Bundle Finance & Performance Committee 27 August 2020

Unfortunately we are presently unable to accommodate attendance by members of the public to our Health Board's committee meetings due to Covid-19 restrictions. However we will publish our draft minutes within 3 working days of the meeting taking place on our website

1 FP20/91 Apologies for absence

Mark Wilkinson - Sally Baxter to deputise

2 FP20/92 Declaration of Interests

3 09:30 - FP20/93 Draft minutes of the previous meeting held on 16.7.20 and summary action plan

FP20.93a Minutes FPC 16.7.20 v.04 public session.docx

FP20.93b Summary Action Log.doc

4 for assurance

5 09:45 - FP20/94 Q2 Annual Plan: Monitoring of progress against actions for F&P

Sally Baxter
Recommendation
The Committee is asked to note the report

Revised report uploaded 25.8.20

FP20.94a Q2PMR.docx

FP20.94b BCU Quarter Two Plan Monitoring Report - July 2020 FINAL v2.0.pdf

6 10:05 - FP20/95 Quality and Performance report

Sally Baxter
Recommendation
The Finance & Performance Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

FP20.95a QAP.docx

FP20.95b QP Report FP - July 2020 FINAL.pdf

7 10:25 - FP20/96 Planned Care update including RTT and essential services

Gill Harris
Andrew Kent and Gavin Macdonald in attendance
Recommendation:
The Committee is asked to note the following:
The overall growth in the waiting times because of the legacy of Covid-19 and the continuing reduction in available/functional capacity.
That essential elective activity still being undertaken is in lower numbers than pre-covid.
The paper describes the challenging scenario for planned care and its mitigations in a pandemic.
That the recovery and re-set is going to take a considerable amount of time and needs to be measured in quarters/years rather than months

FP20.96 Planned care and RTT update august FD1.docx

8 10:45 - FP20/97 Unscheduled Care and Building Better Care update

Gill Harris
Recommendation
The Committee is asked to note the Unscheduled Care performance for July 2020 across BCUHB and for each Health Community

FP20.97 USC REPORT v1.0.docx

9 11:00 - Comfort break

10 11:10 - FP20/98 Capital Programme report Month 3

Sally Baxter
Neil Bradshaw in attendance
Recommendation
The Committee is asked to receive this report and note the reported exceptions

FP20.98 Capital Programme Report - Month 4.docx

11 11:20 - FP20/99 Finance Report Months 4 and 3

Sue Hill
Recommendation:
The Committee is asked to note the reports

FP20.99a M04 Finance Report.docx

FP20.99b M03 Finance Report.docx

12 11:50 - FP20/100 Interim report on Covid 19 financial governance

Sue Hill
Recommendation:
The Committee is asked to:
a) Note the early self-assessment against the key Welsh Government Principles.
b) Note that that the formal "Lessons Learned Report" from the Governance Cell will be issued for discussion at the October Committee Meeting.

FP20.100a Interim report on Covid 19 Financial Governance.docx

FP20.100b Appendix A - COVID Expenditure Summary Analysis.pdf

FP20.100c Appendix B - WG Letter and Guidance 30th March 2020.pdf

FP20.100d Appendix C - DoF Letter of 3rd April 2020.pdf

13 12:05 - Lunch break

14 for approval

15 FP20/101 Estates / Capital Business Cases for approval

15.1 12:30 - FP20/101.1 Nuclear Medicine Consolidation Strategic Outline Case

Adrian Thomas
In attendance:
Mark Elias, Consultant Radiologist
Ian Howard, Assistant Director – Strategic and Business Analysis
Pat Youds, Professional Lead, Radiography/Radiology Manager
David Fletcher, Directorate General Manager, North Wales Managed Clinical Services
Recommendation
The Committee is asked to approve the Business Case for submission to the Board.
(Subject to Board approval the case will then be submitted to Welsh Government).

FP20.101.1.0 Nuclear Medicine SOC Companion Slides v3.pptx

FP20.101.1a Nuclear Medicine SOC F&P Coversheet August 20.docx

FP20.101.1b DRAFT SOC V0.23 19.08.2020.docx

FP20.101.1c Appendix A Imaging Statement of Intent.pdf

FP20.101.1d Appendix B AGW Radiology Services in Wales.pdf

FP20.101.1e Appendix C AWPET Overview Strategic Recs.pdf

FP20.101.1f Appendix D WHSSC PET in Wales Programme Brief.pdf

FP20.101.1g Appendix E Patient Flow.docx

FP20.101.1h Appendix F SOC Cost Forms 24.06.2020.xlsx

FP20.101.1i Appendix G Revenue v.5.xlsx

FP20.101.1j Appendix H NM Consolidation Risk Register V0.03 15.07.20.xlsx

FP20.101.1k Appendix I EQIA Signed 09.01.2020.pdf

FP20.101.1l Appendix J NM PET CT Change Protocol Signed.pdf

FP20.101.1m Appendix K DRAFT RPA Form 25.02.2020 V0.03.docx

15.2 12:45 - FP20/101.2 Staff Lottery - from Charitable Funds

Sue Hill
Recommendation:
The Committee is asked to approve the establishment of a Health Board staff lottery

FP20.101.2a Staff lottery.docx

FP20.101.2b Final_BCUHB Staff Lottery Business Case Version 3.docx

16 13:00 - FP20/102 Committee annual report 2019/20

Sue Hill
The Committee is asked to
\- agree the overall and individual Committee objectives' RAG status ratings
\- approve the Committee Annual Report 2019/20 for submission to the Audit Committee to be held on 17\.9\.20

FP20.102a FPC Committee Annual Report front template.docx

FP20.102b FPC Committee Annual Report 2019-2020 DRAFT v.03 submitted to 27.8.20 meeting.docx

FP20.102c App2 Finance and Performance Committee TOR v5.01.docx

FP20.102d App 3Cycle of Business 2020_21 v1.03.docx

17 for information

18 13:05 - FP20/103 Monthly monitoring report months 4 and 3

Sue Hill
Recommendation
The Committee is asked to note the monitoring reports for months 4 and 3 submitted to Welsh Government

FP20.103a Monitoring Return Month 4.docx

FP20.103b App1 MR Report M4 2021.pdf

FP20.103c Monitoring Return Month 3.docx

FP20.103d App1 MR Report M3 2021.pdf

19 FP20/104 Summary of private business to be reported in public

Sue Hill
Recoomendation
The Committee is asked to note the report

FP20.104 Private session items reported in public v1.0.docx

20 FP20/105 Issues of significance to inform the Chair's assurance report

21 FP20/106 Date of next meeting 29.10.20

22 FP20/107 Exclusion of the Press and Public

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

Finance & Performance Committee
Draft minutes of the meeting held in public on 16.7.20
via Webex

Present:

Mark Polin	BCUHB Chairman *(part meeting)*
John Cunliffe	Independent Member / Committee Vice Chair
Eifion Jones	Independent Member
Helen Wilkinson	Independent Member

In Attendance:

Simon Dean	Interim Chief Executive
Andrew Doughton	Wales Audit representative – to observe
David Fearnley	Executive Medical Director
Lesley Hall	for Executive Director Workforce and Organisational Development (OD)
Gill Harris	Deputy Chief Executive / Executive Director Nursing and Midwifery
Sue Hill	Acting Executive Director of Finance
Chris Stockport	Executive Director Primary and Community services *(part meeting)*
Emma Wilkins	Deputy Director, Financial Delivery Unit (FDU)
Mark Wilkinson	Executive Director Planning and Performance
Diane Davies	Corporate Governance Manager (Committee Secretariat)

Agenda item	Action by
FP20/64 Chairman's opening remarks **FP20/64.1** It was noted that BCUHB was presently unable to accommodate attendance by members of the public to Health Board committee meetings due to Covid-19 restrictions. **FP20/64.2** The Chairman reported that, due to publication timescales, he had undertaken chair's action in order to ensure the following business cases would be discussed at the 23 July Board meeting: • Approval of Revenue Business Case for Defibrillator replacements • Approval of Full Business Case for Digital Health Record **FP20/64.3** He stated that the regular RTT discussion would be undertaken as part of the Board workshop taking place later that day. The Chairman advised that he would commence chairing the meeting and handover to the Vice Chair in order to attend to an urgent matter that had arisen.	

FP20/65 Apologies for absence Apologies were received from Sue Green for whom Lesley Hall deputised	
FP20/66 Declarations of Interest None received	
FP20/67 Draft minutes of the previous meeting held on 27.6.20 and summary action log The minutes were agreed as an accurate record and updates were provided to the summary action log. In respect of the Vanguard unit action, the Chairman requested that any further commissioning should consider potential staff costs not utilised and also the booking issues highlighted within the External contracts report.	
FP20/68 Primary and Community Services - sustainability and transformation **FP20/68.1** The Executive Director Primary and Community services presented this item. He advised that the report provided an update in plans to address primary care sustainability alongside an update on health and wellbeing centres in partnership. He drew attention to the headlines. **FP20/68.2** It was noted that Primary Care services continued to face sustainability issues, with demand on more services to be provided, coupled with a reduction in the number of newly qualifying professionals entering primary care and an increasing number of GPs retiring. To help manage the immediate and ongoing challenges, a GMS '5 Domains risk assessment matrix' was developed by the Health Board to risk assess across a range of areas, based on detailed local knowledge of GP practices from the Area and Primary Care Contracting Teams. Each Area Team, supported by Primary Care contracting and Clinical Governance, regularly review practice issues in relation to sustainability and capacity, **FP20/68.3** In November 2018, the national Strategic Programme for Primary Care was established as an All-Wales, Health Board-led programme that works in collaboration with Welsh Government and responds to *A Healthier Wales*. Before the pandemic, and now moving forward, there were three distinct areas of work required, to further support and ensure the sustainability of primary care services in North Wales, progress of which was set out within the paper. • The further development of the Primary & Community Care Academy • Health and Social Care Localities and increased autonomy • Capacity to make 'whole pathway' thinking the norm **FP20/68.4** The Executive Director Primary and Community services set out some of the alternative methods of consultation undertaken and partnership working which he envisaged being reviewed and progressed as a hybrid. Following discussion of third sector and patient voice involvement it was agreed that the Executive Director Primary and Community services would arrange a discussion with Independent Member Helen Wilkinson to explore this further.	CS/HW

FP20/68.5 The Executive Director Primary and Community services also set out details of the Health & Well Being Hubs created with partners including details of progress with the Community Resource Teams. In the discussion which followed the Committee questioned what adaptations had been put in place due to the Covid-19 pandemic and how many would be moved forward. **FP20/68.6** The Chairman questioned whether there was sufficient balance reflected within the organisation's plan between primary and secondary care which was discussed and it was noted that the Interim Chief Executive also reflected on the Welsh Government's perspective. The Executive Director Nursing and Midwifery also stated that whilst transformation was included within the plan it was not overt. **FP20/68.7** As the Committee questioned reporting arrangements, it was agreed that the Executive Director Primary and Community services would arrange for regular quarterly reports to be brought to the Strategy, Partnerships and Population Health Committee and arrange for the Chairman to receive a virtual meeting introduction to the Academy. The Committee also questioned how training places would be adressed, which was explained and also whether savings could be achieved through addressing areas of duplication. **It was resolved that** the Committee noted • the approach and plans to improve primary care sustainability • the schemes being progressed by the Primary & Community Care Academy (PACCA) and need for future investment • the significant progress made with partners in developing integrated services and health & well being hubs *The Executive Director Primary and Community services left the meeting*	CS CS
FP20/69 Annual plan 2019/20 reconciliation The Executive Director Planning and Performance presented this item. In response to the Committee Vice Chair's question regarding a potential unnecessary delay to review the Ablett Unit as a storage facility (AP072) again given that the Digital Health Record would not change medium storage requirements, he was advised that the Quarter 2 plan would address this issue. In respect of AP052, Learning lessons from the Welsh Community Care Information System pilot and questioned whether an alternative to what was considered obsolete software needed to be found. It was agreed this should be explored further at the Digital and Information Governance Committee. **It was resolved that** the Committee • noted the report including the proposed actions and timescales outlined to feed into BCU's 2020/21 plans • agreed that the Executive Director Planning and Performance advise the Acting Executive Director Finance of the frequency of reporting going forward, as a minimum quarterly and also with the inclusion of progress reporting against milestones, in order to update the Cycle of Business.	MW JC MW

FP20/70 Operational Plan 2020/21 Q1 monitoring report (OPMR) **FP20/70.1** The Executive Director of Planning and Performance presented this item, advising the report provided June 2020 monitoring data. The Chairman requested that member briefings be provided on QOP4.7 Eye Care services QOP4.5 Stroke services (including explanation of how progressing without the agreement of business case) QOP8.2 Specialty plans QOP8.4 Essential service plans He also requested that when objectives moved from amber to purple that these be highlighted with a greater level of detail to ensure the Committee was sighted. **It was resolved that** the Committee noted the report and the impact on end of year delivery and Covid-19 plans going forward	 MW MW GH GH
The Chairman left and the Committee Vice Chair chaired the rest of the meeting	
FP20/71 Quality and Performance (QAP) report **FP20/71.1** The Executive Director of Planning and Performance presented this item, advising that the trend arrows were not appearing due to a technical issue which would be explored further and the report recirculated to members. He advised that Covid-19 indicators were included, drawing particular attention to the Test, Trace and Protect (TTP) work stream, and would require further development eg care home monitoring. He reported that there was concern in respect of the reduction in referrals taking place which was being explored. **FP20/71.2** The Committee questioned how the organisation would address endoscopy services, given social distancing measures, which had re-commenced on all three sites however the activity was low and insufficient to fully address the backlog. The Executive Director Nursing and Midwifery confirmed this to be an area of concern which was actively being addressed, including the introduction of a pan North Wales patient list to ensure that patients at higher risk would be appropriately prioritised. In the discussion which ensued the Committee discussed the return of redeployed staff, positive clinician engagement, risk recognition, need for estate investment and the potential to move to 6 day working. The Committee noted that endoscopy service difficulties were a national issue which were being looked into on a national level. **It was resolved that** the Committee noted the report	 MW
FP20/72 Unscheduled Care and Building Better Care update **FP20/72.1** The Executive Director of Nursing and Midwifery presented the report which outlined the April and May position. It was noted that patient presentation was	

lower due to the Covid-19 pandemic however there was an expectation that moving forward activity would increase due to rising visitor numbers and planning was taking place to address winter resilience in expectation of both flu and Covid-19 in circulation. **FP20/72.2** The Committee questioned the financial implications of current requirements to test patients prior to discharge to care homes which could require an additional 112 beds. The Acting Executive Director Finance advised there was a potential for £8k per month per bed required which was a significant potential spend that needed to be resolved as soon as possible. **It was resolved that** the Committee noted the Unscheduled Care performance for April and May across BCUHB and for each Health Community	
FP20/73 Finance Report Month 2 **FP20/73.1** The Acting Executive Director of Finance presented this report. She advised the in-month position to be £3.3m in-month deficit which was in line with the plan for Month 2. This position assumed that all Covid-19 costs incurred by the Health Board would be fully funded. The cost of Covid-19 in May was reported as £5.1m and the anticipated income from Welsh Government had been included in the position to match this cost. In respect of year to date, the Health Board was overspent by £6.7m, which was in line with the financial plan. The cost of Covid-19 was £36.9m, of which £1m had been funded through the Intermediate Care Fund (ICF) monies. Welsh Government income of £35.9m was anticipated to fund the remainder. The total value of Welsh Government funding available for Covid-19 had not yet been confirmed and was therefore a significant risk to the financial position. **FP20/73.2** Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year was extremely difficult. However, the Health Board was anticipating that it would achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs were fully funded by Welsh Government. **FP20/73.3** The Committee questioned what reassurance had been received in anticipation of the Welsh Government's Covid-19 funding which was now £36m, an increase of £5m in month. The Acting Executive Director of Finance confirmed that the anticipated income to cover Covid-19 costs was a risk to the financial position, and month on month costs continued to change based on the latest forecast information. However, the risk did not equate to the full £36m as BCU had recently received £5m towards Pay costs for Month 1 to 3 (based on Month 1 and 2 actual costs and estimates for month 3), £12m towards the set up costs of the Field Hospitals, and £80k specific funding towards the costs of a Mental Health helpline. Funding continued to be discussed with WG on an ongoing basis. **FP20/73.4** The Acting Executive Director of Finance acknowledged that the non-delivery of savings plans to date were a significant issue as the financial plan for 2020/21 was based on delivering savings of £45m. Savings not delivered in Month 2, due to the impact of Covid-19, were £3.6m (£7.3m for the year to date). Following the	

suspension of the Recovery Programme in March, the Health Board was now considering how best to resume the savings plans that began development in 2019/20. She questioned whether the cessation of these savings plans could be apportioned to Covid-19 costs – as the Health Board would have continued with the services of the Interim Recovery Director and his planned savings activity had Covid-19 not occurred. In her opinion she had confidence that these savings would have been delivered within this period. The Deputy Director FDU, questioned whether the challenging position of delivering in the first 2 months of the year could have been achieved, although this might have been possible in the following months. It was acknowledged that BCU's savings delivery planning had been affected as the Interim Recovery Director had not been retained following the Health Board's necessary response to Covid-19. **FP20/73.5** The Acting Executive Director of Finance agreed to circulate to members, the WA representative and FDU Deputy Director, a summary of savings delivery positions to date for Health Boards in Wales, which indicated that BCU had managed more effectively than the majority. **It was resolved that** the Committee noted the report	SH
FP20/74 Savings Programme 2020/21 report **FP20/74.1** The Acting Executive Director of Finance advised that there had been a considerable reduction from the original programme of 106 potential schemes with a savings value of £27.8m. The recent assessment had identified 66 schemes which were likely to deliver in year, with an estimated delivery value of £12.2m. 10 schemes were currently in delivery with an estimated out-turn value of £1.9m. Whilst there were a further 56 schemes with an estimated delivery value of £10.3m which were identified as pipeline. The savings quoted in the report were net of any investment required to deliver the programme. She drew attention to a small number of schemes where an initial total investment of £799k has been identified within the Poject Initiation Document (PID). **FP20/74.2** The Committee questioned the significant reduction in the latest assessment of savings potential. He highlighted the urgent need to increase capacity in driving forward programmes, including a resourced Programme Management Office (PMO) function. He questioned how the Executive team were currently addressing the capacity issue. The Acting Executive Director of Finance advised that the external PMO were all redeployed to support Covid-19 and a significant number were were now supporting the Trace, Test and Protect (TTP) programme. The Executive team had prepared a draft paper in January to propose a way forward for both service improvement and the savings programme which was part of the WG request around additional funding. It also figured heavily in the recommendations from the Interim Recovery Director's report which had similarly been discussed by the Executive Team and was being taken forward in an action plan that she was leading on. The Committee emphasised the need to address this issue at pace, including exploring internal resources, in order that the organisation could progress. **It was resolved that** the Committee noted	

• the latest assessment of the savings programme for 2020/21 that indicated potential delivery of £12.2m • the increased planned savings value of £1.3m against the position reported in the month 2 monitoring return • the urgent need to risk assess the programme described in the paper to increase confidence in delivery and apply a formal RAG status to each scheme • the additional work required to explore further opportunities • the capacity challenges in driving forward the savings programme in the absence of a resourced PMO function – which the Committee emphasised needed to be addressed at pace.	
FP20/75 Interim discretionary capital programme 2020/21 **FP20/75.1** The Executive Director of Planning and Performance presented this report, drawing attention to the following key points: • the minimum net funding available for 2020/21 was £10.452m after known commitments. • the discretionary allocation equated to 1% of revenue expenditure and, despite seeking alternative sources of funding, demand for capital significantly exceeded resource. • capital requests were prioritised in accordance with agreed criteria and the programme sought a balance between meeting key risks to service continuity and supporting improvements. • the current Covid-19 pandemic had required a re-focusing of resources to support the Health Board's response in the short-term, pending clarification of any additional funding from Welsh Government. • an interim programme was proposed providing core allocations to allow mitigation of key risks in the short term, whilst retaining a contingency to meet further capital expenditure in response to the pandemic. • the interim programme needed to be reviewed on a regular basis and revised as necessary to reflect the emerging requirements of Covid-19 and to allow potential support to service improvement. **FP20/75.2** The Committee Vice Chair stated that the discretionary capital budget was insufficent for the size of the organisation, reflecting the investment enabled maintenance but did not support improvement. However, he agreed that it was necessary to ensure Covid-19 contingency. He was assured this would be regularly reported. The Committee Vice Chair advised that the moving forward of the Digital Health Record, shortly to be discussed by the Board, would also require funding. He reiterated that this programme would be a platform for enabling the organisation's transformation. **It was resolved that** the Committee approved the proposed draft interim and that the programme is reviewed on a regular basis to reflect the emerging requirements of Covid-19 and clarification of any additional funding allocations.	

FP20/76 Annual review Terms of Reference and approve cycle of business 2020/21
 	
FP20/76.1 The Acting Executive Director of Finance presented this item. Following Committee discussion it was agreed that the following amendments be submitted for approval to the Audit Committee:
• Amend meeting frequency from monthly to 'at least 6 times per annum'
• Add in attendance the Chief Executive and Executive Director Nursing and Midwifery
• Amend 3.1.2 3.1.4 references to Integrated Quality and Performance report (IQPR) to Quality and Performance report (QAP)
• Amend 3.1.1 Financial Management:
  • receive assurance with regard to the Health Board Turnaround programme progress and impact/pace of implementation of organisational savings plans.
to
  • monitor turnaround and transformation programmes' progress and impact/pace of implementation of organisational savings plans.
 	
FP20/76.2 In respect of the draft Cycle of Business 20/21, the amendment to plan monitoring reports discussed earlier was agreed to be incorporated.
 	
It was resolved that the Committee
• reviewed and agreed amemndments to Terms of Reference for submission to the Audit Committee
• approved the FPC Annual Cycle of Business 2020/21 subject to the amendments discussed.
	SH/DD
	
	SH/DD

FP20/77 External Contracts Update **FP20/77.1** The Acting Executive Director of Finance presented this report, drawing attention to the challenges presented within the current climate. **FP20/77.2** The Committee questioned whether the block arrangements with English providers might be renegotiated when the current contract expired, given that BCU was spending approximately £6m per month based on 47% activity levels, and whether any retrospective refund might be explored. The Acting Executive Director of Finance advised this was a national arrangement agreed between WG and Central Government which ensured the NHS worked across borders and was funded via WG. She reported that there was close working taking place to support the timely return to business as usual clinical services as soon as was practical. The Acting Executive Director of Finance advised she was part of the group of Executive Directors of Finance Group discussing block contract arrangements with England and there was a clear expectation that patients were part of the conversation in England about resuming services. She agreed to explore this further and provide a member briefing. The Interim Chief Executive emphasised that the WG agreement was very complex. He commented that it would be neccesary to ensure that contracts were in place with English providers in order to ensure that there was a proportionate element of activity provided as services increased.	SH

It was resolved that the Committee noted • the financial position on the main external contracts as reported for the final 2019/20 outturn and month 2 including the anticipated pressures • the work underwayin respect of stabilising wider health/patient care contrats and key risks/related activity • the impact of Covid-19 on external healthcare contracts and the work of the healthcare contracts team (HCCT) • the impact and risk posed as a result of Covid-19 contracting arrangements adopted for contracts with NHS providers • the position in relation to RTT up to 31.3.20 approved • an initial 2 month extension to the current contracting arrangement managed on behalf of the Health Board by Welsh Health Specialised Services Committee for additional capacity with the Spire Hospital	
FP20/78 Workforce quarterly performance report **FP20/78.1** The Assistant Director Workforce & OD presented this item advising that the Workforce Division had been 'totally consumed' by addressing workforce issues related to the reponse to the Covid-19 pandemic. She highlighted the increased staff sickness rates, Covid-19 staff sickness reporting, increase in Health & Safety work undertaken and also vacancy rates. In response to the Committee, the Assistant Director Workforce & OD reported that whilst there had been an improvement with Ysbyty Glan Clwyd nurse staffing rates, there had been a deterioration at Wrexham Maelor, she also pointed out nurse bank activity. **FP20/78.2** The Committee questioned in what type of roles 152 volunteers had been deployed and how the additional 600 volunteers available would be utlised in the future. Examples of a wide variety of different roles were provided across North Wales such as grounds maintenance, catering, admnistration, assisting portering, patient property transfers, front desk signposting, stores, ppe and medicine deliveries, support to testing centres and the set up of field hospitals. In respect of those yet to be deployed, commmunication updates remained in place on current volunteer requirements and also to thank them for their enthusiasm and commitment to support the organisation. It was noted that a smart survey was being developed to ascertain if they were able to continue to offer volunteering hours to the organisation which would be distributed by the end of July with analysis and reporting in August 2020. In addition, an internal electonic portal was being developed for managers to access volunteers with streamlined processes and would be available to support any future surge capacity requirements. A BCUHB working group had been established to commence work reviewing how the remaining volunteers might provide the organisation with a pipeline of possible future temporary/permanent staffing given that some might find themselves unemployed . Transferring those who were able and wanted to provide longer term volunteering support to the Robin's Infrastructure was also taking place. The Committee Helen Wilkinson reflected on the opportunity to build and strengthen partnership working especially in regard to community support. **It was resolved that** the Committee	

noted the report	
FP20/79 PWC recommendations update The Acting Executive Director of Finance advised it had been agreed that the Drivers of the Deficit report would be provided to the October meting. **It was resolved that** the Committee noted the report	
FP20/80 NHS Wales Shared Services Partnership Summary Performance Report Quarter 4 2019/20 **It was resolved that** the Committee noted the report	
FP20/81 Summary of private business to be reported in public **It was resolved that** the Committee noted the report	
FP20/82 Issues of significance to inform the Chair's assurance report To be agreed outside the meeting	
FP20/83 Date of next meeting The next meeting would be held on 27.8.20	
Exclusion of the Press and Public Resolution to exclude the Press and Public “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.”	

BCUHB FINANCE & PERFORMANCE COMMITTEE Summary Action Log – arising from meetings held in public				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
Actions from 24.10.19 meeting:				
Sue Hill	**FP19/236 Finance Academy** Forecasting Best Practice Guide A plan to implement the guidance would be provided In December	~~December meeting (11.12.19)~~ January meeting	Moved to January agenda due to short December meeting Deferred to February 2020 agenda due to timing of January meeting 10.2.19 Deferred to March 2020 agenda 27.2.20 The Chairman requested that the item be addressed at the next meeting 18.5.20 – Deferred to July 2020 23.6.20 Given the current planning guidance from Welsh government requiring the submission of quarterly operational plans, this item was deferred until 29.10.20 meeting	~~Jan 2020~~ February 2020 March 2020 22.4.20 25.6.20 19.10.20
Actions from 27.2.20 meeting:				
Mark Wilkinson	**FP20.23 Matters arising** The Committee questioned the throughput and cost per case of the waiting list initiative undertaken with the Vanguard unit which the Executive Director of Planning and Performance agreed to provide. However, it was noted that the waiting list was anticipated to be increasing.	24.3.20	23.5.20 Request for deferral to July meeting. The Vanguard Unit has been removed from YGC site and there are no current plans to bring another Unit back onto site. The question of sustainable endoscopy services and the potential for outsourcing to play a part in that remain key issues. A retrospective look at VFM will help support future service planning. 30.6.20 briefing note circulated to Committee	25.6.20 Action to be closed

Actions from 4.6.20 meeting:				
Sue Hill	**FP20/55.8 Savings Programme Report** The Acting Executive Director of Finance agreed to provide an update on PMO capacity to members	17.6.20	25.6.20 The requirement for PMO and Service Improvement within the Health Board is part of the response to the WG funding request. A paper will be brought to F & P on 29.10.20. 16.7.20 The Chairman emphasised the need to provide clarity on current PMO capacity, He requested the report be provided to 27.8.20 meeting. 27.8.20 Agenda item FP20/100 private session	~~19.10.20~~ 17.8.20 Action to be closed
Actions from 16.7.20 meeting:				
Helen Wilkinson / Chris Stockport	**FP20/68 Primary & Community Services** Meet to discuss Third sector involvement regarding wellbeing	31.7.20	4.8.20 – Meeting arranged 13.8.20	Action to be closed
Chris Stockport / Mark Wilkinson	**FP20/68 Primary & Community Services** Schedule regular reports to future SPPH meetings	31.7.20	04.08.20 Updates on the transformation programmes for Community Services and Children's Services are included on the SPPH Committee agenda meeting on 13th August. Going forward, the cycle of business to include Primary and Community business, including primary care sustainability and updates on the All Wales Strategic Programme for Primary Care. A meeting has been arranged on 7th September with the Asst Director Primary Care & Community Services to agree the detail.	Action to be closed
Chris Stockport	**FP20/68 Primary & Community Services** Arrange a virtual meeting to introduce the Academy to Chairman	31.7.20	4.8.20 A meeting between the Chairman, Executive Director Primary and Community Services and Academy team has been arranged for 29.9.20 A website for the Primary care & Community Academy has been developed and updates for some of the programme are provided.	Action to be closed

			Link: http://www.primarycare-online.co.uk/	
Mark Wilkinson / Mark Polin	**FP20/69 Plan reporting** Agree frequency of future reporting to F&P with Chairman	24.7.20	Frequency and arrangements for future reporting was discussed and agreed with the Chairman.	Action to be closed
Mark Wilkinson	**FP20/69 Reconciliation** AP072 – ensure addressed in q2 report	17.7.20	19.8.20 – the approved planning appendices separate out medical records review from Ablett and the Acute digital health record. It has its own timescale (31.12.20) and will be tracked via our performance management of the plan.	Action to be closed
~~Mark Wilkinson~~ David Fearnley	**FP20/69 Reconciliation** AP052 – Explore alternative to WCCIS via DIGC (25.9.20)	15.9.20	A report exploring alternatives to WCCIS will be presented to the Digital and Information Governance Committee on 25 September 2020, with feedback to the Board via the DIGC Chair's report.	Action to be closed
Mark Wilkinson	**FP20/70 Q1 monitor report** Arrange to provide further updates on QOP4.7 Eye Care services QOP4.5 Stroke services (including explanation of how progressing without the agreement of business case)	24.7.20	19.8.20 Eye Care Services update provided by Jill Newman and approved by Mark Wilkinson for circulation. Circulated 20.8.20 Stroke Services update is included within this month's QAP report.	Action to be closed
Gill Harris	**FP20/70 Q1 monitor report** Provide further update on QOP8.2 Specialty plans QOP8.4 Essential service plans	24.7.20	4.8.20 QOP 8.4 Member briefing circulated 5.8.20 Chairman requested further detailed report to be prepared on plans to recommence planned elective care Agenda item 27.8.20	Action to be closed
Mark Wilkinson	**FP20/71 QAP report** Recirculate QAP with trend	24.7.20	Circulated to members via email 17.7.20	Action to be closed

	arrow indicators visible			
Sue Hill	**FP20/73 Finance report** Share with other members (incl AD,WA & EW,FDU) the summary of other Health Board's positions regarding their savings achieved to date	24.7.20	Circulated 19.8.20	Action to be closed
Sue Hill / Diane Davies	**FP20/76 ToRs & COB** Amend Tors and forward to Audit Committee to update/include • frequency 6 times per annum • Executive Director N&M in attendance • Chief Executive in attendance • Amend 3.1.2 and 3.1.1 as per the minutes	31.7.20	ToR amendments made and submitted to Audit Committee for ratification at next meeting	Action to be closed
Sue Hill / Diane Davies	Amend COB re frequency of Operational plan monitoring		Advised to be addressed at each meeting – COB updated	Action to be closed
Sue Hill	**FP20/77 External contracts** Provide member briefing on block contracting arrangements	31.7.20	Circulated 19.8.20	Action to be closed

20.8.20

Cyfarfod a dyddiad: Meeting and date:	**Finance & Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Quarter Two Plan Monitoring Report**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad Report Author:	Jill Newman, Director of Performance
Craffu blaenorol: Prior Scrutiny:	This paper has been scrutinised and approved by the Executive Team and the Executive Director of Planning and Performance.
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Finance & Performance Committee is asked to note the report.

Please tick as appropriate

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

Sefyllfa / Situation:

This report provides a self-assessment by the executive leads of the progress being made in delivering the key actions contained in the 2020/21 Operational Plan for Quarter 2.

Cefndir / Background:

The operational plan has a number of key actions required to be delivered during Quarter 2 of 2020/21. The Executive lead reviews on a monthly basis progress against their areas for action and RAG-rates progress. Where an action is complete this is RAG rated purple, where on course to deliver Quarter end position the rating is green. Amber and red ratings are used for actions where there are risks to manage to secure delivery or where delivery is no longer likely to be achieved. For Red rated actions a short narrative is provided.

Asesiad / Assessment & Analysis

Strategy Implications
Delivery of the operational plan actions is key to implementation of the Boards strategy

Options considered
N/A

Financial Implications
Delivery of the operational plan within the budget set by the Health Board is part of ensuring resources are well-managed and care effectively provided within the allocated resources.

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

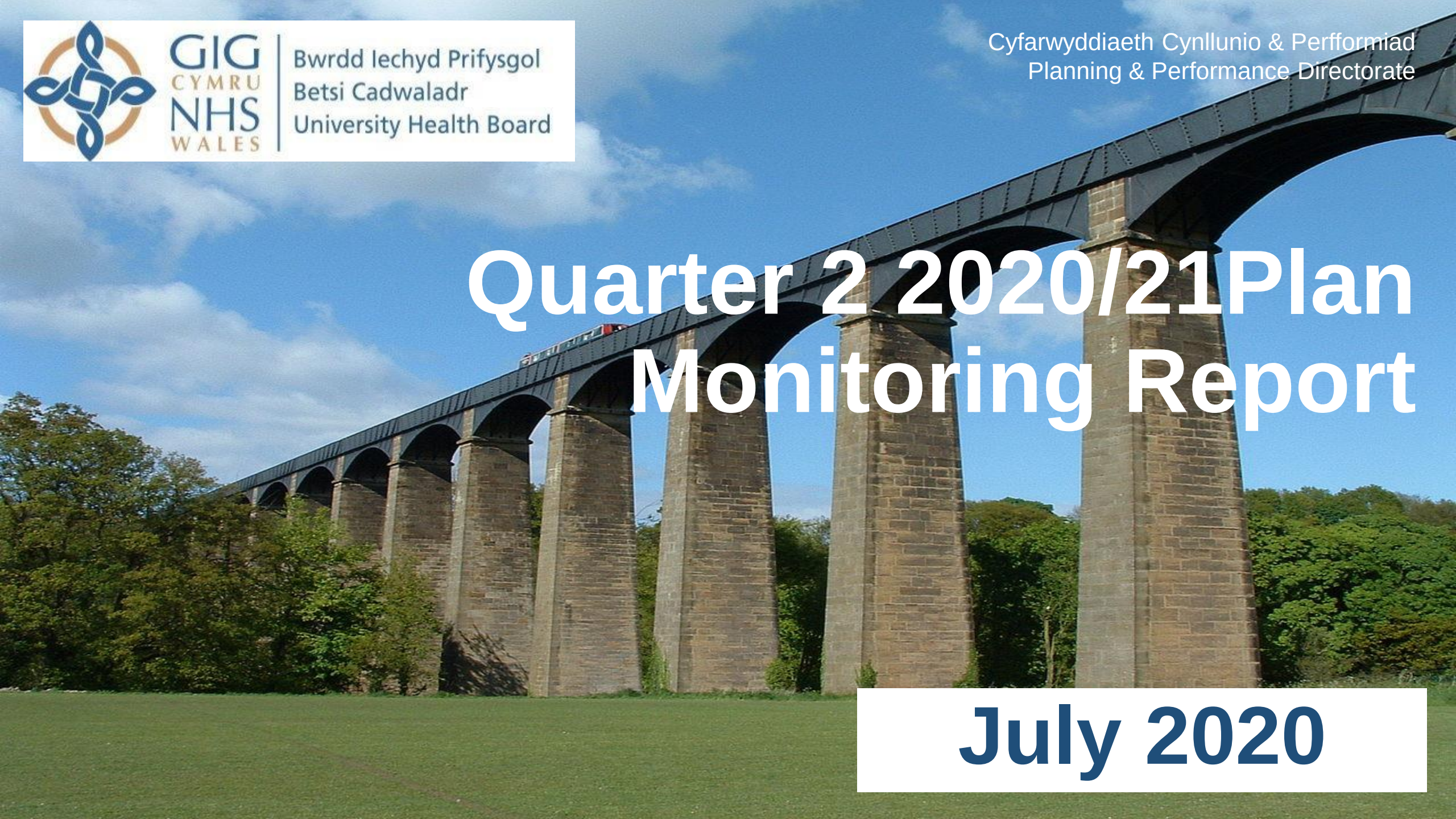
Legal and Compliance

Outline any legal implications of the proposal. Outline what KPIs and/or reporting back to the Board will occur during and after implementation.

Impact Assessment
The operational plan has been Equality Impact Assessed.

