	593	705
Jun	19,451	989	1,694	989	1,694
Jul	19,451	1,122	2,816	1,122	2,816
Aug	19,461	790	3,606	790	3,606
Sep	21,850	960	4,566	960	4,566
Oct	21,095	1,176	5,742	1,176	5,742
Nov	22,301	1,153	6,895	1,154	6,896
Dec	23,877	1,564	8,459	1,564	8,460
Jan	24,377	1,229	9,688	1,246	9,706
Feb	24,377	4,955	13,665	3,959	13,665
Mar	24,201	9,558	24,201	10,507	24,172


CRL Planned, Actual/Forecast Monthly Performance
£000
12,000
10,000
8,000
6,000
4,000
2,000
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Actual/Forecast (Monthly)


CRL Planned, Actual/Forecast Cumulative Performance
£000
30,000
25,000
20,000
15,000
10,000
5,000
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Actual (Cumulative)
Forecast (Cumulative)


CRL Planned and Actual Cumulative Performance
£000
30,000
25,000
20,000
15,000
10,000
5,000
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Forecast (Cumulative)

4. Major Capital Schemes >£1m

Scheme	Stage	Value (£m)	Comment
Royal Alexandra Hospital Redevelopment	FBC	67 + inflation	Full Business Case (FBC) with Welsh Government,
Adult and Older Persons Mental Health Unit	OBC	84	Work has commenced to develop the Full Business Case (FBC).
Wrexham Continuity Phase 1	PBC	54	FBC approved at March 2023 Board, and has been submitted to Welsh Government
Ysbyty Gwynedd Compliance Programme	PBC	250+	Restarting project board to respond to Gateway review request.
Nuclear Medicine	SOC	13	Work is ongoing to develop the Outline Business Case (OBC) and the option appraisal to determine the preferred location.
Conwy/Llandudno Junction Primary Care Development	SOC	17	Welsh Government approved and funded development of OBC

5. Approved Funding 2023/24

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

Capital Programme	**£ '000**
All Wales Capital Programme	2.068
Discretionary Capital	11.399
Total Welsh Government CRL	**13.467**
Capital Receipts	
Donated Funding	
TOTAL	**13.467**

In addition to this, we are expecting funding for:

- EFAB (4.324m)
- Llandudno Junction Hub £0.92m
- Funding fees to develop a business case for the orthopaedic plan(£0.839m).

6. Discretionary Capital 2023/24

The Capital Programme Management Team (CPMT) have been notified of the approval for the draft capital programme, and progression based on the following CIG controls.

- Capital programme leads (Capital Development, Operational Estates, Medical Devices and Informatics) are to work up all schemes to procurement.

- They may commit 75% of their programme holding 25% in reserve.
- Additional funding and slippage is normally confirmed in month 7. Programme leads are therefore required to review their programmes and select those schemes/purchases that can be delivered within the final 4 months of the year as their reserve (subject only to schemes identified as urgent). In reality for all programmes with the exception of Medical Devices the expenditure profiles are phased across the year and this will have limited, if any, impact.
- The capital finance report will show each of the programmes aligned to the Capital Monitoring Tool. Each programme will be shown as over committed by 25%.
- Expenditure will be monitored monthly by the Capital Programme Management Team with variances escalated to the CIG and PFIG as necessary.

The approved Capital Estates Development programme equates to £5.8m with an agreement to reduce by 25% over commitment so initial allocation is £4.35m. The year-end review of Capital Development programme confirmed the following exceptions and cost pressures for 23/24.

Scheme	Value (£)	Comment
Enlli Phase 3, Critical Care YG	+500,000	Pre tender estimate increased due to scope and inflation increases.
204/206 Abergele Rd	-70,000	Scheme not feasible at this stage
Plas Gororau – Phase 1	+168,000	Underspend/slippage in 22/23
NW Cancer Treatment Centre redevelopment	-520,000	Option to move discretionary commitment to 23/24
ED Void Works – YG	+50,000	Underspend for 22/23
WMH Critical Care – Post contract requests	+50,000	Post contract safety requests
MOPS Rooms for East, Central and West	+150,000	Additional Request for Minor procedure rooms to support Orthopaedic Plan.
ED Patient Benefits	+62,000	Underspend for 22/23
WMH Cardiology Ambulatory Pacing	+110,000	Underspend for 22/23
Minor scheme variations <£50K	-40,000	
Total variations	460,000	

Taking into account the above variations on top of the approved programme £5.8m, the revised funding required is £6.26m against an allocation of £4.35m resulting in an overcommitment of £1.91m.

The Capital Investment Group agreed to manage this by holding Enlli Phase 3 and Immunology both in YG at tendered stage. This would release £1.678m against the £1.91m over commitment. Options for the remaining £0.232m will be managed on risk-based approach to the smaller schemes. The basis for this agreement is a number of the schemes on the programme are already contractually committed and on site. Due to current site pressures Enlli Phase 3 would not be able to commence on site until quarter four of 23/24. The Immunology scheme is programmed to be funded over two years so a start in quarter four would align to that.

Teitl adroddiad: ***Report title:***	People (Workforce) Performance Report
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	12th May 2023
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this report is to outline the current workforce performance position as of March 2023. It also provides an update on the current position of Non-Clinical Senior Interims and the Workforce Optimisation programme update aligned to delivery of savings The report presented to this meeting is part of the ongoing development of the revised structure of the report and the level of detail required going forward.
Argymhellion: ***Recommendations:***	The Committee is asked to NOTE the current performance position provided and feedback any improvements on the content of this report for future reporting.
Arweinydd Gweithredol: ***Executive Lead:***	Jason Brannan-, Deputy Director of People
Awdur yr Adroddiad: ***Report Author:***	Nick Graham, Associate Director Workforce Optimisation

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Partial assurance level is due to continued gaps in information against a number schemes.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Living Healthier, Staying Well (LHSW)– Improve the safety and quality of all of our service Integrated Medium Term Plan (IMTP) Employer of Choice
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Leadership is one of the domains for which the Health Board is subject to Targeted Intervention. The domains relating to Mental Health and Learning Disabilities, Glan Clwyd and Vascular Services are impacted by the workforce within these services.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	CRR21-13 Nurse Staffing CRR21-17 Children and Adolescent Mental Health Services (CAMHS) Out of Hours provision CRR22-18 Infection Prevention and Control (IPC) capacity CRR22-23 Unscheduled Care
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	No direct implications arising from this report
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	No direct implications arising from this report.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no direct budgetary implications associated with this paper. Resources for maintaining compliance oversight are built into the workforce teams where collaborative working with finance, planning and transformation alongside service and scheme leads for the relevant outlined areas is taking place.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	BAF21-18 Effective Alignment of Our People
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Not applicable

Reason for submission of report to confidential board (where relevant)	
Next Steps: To agree to ongoing format of the report and finalise this for the next reporting cycle.	
List of Appendices: Appendix 1. Workforce Performance Report	

Workforce Performance Report – April 2023

Jason Brannan

Deputy Director of People

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwalar
University Health Board

Workforce Metrics

Budget/Actual Establishment

Staff Group	Budgeted FTE	Actual FTE	Vacancy FTE
BCU Total	**19077.7**	**17998.9**	**1078.8**
Medical and Dental	1692.8	1570.6	122.2
Nursing and Midwifery Registered	6054.6	5317.7	736.8

There was an actual FTE increase of 116.2 FTEs in March 2023, an increase of 382.6 FTEs on December 2022 and 915 FTEs since March 2022. Budget FTE has increased by 824.9 over the last 12 months.

Additional Clinical Services actual FTE increased by 46.1 in March 2023 and 139.7 across the quarter. Nursing workforce actual FTE increased by 32.1 in March 2023 and Medical staff by 16.7 FTEs. IHC East grew by 44 FTEs in March 2023 whilst IHC Centre and West both increased by 27.4 FTEs.

Vacancy Rates

Staff Group	Vacancy %
BCU Total	**5.7%**
Medical and Dental	7.2%
Nursing and Midwifery Registered	12.2%

Vacancies FTE fell by 81.9 FTE in March 2023 which contributed to a 0.4% reduction in the vacancy rate. Over the last quarter the vacancy FTE has reduced by 270.1 FTEs and the vacancy rate by 1.5%. Mental Health and LD have the highest vacancy rate at 17.4%.

Medical and Dental vacancy rate decreased by 0.9% in March 2023 and Nursing by 0.4%. Additional Clinical Services saw the greatest improvement in vacancy rate decreasing by 1.1% to 1%.

Sickness Absence

Staff Group	Average FTE Lost per Day	Monthly Sickness %	Rolling Sickness %
BCU Total	**1057.5**	**6.02%**	**6.28%**
Medical and Dental	26.8	2.36%	2.71%
Nursing and Midwifery Registered	330.5	6.21%	6.60%

The monthly sickness rate has increased by 0.5% over the last month but has improved since the previous quarter (7.3% in December 2022 to 6.0% in March 2023). The rolling sickness rate for March 2023 is reflective of the rate for the same period last year at 6.3%.

The rolling sickness rates is highest within Estates and Ancillary and Additional Clinical Services staff groups (8.9% and 8.3% respectively) with Registered Nursing sickness at 6.6%. MHLD have a rolling sickness rate at almost 8% with Womens at 7.4%.

Staff Turnover

Staff Group	Turnover Rate %	External Leavers FTE
BCU Total	**9.3%**	**-144.0**
Medical and Dental	12.6%	-12.0
Nursing and Midwifery Registered	8.4%	-33.3

There were 144 FTE external leavers during March 2023 which is significantly lower than the 282.8 FTE leavers in March 2022*.

The turnover rate in March 2023 was 9.3%, down from 9.7% in February 2023.

Admin and Clerical staff group had the greatest number of leavers in March 2023, 47.8 FTE leavers and a turnover rate of 10.2%. Medical and Dental staff group had the highest turnover at 12.6% equating to 12 FTE leavers. Corporate Services has the highest turnover rate at 10.8% followed by IHC East and Integrated Clinical Delivery Primary Care, both at 10.4%.

Agency Usage

Staff Group	Agency Utilised FTE
BCU Total	**929.2**
Medical and Dental	112.6
Nursing and Midwifery Registered	386.8

Agency equivalent FTE usage rose from 713.5 to 929.2 between February 2022 and March 2023 and was 232 higher than March 2022.

Registered Nursing staff group has the highest equivalent usage at 386.8 FTEs followed by AHPs at 247.5 FTEs. The increase in AHP agency utilised FTE is predominantly increased agency usage linked to CAMHS within IHC Centre where agency utilised FTE increased by 112.4 FTEs in March 2023 from February 23.

IHC centre had the highest agency utilised FTE at 359.5 FTEs followed by IHC East at 196.4 FTEs, with IHC West agency utilised standing at 117.4 FTE in March 2023.

Bank Usage

Staff Group	Bank Utilised FTE
BCU Total	**982.9**
Medical and Dental	115.5
Nursing and Midwifery Registered	134.5

Bank equivalent FTE utilised increased by 74.8 FTEs in March 2023 from 908.1 in February 2023. M&D reduced by 6.8 FTEs whilst Nursing increased by 11.4 FTEs. Additional Clinical Services (Nursing) staff group had the highest bank equivalent FTE utilised at 637.9.

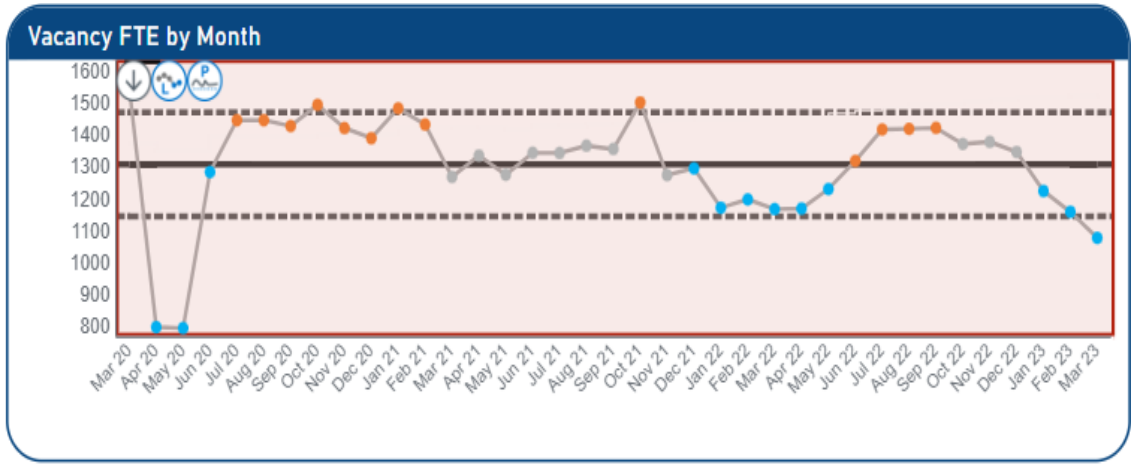
IHC Centre had the highest bank utilised FTE at 251.8 FTEs followed by IHC West at 218.7 FTEs and MHLD at 207.7 FTEs. IHC East utilised the equivalent of 196.4 bank FTEs during March 2023.

**Leavers during March 2022 included 49.5 FTE SpRs transferring to Velindre University NHS.*

Workforce Metrics

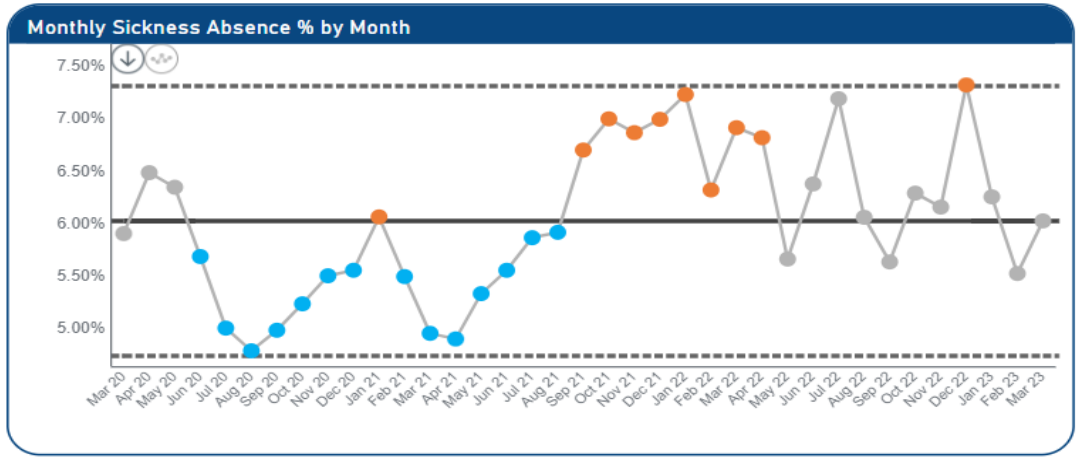
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Vacancy FTE



Vacancy FTE is improving over the last quarter following a period of higher levels through July 2022 to September 2022. Vacancy FTE is currently at it's lowest since May 2020 and the special cause of improvement over the last quarter indicates the trend is unusual and warrants further investigation.

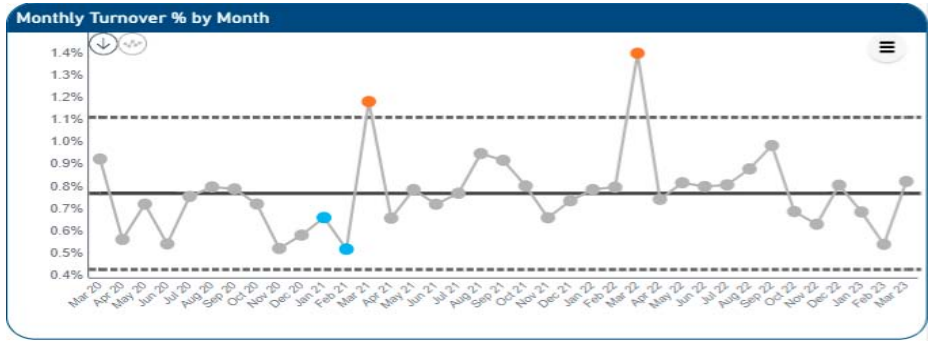
Sickness Absence %



The monthly sickness absence rate has been frequently in excess of 6% since the easing of Covid restrictions in August 2021. The single point outside of the process limit in December 2022 is related to an increase in Cold, Cough and Flu absence, however, this quickly improved through January and February. March 2023 absence has increased but is within the control limits.

Workforce Metrics

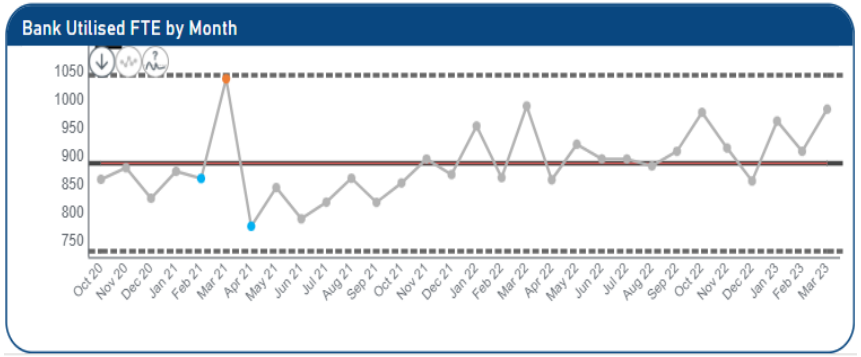
Staff Turnover %



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

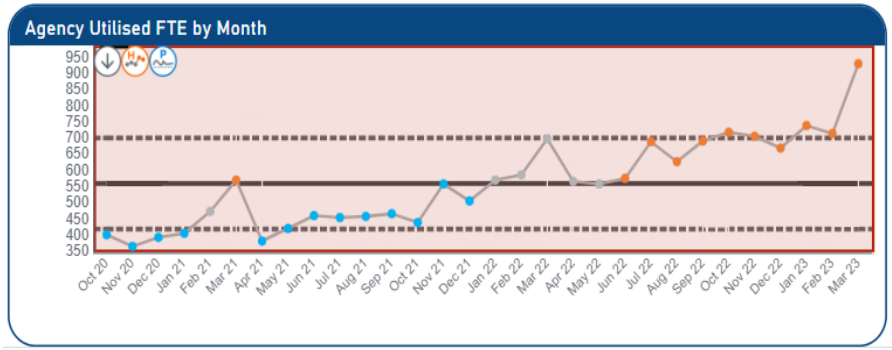
The turnover rate is typically higher in March owing to an increased number of staff retirements. The two points outside of the upper process limit in the above chart relate to the month of March (2021 and 2022) where retirements were significantly higher than usual. By contrast March 2023 has seen fewer leavers/ retirements compared to previous years and the turnover rate has increased by a smaller margin.

Agency Usage FTE



An increase in agency usage in March is typical, as the trend across previous years shows, however, the increase in March 2023, which follows increasing usage throughout the year, has pushed the agency usage well beyond the upper control limit and suggest special cause for concern. This is being looked at across all areas and a number of initiatives are underway to reduce this position.

Bank Usage FTE



Unlike the agency usage FTE, bank usage FTE remains within the control limits across the period and does not indicate any special cause for concern with the exception of March 2021 where there was a sharp increase in usage followed by a sharp reduction.

Senior Interims

Current Position

As of the 30th March 2023 there were a total of 52 senior interims working across the organisation. This is a drop of 8 from the number last reported which stood at 60 as of 30th November 2023. In addition to this the number of interims brought in through an Agency has reduced from 49 at the end of November 22 to 37 as at the end of March 23. This is due to a reduction in the use of agency interims and also to moving some interims to fixed term contract or temporary assignments. Details of which can be seen in the table below.

	01.12.22 (Nov)	01.01.23 (Dec)	01.02.23 (Jan)	01.03.23 (Feb)	01.04.23 (Mar)
No of Interims (Interims with an Identified Name in Post)	49	50	37	37	37
No of FTCs & Temp Assignments (Bank) (With an Identified Name in Post)	11	14	14	15	15
Total	60	64	51	52	52

The benefit of this is that it reduces the average daily cost to the organisation. The average cost per day at the end of November 22 stood at £692.20. The average cost per day as at the end of March 23 stood at £588.18. This is a reduction of £104.02 per day, which equates to a 15% drop in daily rates across the organisation. Details can been seen in the table below.

	01.12.22 (Nov)	01.01.23 (Dec)	01.02.23 (Jan)	01.03.23 (Feb)	01.04.23 (Mar)
Average Rate of Pay (Interims)	£692.20	£687.41	£578.15	£591.30	£588.18

A further focus on interim usage across the organisation is underway with a push to reduce the number further and look to convert any essential positions to fixed term contracts or temporary assignments. This approach will further reduce the average daily rate and look to decrease the over reliance of the organisation on senior temporary interims. This work is being undertaken collaboratively between workforce and finance colleagues, working closely with corporate and IHC teams.

Workforce Optimisation

Medical and Nursing Productivity

To support the identified savings plan for 23/24 the workforce optimisation team in conjunction with finance have been working to identify opportunities across medical and nurse staffing in terms of opportunities to reduce costs.

Two programmes of work are being set up, these are Medical Productivity and Nursing Productivity. These consist of a number of schemes to enable and support the organisation reduce the unit staffing costs associated with these two staffing groups. The targets set are £4m for medical and £2m for nursing. To date opportunities to this value have been provisionally identified. These are being validated with finance and clinical colleagues and will be finalised this month. Work has already started on these programmes with initiatives such as overseas recruitment, nurse agency rationalisation and Wagestream coming on-stream between May and July 23. The programme groups are being formalised and will be clinically led and operationally and corporately supported.

Alongside this workforce are also supporting IHCs with the grip and control elements around the ongoing recovery work, a specific area under review is the level and duration in time of the usage of non-clinical senior interims across the organisation mentioned previously in this report. The key aim is to reduce the reliance on senior interims across the organisation and ensure where they are covering a vacancy or providing specialist skills the length of time they are utilised within the organisation is kept to a minimum.

The Workforce Optimisation programme will also look at longer term stabilisation and sustainability through the health Workforce programme which will support identified areas with high absence to support getting people back to work and facilitate a programme work to tackle the underlying causes of high absence across the identified area. They will work in conjunction with Occupational Health and the Staff Wellbeing Service to provide and embed long term solutions to ensure our staff are fully enabled to work in a collaborative and fully supportive environment that ensures the organisations values are embodied day to day.

Teitl adroddiad: ***Report title:***	Performance Report – Month 12, 2022/23			
Adrodd i: ***Report to:***	Performance, Finance & Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 12, 2022/23. This paper provides Committee members with an update of performance against the Board's Key Performance metrics, the key measures contained within the 2022-23 National Performance Framework and Welsh Government Ministerial Priority Measures under the Quadruple Aims set out in "A Healthier Wales". Key areas of improvement are identified with actions and mitigations being taken by operational teams detailed in the 'Exception Reports' contained within Appendix 1 (IQPR Report) of this paper.			
Argymhellion: ***Recommendations:***	The Committee is asked to: Review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster, Executive Director of Finance and Performance			
Awdur yr Adroddiad: ***Report Author:***	Barbara Cummings, Interim Director of Performance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2022-23.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Performance, Finance and Information Governance Committee
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N The Report has not been Equality Impact Assessed as it is reporting on actual performance.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The pandemic has produced a number of risks to the delivery of care across the healthcare system
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within the annual plan will have direct and indirect impact on the financial recovery plan of the Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed in parts (narratives) by senior leads across the Health Board and relevant Directors. And the full report has been reviewed by the report author.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	This QP report provides an opportunity for areas of under-performance to be identified

Links to BAF risks: *(or links to the Corporate Risk Register)*	and subsequent actions developed to make sustained improvement.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance isn't of sufficient quality to believe performance is or will improve as described.	
Rhestr o Atodiadau: ***List of Appendices:*** *Quality and Performance Report*	

PERFORMANCE, FINANCE & INFORMATION GOVERNANCE COMMITTEE
12 MAY 2023
PERFORMANCE REPORT, MONTH 12 – 2022/23

1 Introduction/Background

This paper provides members with a summary of the Board's Performance against the key measures contained within the 2022-23 National Performance Framework and Welsh Government Ministerial Priority Measures under the Quadruple Aims set out in "A Healthier Wales".

The paper will identify areas of performance:

- Subject to enhanced performance recovery or escalation meeting with colleagues in Welsh Government or NHS Wales Executive.
- Key adverse performance improvement metrics, supplemented by Exception Reports provided by operational management teams and included in the respective sections of the Integrated Quality and Performance Report, provided at Appendix 1 for reference.
- Where possible details of the key mitigating actions being taken to support patients / family as they wait for appointments or treatment for excessive waiting time periods.

Board members are asked to note the contents of this report, confirm agreement to any actions proposed, or identify any additional assurance work or actions it would request Executive colleagues to take.

2 Monitoring Board Performance

2.1 Adverse Performance Concerns

a) Unscheduled Care

BCUHB representatives meet fortnightly (individual A&E site separate meetings) with NHSE Wales colleagues in performance recovery meetings.