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

Cyfarwyddiaeth Cynllunio & Perfformiad
Planning & Performance Directorate



Quarter 2 2020/21Plan Monitoring Report

July 2020

Overview and Purpose of this Report

- The Quarter 2 Plan of the Health Board has been agreed by the Board
- The Plan recognises that the disruptive nature of the pandemic has shortened planning horizons, resulting in plans being time limited to quarterly plans for 2020-21
- The Quarter 2 plan relates to the need to maintain essential non Covid-19 services to minimise risk of harm for life-saving or life-impacting treatments.
- This report is a self-assessment by the Executive Director responsible for each of the work streams of likelihood to deliver the actions set out in the plan by the 30th September 2020, with supporting narrative where the risk to delivery is rated as red, i.e. highly unlikely to be achieved. This report provides an update from each Executive Director for the end of July 2020 actual position. The entire report is the reviewed and approved by the Executive Team.
- Work is underway in developing the plan for Q3 and Q4 which will also reflect the shift in phasing of response to the pandemic from mobilisation towards parallel running of the pandemic and re-activation of some business as usual activities where it is safe to do so. This will reflect transition to sustainable service delivery phase of the plan. In the plan for Q3 and Q4 plan actions incomplete at the end of Q2 2019/20 will be included with revised timescales to deliver, where these actions are still relevant for delivery.

RAG	Every month end	By end of Quarter	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points explaining why and what is being done to get back on track
Amber	Some risks being managed	N/A	Where RAG is Amber: No additional Information required
Green	On track, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

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Chapter 1: Improving Quality Outcomes

QP 01 Improving Quality Outcomes						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Scrutinising Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN1.1	Publish revised year 3 of Quality Improvement Strategy	Executive Director Nursing & Midwifery	30.09.2020	AP 040	QSE	G	G

Chapter 2: Test, Trace, and Protect

QP 02 Test, Trace, and Protect						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Scrutinising Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN2.1	Establish a timely testing programme for antibodies and antigens	Executive Director Of Public Health	30.09.2020	N/A	SPPH	G	G
AN2.2	Lead the development of a 12/24, 7/7 comprehensive tracing programme	Executive Director Of Public Health	30.09.2020	N/A	SPPH	G	G
AN2.3	Establish 'Protect' programme	Executive Director Of Public Health	30.09.2020	N/A	SPPH	G	G
AN2.4	Develop Test, Trace, and Protect	Executive Director Of Public Health	30.09.2020	N/A	SPPH	G	G

QP 03: Promoting Health & Well-being						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN3.1	Review of Healthy Weight Services for children	Executive Director Of Public Health	31.07.2020	AP 002	SPPH	A	R
AN3.2	Review Smoking Cessation service provision to improve performance.	Executive Director Of Public Health	31.12.2020	N/A	SPPH		
AN3.4	Review Alcohol Strategy in partnership with Area Planning Board	Executive Director Of Public Health	31.03.2021	N/A	SPPH		
AN3.5	Review and commence delivery: Immunisation Strategy: *Influenza Plan* ***Linked to Action 6.1 & 6.3***	Executive Director Of Public Health	31.12.2020	N/A	SPPH		
AN3.6	Define *Building a Healthier Wales* expenditure / delivery plan	Executive Director Of Public Health	31.03.2021	N/A	SPPH		
AN3.7	Monitor the impact of the Breast Feeding / Infant Feeding Strategy	Executive Director Of Public Health	31.03.2021	N/A	SPPH		

AN3.1 Review of Healthy Weight Service for Children
Awaiting narrative

QP 04: Achieve compliance with the Primary Care Operating Framework						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN4.1	Use the World Health Organisation framework for essential healthcare services as a schema to ensure we are delivering the breadth of essential services in primary care during COVID-19	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	G	A
AN4.2	Align with the national Strategic Programme to undertake a review of Betsi Cadwaladr commissioned Enhanced Services during Q2.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	A
AN4.3	Development of Locality 2020/21 Plans	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	A
AN4.4	Identify actions for primary care for Q3 and Q4, with a focus on Winter planning	Executive Director Primary & Community Care	11.09.2020	N/A	SPPH	A	A

QP 05: Capture and embed proven technologies in primary care						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN5.1	Capture good practice /legacy actions from use of technology and different working practices during first phase of COVID-19, and share these across primary care	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN5.2	Build on the initial implementation of virtual attendances in General Medical Services.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN5.3	Build on the initial implementation of the e-Consult web-based self-triage platform in General Medical Services.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN5.4	Ensure patients know how to access primary care services and are confident about new ways of working (virtual or if appropriate, face-to-face).	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN5.5	Increase use of primary care technology within care home settings as requested by care homes	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	A

QP 06: Efficient and effective immunisation activities						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN6.1	Develop locality level flu immunisation delivery plans for 2021 ***Linked to Action 3.5 & 6.3***	Executive Director Primary & Community Care	31.08.2020	N/A	SPPH	G	A
AN6.2	In partnership with Public Health and Welsh Government colleagues, prepare rolling plans for the delivery in Primary Care of Covid-19 vaccination programme that can be enacted as soon as a vaccine is available.	Executive Director Primary & Community Care	14.09.2020	N/A	SPPH	G	A
AN6.3	Review uptake of childhood immunisations and implement catch up programmes as required ***Linked to Action 3.5 & 6.1***	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	A	A

QP 07: Develop the Primary Care & Community Academy						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN7.1	Further develop the Advanced Paramedic Practitioner Pacesetter Project	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN7.2	Develop our version of Scottish *Project Joy* scheme for the recruitment of general practitioners & senior primary care clinicians	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	R
AN7.3	Develop business case for Education and Training Local Enhanced Services	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	G	A
AN7.4	Progress support programme for General Practitioner practices in partnership with Royal College of General Practitioners	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN7.5	Further develop the Academy website and social media marketing and promotional material to capitalise upon positive recruitment interest that the initiative has brought.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A

QP 08: Implement General Medical Services Recovery Plan						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN8.1	Agree changes to local covid-19 assessment centres with each Locality that allow step up/ down as appropriate according to prevailing incidence.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN8.2	Commission revised care homes Directed Enhanced Service contract.	Executive Director Primary & Community Care	31.07.2020	N/A	F&P	G	G
AN8.3	Support General Practitioner practices with its *readiness for recovery* including provision of dedicated protected education time session and a recovery plan *toolkit* alongside Welsh Government Operational Guide	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	G	G
AN8.4	Prescribing plan to reduce foot-fall and workload associated with repeat prescribing	Executive Director Primary & Community Care	31.08.2020	N/A	SPPH	A	A

QP 09: Implement Dental Services Recovery Plan						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN9.1	Implement Welsh Government Dental Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN9.2	Continuation & strengthening of Urgent Designated Dental Centres provision for those requiring aerosol generating procedures	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN9.3	Implement the national 'buddy' system to inform contract reform	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R	R

QP 10: Implement Community Pharmacy Recovery Plan						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN10.1	Implement Welsh Government Community Pharmacy Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN10.2	Improve rapid access to palliative care drug	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	A	R

QP 011: Implement Community Optometry Recovery Plan						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN11.1	Implement Welsh Government Optometry Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN11.2	Support the delivery of reinstated secondary care pathways e.g. Glaucoma, Wet Age-Related Macular Degeneration, Optometric Diagnostic and Treatment Centres	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	A	R
AN11.3	Address backlog of activity arising due to Covid.	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	G	G
AN11.4	Reinstate full access to urgent care pathway	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	G	G

QP 12: Develop primary care out of hours services and NHS 111						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN12.1	Implement agreed management structure for Out of Hours	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	A	A
AN12.2	Prepare for implementation of new clinical system and implementation of 111	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	A

AN7.2: Develop our version of Scottish Project Joy scheme for the recruitment of general practitioners & senior primary care clinicians
The proposal will have been developed and submitted for approval however further funding will need to be secured - so will be moving this action to implementation subject to approval by end of Quarter 4 2020/21.

AN9.3: Implement the national 'buddy' system to inform contract
Contract Reform Programme on hold for 2020/21 in line with CDO direction

AN10.2: Improve rapid access to palliative care drug
Negotiations with CPW and internal commissioning processes have delayed implementation. However, this is now on track for completion by 30 September 2020

AN11.2: Support the delivery of reinstated secondary care pathways e.g. Glaucoma, Wet Age-Related Macular Degeneration, Optometric Diagnostic and Treatment Centres
There are a number of factors limiting the capacity of seeing glaucoma patients in primary care ODTCs. Namely, patients are very likely to be shielding and are reluctant to attend; limited tests available mean limited use in the appointments; and difficulties locating which patients would benefit due to access to notes due to staffing shortages. All difficulties are being addressed.

QP 13: Deliver safe Community Hospital services						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN13.1	Consolidation of Home First / Step Down pathways	Executive Director Primary & Community Care	31.07.2020	N/A	QSE	G	G
AN13.2	Consolidation of covid related protocols in Community Hospitals	Executive Director Primary & Community Care	31.07.2020	N/A	QSE	G	G
AN13.3	Maximising stroke rehabilitation services ***Linked to Action 28.5***	Executive Director Primary & Community Care	30.09.2020	N/A	QSE	A	R

QP 14: Support Care Homes and reintroduce CHC						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN14.1	Capture good practice and legacy actions internally and share across partners.	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN14.2	Ensure BCU wide approach to care home support and escalation to ensure sustainability and business continuity (Care Home Directed Enhanced Service, Escalation Levels)	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN14.3	Care home testing	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	G
AN14.4	Community Health Care Framework	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN14.5	Complete the governance and reporting arrangements for the Care Home Group	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A

QP 16: Transform Community Services						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN16.1	Community Transformation Programme	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	G	A
AN16.2	Community Response Team working inclusive of third sector	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	A
AN16.3	Feasibility study for inclusion of Community Geriatrician within Community Response Team model of care	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	A	R

QP 17: Develop Community Resilience						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN17.1	*Complete baseline evidence collation for Right sizing* Community Services	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A	A
AN17.2	Progress implementation of Phase 2 of the Digital Communities initiative	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R	R

AN13.3: (and Linked to Action AN 28.5) Maximising stroke rehabilitation services
West - There is currently no access to virtual platform for follow-ups and in addition the Stroke business case was not supported to develop ESD. It will be Amber by end of September 2020 as there is now the virtual platform Attend Anywhere.
Central -Meeting between Area and Acute on 14th August to discuss stroke rehabilitation for Ysbyty Glan Clwyd (YGC). Development of ESD service is within the Stroke business case for North Wales which is a priority for BCUHB in 2020/21.

AN16.3: Feasibility study for inclusion of Community Geriatrician within Community Response Team model of care
Further local discussion is required to progress this action. Consideration will be given to rolling this over to Quarter 3 if required.

AN17.2: Progress implementation of Phase 2 of the Digital Communities initiative
Further local discussion is required to progress this action. Consideration will be given to rolling this over to Quarter 3 if required.

Chapter 6: Mental Health & Learning Disabilities

QP 18: Mental Health / Learning Disabilities (Part 1 of 2)						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN18.1	Review and refine COVID response, learning from feedback and shared with Clinical Advisory Group for approval. Ensure alignment with Together for Mental Health strategy	Executive Medical Director	01.10.2020	N/A	F&P		
AN18.2	Revised divisional governance & reporting structure in place	Executive Medical Director	31.12.2020	AP 056	SPPH		
AN18.3	Establish a Central Business Unit that will provide the business support function for the Mental Health and Learning Disabilities Division	Executive Medical Director	31.12.2020	N/A	F&P		
AN18.4	Progress key commitments within our Together for Mental Health Strategy	Executive Medical Director	31.12.2020	N/A	SPPH		
AN18.5	Commence implementation of the Primary Care Programme at pace.	Executive Medical Director	01.09.2020	N/A	SPPH	G	A

QP 18: Mental Health / Learning Disabilities (Part 2)						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN18.6	Implementation of recommendations from the Psychological Therapies Review	Executive Medical Director	01.09.2020	N/A	SPPH	R	R
AN18.7	Re-establish the Rehabilitation Programme of work	Executive Medical Director	01.09.2020	N/A	SPPH	A	G
AN18.8	Begin roll out of Attend Anywhere virtual consultation platform across the division	Executive Medical Director	01.09.2020	N/A	F&P	G	G
AN18.9	Implementing division wider QI training plan	Executive Medical Director	01.09.2020	N/A	SPPH	G	G
AN18.10	Commence an Organisational Change programme of work that looks at values and culture to ensure that we all have clarity of purpose and a shared vison of what good looks like	Executive Medical Director	01.01.2021	N/A	SPPH		

AN18.6: Implementation of recommendations from the Psychological Therapies Review

Progression of the Psychological Therapies has been paused for the moment pending the series of engagement sessions that have taken place with the Psychologists . The Division plan to implement in the latter quarter's of the year. Psychological therapies will be an enabling work stream which will be embedded throughout the pathway work

QP 19: Maximise Capacity within Each Site						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN19.1	Review current process for booking and allocation to ensure it is fit for purpose and consistently applied across North Wales.	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	A	A
AN19.2	Delivery of OPD programme	Executive Director Nursing & Midwifery	30.07.2020	N/A	F&P	A	A
AN19.3	Utilisation of workforce dashboard to identify staffing resource	Executive Director of Workforce and OD	30.07.2020	N/A	F&P	N/A	R

Chapter 7: Acute Care: Implementation of our Acute Operational Model across North Wales Page 2 of 6

QP 20: Develop a single risk stratification approach across the pathway of care						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN20.1	**Stage 1** Outpatient transformation project focused upon delivering virtual appointments wherever possible and only face to face where necessary	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	A	R
AN20.2	Stage 4 Specialty specific risk stratification using P1-P4 categorisation as per essential services framework	Executive Director Nursing & Midwifery	30.07.2020	N/A	F&P	G	A
AN20.3	Create specialty multi-disciplinary teams to review cases and ensure clinical handover if surgical team listing patient is not able to operate	Executive Director Nursing & Midwifery	30.07.2020	N/A	QSE	G	A
AN20.4	Review current performance measures to ensure they reflect necessary quality metrics including reviewing and strengthening current reporting structure to ensure patient allocation can be monitored	Executive Director Nursing & Midwifery	31.08.2020	N/A	QSE	G	A

AN20.1 Outpatient transformation project focused upon delivering virtual appointments wherever possible and only face to face where necessary

Outpatients transformation project plan is being submitted to the Executive Team in August 2020

QP 21: Identification of highest priority services with risk based capacity shortfalls						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN21.1	Identify specialties where local resource does not meet needs for P1-P2 demand and implement pan BCU approach including identify specialties with significant variance in waiting times to implement pan BCU approach	Executive Director Nursing & Midwifery	31.07.2020	N/A	F&P	G	A

QP 22: Identification of areas for service review						RAG Rating	
Ref	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN22.1	Review and refresh priority business cases e.g. Ophthalmology, Orthopaedics, Urology & Stroke	Executive Director Nursing & Midwifery	31.08.2020	N/A	SPPH	G	A
AN22.2	Review of specialties identified where a pan BCU risk stratification approach may not on its own provide the necessary impact.					G	A

QP 23: Identify the required metrics to monitor performance						RAG Rating	
Action Number	**Action**	**Lead**	**Target Date**	**2019/20 AP Ref.**	**Board Committee**	**likelihood of delivery by 30.9.20**	**End of July 2020**
AN23.1	a. Quality Outcome Measures of clinical pathways identified	Executive Medical Director	30.09.2020	N/A	QSE	G	R
	b. Pan BCU service metrics developed					G	R
	c. Effectiveness of implementation plans monitored & reviewed					G	R

AN23.1 – Identify required metrics to monitor performance
Initial assessments of new clinical pathways is underway with expectation of responses by the end of August 2020 to enable development of clear and SMART outcome measures by the end of September 2020

Chapter 7: Acute Care: Implementation of our Acute Operational Model across North Wales

QP 24: Improve quality outcomes and patient experience						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN24.1	Identify clinical pathways requiring review or development	Executive Medical Director	30.07.2020	N/A	QSE	G	G
AN24.2	Coordinate with Clinical Advisory Group a programme and timetable for pathway development and review	Executive Medical Director	30.07.2020	N/A	QSE	G	G
AN24.3	Develop pathways in line with the digitally enabled clinical services strategy	Executive Medical Director	30.07.2021	N/A	QSE	G	G
AN24.3b	Establish the Eye Care Digital Programme Board to lead the implementation of the Digital Eye Care programme funded by Welsh Government	Executive Medical Director	30.07.2020	N/A	QSE	A	G
AN24.4	Ensure quality outcome measures are referenced and measurable	Executive Medical Director	30.07.2020	N/A	QSE	A	G
AN24.5	Ensure Patient Reported Outcome Measures and Patient Reported Experience Measures are included and measured in pathway development	Executive Medical Director	31.08.2020	N/A	QSE	A	G

Chapter 7: Acute Care: Implementation of our Acute Operational Model across North Wales Page 6 of 6

QP 25: Provide care closer to home						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN25.1	Provide virtual appointments wherever possible	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	G	A
AN25.2	Support outpatient transformation to identify community facilities where face to face consultations could be offered and deliver appointments and treatments as local as possible where there is equity of access	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	G	R
AN25.3	Primary Care Optometric Diagnostic and Treatment Centres undertaking training with Consultants as part of skill development to provide shared care for Glaucoma patients	Executive Director Nursing & Midwifery				G	A

AN25.2 Support outpatient transformation to identify community facilities where face to face consultations could be offered and deliver appointments and treatments as local as possible where there is equity of access

Restart process includes community hospital clinics however risk assessments are ongoing with antic service August/ September 2020

QP 26: Reduce health inequalities						RAG Rating			
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020	End of August 2020	End of September 2020
AN26.1	Ensure that patients are prioritised using an agreed risk stratification tool and offered the soonest appointment based on their clinical needs	Executive Director Nursing & Midwifery	30.07.2020	N/A	QSE	G	A		

QP 27: Planned Care						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN27.1	Develop preferred service model for acute urology services	Executive Director Nursing & Midwifery	30.09.2020	AP 021	F&P	R	R
AN27.2	Secure approval for orthopaedics business case/ establish Orthopaedics Clinical Network			AP 022			
AN27.3	Develop a Recovery Plan	Executive Director Nursing & Midwifery	30.09.2020		SPPH		
AN27.4	Establish Orthopaedic Clinical Network and hold workshops						
AN27.5	Have completed business case		31.12.2020		F&P		
AN27.6	Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists	Executive Director Nursing & Midwifery		AP 023	F&P	R	R
AN27.7	Systematic review and plans developed to address service sustainability for all planned care specialties (RTT).	Executive Director Nursing & Midwifery		AP 025	F&P	A	R
AN27.8	Implement year one plans for Endoscopy	Executive Director of Therapies & Health Sciences	30.07.2020	AP 025	F&P	G	G
AN27.9	Systematic review and plans developed to address diagnostic service sustainability	Executive Director of Therapies & Health Sciences	30.09.2020	AP 025	F&P	G	G

AN27.1 - Develop preferred service model for acute urology services
The Covid-19 pandemic has meant a number of services are being re-set to ensure delivery of essential services.
The once for North Wales approach (option5) is leading to urology services being delivers across north wales, to ensure all functional capacity is used. Therefore the preferred strategic model is currently not being progressed

AN27.6 - Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists
There has bee a deterioration in performance against the Eye Care Measure in that only 41.6% of patients waited less than 25% over their due date to be seen. This is a consequence of postponement of outpatient activity and inability to replace face to face activity with either virtual or table top reviews. In this specialty diagnosis requires physical examination to provide appropriate treatment.

AN27.7 - Systematic review and plans developed to address service sustainability for all planned care specialties (RTT).
A Due to the Covid-19 pandemic all routine elective activity was paused. New plans were developed for Q2 with Covid-19 restrictions in mind. Currently works is on-going to deliver plans for Quarter 3-4 and how patients can be treated differently and mitigate any harm due to patients waiting longer

Chapter 9: Unscheduled Care

QP 28: Unscheduled Care						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN28.1	**Demand:** Workforce shift to improve care closer to home (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 031	F&P	R	R
AN28.2	**Flow:** Emergency Medical Model (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 034	F&P	A	A
AN28.3	**Flow:** Management of Outliers (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 034	F&P	G	G
AN28.4	**Discharge:** Integrated health and social care (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 038	F&P	A	G
AN28.5	Stroke Services ***Linked to Action 13.03***	Executive Director Primary & Community Care	30.09.2020	AP 039	F&P	A	R
AN28.6	**Flow:** Psychiatric Intensive Care Unit for Mental Health	Executive Medical Director	31.03.2021	AP 036			

AN28.1
Redeployment of staff to support covid-19 has delayed strategic direction of change

AN28.5 – Stroke Services - linked to Action AN13.3 Maximising stroke rehabilitation services
Central -Meeting between Area and Acute on 14th August to discuss stroke rehabilitation for Ysbyty Glan Clwyd (YGC). Development of ESD service is within the Stroke business case for North Wales which is a priority for BCUHB in 2020/21.
West - There is currently no access to virtual platform for follow-ups and in addition the Stroke business case was not supported to develop ESD. It will be Amber by end of Sept as there is now the virtual platform Attend Anywhere.

QP029: Workforce & Organisational Development						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN29.1	Review the previous Workforce Improvement Group structure and establish a revised structure at Strategic, Tactical and Operational Levels	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	G	A
AN29.2	Ensure effective social partnership working as a key enabler for organisational development and transformation. Review the operation and management of social partnership	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	G	A
AN29.3	Provide 'one stop shop' workforce enabling services to support surge requirements; new developments and reconfiguration or workforce re-design linked to key priorities of the Health	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	G	A

QP 30: Workforce Planning and Optimisation						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN30.1	Ensure a robust integrated workforce model is in place with Local Authority partners for specific projects, to support the development of a health and Social Care model across the wider health community	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	G	A
AN30.2	Ensure workforce optimisation plans are in place to support the delivery of safe care and mitigate the impact of COVID-19, the Test, Trace, Protect programme on staff and they support the Health Boards adjusted surge capacity plans for Q2.	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	G	A
AN30.3	Ensure all key workforce indicators are in place and monitored robustly to support all surge and essential services delivery	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	G	A
AN30.4	Ensure agile and new ways of working deployed in order to maintain safety for staff and patients because of COVID-19 are optimised and embedded.	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	G	A
AN30.5	Deliver Workforce Optimisation / Efficiency Plan - reducing waste and avoidable variable /premium rate pay expenditure. Demonstrating value for money and responsible use of public funds	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	F&P	A	A

QP 31: Occupational Health Safety and Equality						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN31.1	Implement Year 2 of the Health & Safety Improvement Plan is implemented to staff are proactively protected, supported and safe, including black, Asian, and minority ethnic, older people, co-morbidities and pregnant workers and that all environmental and social impacts are monitored and complied with	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	G	A
AN30.2	Effective infrastructure in place to ensure wellbeing and psychological support is accessible to all staff	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	G	A
AN30.3	Ensure ongoing effective management of training, equipment and supplies in line with emergency guidance	Executive Director	30.09.2020	N/A	QSE	A	R
AN30.4	Implement the Strategic Equality Plan revised year 1 actions to help ensure that equality is properly considered within the organisation and influences decision making at all levels across the organisation	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	A	A

AN30.3:Ensure ongoing effective management of training, equipment and supplies in line with emergency guidance

Risk identified re record management, competency validation and assessment. Health & Safety Executive (HSE) alert being managed with Situation, Background, Assessment & Recommendation (SBAR) through Health and Safety governance structure.

Chapter 11: Digital Health

QP 32: Digital Health / IM&T						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN32.1	Phase 3 of Welsh Patient Administration System re-focus on West implementation	Executive Medical Director	30.06.2021	C/Fwd	DIGC		
AN32.2	Seek approval for funding for Welsh Emergency Department System	Executive Medical Director	30.09.2020	N/A	F&P	R	R
AN32.3	Development of the digital health record	Executive Medical Director	30.09.2020	N/A	DIGC	G	G
AN32.4	Implementation of Health Records Project	Executive Medical Director	31.12.2020	C/Fwd	DIGC		
AN32.5	Implementation of Digital dictation project	Executive Medical Director	31.08.2020	N/A	DIGC	G	G
AN32.6	Development of priority business cases for sustainability of services	Executive Medical Director	31.10.2020	N/A	DIGC		
AN32.7	Scale up Implementation of Office 365	Executive Medical Director	31.12.2020	N/A	DIGC	G	R
AN32.8	Implement COVID-19 hardware response	Executive Medical Director	31.01.2021	N/A	DIGC	A	R
AN32.9	Welsh Community Care Information System Programme Implementation.	Executive Medical Director	**Moved to 2021/2022**	AP 052	DIGC		
AN32.10	Delivery of Health and Social Care Advisory Service recommendation for good record keeping across all patient record types.	Executive Medical Director	Within 6 month of project manager in place	AP 056	DIGC		
AN32.11	Delivery of digital infrastructure rolling programme	Executive Medical Director		AP 058	DIGC	G	G
AN32.12	Provision of infrastructure and access to support care closer to home	Executive Medical Director	Further review with Area teams/ dependent on Office 365	AP 059	DIGC	G	G

AN32.2: Seek approval for funding for Welsh Emergency Department System (WEDS)
Implementation timescale of WEDS is a key inter-dependency of the Welsh Patient Administration System (WPAS) West project. Health Board business cycle for funding approval risks de-railing this. Implementation must happen in the Autumn or risk postponement until Summer 2021, and the department having to implement WPAS ED module in the interim. Chief Information Officer (CIO) in discussion with Chief Executive to overcome this challenge.

AN32.7: Scale up Implementation of Office 365
Final approval has now been received from the Director of Finance (DoF) to recruit suitably qualified staff to make up the Office 365 implementation team. Recruitment has now commenced with interviews indicatively planned for mid-Sept. Other planning activities are underway with our Microsoft O365 partner Insight to solidify roll-out plans with a view to implementing at pace once the team is recruited to.

AN32.8: Implement COVID-19 hardware response
Since the end of March, requests for Laptops attributable to Covid-19 and agile working have totalled 1,100. To Date, circa 500 have been installed.

QP 33: Estates & Capital						RAG Rating	
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	likelihood of delivery by 30.9.20	End of July 2020
AN33.1	Well-being hubs	Executive Director of Planning and Performance	30.09.2020	AP 064	SPPH	G	G
AN33.2	Ablett Mental Health Unit Outline Business Case	Executive Director of Planning and Performance	30.11.2020	AP 069	SPPH		
AN33.3	Central Medical Records review	Executive Director of Planning and Performance	31.12.2020	AP 072	SPPH		
AN33.4	Residencies: Outline Business Case	Executive Director of Planning and Performance	31.12.2020	AP 073	SPPH		
AN33.5	Wrexham Maelor continuity programme	Executive Director of Planning and Performance	31.03.2021	N/A	SPPH		
AN33.6	North Denbighshire Community Hospital	Executive Director of Planning and Performance	30.11.2020	N/A	SPPH		
AN33.7	Ysbyty Gwynedd compliance	Executive Director of Planning and Performance	30.11.2020	N/A	SPPH		
AN33.8	Complete reviews to initiate the following programmes:	Executive Director of Planning and Performance	30.09.2020	N/A	SPPH	G	G
	- Health economy programme business case					G	G
	- Relocation of services from Abergele					G	G
	- Rationalisation of Bryn y Neuadd					G	G

Further Information

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website www.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

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

follow @bcuhb
http://www.facebook.com/bcuhealthboard

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality & Performance Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Mr Mark Wilkinson, Executive Director of Planning & Performance
Awdur yr Adroddiad Report Author:	Dr Jill Newman, Director of Performance
Craffu blaenorol: Prior Scrutiny:	This paper has been scrutinised and approved by the Executive Director of Planning and Performance.
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Finance & Performance Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

Please tick as appropriate

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

Sefyllfa / Situation:

It is important to note that performance reporting of many of the national indicators has been stood down to enable the health board to focus on the mobilisation phase of the pandemic. Staff time has been released to manage the pandemic and therefore the data included in this report has not been subject to the full level of validation and quality control as would normally be included in performance reports.
This report includes available indicators from the National Delivery Framework, together with a section on Covid-19 and Essential Services Delivery.

The Financial Report will be presented separately.

Cefndir / Background:

Our report outlines the key performance and quality issues that are delegated to the Finance & Performance Committee. The summary of the report is now included within the Executive Summary pages of the QAP and demonstrates the work related to Covid-19, essential service delivery as well as the key measures contained within the 2020-21 National Delivery Framework. This framework has been revised to provide performance measures under the Quadruple Aims set out in A Healthier Wales.

Strategy Implications
The performance measures within the report are aligned with the National Delivery Framework.

Options considered

Not Applicable

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

Risk Analysis
The present pandemic has produced a number of risks to the delivery of care across the healthcare system. The paper highlights the risks arising directly from Covid-19 and the need to maintain essential non-Covid-19 services. The impact of Covid-19 on non-Covid-19 planned care is reported together with the interdependencies between ensuring safe re-start of elective care and balancing the risk of covid-19 for patients, staff and system capacity.

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

Impact Assessment

The Report has not been Equality Impact Assessed

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

Quality & Performance Report







Finance & Performance Committee

July 2020

About this Report

Covid-19 Pandemic

It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance. It is also important to note that national reporting and performance management arrangements have been suspended at this time. In order to release staff time to manage the mobilisation of the pandemic response normal validation and sign off processes have been reduced, so caution needs to be applied to data quality presented in the report.

The format of the report reflects the published National Delivery Framework for 2020-21 which aligns to the Quadruple aims contained within the statutory framework of A Healthier Wales. Sections are added to reflect Covid-19 key performance indicators and the work on maintaining essential services.

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

The operational planning for 2020-21 has been impacted by the pandemic with planning cycles re-defined into quarterly plans. The Quarter 2 operational plan has been signed off by the Board and submitted to Welsh Government. The progress against the actions contained within this plan are reported in the accompanying Q2 Operational Plan monitoring report. This plan includes actions which were incomplete at the end of 2019-20 and remain relevant to delivery of the Boards objectives.

As a consequence of the changes in the planning cycle for 2020-21 and the uncertainty around the future levels of Covid-19 the ability to produce month on month profiles to monitor performance against is severely limited. Therefore the report contains factual information on performance indicators.

The direction of travel of performance is indicated through trend arrows (*shown in next column)*

↑ Performance has improved since last reported

↓ Performance as got worse since last reported

→ Performance remains the same as last reported

The intention for future reports is to continue to align the reporting of covid-19 related pandemic indicators with the essential services service status and the National Delivery Framework while developing the reporting against the actions in the quarterly operational plans..

Key Messages

- Covid-19 continues to circulate requiring vigilance in application of Social Distancing and IPC measures
- Unscheduled Care demands are increasing resulting in high levels of bed occupancy on Acute Sites
- Essential Services continue to be delivered, risk balanced approach to restarting non essential services

Executive Summary

Overview:

July 2020 has brought new challenges for delivery of patient care. We have seen the reduction in the level of Covid-19 circulating but increased intensity of work on localised outbreaks and widening of Test , Trace and Protect. With the change in lock-down requirements we have experienced increases of Unscheduled Care demand. At the same time the endemic nature of Covid-19 has resulted in a widening of conditions needed to be managed under the Essential Service Framework so increasing demand on planned care. Re-starting non-essential planned care services has been a key focus of attention with the move away from traditional site based management of RTT waiting lists towards pan-BCU risk stratified surgical lists and development of alternatives to face to face outpatient services. There is a recognition locally and nationally that the pandemic challenges will require completely different ways of delivering planned care. Non essential services are recommencing following careful risk assessment . It is recognised that the productivity of these services will be severely reduced compared to pre-Covid-19 levels with capacity available insufficient to meet previous demand or address service backlogs. In addition we note that public confidence is reduced at this time with some patients preferring to defer non essential treatments.

Covid-19

Unfortunately, there have been **412** deaths confirmed as Covid-19.

Increased capacity for testing in the BCU area established. The Test, Trace and Protect work stream is in place and will continue to be implemented in the coming weeks to assist in controlling the rate of transmission.

As at 13th August 2020, **72,870** people were tested for Covid-19 in North Wales, **4,719** of which tested positive and **68,151** tested negative.

During July the health board has worked with partners on specific localised outbreaks and re-enforced the key messages for safe behaviours with our staff and our population.

Essential Services

During July a further assessment was undertaken against the revised Welsh Government Essential Services framework. This demonstrated most services remained compliant with the guidance, however delays were present in diagnostic pathways and phlebotomy service which were impacting on essential services. Additional phlebotomists have been recruited to increase service capacity and diagnostic priorities re-aligned with the second cath lab re-opening and additional endoscopy sessions established. We continued to use the facilities at Spire Yale for diagnostics and essential surgery procedures.

Referrals for urgent suspected cancer have increased in July, returning to their near pre-Covid-19 levels.

The volume of confirmed strokes has also seen a return to pre-Covid-19 volumes.

Quadruple Aim One: Prevention and Self-Management

During July the national screening programmes for Breast and Bowel have recommenced and BCU is supporting this work with a plan to address the backlog of patients created while the service was not available. Work is underway to re-establish the Aortic Aneurysm programme during August 2020.

During July staff were recruited(presently going through pre-employment checks) to commence work on the prostate surveillance self-management programme.

Work has progressed in preparation for the 2020-21 Flu Vaccination Campaign.

Executive Summary

Quadruple Aim 2: Accessible Digitally Supported Services.

Unscheduled Care

Attendances to our Emergency Departments have continued to recover. **15,705** attendances in July 2020 compared to **23,163** in July 2019 and an average of **19,875** attendances per month over the last 2 years. Performance on the unscheduled care indicators is significantly improved compared to pre-Covid-19 performance, however this has deteriorated in July with the increase in attendance. Emergency admissions are increasing and combined with care home safe discharge policies are contributing to increasing bed occupancy.

Planned Care

The restart of non essential planned care services is challenging due to :

a) Ongoing risks associated with covid-19 and need to provide safe access for patients and safe working environments for staff

b)Staff availability due to on-going redeployment of staff to Covid-19 areas, shielding and sickness absences during July

c) Clinical time required to risk assess and prioritised current waiting lists in line with latest guidance.

d) IM&T and managerial resource required to redesign data capture, booking and scheduling processes to a clinically risk stratified waiting list.

e)Additional time required for donning and doffing of protective equipment and cleaning of rooms and equipment between cases

d) Increased lead in time for surgery in line with pre-operative assessment self-isolation and testing requirements

f) Patient confidence and preference to defer treatments.

The combination of these factors means that restarting non essential surgery is taking time to ensure it can be safely provided for patients and staff. The outcome will mean the volume of activity which can be delivered is significantly lower than in pre-Covid-19 era. Alternatives to treatment and programmes to identify change in and prevention of deterioration in condition while waiting are being developed for some specialties. The financial and value for money analysis of efficient and effective care will need to be reconsidered. This is not unique to BCU as a health board.

Quadruple Aim 3: Workforce

Staff health and well-being remains a key priority for the Board at this time.

Additional well-being support is being provided.

Staff response to Covid-19 and the changes that have been implemented quickly is to be commended. The sickness rate is currently the best in Wales and the rate of covi-19 related absences has reduced to 0.5%.

Mandatory training has maintained despite the challenges of delivering this at this time.

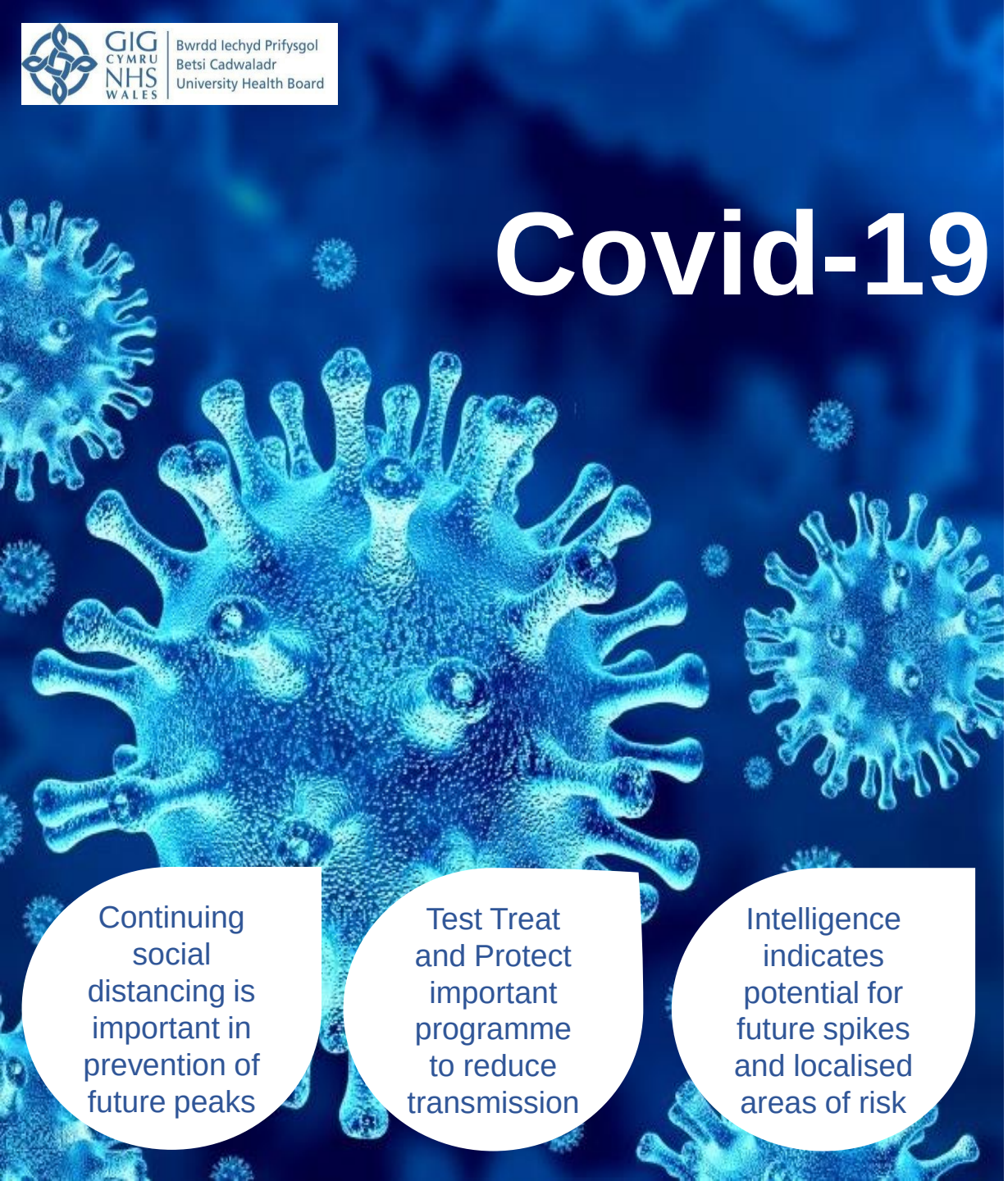
PADR rates have also improved , with focus targeted on divisions were rates are lower than expected.