Performance delivery in March 2023 against the 4 hour AE/MIU target was 65.6%, at BCU level - a deterioration from the position in February 2023 of 70.3%.

There was also significant deterioration in performance in relation to ambulance handover waits. The number of over 1 hour handover delays increased to 2192 in the month, an increase of 813 on February 2023. This was the highest monthly volume of such delays in the whole of 2022/23. Comparative performance across Wales indicates BCU as worst performer in terms of overall volume of 1 hour handover delays, and YGC Hospital as being the worst hospital site against this indicator in Wales.

Whilst some infection prevention decisions have been a small contributory factor, 4hr performance for those that have attended Emergency Departments and have not been subsequently admitted has also continued to deteriorate. Spatial management within each of the 3 department's does present operational management issues and which is reflected by the substantial increase in hourly occupancy numbers. There is also a marked deterioration in 12 hour performance pan BCUHB, with the West IHC having a substantial

deterioration in 12 hr delays. During March this was owing to a level 2 outbreak that reduced bed capacity, further impacting on flow in comparison to Feb 2023.

Metric	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Performance (4hrs)	**59.8%**	**61.8%**	**60.3%**	**60.7%**	**62.9%**	**61.9%**	**64.1%**	**58.7%**	**68.5%**	**70.3%**	**65.6%**
West	68.3%	68.8%	69.1%	67.1%	66.6%	63.0%	68.1%	59.4%	68.5%	69.2%	63.4%
Centre	61.0%	64.7%	65.1%	64.2%	65.7%	65.6%	64.9%	62.6%	69.7%	72.8%	71.5%
East	48.7%	49.9%	42.6%	47.3%	55.2%	55.6%	59.3%	53.1%	67.1%	68.0%	59.8%
Attendances (BCU)	**14841**	**14261**	**14742**	**14432**	**13665**	**14695**	**13792**	**14538**	**12549**	**12209**	**14004**
West	4739	4487	4756	4651	4280	4500	4033	4276	3728	3657	4328
Centre	5529	5091	5181	5092	4794	5270	4898	5189	4407	4335	4914
East	4873	4683	4805	4689	4591	4925	4861	5073	4414	4217	4762
Over 1 hour ambulance handover delays	**1884**	**1933**	**2038**	**1898**	**1908**	**2026**	**1871**	**2125**	**1646**	**1468**	**2192**
West	526	594	662	610	620	662	592	704	372	328	615
Centre	818	812	805	867	830	844	896	816	721	679	925
East	540	527	571	421	458	520	383	605	553	461	652
Over 12 hour waits in A&E from arrival to admission or discharge	**3249**	**3124**	**3462**	**3507**	**3106**	**3178**	**2802**	**3384**	**2302**	**2057**	**2865**
West	679	741	842	844	858	873	767	1059	686	612	835
Centre	1331	1294	1327	1455	1319	1313	1227	1355	1084	930	1143
East	1239	1089	1293	1208	929	992	808	970	532	515	887

Summary of Performance at BCU and IHC site level (Source: IRIS Emergency Care System 4/5/23)

Medically fit for Discharge numbers continue to remain excessive at 300, which in essence reflects the full occupancy of a DGH, alongside the discharge profile still occurring at peak during 1700-1800hrs each day, as opposed to earlier in the day.

WAST arrivals have reduced but the data reflects an increase in delays >1hr with the majority occurring during the out of hours period. March performance has been the worst month year to date:

Recovery Actions include:

a) A clear focus on not bedding down of SDEC or assessment areas within the Emergency areas
b) As part of the IHC escalation plans, assessment areas are to be ring fenced to allow a pull from the ED's and reduce the length of stay within the Emergency departments.
c) MFFD reduction will be supported by real-time actions on STREAM when fully rolled out. This is a discharge management reporting system in implementation.
d) Enhanced escalation requirements alongside the escalation process when declined immediate release requests occur.

b) Planned Care

Elective Care / Waiting List Reduction

BCUHB undertakes Planned Care Improvement and Recovery Meetings monthly with NHS Wales' Delivery Unit colleagues. These meetings are to review the overall waiting list of the Board and the actions and subsequent progress the Board is making in reducing patient waits

in excess of 52 weeks, 104 weeks and 156 weeks wait for appointment or treatment. This is following earlier progress against delivery and recovery milestones failing to be achieved.

The Board did achieve its revised recovery trajectories for all reduction targets at the end of March 2023.

End of March - RTT	>36 Weeks	>52 Weeks	>104 Weeks	>156 weeks
BCU	57,407	35,968	9,769	3,813
West	18,191	10,678	2,396	1,023
Centre	18,828	12,118	3,089	1,256
East	20,388	13,299	4,287	1,534

Year End RTT Waiting List Cohorts (BCU RTT Monthly Return Mar 2023)

At the end of March 2023:

- The number of patients waiting in excess of 52 weeks for their 1st OP appointment was 35,968, the lowest number year to date, and a reduction of 11,443 since April 2022. BCUHB's waiting list reported 24% of the total number of patients waiting against this measure in Wales in January 2023 (as compared to the BCU population share of 22%).
- The number of patients waiting more than 104 weeks for referral to treatment was 9769, the lowest number year to date, a reduction of 8,026 since the reported position in April 2022. BCUHB's waiting list reported 28% of the total number of patients waiting in Wales against this measure in February 2023 (again versus 22% of total population).
- The number of patients all stages whose waiting time for treatment breached 156 week was 3,813. Latest information indicates that only 110 of these patients have dates for treatment. We had planned (and WG expect) all these patients to be treated by the end of June.

c) Stroke Services

The percentage of stroke patients directly admitted to an Acute Stroke Unit within 4 hours of clock start remains consistent for the latest rolling quarter at 22.5% - the target is 40%. This is an improvement on the same period 12 months ago when performance was as low as 14%.

Current actions being taken to address performance include:

- Specialist Inpatient Rehabilitation Units and Early Supported Discharge for stroke live in each IHC and reporting into SSNAP from Q1 of 2022/23. This will improve flow and reduce length of stay, freeing up capacity in the Acute Stroke Units.
- Ongoing recruitment activity, particularly across Therapy services, to improve the response at all parts of the Pathway
- Direct to CT Pathway being implemented in all acute sites by Q3
- Use of CT scan pathway proforma being reviewed and audited and awareness raising ongoing across medical teams in ED
- Project in progress to implement AI in radiology to support decision-making for stroke patients on thrombolysis and thrombectomy. This will help speed decision-making for thrombectomy referrals.

d) Diagnostic Waits

At the end of March 2023:

- The total number of patients in excess of the 8 week target waiting for their specified diagnostic is 8,119, a slight improvement (-49) on the position reported in April 2022. Performance against the 8 week target by diagnostic service type is provided below:

    - Endoscopy is not currently meeting the 8 week target. However, the overall over 8 week diagnostic endoscopy position continues to improve and has reduced by 569 patients since the beginning of the year (April 22), now reporting at 2,098. Competing challenges to this continue, due to surveillance patient demand and an increase in urgent suspected cancer (USC) demand. Additionally, there are estate risks to decontamination services that need to be addressed. Actions being taken to address these challenges include:
        - Insourcing will continue on each site to support the backlog reduction with a phased approach to reduce as we appoint staff to support a 7 day working model.
        - The new Endoscopy management system (Medilogik) is now live in two of our endoscopy units, this will support the overall performance reporting and create the ability to manage patients across BCU.

    - During 2022-23, increased activity for CT (+25.7%); MRI (+8.9%) and ultrasound (+5.3%) has been delivered, compared with pre-pandemic 2019-20 levels. Demand in each modality has increased as follows: CT (+24.4%); MRI (+9.0%) and ultrasound (+4.9%).

      The performance trend for radiology waiting times has remained broadly static in March 2023, with the number of patients waiting over 8 weeks for radiology diagnostics 4232 (-10) in the three main modalities as follows: CT 134 (+12); MRI 1119 (-224); Ultrasound 2968 (+202). Actions being taken to address performance include approval of 12 month renewal of insourcing contracts for CT / MRI and ultrasound, providing sustained additional capacity throughout 2023-24.

    - The performance trend for Neurophysiology waiting times has deteriorated in March 2023. The number of patients waiting over 8 weeks is 896, an increase of 105 from the end of February 2023 position. There are 667 consultant-led EMG breaches (+73) and 229 physiologist-led NCS breaches (+32). Waits for cardiology diagnostic tests are significant. The longest waits are for echocardiograms, and we have 1,095 patients breaching 8 weeks, with the longest wait being 42 weeks. The return of 'accommodation' on the Wrexham site and the commencement of this activity will see improvements in waiting times through 2023/24.

e) Cancer

BCUHB representatives meet monthly in Performance and Escalation Meetings with Welsh Government representatives.

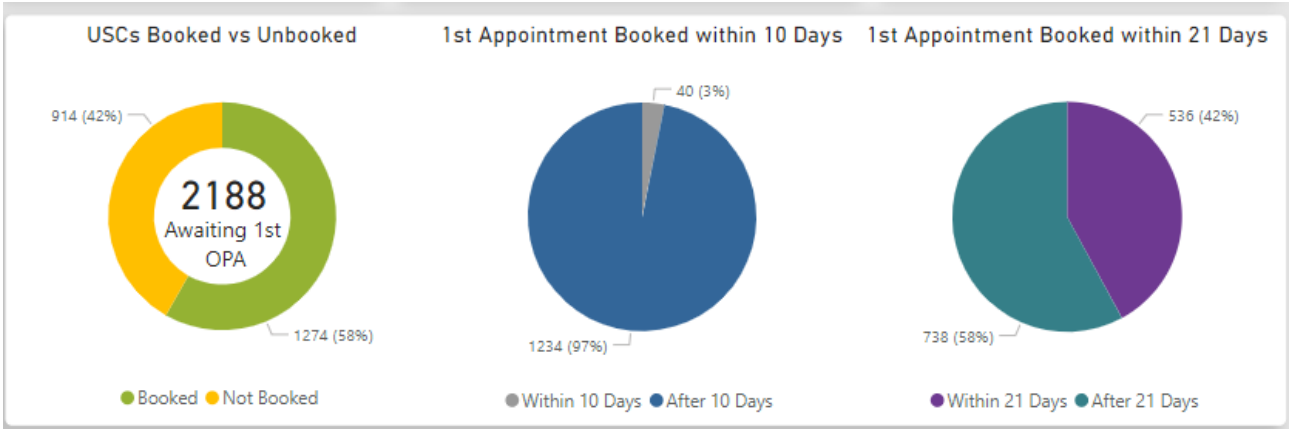
Performance has been consistently between 58% and 67% of patients treated within 62 days of suspicion of cancer since April 2022. However, performance has dropped to the lower end of this range ie below 60% in 3 of the last 4 months.

The drop in performance has been due to:

- A consistent increase in suspected cancer referrals meaning patients are not being seen within the local 10 day target for 1st appointment
- Continuing pressures in diagnostic capacity in particular in endoscopy and urology services
- Reduced dermatology capacity, in particular in the West

Actions being taken to recover performance include:

- Rebalancing of capacity to increase the percentage of USC patients seen within 10 days of referral – all specialties have been asked to amend clinic templates in line with latest 80th or 95th percentile demand in order to ensure suspected cancer patients are seen within 10 days. The snapshot below clearly shows the scale of the corrective activity needed to 're-set' first OP capacity and clear the 'backlog' to allow booking of patients within the 10 day pathway milestone.



Latest – 5/4/23 live position from IRIS, Cancer Dashboard.

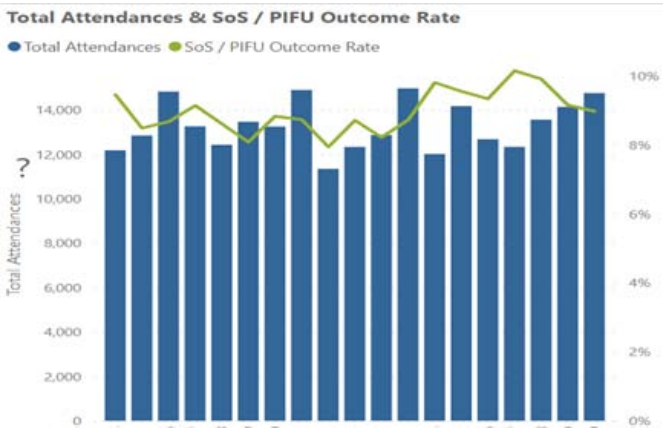
- Increased diagnostic capacity through implementation of the endoscopy business case (see separate endoscopy report) and increased prostate biopsy capacity in West and East
- Improvement work to streamline cancer pathways continues including:
  straight to scan pathway to be implemented on prostate pathway in Q1 2023/24 following recruitment to co-ordinator posts
- Case for single nurse led triage hub for colorectal referrals being developed
- Tele-dermoscopy project being led by Central IHC with support from national team

- Pathway review programme to commence in gynaecology and breast in Q1 2023/24

f) Out-Patient Follow-Up Appointments

At the end of March 2023 there were 80,322 patients whose follow-up appointment had been delayed since their clinical due date by 100%. Since April 2022 this position has increased by 24,614 patients. Latest benchmarking information (Jan 23) indicates BCUHB numbers are 32% of the total volume of such waits across Wales.

A programme of work on redesign of OP pathways to introduce Patient Initiated Follow-Up and other initiatives is underway. As of end of March 2023, the current uptake of these pathways in the 10 priority specialties across BCU has increased from 5.8% (in Nov 22) to now 9.1%.



Source Data: IRIS RTT Planned Care

Planned care teams are also increasing the virtual follow-up's (telephone/video consultations) with 23,117 patients having attended a video consultation year to date. Video Group Clinics are also being implemented and rolled out across 10 specialty areas as per Welsh Government direction. There has been approximately 172 Video Group Clinics undertaken during 2022/23.

g) Ophthalmology

The percentage of ophthalmology R1 (meaning highest priority) appointments attended which were within their clinical target date or within 25% beyond their clinical target date for February 2023 is 50.6% against a national target of 95%. The highest in year performance was 54.5% in August 2022. Latest benchmarking (Jan 23) reports the Trust's performance as 7th across all Wales Health Boards. Performance for March is not published until later this month.

h) Mental Health & Learning Disability (Adult) Services

BCUHB representatives meet Welsh Government colleagues monthly in Enhanced Performance Support meetings. Recovery trajectories are in place for 4 metrics, to achieve 80% for each metric.

The latest performance for February 2023:

- The percentage of mental health assessments undertaken within 28 days of receipt of referral - performance improved in month to 74.4% and is in line with the recovery trajectory.
- The percentage of therapeutic interventions started within 28 days following an assessment – performance has achieved target at 85.1%.
- The percentage of patients waiting less than 26 weeks to start psychological therapy remains above the target level at 89.9%
- The percentage of health board residents in receipt of secondary care services who have a valid care and treatment plan remains above target level at 86.27%.

i) Children and Adolescent Mental Health Services (CAMHS)

BCUHB representatives meet monthly Welsh Government colleagues in Enhanced Performance Support meetings.

Latest performance for February 2023:

- The percentage of mental health assessments undertaken within 28 days of receipt of referral was 57.8% - an increase of 16% on last month's performance though still slightly below the expected improvement trajectory. Additional capacity was put in place during February to recover the January 2023 position and meet the improvement trajectory for full compliance with Part 1a by end of March 2023.

- The percentage of therapeutic interventions started within 28 days following an assessment in January was 27.7% which is slightly below the expected improvement trajectory. This is still on track for delivery by the end of September 2023.

j) Primary care

The dashboard shows data around primary care performance, but there is currently no commentary on issues and actions. This will be addressed in future months.

3 Recommendation

PFIG members are asked to note the contents of this report and confirm agreement to actions proposed (including within the Exception Reports in Appendix 1), and identify any additional assurance work or actions it would like Executive colleagues to take.

Quality and Performance Report

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

Performance to March 31st 2023
Presented on 12th May 2023

Performance, Finance and Information Governance Committee

Table of Contents

Chapter 1

Quadruple Aim 2:

People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

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

- 1a: Primary and Community Care

Measures: Primary & Community Care

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21	Q1 21-22	Q2 21-22	Q3 21-22	Q4 21-22	Q1 22-23	Q2 22-23	Q3 22-23	Q4 22-23
QA 2	Primary & Community Care	Number of Urgent Primary Care Centres (UPCC) established in each Health Board footprint (i.e. both UPPC models)	Quarterly	As outlined in Health Board's Six Goals Programme Plan	3		1	1	2	2	2	3	3	6	6	3	Latest Data Reported
QA 2	Primary & Community Care	Number of new patients (children aged under 18 years) accessing NHS dental services	Quarterly	4 quarter improvement trend	3,609	New Measure for 2022-23								2,154	3,244	3,934	3,609
QA 2	Primary & Community Care	Number of new patients (adults aged 18 years and over) accessing NHS dental services	Quarterly	4 quarter improvement trend	6,078	New Measure for 2022-23								3,481	4,803	6,065	6,078
QA 2	Primary & Community Care	Number of existing patients accessing NHS dental services	Quarterly	4 quarter improvement trend	27,213	New Measure for 2022-23								34,224	37,726	35,057	27,213
QA 2	Urgent & Emergency Care	Percentage of total conveyances taken to a service other than a Type One Emergency Department	Quarterly	4 quarter improvement trend	1.96%	2.08%	2.56%	2.10%	1.95%	2.20%	2.20%	2.04%	2.15%	2.28%	2.70%	1.96%	Latest Data Reported

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	2019-20	2020-21	2021-22	2022-23	2023-24
QA 2	Primary & Community Care	Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours	Annually	100%	77.1%	41.6%	59.8%	77.1%	Latest Data Reported	

- 1b: Urgent and Emergency Care

Measures: Urgent & Emergency Care Page

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QA 2	Urgent & Emergency Care	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patients clock start time	Monthly	Most recent SSNAP UK Qtr mean (40.9%)	22.4%	10.6%	13.6%	27.2%	38.3%	32.4%	21.9%	14.7%	27.5%	25.9%	29.30%	22.2%	22.4%
QA 2	Urgent & Emergency Care	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	Monthly	95%	65.6%	54.9%	59.8%	61.8%	58.4%	60.7%	62.9%	61.9%	64.1%	58.8%	68.5%	70.3%	65.6%
QA 2	Urgent & Emergency Care	Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer, or discharge	Monthly	0	2870	3,584	3,249	3,124	3,462	3,507	3,106	3,178	2,802	3,384	2,302	2,057	2,870
QA 2	Urgent & Emergency Care	Median time (minutes) from arrival at an emergency department to triage by a clinician	Monthly	12 month reduction trend	30	43	37	34	34	27	28	27	26	32	22	24	30
QA 2	Urgent & Emergency Care	Median time (minutes) from arrival at an emergency department to assessment by a senior clinical decision maker	Monthly	12 month reduction trend	137	188	177	154	175	166	143	142	135	155	93	109	137
QA 2	Urgent & Emergency Care	Percentage of patients (aged 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	Monthly	12 month improvement trend	66.2%	72.4%	71.1%	69.3%	68.7%	67.2%	66.2%	65.8%	65.3%	64.6%	66.2%	Latest Data Reported	
QA 2	Urgent & Emergency Care	Percentage of stroke patients who receive mechanical thrombectomy	Monthly	10%	0.0%	0.0%	5.9%	1.9%	0.0%	0.0%	3.0%	2.5%	1.0%	0.0%	0.0%	2.0%	0.0%
QA 2	Urgent & Emergency Care	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Monthly	65%	44.3%	46.2%	49.7%	45.6%	42.9%	46.2%	45.5%	45.0%	44.8%	37.7%	53.2%	51.3%	44.3%
QA 2	Urgent & Emergency Care	Number of ambulance patient handovers over 1 hour	Monthly	0	2192	1749	1884	1932	2037	1898	1908	2027	1871	2125	1646	1466	2192

Narrative: Emergency Care

Performance Overview

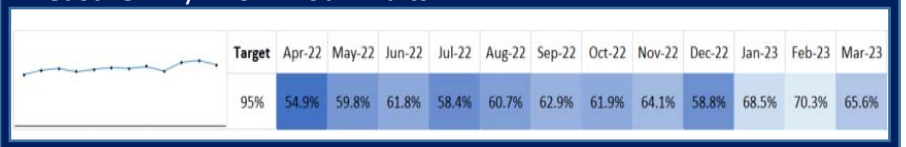
- 4hr/12hr pan BCUHB continues to deteriorate, with minimal improvements noticeable centrally around 4hr performance. Infection prevention elements have been an element of a contributory factor. 4hr performance for those that have been discharged has continued to deteriorate owing to lack of capacity with the Emergency departments which is reflected by the substantial increase in hourly occupancy numbers. There is also a marked deterioration in 12 hour performance pan BCUHB, with the West IHC having a substantial deterioration in 12 hr delays, during March this was owing to a level 2 outbreak that reduced bed capacity further impacting on flow in comparison to Feb 2023.
- Medically fit for Discharge numbers continue to remain excessive of 300 which in essence reflects the full occupancy of a DGH, alongside the discharge profile still occurring at peak during 1700-1800hrs each day.
- WAST arrivals have reduced to IHC's but the data reflects an increase in delays >1hr with the majority occurring during the out of hours period. Marchs performance has been the worst month year to date

Performance Recovery Actions Being Taken

- A clear focus on not bedding down of SDEC or assessment areas within the Emergency areas will allow for a rapid improvement on 4hr performance for those that are discharged, whilst ensuring the capacity to stream across to SDEC reducing the risk of admitting to assess.
- As part of the IHC escalation plans, assessment areas are to be ring fenced to allow a pull from the ED's and reduce the length of stay within the Emergency departments. Internal professional standards will be re launched with support from IHC Medical Directors to reduce the lost hours whilst awaiting duplicate clerking along with awaiting assessment in the ED.
- MFFD reduction will be supported by real-time actions on STREAM along with a request to IHC's to ensure senior presence on wards to allow a check and challenge with clear outcomes and MDT input.
- Ambulance handovers – A small group has been created to support immediate actions that ensure clear escalation to IHC directors when delays occur that support clear actions to assist with creating capacity to improve flow alongside escalation process when declined immediate release requests occur. A perfect day occurred on the 20th April to review conveyance/ time lost to ensure all appropriate pathways have been utilised.

Supporting very high-level Data

Measure: ED/MIU 4 Hour Waits



Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
95%	54.9%	59.8%	61.8%	58.4%	60.7%	62.9%	61.9%	64.1%	58.8%	68.5%	70.3%	65.6%

Measure: Patient ambulance handovers over 1 hour

Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0	1749	1884	1932	2037	1898	1908	2027	1871	2125	1646	1466	2192

Risks to Operational Recovery

Increasing medically fit numbers that will further impact on flow and capacity that will impact on patient safety and flow.

Infection prevention bed closures, impacting of flow whilst exposing patient and staff to increased risk due to corridor nursing.

Bedding down of assessment areas (Acute/SDEC) that will impact on alternative pathways and moves out from the ED's

Inability to release ambulances , increasing WAST Clinical safety plan, resulting in increased acuity of self presenters.

Mitigating Clinical Risk - Actions Being Taken

Senior IHC in reach to MFFD meetings to support increased check and challenge along with ensuring clear actions.

Reducing bedded down assessment areas which in turn stops corridor nursing that increases risk of cross contamination.

Amendments to hospital full protocols to remove/mitigate plans for assessment areas from Surge planning.

Narrative: Stroke

Performance

- Position held for % patients admitted to stroke unit within 4 hours. Demonstrate that the trend in activity and performance *has been significantly higher during Q2 of 2022/23.*
- *The number of patients spending 12 Hrs or more has increased, the pressure on the system is causing this with the lack of through put.*
- *Anecdotally there have been Mechanical Thrombectomy referrals (Repatriation of patients from Walton have taken place). However, the data for March 2023 has not been uploaded from SSNAP yet. Overall, however, the trend is very low.*

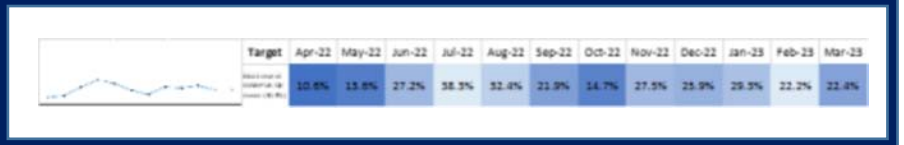
Actions to address under performance

These need to be intelligent and believable, e.g. provide supporting evidence (attach evidence) or at least reference other work and documents that contain the plan and details that support your actions. Please include a forecast – even if this has margins of error and/or is a work in progress.

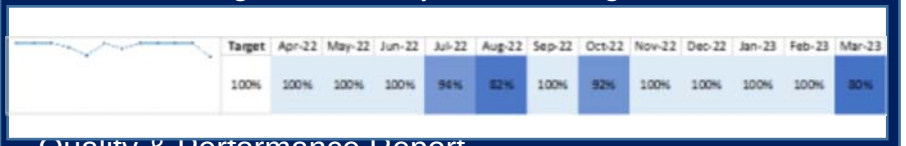
- Specialist Inpatient Rehabilitation Units and Early Supported Discharge for stroke live in each IHC and reporting into SSNAP fromQ1 of 2022/23. This will improve flow and reduce LoS, freeing up capacity in the Acute Stroke Units.
- Ongoing recruitment activity, particularly across Therapy services, to improve the response at all parts of the Pathway
- Direct to CT Pathway being implemented in all acute sites by Q3
- Use of CT scan pathway proforma being reviewed and audited and awareness raising ongoing across medical teams in ED
- Project in progress to implement AI in radiology to support decision-making for stroke patients on thrombolysis and Thrombectomy – using Brainomix's e-stroke product. This will help speed decision-making for Thrombectomy referrals
- Review of 2023/24 action plans under way across Each IHC to address improvements against the outcome of the Business Case

Supporting very high-level Data

Measure: Stroke unit 4 hour direct admissions



Measure: Percentage of Thrombolysis Rates for Eligible Patients



Risks and Mitigations

- Staffing levels may not be achievable across the Pathway – ongoing recruitment activities in progress
- Overall pressure on ED will have adverse impact on timely decision-making on Thrombectomy – this can be mitigated through ongoing ring fencing of stroke beds, direct to CT Pathway in ED, and awareness of staff in ED for stroke "walk-ins"
- New national stroke guidelines include relaxation of the 6 hour window for mechanical Thrombectomy. This may enable more referrals, confirmation on assurance compliance with this guidance during May across all sites.

- 1c: Elective and Planned Care

Measures: Elective Planned Care page

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QA 2	Elective & Planned Care	Percentage of patients starting their first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	Monthly	Improvement trajectory towards a national target of 80% by 2026	58.0%	67.2%	62.3%	63.3%	66.1%	61.7%	61.8%	62.3%	59.6%	64.8%	59.8%	58.0%	Latest Data Reported
QA 2	Elective & Planned Care	Number of patients waiting over 8 weeks for a diagnostic endoscopy	Monthly	Improvement trajectory towards a national target of zero by Spring 2024	2098	2,667	2,563	2,463	2,306	2,260	2,250	1,964	1,745	1,995	2,093	2,136	2,098
QA 2	Elective & Planned Care	Number of patients waiting more than 8 weeks for a specified diagnostic	Monthly	0	8119	8,168	8,761	8,848	9,078	9,776	9,464	8,068	8,034	9,377	9,333	8,057	8,119
QA 2	Elective & Planned Care	Number of patients waiting more than 14 weeks for a specified therapy	Monthly	12 month reduction trend towards zero by spring 2024	2192	6,364	6,682	6,602	6,151	5,837	5,450	5,087	4,271	3,651	2,387	2,663	2,192
QA 2	Elective & Planned Care	Number of patients waiting over 52 weeks for a new outpatient appointment	Monthly	Improvement trajectory towards eliminating over 52 weeks by 31.12.22	12780	24,223	24,405	24,641	25,379	26,515	26,475	25,419	23,704	21,606	18,327	15,423	12,780
QA 2	Elective & Planned Care	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Monthly	Improvement trajectory towards a reduction of 30% by 31.03.23 against a baseline of 31.03.21	80322	55,708	56,714	59,128	61,480	64,371	63,286	64,927	65,834	70,082	75,926	77,334	80,322
QA 2	Elective & Planned Care	Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	Monthly	95%	50.6%	47.4%	50.0%	54.0%	54.0%	54.5%	52.2%	52.5%	51.0%	55.2%	49.4%	50.6%	Awaiting Data
QA 2	Elective & Planned Care	Number of patients waiting more than 104 weeks for referral to treatment	Monthly	Improvement trajectory towards a national target of zero by 2024	9769	17795	16824	15943	15301	15392	14677	13922	12947	12667	12012	11011	9769
QA 2	Elective & Planned Care	Number of patients waiting more than 36 weeks for referral to treatment	Monthly	Improvement trajectory towards a national target of zero by 2026	56754	61685	62866	63273	64871	65959	64788	64070	63356	62626	62728	62045	56754
QA 2	Elective & Planned Care	Percentage of patients waiting less than 26 weeks for referral to treatment	Monthly	Improvement trajectory towards a national target of 95% by 2026	57.7%	50.5%	50.8%	47.0%	54.0%	46.6%	46.9%	53.4%	53.7%	52.7%	53.0%	54.79%	57.71%

Narrative: Referral to Treatment

Performance

Against the RTT standards, Planned Care has been focusing on the longest waiting patients on an Open pathway and monitoring this trend against the ministerial priorities. The number of patients waiting have reduced to the current position

Stage 1 >52 Weeks position is 3,881 (April 2022 – 53,439)

All Stages >104 Weeks position is 10,141 (April 2022 - 40,971)

All Stages >156 Weeks position is 12,394 (April 2022 – 17,934)

Actions to address under performance

An initial trajectory against the above ministerial priorities was completed, with forecasts developed. Planned Care have been monitored against these forecasts by Welsh Government and NHS Wales on a monthly basis.

- Continued Actions include;
- Outpatient Programme
- Additional Capacity through internal mechanisms and working with alternative providers.
- Robust Performance Management linked to the Accountability framework.
- Forecasted position against the ministerial priorities;

  Stage 1 >52 Weeks position is 13,480

  All Stages >104 Weeks position is 10,379

  All Stages >156 Weeks position is 4,169

Supporting very high-level Data

Measure: No. of patients waiting more than 36 wks for referral to treatment

Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	61685	62866	63273	64871	65959	64788	64070	63356	62626	62728	62045	56754

Quality & Performance Report
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Risks and Mitigations

- Risk: Patients – Continue to wait, whilst their condition deteriorates, mitigation – additional capacity being secured for patients to be seen and treated
- Risk: Staffing – PAAR Rate continuing post 1st April, mitigation – Insourcing/Outsourcing

Narrative: Follow-up Outpatients Waiting List

Performance

We are on boarding pathways across many specialties such as See on Symptoms (SOS) and Patient Initiated Follow-up (PIFU). As of end of March 23, the current uptake of these pathways in the 10 priority specialties across BCU has increased from 5.8% (in Nov 22) to now 9.1%.

Planned care is also increasing the virtual follow-up's (telephone/video consultations) with 23,117 patients attended a video consultation with 42 different specialties having this available with more coming on-board towards the end of the Financial Year. Video Group Clinics are also being implemented and rolled out across 10 specialty areas as per Welsh Government. There has been approx. 172 Video Group Clinics undertaken during 2022/23.

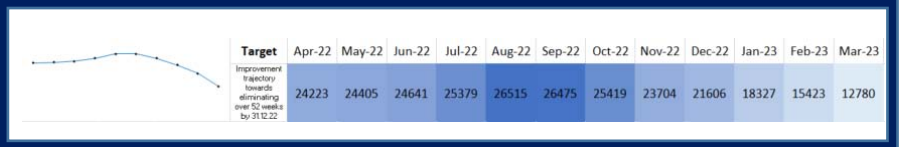
Actions to address under performance

The Planned Care Team have presented the use of SOS/PIFU pathways at BCU RTC workshops to support with spread and adoption as well as regular agenda items on Senior Clinician Meetings across the three sites. There is monthly local Steering Group meetings for the Work stream 2 programme with both operational and clinical membership from specialties.
Specialty teams are reviewing how they can place existing follow up patients (pre SOS/PIFU roll-out) onto an SOS or PIFU pathway to support with waiting lists initiatives. Case studies being produced to support wider adoption of this.

Letter to be sent out to all clinical teams with narrative and guidance with how to implement Virtual /Video appointments.
Case studies from both Ophthalmology and CAMHS have been completed and shared at BCU wide Virtual steering group to support with wider adoption.
Team were asked to present increasing virtual activity at the All Wales TEC-Cymru Programme board.
Business case submitted to TEC-Cymru April 23 to apply for funding to support the project.

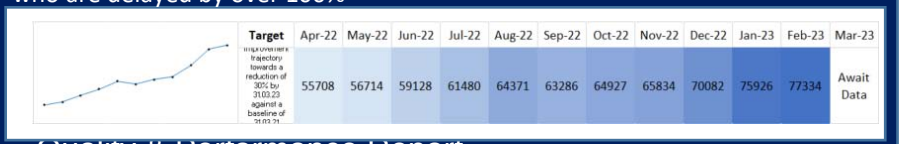
Supporting very high-level Data

Measure: No. of patients waiting over 52 wks for a new outpatient appointment



Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Improvement trajectory towards eliminating over 52 weeks by 31.12.22	24223	24405	24641	25379	26515	26475	25419	23704	21606	18327	15423	12780

Measure: No. of patients waiting for a follow-up outpatient appointment who are delayed by over 100%



Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Improvement trajectory towards a reduction of 30% by 31.03.23 against a baseline of [illegible]	55708	56714	59128	61480	64371	63286	64927	65834	70082	75926	77334	Await Data

Risks and Mitigations

Clinical Engagement is vital and requires frequent senior level clinical leadership to encourage utilisation of both pathways.
SOP has been completed and online module under construction to support new and existing staff with how to adopt the pathways where clinically appropriate
Clinical teams not having appropriate equipment and capacity to deliver Video consultations. Revenue funding available from approved business case to support with web-cams and headsets.
Outcomes – data is reliant on the correct outcome/usage of pathways being recorded accurately within WPAS.

Narrative: Cancer

Performance

Performance has been consistently between 58 and 67% of patients treated within 62 days of suspicion of cancer since April 2022. However performance has dropped to the lower end of this range ie below 60% in 3 of the last 4 months.

The drop in performance has been due to:

- A consistent increase in suspected cancer referrals meaning patients are not seen within the local 10 day target for 1st appointment
- Continuing pressures in diagnostic capacity in particular in endoscopy and urology services
- Reduced dermatology capacity in particular in the West

Actions to address under performance

Rebalancing of capacity to increase the percentage of USC patients seen within 10 days of referral – all specialties have been asked to amend clinic templates in line with latest 80th or 95th percentile demand in order to ensure suspected cancer patients are seen within 10 days

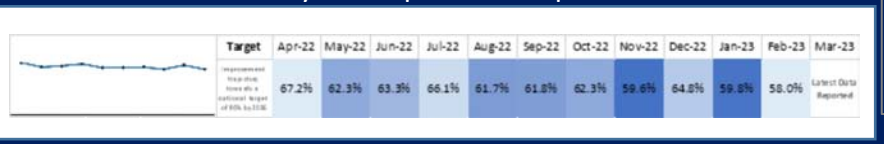
Increased diagnostic capacity through implementation of the endoscopy business case (see separate endoscopy report) and increased prostate biopsy capacity in West and East

Improvement work to streamline cancer pathways continues including:

- Straight to scan pathway to be implemented on prostate pathway in Q1 2023/24 following recruitment to co-ordinator posts
- Case for single nurse led triage hub for colorectal referrals being developed
- Teledermoscopy project being led by Central IHC with support from national team
- Pathway review programme to commence in gynaecology and breast in Q1 2023/24

Supporting very high-level Data

Measure: % of patients starting their first definitive cancer treatment within 62 days from point of suspicion



Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	67.2%	62.3%	63.3%	66.1%	61.7%	61.8%	62.3%	59.6%	64.8%	59.8%	58.0%	Latest Data Reported

Risks and Mitigations

The Cancer Partnership Board (clinical lead posts) remains unfunded from April 2023 onwards leading to a risk of losing momentum on pathway improvement work. Funding bid submitted as part of annual planning process

Clinical oncology consultant vacancies partially mitigated with locums and new substantive consultant to commence in Q2 2023/24. Discussions ongoing with external providers in North West England to ensure continuity of service

Reduced ENT cancer surgery capacity for a period of 6 months. Discussions ongoing with external providers to ensure continuity of service

Narrative: Diagnostic Waits, Radiology & Neurophysiology

Performance

Radiology: During 2022-23, increased activity for CT (25.7%); MRI (8.9%) and ultrasound (+5.3%) has been delivered, compared with pre-pandemic 2019-20 levels. Demand in each modality is as follows: CT (+24.4%); MRI (+9.0%) and ultrasound (+4.9%). The performance trend for Radiology waiting times has remained broadly static in March 2023, with the number of patients waiting over 8 weeks for radiology diagnostics 4232 (-10) in the three main modalities as follows: CT 134 (+12); MRI 1119 (-224); Ultrasound 2968 (+202). Health Board weekend insourcing (through SHS) has led to an increase in demand from this source of 574 requests since the last report, as follows: CT 106; MRI 98; Ultrasound 161; X-ray 148; Others 61.

The performance trend for Neurophysiology waiting times has deteriorated in March 2023. : The number of patients waiting over 8 weeks is 896, an increase of 105 from the end of February 2023 position. There are 667 consultant-led EMG breaches (+73) and 229 physiologist-led NCS breaches (+32).

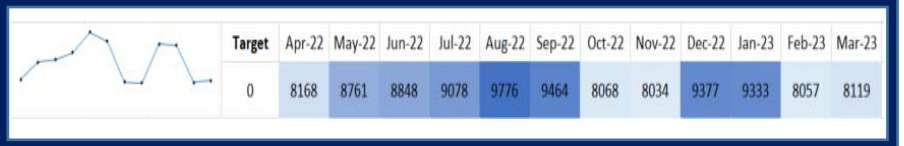
Actions to address under performance

The Radiology IMTP proposal for full 12 month renewal of insourcing contracts for CT / MRI and ultrasound has been supported, providing sustained additional capacity throughout 2023-24. Initial forecasting provides a good level of assurance for sufficient capacity with respect to CT and MRI modalities to achieve the 8 week zero breach target. A lower level of assurance exists for ultrasound, principally due to lower than required staffing levels, in spite of access to insourcing solutions. Higher than forecast demand also is a risk for all three modalities. A weekly waiting list management group will prioritise the elimination the longest waiting patients for each modality, with interim quarterly targets established for 2023-24.

Neurophysiology: Wrexham accommodation for neurophysiology has now been handed over at the end of March 2023. Preparation of this area for clinical activity is an immediate priority. Physiologist staffing levels remain the primary concern. Recent locum appointment did not progress, limiting expected capacity increases. Recruitment to the two vacant posts progressing, with interviews to be held in April. A tender for insourced staffing support has been initiated. Coupled with locum and likely new appointments, these actions will create additional capacity to clear the backlog in 2023-24 and meet likely pent up demand.

Supporting very high-level Data

Measure: No. of patients waiting over 8 weeks for a diagnostic



Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0	8168	8761	8848	9078	9776	9464	8068	8034	9377	9333	8057	8119

Risks and Mitigations

Radiology: In spite of sustained record activity, increasing demand means there is a risk that overall capacity will be insufficient to meet demand in 2023-24, particularly in ultrasound. All current solutions will be maintained throughout 2023-24 as a minimum with identification of additional capacity a priority for the team.

Neurophysiology: Recruitment to vacant posts remains the main risk, with other actions set to completed by end Q2 2023-24..

Narrative: Diagnostic Waits, Endoscopy

Performance

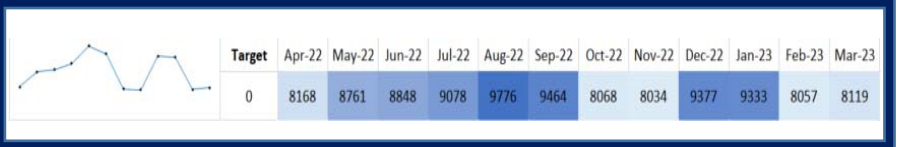
Endoscopy are not currently meeting the 8 week target however, the overall over 8 week diagnostic endoscopy position continues to improve and year end position for over 8 week breaches was 1654. The aim is to ensure the ministerial target is met by the end March 2024.

Actions to address under performance

- Insourcing will continue on each site to support the backlog reduction with a phased approach to reduce as we appoint staff to support a 7 day working model.
- The new Endoscopy management system (Medilogik) is now live in two of our endoscopy units, this will support the overall performance reporting and create the ability to manage patients across BCU.
- Our key performance indicators for endoscopy continue to be measured to ensure best utilisation and efficiency of the endoscopy lists.
- The endoscopy Demand & Capacity model has been refreshed and submitted to the National Endoscopy programme team. Work continues to ensure the solutions within this are met.
- Validation of waiting lists to ensure accuracy of lists is ongoing.

Supporting very high-level Data

Measure: No. of patients waiting over 8 weeks for a diagnostic



Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0	8168	8761	8848	9078	9776	9464	8068	8034	9377	9333	8057	8119

Measure: No. of patients waiting over 8 weeks for a diagnostic endoscopy

Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Improvement trajectory towards a national target of zero by Spring 2024	2667	2563	2463	2306	2260	2250	1964	1745	1995	2093	2136	2098

Risks and Mitigations

Risk

- There are estates risks in relation to decontamination facilities on two of our sites.
- Remaining posts as part of the endoscopy business case need final approval to ensure a 7 day in-house model can be achieved.

Mitigations

- Solutions identified for decontamination services, capital investment required.
- Continuation of insourcing required as a phased approach to ensure weekend activity continues until substantive recruitment is completed.

Narrative: Cardiology

Performance

We are unable achieve the eight-week diagnostic target based on the current mismatch in capacity and referral demand. The current shortage of cardiac physiologists is a UK-wide problem, and is wider than North Wales. Demands on cardiac services were building pre-COVID in part due to an ageing population and the increase in conditions such as heart failure and atrial fibrillation, and also because many treatment pathways now include the requirement for cardiac investigations. This rising demand had been predicted and at the last formal manpower review of cardiac physiology in 2006 a significant uplift in staff had been recommended but had not taken place.

The longest waits are for echocardiograms, and we have 1089 patients breaching, with the longest wait being 39 weeks. Following the West data migration, surveillance patients are being misreported on referral to treatment (RTT) waiting lists, which is inflating figures.

Actions to address under performance

- The service is undergoing demand and capacity modelling for future service provision.
- We are expanding our physiologist led pathways in both community and secondary care.
- Short-term utilisation of locum staff.
- The implementation of the heart failure business case will support several areas of the pathway.
- Ongoing validation to resolve data issues, and by end of April, we will be at 30 weeks wait for echocardiograms.

Supporting very high-level Data

Measure: tbc

No national measure here – being developed locally

Risks and Mitigations

Risk –
A continued increase in referrals for cardiac diagnostics and this delays timely assessment.
Known national workforce recruitment challenges and no funding agreed to over recruit to for fill all-Wales cardiac physiology plan.
Challenges to recruit new staff.

Mitigation-
Ongoing pathway work with the introduction of NT-proBNP blood test to ensure appropriate ordering of echocardiograms.
The departments are booking guided by clinical need.
Operational teams monitor the waiting list closely and work with clinicians to manage patient risk.
International posts supported.

Narrative: Eye Care

Performance

A. Hospital Capacity-Gaps (Vacancies) trends. Expanded Integrated pathway, redressing 20% Primary care capacity gap.

B. Data Completeness and quality modelling/forecasting/planning/delivery and performance modelling impacts.

C. ↓ Resources (staffing and estates) impact on capacity to deliver performance.

D. National Digital programme "Go Live" delay. (Key enabler of performance improvement and Integrated Pathway expansion).

E. Clinical and Operational Leadership vacancy and conflicting demand impact on leadership for change planning and delivery of pathways that deliver performance improvement

Actions to address under performance

A. Ophthalmology Teams progressing 100% Pre-Covid capacity delivery plans. Integrated Teams progressing Transformational pathway delivery.

B. Ophthalmology Area Teams to redress Clinical Condition data gaps to tolerance of ≤300 null entries by close of November 2022. Target reset to April 2023 due to Administration capacity gaps. (Report attached)

C. Capacity recovery from Cataract Outsourcing (600 Routine Patients/month) and site action to deliver of ≥5 complex patients/theatre session "initial phase" target

D. Expand BCU Digital pre-mobilisation to include Glaucoma and Cataract: to ensure Go Live readiness when National Programme functional. BCU Digital Team to test concept/implement "interim" Local Solution for Optometry Diagnostic Integrated Pathways

E. BCU Medical Directors Office progressing Clinical Lead recruitment and role review solutions.

Supporting very high-level Data

Measure: % of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date

Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
95%	47.4%	50.0%	54.0%	54.0%	54.5%	52.2%	52.5%	51.0%	55.2%	49.4%	50.6%	Await Data

Quality & Performance Report
Performance, Finance and Information Governance Committee

Risks and Mitigations

Organisational and Service User Risks from delayed access to care from:-
A. Clinician capacity gaps**. Mitigation**: *Expanded number of Primary Care partners to close of March 2023. Network Gap Analysis against National Pathways to inform options.
B. Admin capacity impact on data redress and Pathway delivery. Mitigation: Fixed term posts pending option-appraisal.
C. Estates impact on theatre utilisation. Mitigation: Longer-term Regional Treatment Centres (2028). Interim: Outsourcing
D. Delayed Integrated Pathway delivery with Primary Care Optometry. Mitigation: Interim local Digital solutions Q4, 2022
E. Reduced engagement and delivery. Mitigation: Interim clinical leadership support from Office of Medical Director

- 1d: Child and Adolescent Mental Health Services (CAMHS)

Measures: Children and Adolescent Mental Health Services

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QA 2	CAMHS	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	Monthly	80%	100.0%	100.0%	50.0%	66.7%	100.0%	100.0%	100.0%	50.0%	80.0%	100.0%	50.0%	100%	Latest Data Reported
QA 2	CAMHS	Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	Monthly	80%	57.8%	25.0%	26.1%	24.3%	35.1%	39.8%	26.1%	38.5%	47.0%	52.3%	41.7%	57.8%	Latest Data Reported
QA 2	CAMHS	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged under 18 years	Monthly	80%	27.7%	18.2%	30.8%	20.1%	46.3%	26.5%	22.9%	26.9%	20.5%	29.0%	17.9%	27.7%	Latest Data Reported
QA 2	CAMHS	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	Monthly	90%	97.9%	93.3%	94.6%	89.2%	94.1%	93.0%	95.0%	93.3%	94.6%	91.8%	92.4%	97.9%	Latest Data Reported
QA 2	CAMHS	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Monthly	80%	34.3%	43.0%	45.8%	46.3%	44.2%	41.2%	40.1%	39.6%	36.7%	33.4%	30.8%	34.3%	Latest Data Reported

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	2019-20	2020-21	2021-22	2022-23	2023-24
QA 2	CAMHS	Rate of hospital admissions with any mention of intentional self-harm for children and young people (aged 10-24 years) per 1,000 population	Annually	Annual reduction	6	5	5	6	Latest Data Reported	

Narrative: Children & Adolescent Mental Health Service

Performance

February position for delivery of Mental Health Measure Part 1a for assessment improved, with further 37% reduction in numbers waiting over 28 days. Ongoing improvement for year end in total numbers waiting over 28 days for assessment with noted challenges around MHM compliance being based on in month attendances.

Mental Health Measure Part 1b on track for delivery end September 2023. Reduction in overall numbers waiting over 28 days continues in line with trajectory

Trend in compliance for SCAMHS variable due to reduction in staffing for allocation of care coordination due to staff vacancies.

MHM Part 2 compliance remains above target.

Actions to address under performance

Enhanced performance monitoring meetings at Integrated Health Care (IHC) level continue at a senior level with DU support fortnightly

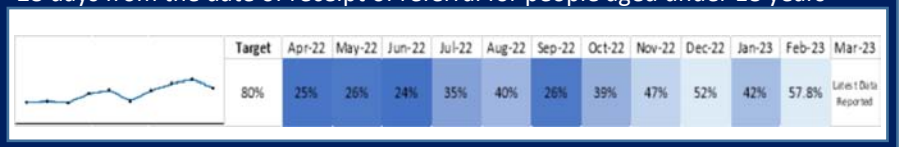
Review of efficiencies across the service to reduce DNA / late notice cancellations / N:R rates and implementation of patient initiated follow up to support improved throughput across teams.

Outsourcing to external provider continues with additional revised offer for face to face activity for complex cases supporting increased allocation.

Trajectories and further improvement planning for delivery of all target measures 2023/24 are under continuous review in IHC's for further assurance

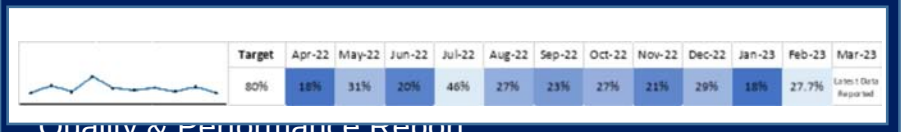
Supporting very high-level Data

Measure: % of MH assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years



	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	80%	25%	26%	24%	35%	40%	26%	39%	47%	52%	42%	57.8%	Latest Data Reported

Measure: % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged under 18 years



	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	80%	18%	31%	20%	46%	27%	23%	27%	21%	29%	18%	27.7%	Latest Data Reported

Risks and Mitigations

Workforce challenges with further reduced capacity due to 20% vacancy factor and difficulties in recruiting. Recruitment campaign ongoing supported by W&OD. Development of CAMHS workforce plan for sustainable workforce, working with BCUHB W&OD Associate Director and Mental Health Workforce Leads and service linked with HEIW around Workforce Development and Strategy Implementation.

Risk of further increase in demand, along with higher acuity and complexity of patients seen within caseloads. Risk that private provider face to face capacity does not meet demand of required services. Pathway development ongoing in early intervention and prevention, including review of Multi-Agency working across to support universal services.