Quadruple Aim 4: Value-based, outcome focussed healthcare

Due to impact of Covid-19 additional resources have been required to support mobilisation. These will be reported within the Finance papers

Dental Care – This measure will normally be reported under Quadruple Aim 4 in line with the National Delivery Framework

Due to impact of Covid-19 Pandemic and the measures put in place to prevent the spread of the virus, all routine dental services have been suspended however, patients can access dedicated urgent dental care services established in North Wales



Key Messages

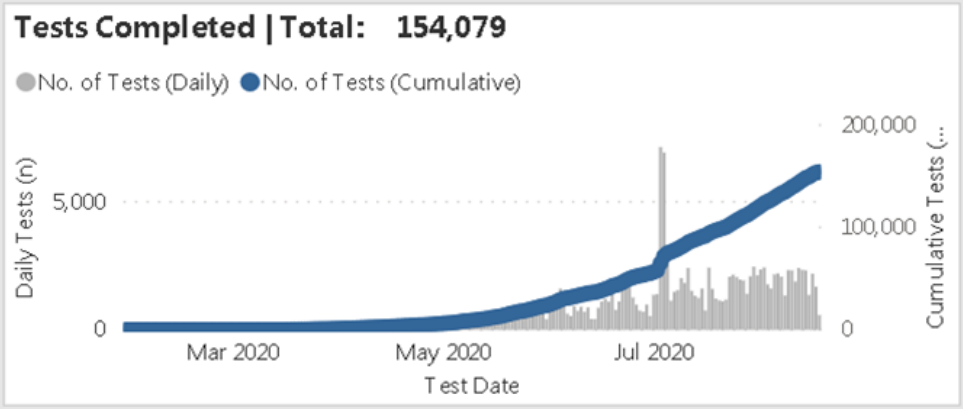
- Initial Peak of Covid-19 has past, however risk is still present
- Good social distancing and infection prevention is essential to sustain lower levels of Covid-19
- Covid-19 forecasting is being used to plan for Q3/4

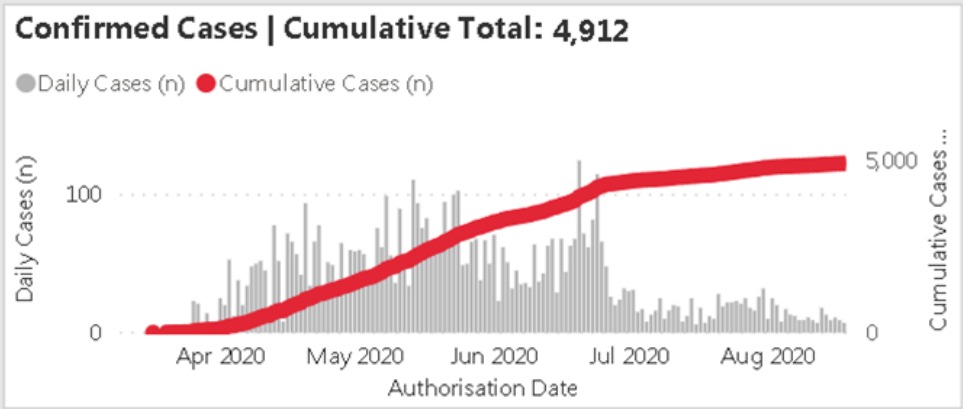
Measures

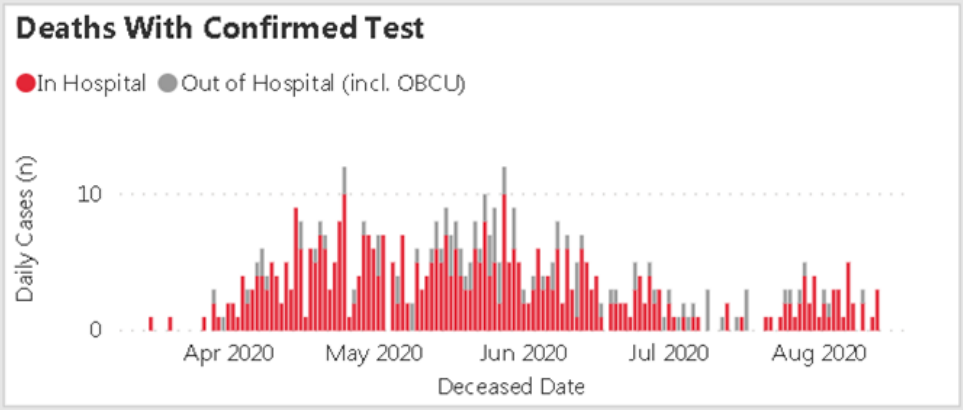
Measure	at 17th August 2020
Total number of tests for Covid-19	**76,559**
Number of results: Positive	**4,760**
Number of results: Negative	**71,799**
% Prevelance of Positive Tests	**6.2%**
Number of Deaths - Confirmed Covid-19	**415**

Source: Public Health Wales coronavirus Dashboard, accessed 18th August 2020

Covid-19 Test Information



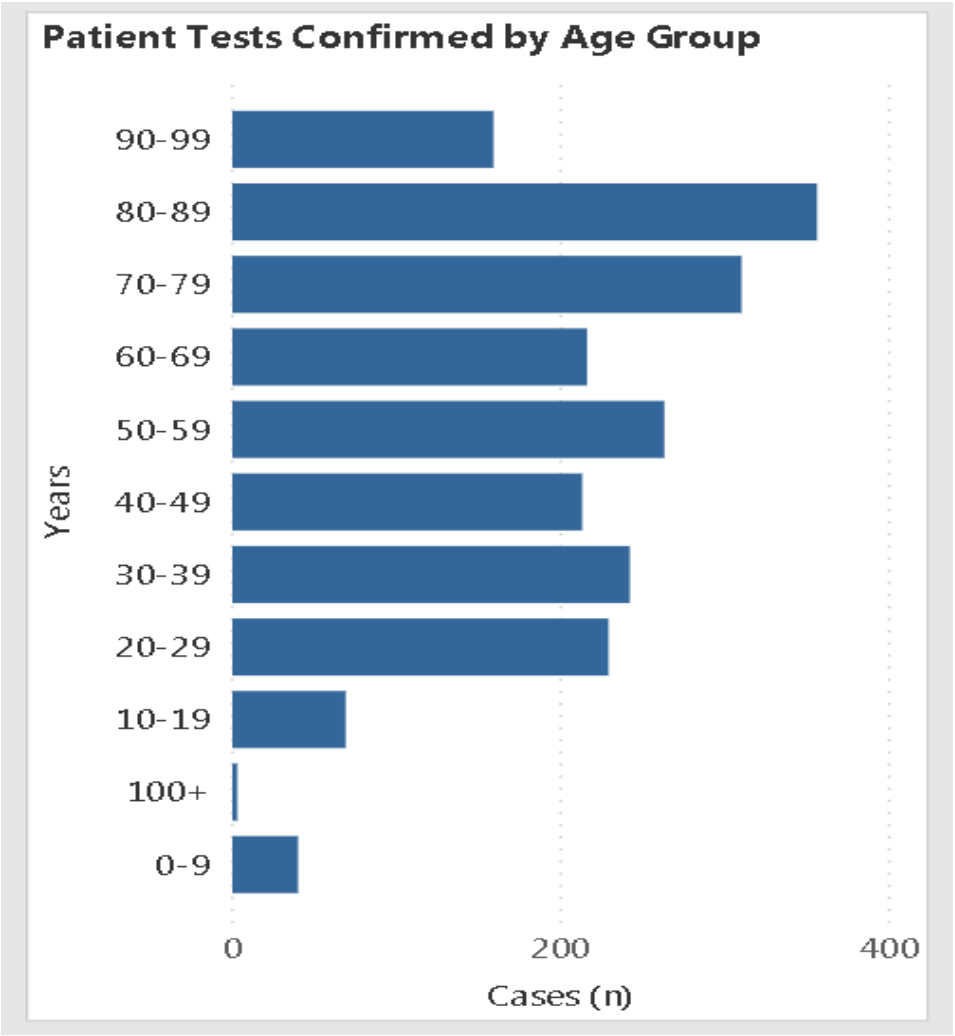




Averager rate of Covid-19 Tests turned around with 24 Hours in the last 7 days

51%

Source: BCU Coronavirus Dashboard, accessed 18th August 2020



Essential Services

Maintaining essential service activity is key for patients with life-threatening conditions

Essential services form a small proportion of specialties normal business

BCU monitors compliance with Essential Services Framework monthly

Key Messages

Essential Services are those which need to continue throughout the pandemic to reduce risk of harm

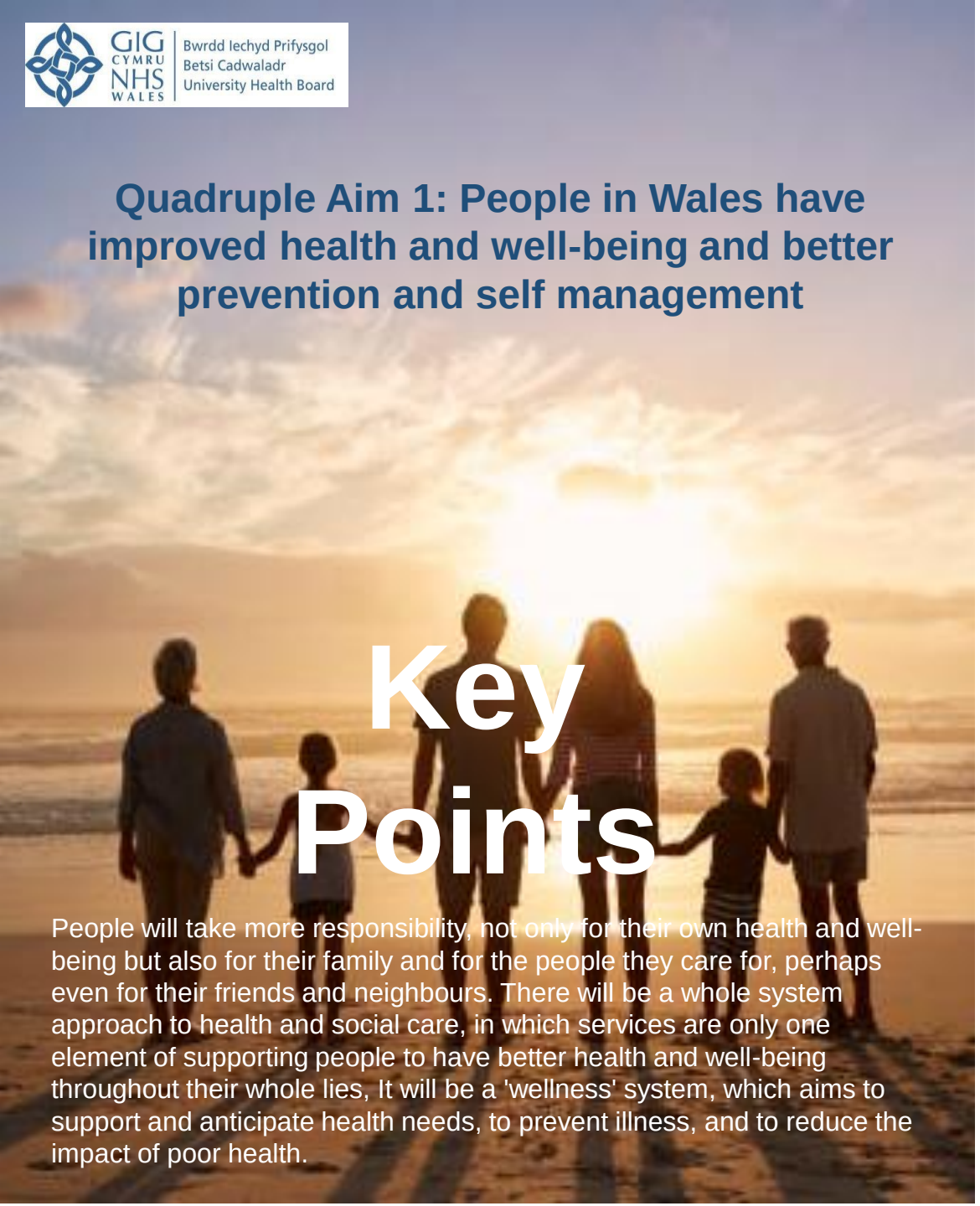
Essential services covers a wide range of Primary, Community and Secondary and Tertiary care Pathways

Majority of Essential Services continuing

Measures

Average Number comparison:	Pre Covid-19	Post Covid-19
Referrals into Secondary Care (average per week)	4,846	3,443
Referrals Urgent, suspected Cancer (average per week)	539	410
New Outpatient Attendances (Year to Date April - July)	88,479	45,631
Follow Up Outpatient Attendances (Year to Date April to July)	183,614	101,803
Diagnostic 8 Weeks Breaches (Per Month)	2,061	13,312
Patients over 62 Days open on Urgent, suspected cancer pathway	113	348
Elective Inpatient/ Daycase Procedures (Year to Date campared to same period 2019)	10,998	3,505

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



Key Points

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

Key Messages

- Screening services restarted in July 2020
- Additional sessions are required to deliver the Bowel Screening recovery programme
- Breast Screening invitations are being sent for patients to attend the Assessment Centres

Measures

Measure	Target	Actual	Trend
Bowel Screening			
Cervical Screening			
Breast Screening			

Following a cessation of Breast, Bowel and Aortic Aneurysm screening services in March, Breast and Bowel screening recommenced, at the end of July. Aortic Aneurysm screening is planning to recommence in August. Cervical Screening has continued in BCU throughout the pandemic.
The service restarts are on a limited basis at present due to staffing, equipment and environmental factors. The assessment centres at Llandudno and Wrexham are being used for screening, until the mobile units can be modified to support social distancing.
The bowel screening programme is re-inviting patients previously undergoing testing and it is expected a proportion of patients will convert to endoscopy from September 2020.

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

Key Points

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

- Unscheduled Care demand is starting to increase
- Planned Care system switching from RTT to clinically risk stratified care
- Diagnostic waits increasing as service capacity is constrained to ensure safe provision

Key Messages

- Planned Care delivery will require a new approach to address clinical risk and service capacity
- Bed Occupancy on acute sites is relatively high
- Unscheduled Care Performance while lower than June 2020 remains better than in July 2020

Top 5 Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
July 20	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	>75%	79.71%	↓
July 20	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	704	↓
July 20	Number of Ambulance Handovers over 1 Hour	0	348	↓
July 20	Number of patients waiting more than 36 weeks for treatment	0	30,167	↓
July 20	Number of patients waiting more than 52 weeks for treatment	0	10,904	↓

Quadruple Aim 2: Unscheduled Care Measures

Period	Measure	Target	Actual	Trend
Q2 20/21	Percentage children regularly accessing NHS Primary Dental Care	TBA	60.20%	N/A
July 20	Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered	100%	0%	↓
July 20	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	>= 65%	69.53%	↓
July 20	Number of Ambulance Handovers over 1 Hour	0	348	↓
July 20	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	>95%	79.71%	↓
July 20	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	704	↓
July 20	Percentage of survival within 30 days of emergency admission for a hip fracture	>= 80%	88.90%	↑
July 20	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time.	>= 50%	43.90%	↑
July 20	Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours of the patient's clock start time	>= 85%	73.00%	↑
July 20	Percentage compliance against the therapy target of an average of 16.1 minutes of Speech and Language Therapist input per stroke patient	TBA	30.50%	↑
March 20	Percentage of stroke patients who receive a 6 month follow up assessment	TBA	28.20%	↓
July 20	Number of health board patients non mental health delayed transfer of care	> 30	7	↓
July 20	Number of health board beddays non mental health delayed transfer of care		272	↓

Stroke 6 month follow up Time is reportd 6 months in arrears

Quadruple Aim 2: Overview (page 1)

The inter-relationship between unscheduled and planned care is further intensified with increased complexity during the pandemic. We are therefore needing to be agile in preparing for continuing uncertainty in the levels of Covid-19 we can expect over the coming months. This variation in level will impact on our ability to deliver other services and so surge plans will need to flex to respond to this. We envisage this will continue throughout the remainder of the year. The understanding of these interdependencies are key to the principles we are adopting in delivering services during Quarter 2 and in producing our Q3/4 plans.

The complexities we are addressing through our actions includes:

- Addressing the needs of patients who have contradicted Covid-19
- Addressing the needs of patients with other emergency conditions
- Addressing the needs of patients with non-emergency but nevertheless life-threatening of life-changing conditions (Essential Services)
- Protecting future generations and vulnerable groups from long-term harm
- Protecting our staff and patients from harm
- Working with partners to manage across the health and social care systems (including the fragility of independent and 3rd sector providers)
- Building confidence for our population to re-engage in accessing emergency and planned care services
- Adapting estate and processes to provide socially – distanced environments
- Ensuring our staff have appropriate PPE available
- Embracing and sustaining new ways of working and technological innovations with patients
- Communicating and disseminating information on our services widely.

Our approach is therefore to ensure we are able to meet the needs of patients contracting covid-19, meet unscheduled care demands, maintain essential services and restart as much planned care service as our capacity permits. We recognise that reduction in planned care capacity will mean longer waits for routine treatment and we are seeking alternatives to treatment to support patients while they are waiting. We also recognise that reduction in planned care capacity will result in increased unscheduled care demand and are seeking to minimise the impact of this. Our priority is to prevent harm by directing our available capacity to those patients with greatest clinical need.
The following pages of this report cover the situations which we are working to address in both unscheduled and planned care services, and sets out the scale of the challenges we face in supporting the health and well-being of our population at this time.

Quadruple Aim 2: Narrative - Unscheduled Care (page 1)

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance.

Emergency Department (ED) Performance

Performance against the 4 hour wait target has seen a slight deterioration in July to **79.7%**, compared to recent months during the first wave of Covid-19 pandemic when performance was 87% in April.

There has been a month on month increase in the number of attendances across the 3 sites and the number of patients waiting over 12 hours and ambulance handover delays have also increased.

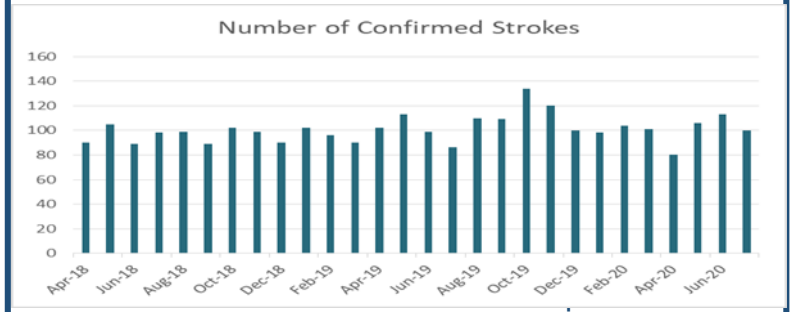
The increase in attendances has impacted on the ED performance for 4 hour, 12 hour and ambulance handover delays although they remain improved compared to the same period last year.

As unscheduled care pressures are indicating a return to usual demand there remains an anticipation that this will continue to reflect performance levels pre Covid-19. Focus is being given to refreshing the unscheduled care improvement programme of work reflecting on lessons learned from Covid-19.

The Unscheduled Care Improvement Group has reformed and met early in August 2020. We are working jointly with WAST on conveyance and handover improvements. A deep dive is underway at YGC and the EDQEF actions are being refreshed to improve performance. The Q3/4 winter and surge plans are being produced during August and September 2020.

Stroke Care Performance

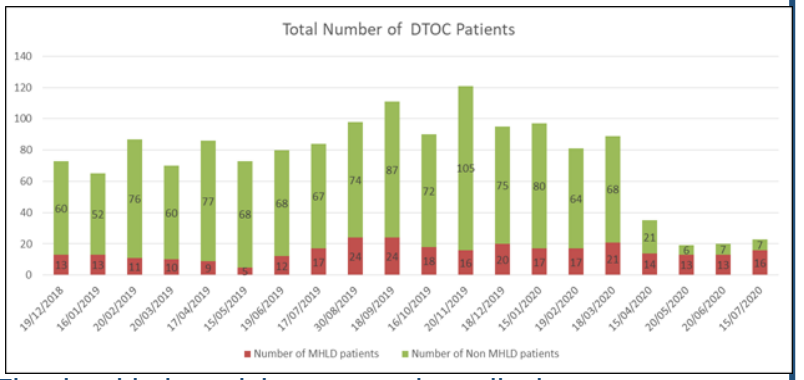
The number of confirmed strokes reported each month has returned to the levels seen before covid-19 and as now comparable with 2019 levels;



deterioration in performance and this deterioration, particularly in therapy and rehabilitation continued during Covid-19. Some therapy staff were redeployed to support Covid-19 areas. The rehabilitation service in Central has been re-established. However the recent national mapping of therapy resource confirms the shortfall in provision of therapists for rehabilitation. This shortfall is reflected in the stroke business case. Findings from the mapping exercise are being developed into an action plan by the end of August.

Delayed Transfers of Care Performance

The number of non Mental Health Patients delayed for discharge is low and significantly reduced compared to pre-Covid-19 levels.



The health board has moved to discharge to assess pathways and CHC assessment panels and processes have been changed. MHLD are reviewing the reasons why the reduction in non-mental health delays has not been replicated in their services.

Weekly non Mental Health discharge pathways are reported and variance with the 5 pathways investigated with a view to embedding these as part of normal practice.

Quadruple Aim 2: Narrative – Unscheduled Care (Page 2)

Covid-19 Pandemic
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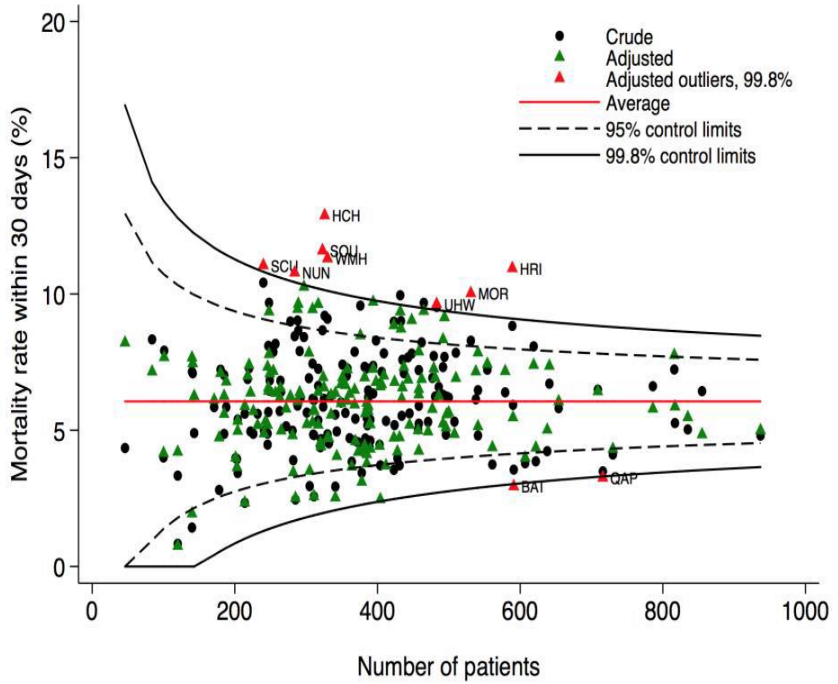
GP Out of Hours – Very Urgent cases not assessed within 1 hour

We had two very urgent cases throughout July, both of which failed to meet the one hour target. A root cause analysis was undertaken and any lessons learnt identified and documented . Both cases involved the requirement for support at home for palliative care patients, one of whom had suffered a fall. The breaches of the one hour did not result in harm occurring to either patient. Lessons from both cases demonstrated the need to improved documentation of calls and record-keeping. In the second case increased awareness of the categorisation of calls was required. The lessons from both cases have been shared with staff.

Fractured Neck of Femur

BCU are participating in the national programme to improve patient outcomes following the patient suffering a fractured neck of femur. As part of this programme each of the three sites are working to improve 4 particular measures
contained in the national database. These are :prompt ortho-geriatrician assessment, prompt surgery,
not delirious post operatively and return to normal place of residence.
During Covid-19, changes to ward locations and staffing has made it difficult to maintain the National Database.
The patient pathway has continued throughout the Covid-19 period with changes made to manage covid-19
Patients on different wards. The temporary loss of the trauma ward and redeployment of the ortho-geriatrician
impacted on the pathway being delivered consistently for all patients in Wrexham.
The mortality rate following hip fracture is included in the National Hip Fracture Database Annual report 2019.
While this data relates to 2018, it is noted that none of the North Wales acute hospitals are an outlier and
Wrexham
Maelor Hospital is one of 9 hospitals with a mortality rate better than the lower 95% limit.



The challenge

Planned are has been significantly disrupted from the Covid pandemic
Long waiters over 36 weeks has increased to over 30,000
Activity is 37% for IP/DC compared to last year
Turn around times in theatres have increased
Theatre and ward capacity is still lower due to
Covid carve out
Essential services are still being maintained
But at reduced activity
Re-starting of services in a reduced footfall is taking longer than first thought
Welsh Government has introduced a risk stratification approach, guidance only on stage 4 presently

% of previous activity delivered			
NEW OPD	FU OPD	other OPD	Elective IPDC
46%	54%	24%	37%

Actions

- Essential service being maintained weekly/monthly monitoring to ensure compliance and increase
- Meet demand
- Introduce risk stratification for stage 4 and planned
- “Once for North Wales” approach for high risk specialties is being implemented
- Re-start for routine services is being planned, expecting increase in September
- OPD activity for Cancer is almost back to pre-covid levels
- Routine referrals is slower
- Virtual clinics is being planned for further role out
- SOS and PIFU toolkits are complete and being rolled out
- Orthopaedic network plan being implemented, strategic business case requires significant review

Activity v Plan Comparison				
	% of previous activity delivered			
Provider	NEW OPD	FU OPD	other OPD	Elective IPDC
COCH	42%	56%	27%	35%
RJAH	18%	46%	11%	14%
BCU	46%	54%	24%	37%

Progress to date

- Essential service being maintained
- Risk stratification being implemented for stage 4 and planned
- Task and finish group to cover IT governance and PAS to measure risk stratification
- Clinical engagement re new approach
- Once for north Wales for p2/3 patients is live in
- Endoscopy, Ophthalmology (August)
- General surgery August/September)
- Orthopaedics (august/September)
- OPD programme- SOS/PIFU now BAU
- Virtual clinics requires further push due to roll out issues
- Review of diagnostic extra capacity for endoscopy and CT
- Applying this to diagnostic and treatment centre approach as an option
- Options for non-operative pathways/primary care and field hospital usage
- Winter plan key and working relationship with unscheduled care

Risks

- Screening programmes re-start increases risk for Endoscopy/breast/diagnostics
- Routine referrals increase
- Winter plan needs to be closely integrated with primary care/unscheduled care
- IT infrastructure to monitor risk stratification (IT update forecast in September)
- No national guidance on stratification for OPD/diagnostics
- Independent sector (spire contract)
- RJAH contract
- Patients declining dates due to covid threat requires improved communication strategy
- Reduced capacity means patients will be waiting much longer within P4 risk stratification
- Non-operative pathways may require investment and upscaling
- Full review of risk register is required in August/September to incorporate new risks

Planned Care

Quadruple Aim 2: Planned Care Measures

Period	Measure	Target	Actual	Trend
June 20	Percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)	>= 98%	100%	→
June 20	Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days of receipt of referral	>= 85%	75.40%	↓
June 20	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	TBA	75.81%	↑
July 20	Number of patients waiting more than 8 weeks for a specified diagnostic	0	13,312	↓
July 20	Number of patients waiting more than 14 weeks for a specified therapy	0	4,003	↓
July 20	Percentage of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments	>= 95%	41.60%	↓

Period	Measure	Target	Actual	Trend
July 20	Percentage of patients waiting less than 26 weeks for treatment	>= 95%	55.26%	↓
July 20	Number of patients waiting more than 36 weeks for treatment	0	30,167	↓
July 20	Number of patients waiting more than 52 weeks for treatment	0	10,904	↓
July 20	Number of patients waiting for a follow-up outpatient appointment	Reduce	195,350	↓
July 20	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	34,721*	63,198	↓

Follow Up Outpatients 100% overdue less than 34,721 by 31st March 2021

Quadruple Aim 2: Narrative - Planned Care (page 1)

Covid-19 Pandemic

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Referral to Treatment (RTT) Performance

Referral to treatment was established as the mechanism to manage waiting times in Wales from 2009. The Covid-19 pandemic has resulted in low levels of routine referrals to secondary care together with the postponement of routine elective outpatient , diagnostic and Inpatient and Daycase procedures. In part this national decision was to release resource to address the pandemic and in part to ensure patients not requiring urgent treatment could be safely separated from sites were covid-19 was present and in-part to protect the staff from exposure to Covid-19.

The consequences of the postponement of routine appointments has had a marked impact on RTT activity and waits. During the first quarter of 2020-21 only essential services activity was undertaken. Through July 2020 surgical services have been adopting a risk stratification approach in line with national and Royal College guidance to identify patients who are in priority 1 a –surgery within 24 hours, priority 1b –surgery within 72 hours, priority 2 –surgery within 1 month, priority 3 –surgery within 3 months and P4 surgery beyond 3 months. This risk stratification of our waiting lists enables a pan-BCU waiting list to be developed with available capacity allocated to those with highest priority.

This is an important but radical change in approach, requiring new data capture, IT system development and booking and scheduling processes to be established. Work is moving rapidly locally and nationally to address this for inpatient and daycases and is commencing to apply 3 risk tiers based on clinical condition to outpatient appointments.

During July specialties commenced the re-set process including assessment of the environment, staffing, infection prevention measures needed to recommence routine surgery and face to face consultations. The pre-operative pathway was put in place requiring patients to self-isolate for 14 days prior to surgery and to be swabbed for Covid-19 72 hours prior to surgery. The consequence of the necessary precautions is to reduce the flexibility of elective services , as short notice appointments can no longer be used to maximise capacity arising from cancellations etc. In Productivity is significantly reduced due to the environmental and social distancing measures in place. Patient confidence and willingness to proceed with routine appointments at the present time is also reduced, with some patients on our waiting lists wishing to defer appointments or treatment. Overall impact has been a slight increase in the volume of the waiting list but a significant increase in the length of routine waits and a significant reduction in elective activity. This change is being seen throughout Wales and across the wider NHS.
Going forward the planned care services will need to be agile, to increase capacity at times of low Covid-19 and Unscheduled Care pressures and reduce activity as Covid-19 and unscheduled care pressures indicate.

Quadruple Aim 2: Narrative - Planned Care (page 1)

Covid-19 Pandemic

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Cancer Performance

Cancer services form part of the Essential Services framework. These have been maintained throughout the Covid-19 period in line with national guidance. However this does not mean that the services have been able to work as normal or that activity levels reflect previous pre-Covid-19 levels. Initially referrals for Urgent Suspected Cancer fell significantly. These have recovered during July to closer to pre-Covid-19 levels, however concern continues that some patients may not have presented . Early analysis suggests this may be the case with those currently being diagnosed being generally at later stages in their disease.

Initially advice resulted in a number of treatment regimes being altered for reasons of staff and patient safety. This has resulted in a higher proportion of patients proceeding to radiotherapy or chemotherapy for their first definitive treatment and fewer patients being directed to surgery.
Guidance has continually been refreshed and therefore some patients who were initially not able to proceed to surgery, have been re-reviewed and progressed to surgery.

Diagnostic capacity has been reduced, priority has been given to suspected cancer patients and work undertaken to equalise cancer access times between sites for services such as endoscopy. This has entailed patients being offered appointments based on service capacity as opposed to clinical location. Diagnostic capacity remains constrained both in terms of workforce availability, and equipment time. Many of our diagnostic departments are not designed to easily accommodate 2 metre social distancing and so appointment scheduling has needed to be revised to support patients and staff well-being. Additional cleaning of all equipment between patients has added to the length of procedures further reducing imaging time available for patients.

The patients over 62 days from referral increased during the first quarter as a consequence of the above factors. July has seen improvement in the numbers over 62 days, largely due to improvements in diagnostic access. However with screening services recommencing and referrals returning to pre-Covid-19 levels it is highly likely that the demand on cancer services will continue to increase. This will require creation of additional capacity to enable this improving position to continue and to eliminate the backlog of patients that current exists.

BCU continued to use Spire Yale for elective surgery during July as well as schedule patients in accordance with their clinically determined priority .

Quadruple Aim 2: Narrative - Planned Care (Page 2)

Covid-19 Pandemic

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Narrative for Follow-up Backlog Performance

The levels of follow up activity have fallen during the covid-19 period in part due to the postponement of routine activity. Virtual consultations, primarily by telephone are continuing where suitable for management of on-going patient care.

AttendAnywhere, a video platform for virtual consultation was piloted and roll out commenced during July 2020, initially with 72 professional areas expressing an interest in using this technology with their patients.

BCU has also been instrumental in developing the Patient Initiated Follow Up process for patients with long term conditions and the See on Symptoms process to enable patients to be discharged with a view to returning within the next few months should they find they are unable to self-manage their condition.

The self-management project for prostate surveillance is progressing with staff recruited expected to be in post in the next 2 months and the tender for this software having closed.

Overall the reduction in elective activity has reduced the rate of the additions to the follow up waiting list and so the size of the list has not significantly increased. However the increased use of virtual follow up is not suitable for all patients. The take up of this is not sufficient at this time to overcome the loss of face to face activity and therefore the volume of patients overdue their follow up continues to increase.

The outpatient improvement programme has developed action plans and a trajectory for improvement to deliver year end targets

Narrative for Ophthalmology Performance

Ophthalmology services operate a risk stratified waiting list via the introduction of Eye Care Measures in 2019. However the service entered Covid-19 with a large volume of patients at highest risk of harm being overdue their target date to be seen.

During Covid-19 the clinicians have further risk stratified patients through a table top process and also conducted telephone consultations. The a high proportion of patients virtual appointments are not suitable as the diagnostics are required to be able to detect changes in the eye overtime. Unfortunately some eye diseases such as glaucoma can progress unknown to the patient and therefore regular clinical monitoring is required.

New pathways were introduced to support both emergency and urgent eye care to be delivered. The emergency pathway has been effective with 2911 episodes recorded through the work of the primary care hubs. Only 13% of these patients needed onward referral to the Hospital Eye Service. The urgent care pathway has not been fully utilised and reasons for this are being further investigated. The cataract pathway has been redesigned for patients who are classified as Risk 2 and sites have tested this and will be implementing the restart of surgery from August.

Overall the risk to R1 patients remains high, with the volume overdue the target increased to 17,277 and only 41.6% now within the national target. Work is continuing to re-establish community ODTCs to provide additional capacity.

Quadruple Aim 2: Narrative - Planned Care (Page 2)

Covid-19 Pandemic
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Diagnostics Performance
The impact on diagnostic services was covered under the cancer section of this report and applies equally to routine elective waits for diagnostics.

Plans to increase capacity include the appointment of our regular diagnostic agency to increase imaging capacity for CT and MRI to seven days throughout BCU. We have secured an additional CT Scanner via the national programme and this will be on site during August and expected to be operational in September.
MRI mobile capacity will be required to replace the estimated 35% loss of internal activity

Work is taking place to determine the value of creating a diagnostic and treatment centre in North Wales. Once this is completed the outcome of the analysis will be reported and any potential business case developed.

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

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

Sickness Absence Rates best in Wales at 4.60%

Despite Challenges of Covid-19, Mandatory training rates remain high

PADR rates increasing

Key Messages

Staff health and well-being is a key priority for the health board

Staff have responded well to the demands placed upon them

At 8%, filling of substantive posts better than target rate of 7.8%

Period	Measure	Target	Actual	Trend
July 20	Personal Appraisal and Development Review (PADR)	>= 85%	66.90%	↑
July 20	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	>= 85%	84.10%	↓
July 20	Percentage of sickness absence rate of staff	< 5%	4.60%	↑

Quality and Performance Report
Finance and Performance Committee

Quadruple Aim 3: Narrative – Workforce

Covid-19 Pandemic
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PADR

PADR Compliance has increased from 65.7% in June to 66.9% in July. Out of 22 divisions 14 have increased in compliance since June ranging from 0.34% to 9.11% increase. 2 have stayed the same at 33.33% and 30.77% and 6 divisions seeing a decrease of between 0.23% to 2.4%. The 6 divisions that have seen decreases have been contacted to share their detailed reports for action. YGC made the biggest increase of 9.11%. Other actions taken place during July include:-

- OD team working with HR colleagues to identify the areas and Senior Managers to target and provide support to improve compliance within their divisions
- Shared guidance on planning and conducting virtual PADRs ensuring the staff and managers not able to conduct face to face PADRs can become more confident in working in a different way
- Re-emphasis on qualitative conversations and allowing a less formal process. To facilitate this revised guidance and forms have been developed. Prior to release there will be an exercise to consult with staff and managers for feedback on this draft guidance.

Sickness Absence

Non-Covid related sickness absence has reduced in the last 4 months. The July 2020 figure of 4.6% is a significant improvement from the same time last year (5.2% July 2019). Covid related sickness has fallen from a high of 2% in May to 0.5% in July 2020.

Sickness Rates are being addressed across BCU via the Workforce Wellbeing Group and the 3 regional Staff Wellbeing Support Service hubs.

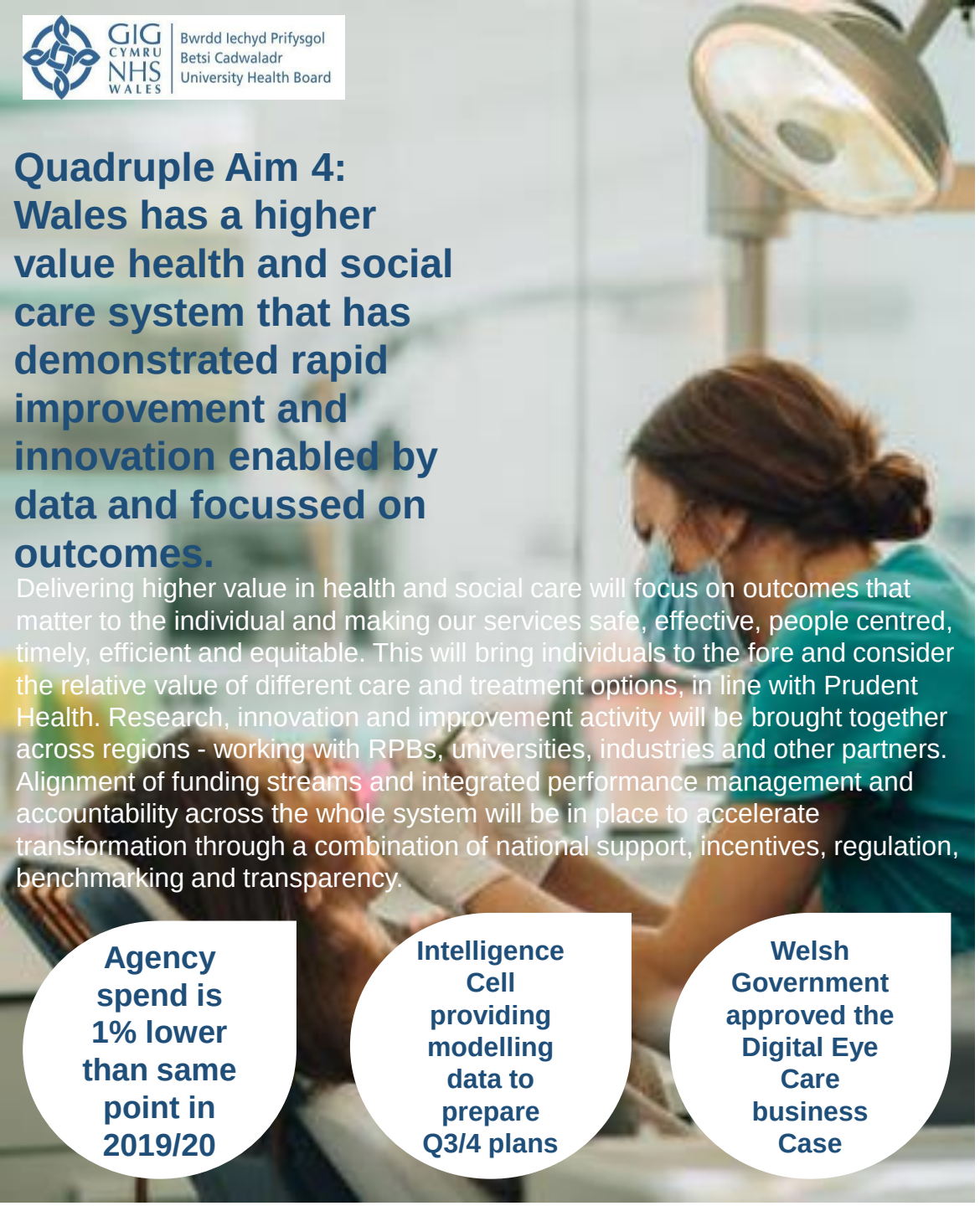
Workforce & OD teams including HR managers and Occupational Health professionals continue to offer focussed support to hotspot areas and to complex cases.

Mandatory Training

Level 1 MT has fallen slightly this month to 84.1% as Covid continues to impact both in terms of managerial focus and reduced face to face training. In line with Safe and Agile working, Subject Matter Experts delivering mandatory training are being supported to develop a variety of training delivery methodologies ranging from workbooks for those with difficulty accessing IT facilities, videos of sessions hosted on the Intranet and delivery of live virtual training sessions. Access to appropriate virtual platforms is key to ensure quality virtual delivery.

Delivering training in a variety of ways to ensure ease of access for staff has created challenges in terms of ensuring the accurate recording of compliance. These issues are being worked through and should be resolved during August.

Focussed work continues to support the 2 areas of lowest compliance which are Estates & Facilities staff and Medical & Dental staff.



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

Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring individuals to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions - working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.

Agency spend is 1% lower than same point in 2019/20

Intelligence Cell providing modelling data to prepare Q3/4 plans

Welsh Government approved the Digital Eye Care business Case

Key Messages

- Patients and families supported stay in touch via innovation and technology while in hospital
- Consultant Connect implemented across Primary Care as a professional advice line
- Digital Health Record for Secondary Care supported by Executives

Period	Measure	Target	Actual	Trend
July 20	Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	TBA	22.00%	↓
Q4 19/20	Percentage of critical care bed days lost to delayed transfer of care (ICNARC definition)	Reduce	15.00%	↑
July 20	Agency spend as a percentage of total pay bill	Reduce	4.80%	↑

* Dental surgeries remain closed for non-urgent treatment there figure provided should not be compared with pre-covid-19 figures.

Quadruple Aim 4: Narrative – Agency Spend

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in July 2020 is not compared as 'like-for-like' to previous months/ years performance.

Agency Spend as % of Total Spend

Key points are:
Non core spend has reduced from £8,584,000 in June to £8,292,000 in July 2020. Agency as a percentage of total spend has improved month on month and year on year currently 4.8%, July 2020 (June 2020 = 4.9%, July 2019 = 5.2%). There has been increases in N&M Agency spend this fiscal year with it now representing 5.8% of total N&M spend, this is up month on month and the same as at this point last year (despite increased N&M establishment and demand).

Actions to address:

a) Filling substantive vacancies – BCU overall vacancy rate is better than the 8% target at 7.8%, however there are still shortages in key staff groups. The overall M&D vacancy rate is at 9.9%. Actions have ben taken to speed recruitment and the average working days taken from vacancy creation to staff in post for all M&D posts in BCU has been reduced from 110.9 days in the three months to May to 96.5 days in the three months to August. An action plan to further speed up M&D recruitment process and to give focus to high cost vacancies is in place. N&M vacancy percentage is at 13.6% after rises due to increased establishment (whilst we have only 9 fewer N&M staff in post than this time last year the N&M establishment has increased by 134 FTE over the same period).

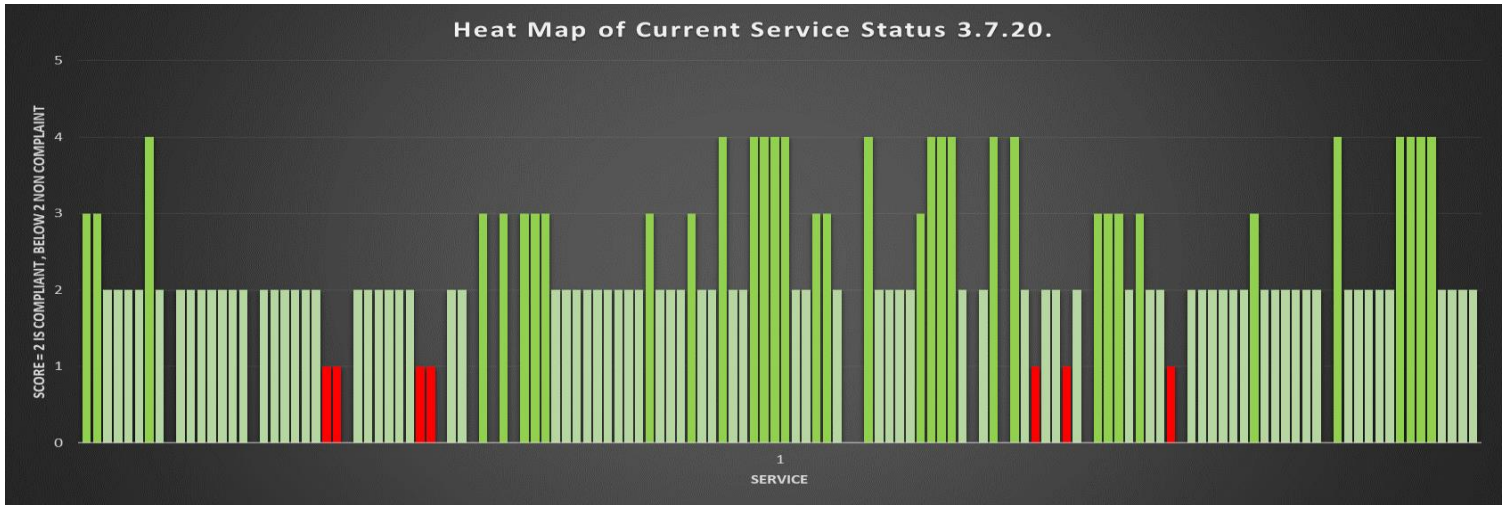
b) Reducing sickness absence – Non-Covid related sickness absence has reduced in the last 4 months. The July 2020 figure of 4.6% is a significant improvement from the same time last year (5.2% July 2019). Covid related sickness has fallen from a high of 2% in May to 0.5% in July 2020. Sickness Rates are being addressed across BCU via the Workforce Wellbeing Group and the 3 regional Staff Wellbeing Support Service hubs. Workforce & OD teams including HR managers and Occupational Health professionals continue to offer focussed support to hotspot areas and to complex cases.

c) Increasing supply of internal temporary staff– Particularly in nursing and medical & dental staff groups to provide a more cost effective alternative to Agency. N&M - Focussed recruitment of N&M staff has seen large increase in 'bank only' workers with 424 'bank only' N&M registered staff now registered to internal bank, up from 307 in March. In July 2020 16,160 hours of N&M registered bank work was delivered compared to 12,724 hours in the same period last year. M&D - Medical Staff Bank (MSB) - Recruitment to MSB has seen large increase in 'bank only' workers with 228 'bank only' Medical Staff Bank registered staff, up from 138 in March. In July 2020 13,857 hours of MSB registered bank work was delivered (MSB was only started in November 2019).

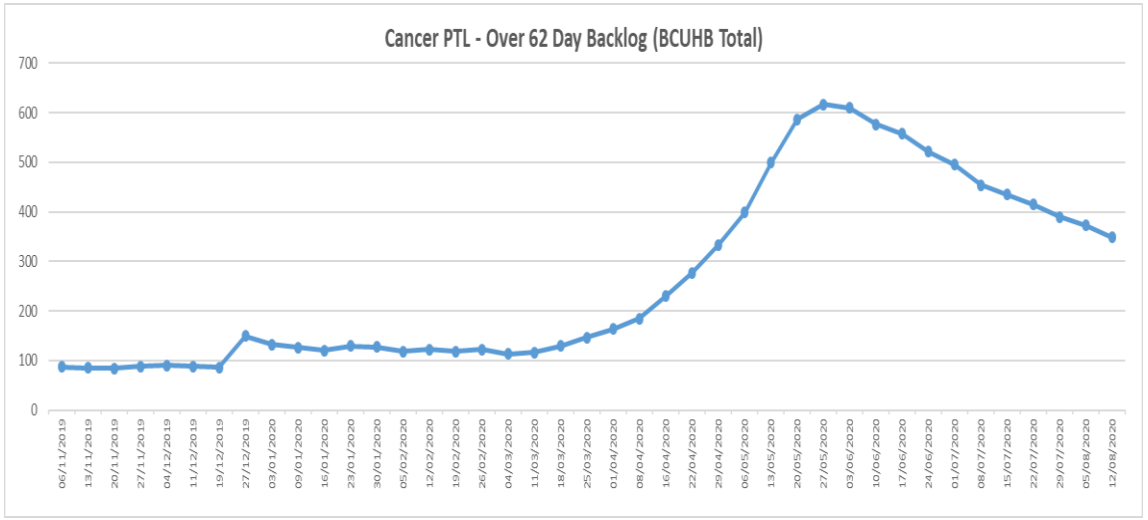
Essential Services - Covid-19: Primary Care Updates

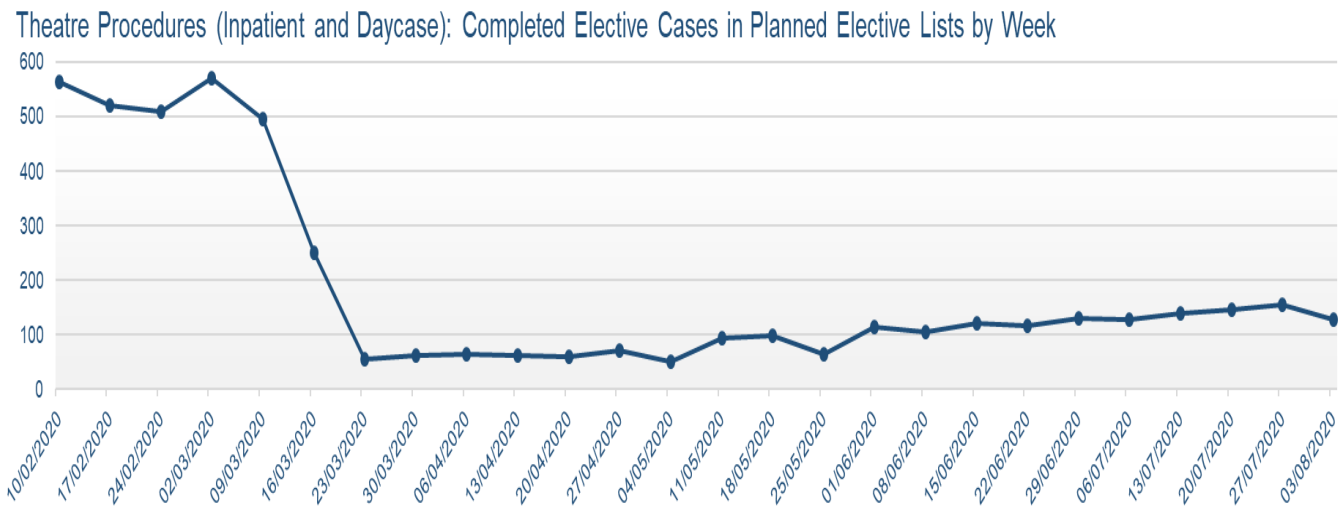
GP Practice Escalation Levels	Date: 03/08/20 BCUHB NWIS REPORT	Date: 16/08/20 BCUHB NWIS REPORT	Date: 16/08/20 All Wales NWIS REPORT
No of GP practices reporting	103	103	403 (ALL)
No. of GP practices reporting Level 5 (CLOSED)	0	0	0
No. of GP practices reporting Level 4 (severe pressure)	0	0	4
No. of GP practices reporting Level 3 (moderate pressure)	2	3	12
No. of GP practices reporting Level 1 & 2 (no/steady pressure)	101	100	387
No./% of GPs absent/self isolating/carers/COVID +ve (excludes locums)	39 8.07%	39 7.99%	140 7.95%
No./% of MDT staff absent/self isolating/carers/COVID +ve	32 6.13%	34 6.54%	129 7.95%
No./% of admin staff absent/self isolating/carers/COVID +ve	92 8.14%	90 7.83%	349 8.77%

Essential Services Review Chart

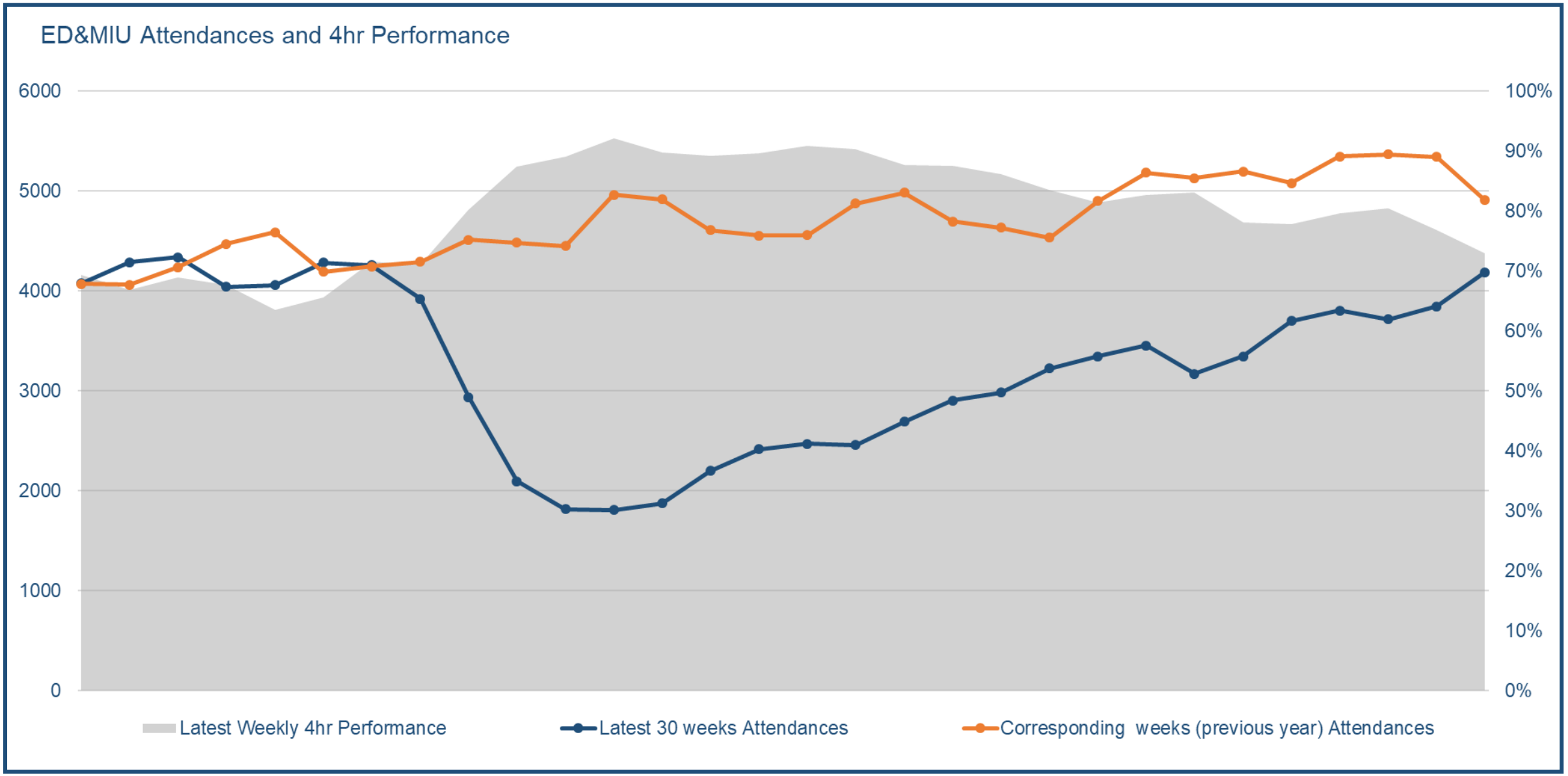


Essential Services have largely been maintained throughout the Covid-19 period. The majority of these pathways are based in primary and community care. However focus is often directed to the Cancer and Surgical elements of Essential Services. The graph below shows the improving position for the Cancer services backlog and the impact of Covid-19 on theatre activity with only essential service procedures being undertaken.





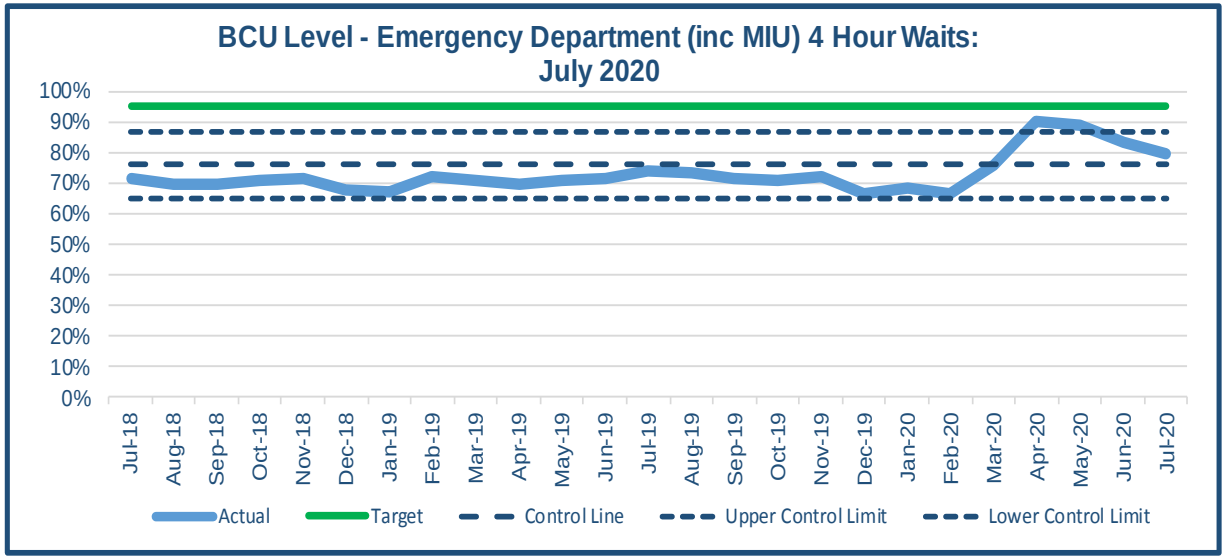
Quadruple Aim 2: Unscheduled Care: Attendances

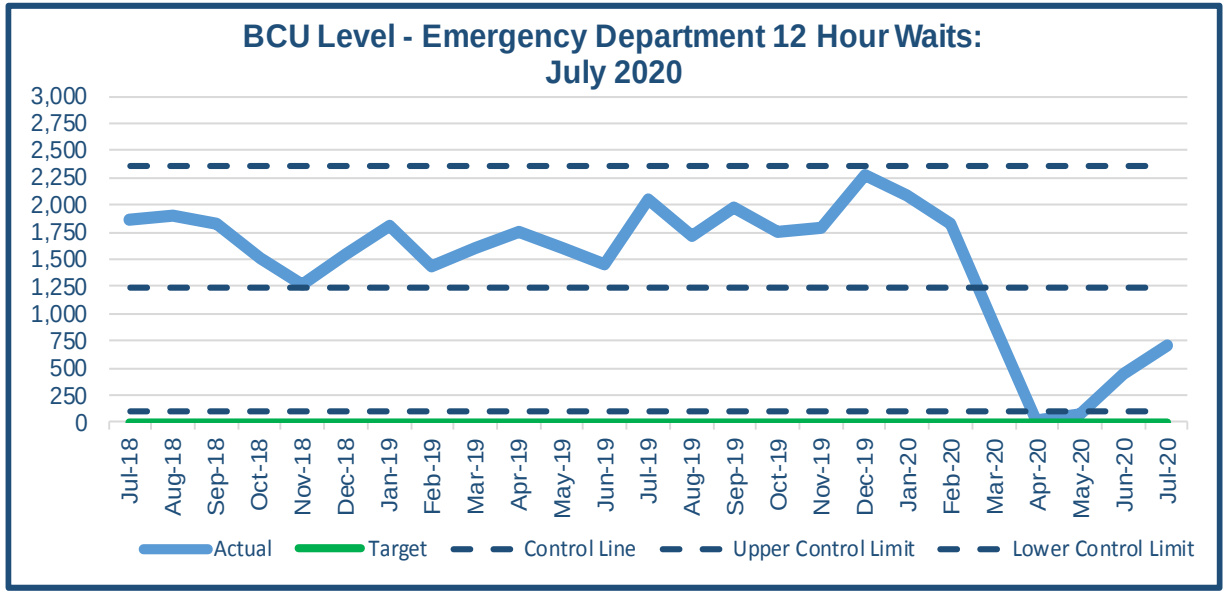


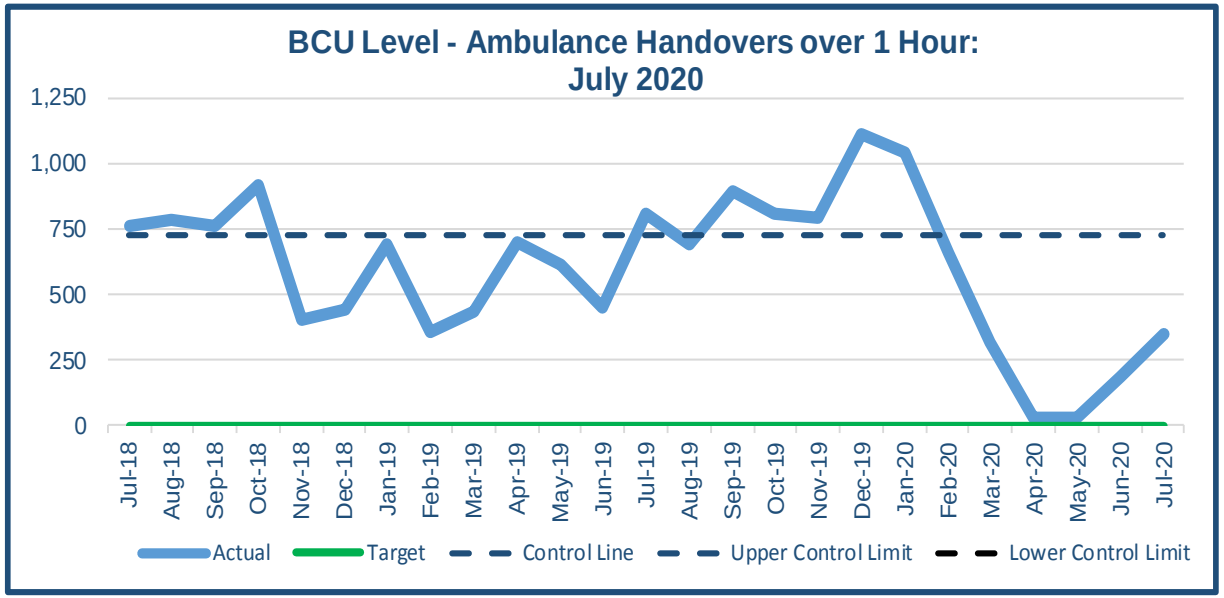
Quadruple Aim 2: Unscheduled Care: Performance

Position as at end of 16th August 2020	Apr 20	May 20	Jun 20	Jul 19	Jul 20	August 1st - 16th 2019	August 1st - 16th 2020
ED&MIU 4 Hr Performance	87.31%	86.43%	80.47%	73.77%	79.71%	72.11%	**75.04%**
ED 4 Hour Performance	85.13%	84.03%	76.65%	61.93%	75.17%	59.24%	**68.27%**
ED 12 Hour Performance	54	96	466	2044	704	932	**636**
1 Hour Ambulance Handover	32	30	187	811	348	339	**392**
Red 8 Minute	72.44%	69.53%	70.06%	68.16%	65.82%	69.30%	**60.67%**

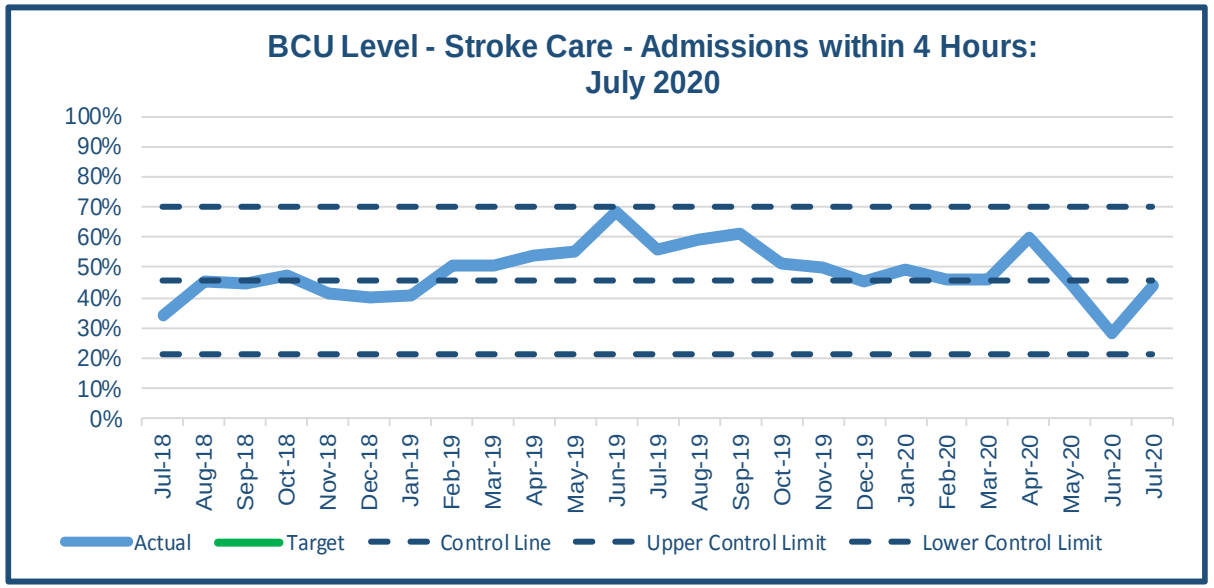
Quadruple Aim 2: Charts Unscheduled Care Page 1

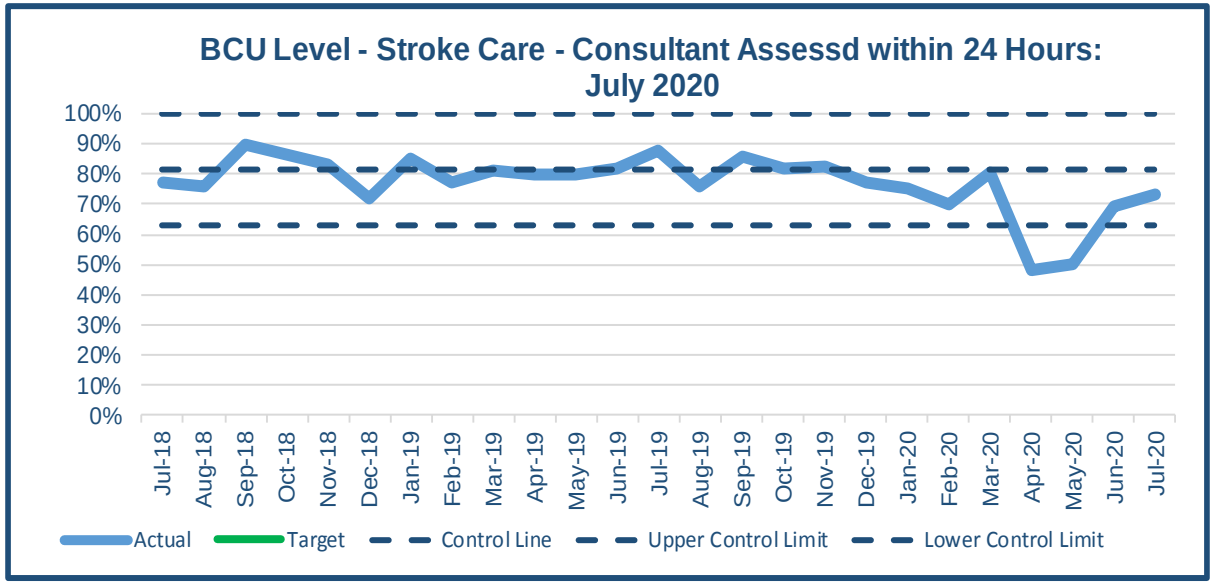


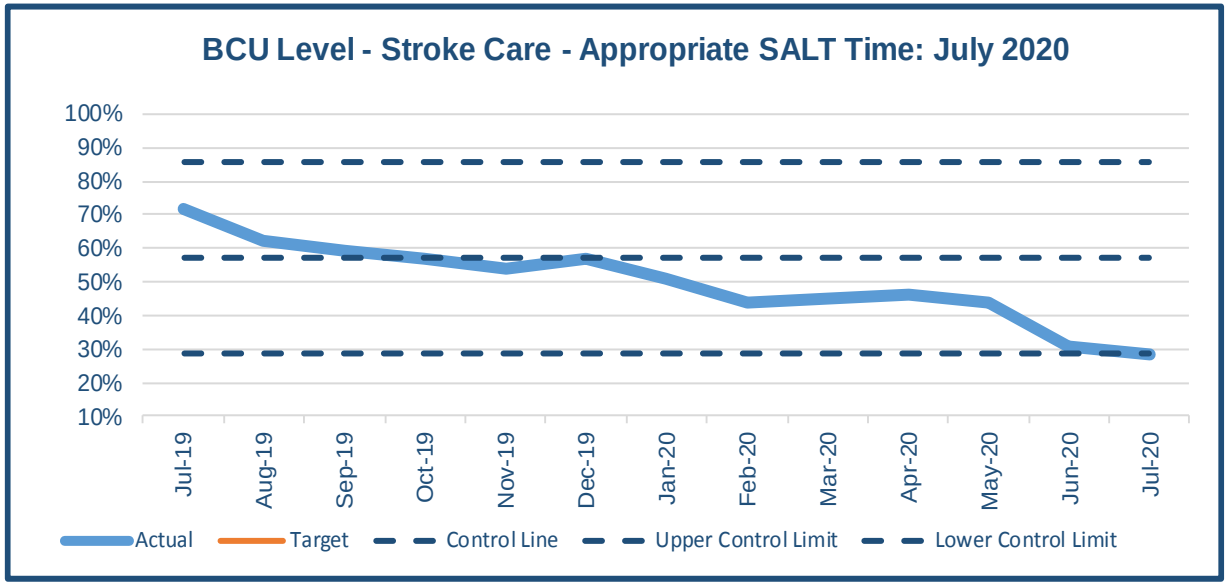




Quadruple Aim 2: Charts Unscheduled Care Page 2

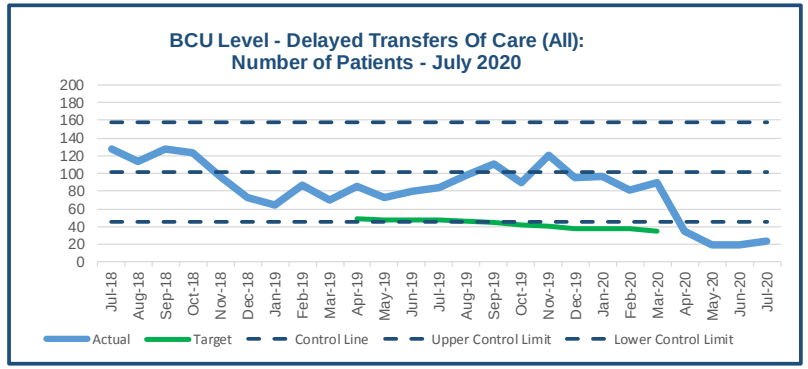


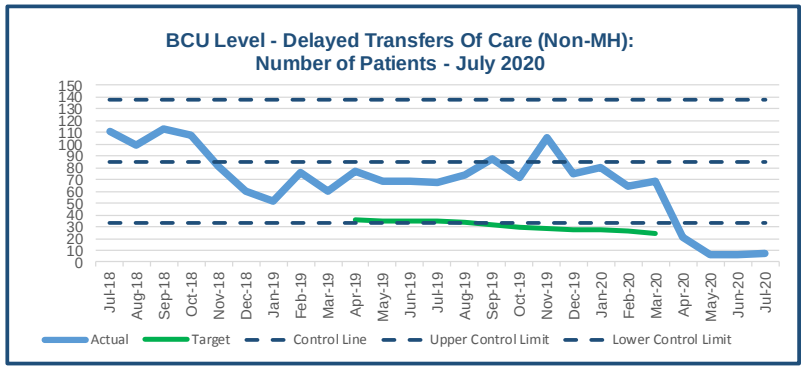


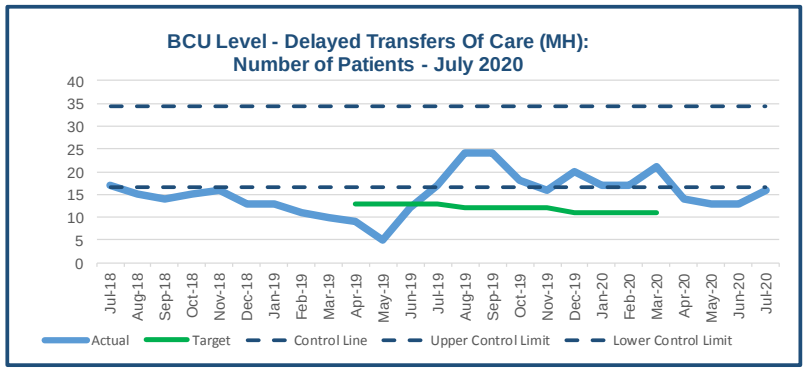


Quadruple Aim 2: Charts Unscheduled Care page 3

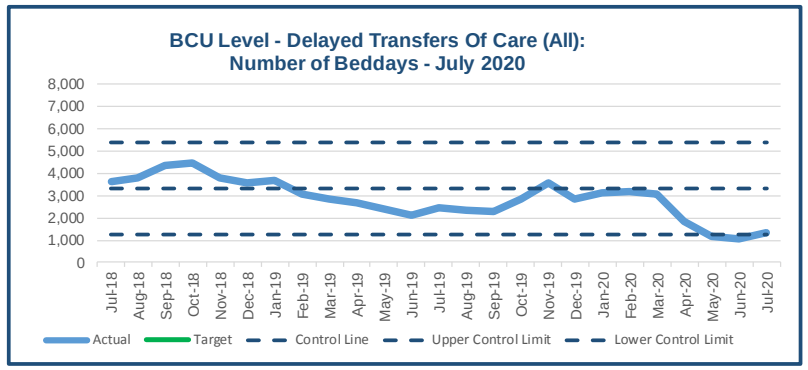
Delayed Transfers of Care (DToC) Number of Patients