- 1e: Adult Mental Health Services

Measures: Adults Mental Health Services

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QA 2	Adult MHS	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital between 09:00 and 21:00 hours that have received a gate-keeping assessment by the CRHT service prior to admission	Monthly	95%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Latest Data Reported
QA 2	Adult MHS	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital who have not received a gate keeping assessment by the CRHTS that have received a follow up assessment by the CRHTS within 24 hours of admission	Monthly	100%	100.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Latest Data Reported
QA 2	Adult MHS	Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	Monthly	80%	74.4%	54.5%	62.5%	69.5%	75.2%	77.1%	66.8%	72.2%	70.8%	71.9%	65.5%	74.4%	Latest Data Reported
QA 2	Adult MHS	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults aged 18 years and over	Monthly	80%	85.1%	77.8%	78.5%	82.2%	81.2%	72.9%	71.8%	73.4%	76.3%	80.9%	72.5%	85.1%	Latest Data Reported
QA 2	Adult MHS	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Monthly	80%	89.9%	69.6%	64.4%	74.6%	79.4%	88.0%	93.7%	94.4%	89.8%	93.8%	80.3%	89.9%	Latest Data Reporte
QA 2	Adult MHS	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	Monthly	90%	86.3%	86.5%	86.7%	83.2%	81.7%	84.3%	84.2%	84.7%	83.8%	82.0%	83.6%	86.27%	Latest Data Reported

Narrative: Mental Health Measure

Performance

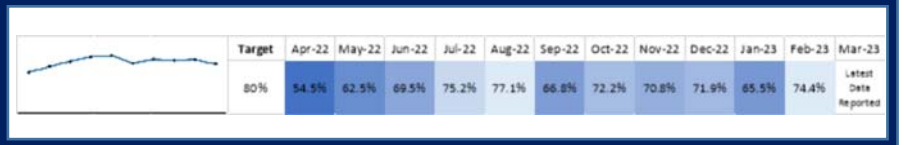
Our performance trend is impacted by a number of contributing factors which we monitor routinely as part of our service level delivery. Our demand into the Mental Health Measure (MHM) part 1a, although relatively static in terms of overall numbers, is subject to a number of peaks in year (Quarter 1 and Quarter 3) and on the acuity of need. Our performance is improving in line with forecast trajectories aiming to reach compliance by the end of March 2023. Our demand through the MHM is not the entirety of referrals through our Community Mental Health Teams (CMHT), as we take into consideration the entire demand across services to ensure a whole system understanding. Over the last 2 years we have received on average 1107 referrals per month coming through our MHM routes, but the number of referrals dealt with by our CMHTs is an average of 3138 for the same period. We are currently looking at the level of acuity and the impact this has on conversion into treatment pathways, plus the effect of new initiatives which will impact on our performance e.g. service redesign work and 111 press 2 service provision.

Actions to address under performance

As part of our response to the ministerial priorities for 24/25 a focus for the Division is service change to improve access, reduce waiting times and redesign of our Local Primary Mental Health Support Services (LPMHSS). A workshop was held in March 2023, with key leads across the division to look at short term interim solutions along with the longer term service redesign options/models. When a shortlist of options is agreed we will work with our partners and stakeholders to refine these ensuring effective engagement and direction. These solutions will include a review of systems and processes across our teams to ensure appropriate, consistent and equitable ways of working and will link in with existing work streams for the delivery of crisis care services including 111 press 2 to ensure we have a whole system approach. Work has begun to rationalise existing administrative processes across the CMHTs to ensure we have removed any variation in practice and Standard Operating Procedures are being developed and agreed for the division as a whole. Data cleansing and rationalisation of processes within the SharePoint system has begun, which will support the piloting of the Welsh Community Care Information System (WCCIS).

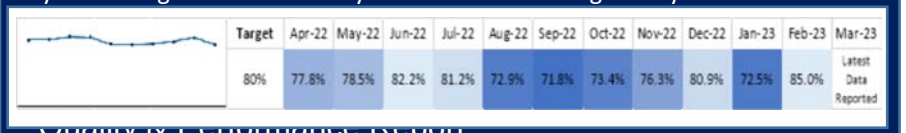
Supporting very high-level Data

Measure: % of MH assessments undertaken within (up to & including) 28 days from the date of receipt of referral for adults aged 18 and over



	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	80%	54.5%	62.5%	69.5%	75.2%	77.1%	66.8%	72.2%	70.8%	71.9%	65.5%	74.4%	Latest Data Reported

Measure: % of therapeutic interventions started (up to & including) 28 days following an assessment by LPMHSS for adults aged 18 years and over



	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
	80%	77.8%	78.5%	82.2%	81.2%	72.9%	71.8%	73.4%	76.3%	80.9%	72.5%	85.0%	Latest Data Reported

Quality & Performance Report
Performance, Finance and Information Governance Committee

Risks and Mitigations

Staffing remains our biggest risk for the delivery of effective and timely care to our service users. Whilst there is risk across our teams the level of risk varies and at present Denbighshire, Anglesey and Conwy are experiencing the greater pressures. We continue to pursue the vacancies within our current establishment, continuing the Just R Marketing campaign, but as noted above the work being undertaken to look at service redesign will impact on how our current staffing is utilised. We will, alongside our internal service redesign, be reviewing our commissioned services to ensure we have robust contractual agreements that compliment and enhance our core services and work with our partners to ensure they form part of our whole system approach.

Chapter 2

Quadruple Aim 3:

The health and social care workforce in Wales is motivated and sustainable

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

- 2a: Workforce

Measures: Motivated & Sustainable Workforce

QA	Theme	Measure	Reporting Frequency	Target	Latest Position	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QA 3	Motivated and Sustainable Workforce	Agency spend as a percentage of the total pay bill	Monthly	12 month reduction trend	7.7%	6.1%	6.8%	7.1%	7.2%	6.8%	6.5%	8.3%	8.4%	8.4%	8.0%	6.7%	7.7%
QA 3	Motivated and Sustainable Workforce	Percentage of sickness absence rate of staff	Monthly	12 month reduction trend	6.0%	6.8%	5.7%	6.4%	7.2%	6.1%	5.6%	6.3%	6.2%	7.3%	6.2%	5.5%	6.0%
QA 3	Motivated and Sustainable Workforce	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	Monthly	85%	87.8%	85.0%	84.7%	84.8%	84.8%	85.5%	86.2%	86.7%	86.7%	86.6%	87.1%	87.3%	87.80%
QA 3	Motivated and Sustainable Workforce	Percentage headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including doctors and dentists in training)	Monthly	85%	73.9%	65.5%	65.3%	66.2%	65.3%	66.5%	67.7%	69.7%	71.0%	71.6%	72.5%	73.0%	73.9%

Narrative: Sickness Absence

Performance

Monthly Sickness has increased 0.50% since Feb-23 to 6.2%. Rolling Sickness has decreased 0.08% since Feb-23 to 6.28%. Non-Covid Monthly Sickness has increased 0.16% since Feb-23. Covid Monthly Sickness has increased 0.34% since Feb-23. Long Term Monthly Sickness has increased 0.01% since Feb-23.
The Average Length of Sickness Absence during 31-Mar-22 - 31-Mar-23 is 14.0 days (14.1 Feb 23).
As at the end of March there were 1270 open sickness absences (1177 Feb 23). There are 558 long term open sickness absences as at 31-Mar-23. S10 Anxiety/stress/depression/other psychiatric illnesses was the Highest Sickness Reason for Absence During Mar-23 with 7,663 FTE Days Lost. This equates to 23.4% of all Sickness Absence Reasons. Estates & Ancillary remain having the highest sickness rate of 8.79% (8.14% Feb 23).

Actions to address under performance

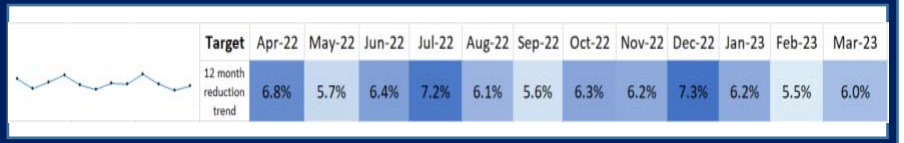
Support for managers with long-term absence, regarding meetings, letters and guidance on policy along with delivery of attendance management training. Targeted interventions for those with the highest sickness rate.

Managing Attendance Training provided.

Psychological, Emotional and well-being support remains in place and promoted to staff.

Supporting very high-level Data

Measure: % sickness absence rate of staff



	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
12 month reduction trend		6.8%	5.7%	6.4%	7.2%	6.1%	5.6%	6.3%	6.2%	7.3%	6.2%	5.5%	6.0%

Risks and Mitigations

Mitigation has included reviewing the short-term frequent absences to ensure that Return to Work meetings are held after every absence and that the underlying reasons for absence are taken into account. Where staff need support, they are referred to the occupational health department. Adjusted duties are also considered to mitigate short term absence turning into longer term absence.

Narrative: Mandatory Training

Performance

Mandatory training at level 1 currently illustrates a compliance of 87.8%, an increase of 0.4% on last month's figure and remaining above the national target of 85%.

Level 1 training has continued to rise by 0.1% to 0.4% above the national target for eight consecutive months.

Training at level 2 is currently showing a compliance figure of 81% illustrating a further significant increase from last month This has continued to increase by 0.3% to 0.4% each month through both quarter 3 and quarter 4.

Actions to address under performance

April implemented the first merge of Clinical and Non-clinical Induction/Orientation which included a program to include both Manual Handling & Violence Training, to date there has been full attendance within the first two sessions delivered.

There is still a requirement for a review of Manual Handling training as currently there remains a waiting list for people handling courses.

Manual Handling compliance along with ''Did not attend ' figures continues to be closely monitored [two weekly].

Supporting very high-level Data

Measure: % compliance for all completed L1 competencies of the Core skills and Training Framework by Organisation

Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
85%	85.0%	84.7%	84.8%	84.8%	85.5%	86.2%	86.7%	86.7%	86.6%	87.1%	87.3%	87.8%

Risks and Mitigations

We may notice a marginal decrease in compliance for Mandatory training in April 2023 as the organisation has recently mandated the Welsh Language Standards requirement for all staff to complete the Welsh Language Awareness module which has been attached as a competency to all staff.

Level 2 of Manual handling is currently reported at 54%, Which remains the same as the previous month.

Narrative: PADR

Performance

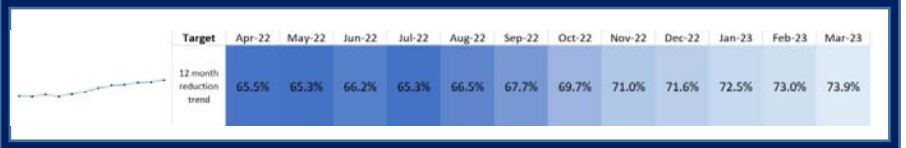
PADR Compliance has once again seen an increase in March up to 73.9%. This is in comparison to 66.7% back in March 2022 which is over a 7% increase in organisational compliance compared to this time last year.
Organisational Compliance has seen a month on month increase since August 2022, highlighting that the work undertaken by the local Pay Progression group to implement the National Pay Progression Policy is driving an increase in compliance.

Actions to address under performance

May will see a series of Stronger Together information events to engage key stakeholders across the organisation in various workstreams. The Personal contribution workstream as part of the Stronger Together Programme will form part of the sessions where next steps will include a review of the PADR process to ensure any improvements/adaptations provide the best experience for individual and teams to develop and perform to the best of their abilities.

Supporting very high-level Data

Measure: % headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (including Doctors and dentist in training)



	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
12 month reduction trend		65.5%	65.3%	66.2%	65.3%	66.5%	67.7%	69.7%	71.0%	71.6%	72.5%	73.0%	73.9%

Risks and Mitigations

Operational pressures may continue to impact negatively on the capacity to carry out PADRs. On-going conversations continue to take place through Integrated Health Communities Governance structures to monitor PADR compliance

Further Information

Quality & Performance Report
Betsi Cadwaladr University Performance, Finance and Information Governance Committee

Further information is available from the office of the Director of Performance for further details regarding this report. And 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

Teitl adroddiad: ***Report title:***	Business Case for a Community Complex Conditions Service			
Adrodd i: ***Report to:***	PFIG Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The committee is asked to consider a Business Case for a Community Complex Conditions Service, integrating Long Covid, CFS/ME, Breathing Pattern Disorders, FAs and PPS service under one umbrella. The committee is asked to note that recurrent funding for option 4 (the Community Complex Conditions Service) has been confirmed by Welsh Government.			
Argymhellion: ***Recommendations:***	The committee is asked to support Option 4. This option will establish a Community Complex Conditions Service in BCUHB, integrating Long COVID, Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Breathing Pattern Disorders, Persistent Physical Symptoms (PPS), and Frequent Attenders (FA) in order to improve patient outcomes, provide sustainability and address current and future demand for services and gaps in service provision			
Arweinydd Gweithredol: ***Executive Lead:***	Gareth Evans, Acting Executive Director Therapies & Health Science			
Awdur yr Adroddiad: ***Report Author:***	Claire Jones, Long Covid Therapy Lead Dr Rachel Skippon, Consultant Clinical Psychologist, Long Covid Psychology Lead Natasha Turner, Operations Manager Long Covid			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☒	Am sicrwydd *For Assurance* ☐	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: BCUHB adopted a strong principal of co-design, working closely with people with lived experience of Long Covid and clinical practitioners to design the Long Covid Service, which meets the needs and expectations of the local population. The Long Covid Lived Experience Consultation Group is				

now well established and regularly well attended and similar conversations have occurred with established CFS/ME groups. The existing Long Covid service and leadership team is now established and well placed to implement the plan.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This business case seeks to address key priorities within: BCUHB's Covid 19 response and recovery Living Healthier, Staying Well Primary and Community Strategy
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Yes, please see attachment
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/a
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The top risk associated with the current service is: There is a risk is that funding may not continue after March 2023. This could result in no dedicated service available and an increased demand on other services after March 2023. This would have a detrimental effect on the physical and mental health of Long COVID patients and people suffering with other chronic health conditions. It could also cause reputational damage to the HB/WG if services are stopped. Current risk score is 15. Please see section below for links to BAF
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The cost of Option 4 is £2,169,463 of which £1,893,023 requires new investment. Recurrent funding for option 4 of £1,893,023 has been confirmed by Welsh Government (Appendix 6)
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The remaining vacancies can be advertised on a permanent basis thus increasing the likelihood of successful recruitment.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	**November 2021 – March 2022** – Engagement and consultation with range of key

Feedback, response, and follow up summary following consultation	stakeholders regarding development of Long COVID service to support other conditions and services. This was following discussions within the health board and on an all-Wales basis regarding extension of Long COVID services nationally to support other similar conditions e.g. CFS/ME. **February – April 2022** – Development of this business case to secure sustainable funding for the Long COVID service and to extend to support other similar conditions as directed by Welsh Government (WG, March, 2022 – see Appendix 1). **May 2022** – Approval of business case by chair of BCUHB Long COVID Strategic Oversight Group and Acting Executive Director of Therapies and Health Sciences & Chief Finance Officer East Area (Long COVID sits within East Area for management purposes). **June 2022** – Submission to Health Board Business Case Review Team panel. **September 2022** –Approval for option 3 at Executive Team with strong support to move towards option 4. **January 2023** -PFIG Committee request further information on financial support available from WG. **March 2023** – Revised case approved by HBLT
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF 1.5 Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm BAF 3.3 Risk of significant delays to access to Primary Care Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital, resulting in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** ***1. Implement in full option 4***	
Rhestr o Atodiadau:	

List of Appendices:

1. Letter from WG - Funding to support expansion of the Adfeiriad model of care
2. WEDFAN IA Covid 19
3. WEDFAN YGC data
4. Patient feedback
5. EQIA

Division	IHC East
Development or Scheme	**Enhancement of Long COVID Service to meet population need (Part A) & address gaps in BCUHB service provision for Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Persistent Physical Symptoms (PPS), Frequent Attenders (FA) and Breathing Pattern Disorder (BPD) by developing an overarching Community Complex Conditions Service (Part B)**
Author/s	Claire Jones, Advanced Clinical Practitioner, Long COVID Therapies Lead Dr Rachel Skippon, Consultant Clinical Psychologist, Long COVID Psychology Lead Natasha Turner, Long COVID Operations Manager
Version	1.6.4
Date	22.04.23

1. Executive Summary

- The BCUHB Long COVID service opened to referrals in December 2021. In the first fourteen months of being open, the service received over 1594 referrals. Non recurrent Welsh Government (WG) funding had been provided for the service until the end of March 2023. WG have now confirmed recurrent funding from April 2023 (Appendix 1).

- Whilst there remains a high degree of uncertainty around Long COVID, early indications suggest that in people who have previously tested positive for COVID19 the prevalence of Long COVID is around 15% (ONS, 2021). The number of those reporting ongoing symptoms more than one year after COVID-19 infection continues to increase. Based on a population number of 715,000 (579,711 aged over 16) and ONS datasets, it is estimated that there is around 13,320 (10,800 aged over 16) patients living in BCUHB with Long COVID which have persisted for more than 12 weeks. It was anticipated that rates of Long Covid in the community would begin to reduce with widespread vaccination and the dominance of the perceived less severe Omicron variant of the COVID-19 virus. Unfortunately, these developments do not appear to have reduced rates of Long Covid. This is borne out in both

national and international scientific literature (Ghirga, 2022) and the referral rates to the BCUHB Long Covid service, which continue to maintain a steady rate.

- Significant health and socio-economic harms for the individual have been associated with Long Covid, and a significant increase and substantial long-term burden on NHS services was anticipated and is now apparent. Welsh Government, along with the services delivering Long Covid support across Wales, has identified that there is a need to develop services to support patients with similar conditions to Long COVID. People with conditions such as CFS/ME and PPS have historically not been supported sufficiently, or at all, across NHS Wales (Welsh Association of ME and CFS Support, 2021). Despite the often highly disabling nature of these conditions and significant burden they place on various points of the health care system (due to the lack of comprehensive and appropriate service provision). As a result, WG have indicated that Long COVID services across Wales should plan to expand to support other such similar conditions, capitalising on the sharing of resources and expertise being developed in the Long COVID services.

- Prior to the development of the BCUHB Long Covid Service, there was no defined pathway for patients experiencing symptoms of Long Covid. Patients were being referred into various existing services, resulting in complex challenges for already stretched services and limited and varying support for patients. This made it difficult to evaluate the impacts or outcomes of the longer-term effects of COVID-19 on the health of our patient population.

- This Business Case recommends investment into integrating Long COVID, CFS/ME, Breathing Pattern Disorders, FAs and PPS services under one umbrella service. The current Long Covid Service has been funded on a non-recurrent basis but has now received confirmation of recurrent funding from Welsh Government from April 2023.

    - **Vision**

- **Part A**: All people presenting with ongoing symptoms of COVID-19 12 weeks or more after a suspected or confirmed COVID 19 infection (i.e. presenting with Long COVID) in North Wales can access the BCUHB Long COVID Service either through self-referral or referral from their health care professional. They will receive specialist biopsychosocial initial assessment, follow up support and intervention to manage and reduce the impact of their condition in a timely manner in locations close to their home. The Long COVID service reduces the burden of these patients on primary and secondary care services by managing challenging symptoms and

reducing secondary care referrals and ensuring the appropriateness of those that are made through specialist management and close liaison with secondary care services.

- **Part B**: In addition to people with Long COVID, all people presenting with CFS/ME, Breathing Pattern Disorder, Persistent Physical Symptoms (PPS) in a pilot range of services (Cardiac Rehabilitation, Pulmonary Rehabilitation, Psychiatric Liaison or identified through a pattern of frequent attendance to health services), in North Wales, can access an integrated Community Complex Conditions Service, which would house specific services to address these conditions but with integrated utilisation of resources and delivery of communal support where appropriate. These comprehensive and integrated services would be addressing the current gaps in service provision for both people with these additional patient populations, therefore increasing equality of access to services and delivering improvements in patient outcomes, with greater sustainability of smaller specialist services.

  - **Purpose**

- This business case document makes recommendations based upon an evaluation of the recently established Long COVID service and the Welsh Government desire to develop these Long COVID services to support similar conditions such as CFS/ME. Such conditions share a similar aetiology and presentation, and require similar support delivered by staff with similar skills and experience.

- It describes the case for enhancing the staffing level of the successful Long COVID service to enable it to expand its capacity to meet the sustained demand across North Wales (Part A).

- The business case also describes the existing gaps in and threats to service provision for CFS/ME, Breathing Pattern Disorders, PPS and FA across BCUHB and demonstrates why the creation of an overarching community complex conditions service, integrating these smaller specialist services, would develop the sustainability of the services. The business case outlines how this approach would utilise the resources most effectively to provide supportive and enriched opportunities for staff development and improve patient outcomes by ensuring the services can offer the full range of intervention and support outlined in clinical best practice guidance (e.g. Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management, NG206); while also reducing burden on other services in both primary and secondary care (Part B).

  - **Recommendation**

- A Community Complex Conditions Service should be established in BCUHB, integrating Long COVID, CFS/ME, Breathing Pattern Disorders, PPS, and FAs in order to improve patient outcomes, provide sustainability and address current and future demand for services and gaps in service provision. Funding for the balance of option 4 (the full Community Complex Conditions Service) has been confirmed by Welsh Government (Appendix 1).

- **Approval Process**

- **March – July 2021** – Co-development and design of Long COVID Business Case 1 with people with lived experience of Long COVID and range of health professionals from cross the Health Board.
- **July 2021** – BCUHB Long COVID Strategic Oversight Group Approval of Long COVID Business Case 1.
- **August 2021** – Submission and approval of original business case for temporary service provision in line with Welsh Government recommendations and temporary Adferiad funding.
- **November 2021** – Breathing pattern disorder service Business Case approved by BCUHB Long COVID Strategic Oversight Group to be implemented from within existing Long COVID Adferiad budget.
- **November 2021 – March 2022** – Engagement and consultation with range of key stakeholders regarding development of Long COVID service to support other conditions and services. This was following discussions within the health board and on an all-Wales basis regarding extension of Long COVID services nationally to support other similar conditions e.g. CFS/ME.
- **February – April 2022** - Development of this business case to secure sustainable funding for the Long COVID service and to extend to support other similar conditions as directed by Welsh Government (WG, March, 2022 – see Appendix 1).
- **May 2022** – Approval of business case by chair of BCUHB Long COVID Strategic Oversight Group and Acting Executive Director of Therapies and Health Sciences & Chief Finance Officer East Area (Long COVID sits within East Area for management purposes).
- **May 2022** – Submission to HBRT.
- **June 2022** – Submission to Health Board Business Case Review Team panel.
- **September 2022** –Approval for option 3 at Executive Team with strong support to move towards option 4 dependent upon funding.
- **January 2023** -PFIG Committee - requested further information on financial support available from WG.
- **March 2023** – Revised case approved by HBLT

- **The Strategic Case**
    - **Overview of the Business Case**

- Long-COVID is defined by the National Institute of Health & Care Excellence (NICE) as “signs or symptoms that develop during or after an infection consistent with COVID-19 which continue for more than 12 weeks and are not explained by an alternative diagnosis”. NICE guidelines and WG guidance recommend referral to a ‘Long-COVID Assessment Clinic’ if symptoms persist for 6-12 weeks.

- Whilst there remains a high degree of uncertainty around Long-COVID, early indications suggest that in people who have previously tested positive for COVID19, the prevalence of at least one symptom for 12 weeks or more is around 15% (ONS, 2021). An estimated 1.7 million people living in private households in the UK (2.7% of the population) were experiencing self-reported long COVID (symptoms persisting for more than four weeks after the first suspected coronavirus (COVID-19) infection that were not explained by something else) as of 7th April 2022. Of these 1.7 million, 1.2 million (69%) first had (or suspected they had) COVID-19 at least 12 weeks previously, and 784,000 (45%) first had (or suspected they had) COVID-19 at least one year previously. The number of those reporting ongoing symptoms more than one year after COVID-19 infection continues to increase.

- Detailed data modelling and analysis of the projected caseloads across North Wales continues to enable right-sizing of services with a degree of confidence, however by way of giving some indication of the potential magnitude of the challenge facing services there has been 182,529 confirmed positive cases and 4,009 hospital admissions resulting from COVID-19 across the BCUHB (as of 24.03.2022). Alongside this, an unknown number of people have experienced COVID-19 symptoms, have perhaps been asymptomatic, or have self-cared at home and not accessed a confirmatory test. Symptoms can continue beyond 12 months following the initial acute infection, and some patients are still experiencing significant, disabling symptoms more than 2 years post COVID-19 onset. Based on a population number of 715,000 (579,711 aged over 16) and ONS datasets, it is estimated that there is around 13,320 (10,800 aged over 16) patients living in BCUHB with Long COVID which have persisted for more than 12 weeks.

- It is clear therefore that significant health and socio-economic harms for the individual have been associated with Long-COVID, and a significant increase and substantial long-term burden on NHS services was anticipated and is now apparent.

- The Institute of Clinical Science and Technologies launched the All-Wales guidance for Long COVID (18.06.21) to support Primary & Secondary Care practitioners. In line with this guidance, BCUHB have developed a Long COVID Pathway and Multi-disciplinary Service aligned with the All-Wales Community Pathway.
- The BCUHB Long COVID service opened to referrals in December 2021. In the first fourteen months of being open, the service received over 1594 referrals. Welsh Government funding had been provided for the service until end of March 2023. Unfortunately, this funding was insufficient to enable the service to provide a comprehensive and timely service to the high numbers of patients being referred. The service also faced difficulty in recruiting sufficient staff to deliver the service as fixed term posts (necessary because of the nature of the funding) are less attractive to potential new staff. This business case seeks to address these issues through recurrent funding for the BCUHB Long COVID service. (Part A)

- Welsh Government, along with the services delivering Long COVID support across Wales, has identified that there is a need to develop services to support patients with similar conditions to Long COVID. People with conditions such as CFS/ME and PPS have historically not been supported sufficiently, or at all, across NHS Wales (Welsh Association of ME and CFS Support, 2021). Despite the often highly disabling nature of these conditions and significant burden they place on various points of the health care system (due to the lack of comprehensive and appropriate service provision). As a result Welsh Government have indicated that Long COVID services across Wales should plan to expand to support other such similar conditions, capitalising on the sharing of resources and expertise being developed in the Long COVID services. This business case seeks approval to enable the expansion of the Long COVID service to provide support and intervention for CFS/ME, PPS, FA and BPD. (Part B)

2.1 The Current Service

Part A.

Prior to the development of the BCUHB Long COVID Service, there was no defined pathway for patients experiencing symptoms of Long-COVID. Patients were being referred into various existing services, resulting in complex challenges for already stretched services and limited and varying support for patients. This made it difficult to evaluate the impacts or outcomes of the longer-term effects of COVID-19 on the health of our patient population.

BCUHB is currently utilising WG Adferiad Funding to deliver a pan-North Wales multi-disciplinary team (MDT) Long-COVID Service. The service opened to referrals on 2nd December 2021. Patients can either self-refer or be referred by their healthcare professional. The Adferiad funding was originally agreed until March 31st 2022 and subsequently extended for a further 12 months until end of March 2023.

BCUHB adopted a strong principal of co-design, working closely with people with lived experience of Long COVID and clinical practitioners to design the Long COVID Service, which meets the needs and expectations of the local population. The Long-COVID Lived Experience Consultation Group is now well established and regularly well attended.

Initially, patients reported that they felt *"very frustrated" "lost and confused" "not listened to"* and even *"abandoned".* Feedback from the Group to date has been far more positive and patients now appreciate that their voices have been and are continuing to be heard. The group participated in the co-development of the service, and are now actively participating in ongoing evaluation of the service. This group is now being used as an exemplar of the Long Covid Bevan Commission for the Health Board and BCUHB have been asked to speak at the Improvement Cymru National Conference in May regards the Long Covid Lived Experience model.

The service has been developed in line with relevant national & local strategies to deliver 'care closer to home' and to empower & support patients to self-manage their symptoms wherever appropriate & possible.

The pan-BCUHB MDT delivers bio-psychosocial assessment, clinical interventions and case management. The team also provide guided self-management support & referral into existing specialist services and community support as required.

However, the development of the new Long Covid Service has met with a variety of challenges including difficulty recruiting to fixed term posts (necessary due to the time limited funding from the Adferiad fund) and difficulty accessing accommodation from which to deliver the service. It was also anticipated that rates of Long COVID in the community would begin to reduce with widespread vaccination and the dominance of the perceived less severe Omicron variant of the COVID-19 virus. Unfortunately, these developments do not appear to have reduced rates of Long COVID. This is borne out in both national and international scientific literature (Ghirga, 2022) and the referral rates to the BCUHB Long COVID service, which continue to maintain a steady high rate (around 1000 referrals in

the first 6 months of the service opening). Even if the service had managed to fill all of its vacant posts it would still have insufficient capacity to serve all the people who are referred into the service in a timely and comprehensive manner. It is reassuring however that if the service were to gain recurrent funding, we expect this to mitigate the recruitment risk given that there has been a lot of interest in the temporary roles previously advertised. Staff were not able to be released for secondment and we have had success in recruiting to several permanent roles within the service.

Part B.

As described above, WG have indicated that Long COVID services from each health board to extend their services to also support people experiencing similar conditions (Appendix 1). The BCUHB Long COVID service have undertaken a period of consultation with relevant stakeholders including those with lived experience to consider how best to deliver this WG directive. It has been identified that a number of conditions share a range of commonalities that suggest a more connected and integrated service would be beneficial.

CFS/ME, PPS, FA and BPD all share: a common framework for understanding their aetiology; require similar biopsychosocial assessment, diagnosis and interventions/management support; and need their care to be delivered by clinical staff with similar specialist knowledge, skills and experience. Part B of this business case seeks resources to integrate existing services for Long COVID, CFS/ME, FA and PPS and to form a new BPD service to be delivered under an umbrella community complex conditions service. This new umbrella service would maintain the functions essential to each component service (e.g. specialist diagnosis in the CFS/ME service and peer support from others with the same conditions experienced in group interventions) whilst also allowing for shared resources; increasing capacity and breadth of service for all of these patient groups.

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis

People with CFS/ME in North Wales are currently served by a small specialist service. This service has a base in Llanfairfechan and another in Connah's Quay. There is currently 0.67 WTE of a band 8C Consultant Clinical Psychologist in Llanfairfechan along with 0.4 WTE of a band 8a physiotherapist. In Connah's Quay there is 0.2 of a band 8C Consultant Clinical Psychologist and 0.2 of a band 7 physiotherapist. There is no administrative resource attached to the service. The CFS/ME service currently receives approximately 300 new referrals per year. However, as CFS/ME is a long-term condition with recurrent phases of relapse, the service also holds a large caseload of existing/prior patients who can access the service when experiencing a relapse.

Whilst this service currently delivers specialist assessment and diagnosis along with individualised support, it has been identified that with the current resources it has not been possible to provide the full range of support and clinical service recommended in the NICE clinical guidance for CFS/ME (NG206). For example, the current service does not have access to medical diagnostics and consultation, input from occupational therapy, links with social services for community support, or capacity for domiciliary input or annual reviews.

Small services carry with them an inherent sustainability risk due to the limited numbers of highly specialist staff they employ, holding small WTE posts. Any staffing changes can have a significant impact on their capacity and future delivery. Both consultant psychologists in the CFS/ME service will be retiring from the organisation in the next 10 months. Prior to this business case, there has not been a succession plan for these posts. Without the integration and further resourcing sought in this business case, it is possible the CFS/ME service will cease to function effectively.

NICE estimates prevalence of CFS/ME to be at least 0.2-0.4% of the UK population, which is equivalent to 1 in 250 people or 260,000 people in total. Within the UK, there are over 250,000 people with the condition in England and Wales. 25% of these people have a severe disease and are bed bound. The prevalence of CFS/ME in Wales is around 0.3% which would suggest around 9,500 people are affected. Approximately 25% are severely affected. Based on a population of 700,000 for North Wales, 0.3% there are an estimated 2,100 people with CFS/ME.

Persistent Physical Symptoms

Persistent physical symptoms may be more familiarly known as medically unexplained symptoms (MUS). MUS refer to persistent bodily symptoms that cannot be adequately explained by organic pathology (Deary, Chalder & Sharpe, 2007). MUS also refers to symptoms of an identified disease or organic condition which are more severe, more persistent or limit functioning to a greater degree than expected. Although the term MUS has been commonly used in health care, PPS has become more frequently used as it describes what the experience is, rather than what it is not and research indicates that patients prefer PPS and find it less stigmatising (Picariello, Ali, Moss-Morris & Chalder, 2015). PPS is therefore the term used throughout this business case.

Frequent Attenders

Frequent attenders (those attending an emergency department five or more times per year (RCEM, 2017)) impose substantial cost and resource burdens on Emergency Departments (EDs) as well as other first contact providers of care such as GPs. Across the three EDs in Betsi Cadwaladr University Health Board (BCUHB) there were 2724 frequent attenders in 2018 accounting for 18,918 attendances, the highest in any of the Health Boards in Wales (WEDFAN Steering Group, 2019). The mean total

time in ED was 46 hours per frequent attender in BCUHB, compared to the mean of 5.2 hours per patient for all ED patient attendances across Wales.

Frequent attenders are a heterogeneous group, however some common cohorts can be identified within this group, such as people experiencing PPS, people with long term and/or complex physical or mental health problems who's scheduled care has broken down in some form and people who experience significant vulnerability (which can be due to a wide range of factors such as isolation, insecure finances, poor housing, history of trauma, abusive relationships, substance misuse, involvement with the criminal justice system).

Existing Service for PPS and Frequent Attenders

Currently the Health Psychology Liaison Team (HPLT) is funded to support people with PPS and also those who are frequent attenders (FA) to health care services. The HPLT comprises of 0.8 WTE Consultant Clinical Psychologist Lead and 2 x 0.6 WTE Band 8a Clinical Psychologists for this pan BCUHB service. There is no administrative resource or office base for this service. Given the very wide remit of this small service, it has been necessary to take a stepped care approach to supporting these patient groups. This involves delivering consultation, training and clinical supervision to staff some of the services seeing presentations from people who are frequent attenders or those with PPS (these are often the same people), then either co-working or in a small number of cases working directly and independently with those with the most complex presentations. To date HPLT has focused on supporting psychiatric liaison services and inpatient settings and delivering the nationally rolled out multi-agency model for supporting those who are frequent attenders (WEDFAN, 2018).

It has been recognised that patients with PPS present in every speciality (Picariello, 2015) and in primary care (Neal et al, 1998) and that the HPLT has not had sufficient capacity to support the vast majority of patients or services facing these challenging presentations. This is particularly the case in primary care; despite this being where there is most potential for intervening early, often prior to iatrogenic harm and when people are potentially more open to working in a collaborative way to address their needs. Research indicates that PPS account for at least 20% of GP consultations and 30-50% of secondary care referrals (Deary, V., Smithson, J. & Faye, M., 2016; Husain & Chalder, 2021; Naylor et al., 2016). As with the CFS/ME service, the needs of patients with PPS should be met by a comprehensive multi-disciplinary team who can take a holistic approach to their care (NICE, 2021).

Patients who present with PPS do not have a consistent pathway within BCUHB. They may continue to be supported long term by the initial speciality to which their initial presentation took them, equally they may end up referred to mental health services, or not supported by any service and sometimes

when their frequent presentation becomes perceived as problematic by the services they attend, they may even end up in the criminal justice system. Most secondary care specialities are ill-equipped to support the long-term needs of people who present with PPS. Some exceptions to this are chronic pain services, brain injury services and psychiatric liaison (along with CFS/ME and Long COVID services) who already provide support and intervention for people who meet the criteria for small elements of the PPS population within their speciality.

Best practice guidelines indicate that services supporting people with PPS and those who frequently attend services should provide an holistic biopsychosocial assessment and individualised multi-disciplinary support/intervention. This should include helping patients to understand their condition, tailoring interventions to address their particular presentation and providing support to optimise all other areas of their health and well-being and support to optimise their engagement with health care services. To deliver this comprehensive pathway requires a multi-disciplinary, community focused service, engaged with a range of services and stakeholders. At the current time, the HPLT is hampered by being a very small pan BCUHB service, which has a very large remit. As a result, it can only work in collaboration with other services with limited direct input to this patient group. It has limited capacity to increase awareness of PPS across the health board or to provide comprehensive support to all services that could benefit from it. The service has also experienced persistent difficulties in recruitment in part due to the small WTE of the posts and due to the professionally isolated area of practice.

People identified as frequent attenders can present to a wide range of health care services but most often to primary care providers and emergency departments. The Welsh Emergency Department Frequent Attenders Network (WEDFAN) is a national network, which has developed multi-agency model for supporting people who frequently attend services. This model meets the requirements for best practice laid out in a range of best practice clinical guidance (RCEM, 2017). The model has proven to be effective in reducing frequent attendance, reduce burden on services and increasing well-being for patients nationally and in BCUHB (WEDFAN COVID-19 Impact Assessment, 2020, Appendix 2).

The HPLT have been a member of the network since its inception and have supported the development of the model. The team have delivered the frequent attender multi-agency panel model across both the Central and East areas of BCUHB (the YG emergency department lead the West Area panel. This has been funded internally by YG). This was possible due to the receipt of several rounds of short term funding; initially from WG and subsequently from winter monies. This funding enabled the appointment of a frequent attender case manager working closely with the psychologists as part of the HPLT. HPLT participated in a WG funded project delivering the WEDFAN model. The effectiveness of the model in reducing attendances of frequent attenders and reducing their length of stay during

attendances was replicated locally. (WEDFAN Winter Funding 2019/20 YGC BCUHB Data, Appendix 3)

Unfortunately, without the continuance of this funding, it has not been possible to continue providing the national WEDFAN multi-agency panel model of support for frequent attenders in the east and central areas of BCUHB. However, the HPLT continue to work with frequent attenders on an individual basis and in collaboration with psychiatric liaison and other partners.

Breathing Pattern Disorder

Breathing pattern disorders (BPD) are a spectrum of disorders, which include dysfunctional breathing and hyperventilation syndrome (HVS). BPDs are defined as symptoms of breathlessness, which persist in the absence of, or in excess of the magnitude of physiological respiratory or cardiac disease. BPD are common following an illness, which affects the respiratory system. Acute illness such as chest infection, COPD, acute heart failure, surgery or viral illness may have required a change in the work of breathing, e.g. faster rate, deeper inspiration or use of accessory respiratory muscles. Once the patient has recovered, breathing should return to normal, but in some cases, the changes in breathing pattern can become habitual, resulting in chronic dyspnoea. This can lead to secondary symptoms of fatigue, reduced exercise tolerance, anxiety, dizziness, headaches, chest pain, tingling and numbness, resulting in a significant impact on health and quality of life.

Breathing retraining incorporating reducing respiratory rate and/or tidal volume should be offered as a first-line treatment for dysfunctional breathing/hyperventilation syndrome (BTS and ACPRC, 2009). A combined Physiotherapy and Psychological approach helps to address the complex interactions of pathophysiological, psychological and biomechanical causes. It is estimated that 9.5% of the general adult population have a BPD/HVS (Jones et al, 2013) With the added impact of the new post-viral illness of Long COVID; the need for services to support patients with BPD is at an all-time high. While there is currently limited data on how common BPDs are among Long COVID sufferers and breathlessness is one of the most commonly reported symptoms.

A key risk is that patients living in BCUHB with BPD are not able to access support, with limited non-funded services currently only offered in the East area. This is resulting in a postcode lottery, with inequity of services and the health board incurring costs to refer patients to specialist services in England. There is a risk that the demand for BPD support services is unknown The number of patients referred to Physiotherapy service with Dysfunctional Breathing in East for 2019-20 was 33. We are already seeing a large increase in the number of respiratory referrals to Physiotherapy. There are currently 38 referrals to respiratory physio awaiting triage (longest wait = 19 weeks), with 17 being for

the DBS. There have been 18 referrals for respiratory physio in the last 4 weeks. If this referral rate continues, it will equate to 216 patients compared to the 56 referred in 2019/20. It should also be noted that the majority of the referrals come from Respiratory consultants, who are selective in their referrals as they are aware of capacity issues within the service. The demand for services in Central and West areas is currently unknown. There is also potential lack of clarity & understanding of the numbers of acute COVID-19 patients or community COVID-19 transmissions which may result in longer-term chronic health conditions, or an awareness of latent demand in the system due to asymptomatic cases in the community who may have developed long-term chronic conditions This could result in unanticipated demand pressures on Primary Care, Respiratory, Cardiology, Neurology and Pain Management Services Inherent risk score = 20 (DATIX ref 3963 / BAF ref 20-25) There is a risk that establishment of Long-COVID pathways may cause further pressures on services and patient waiting lists, including primary care, respiratory, therapies, cardiology and neurology This may be caused by increasing numbers of referrals for Long-COVID rehabilitation therapies which will add additional unexpected demand at the same time as restarting existing services This may cause an impact on patient waiting times for both Long-COVID and other existing long-term chronic health conditions Inherent risk score = 16 (DATIX ref 3965 / BAF ref 20-25).

Relevant National and Local Strategies

Rather than develop one-stop Long-COVID centres, the devolved NHS in Wales adopted a Community Pathways approach aligned with the WG Strategy: 'A Healthier Wales: Our Plan for Health and Social Care (2019)' and locally, the BCUHB Strategy: 'Living Healthier, Staying Well: Working in Partnership to Deliver Excellent Care Across North Wales (2019-2022)'.

Investment of funding to support emerging impacts of Long-COVID and similar conditions such as CFS/ME, PPS, FAs and BPD will provide a sustainable legacy of improvement into existing and long-term chronic health conditions well beyond the COVID-19 pandemic, in line with the principles of the Future Generations (Wales) Act (2015).

The approach advocated in this business case to create an umbrella service (Part B) enabling the sharing of resources, development of staff and more sustainability for small specialist services follows the principles of prudent health care (Bevan Commission, 2015; Welsh Government, 2019) and is anticipated to create greater benefits for patient outcomes and staff well-being as well as being greater value for money.

2.2 The Case for Change – Benefits of the scheme

Part A

Increasing the capacity of the Long COVID service will enable delivery of timely specialist biopsychosocial assessment and an increased range of support and intervention. Currently demand exceeds what it is possible to deliver in a reasonable time frame.

The current service provides comprehensive assessment and formulation of needs with the offer of two main forms of intervention: brief 1:1 follow-up and/or a 12-week group intervention, which includes psychological and physiotherapy input to enable patients to develop self-management strategies and coping skills for the condition. The 12-week group covers understanding Long COVID, fatigue, breathing pattern disorder, optimising sleep and nutrition, supporting mental health difficulties and well-being, and managing life changes such as work and relationships. As well as benefiting from the skills and knowledge offered by the content of the groups, patients benefit significantly from the peer support they gain from each other.

However, it is recognised that there is a need to stratify this offer to more effectively support the range of needs, which are presented and make best use of resources. Not all patients require the full 12-week programme or all elements of it. Enhancing the resourcing of the Long COVID service would enable delivery of a range of group programmes including short skill based workshops, clinically managed exercise groups, mental health and wellbeing focused groups and workshops. These interventions will include delivery both in-person at a range of community venues and online to increase accessibility, particularly for those whose symptoms prevent them from attending in person. It is anticipated that these more tailored group offers will enable more people living with Long COVID to receive the right support at the right time. It will also enable those will more severe difficulties to progress through the available support rather than receiving one group with no further support. Additionally the increased resourcing of the Long COVID service will ensure the team have capacity to work with patients on an individual basis where this may be required due to complexity or severity of need.

All of these improvements to the service will ensure that it continues to reduce the burden of Long COVID on existing services both in primary care, community services and secondary care. This is achieved by maintaining excellent links and relationships with these other services, consulting colleagues from these services as required and managing much of the symptoms that may have previously resulted in a referral to another service such as patients with breathlessness being referred to respiratory services for example.

Situating the support and intervention for people living with Long COVID in local venues enhances reconnection with their community and the resources it has to offer. All the Long COVID groups are

currently delivered in local leisure centres with this intention in mind. It is hoped that by making these connections, patients are more likely to continue to develop positive well-being despite living with a long-term condition by becoming more involved in what their community has to offer. In this way sustaining the gains achieved from the group intervention and developing independent means of maintaining their wellbeing, reducing dependence on health and care services in the longer term and creating better outcomes for the individual. These aims are in line with the aims of the WG “A healthier Wales” (2021) and BCUHB “Living healthier, staying well” (2018) strategies as well as the aims of the Wellbeing of Future Generations Act (2015) and prudent health care agenda (Bevan Commission, 2015, Welsh Government, 2019).

Part B

For people experiencing CFS/ME, PPS, BPD and those who are FA, clinical pathways and services within BCUHB, are somewhat fragmented and delivered through very small services. The sustainability of these services is at risk due to the size of the services, a small change in staffing (e.g. long-term sickness, retirement etc. of one staff member) can have a significant impact on the running of the services.

The clinical presentations of CFS/ME, PPS, BPD and FA are complex and require highly specialist provision. There is often a lack of awareness of the services delivering this care, along with poor understanding of the needs of these patient groups and the clinical interventions required to support them, within more mainstream health care disciplines and departments. This creates isolation for the staff involved and lack of opportunities for professional development, while also limiting the effectiveness of the support available to patients.Aetiology of CFS/ME, PPS, BPD and Long COVID (all of whom may represent a significant proportion of FA) can be understood using the same explanatory framework known as central sensitisation (Fleming & Volcheck, 2015). While the presentations of these different conditions may vary, Central Sensitisation informs the interventions which are required and can be tailored to individual needs to support effective recovery and management of this umbrella of complex conditions (Gouman et al, 2021; Hussain and Chalder, 2021 and Nijs et al, 2016).

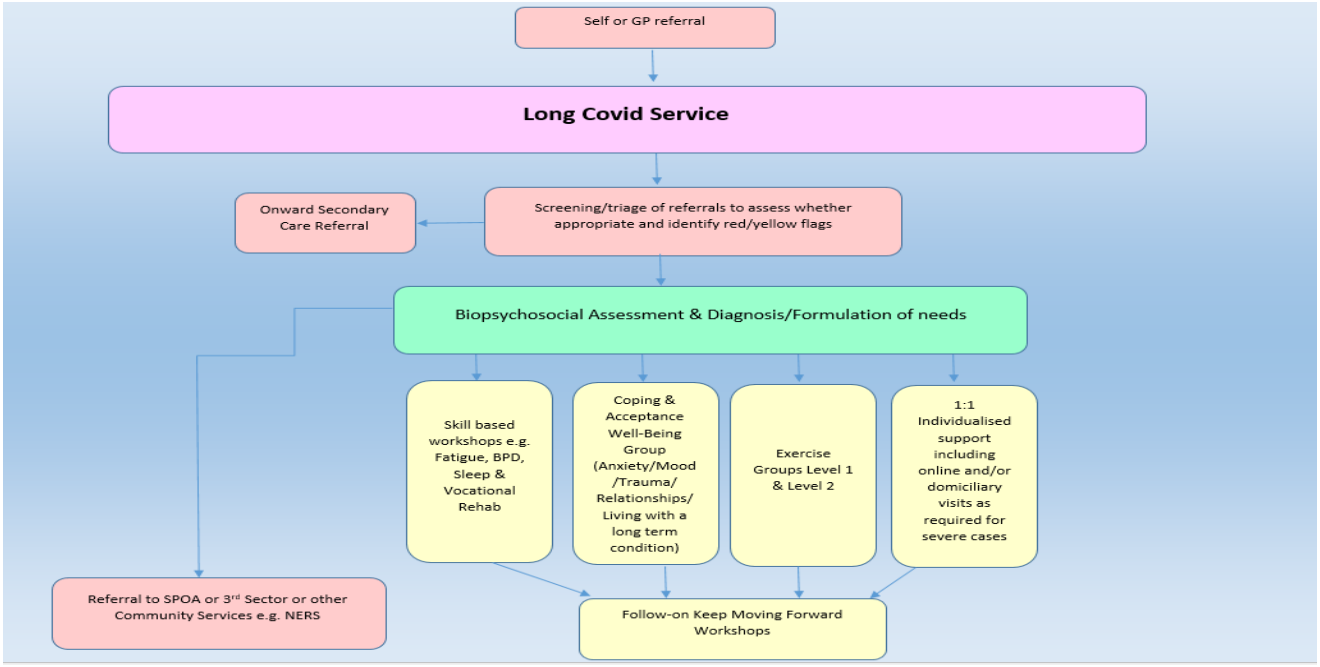
An umbrella community complex conditions service bringing together the management of these patient groups would create a range of benefits:

- Workforce Development – It enables a more experienced, well-supported team of staff.
- Sustainability - It would improve sustainability through shared resources, opportunities for staff development across a range of conditions and improve the likelihood of successful recruitment and retention.