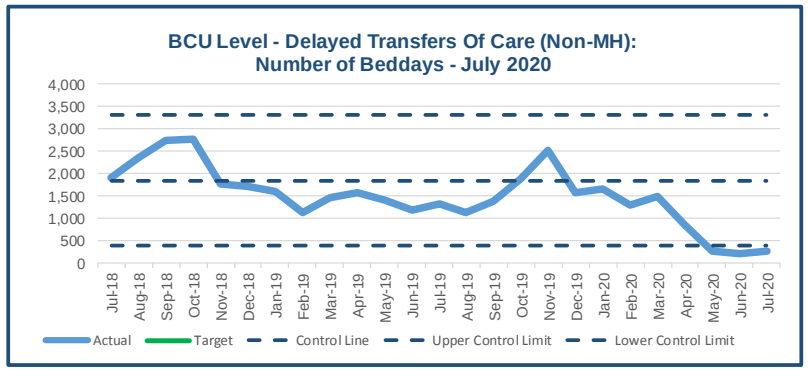


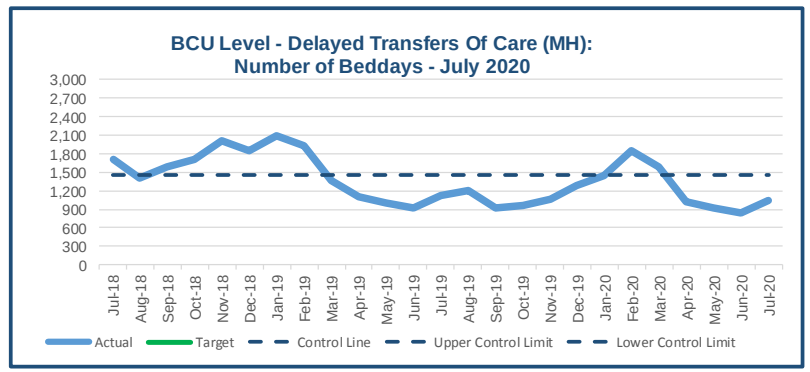




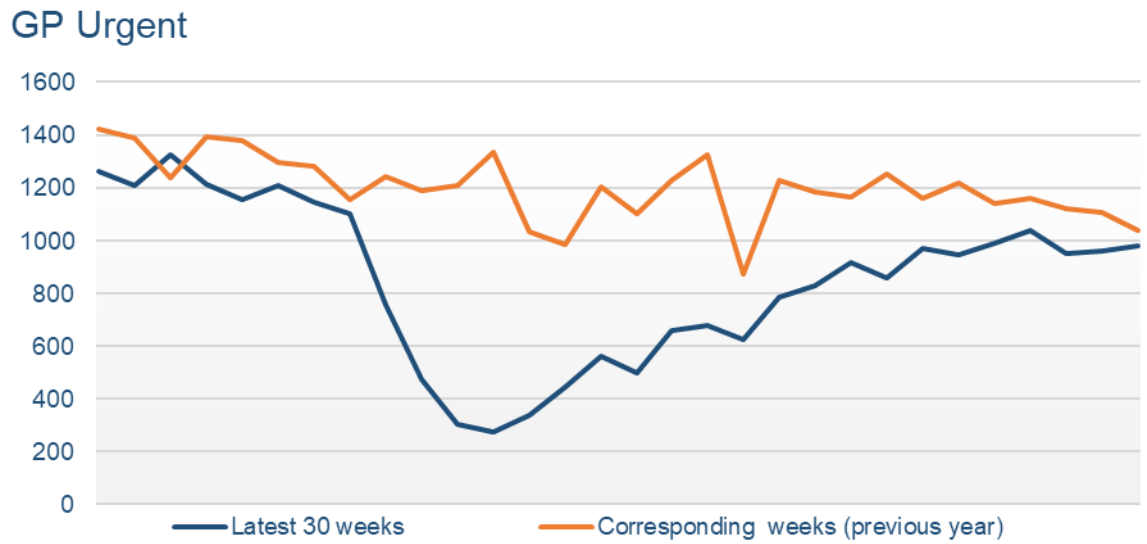
Delayed Transfers of Care (DToC) Number of Beddays

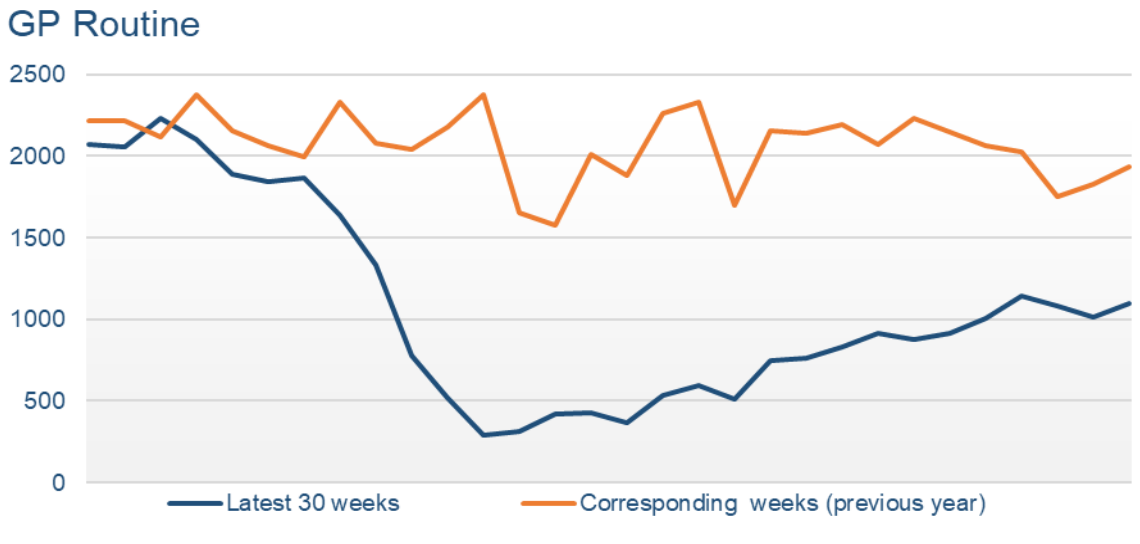


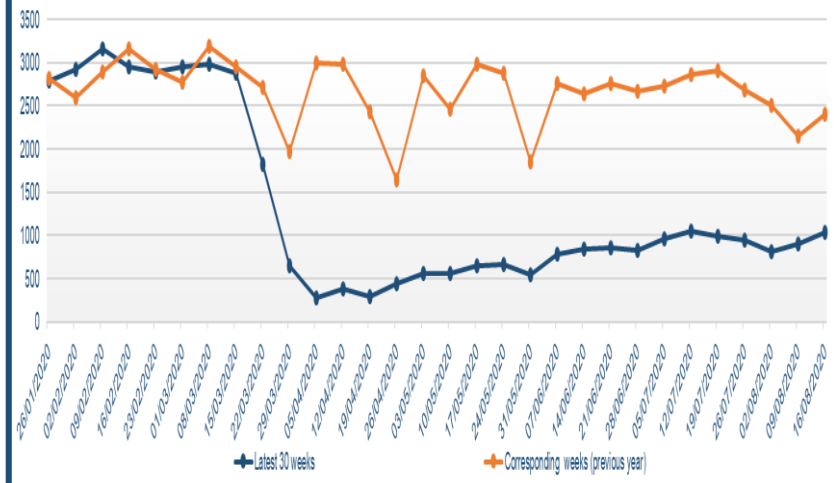


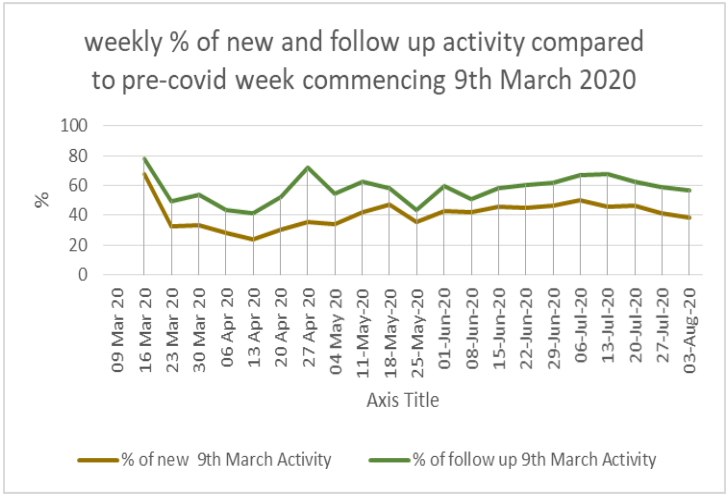


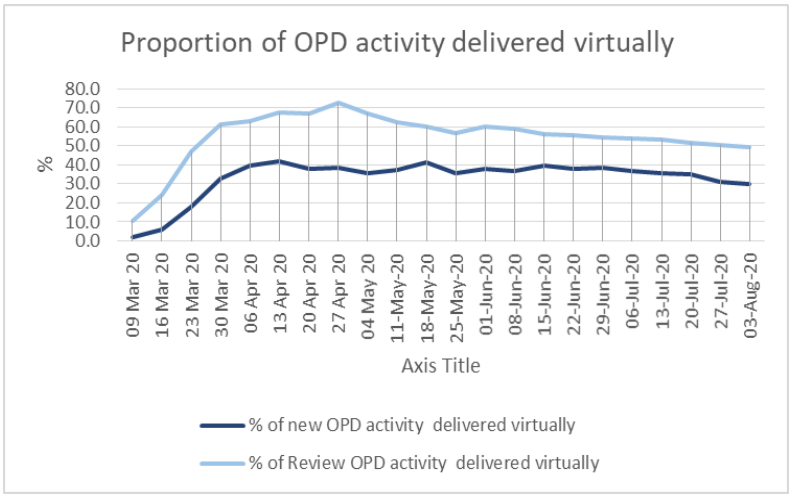
Quadruple Aim 2: Covid-19 Impact on Planned Care Referrals & Outpatient Activity





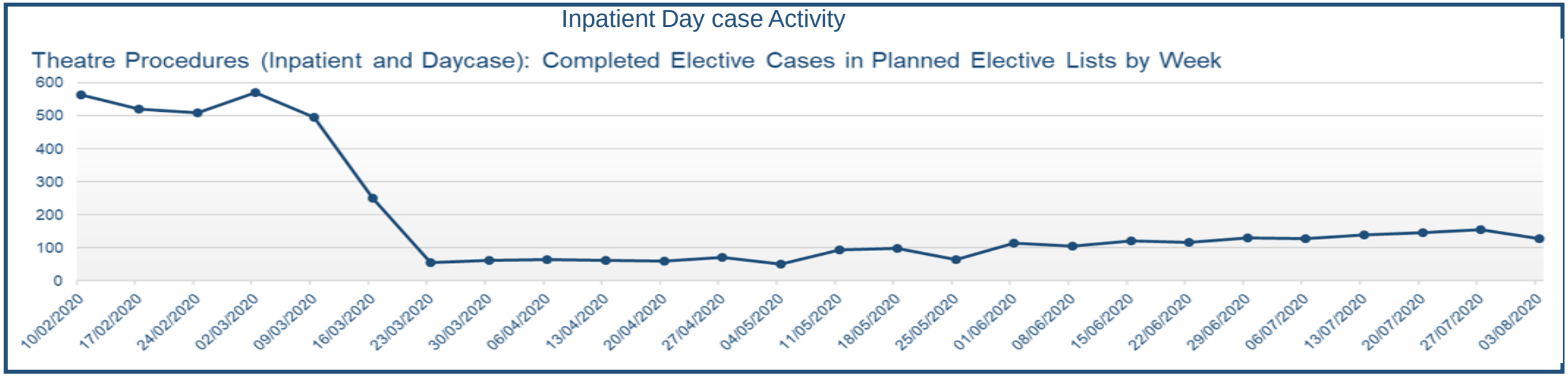






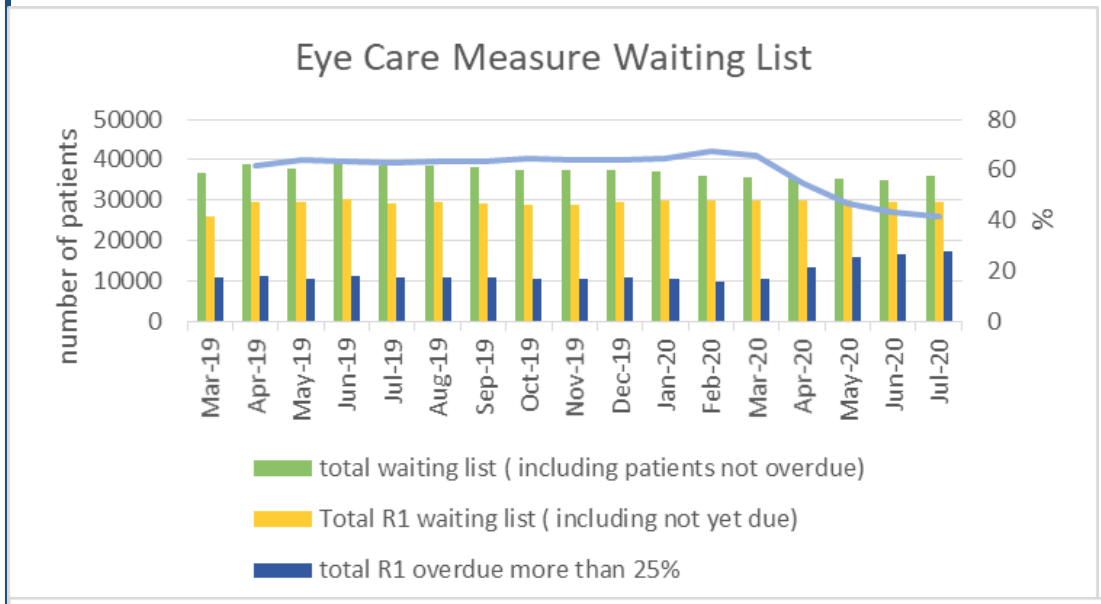
Quadruple Aim 2: Covid-19 Impact on Planned Activity

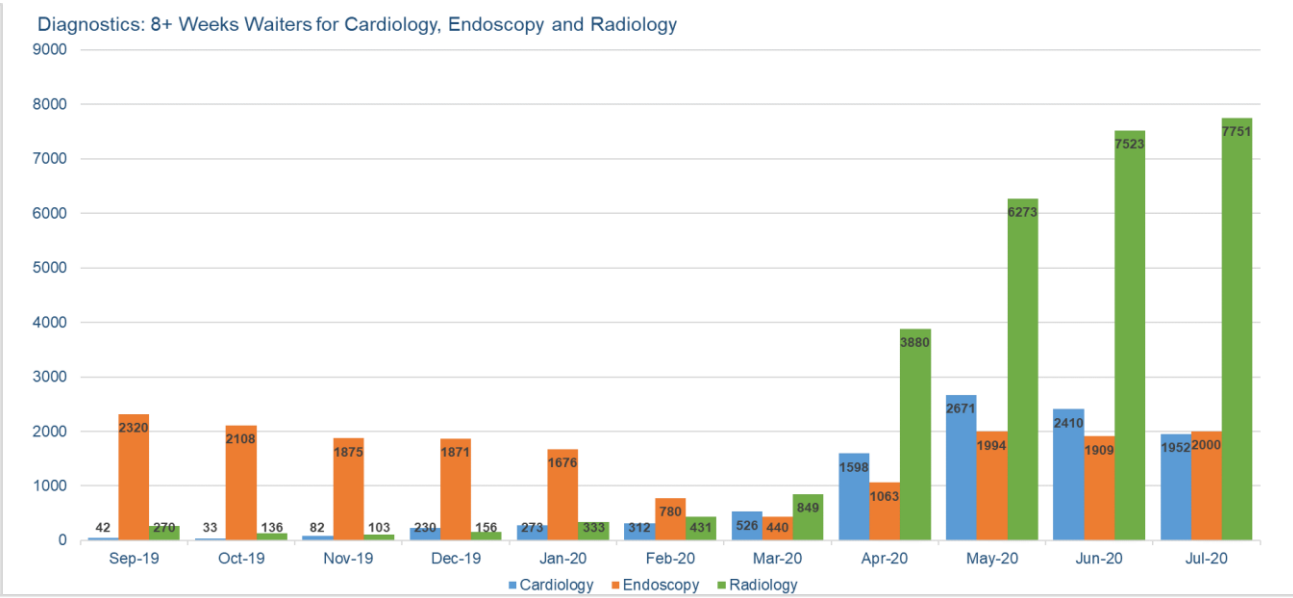
Inpatient Day case Activity

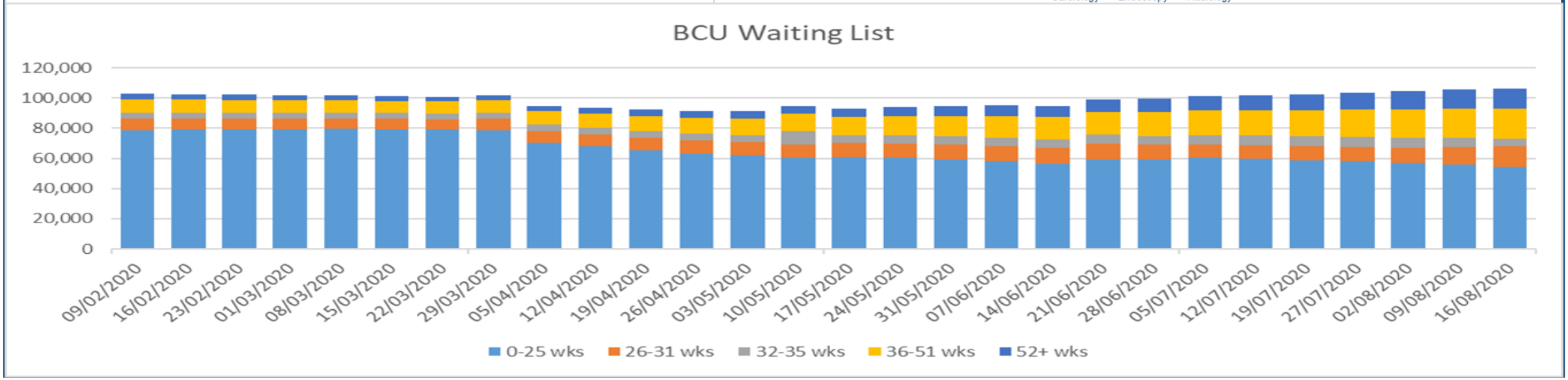


Activity v Plan Comparison																
	2019-20 OUTTURN				Pro-rata Quarterly delivery				Q1 Actual				% of previous activity delivered			
Provider	NEW OPD	FU OPD	other OPD	Elective IPDC	NEW OPD	FU OPD	other OPD	Elective IPDC	NEW OPD	FU OPD	Other OPD	Elective IPDC	NEW OPD	FU OPD	other OPD	Elective IPDC
COCH	6596	13429	9001	4993	1649	3357	2250	1248	685	1876	602	443	42%	56%	27%	35%
RJAH	6717	15361	1854	2638	1679	3840	464	660	305	1776	49	95	18%	46%	11%	14%
BCU	268488	533301	1961	47429	67122	133325	490	11857	31194	71519	117	4421	46%	54%	24%	37%
NB -RJAH activity for IPDC in Q1 includes trauma activity . Actual split is 55 elective IPDC and 40 Trauma pathway IPDC																

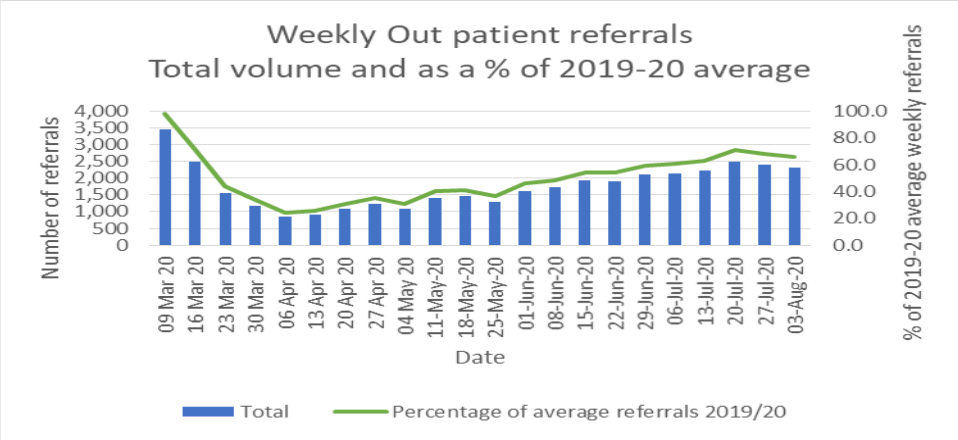
Quadruple Aim 2: Covid-19 Impact on Waiting Lists

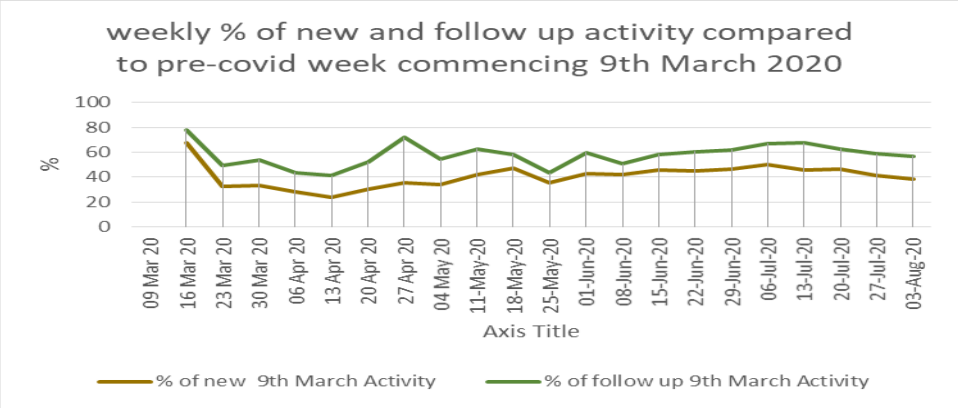


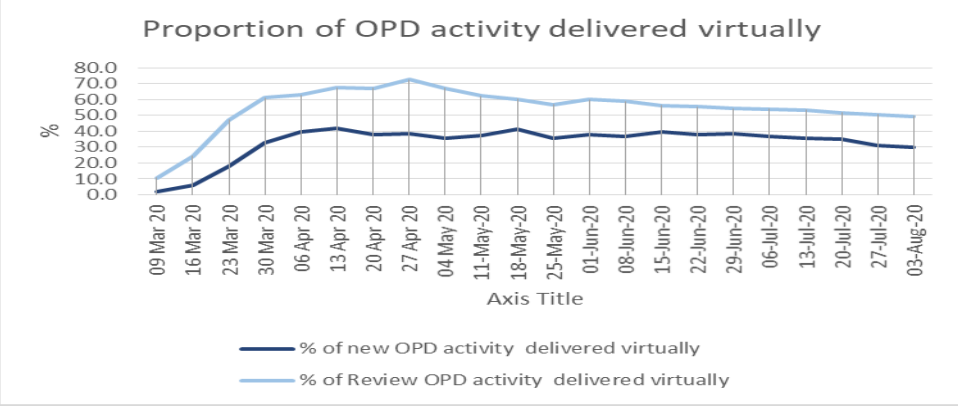


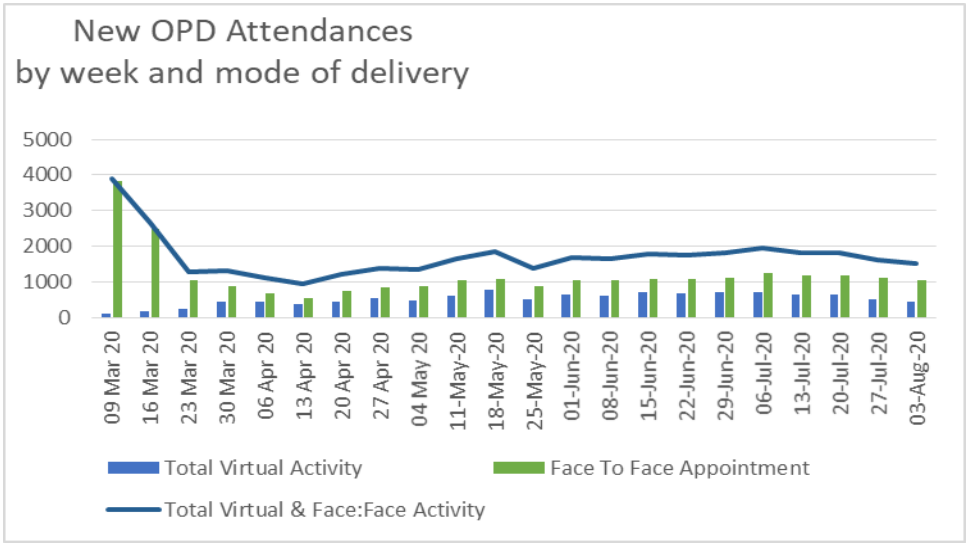


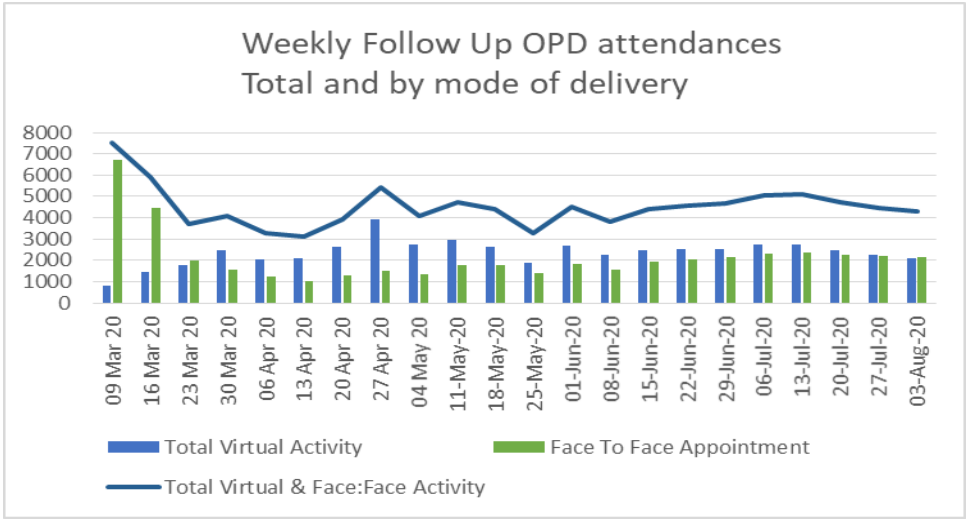
Quadruple Aim 2: Charts Planned Care Page 1