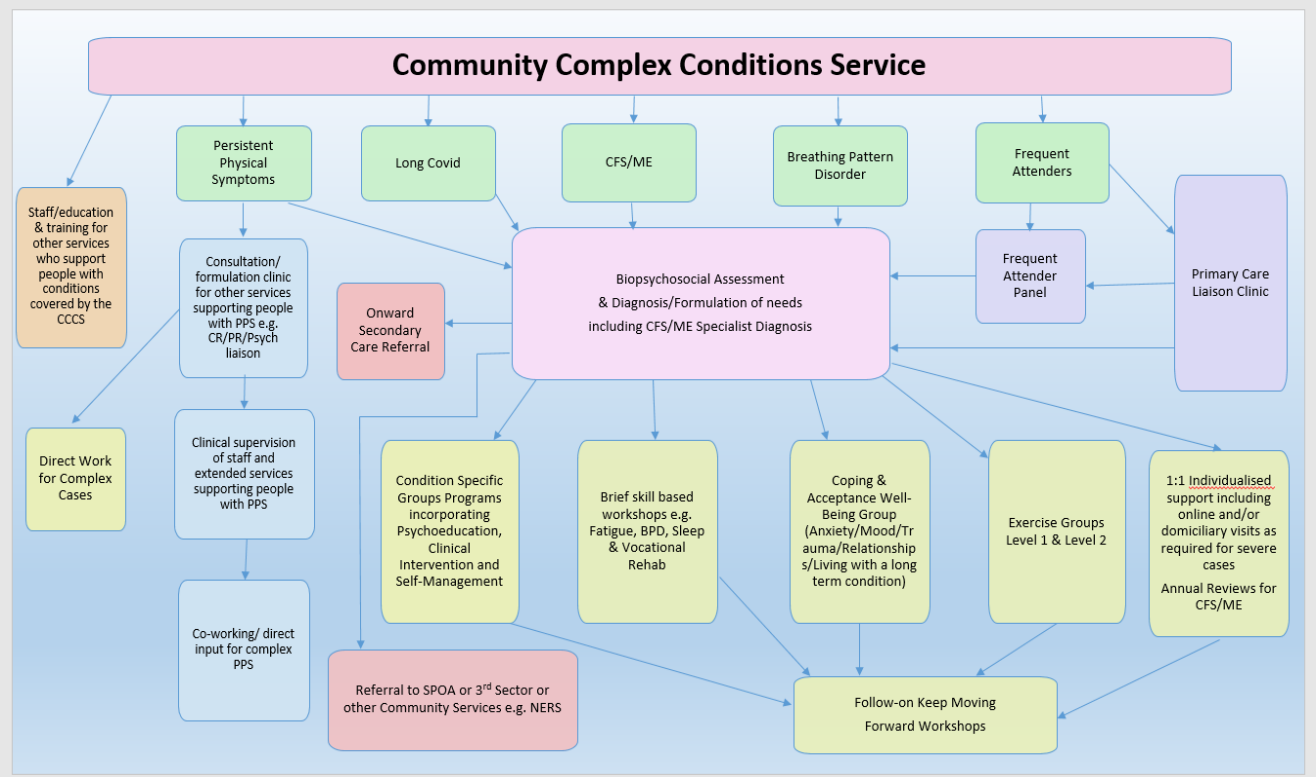
- Community Resources - It would enable the development of greater links with communities and community resources, helping the service to transition people from clinical support to community engagement and involvement as their recovery and self-management improves.
- Support for Other Services - It would increase the capacity to deliver increased support to a range of services/specialisms who find these patient groups within their services through: increasing awareness of the conditions and specialist support available for them, providing specialist advice, delivering staff education, offering consultation, supervision and co-working.
- Improved Patient Experience - For patients with these conditions there would be a more timely, equitable, comprehensive, effective and integrated clinical care pathway.
- Improved Patient Outcomes – It is anticipated that all of these improvements, enabling the meeting of best practice guidance, would lead to improved outcomes for patients

2.3 Proposed Service Development

Current model:



New model:



2.4 Areas Affected by the Proposal, Inter-dependencies

The success of the Long Covid Service to date has depended on the positive, collaborative relationships, which have been developed with other existing services including Cardiac Rehabilitation, Pulmonary Rehabilitation, Psychiatric Liaison, Pain Teams, Cancer Services, and Secondary Care specialisms. These relationships have led to appropriate signposting of patients from and to the Long Covid Service and to a more integrated pathway between Primary, Community and Secondary Care.

It is expected that similar relationships and pathways will be developed and integrated with the range of conditions, which it is proposed will be brought into the Community Complex Conditions Service.

In relation to the existing CFS/ME, PPS and FA, there will need to be a co-ordinated transition and integration of services. This will be detailed in subsequent implementation plans and co-developed with those services, allowing for improved compliance with NICE guidance (e.g. NG206, 2021).

Both Long COVID and CFS/ME have a high political and public profile and have attracted significant media attention, both locally and nationally. The Long COVID service leads have engaged a wide range of stakeholders, including those with lived experience, in designing and developing the long COVID service. They have also been active in implementing a communications strategy outlining the

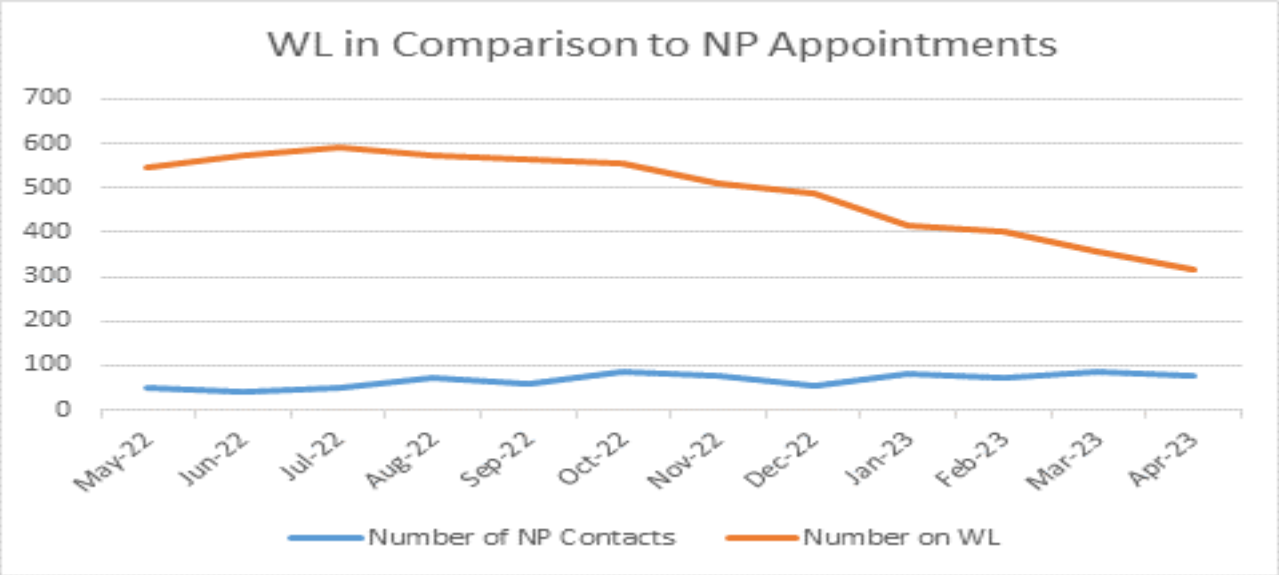
launch of and engagement with the service across both traditional and social media. They are in contact with the Welsh Association of ME & CFS Support (WAMES) regarding the further development of the Long COVID service to work with other similar conditions in order to implement the most up to date NICE guidance.

2.5 Performance, Activity and Contracting

Long Covid is a new, multi-systemic and complex condition. The number of potential, non-specific symptoms of Long Covid is in excess of 100 (ONS, 2022). It is vital to first rule out other causes of symptoms, which often requires a battery of diagnostic tests and clinical examination. The service therefore requires an appropriately qualified multidisciplinary team of professionals who are able to provide holistic, biopsychosocial assessment, support and intervention in the community. This team includes Advanced Clinical Practitioners, Allied Health Professionals, Clinical Psychologists, Assistant Psychologists and a GP. Due to the nature of Long Covid, the service does not sit under one medical specialisms remit, although as mentioned, its delivery and success has been supported by the collaborative relationships with numerous other existing services to ensure safe and effective pathways are maintained. It cannot be outsourced to a third party provider, as no such services exist.

Building on this successful approach, the community complex conditions service (Part B) would therefore be jointly, clinically led by a Consultant Therapist and a Senior Consultant Clinical Psychologist. Together they will hold overall clinical responsibility for this group of patients, owing to the multi-system presentation not falling to any one medical speciality, this approach enables most effective clinical management of the conditions. It also supports the principles of the Allied Health Professionals Framework for Wales (Welsh Government, 2020) and prudent health care (Bevan Commission, 2015; Welsh Government, 2019) to support clinicians to work to the top of their licence delivering effective and prudent best practice. An Operational Manager holds responsibility for the operational delivery of all aspects of the Long COVID Service, and this is necessary given that the service is delivered by a large team, pan-BCUHB

Since launching in early December 2021, the Long COVID service has received in excess of 1500 referrals. It was previously anticipated that the referral rates to the service would start to reduce as a result of the Omicron variant being less severe and a high rate of vaccination. However, this has not been the case, with a steady referral rate continuing. Recruitment has proved challenging with posts advertised on a fixed-term basis and as a result, waiting times for patients to receive a first appointment with the service have been long. In recent months the gap between demand and capacity has closed such that the numbers waiting have decreased.



Data from the most recent Adferiad Report demonstrates a reduction in patients accessing Primary Care since receiving input from the Long Covid Services in Wales (data for Health Boards is grouped together for the purpose of the report):

	Existing service users	New referrals	Follow-up	Discharge
Number of responders	225	597	115	138
% who answered the question	97%	97.50%	95%	93.20%
Minimum value	0	0	0	0
Median (IQR)	4 (2,6)	4 (2,6)	4 (2,6)	3 (1,5)
Maximum value	20	100	30	20

Summary statistics for [Q7]: “How many GP visits/contacts (face-to-face or remotely) have you had in the last 6 months related to COVID-19?” IQR = Inter-Quartile Range.

The small specialist services supporting patients with CFS/ME, PPS and those who are frequent attenders do not currently have sufficient capacity to meet the needs of the patient groups they serve. Neither are they set up as multi-disciplinary teams. Breathing Pattern Disorders do not have a funded, equitable service to support them. The development of a community complex conditions umbrella service would enable the delivery of a multi-disciplinary approach to all of these conditions with greater capacity and a greater range of support and intervention available.

Given that PPS is such a broad remit and patients with this presentation can be found in all medical specialities, it is necessary to deliver this service with some boundaries to pilot effective delivery prior to rolling out more broadly. It is anticipated that this could begin by working in collaboration with cardiac rehabilitation, pulmonary rehabilitation and psychiatric liaison. This would be building on the existing work of the HPLT and the close working relationships, which have been developed through the delivery of the Long COVID service.

2.6 Milestones and Quantified and non-Quantified Benefits

Achieved Milestones and Quantifiable and non-Quantifiable Benefits

The initial service milestones for the Long Covid Service have been partly achieved, following the successful co-design of the BCUHB Long Covid pathway working with patients with lived experience of Long Covid.

The recruitment of:

- 1.0 WTE Therapy Lead/Advanced Clinical Practitioner
- 0.6 WTE Consultant Clinical Psychologist
- 1.0 WTE Clinical Specialist Physiotherapists (permanent contract)
- 2.0 Clinical Specialist Occupational Therapists (permanent contract – due to commence June 2022)
- 0.6 WTE Advanced Clinical Practitioner
- 3.0 Admin Co-ordinators
- 0.2 General Practitioner
- 6.0 Assistant Psychologists (3 in post and 3 due to start in June 2022)

Delivering assessment, individually tailored support and both 1:1 and group interventions across all areas of BCUHB in multiple community venues. All staff complete ACT (Acceptance and Commitment Therapy) Training Within the existing service, some posts remain vacant, mainly due to posts being advertised on a temporary basis.

Future Milestones and Quantifiable Benefits – see 3.2 Benefits of the Options and 4.1 Financial Case and Implementation Timeline

Future Milestones

- Successful recruitment of team
- Securing venues
- Implementation plan
- Integration of CFS/ME service into CCC Services
- Delivery of Breathing Pattern Disorder Service integrated with CCC and delivered across all areas of BCUHB
- Integration of PPS and FA service (currently HPLT) into CCC Service

Quantifiable and non-Quantifiable Benefits

- Continued support for LC patients, a current estimate of 1.9% (10,800) of population of BCUHB
- Increased range and capacity of support for CFS/ME, PPS, FA and BPD
- Reduction in waiting times for access to treatment with no patients waiting over the 14 week target for Therapy Services
- Reduced referrals to secondary care – we have only made 8 referrals to secondary care services since the service launched.
- Reduced primary care contacts – LC not coded effectively in PC to provide actual figures
- Reduced A&E & Primary Care presentations – FA, PPS, BPD
- A Social Return on Investment (SROI) analysis, for two Local Health Boards (similar care model), identified that key outcomes for service users were feeling listened to and believed; being part of a group leading to a sense of community; better health; feeling cared about; and feeling able to cope. The SROIs were calculated as a ratio greater than 5, meaning that for every £1 invested there was a social return greater than £5, with almost all sensitivity analysis scenarios remaining with a ratio greater than 1.
- Positive feedback from patients (see Appendix 4)
- Improved case management for complex patients in the community, closer to home
- Self-referral option to service has reduced impact on PC
- Improved patient engagement and co-development of services through the Lived Experience Consultation Group
- Evidence suggests that COVID increases the risk of cardiovascular events and other secondary health problems (Tanne, 2022). Part of the role of the Long Covid MDT involves cardiovascular

risk management and health and wellbeing promotion, which will contribute to reducing the risk of cardiovascular events and therefore reducing hospital admissions.

3. Formulation and Short-listing of Options

3.1 Overview of Options – Main Business case Options

- **Option 1:** Cease the Long COVID Service
- **Option 2:** Provide recurrent funding for Long COVID service at current service level
- **Option 3:** Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to better meet local demand to reduce waiting times.
- **Option 4:** Provide recurrent funding for development of Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand (as in option 3), but also create and resource an umbrella service which would also house CFS/ME service, PPS service, FAs and Breathing Pattern Disorder Service. (Part B)

3.2 Benefits of the Options – Main Business case Options

Option 1: Cease the Long COVID Service

- Funding identified by WG could be used for another priority

Option 2: Provide recurrent funding for Long COVID service at current service level

- Continue to provide the current service to patients on a permanent basis
- An offering of permanent staffing will mitigate the risk of being unable to recruit to temporary posts (this has proven to be a barrier to date with only temporary positions being advertised and remaining vacant). Sustainable option to continue providing a service for the high number of patients already receiving input from the Long COVID service
- Continuation of service provision for new patients requiring a referral into Long COVID Service

Option 3: Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to better meet local demand to reduce waiting times

Benefits as option 2, with additional benefits as follows:

- Being able to reduce the waiting list
- Increased patient contact with clinicians (see Appendix 4 for patient feedback)
- More clinical interventions to be provided, e.g. group sessions, workshops to support self-management for key impacting symptoms
- Better outcomes for patients
- Reduced demand on other services within secondary care through more appropriate referrals
- Reduction in GP contacts

- Better long term patient health with patients more equipped able to manage their symptoms and risk factors for disease prevention

Option 4: Provide recurrent funding for development of Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand (as in option 3), but also create and resource an umbrella service which would also house CFS/ME service, PPS service, and Breathing Pattern Disorder Service

Benefits as option 3, with additional benefits as follows:

- Providing a service offering for those who come under the umbrella of CFS/ME, PPS, FAs and BPDs, pooling resources and staff expertise across the three services and addressing the service gaps for these conditions. This is also in line with most recent WG recommendations to extend current LC provision to such conditions (Appendix 1)
- Expertise of staff to be available to a wider patient group across the three services
- Address gaps in service provision
- Better outcomes for a wider group of patients across the three services e.g. improved timeliness of access to services for all these patient groups, and improved patient experience due to being able to offer a service to this patient group which meets NICE guidance
- Reduce impact upon existing services, e.g. Cardiac Rehabilitation, Pulmonary Rehabilitation where there is a lack of Psychology access, allowing them to focus more on disease specific management and hence reduce their waiting lists. It should be noted that such input from the new CCC Service would be an enhancement of what is currently offered by these existing services, and that funding for PR and CR to deal with long waiting lists and gaps in service where staffing is a barrier will need to be considered as part of a separate case.
- The development of the Community Complex Conditions service will enable BCUHB to offer a dedicated service for a range of complex, chronic health conditions including CFS/ME that meets current NICE guidance (NG 206, October 2021), which is something that we do not currently offer now. There is currently no pathway within BCU for PPS/MUS (medically unexplained symptoms) and this would create one.

3.3 Cost and Resource Information for the Options

Welsh Government has recently confirmed recurrent funding from April 2023 onwards of £1,893,023 for ongoing Long Covid services and to support people with other long-term conditions such as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Multiple Sclerosis (MS).

Option 1 – Cease the Long COVID Service

The available funding of £1,893,023 from Welsh Government is not drawn down.
Existing staff are redeployed or released at the contract end point with no financial impact on BCUHB. Patients with Long Covid will increasingly access services through primary care and ongoing referrals into secondary care specialists.

Option 2 – provide recurrent funding for Long COVID service at current service level
Costs for continued service levels are shown below.

Department	Band	WTE	Annual cost
ACP	7	2	£115,074
AHP	7	5	£287,685
Psychology	8A	2	£133,992
Psychology	4	5	£184,044
Therapies	8A	1	£66,996
Medical	M&D	0.2	£24,000
Psychology	8C	0.6	£57,133
Admin	7	1	£57,537
Admin	5	1	£39,200
Admin	4	3	£92,022
Total		**20.8**	**£1,057,683**
Plus 10% non-pay			£105,817
Accommodation lease costs			£20,400
	Total		**£1,183,900**

Option 3 – Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to better meet local demand to reduce waiting times

Costs for the enhanced service model.

Department	Band	WTE	Annual cost
ACP	7	2	£115,074
AHP	7	5.2	£296,216
Psychology	8A	3	£200,988
Psychology	4	4	£122,696
Therapies	4	2	£61,348
Medical	M&D	0.4	£48,000
Psychology	8D	1	£110,008

Therapies	8C	1	£96,035
Admin	7	1	£57,537
Admin	4	3	£92,022
Total		**22.6**	**£1,199,924**
Plus 7% non-pay			£70,893
Accommodation lease costs			£30,600
	Total		**£1,301,417**

Option 4 – provide recurrent funding for development of Community Complex Conditions service (in addition to existing funding for CFS/ME and HPLT services which will come under the new umbrella service) as recommended by WG

New Proposed Staffing model for CCC Permanent Staffing Structure			
Role	**Band**	**WTE**	**Annual cost**
Consultant Psychologist (Lead)	8D	1	£116,397
Consultant Therapist (Lead)	8C	1	£97,794
Clinical Psychologist	8C	1.2	£117,604
Clinical Psychologist	8B	0.6	£48,936
Clinical Psychologist	8A	4.6	£320,793
Advanced Clinical Practitioners	8A	2.2	£152,768
Pharmacist	8A	0.5	£33,750
Frequent Attender Case Manager	7	1	£59,851
MH/LD Specialist Nurse	7	1	£59,851
Allied Health Professionals	7	2.5	£151,512
Advanced Clinical Practitioners	7	1.2	£72,073
OT & Physio's	6	3	£154,821
Assistant Psychologists	4	4	£133,916

Technical Instructors	4	3	£99,809
Medical - GPwSI	M&D	0.4	£48,000
Operations Manager	7	1	£59,851
PALS Officer	5	1	£40,989
Co-ordinator	5	1	£40,989
Administrators	3	4	£117,577
Total staffing resources		**34.2**	**£1,927,281**
Plus 10% non-pay			£192,728
Accommodation lease costs			£49,454
	Total		**£2,169,463**

Less HPLT/CFS Existing Budget	-£ 276,440
Budget Required	**£1,893,023**

Option 4 above also includes the current funding for CF/ME service and HPLT service funding that will be brought over into the new umbrella service. These budgets are outlined below;

CFS/ME Service	**Band**	**WTE**	**Cost**
Psychology	8C	0.8	£78,235
Physiotherapy	8A	0.4	£27,000
Physiotherapy	7	0.2	£11,970
Existing budget for HPLT			**Cost**
HPLT Psychology	8C	0.8	£78,235
Psychology	8A	1.2	£81,000
Total			**£276,440.00**

3.4 Cost and Resource information for the Options

Option		Recurrent Cost	Existing Budget	Total Investment Required	Recurrent Investment Required	Recurrent Activity
	WTE	£	£	£	£	Capacity Increased
1: Cease long COVID service	0	0	0	0	0	0

2: Provide recurrent funding for Long Covid service at current service level.	20.80	1,183,900	0	1,183,900	1,183,900	0
3: Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to better meet local demand to reduce waiting times	22.60	1,301,407	0	1,301,407	1,301,407	565 additional patient contacts, including assessment and groups
4: Provide recurrent funding for development of Community Complex Conditions service (in addition to existing funding for CFS/ME and HPLT service which will come under the new umbrella service).	34.2	2,169,463	276,440	1,893,023	1,893,023	1415 additional patient contacts, plus support and education for external services with addition of CFS/ME/BPD/PPS/ FAs

3.5 Key Assumptions and Dependencies of the Option

Option	Key assumptions and dependencies
1: Cease Long Covid service	• Existing caseload and demand is redirected elsewhere. • The WG funding is available for another priority
2: Provide recurrent funding for Long Covid service at current service level.	• Recurrent funding is available from WG
3: Provide recurrent funding for Long Covid service to increase the capacity.	• Recurrent funding is available from WG • Successful recruitment into permanent posts • Sufficient and comparable demand which continues into the service
4: Provide recurrent funding for development of Community Complex Conditions service (in addition to existing funding for CFS/ME and	• Recurrent funding is available from WG • Successful recruitment into permanent posts • Sufficient and comparable demand which continues into the service

HPLT service which will come under the new umbrella service).	• Successful development and continued engagement with CFS/ME and HPLT service leads

3.6 Options Appraisal

3.6.1 Criteria for Assessing the Options

- Additional Cost
- Improving patient outcomes
- Meeting patient and carer expectations
- Improved accessibility for important health conditions
- More appropriate secondary care referrals for LC, PPS & CFS/ME
- Patient Experience
- Specialist care closer to come (shorter care pathways)
- Equity of access
- Alignment with WG & HB strategic policy
- Investment will provide longer term sustainable benefit to the health board and the population we serve

3.6.2 Scoring framework for Assessing the Option

Relative Strengths and Weaknesses (indicative scoring, 0= weakness 4=strength).

3.6.3 Selection of Preferred Option

	Option 1: Cease the Long COVID Service	Option 2: Provide recurrent funding for Long COVID service at current service level	Option 3: Provide recurrent funding for Long COVID service to increase the capacity of the service	Option 4: Provide recurrent funding for development of Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand (as in option 3), but also create and resource an umbrella service which would also house CFS/ME

				service, PPS service, and Breathing Pattern Disorder Service.
Cost (£/year)	£ 0	£1,183,900	£1,301,417	£2,169,463
Improving patient outcomes	0	3	3	4
Meeting patient and carer expectations	0	2	3	4
Improved accessibility for important health conditions	0	1	2	4
More appropriate secondary care referrals for LC, PPS & CFS/ME	0	2	2	4
Patient Experience	0	2	4	4
Specialist care closer to home (shorter care pathways)	0	3	3	4
Equity of access	0	2	3	4
Alignment with WG & HB strategic policy	0	3	3	4
Investment will provide longer term sustainable benefit to the health board and the population we serve	0	2	3	4
Total	0	20	26	36

Recommendation: Option 4:

Provide recurrent funding for the development of a Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand within national performance target level but also create and resource an umbrella service which would also house CFS/ME service, PPS service, and Breathing Pattern Disorder Service, in line with the Welsh Government expectations (Appendix 1).

4 The Financial Case

4.1 Implementation

It's envisaged that roll-out of option 4 would take place during 2023-24 to ensure effective engagement, safe implementation and successful recruitment of staff. It will require recruitment of new staff and a consolidation of existing services into the new model.

4.2 Value for money

A Social Return on Investment (SROI) analysis was carried out by Cedar for the Adferiad Project, with two other Local Health Boards in Wales. While the Long COVID Service in BCUHB has only been

running since December 2021, Cardiff and Vale UHB's and Cwm Taf Morgannwg UHB's Long COVID Rehabilitation Services have been running for slightly over one year, and also have multi-disciplinary teams including physiotherapists, occupational, speech and language therapists. There is also provision from psychologists, GPs and dietitians in some teams. Both services perform one-to-one assessments and interventions using a similar model to BCUHB. C&V UHB have used group interventions from the start and CTM UHB have carried out one face to face group, following user feedback. Additional group provision has been made available via the Welsh National Opera programme at both sites as it has in BCUHB.

The SROI analysis identified that key outcomes for service users were feeling listened to and believed; being part of a group leading to a sense of community; better health; feeling cared about; and feeling able to cope; all in keeping with the A Healthier Wales approach. The SROIs were calculated as a ratio greater than 5, meaning that for every £1 invested there was a social return greater than £5, with almost all sensitivity analysis scenarios remaining with a ratio greater than 1.

Prior to the establishment of the LC service, patients were being referred to individual secondary care services for assessment. For example, the presentation of one Long COVID patient could result in referrals to Cardiology, Respiratory, Neurology, Gastroenterology and various diagnostics services. Feedback from patients revealed that care was felt to be disjointed, with little support and long waits for assessment. The inclusion of Advanced Clinical Practitioners with skills including clinical examination, diagnostics, chronic disease management and non-medical prescribing, has meant that in most cases, referrals to secondary care are avoided with patients being assessed, referred for diagnostics and managed in-house, and any referrals, which are made, are appropriate and made following communication with secondary care clinicians.

The LC service was able to utilise funds from the last financial year to purchase 2 x portable ECG machines. This has meant that ECGs could be performed in-house, without impacting upon the already stretched secondary care cardiology services at all 3 sites in BCUHB. This has resulted in a significant reduction in patients needing to travel further access the DGHs, and with around 20% of LC patients requiring an ECG, will no doubt have significantly mitigated the risk of increasing waiting lists for those needing to be screened for serious arrhythmias. This approach provides value for money, with opportunistic diagnostics making the most of every contact and creating a more streamlined patient journey. Likewise, chest x-ray and blood tests can be requested and reviewed in house with similar benefits and releasing primary and secondary care capacity. Pulse oximeters are being purchased to allow overnight pulse oximetry for patients suspected to have Obstructive Sleep Apnoea (OSA), which could be further impacting their symptoms. This will reduce impact on

diagnostic waiting lists and allow them to be referred directly for virtual review, reducing waiting times for management of OSA for this group of patients by 6 months.

4.3 Financial risk

The current costs for Long Covid had been supported on a non-recurrent basis during 2022-23 by Welsh Government. On February 1st 2023 Welsh Government notified the Health Board of recurrent investment of £1,893,023. This new allocation reduces the financial risk to the Health Board.

5 Service Management

5.1 Governance

During the implementation period the Long COVID Service and staff will continue to be managed across BCUHB as one team. Clinical, professional and managerial leadership will be provided by a Consultant Therapist, Consultant Clinical Psychologist and an Operations Manager reporting to the East Integrated Health Community.

Whilst the Long COVID service sits within the IHC AHPs they will continue to work in close engagement with the Psychology leadership team. This model has worked well in practice – an example of effective working across management teams/structures, with staff benefitting from professional support and leadership yet fully engaged with both primary care colleagues at cluster and practice level and secondary care.

The final structure for the service will be reviewed as part of the implementation.

5.2 Scheme Plan – Implementation Timeline

The roll-out of option 4 of this business case would take place in three phases over two years to ensure effective engagement, safe implementation and successful recruitment of staff. As detailed in the costs above (section 4.1, page 38), the aim will be to have 50% of staff in post by the end of Year 1, 75% of staff in post within the first 6 months of Year 2, and 100% of staff in post by the end of Year 2.

Once the business case is approved, detailed implementation plans will be developed. The location for the roll out will continue within the current service locations that are in place now. Engagement with the CFS/ME service and HPLT service is ongoing. These services will continue to be fully engaged with developments and with the roll out of the new umbrella service.

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 the Long COVID Strategic Oversight Group and reported back through the BCUHB governance structure as required.

Cedar provide regular reports based on a cross-sectional survey administered to users of the Long COVID service provided by the seven local health boards in Wales. This is currently funded by the 'Adferiad' (Recovery) programme. The data collected includes: responders' demographics, any COVID-19-related symptoms they experienced, the number of interactions they had with the healthcare system because of COVID-19 (primary, secondary and rehabilitation care), their general quality of life and their feedback on the interactions they had with the service (PROMS and PREMS). The BCUHB Long COVID Service also collects data for the purpose of measuring clinical outcomes as well as patient experience via the CIVICA system.

Whilst it is not yet known whether the Cedar agreement will continue on a permanent basis, this information will continue to be gathered and utilised to inform service development and improvement by the BCUHB service.

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 area. This will include:

- Demand and activity
- Referral rates to the community complex conditions service for each of the conditions
- Appropriateness of onward referral
- Patients experience
- Referrers experience
- Clinical outcome measures

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. An informatics dashboard has been created to show our performance data, including referral numbers, numbers of appointments, and waiting time data.

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 Primary Care capacity, as well as reducing impact on secondary care and diagnostic services.
- The scheme is well regarded by the public 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 have been developed and have been essential to the success of the scheme to date. These specific relationships will continue to be developed with other key stakeholders in primary and secondary care.
- There is a risk that the service may not be able to recruit to all posts, given the current rate of vacancies within the HB. To date, advertising of permanent posts to recruit to the LC service has demonstrated sufficient interest in posts with a number of suitable applicants, in contrast to when these posts were advertised on a temporary basis and sometimes did not attract any applications. It is therefore felt that permanent positions should generate sufficient interest from suitable applicants.

7 Conclusions

The current Long COVID Service continues to receive new referrals. It is anticipated, based on data modelling of rates of COVID-19 and prevalence of Long COVID, that this service demand is likely to continue (Part A). CFS/ME, Breathing Pattern Disorders, FAs and PPS share a similar aetiology and presentation, requiring support delivered by staff with similar skills and experience. Existing gaps in and threats to service provision for CFS/ME, Breathing Pattern Disorders and PPS across BCUHB demonstrates why the creation of an overarching community complex conditions service, integrating these smaller specialist services, would develop the sustainability of the services. It would utilise the resources most effectively and improve patient outcomes by ensuring the services can offer the full range of intervention and support outlined in clinical best practice guidance (NICE, 2021) while also reducing burden on other services in both primary and secondary care (Part B).

A Community Complex Conditions Service should be established with permanent funding in BCUHB, integrating Long COVID, CFS/ME, Breathing Pattern Disorders, FAs and PPS, provided in order to improve patient outcomes, provide sustainability, address current and future demand for services and gaps in service provision.

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Yr Athro/Professor Chris Jones
Cyfarwyddwr Clinigol Cenedlaethol, GIG Cymru
a Dirprwy Brif Swyddog Meddygol
National Clinical Director, NHS Wales and Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

To:
Chief Executives of Health Boards
Health Board Directors of Therapies and Health Science
Health Board Directors of Finance
Health Board Directors of Primary and Community Care
Cc.
Health Board Medical Directors
Health Board Directors of Nursing

1st February 2023

Dear Colleagues,

Building Community Capacity - Funding to support continuation and expansion of the Adferiad (Recovery) Model of Care 2023/24 onwards.

The Minister for Health and Social Services has agreed an increase in funding for Adferiad (Recovery) Services to £8.3 million on a recurrent basis. £300K will be top sliced, a proportion of which will include support for the continued availability of the guideline for the long COVID pathway and the self-management Covid recovery app.

This decision affirms Welsh Government's commitment and focus on strengthening community-based services by expanding capacity in primary and community care. It is also in response to the feedback we have received from those involved in the management and front-line delivery of Adferiad services, in particular with regards to:

- Supporting sustainable service planning for the long-term, and overcoming the recruitment and retention challenges within Adferiad services to date, and
- Widening access to the integrated, multi-professional rehabilitation and recovery model of care established for people with long-COVID, to a 'needs based' and 'needs driven' model.

As a positive legacy from the pandemic, it is prudent to build on the success of Adferiad services moving forward, capitalising on the workforce skills and expertise developed as these services have evolved. Widening the access model to people with other medical and long-term conditions, but with similar symptoms and needs to those with long-COVID, speaks to this legacy.

The 'other' conditions amenable to the Adferiad integrated, multi-professional rehabilitation and recovery model of care include, for example: myalgic encephalomyelitis (ME) and chronic fatigue syndrome (CFS), fibromyalgia and chronic pain. The need for local flexibility is acknowledged to ensure other patient groups with

similar needs and symptoms are provided for, for example, other conditions associated with post viral infection, non-differential conditions and those that are medically unexplained.

Our expectation is that whilst continuing to provide services for people with Long COVID, equitable access to others whose symptoms and medical needs would benefit from the Adferiad model of care are addressed. This must encompass the whole of the patient journey from diagnosis, to specialist assessment when needed, and effective rehabilitation and recovery through Adferiad service provision.

We expect this further investment in Adferiad Services to maximise opportunities for integration and collaboration with other complementary areas of work, locally and nationally, ensuring maximum value for money from this investment. This will include drawing on developments linked to the *Allied Health Professions (AHP) Framework for Wales: Looking Forward Together* and programmes of work and activity driven by the Strategic Programme for Primary Care (SPPC) and supporting the specific priorities set out in the Minister's 2023-24 Planning Framework. Where regional working solutions add further value and opportunities to improve outcomes and experience for people, we expect these to be fully explored and developed.

Accountability
Directors of Therapies and Health Science (DoTHS) should remain accountable for this funding and the services it provides. However, DoTHS and Health Board Directors of Primary and Community Care (DPCC) should work together to embed this as part of the Pan Cluster Planning Groups under the Accelerated Cluster Development programme.

A separate letter will be following in respect of the recently announced £5m funding to increase Allied Health Professionals and access to community based care. We will be expecting good alignment of these services to improve seamless care.

Funding allocations
The £8m allocation of funding for 2023-24 will be distributed based on previous submissions provided by Directors of Therapies and Health Science and the identified amount required to widen the access model to Adferiad services. This has been adjusted proportionally to reflect that £300K has been top sliced. Each Health Board allocation is outlined at Annex 1.

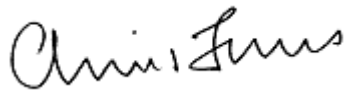
Reporting and Evaluation
You will need to evidence through your reporting how Adferiad services have continued to develop in line with the expectations set out above, ensuring patient quality of life outcomes and experience remain at the centre. You will also need to evidence how the Adferiad services have adapted to capture the needs of the range of patients referred to above, any other locally identified patient groups, and how best practice has been shared and adopted across NHS Wales. You will need to evidence how this is embedded as part of the pan cluster planning groups under the Accelerated Cluster Development Programme.

In collaboration with Health Boards and people with lived experience, we will review the existing evaluation framework with you, building on this to develop a suitable evaluation framework by July 2023. The aim is to embed this within existing IMTP processes and routine monitoring. Whilst this is being developed, we will work with you to agree an interim reporting structure, building on evaluation to date.

Together with the relevant clinical standards and NICE Guidance, the *Rehabilitation Service Evaluation Framework*[1] will continue to provide the basis of the reporting and evaluation.

For further information or for any queries you have in relation to this letter please contact Tracey.Williams015@gov.wales and Bethan.Davies027@gov.wales.

Yn gywir/Yours sincerely



YR ATHRO/PROFESSOR CHRIS JONES

[1] Rehabilitation service evaluation framework | GOV.WALES

Annex 1: The breakdown of funding allocation per Health Board is as follows:

Health Board	Allocation
ABUHB	£1,216,390
BCUHB	£1,893,023
C&VUHB	£1,144,358
CTMUHB	£1,144,358
HDUHB	£1,226,512
PtHB	£421,727
SBUHB	£953,632
COVID recovery app and other costs	£300,000
Total	**£8.3m**

WEDFAN Impact Assessment: COVID 19

SUMMARY

- Frequent Attenders account for 85,000 attendances to EDs in Wales a year (Appendix 1 Infographic)
- Case management, led by ED Case Managers, with multi-agency support, reduces these ED attendances by 95% *(data from 5 years of part time case management work across Wales)*
- ED attendances and length of stay are the greater resource demand from this cohort but yearly baseline admissions into hospital beds from these attendances is 13%
- Case Management decreases the conversion rate from ED attendance to hospital admission by 36%
- Case Managers are currently being pulled out of these roles to go back into areas such as general ward nursing, mental health and emergency care
- Frequent Attenders will therefore continue to use services and be admitted at an increased rate (see demographics below) – but now will have no co-ordinated support to help them through this pandemic and reduce this demand
- It is strongly advised that Case Management continues in each ED to ensure demand is reduced as safely as possible across USC during this time of unprecedented challenge, and that there is a nationally led co-ordination of this work to ensure it links in with the strategic aims of the National Programme for Unscheduled Care

Context

Frequent Attenders to Emergency Departments are those who attend EDs 5 times a year or more. In Wales, services are in place to support the higher end of this cohort – those who attend EDs 4 times a month.

These services are managed and supported by the National Programme for Frequent Attenders to USC, and are led by ED Case Managers

There are Frequent Attender Services in each of the health boards in Wales with a Tier 1 ED

Current status in Wales

- 12,362 frequent attenders (5 times a year or more)
- 84,635 attendances in a year
- A total time spent of 386,330 hours in Emergency Departments **in one year** across Wales (equivalent to 44 years)
- 8.5% of all ED attendances in Wales are by a frequent attender

During COVID-19, Frequent attendees are still making contact with Unscheduled Care, due in most part to the demographics from which the most vulnerable are drawn:

- Those with ACE's who have an increased risk due to poor physical health needs.
- Older adults who are isolated and may have a number of co-morbidities
- Patients with health anxiety who require intensive psychological support
- Patients known to mental health services that are at risk of harm and challenging behaviours during periods of stress and emotional turmoil
- Rough sleeping and homeless patients who attend with unmet physical and mental health needs.
- Patients with learning disabilities who have health anxiety or challenging behaviours that can increase further trauma without the correct management plan
- Palliative Care patients
- Persons using substances to help self-manage stressors

The Frequent Attender Case Manager role is to:

- Reduce contacts with Unscheduled Care
- Reduce time spent in the Emergency Department
- Reduce time WAST are on scene with patients
- Reduce time practitioners spend on consultations in the Out of Hours service.
- Co-ordinate multi-agency support across health, local authority, police and 3rd Sector agencies
- Create Multi Agency Anticipatory Care Plans for patients to promote a consistent approach on each contact.
- Hold the ring on communication between agencies, promoting joint decision making
- Provide support to patients on a daily basis as a point of contact rather than 999 or ED

National Support for this work stream

WEDFAN is working with the Emergency Department Quality and Delivery Framework Programme to support the redirection, navigation and streaming of their patient cohort away from USC, particularly during the COVID-19 pandemic

The Operational Support Manager is actively engaged in sourcing and co-ordinating support from a wide range of services/agencies across the public, private and 3rd Sector, in order to continue supporting this work stream and reduce demand on USC, freeing up capacity for both COVID-19 and non COVID patients

It is recommended that this work continues during the pandemic to:

- Support Unscheduled Care services to decrease attendances and length of stay
- Decrease admission conversion rates thereby releasing bed occupancy
- Ensure patients have continued support from available or alternative community services
- Continue to increase the well-being of the patients the service supports
- Continue to work with the other agencies remotely
- Ensure all current Anticipatory Care Plans are updated with actions to incorporate COVID-19
- Continue highlighting and sharing Information Alerts between EDs for frequent attenders of multiple EDs
- Liaise with partner agencies like Police and Counter Fraud for the sharing of risk
- Support the EDQDF with streaming principles and options to align with the Redesigning Access to Emergency Care model

For further information/data, please contact: william.adams3@wales.nhs.uk or anna.sussex@wales.nhs.uk

All of Wales

Attendances to Welsh Emergency Departments involving 5 or more visits per year

WEDFAN
Welsh Emergency Department Frequent Attenders Network

Average attendee

1.4 attendances per person

Frequent attenders*

6.8 attendances per person

No of Attenders vs No of visits

Length of stay

5.2 hrs per attender
3.7 hrs pervisit

TOTALS FOR ALL ATTENDEES
No of attendees: 746,861
No of visits: 1,048,532
3,902,543 hrs

TOTAL COST FOR ALL ATTENDEES
£401,181,420

Length of stay

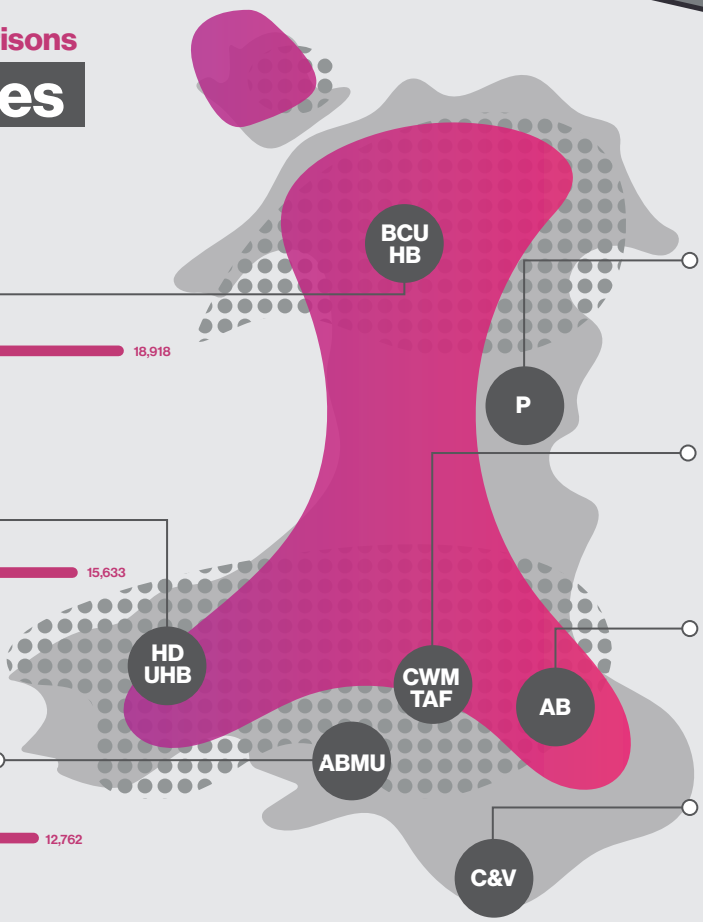
32 hrs per attender
4.6 hrs per visit

TOTALS FOR ALL ATTENDEES
No of attendees: 12,362
No of visits: 84,635
386,330 hrs

TOTAL COST FOR ALL FREQUENT ATTENDERS
£39,714,724

Health board comparisons

Attendences by region



BETSI CADWALADR UNIVERSITY HEALTH BOARD
Attendees: 2,724
Attendances: 18,918
125,686 hrs £12,920,520

POWYS TEACHING HEALTH BOARD
Attendees: 558
Attendances: 4,941
3,058 hrs £314,362

HYWEL DDA HEALTH BOARD
Attendees: 2,329
Attendances: 15,633
68,198 hrs £7,010,754

CWM TAF HEALTH BOARD
Attendees: 1,965
Attendances: 12,909
52,822 hrs £5,430,101

ANEURIN BEVAN HEALTH BOARD
Attendees: 1,296
Attendances: 8,648
40,226 hrs £4,135,232

ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD
Attendees: 1,882
Attendances: 12,762
63,169 hrs £63,169

CARDIFF & VALE HEALTH BOARD
Attendees: 1,608
Attendances: 10,824
33,172 hrs £3,410,081

*Frequent attender = A person who visits an ED 5 or more times in one year

**These figures do not include the 2,500 "hospital hoppers" included in the all Wales figures

***Figures correct as of: xx/xx/xxxx

WEDFAN

Welsh Emergency Department Frequent Attenders Network

WEDFAN WINTER FUNDING 2019/20

YGC BETSI CADWALDR UHB DATA

ABSTRACT

Data Findings and Funding Outcome: Welsh Emergency Department Frequent Attender Network

William Adams, Anna Sussex

WEDFAN Operational Support Manager, National Strategic Lead

POINTS OF NOTE: (YGC Data)

20 Patients (same patients followed/case managed through funding period)

92% reduction in ED attendances during funding period

84% reduction in length of stay during funding period

75% reduction in inappropriate repetitive investigations during funding period

88% reduction in costs during funding period

Month	Cost	Reduction	Overall Reduction
Month 1	£79,475.19		
Month 2	£25,451.11	£54,024.08	
Month 3	£11,186.04	£14,265.07	£68,289.15

Recruitment

The initial recruitment came under a number of issues. Firstly the current Support Lead, who is a Clinical Psychologist from the Health Psychology Department, could not obtain any confirmation that the Emergency Department would support this pilot. Decision was then made to process the post through the Liaison Psychiatry Department, which is where the current Frequent Attender panel hosts its multi-agency meetings. During the processing of this, the Emergency Department agreed to then support the pilot for recruitment process and line management.

Alcohol Liaison Nurse from Liaison Psychiatry was interviewed in January 2020 and commenced in the post in February 2020.

There were no expressions of interest for the Band 3 post.

Total for Band 7:	£8,297.16
Total for Band 3:	£0.00
Total Spend:	£8,297.16

Total Spend for the recruitment: £8,297.16

The role of the Case Manager is as follows;

• Reduce contacts with Unscheduled Care

• Reduce time spent in the Emergency Department

• Reduce time WAST are on scene with patients

• Reduce time practitioners spend on consultations in the Out of Hours service.

• Co-ordinate multi-agency support across health, local authority, police and 3rd Sector agencies

• Create Multi Agency Anticipatory Care Plans for patients to promote a consistent approach on each contact.

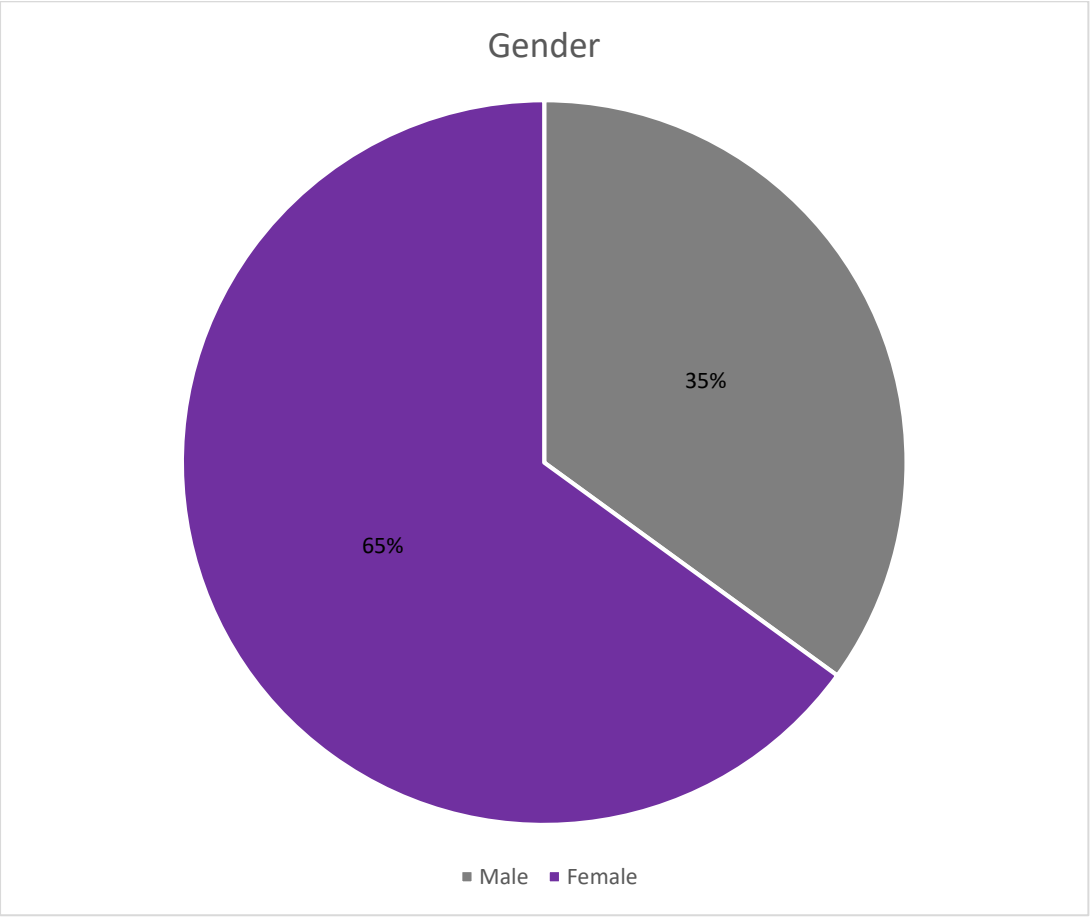
• Hold the ring on communication between agencies, promoting joint decision making

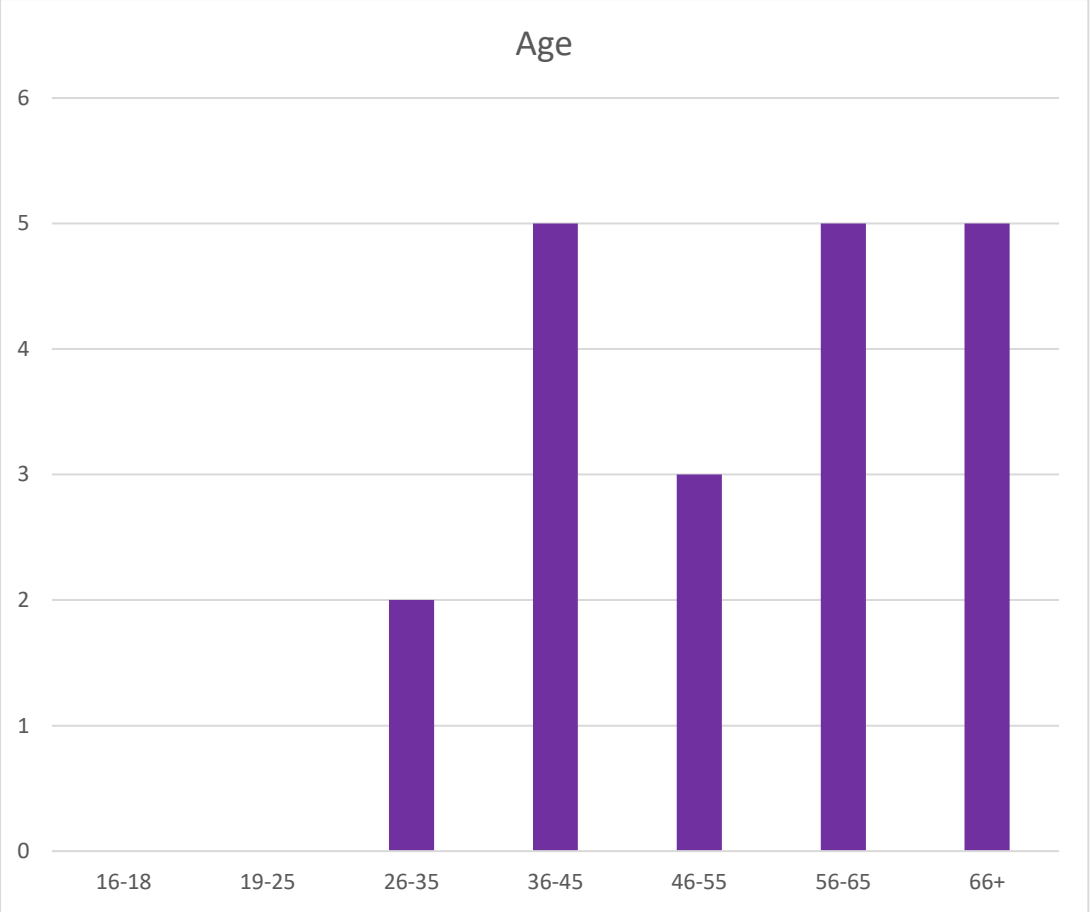
• Provide support to patients on a daily basis as a point of contact rather than 999 or ED

Data

	Month 1	Month 2	Month 3
NUMBER OF PATIENTS	20	20	20
ED VISISTS	83	26	16
WAST CALLS	55	47	0
OOH CALLS	32	0	0
TOTAL OF CONTACTS	201	73	16
COST OF WAST	£13,244.00	£7,238.00	£0.00
COST OF OOHS	£1,248.00	£0.00	£0.00
LENGTH OF STAY IN ED (HOURS)	520	132	80
NUMBER OF INVESTIGATIONS	291	127	71
NUMBER OF CDU STAYS	5	2	0
TOTAL COST OF LENGTH OF STAY AND INVESTIGATIONS	£56,636.82	£16,613.11	£9,586.04
TOTAL ADMISSIONS INTO HOSPITAL FROM ED	15	1	1
TOTAL COST ED/WAST/OOH/ADMISSION	£79,475.19	£25,451.11	£11,186.04

Demographic





Mean Age – 50 years

If the work was to continue, it will:

Support Unscheduled Care services to decrease attendances and length of stay

Decrease admission conversion rates thereby releasing bed occupancy

Ensure patients have continued support from available or alternative community services

Continue to increase the well-being of the patients the service supports

Continue to work with the other agencies remotely

Ensure all current Anticipatory Care Plans are updated with actions to incorporate changes in Emergency Departments modelling.