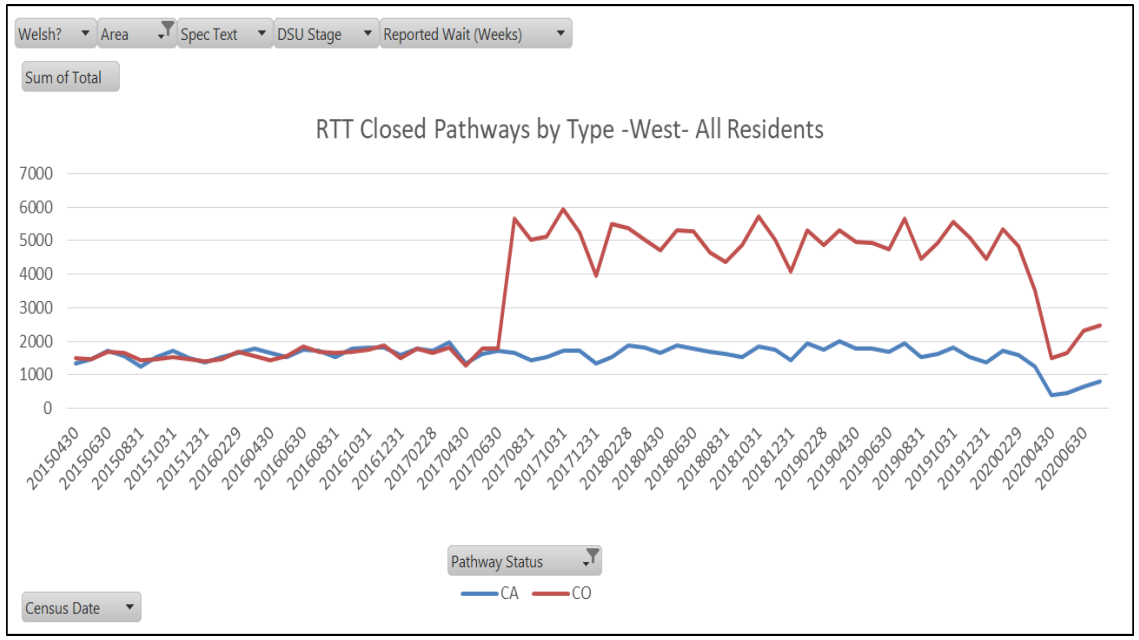


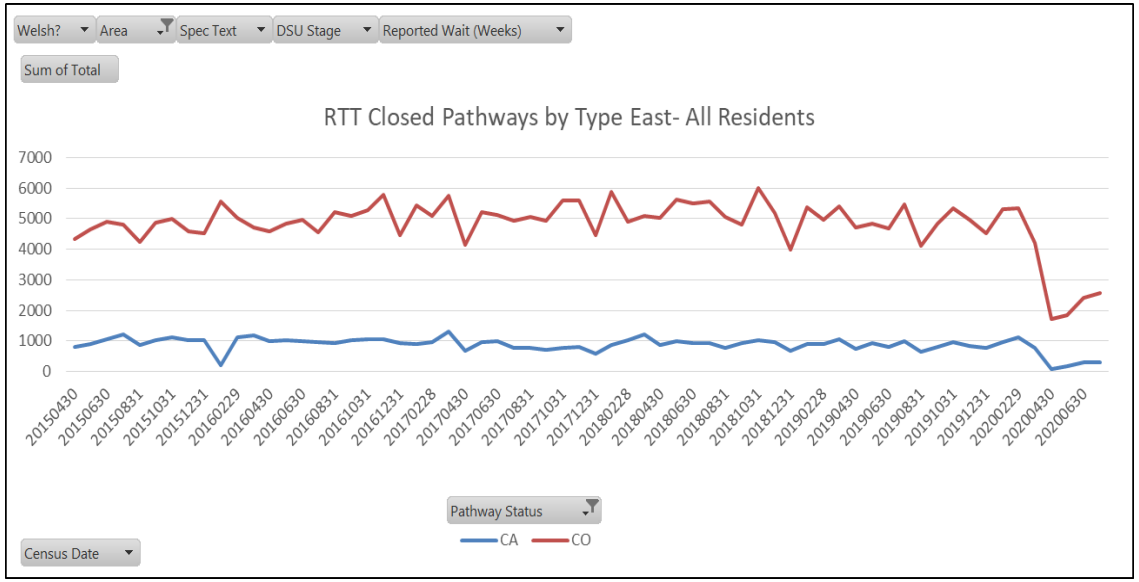


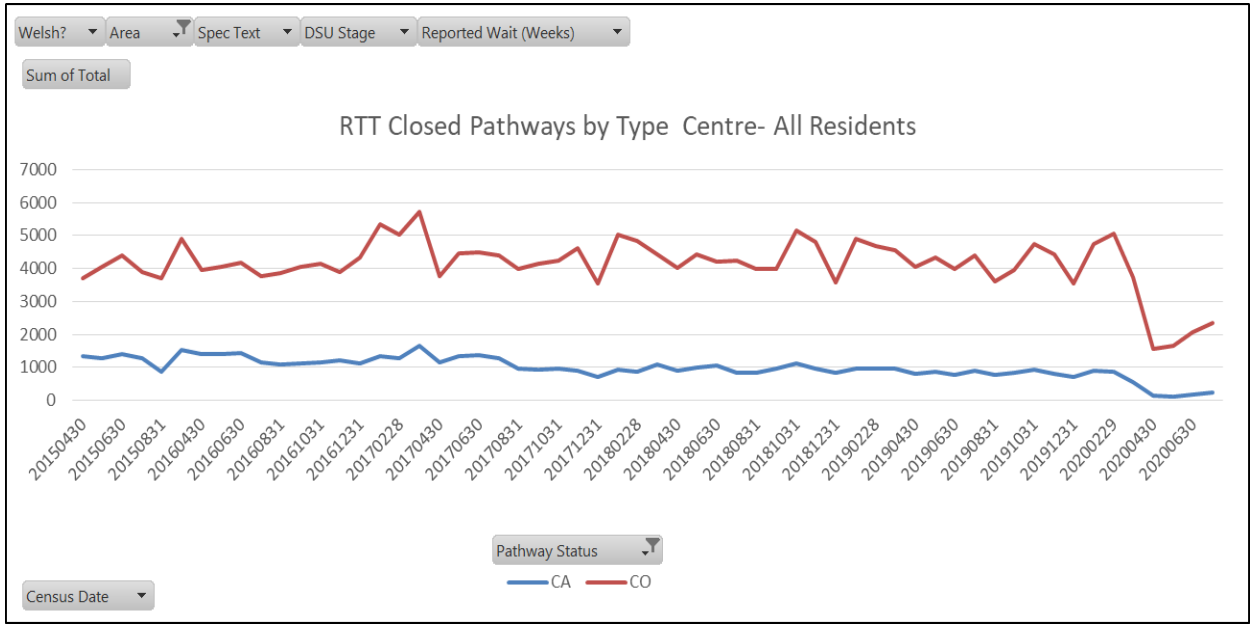




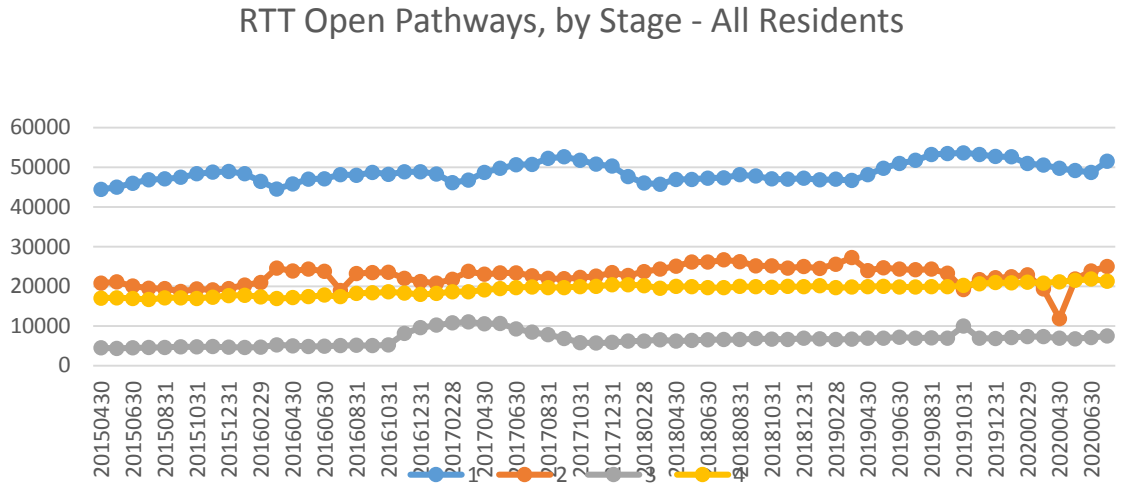
Quadruple Aim 2: Planned Care Page 2

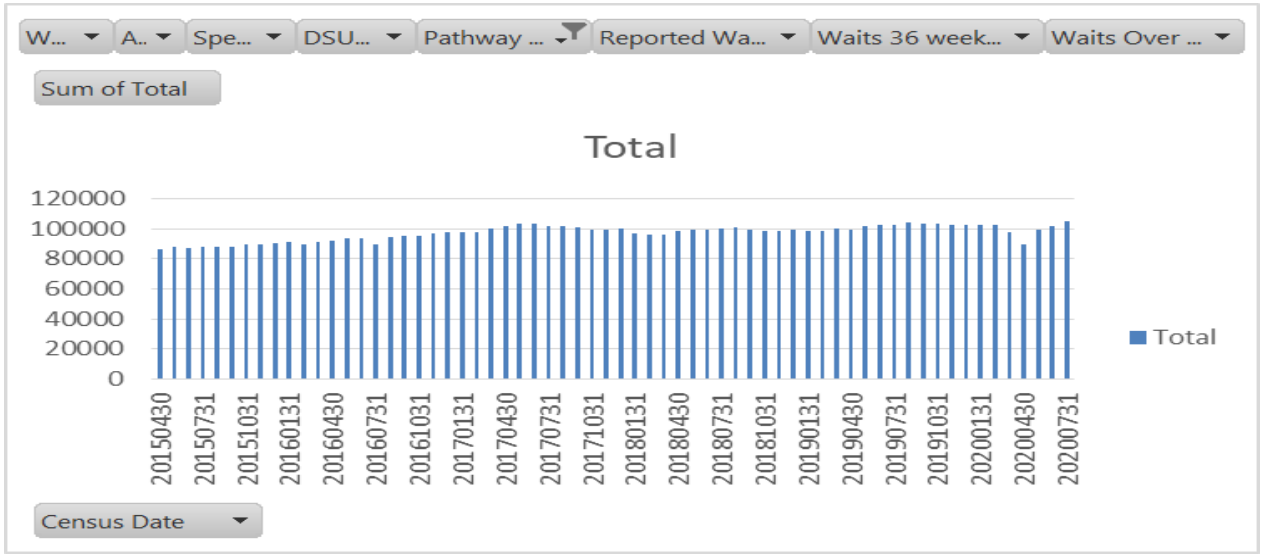


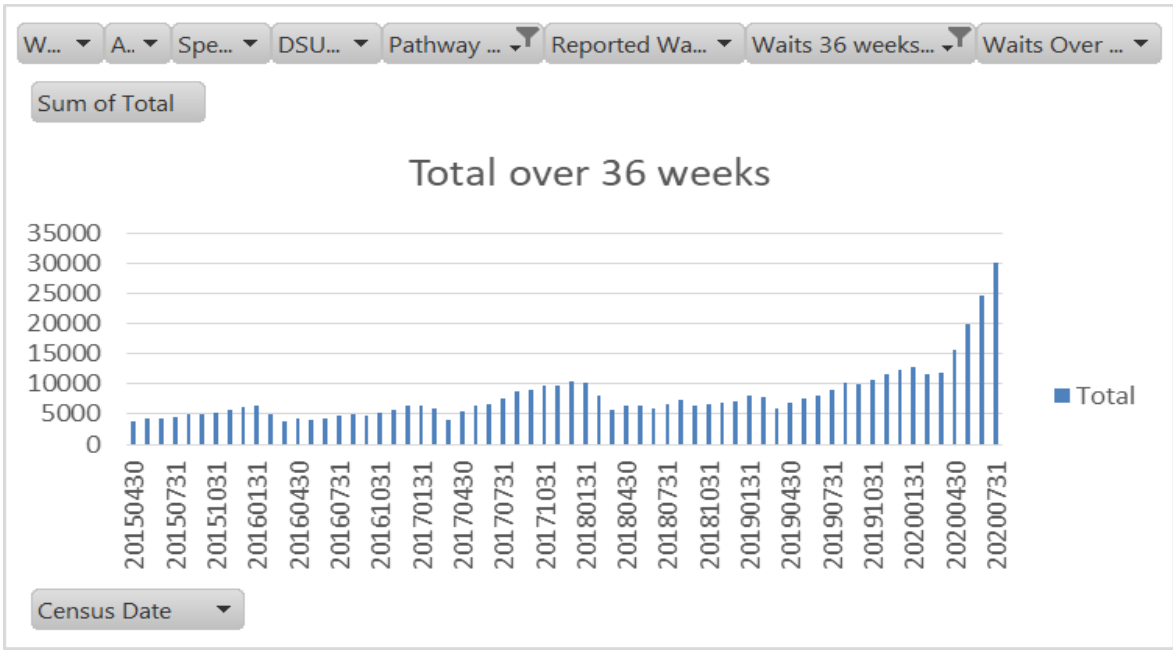


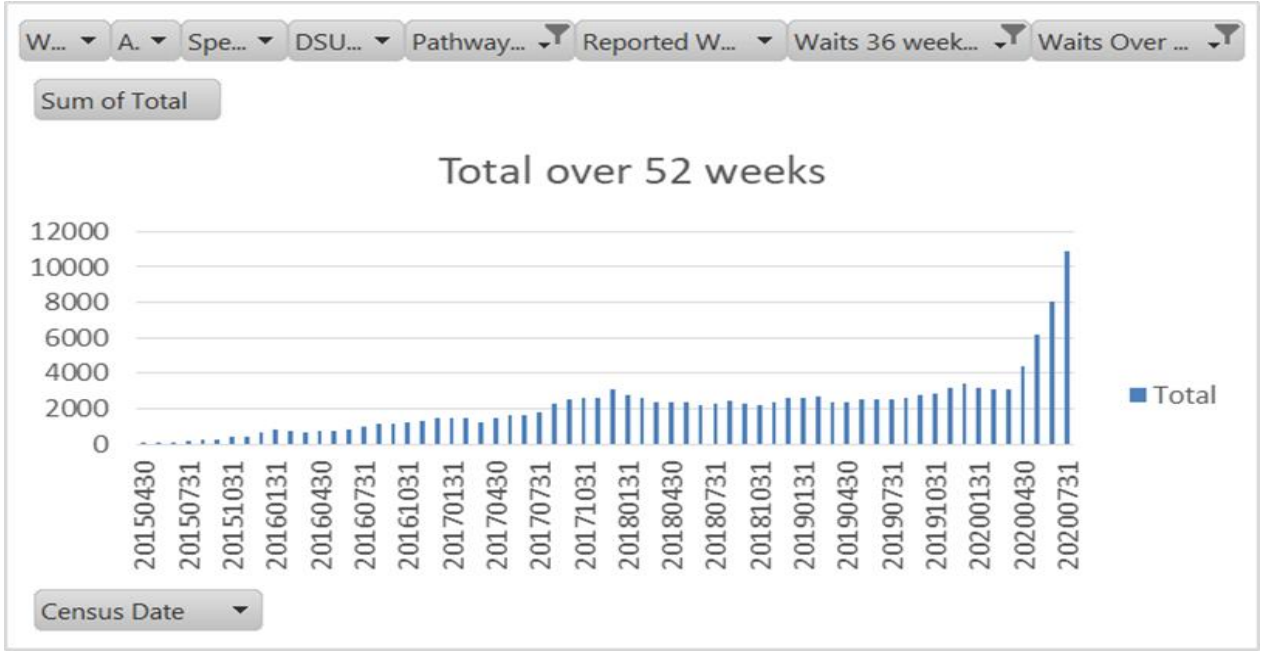


Quadruple Aim 2: Charts Planned Care Page 3

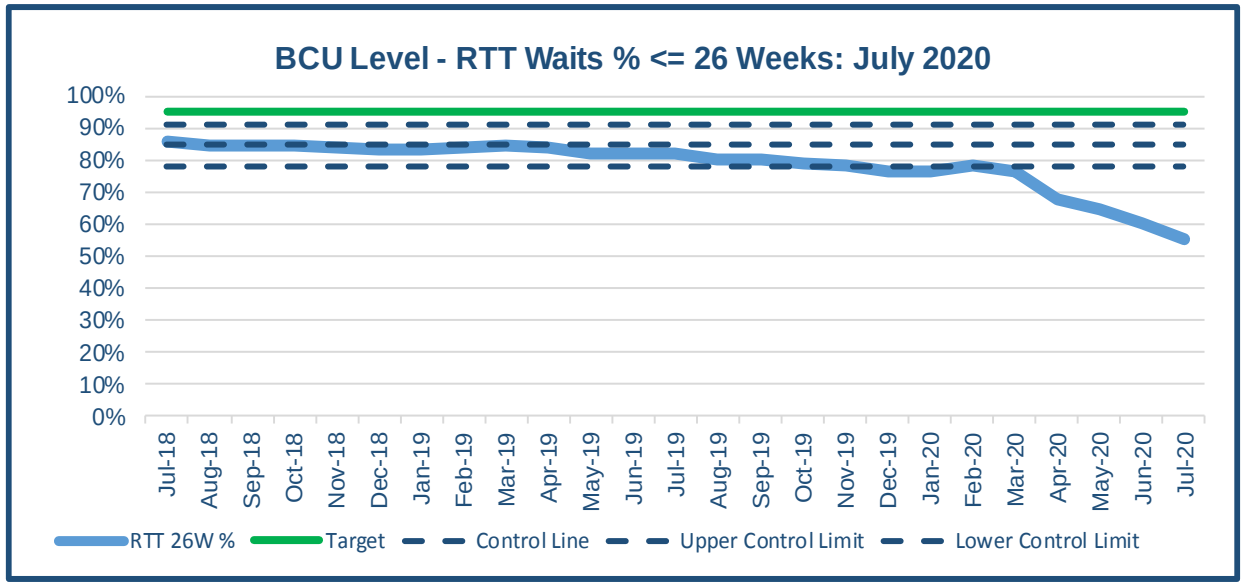


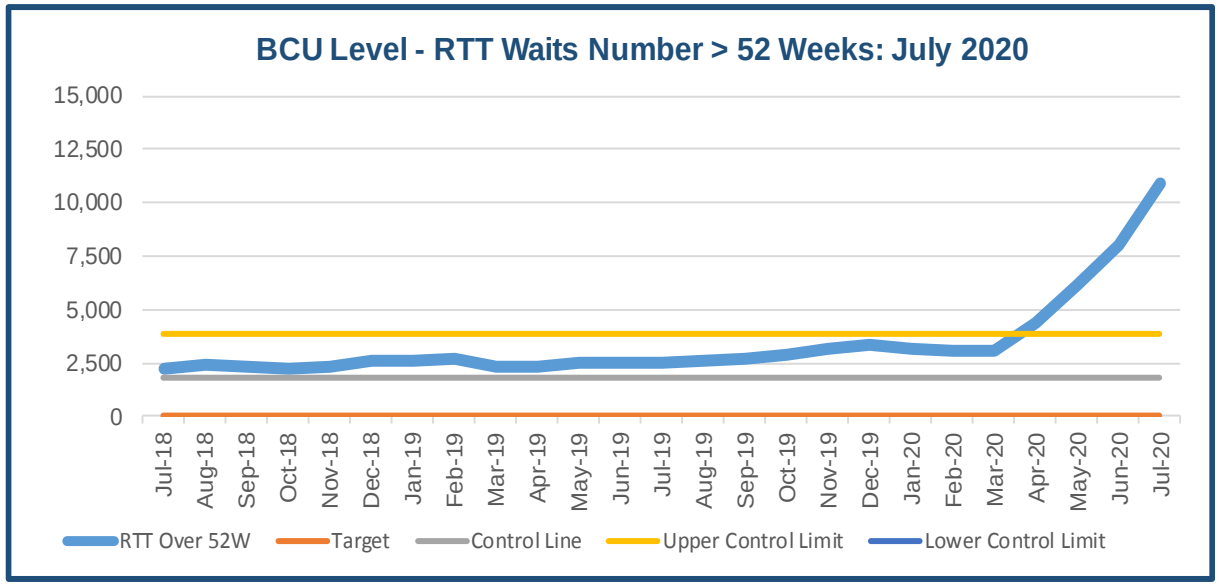


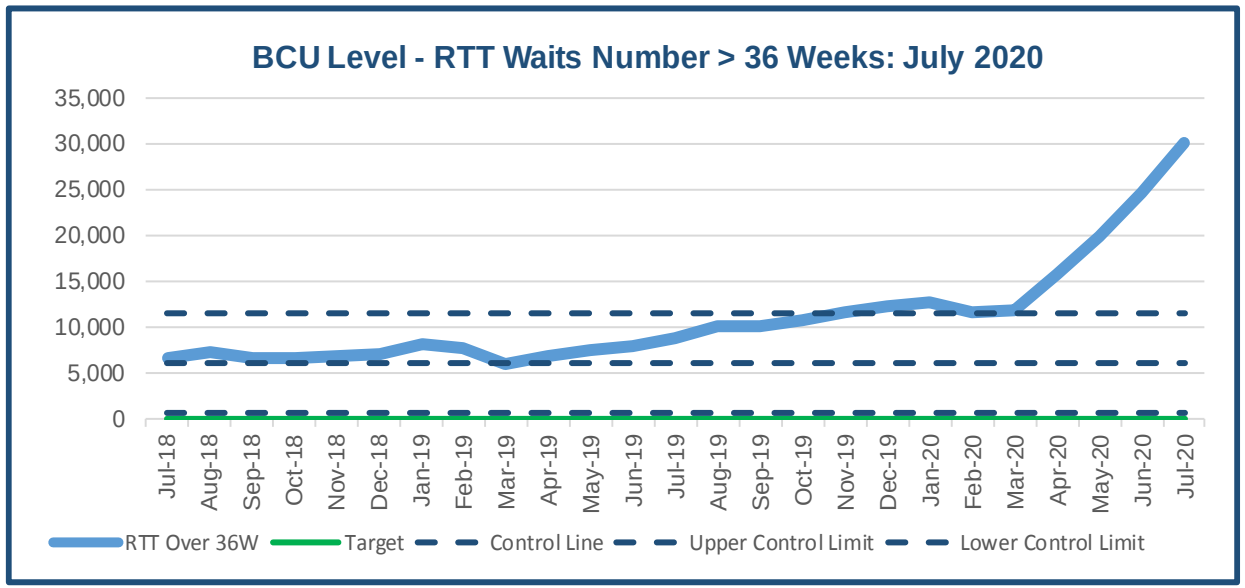


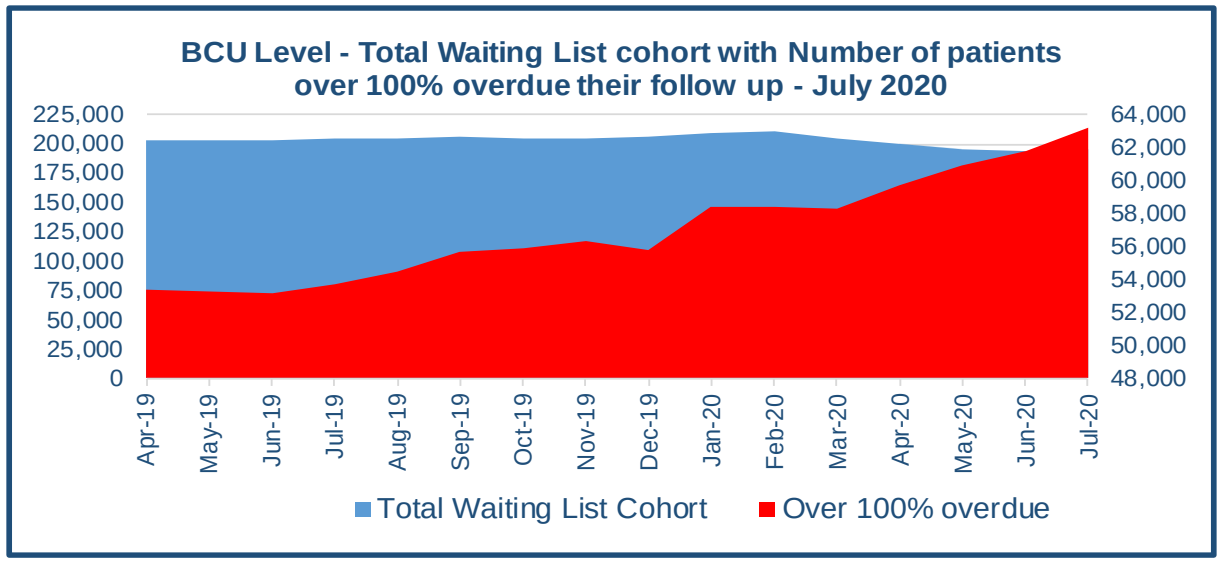


Quadruple Aim 2: Charts Planned Care page 4

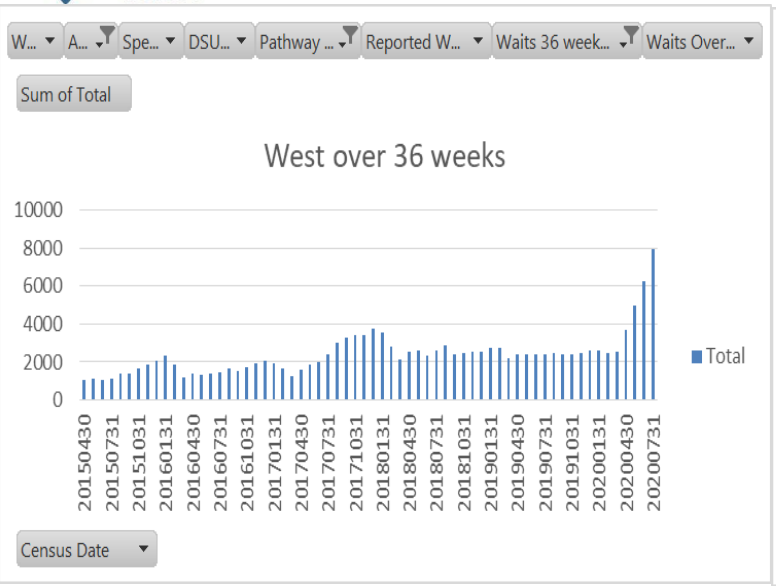


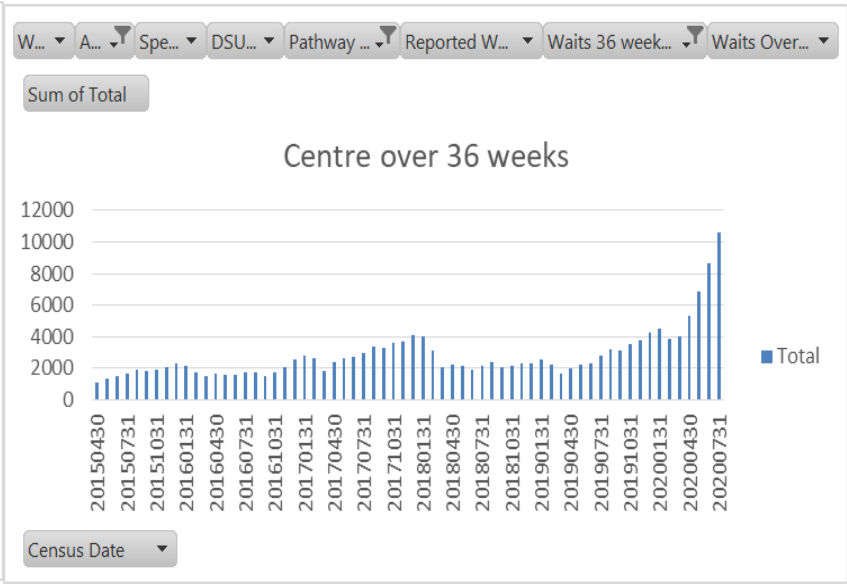


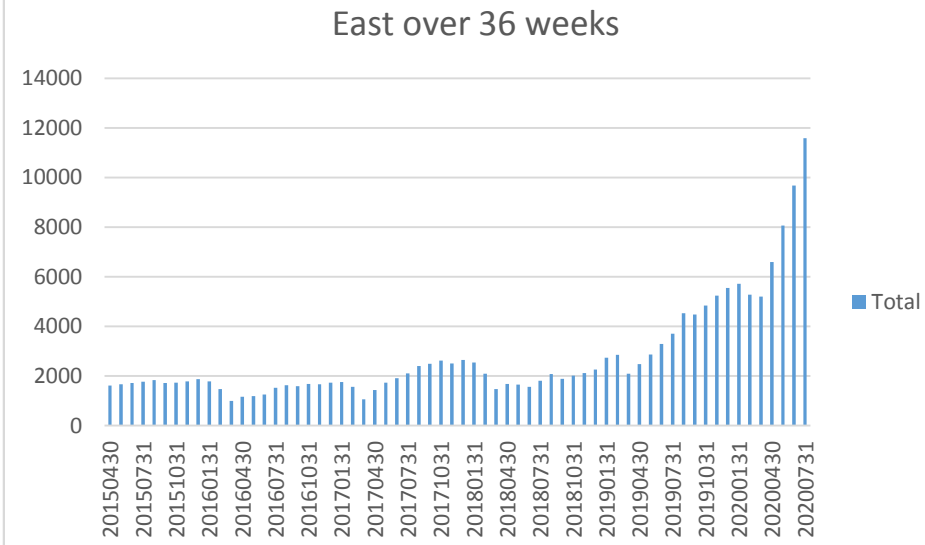


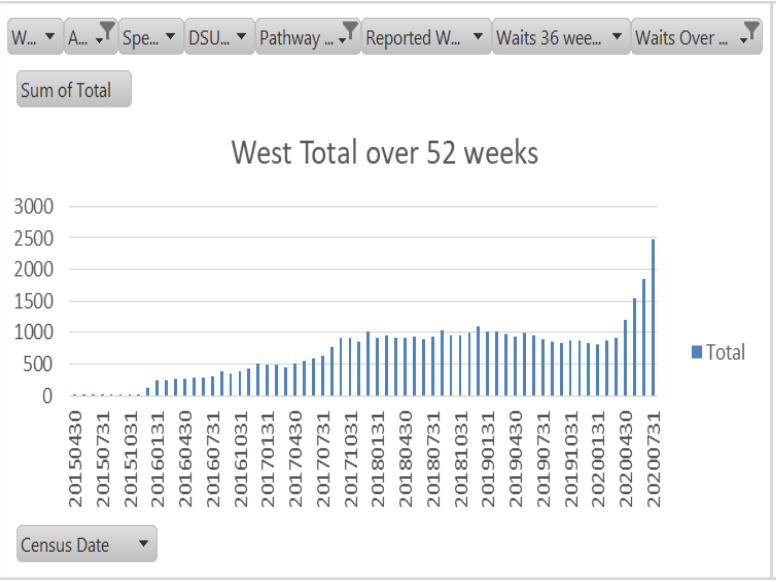


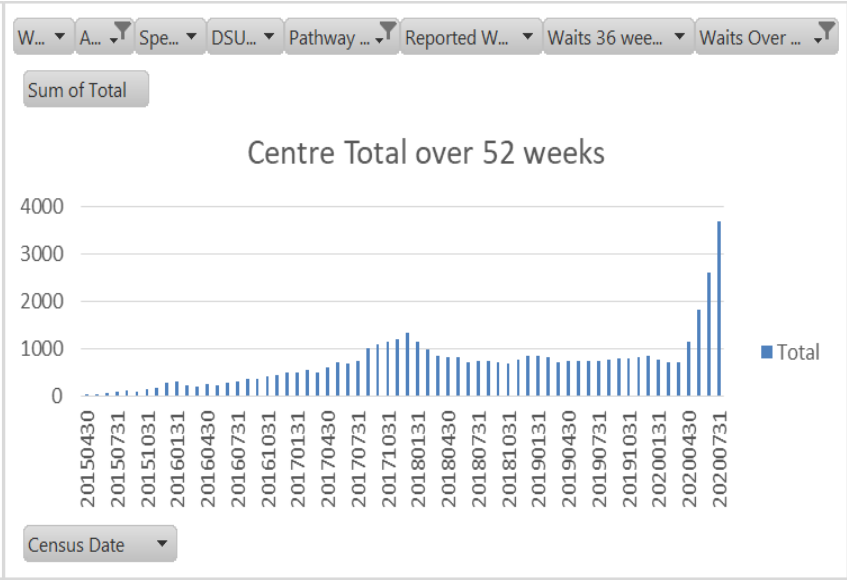
Quadruple Aim 2: Planned Care Page 5

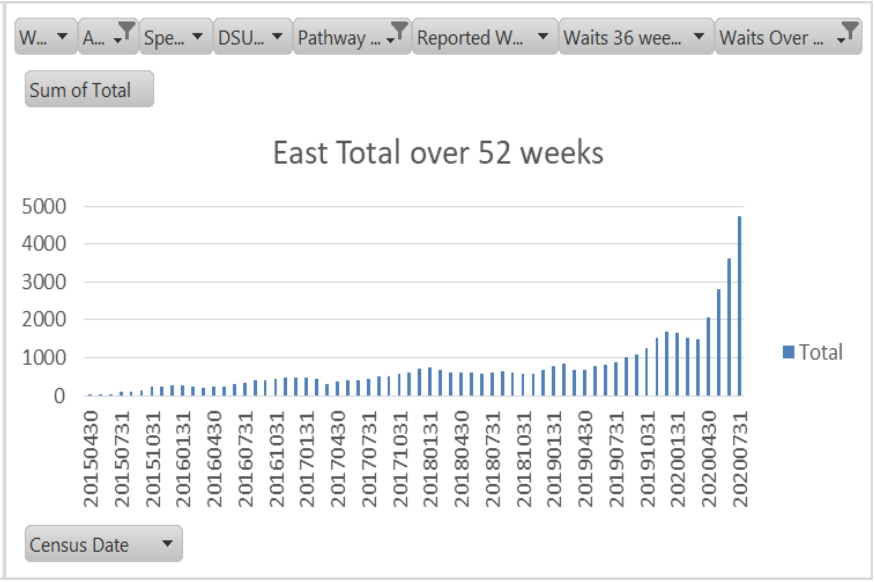




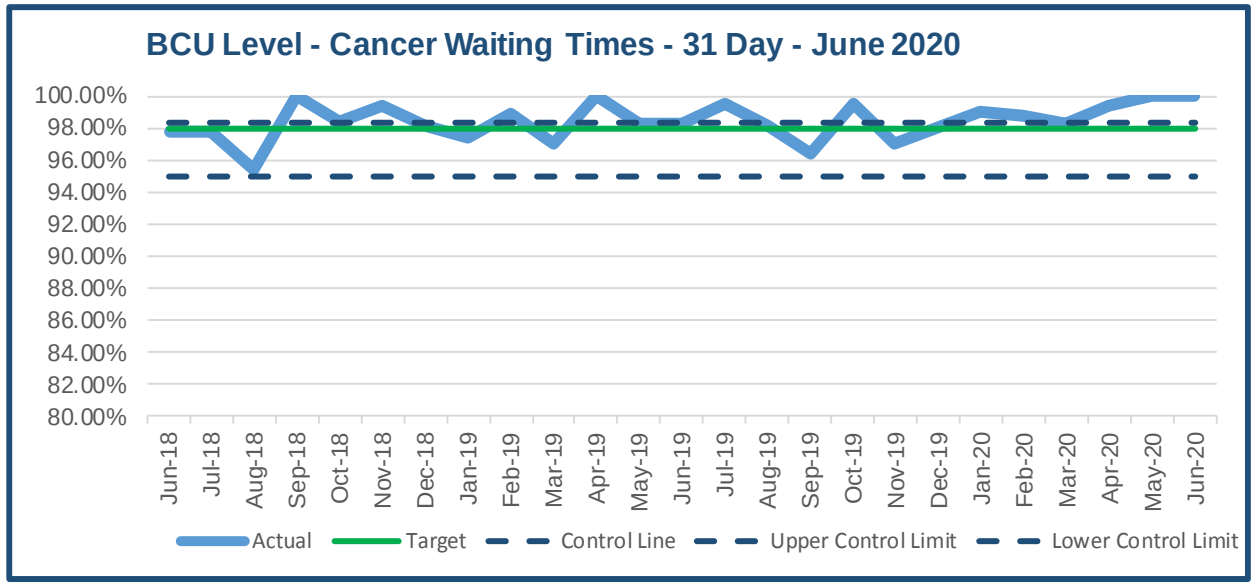


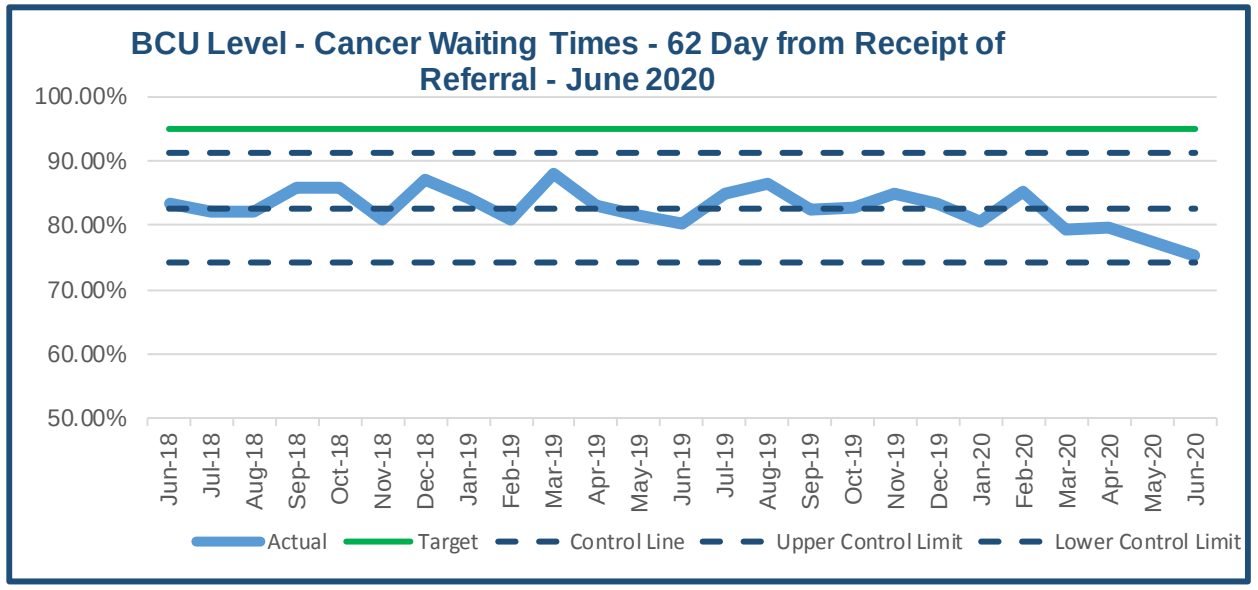


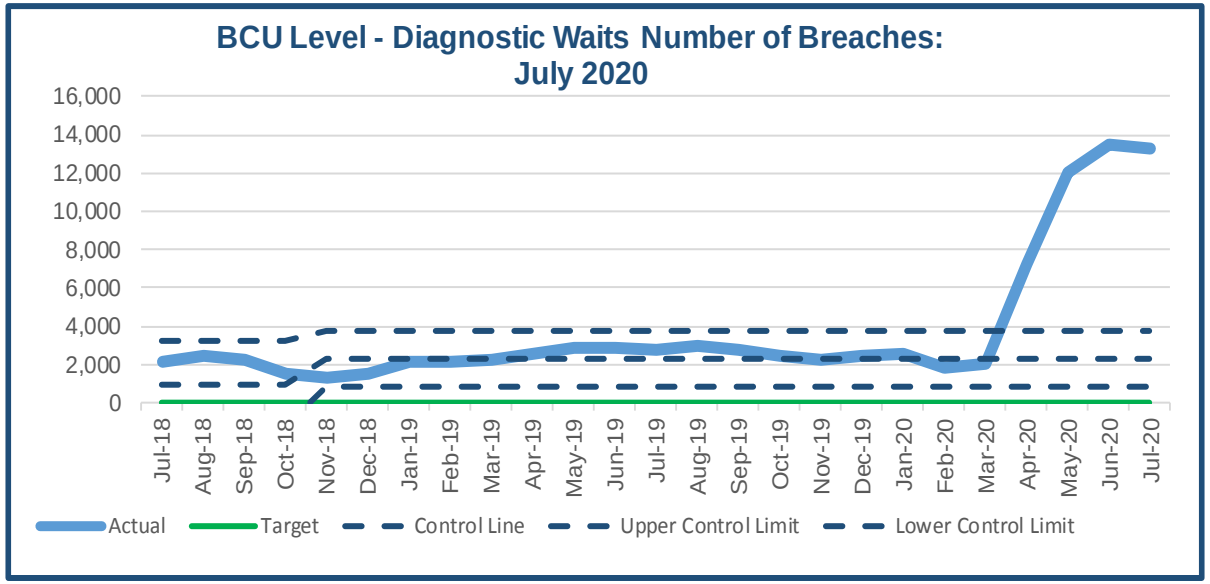




Quadruple Aim 2: Charts Planned Care page 6

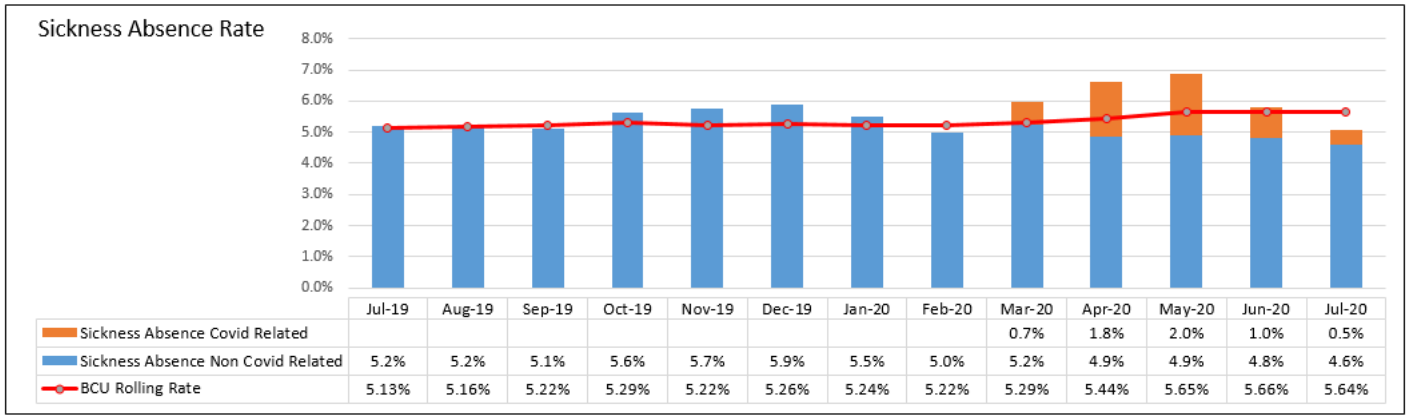






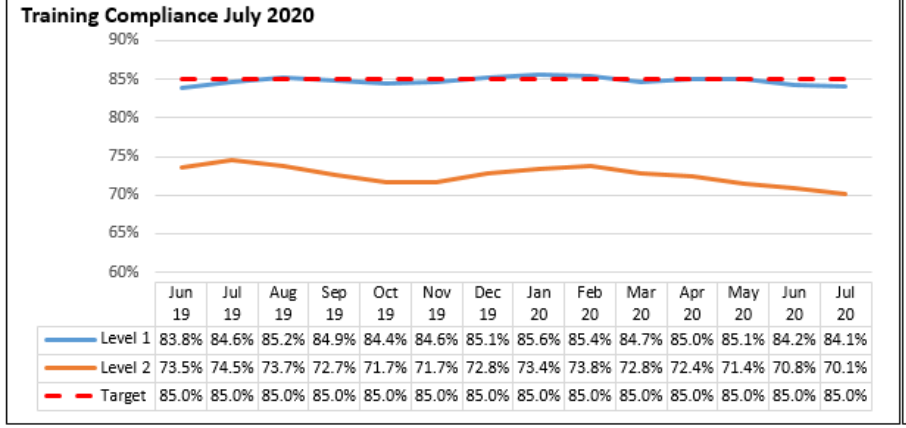
Quadruple Aim 3: Charts

Sickness absence Rates

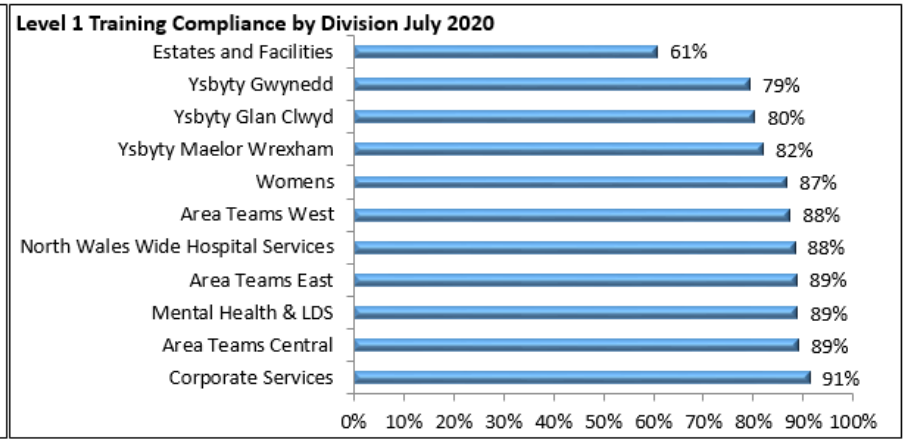


	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Sickness Absence Covid Related									0.7%	1.8%	2.0%	1.0%	0.5%
Sickness Absence Non Covid Related	5.2%	5.2%	5.1%	5.6%	5.7%	5.9%	5.5%	5.0%	5.2%	4.9%	4.9%	4.8%	4.6%
BCU Rolling Rate	5.13%	5.16%	5.22%	5.29%	5.22%	5.26%	5.24%	5.22%	5.29%	5.44%	5.65%	5.66%	5.64%

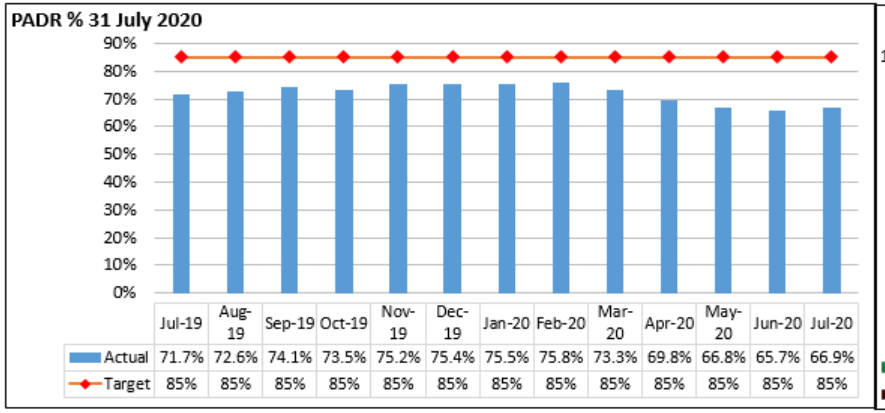
Core Mandatory Training Rate



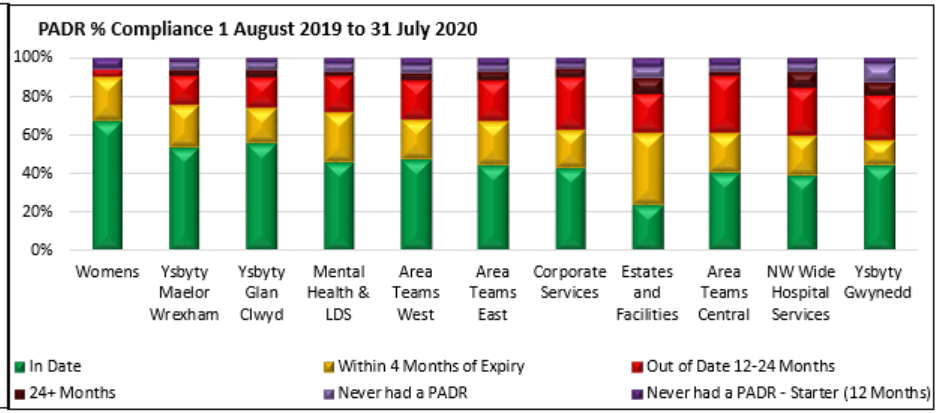
	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Level 1	83.8%	84.6%	85.2%	84.9%	84.4%	84.6%	85.1%	85.6%	85.4%	84.7%	85.0%	85.1%	84.2%	84.1%
Level 2	73.5%	74.5%	73.7%	72.7%	71.7%	71.7%	72.8%	73.4%	73.8%	72.8%	72.4%	71.4%	70.8%	70.1%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



PADR



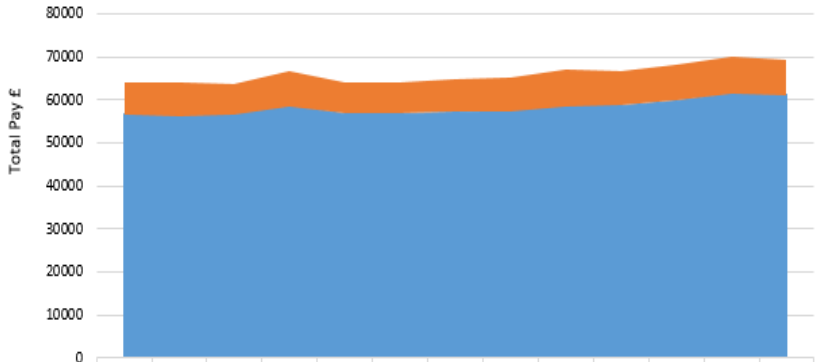
	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Actual	71.7%	72.6%	74.1%	73.5%	75.2%	75.4%	75.5%	75.8%	73.3%	69.8%	66.8%	65.7%	66.9%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



Quadruple Aim 4: Charts

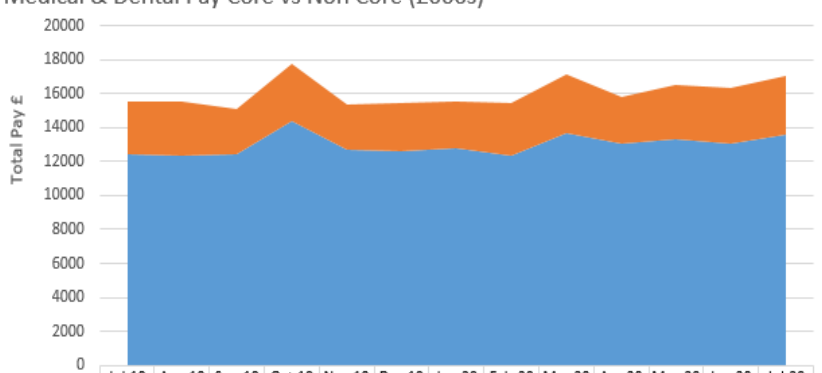
Agency & Locum Spend

BCUHB Pay Core vs Non Core (£000s)



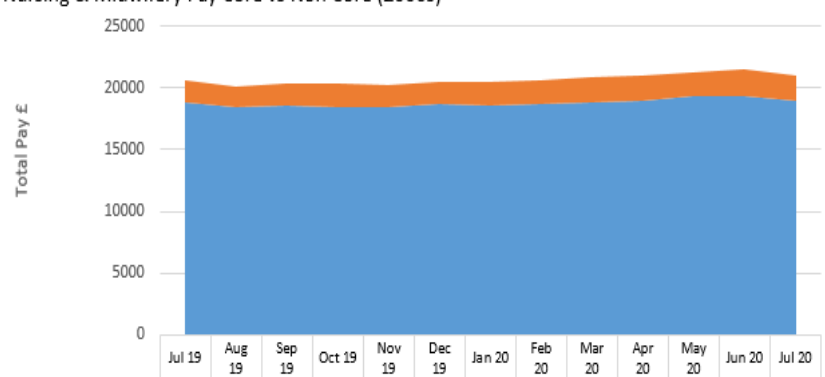
	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Non Core	£7,623	£7,843	£7,291	£7,978	£7,137	£7,190	£7,500	£7,880	£8,427	£7,911	£8,207	£8,584	£8,292
Core	£56,590	£56,337	£56,580	£58,563	£56,911	£56,930	£57,222	£57,327	£58,624	£58,799	£59,944	£61,550	£61,118

Medical & Dental Pay Core vs Non Core (£000s)



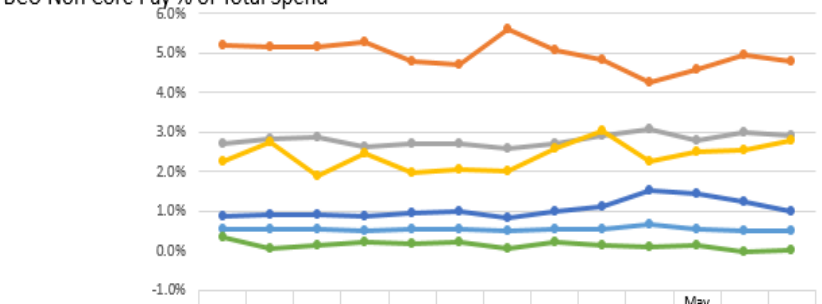
	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Non Core	£3,136	£3,234	£2,710	£3,333	£2,632	£2,777	£2,777	£3,061	£3,454	£2,805	£3,231	£3,281	£3,524
Core	£12,399	£12,321	£12,394	£14,379	£12,735	£12,620	£12,774	£12,365	£13,664	£13,030	£13,295	£13,026	£13,555

Nursing & Midwifery Pay Core vs Non Core (£000s)



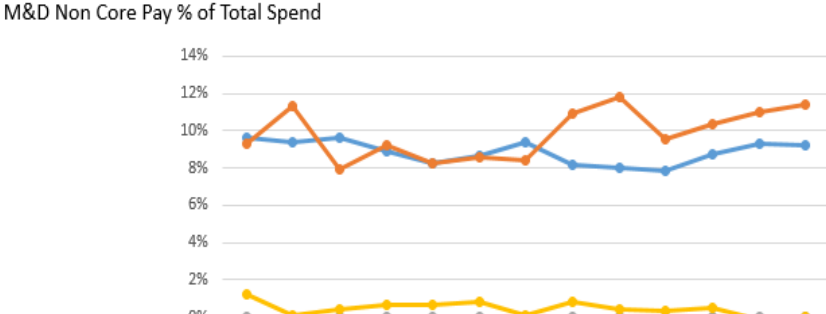
	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Non Core Pay (£000s)	£1,855	£1,722	£1,772	£1,915	£1,778	£1,733	£1,897	£1,886	£1,996	£2,074	£1,964	£2,178	£2,059
Core Pay (£000s)	£18,765	£18,392	£18,604	£18,399	£18,505	£18,695	£18,637	£18,719	£18,837	£18,930	£19,316	£19,395	£18,922

BCU Non Core Pay % of Total Spend



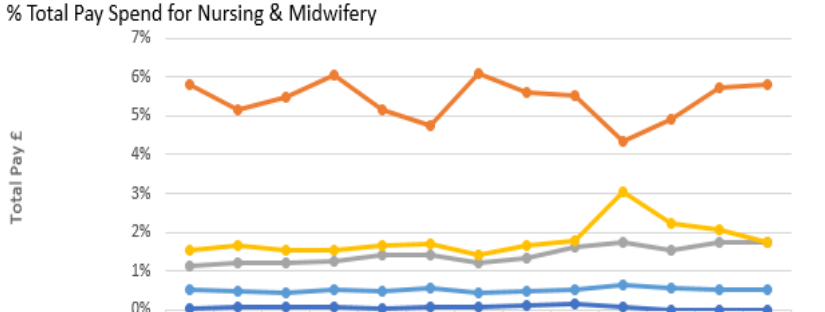
	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Additional Basic Pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%	0.6%	0.6%	0.5%	0.5%
Agency	5.2%	5.2%	5.1%	5.3%	4.8%	4.7%	5.6%	5.1%	4.8%	4.3%	4.6%	4.9%	4.8%
Bank	2.7%	2.8%	2.9%	2.6%	2.7%	2.7%	2.6%	2.7%	2.9%	3.1%	2.8%	3.0%	2.9%
Locum & Other Medical	2.3%	2.8%	1.9%	2.5%	2.0%	2.1%	2.0%	2.6%	3.0%	2.3%	2.5%	2.6%	2.8%
Overtime	0.9%	0.9%	0.9%	0.9%	0.9%	1.0%	0.8%	1.0%	1.1%	1.5%	1.5%	1.3%	1.0%
WLI	0.3%	0.1%	0.1%	0.2%	0.2%	0.2%	0.1%	0.2%	0.2%	0.1%	0.1%	0.0%	0.0%

M&D Non Core Pay % of Total Spend



	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Agency	10%	9%	10%	9%	8%	9%	9%	8%	8%	8%	9%	9%	9%
Locum & Other Medical	9%	11%	8%	9%	8%	9%	8%	11%	12%	10%	10%	11%	11%
Overtime	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
WLI	1%	0%	0%	1%	1%	1%	0%	1%	0%	0%	0%	0%	0%

% Total Pay Spend for Nursing & Midwifery



	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20
Additional Basic	0.5%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%	0.5%	0.5%	0.7%	0.6%	0.5%	0.5%
Agency	5.8%	5.1%	5.5%	6.1%	5.2%	4.8%	6.1%	5.6%	5.5%	4.4%	4.9%	5.7%	5.8%
Bank	1.1%	1.2%	1.2%	1.3%	1.4%	1.4%	1.2%	1.3%	1.6%	1.7%	1.5%	1.8%	1.7%
Overtime	1.5%	1.7%	1.5%	1.5%	1.7%	1.7%	1.4%	1.7%	1.8%	3.1%	2.2%	2.1%	1.7%
WLI	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%

Further Information

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

- performance reference tables
- tolerances for red, amber and green
- the Welsh benchmark information which we have presented

Further information on our performance can be found online at:

- Our website www.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

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

follow @bcuhb
http://www.facebook.com/bcuhealthboard

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **27.8.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Planned care update including RTT**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Executive Director Nursing and Midwifery / Deputy Chief Executive
Awdur yr Adroddiad **Report Author:**	Andrew Kent/ Dr Kakali Mitra, David Fletcher, John Collins, & Pat Youds
Craffu blaenorol: **Prior Scrutiny:**	Executive Director Nursing and Midwifery / Deputy Chief Executive, Interim Chief Operating Officer, Executive Team, Planned Care Group
Atodiadau **Appendices:**	Appendix 1- list of essential services

Argymhelliad / Recommendation:

The Committee is asked to note the following:

- The overall growth in the waiting times because of the legacy of Covid-19 and the continuing reduction in available/functional capacity.
- That essential elective activity still being undertaken is in lower numbers than pre-covid.
- The paper describes the challenging scenario for planned care and its mitigations in a pandemic.
- That the recovery and re-set is going to take a considerable amount of time and needs to be measured in quarters/years rather than months.

Please tick as appropriate

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

Sefyllfa / Situation:

This paper continues the story of how planned care is maintaining essential services and the approach to re-starting elective activity across the organisation.
The paper describes the approach of risk stratification and how it is being applied, as we move away from the traditional RTT methodology.

Cefndir / Background:

Planned care is undergoing significant changes in response to the Covid pandemic, the paper describes these challenges and actions to date in sustaining and re-starting services

Asesiad / Assessment & Analysis

Strategy Implications

This paper links into how the strategic elements of planned care are requiring a review and how the current measures are becoming less relevant as a new set of metrics are being introduced to deliver safe patient care. Some business cases will also require review in light of the delivery changes occurring

Options considered

N/A

Financial Implications

The financial implications are yet to be fully understood

Risk Analysis

The major risks are currently being reviewed at the end of August. This paper describes a risk in stratifying patients due to the IT system. This is on the risk register with its associated mitigations

Legal and Compliance

N/A

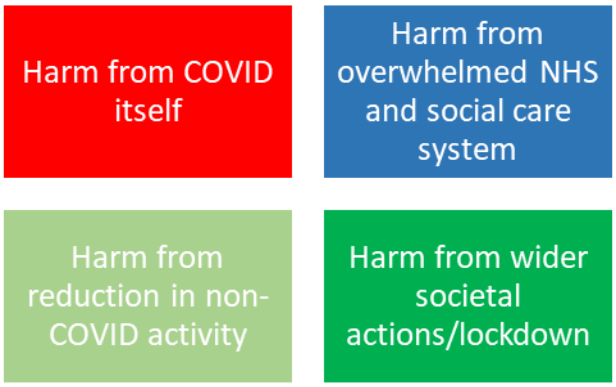
Impact Assessment

N/A

Update Planned care (RTT)

Introduction

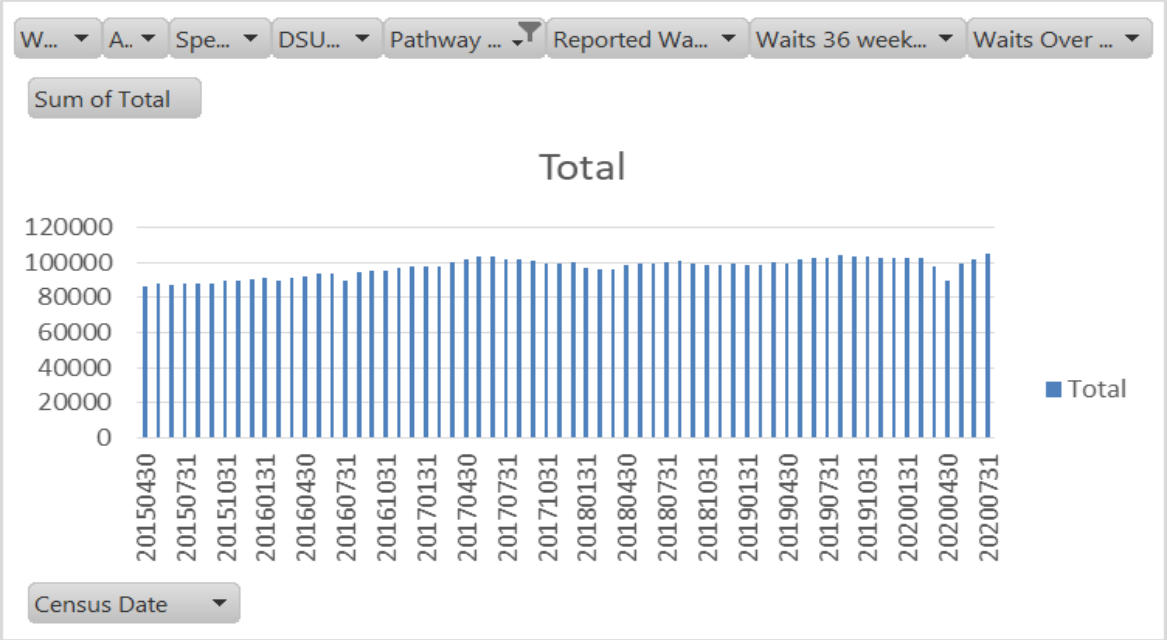
This paper continues the story of risk stratification and its implications on the Q2 plan and waiting list size in relation to the long waiters. Planned care continues to deliver essential services and stratified patients requiring operations in the next 3 months (Q2 activity) it is also planning an approach to re-starting elective work across the organisation. This is being undertaken whilst remaining committed to treating those patients in the greatest need based on the four principles below.



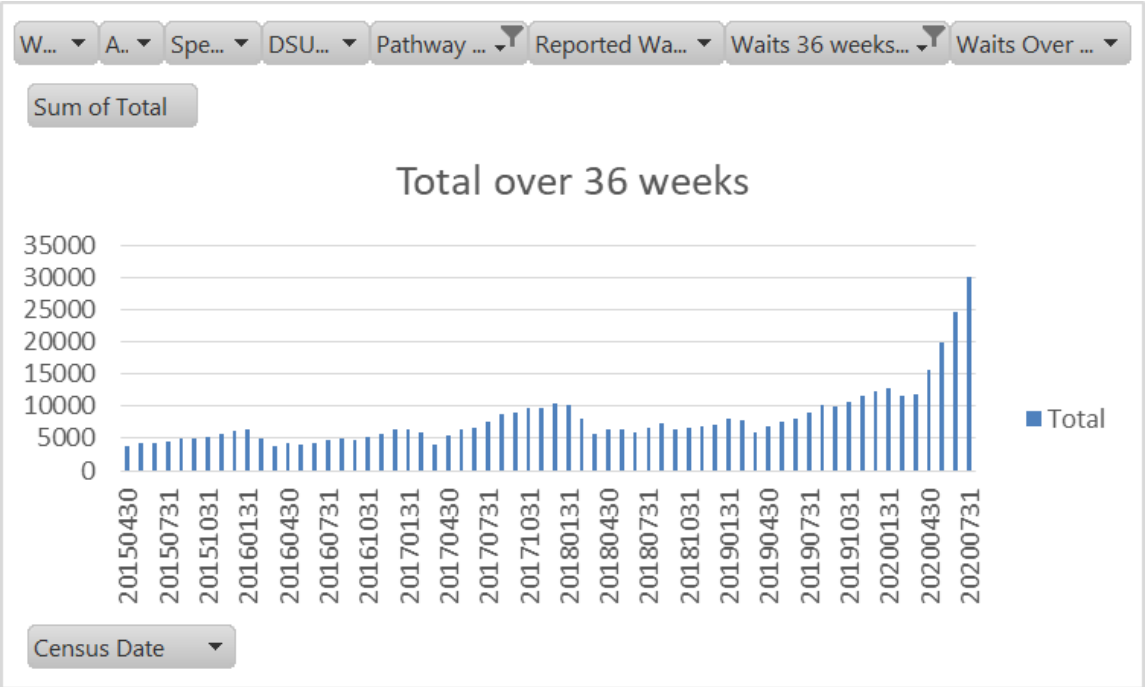
As we approach the Q3/4 period, the ability for planned care to deliver the required activity will be challenging. Previously the organisation has relied on planned care reductions in activity to provide extra capacity for unscheduled care, particularly bed capacity. This year the landscape has completely changed. The pausing of all routine activity, increasing theatre turnaround times combined with new bed spacing regulations, means a reduction in capacity. Therefore, planned care cannot reduce its activity to support unscheduled care, as elective patients may come to harm. This new approach poses a significant risk to the unscheduled care winter plan and stresses the importance of whole system working to support patients being treated in the organisation.

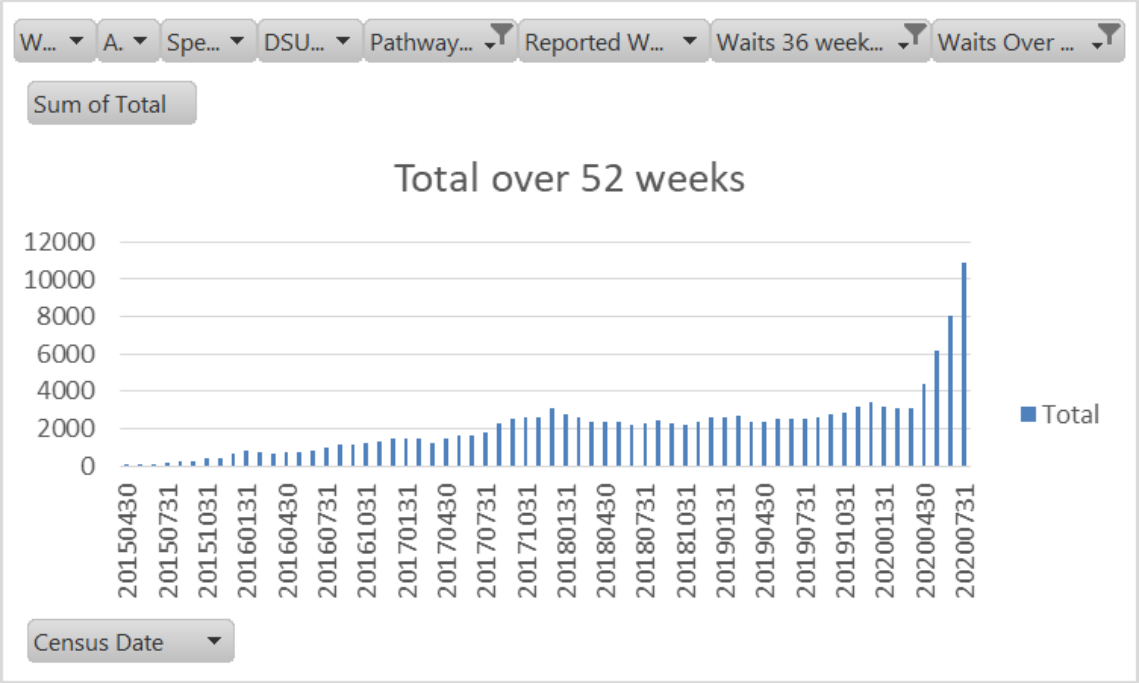
Context

The total waiting list size continues to increase slowly; the drivers to the growth are the slower return to previous pre-covid referral levels and the inability to go back to previous productivity levels for the reasons described in this paper. The total waiting list size now stands over 100,000.



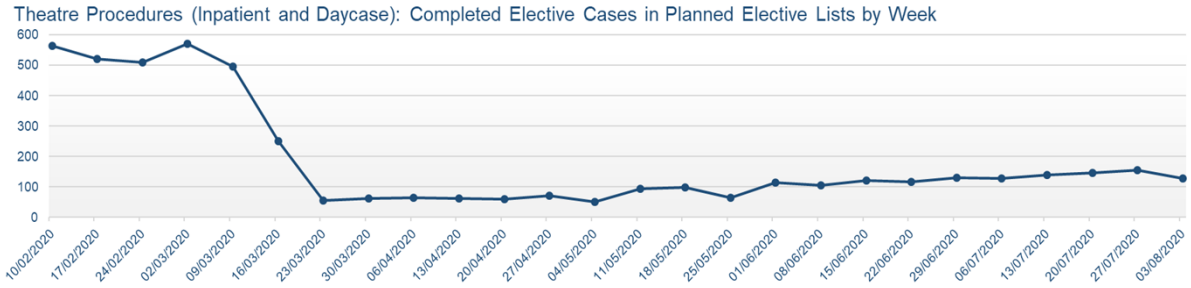
In In addition patients continue to wait longer and when applying the RTT measure; the over 36 week waits and over 52-week waits are growing significantly in the total list size. 30,167 are over 36 weeks (10,904 of which are over 52 weeks).





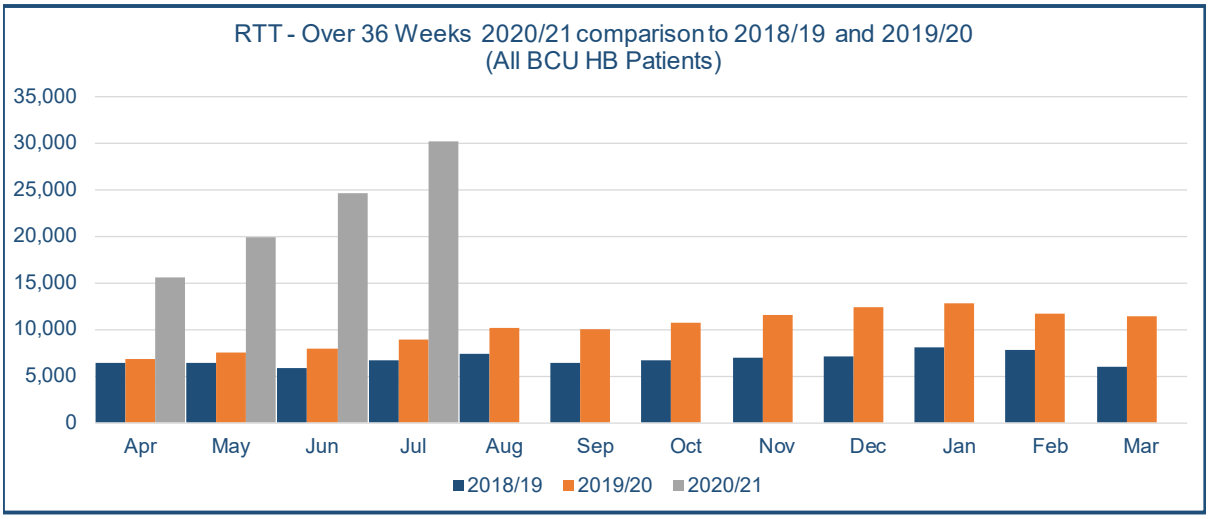
The organisation has continued to deliver essential services as part of the Welsh Government response to the Covid pandemic but the committee will re-call that essential services are not just planned care activity but are whole system across a number of services, the majority being in primary care. The essential services for secondary and planned care in particular was the maintenance of cancer, life threatening surgery, diagnostics (Endoscopy in particular) and urgent operations that required surgery within the next 72 hours to 3 months. The essential services assurance and re-start of services discussion is subject to another paper being presented at F&P this month.

This led to all routine and planned surgery including OPD activity to be paused. The graph below illustrates the reduction in theatre activity since February 2020.



This reduction in theatre activity by treating only essential and high-risk stratified patients has led to the long waiters - waiting even longer. The table below highlights the size of the problem of patients waiting over 36 weeks when put into context with the previous 3 years.

RTT - Over 36 Weeks 2020/21 comparison to 2018/19 and 2019/20 (All BCU HB Patients)



All BCU	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	5,418	6,289	6,626	7,528	8,781	9,066	9,693	9,629	10,469	10,086	8,014	5,714
2018/19	6,404	6,428	5,814	6,631	7,364	6,351	6,643	6,932	7,144	8,034	7,826	6,004
2019/20	6,870	7,499	7,998	8,900	10,157	10,052	10,768	11,525	12,378	12,792	11,654	11,460
2020/21	15,658	19,913	24,613	30,167								

The significant drivers, at stage four, is the reduction of theatre activity within the organisation and the chart below demonstrates the reduction of capacity compared to last year, including two other organisations that serve our population.

Activity v Plan Comparison				
	% of previous activity delivered			
Provider	NEW OPD	FU OPD	other OPD	Elective IPDC
COCH	42%	56%	27%	35%
RJAH	18%	46%	11%	14%
BCU	46%	54%	24%	37%

The table above does show that for IP/DC we are at 37% activity compared to the previous year. Benchmarking with two other providers that we work with this shows favourably.

RJAH and the Countess of Chester previously provided activity for the organisation last year. It is doubtful that they will be able to provide any significant contribution for the rest of the year, providing an added risk to this story.

This supports the challenging situation for the rest of the year with Q3 and 4 approaching.

A number of factors are still contributing to re-starting services, although activity is higher in Q2 as planned, the activity was planned in seeing essential and high risk stratified patients. Not all theatre capacity are yet open and the functional capacity is lower than last year. The major factors in not being able to get all theatres up and running again are varied, the major drivers are:

- Workforce- staff from theatres are still being deployed into other areas.- this continues at East and West
- Theatre turnaround times are longer due to PPE considerations across all sites
- ITU capacity is still escalated into ward spaces at the West site.
- The need to carve out red areas for suspected covid patients still means some wards and theatres are not available as they are in red areas, particularly at the East site.
- Staff are taking annual leave or are unavailable, across all sites
- Some staff are returning from shielding.
- Increase in unscheduled care activity particularly at the Centre site causing escalation into planned care environment.

RTT and new measurements.

There are growing indications that the Welsh government are considering permanently revising the RTT measures in the light of the covid pandemic. These measures are being adopted and are listed again for reference.

- Priority Level 1a Emergency – operation needed within 24hours
- Priority level 1b Urgent – operation needed with 72 hours
- Priority level 2 Surgery that can be deferred for up to 4 weeks
- Priority level 3 Surgery that can be delayed for up to 3 months
- Priority level 4 Surgery that can be delayed for more than 3 months

Planned care have completed transferring the stage 4 patients who were on the RTT to the risk stratification. It is still time based, which will pose delivery issues for the organisation, as there was significant patients waiting in the previous RTT system, who again will not meet these new time indicators. In early August, we had risk stratified over 10,000 patients on the RTT high-risk specialties and 3,500 of those patients were P2/3 combined. This number represents the total number of patients required to be treated in Q2. When reviewing the Q2 capacity plan there is a deficit in achieving these numbers after treating P1 and P2 patients.

This indicates that some P3 and all of P4 patients will not be treated in the timescales required, further compounding the longer waiting times.

This dynamic, compounded with our starting position of long waiting patients, means that we have to look at other solutions that may be non-operative or treated outside a DGH environment, such as a diagnostic and treatment centre approach for the larger benign specialties such as orthopaedics, which is discussed later in this paper.

To help mitigate these risks the access group are monitoring activity versus plan and more capacity that is functional is indicated to come on line from September. If unscheduled activity does not increase, giving an opportunity to see more P3 patients.

Early indication is that we will move nationally to a “personal target date” approach. Which would be a pragmatic way of treating patients and one that we as an organisation could measure. This would allow a comparison and outcomes based

approach for patients with the same condition but have differing needs or pre-existing conditions meaning patients would have a different target date.

To give an example a patient needing a hip arthroplasty who is severely limited in movement, in pain and has pre-existing conditions that require urgent mobility, would get a PTD earlier than a patient who may require a hip arthroplasty but has no other pre-existing conditions. In the RTT system, this would be based on the date of referral and not take into account these factors to the same level.

It is important to note this situation is fluid and the planned care group will need to remain agile and responsive to this current thinking and communication from Welsh government.

In addition, we have had no indication on how OPD and diagnostics will be measured in the near future. Although a similar approach is recognised, with a possibility of whole pathway milestones being adopted.

The significant risk to the organisation is how the new measures will be recorded, as the PAS system is currently unable to record risk stratification and therefore is being placed in “free text” and the information to develop a PTL is pulled from this source. Leaving a risk that patients could be missed if there is an error in the way the free text is entered. A task and finish group is currently working and monitoring this situation to mitigate the risk and staff have been explicitly informed on how the free text needs to be entered. There are some indications at the time of writing that an adaption to the IT system will be made in early September, allowing accurate recording. As an interim mitigation, each service DGM is updating manually their own spreadsheets to ensure operationally no patients are missed during this transition.

Therefore, the organisation is in a state of transition, the planned care group are re-designing its whole process of patient management, whilst still delivering essential services, urgent care and re-starting routine services. Operationally it is a very complex and challenging environment, including keeping clinicians and partners engaged and involved in these change processes.

In future, the organisation will be reporting both risk stratification, waiting list size and RTT stages, until we get further clarification from Welsh government and all suitable reporting platforms are complete.

All these changes is demonstrating that the covid pandemic, arguably, has had more long term impact on planned care than other parts of the system and planned care is having to re-design itself whilst still trying to deliver care to our patients.

The re-set audit at specialty level, due in late August, will give the planned care group further information to understand why these services cannot start and what support can be given to allow them to become operational again. However, we are seeing the desire for more capacity to be opened up in late August and early September.

Previously planned care was focused on ensuring the surgical treatment required was delivered in as timely fashion as possible. We are now in an environment that patients will have to wait longer and the specialty of orthopaedics is a good example of this.

Planned care now needs to introduce other approaches to delivering non-operative care and communication to our patients, so that we can monitor patients whilst waiting and help keep them educated on life style requirements. This means more integration with primary care, pre-habilitation and good communication re their safety coming into a hospital environment. Early evidence is showing patients are declining attending the hospitals for operative procedures due to the risk of covid. This is being observed in ophthalmology and orthopaedics at the spire. Discussions are being undertaken on how we can improve our communication to reduce DNA's particularly as theatre capacity is extremely precious and there is a 14-day self-isolation requirement, meaning "standby patients," an approach previously used, cannot be utilised at this time.

Essential services

The Health Board have reviewed compliance with the Essential Service Framework on a monthly basis. The August review is underway, the latest report (July) demonstrates the majority of essential services are being maintained and actions have been implemented to address shortfalls. However, delays were present in diagnostic pathways and phlebotomy service, which were affecting essential services. Additional phlebotomists have been recruited to increase service capacity and diagnostic priorities re-aligned with the second Cath lab re-opening and additional endoscopy sessions established. We continued to use the facilities at Spire Yale for diagnostics and essential surgery procedures.

Referrals for urgent suspected cancer have increased in July, returning to their near pre-covid levels.

The volume of confirmed strokes has also seen a return to pre-covid volumes.

The Committee is reminded that Essential Services are those services that need to continue throughout Covid 19 to avoid the risk of harm arising from life threatening and life changing treatments. The framework applies to services across the whole of the healthcare system. Appendix 1, lists the essential services.

Re-start of services

The activity delivered in Q1 2020-21 represents the work, which has continued to deliver essential services in secondary care for North Wales residents in BCU and commissioned services at Countess of Chester and Robert Jones Agnes Hunt (note essential services span primary, community, secondary, tertiary and mental health services):

As the levels of Covid-19 are reducing at present, it is important to continue to provide elective services within our available capacity and where safe to do so. There are significant challenges in re-starting services safely including:

Below is the table of services signed off to recommence up to 11.8.20. Since that date further approvals have been granted for podiatry services and requests received to restart a number of other therapy services in the community.

Number	Service	Specific Areas included in documentation	CAG review	Approval date
1	Therapies	Routine therapy services in HMP Berwyn	15/07/20	28/07/20
2	Therapies	Strategy for the resumption of BCU Dietetic Outpatient services	22/07/20	24/07/20
3	Radiology	Radiology Pathway For Imaging Cardiac Patients - V4 July 2020	22/07/20	24/07/20
4	SALT (Speech & Language Therapy)	Clinical Pathway Proposal SALT Phase 2 COVID v2	22/07/20	28/07/20
5	YGC	Overview and recommendations for recovery YGC 29072020 (Main document and Restart-checklists embedded for the following services) 1. Relocation of surgical ED back to ED 2. Relocation of Paediatric assessment back to ED 3. Return of GIM on call rota to pre COVID 4. Re-start of cardiac physiology 5. Re-start of medical day cases, including cardioversions 6. Angiograms and PCI 7. Restart of Orthodontic treatments (CAG approved) 8. Re-start of Oxygen Assessment Clinics in community 9. Pacemaker and TOE service 10. Drive through pulse oximetry service 11. Increase in MOPS for Maxillo Facial – 1 additional theatre list a week 12. Re-start of face to face Cardiology clinics at YGC – 15 a week 13. Re-start of face to face Cardiology clinics in community – 2 per week	05/08/20	10/08/20

		14. Re-start of Dermatology face to face clinics at YGC and community 15. Re-start of Dermatology MOPs at YGC 16. Re-start of COTE face to face clinics in YGC and community 17. BCU Ophthalmology service 18. Diabetes face to face outpatient clinics – acute and community 19. Rheumatology face to face outpatient clinics – acute and community 20. Rheumatology medical day cases 21. Home visits for oxygen assessment		
6	Ophthalmology	Coronavirus Elective Cataract Pathway V1.6	05/08/20	07/08/20
7	MaxFax	North Wales Restorative Patient COVID-19 Pathway - Transitional Phase - V1.0 10 July 2020Re-set Checklist restorative	07/08/20	10/08/20
8	Radiology	BCU Covid Recovery GP Plain Film V2	07/08/20	07/08/20
9	Childrens	Childrens Medical Day Cases Re-start	07/08/20	07/08/20
10	Childrens	Childrens Drive through HbA1c testing	07/08/20	07/08/20
11	Obstetrics & Gynaecology	Planned care switch on v12	07/08/20	07/08/20

A more detailed re-start paper has been submitted to the committee, following a chair's request. The committee are asked to refer to that paper for further detail

Orthopaedics

As mentioned Orthopaedics is one of the largest benign services, which has high volumes but is not regarded as essential or life threatening and therefore has had little "cold surgical" capacity. Any orthopaedic activity will have been related to trauma or planned surgery.

The table below shows the transfer, as of the beginning of July, of patients from RTT to risk stratification. As the reader will note there is some discrepancy of P2 patients between sites and this demonstrates one of the issues on how surgeons are interpreting the risk stratification, which illustrates 434 P2's (requires surgery within 4 weeks) compared to 3 and 36 at the two other sites. Although this has been seen in other specialties this is the most notable difference.