Continue highlighting and sharing Information Alerts between EDs for frequent attenders of multiple EDs.

Provide a partnership with agencies like Police for the sharing of risk

Positive feedback from patients within the BCUHB Long Covid Service

- Only had 2 sessions. Feels empathy and good understanding of my needs. More frequent session's maybe to improve service. Definitely signs of improvement, able to do some gardening & housework albeit short sessions. Also walking more but uphill a struggle. BP is elevated still under meds review. Still around 145/94 on average. Taking 100mg Losartan daily. Sleep still an issue up for 2-3 hours most nights.

- Claire was exemplary in her care, and the service is wonderful. She was outstanding. Things have such a dull, grey uniformity and it's great to have a shining star. The site is amazing.

- Staff were easy to talk to and informative. Was also nice to hear what others were going through and feel understood. Nothing to improve on. Initially found the journey difficult but understand this cannot be helped.

- All staff very professional, caring and supportive. Haven't heard any treatment suggestions, which we've all been hoping for. Diagnostic testing would be welcomed.

- Very understanding and caring responses under a difficult situation that we are ALL still learning about. Maybe a route into Biomedical area would improve experience. Thank you to everyone who helped me, they were absolutely fantastic and very professional and caring and listened sympathetically.

- Saw a pleasant lady in clinic, not a good enough service just a tick box exercise, need to provide aims and objectives before appointment indicating what you can provide.

- Saw the same person each time in the same place. She was very compassionate in her manner. Far to travel to clinic especially with a hospital in Bangor.

Extract from the "Adferiad" (Recovery) Long COVID National Evaluation (Cedar)

- When asked about their experiences with the Long COVID service, the majority of responders in all groups reported that they '*always'* felt '*their concerns were listened to/understood*', and that they were '*supported to get the help and information they needed*'. More responders said that they were '*always involved enough in deciding what support they received*' than any other answer option. More than 70% of responders rated their overall experience with the Long COVID service above average (i.e. >5), and more than 88% would recommend the service.

- In the free text feedback about service user experience, many responders expressed their gratitude to the Long COVID service for feeling listened to and acknowledged, having received helpful treatment and advice and been put in touch with other fellow sufferers who can understand what they are going through. However, other responders urged the service to become more tailored around different users' needs. They suggested support should expand beyond rehabilitation/symptoms' management and develop tighter links with medical consultants, since this would allow prompt medical testing and diagnosis to inform treatment. Some responders would prefer more face-to-face appointments, now that rules allow, and longer/more frequent sessions. Keeping service users up-to-date with research developments in Long COVID treatment was mentioned as beneficial.

Positive Feedback Themes from "Adferiad" (Recovery) National Evaluation

Themes (Positive feedback)

Excellent support from the Long COVID service

- *"The support and understanding and patience was amazing"*
- ***"T**he team have been quick in responding with emails and sending out information. Excellent communication […] I have recommended service to a friend and I have told my manager about the service so hopefully it will spread awareness."*
- *"It's a very good service"*
- *"Great follow up sessions."*
- *"Positive experience, been great having somebody to understand and reassure. Thank you. You should be applauded for your service and for all that you are going."*
- *"Can't thank you enough. It's good to know someone cares"*
- *"Help provided has been amazing due to new Long COVID. Knowing able to email and contact. accessibility of service has been fantastic"*
- *"The experience has been outstanding; I would like to thank you all. You called me on a down day and picked me back up."*
- *"Good communication and flexible service"*
- *"I think the Long COVID team/service should be commended."*
- *"It's a service that's very much needed."*

Responders felt put at ease, listened to and acknowledged by the Long COVID team

- *"Having support knowing not on my own and someone to advise and support recovery"*
- *"They had time to listen and I felt fully supported by their suggestions and the help offered."*
- *"I have felt completely valued, listened to, consulted about and in control of my recovery."*
- *"To find that the staff were open, friendly, understanding, patient, empathetic, knowledgeable and supportive was immensely helpful. To feel that someone understands and supports you and reassures you that this is not all in your head and is real and knows how that COVID 19 can be very debilitating, is so reassuring and helps you both physically and mentally."*
- *"Friendly, supportive staff, empathetic and listening to my concerns. Thank you!"*
- *"I always felt someone was there to listen to me, I didn't feel ignored."*
- *"I feel wonderful talking to you; I feel at ease and look forward to when you call."*
- *"The team were very accommodating, very understanding, caring and they listened to me."*
- *"The staff are very nice and are trying to help. They were amongst the first to actually listen to my experience and I am very grateful to them."*
- *"The Long COVID team have been extremely understanding and it's been very helpful having someone to talk to about my symptoms who does not make me feel like a hypochondriac "*
- *"The service staff were the first NHS staff who listened and empathised with my experience of Long COVID."*
- *"I was finally listened to, someone believed in me. To be able to talk to someone and go through plans for my rehabilitation, although there is no magic wand I feel that with help and support I will get through this."*

Responders found the Long COVID service staff knowledgeable and the advice/treatment provided helpful

- *"I feel that this help and support has been invaluable to me and has given me so many strategies to help me cope with my ongoing symptoms."*
- *"It made a big difference to me, I feel better able to cope and feel better in terms of symptoms"*
- *"you've always been brilliant and come up with good ideas of support. You have also chased everything up which has been helpful"*

- *"Strategies to put in place useful"*
- *"Emails were useful to follow up on information given, the exercises I found particularly useful"*
- *"Through the Long COVID Service I have learned more about the condition."*
- *"They […] worked with me and enabled me to identify how I could constructively move forward supported by them and how I could best support myself. […] I am not cured, but I am in control - patient centred care and ownership by the patient/client. […] I have recommended this service to others including young people who are really struggling with Long COVID and related mental health issues."*
- *"Practical advice that facilitated some autonomy over the condition."*

Responders mentioned specific components of the Long COVID service that improved their recovery

- *"I have been given information, advice, physical, emotional and financial support from a wide range of services […] pain and fatigue clinic, respiratory services, speech and language therapists and Silvercloud supporters. Amazing!"*
- *"Pulmonary rehabilitation for Long COVID was very good in helping me understand what was happening to my body and gave me tips on how to help myself."*
- *"The session in sleep was particularly useful and I wish that had been longer."*
- *"The Rehab team physio who I had a 1:1 phone call assessment with was excellent."*
- *"Breathing exercise were good and memory aides helped."*
- *"[…] I found the activity dairies really useful also as it has helped me to monitor and self-manage better."*
- *"Help from the physio with moving and support with PTSD [Post-Traumatic Stress Disorder]."*
- *"Having someone to talk through the difficulties with mental health issues. Physical activity from rehab – physiotherapy."*
- *"Very good support from occupational therapist when required."*
- *"Going on an EPP [Education Programs for Patients] course was invaluable"*
- *"1-2-1 with psychologist".*
- *"Range of suggestions given by speech to manage symptoms"*
- *"Oral spray for dry mouth from the speech therapists was helpful"*
- *"Just having the support and advise about pacing was great, I just wish I could have had it 12 months earlier. "*

Responders valued the group sessions, which allowed them to get mutual support, sharing and recognition from the interaction with other patients

- *"Meeting others in the same boat was a huge positive."*
- *"The online group sessions with others who are going through the same thing are really helpful to give you the opportunity to share your problems with them and to gain and share tips and strategies from others who have been or are going through the same things."*
- *"Good to connect with others who had Long COVID."*
- *"Group zoom meetings - sharing information with other sufferers"*

Good support from GPs

- *"The GP spent time to understand the problems, arrange tests to rule out other issues, tried different medications and then referral to the Long COVID rehab service."*
- *"The GP acted on suggestions given by the team, an appointment with another service was also arranged directly."*

Responders felt the Long COVID service was personalised around their needs

- *"I felt that the rehab on offer was based on what I needed."*
- *"Friendly, sympathetic medical staff who listened, understood and tried to cater for individual needs."*
- *"Individually tailored rehab".*
- *"It was helpful to discuss ongoing symptoms and receive personalised advice on current management."*

For:	BCUHB Long COVID Service Business Case
Date form completed:	18th August 2022

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?

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Business Case Proposing Enhancement of the BCUHB Long COVID Service to meet population need (Part A) and to address gaps in service provision for Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Persistent Physical Symptoms (PPS) and Breathing Pattern Disorder (BPD) by developing an overarching Community Complex Conditions Service (Part B).
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Stakeholders highlighted that low levels of literacy and pervasive language disorders are known to exist in communities at higher risk of COVID-19, CFS/ME & PPS which can create challenges seeking help. The outline vision of this Programme is to enhance the existing Long COVID Service: To provide the required levels of care and support for our patients and staff to address the longer-term effects of the conditions outlined above. In addressing the issues identified and to deliver the stated vision the following objectives of this programme have been defined: Objective 1: To develop the patient pathways as required to support the local population manage the longer-term health conditions resulting from Long-COVID and improve their outcomes Objective 2: To manage the impact of Long-COVID on our health & care workforce across the BCUHB regions Objective 3: To work with partners to develop the knowledge base around Post-COVID recovery. Objective 4: To deliver sustainable service

		improvements for similar longer-term conditions including CFS/ME, PPS and BPD.
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?	The Long-COVID Strategic Oversight Group will oversee the performance and delivery of the various work streams associated with the pan North Wales BCUHB Long-COVID service to ensure that the population of North Wales is provided with the most appropriate and effective pathways to manage the longer-term chronic pain management conditions arising from the Coronavirus pandemic. The Group will escalate decisions to the Executive Management Team and the Board as required within the scheme of delegation.
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Welsh Government has resourced Long COVID services across Wales through the Adferiad fund. In the latest funding announcement WG directed Long COVID services to use the funding to support not only Long COVID but also other similar conditions such as CFS/ME. The business case this document is reviewing makes the case for such service development in BCUHB.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The following stakeholders have been identified • Patients • Primary Care • Community • Nursing • Secondary Care • Respiratory • Cardiology • Neurology • Mental Health • BCU Staff • Workforce / OH • LA Social Care • Care Homes • Wales COVID-19 Evidence Centre: Gathering research and evidence to influence and support the national programme involvement in work streams to develop knowledge base and address socio-economic issues.

		• Regional Partners: Interdependencies with Health & Social Care Recovery Group – consider most suitable governance arrangements. • Expert Patient Programme • Chronic Disease Self-Management Programme • Public Health Wales
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Long COVID and CFS/ME both have a high public and political profile. This can lead to a diverse range of views about how to support these conditions and the potential for misinformation about best practice. The Long COVID service was developed through a comprehensive co-design process. In its delivery it continues to have the benefit of an active lived experience consultation group working together with the clinicians leading the service. This helps to ensure the voice of people with lived experience of the conditions we serve is at the heart of service development and delivery.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The proposed service development outlined in this business case will enable BCUHB to provide a comprehensive biopsychosocial multi-disciplinary service, which meets best practice clinical guidance, and delivers care closer to home, for people with a range of complex conditions. It has been widely documented in research literature that people with Long COVID, PPS and CFS/ME have often felt isolated, unsupported and that services did not meet their needs nor have the specialist knowledge and expertise to support them effectively and comprehensively. The service development in this proposal would enable BCUHB to address all of these issues for the people in North Wales experiencing these conditions.

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

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**	**How will you reduce or remove any negative Impacts that you have identified?**

			website here	

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.

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	x	According to research published by Age UK, around 3.3. million people over 70 in the UK have had their mental wellbeing affected by the COVID-19 pandemic, experiencing feelings of worry, stress, anxiety and loneliness.	Work with Age UK via the Equality Stakeholder Group representative and with the Community Health Council to ensure guidance and materials are inclusive of those issues that may be faced by older people and

					This may impact upon older people when asked to engage in Long COVID recovery programmes and an assurance and reassurance approach will need to be developed to ensure people are not isolated from the programme. It appears that ongoing symptoms of COVID-19 may be more likely to be reported in older people. However, there seem to be different clusters of symptoms in different ages, which means that there could be different presentations for children and younger people and adults compared with people aged over 65. There could be difficulty accessing care for older people who cannot easily ask for help because of mobility or sensory impairments. These factors may lead to older people becoming less likely to seek	address those concerns. Development of a FAQs for staff involved in the programme to include questions based on age. Review and redraft of the objectives to explicitly acknowledge the need for services to be fully accessible to people with protected characteristics. Suggest objective 1. Development of leaflet/flyers describing the Long COVID service and how to access it. These will be made available in community venues now that pandemic restrictions allow for this action. This will improve access for those that maybe digitally excluded.

					help. Stakeholders highlighted that the prevalence of post-COVID-19 syndrome is unknown in care homes. However, the high incidence of acute COVID-19 infection in these settings and the emerging evidence of higher rates of reported ongoing symptoms in older people suggests that these factors should be considered when drafting recommendations. It was also highlighted that existing services may have exclusion criteria, related to age, which may lead to inequitable access. One stakeholder highlighted that older people with acquired communication impairments or dementia could be less likely to report symptoms and may require additional support (such as speech and language therapy) to facilitate access to	

					care. Some older people may be less active on digital media (such as social media) and so may not be exposed to campaigns that raise awareness about post-COVID-19 syndrome affecting older people. As a result, older people might be at higher risk of presenting late to services.	
Disability	x		x	x	There may be some situations when pre-existing comorbidities or mental health illness may create challenges for people seeking help and accessing services People with communication, speech and language difficulties may not be able to describe, explain or communicate subtle or complex symptoms, which may not be obvious to those caring for them. These specific and unique issues have the potential to impact on	All pathway development work to fully use evidence of the impact of comorbidities and physical, mental and sensory impairments. Long COVID added as a prompt in EQIA Training, procedure and template.

					healthcare accessibility Some frequently reported symptoms of COVID-19 may result in disability and create challenges for seeking help and accessing services. People living with long COVID may be protected under the Equality Act as a long-term condition that affects people's day to day activity. This will have implications for services and for the Health Board as an employer as we will need to ensure Long COVID is considered in our Equality Impact Assessments.	
Gender Reassignment		x			Evidence shows that transgender people have higher levels of mental health problems. As the long-term effects of long COVID are increasingly understood the intersectionality of this with transgender people – added to	

					the fact that trans people often are more reluctant to access health services. 4% of trans respondents have sought medical help for depression or anxiety and 72% have self-harmed now or in the past. This compares to 42% and 52% of the LGBQ+ sample and 29% and 35% of the heterosexual non-trans sample respectively.	
Pregnancy and maternity	x		x		Women who are pregnant, and parents and carers of young children who are struggling with symptoms, may have difficulty attending their midwifery or health visitor appointments as well as difficulty accessing health and social care services where they could gain advice and assistance. This may increase the likelihood of a	

					delay in seeking help.	
Race	x		x	x	There is evidence of poorer outcomes from COVID-19 in black, Asian and minority ethnic populations. This has been linked to a number of potential factors. Higher rates of comorbidities, such as cardiovascular disease, obesity and diabetes in some black, Asian and minority ethnic populations, which have been associated with COVID-19 mortality. A person's occupation, for example over-representation in key worker roles in health and social care; pre-existing socioeconomic factors (such as housing conditions), which could affect people's ability to maintain infection control and prevention measures, and to follow healthy	Programme to be reviewed alongside and in light of the publication of the Wales Race Equality Action Plan. Evidence to continue to be collated by the programme. All feedback from patients and families to be monitored by protected characteristic. Data on incidents of Long COVID to be reviewed by protected characteristic where this data is available. Requests for translation services and interpretation for services in other languages to be monitored and materials and information to be translated in to the top 5 other spoken languages in

					lifestyles that might assist in reducing risk. While the prevalence of prolonged COVID-19 symptoms in black, Asian and minority ethnic groups is currently not known. It is important to consider these factors when drafting recommendations. People from black, Asian and minority ethnic groups may feel marginalised, have experienced racism, or have had previous experiences with a culturally insensitive healthcare service that could create barriers to engagement with healthcare services. For people whose first language is not English or Welsh, there may be communication difficulties and a need for an interpreter especially for seeking help and effective shared decision making.	North Wales as identified through WITS

Religion, belief and non-belief		x			People may feel or have experienced stigma based on their religion or belief when accessing healthcare services that may create challenges for seeking help.	
Sex	x		x	x	There are known differences in terms of poorer outcomes from COVID-19 for men compared to women, so it is important to consider potential differences in clusters of symptoms when drafting recommendations. It will be important to gather data on our cohort of long COVID patients to increase our understanding of the differences in impact. Stakeholder's referenced emerging evidence that women are more likely to report ongoing symptoms compared to men. However, it is	Data to be gathered on all patients on the Long COVID pathways by protected characteristics and regularly reviewed by the Programme Board.

					important to consider that male help-seeking behaviours tend to be different and therefore symptoms could be under-reported.	
Sexual orientation		x			People may feel or have experienced stigma based on their sexual orientation when accessing healthcare services that may create challenges for seeking help.	
Marriage and civil Partnership (Marital status)		x			People may feel of have experienced stigma based on their marital status when accessing health care services that may create challenges for seeking help.	

Socio Economic Disadvantage	x		x		Poverty and poor housing may have substantial impacts on accessibility to healthcare resources. Often it is those who have the greatest need for healthcare services who live furthest away from them. This could cause further delay in seeking help. People who are homeless may face challenges accessing care or may present late to services, so they may be more likely to have adverse outcomes to if they accessed services sooner. Stakeholders highlighted that low levels of literacy and pervasive language disorders are known to exist in communities at higher risk of COVID-19, which can create challenges seeking help. Healthcare services are	

					increasingly using digital methods for people to access care. This could create challenges for people with disabilities, low digital literacy, or people who do not have devices or connectivity to use these services. Online forms are an additional barrier to some people (for example those with communication or dexterity difficulties) in accessing healthcare. This factor may lead to some groups of peoples becoming less likely to seek help. People may feel or have experienced stigma based on their socio-economic background when accessing healthcare services that may create challenges for seeking help. Poverty may also impact on the individual's ability to access online material or apps for GP	

					appointments and health information, creating a further barrier within a health literacy and access context. One stakeholder highlighted emerging evidence of a link between social deprivation and incidences of COVID-19 that needs to be explored further. Stakeholders highlighted that inequities are faced by groups such as people in prison, Gypsies and Travellers, Armed Forces personnel and people who have been trafficked should be considered when drafting recommendations.	

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

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		x		Article 2 – Right to life	People have the right to live to the highest attainable standard of health. Feedback from patients, including recent patient stories captured on video, details the positive impact the service has had on people's life and health in comparison to how	Continued engagement with patients with Lived Experience. Continued co production and co development of the service. Continued

					things were for them before the Long Covid pathway was available. Further development of the service will capture a wider patient group of the population of NW living with a chronic health condition by addressing the current gaps in service provision for this patient group.	engagement with the Patient Experience team and the collation of patient feedback and stories.

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			All documentation relating to the scheme will be readily available in Welsh and English.	
Treating the Welsh language no less favourably than the English language		x			All documentation relating to the scheme will be readily available in Welsh and English.	

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 service was originally co-designed and co-produced with patients with Lived Experience. This has and continues to be an integral part of the service development to date. The service continues to work closely with the PALS service and engages with the Lived Experience Pathway group, which meets monthly. The views of the patients have been listened to and acted on throughout.	
Have any themes emerged? Describe them here. Patients that are digitally excluded and with language barriers, disabilities or other socio-economic disadvantages, resulting in lack of information available to these groups on the service and what is available to them.	
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations? The service works closely with the Lived Experience Pathway group and continue to listen to the views of patients. Co-design and Co-production of the service is an integral part of our service development. We will continue to work to ensure all population groups are captured and our service is accessible to everyone who requires it. Our recruitment plan has been adapted to incorporate a patient engagement officer role.	

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

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid*	Business Case Proposing Enhancement of the BCUHB Long COVID Service to meet population need (Part A) and to address gaps

p13-18)	in service provision for Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Persistent Physical Symptoms (PPS) and Breathing Pattern Disorder (BPD) by developing an overarching Community Complex Conditions Service (Part B).

2. Brief Aims and Objectives: (Copy from Form 1)	The outline vision of this Programme is to enhance the existing Long COVID Service: To provide the required levels of care and support for our patients and staff to address the longer-term effects of the conditions outlined above. In addressing the issues identified and to deliver the stated vision the following objectives of this programme have been defined: Objective 1: To develop the patient pathways as required to support the local population manage the longer-term health conditions resulting from Long-COVID and improve their outcomes Objective 2: To manage the impact of Long-COVID on our health & care workforce across the BCUHB regions Objective 3: To work with partners to develop the knowledge base around Post-COVID recovery. Objective 4: To deliver sustainable service improvements for similar longer-term conditions including CFS/ME, PPS and BPD.

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	

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, you should be able to answer 'No' to this question.**		No
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	
4. Did your assessment		No

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?	Where negative impact has been identified, mitigations are in place to proceed.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?		No
	Mitigating actions in place to address.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes	
	How is it being monitored?	Long Covid Strategic Oversight Group meets monthly to monitor implementation.
	Who is responsible?	Long Covid Service Leads
	What information is being used?	Engagement with PALS service and data from Patient Experience feedback and reports.
	When will the EqIA be reviewed?	September 2022

7. Where will your policy or proposal be forwarded for approval?	Health Board Executive 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
	Rachel Skippon Claire Jones Natasha Turner	Consultant Clinical Psychologist Long Covid Therapy Lead Operations Manager

Senior sign off prior to committee approval:	Gareth Evans	Acting Executive Director of Therapies
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:	None identified.	N/A	N/A
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	Changes to the recruitment plan	Service Leads	Complete
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	A patient leaflet has been produced to provide information and support to people. A PALS officer for the service will help to capture patients that are digitally excluded or who have language barriers, disabilities	Service Leads	Complete

place?	or other socio economic factors affecting their ability to access information.		
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.	None identified. Mitigating actions are in place.	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Recruitment of a PALS officer for the service.	Service Leads	September 2022

Teitl adroddiad: ***Report title:***	**Summary of business considered in private session to be reported in public**			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 12 May 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The Finance, Performance and Information Governance Committee considered the following matters in private session at the 23.2.23 meeting • Revised Energy governance and procurement arrangements in NHS Wales. These were endorsed and Health Board approval recommended. • Dental contractor request to novate contract was approved. • Draft IMTP update • A digital system progress update			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster Interim Executive Director Finance			
Awdur yr Adroddiad: ***Report Author:***	Diane Davies Corporate Governance Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	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
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Rheswm dros gyflwyno adroddiad i bwyllgor cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential Committee (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Advised in private session reports where appropriate	
Rhestr o Atodiadau: Dim ***List of Appendices:*** None	