Speciality	P1a	P1b	P2	P3	P4
Orthopaedics WEST	0	0	3	113	2740
Orthopaedics EAST	0	0	434	183	440
Orthopaedics Centre	0	3	36	102	1425
Orthopaedics sub total	0	3	473	398	4605

Following discussions with the clinicians, there is a need for a new and different approach to managing orthopaedics both tactically and strategically. The former is to use a network approach between all three sites, RJAH and the Spire. However, at the time of writing, this network of sites is becoming problematic due to contractual issues with the Spire at Wrexham and the RJAH now continuing to undertake trauma, rather than orthopaedics for the rest of Q2, both are being challenged by the organisation.

Secondly, the clinicians are reviewing pathways at subspecialty level, the use of digital apps and the commencement of certain hand procedures outside a normal theatre environment, releasing capacity for other procedures and beginning to form a hand surgery service are some of the changes being made.

There is also a piece of work at how patients can be supported non-operatively for the near future.

In August, orthopaedic patients will commence treatment at the Spire and both the East and West site will commence limited orthopaedic capacity in late August early September.

This work described now requires the orthopaedic strategy to be reviewed in the near future, as the landscape has significantly changed.

A comprehensive orthopaedic paper will be presented to the executive team in August.

Diagnostics

At the end of July, the number of patients waiting less than 8 weeks, which includes a number of urgent/USC examinations waiting to be appointed and routine referrals from out-patients clinics that have continued to operate virtually, amounted to more than 4,500 whilst those waiting more than 8 weeks amounted to over 8,000 patients. Of nearly 13,000 patients awaiting imaging, only a few will have been deliberately deferred for follow up examinations to monitor for resolution and recurrence. The patient backlog numbers, which are now increasing more rapidly as more activity takes place, are:

Modality	Area	< 8weeks	>8 weeks	Total
CT	West	295	409	704
	Cent	303	644	947
	East	321	766	1087
	Total	**919**	**1819**	**2738**
Fluoroscopy	West	37	71	108
	Cent	8	22	30
	East	16	28	44
	Total	**61**	**121**	**182**
MRI	West	298	527	825
	Cent	241	697	938
	East	321	564	885
	Total	**860**	**1788**	**2648**
Non-Obstetric Ultrasound	West	898	1547	2445
	Cent	887	870	1757
	East	887	1760	2647
	Total	**2672**	**4177**	**6849**
Nuclear Medicine	West	47	26	73
	Cent	18	41	59
	East	46	154	200
	Total	111	221	332
Grand Total		**4623**	**8126**	**12749**

Recovery Plan

A recovery plan for the backlog of over 500 GP patients requiring plain film imaging has been approved and has commenced. However, for the remaining 12,500 patients, there is an imperative for those requiring treatment sooner rather than later to have their imaging first, regardless of the referring specialty. This risk stratification must be decided upon by the referring clinicians and will require the return of all radiology referrals and subsequent review of individual patients. This approach is acknowledged as that required by the Royal College of Radiologists in their 'Interim Guidance on restarting elective work'. Although a major task, the identification and appropriate prioritisation of patients is essential to managing the risk of delayed diagnostics and associated harm.

The risk stratification methodology will be as follows:

P1 High probability of potentially life threatening condition.

P2 High probability of condition potentially causing significant long-term harm

P3 Possibility of potentially life threatening condition

P4 Possibility of condition potentially causing significant long-term harm

P5 Unlikely to be life threatening or causing significant long-term harm

Patients falling in the P1 and P2 categories should already be presenting and imaged as USC/Urgent referrals through the 'essential services' pathway. However, it is anticipated that there may still be some P1 and P2 that emerge from the risk stratification of routine patients, due to the delays in patient management. In moving forward Radiology proposes, subject to the caveat on the resuming of activity below, to appoint patients in risk priority order, commencing with any P1 and P2s before moving onto patients identified as P3 followed by P4 and finally, P5. The patients within each risk category will be appointed in chronological order. It is expected that this risk stratification process will also identify patients who no longer require any imaging.

Due to the volume of referrals that will require stratification, forms will be returned in controlled batches with patients waiting for the longest periods being considered first. Control measures will be put in place to ensure referrals do not get lost and that an action is received for each and every patient.

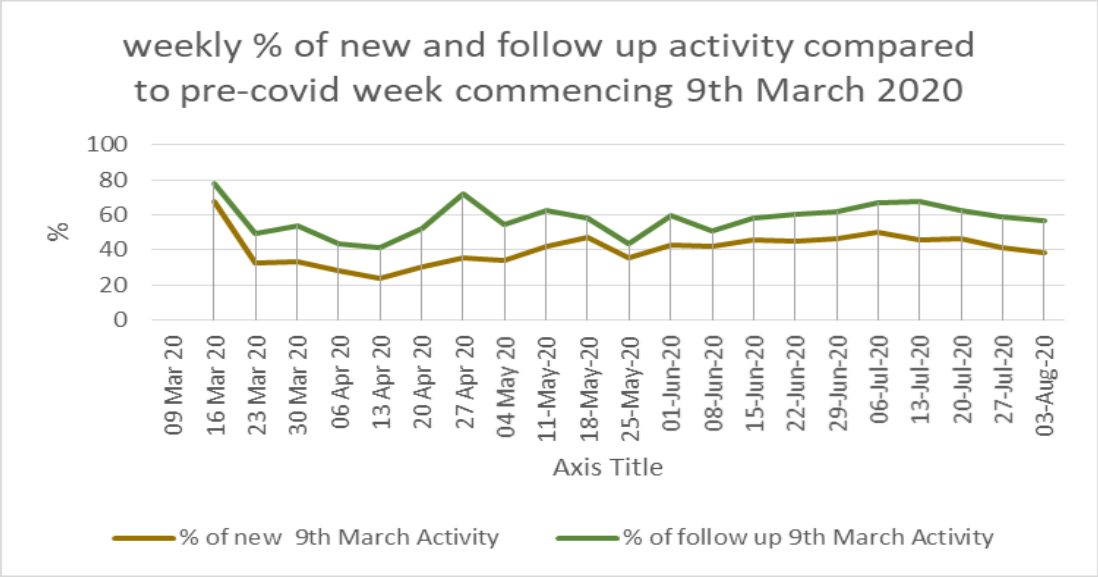
As referred to, currently going through CAG are service plans for resuming urgent patient activity via face-to-face clinics in addition to those held virtually. It is expected that the most of the imaging referrals will be P1 or P2 although some may be routine. Depending on the number of urgent referrals, it is possible that these patients could take up all available capacity and the routine imaging backlog may never come to the fore. There is real concern that within the 'routine' category, there will be patients with unsuspected cancers as more than half of cancers are detected on patients not referred as USCs.

Therefore, Radiology proposes that unless the capacity available is in excess of that required for P1 and P2 patients, some appointments are reserved for P3 patients.

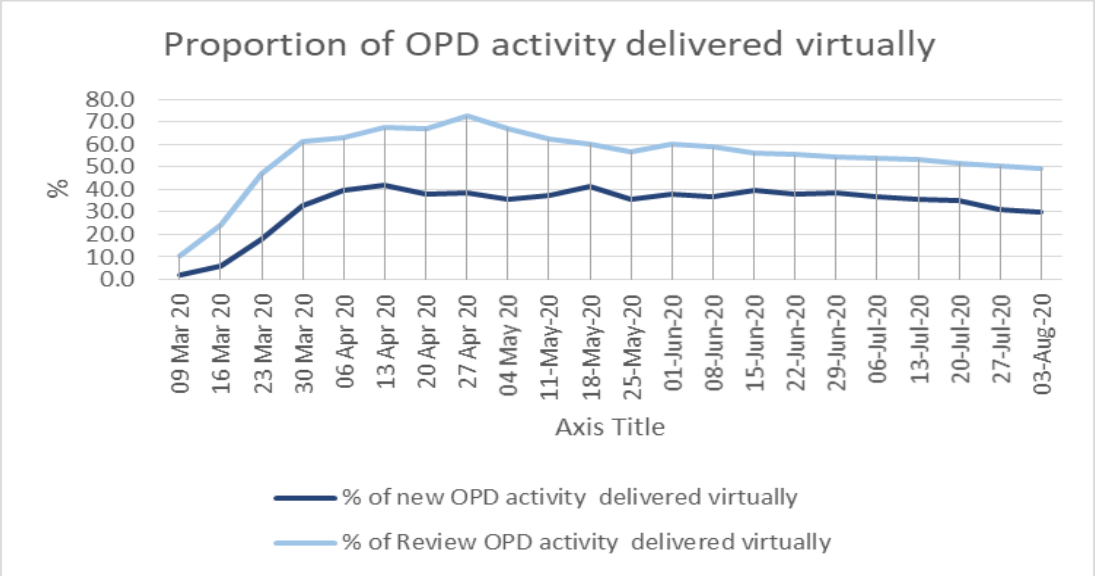
Plans are being developed for providing the additional activity required via in-sourcing and mobile scanners. The availability of a DoH CT in a modular build has been secured and will be located in YG for 6 months in the first instance. The possibility of setting up Diagnostic Treatment Centres in BCU is also being explored, the advantage being the availability of green sites.

Outpatients

As mentioned previously there are risks to OPD delivery. The graph below compares activity for new and follow-ups since March. Clinics space now needs to provide social distancing and protection for staff.



Since the pandemic there has been a strategic direction in non-face to face contact, the graph below shows this is being more successful in follow-ups, than in new, which is clinically understandable, 30% of new activity is virtual compared to 50% of review patients. The roll out of attend anywhere has played a factor in this and the OPD improvement group have agreed to take over the roll out of this work, from the IT steering group in the near future.



Next steps/risks

The planned care transformation group meets weekly to co-ordinate this complex piece of work, sustaining essential services, re-starting routine activity, implementing and designing new measurements of care, whilst still trying to book patients into capacity that is 30% lower than last year.

Conversations have commenced regarding diagnostic and treatment centres, extra theatre capacity and how primary care can respond and assist in the non-operative

elements of care. An extremely close working relationship with unscheduled care will be more important than ever as we move into this winter period to allow planned care to function as optimally as possible.

The Q3/4 planning is underway; this will point to how much functional capacity we believe we will have for the rest of the year. This opportunity will allow a calculation of how much extra diagnostic and theatre capacity will be required to reduce the P3/4, long waiters. Once this is understood an option appraisal will be put together of the best possible strategic fit, including the use of field hospitals and/or community estate. Which would allow a Day case-treatment centre/In-patient hub and spoke model across North Wales, identifying the capacity to reduce the 2019 end of year backlog and the covid pandemic backlog, which occurred in Q1.

The planned care group is required to be agile as work is dynamic and fluid. National guidance is being released weekly; the requirement to deliver and sustain essential services with re-starting activity and the need to look at how services can be delivered outside the hospital capacity is a priority, whilst keeping a close eye on the covid threat during the coming months and supporting unscheduled care during this period.

Conclusion

This paper has captured many, but not all, of the changes and challenges currently being undertaken in planned care, whilst still delivering a service to patients. New ways of working are rapidly being implemented in this post covid era and previous ways of working are requiring adjustment and re-design. The functional capacity is still significantly less than last year providing challenges to elective activity on an on-going basis.

Many strategies previously considered, now need review in the light of the post covid changes to planned care.

The committee is asked to note the following:

- The overall growth in the waiting times because of the legacy ofCovid-19 and the continuing reduction in available/functional capacity.
- That essential elective activity still being undertaken is in lower numbers than pre-covid.
- The paper describes the challenging scenario for planned care and its mitigations in a pandemic.
- That the recovery and re-set is going to take a considerable amount of time and needs to be measured in quarters/years rather than months.

Appendix 1- Essential Services

- Access to primary care services (providing *essential*, *additional* and a limited range of *enhanced* services that fulfil the WHO high priority categories)
- Urgent surgery including access to urgent diagnostics
- Urgent cancer treatments including access to urgent diagnostics
- Life-saving or life impacting medical services including access to urgent diagnostics
- Life-saving or life impacting paediatric services including time critical vaccinations, screening, diagnostic and safeguarding services
- Maternity Services including antenatal screening
- Neonatal Services including transport
- Mental health crisis services including perinatal care
- Mental health in-patient services at varying levels of acuity
- Community MH services that maintain a patient's condition stability (to prevent deterioration, e.g. administration of Depot injections)
- Substance Misuse services that maintain a patient's condition stability (e.g. prescription and dispensing of opiate substitution therapies)
- Urgent eye care
- Termination of Pregnancy Services
- Other infectious conditions (sexual and non-sexual)
- Renal care- dialysis
- Transplant patients
- Urgent supply of medicines
- Blood services, products and collection
- Palliative Care in all hospital & community settings

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **27.8.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Unscheduled Care and Building Better Care update** **(Covid19 impact on 2019/20)**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Deputy CEO / Executive Director of Nursing & Midwifery
Awdur yr Adroddiad **Report Author:**	Kate Clark, Secondary Care Medical Director Gavin MacDonald, Interim Chief Operating Officer
Craffu blaenorol: **Prior Scrutiny:**	Review by Deputy CEO - Unscheduled Care Improvement Group currently stood down due to COVID
Atodiadau **Appendices:**	Appendix 1 – USC Building Better Care KPIs

Argymhelliad / Recommendation:

The Committee note the Unscheduled Care performance for July 2020 across BCUHB and for each Health Community

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

This report provides an update against the unscheduled care performance at the end of July 2020. This paper does not cover the Building Better Care programme beyond March since the programme was put on hold due to the Covid-19 pandemic. Work has commenced to review and refresh the Building Better Care improvement programme, consolidating the work done to date, building on the improvements and developments delivered pre-COVID and to agree the way forward for the Unscheduled Care improvement programme as unscheduled care pressures begin to increase following the first wave of COVID-19.

Cefndir / Background:

The Building Better Care Programme was put on hold in early March in line with the expectations set out by the Health Minister in a letter on 13 March to prepare the Covid-19 response. Throughout March the Emergency Departments (EDs) focused their efforts on developing and implementing plans responsive to the predicted Covid-19 surge. This involved re-organisation of their departments and development of clinical pathways to stream activity away from ED to allow provision for treating Covid-19 patients. Each department also established red and green zones to support both patients and staff to reduce exposure to Covid infection. This included re-purposing areas to streamline flows for minor injuries, surgical assessment, paediatric and respiratory assessment. Each site provided surge plans outlining these details. The clinical pathways were supported by specialties to stream patients away from ED directly to assessment units.

ED attendances are now showing a steady increase from 7,773 in April to 12,785 in July, however, this remains lower than the same period last year which reported 15,804 attendances in July 2019. Overall, the combined 4 hour performance dropped from 87.3% in April and 86.5% in May to 77% in June before rising again slightly to 79.7% in July. This is an improved position on 73.8% reported in July 2019.

The increase in attendance figures support the organisation's anticipation so far that this will continue to reflect pre-covid levels. The impact of this, any increase in Covid 19 and the implications of the increase in requirements for step down beds to support the care home sector are currently being considered to inform the capacity required for future planning, including best potential usage of temporary hospital capacity.

Whilst the number of patients who waited in ED for more than 12 hours in July is showing a continued increase from 38 in April, to 704 in July, this is a significant reduction compared to 2,044, 12 hour waits in July last year. The main reason for the delay was the lack of flow from ED. The number of patients waiting in ED for longer than 24 hours significantly decreased in April to 3 for the month but rose to 56 in June and fell slightly to 38 in July.

Ambulance performance

Ambulance CAT A performance
The 8 minute red performance target relates to ambulance response to red calls (very urgent) which has shown a deteriorating performance from 72.44% in April to 65.82% in July which is just achieving the 65% performance target.

Ambulance handovers over 60 minutes
There was a significant improvement in the >60 minute ambulance handover performance, which saw a reduction in the number of delays >60 minutes from 320 in March to 32 in April and 30 in May, however this increased to 187 in June and 348 in July.

West Health Locality

4 hour performance
The combined 4 hour performance for July in the West Area was 88.7% which was a slight improvement on June 77.5%. ED only performance was 85.8% in July.

12 hour performance
There were 47 patient delays >12 hours within YG ED for the month of July and 4 patients waiting over 24 hours.

Ambulance 60 minute handover performance
There were 26 Ambulance handover delays >60 minutes for the month of July which increased from 5 in June. This is due to an increased number of WAST arrivals in July and reduced ED capacity as a result of red and green areas.

Under 18 years of age breaches
There were 26 breaches for under 18 year olds in July and 29 in April. .

Central Locality

4 hour performance
The combined 4 hour performance for Central area in July was 76.3% which is a slight drop in performance from 80.4% in June.. ED only performance was 68.3% in July%.

12 hour performance
There were 320 patient delays >12 hours within YGC ED in July which saw a significant increase in June to 326 from 19 in May. There were 19 patient delays over 24 hours in ED in July which is an improvement on 45 reported in June.

Ambulance 60 minute Handover performance
There were 275 Ambulance handover delays >60 minutes for the month of July and 172 in June. Pre-covid handover delays were of concern at this site. Further work to review and refresh the pre-covid action plan to address this is underway. Delays are mainly as a result of enforcing appropriate distancing and infection prevention measures within the department. Pre-covid the department would frequently house 60+ patients. As a result of the IP and distancing measures to safeguard patients from covid exposure, the department should not house more than 40 patients.

Under 18 years of age breaches
There were 24 breaches for under 18 year olds for the month of July and 12 in June.

East Locality

4 Hour performance
The combined 4 hour performance for East area in July was 76%, which was a decrease from 82.7% in June. ED only performance was 73.8% in June.

12 hour performance
There were 337 patient delays >12 hours within YGC ED in July and 100 in June. There were 15 patient delays over 24 hours in ED and 10 in June.

Ambulance 60 minute Handover performance
There were 47 Ambulance handover delays >60 minutes for the month of July and 10 in June.

Under 18 years of age breaches
There were 31 breaches for under 18 year olds for the month of June and 15 in June.

Performance summary (no National reporting due to Covid-19)

Previous improvements in the Emergency Department performance was in part due to the effectiveness of the patient pathways put in place for specialties as well as a reduction in attendances. Attendances are now continuing to increase with numbers on all sites showing trends towards ‘usual’ demand. Plans are under way across Secondary Care and within the Health Communities to prepare for the re-introduction of phases of essential services as per guidance as well as managing Covid-19.

Asesiad / Assessment & Analysis

Strategy Implications
This report relates directly to the Health Boards strategic and business plans up until 13th March when the programme was put on hold to plan for Covid-19.

Financial Implications
Ongoing financial challenges exist in each of the Health Boards Emergency Departments. These predominantly relate to workforce and the need to establish this substantively in order to reduce the reliance on premium cost bank and agency workers.

Financial improvements will be delivered by optimising patient pathways, use of assessment units and ambulatory pathways to avoid admission. This will also need to be supported in the longer term with improvement in flow and discharge management to reduce the use of escalation beds on each site. This will be impacted in the short term by the current requirements to test patients prior to discharge to care homes which may require an additional 112 beds

Risk Analysis
Governance issues relate to improving performance and improving the patient experience. There is a risk register in place for project deliverables against the milestones.

Legal and Compliance
There are no associated legal implications. BCUHB is currently Governed by a Command structure and USC sits under the Clinical Pathways SRO. The USC Building Better Care Programme was put on hold in March 2020, but the group is currently being re-established.

Impact Assessment
No associated impact or specific assessments required.

USC Building Better Care KPIs **Appendix 1**

Trajectory (daily average)

Monthly position (daily average)

YG | YGC | WMH

	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020
MIU attendances	202	176	155	147	158	158	120	45	62	78	94	113
WAST arrivals	154	154	137	139	137	143	122	107	120	130	140	130
Admissions via GP	57	61	65	60	58	43	34	23	25	29	33	29
Care homes	14	16	16	15	15	10	11	12	11	11	12	10
4 hour (inc MIU)	71.7%	71.2%	72.2%	66.7%	64.6%	63.3%	72.8%	87.3%	86.5%	80.5%	79.7%	76.0%
60 min handover	30	26	26	36	34	23	10	1	1	6	11	22
ED waits over 12 hours	66	58	60	73	74	65	30	1	3	15	23	35
ED waits over 24 hours	18	13	13	21	26	16	8	0	0	2	1	5
Under 18s over 4 hours	15	14	11	16	14	16	10	1	1	2	3	7
DTOC bed days	33	34	47	39	30	28	26	6	1	1		
MFD bed days	122	146	163	123	125	145	145	56	72	84	83	106
Morning discharges	15%	16%	17%	15%	15%	15%	16%	14%	15%	15%	14%	15%
Weekend discharges	77	91	89	81	61	80	79	54	84	75	84	71
LOS>21	199	175	196	183	205	213	199	118	90	112	119	161

Trajectory (daily average)

	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
MIU attendances	185	165	149	133	143	160	173
WAST arrivals	125	125	125	125	125	125	125
Admissions via GP	40	40	38	36	34	32	30
Care homes	7	6	6	6	5	5	4
4 hour (inc MIU)	76.4%	77.4%	76.1%	76.1%	76.8%	78.5%	80.5%
60 min handover	4	2	0	0	0	0	0
ED waits over 12 hours	33	31	32	29	29	29	27
ED waits over 24 hours	0	0	0	0	0	0	0
Under 18s over 4 hours	0	0	0	0	0	0	0
DTOC bed days	40	34	26	23	23	20	24
MFD bed days	54	54	41	42	41	33	28
Morning discharges	24%	25%	26%	28%	29%	30%	30%
Weekend discharges	170	175	180	190	190	190	190
LOS>21	260	271	266	268	290	305	317

90 day plan measures definition

Dem1.1	MIU	Average daily attendances at MIU
Dem1.2	Ambulance	Average Daily arrivals at Emergency Departments by ambulance
Dem2.1	GP admissions	Admissions where source = GP (acute)
Dem2.3	Care home	Emergency admissions where patient postcode is care home (acute)
Flo1.1	>4hr (inc MIU)	Average combined ED and MIU 4hr performance
Flo1.2	60 minute	Average daily number of ambulance handover that exceed 60 mins
Flo1.3	Average wait	Mean wait in ED (hours)
Flo2.1	24 hours	ED wait over 24 hours
Flo2.2	Non-adm >4hr	Patients wait over 4 hours who are not admitted
Flo2.3	Paeds >4hr	Patients wait over 4 hours who are under 18
Dis1.1	Total bed days	Average daily total beds occupied (acute)
Dis1.2	DTOC	Average daily beds occupied with DTOC patients (acute)
Dis1.3	MFD	Average daily beds occupied with MFD patients (acute)
Dis2.1	Morning	Proportion of patients discharges before noon (acute)
Dis2.2	Weekend	Daily average number of discharges on Saturdays & Sundays (acute)
Dis2.3	LOS>21	Number of patients who have been in hospital for over 21 days (acute)

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Capital Programme Report Month 4**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson, Executive Director of Planning and Performance
Awdur yr Adroddiad **Report Author:**	Neil Bradshaw – Assistant Director – Capital Denise Roberts – Financial Accountant Tax & Capital
Craffu blaenorol: **Prior Scrutiny:**	The capital programme has been supported by the Executive Team and Estates Improvement Group.
Atodiadau **Appendices:**	0

Argymhelliad / Recommendation:

The Committee is asked to receive this report and note the reported exceptions.

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

Sefyllfa / Situation:

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

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

Cefndir / Background:

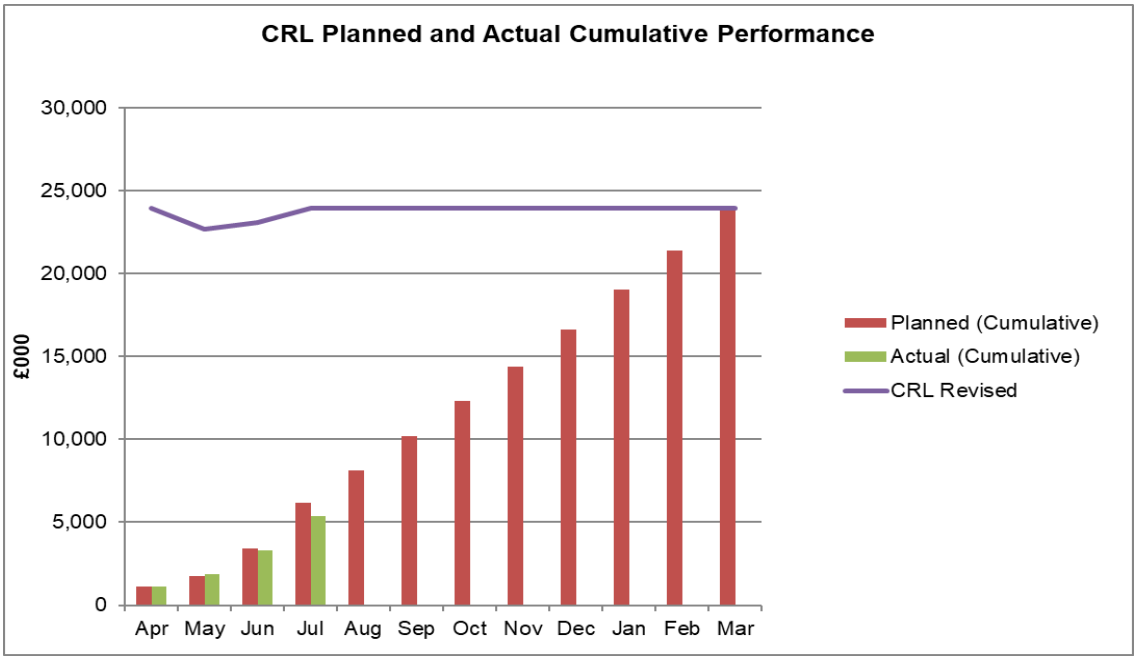
The agreed capital funding from all sources may be summarised as follows:

Capital Programme	**£ '000**
All Wales Capital Programme	11.009
Discretional Capital	12,921
Total Welsh Government CRL	**24,930**
Capital Receipts	150
Donated Funding	1,027
TOTAL	**25,107**

Asesiad / Assessment

Expenditure Planned/Actual

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



Funding	Target (£'000)	Performance (£'000)	% Spend to date
All Wales	11,009	4,887	44%
Discretionary	12,921	480	4%
Subtotal CRL	**23,930**	**5,367**	**22%**
Capital Receipts	150	0	0%
Donated Capital	1,027	357	35%
Grant Capital	0	0	0%
Total	**25,107**	**5,724**	**23%**

`

It should be noted that the majority of All Wales expenditure to date relates to the Health Boards response to covid-19 in support of additional surge capacity (excluding the field hospitals) and additional equipment.

The field hospitals are classified as revenue expenditure, as the assets are neither owned nor leased long term by the Health Board, and are subject to separate funding support from Welsh Government.

All Wales Capital Programme

The pandemic has had an adverse impact on the progress of a number of schemes planned to commence on site during the first quarter of 2020/21 (ie. extension/refurbishment of Ruthin Hospital, Substance Misuse units at Holyhead and Shotton and the Integrated Dementia unit at Bryn Beryl hospital) . However, these schemes have now all commenced and mitigating measures have been implemented to maintain social distancing and minimise risks. It is expected that these measures will further extend the overall programme and potentially increase the out turn cost. Welsh Government have issued guidance on the contractual implications of covid-19. The Health Board is providing details of the potential programme and cost implications to Welsh Government via the monthly progress reports and is actively pursuing measures to mitigate programme and cost risks.

Due to the challenges of releasing staff to attend project boards and design user groups alternative governance arrangements were put in place to allow the designs of the Royal Alexandra Hospital (formerly known as North Denbighshire Community hospital) and the redevelopment of the Ablett unit to progress. However, physical surveys could not progress during quarter 1 and the development of the business cases have therefore been delayed. Both the full business case for the Royal Alexandra hospital and the outline business case for the Ablett unit are expected to be submitted to the committee in October.

It should be noted that since the approval of the outline business case for the Royal Alexandra hospital the Welsh Government have issued guidance re-basing the calculation of capital cost for all business cases this, combined with adapting the design to respond to the Welsh Government's climate emergency, the necessity to appoint a new supply chain partner and the condition of the existing building, are all expected to increase the target cost for the project.

Discretionary Capital Programme

In July the committee agreed the following programme:

	£m	£m
Commitments brought forward		
- YGC brokerage	1.500	
- Wrexham Maelor Isolation suites	1.600	
- Mental health	0.400	
- PACU equipment	0.169	
- Year 2 pressure vessel replacement	0.300	3.969
Risk and compliance		
Medical devices urgent replacement		1.700
Backlog maintenance:		
- West	0.500	
- Centre	0.500	
- East	0.250	
- BCU wide – asbestos and fire protection	0.250	1.500
Facilities		0.150
Informatics core replacements		1.500
Compliance:		
- Wrexham Maelor continuity	1.000	
- YGC – refurbishment of aseptic unit	0.350	
- YGC maternity ward HIW inspection	0.200	
- Health and safety gap analysis	0.250	1.800
COVID-19 contingency		3.802
TOTAL		**14.421**

The capital programme groups are now progressing the approved programmes and schemes.

The hospital management team at Ysbyty Wrecsam Maelor have reviewed the programme and works to create the isolation suites. Due to the impact of the works on the existing services and potential reduction in bed capacity they have now requested that the scheme is delayed until the new year.

Potential additional COVID-19 expenditure

The Welsh Government have indicated that additional funding will be made available to support the establishment of field hospitals and initial surge capacity. However, they are unable to guarantee any further funding pending a review of total resource requirements. As a consequence the programme includes a contingency for potential additional expenditure in support of our further response to the pandemic.

In preparation for a potential "second wave", as indicated by the current modelling, the Health Board has reviewed the initial response to the pandemic and identified the following additional capital requirements:

	£m	**£m**
Contingency		3.802
Invasive Ventilators (previously approved)	1.692	
Filtered water to critical care units	0.097	
Environmental works to Cynydd ward, Ablett unit	0.361	
YG – increase ITU capacity	0.548	
YGC – Ward 14 ventilation and infection prevention	0.187	
WMH – infection prevention works	0.350	
WMH – increase dialysis capacity on Cunliffe ward	0.031	
Sub-total	3.266	(3.266)
	Remaining	**0.536**

The above have been reviewed and supported by the Executive Team and/or the Estates Improvement Group.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **27.8.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Finance Report Month 4 2020/21**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Eric Gardiner, Finance Director - Provider Services
Craffu blaenorol: **Prior Scrutiny:**	Acting Executive Director of Finance
Atodiadau **Appendices:**	Appendix 1: Summary of Position by Division Appendix 2: COVID-19 Expenditure & Income Appendix 3: Savings Appendix 4: Income Appendix 5: Expenditure Appendix 6: Financial Risks and Opportunities Appendix 7: Prescribing Analysis

Argymhelliad / Recommendation:

It is asked that the report is noted.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the financial performance of the Health Board as at 31 July 2020 and reflects the financial impact of the continuing response to the COVID-19 pandemic.

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, was to deliver a deficit of £40m, based on achieving savings of £45m. The plan did not take into account the impact of COVID-19, and therefore it will change throughout the year; the Health Board has also submitted plans for both Q1 and Q2 to Welsh Government which incorporate the impact of Covid-19 and we are currently developing a consolidated plan for the second half of the financial year.

In the first four months of the year, expenditure has been considerably higher than planned due to the pandemic response and we have already seen that savings delivery has been significantly impacted, as the Health Board prioritised the clinical and operational response to the pandemic. The uncertainty about the potential resurgence of COVID-19 and the essential infection prevention measures that have been implemented means that the forecast expenditure is much higher than planned and savings delivery will be significantly reduced for the remainder of the year.

Due to the uncertainty around the costs related to COVID-19 and the number of unknown variables, forecasting a position for 2020/21 will be extremely difficult. The Health Board is currently anticipating

that the plan of a £40m deficit will be achieved. This is based on the assumption that all COVID-19 costs will be funded by Welsh Government although this remains a significant risk to the financial plan and Appendix 2 includes a new table which clearly splits the anticipated income between allocated, received and assumed.

Asesiad / Assessment:

1.0 Strategy Implications

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

2.0 Options considered

Not applicable – report is for assurance only.

3.0 Financial Implications

3.1 Summary

Current Month		Year to Date		Full Year Forecast	
Plan	£3.3m Deficit	Plan	£13.3m Deficit	Plan	£40.0m Deficit
Actual	£3.3m Deficit	Actual	£13.3m Deficit	Forecast	£40.0m Deficit
Variance	Balanced	Variance	Balanced	Variance	Balanced

Achievement Against Key Targets

Revenue Resource Limit	✓	Public Sector Payment Policy (PSPP)	✓
Savings & Recovery Plans	✗	Revenue Cash Balance	✓
Capital Resource Limit	✓	Medium Term Plan	✗

- Key points for the month:
  - The Health Board's balanced position is based on the assumption that Welsh Government will provide funding to neutralise the impact of COVID-19. This assumption is under review.
  - Progress on savings schemes has been limited and it is forecast that there will be a shortfall of £30.8m against the target. This is currently included as a cost of COVID-19.
  - Excluding COVID-19 impacts, Prescribing over spends are the most significant area of concern, with month on month increasing spend and a £2.9m over spend.

3.2 Revenue Position

	Actual				Cumulative		
	M01	M02	M03	M04	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	(154.7)	(128.5)	(133.2)	(140.1)	(556.5)	(556.5)	0.0
Miscellaneous Income	(9.7)	(9.8)	(9.3)	(9.6)	(44.2)	(38.4)	5.8
Health Board Pay Expenditure	65.0	66.1	68.1	67.3	269.2	266.5	(2.7)
Non-Pay Expenditure	102.8	75.5	77.7	85.7	344.8	341.7	(3.1)
Total	**3.4**	**3.3**	**3.3**	**3.3**	**13.3**	**13.3**	**(0.0)**

- Overview (Appendix 1): The £3.3m in-month deficit, £13.3m year to date deficit, is in line with the plan for Month 4. This position assumes that all COVID-19 costs incurred by the Health Board are fully funded. The value of Welsh Government funding available for COVID-19 has not yet been confirmed and this is therefore a significant risk to the financial position. Following discussions with Welsh Government, the Health Board is reviewing its income assumptions around anticipated COVID-19 funding, with a view to effecting any amendments in Month 5.

- Impact of COVID-19 (Appendix 2): The overall net cost of COVID-19 on the year to date position is £52.6m. Some specific funding sources have been redirected to COVID-19 to provide funding of £2.4m. £17.5m of Welsh Government income has been received to cover year to date costs and a further £32.7m of Welsh Government funding anticipated, giving a nil overall impact on the position.

	M01	M02	M03	M04	YTD
	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	46.9
Lost income	1.2	1.4	1.2	1.6	5.4
Non delivery of savings	3.7	3.6	2.0	2.7	12.0
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(10.0)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(1.3)
Cluster funding	0.0	0.0	(0.3)	(0.1)	(0.4)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0
Total COVID-19 costs	**30.8**	**5.1**	**7.5**	**9.2**	**52.6**
Funding:					
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(1.6)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	(0.1)
WG - anticpated & received	(30.8)	(5.1)	(7.5)	(6.8)	(50.2)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

WG funding received	(17.5)
WG funding anticipated	(32.7)
Total	**(50.2)**

In Month 4, actual expenditure was £7.1m. Offsetting underspends are seen in Elective Care, where activity has significantly reduced as part of the pandemic response, with limited planned activity in July leading to cost reductions of £2.6m. In addition, there has been £0.5m slippage against some investments planned for 2020/21 and the use of £0.1m of Cluster funding. This gives a total cost of COVID-19 for July of £8.2m.

- Forecast: The Health Board is anticipating that it will achieve the £40.0m deficit, as per the financial plan, at the end of the year, on the basis that all COVID-19 costs are fully funded by Welsh Government. Any changes to income assumptions for anticipated Welsh Government COVID-19 funding will impact on this forecast.

- Savings (Appendix 3): The identification of savings plans and the delivery of plans already identified has been severely impacted by COVID-19. Savings are currently forecast to under deliver by £30.8m against the £45.0m target.

- Further details on income and expenditure are included in Appendix 4 and Appendix 5.

3.3 Balance Sheet

- Cash: The closing cash balance for July was £3.1m, which included £2.5m cash held for capital projects. The revenue cash balance of £0.6m was within the internal target set by the Health Board. The cash flow forecast is currently reporting a shortfall of £38.7m at the end of the year. The Health Board will consider all possible actions to minimise the level of Strategic Cash Assistance required, with current forecasts indicating that £32.7m will be required from Welsh Government to support payments.

- Capital: The Capital Resource Limit (CRL) for 2020/21 is £23.9m. Actual expenditure to the end of July was £5.4m, which was in line with the plan.

- PSPP: The Health Board achieved the PSPP target to pay 95% of non-NHS invoices within 30 days.

4.0 Risk Analysis (Appendix 6)
There are currently four identified risks to the financial position and one opportunity.

5.0 Legal And Compliance
Not applicable.

6.0 Impact Assessment
Not applicable.

Appendix 1 – Summary of Position by Division

	M01 Actual £000	M02 Actual £000	M03 Actual £000	M04 Actual £000	Cumulative Budget £000	Cumulative Actual £000	Variance £000
WG RESOURCE ALLOCATION	(154,715)	(128,474)	(133,260)	(140,076)	(556,524)	(556,524)	0
AREA TEAMS							
West Area	13,969	13,417	13,666	14,796	54,746	55,073	327
Central Area	18,101	17,247	18,204	18,507	70,419	71,319	899
East Area	19,908	19,137	19,730	21,713	78,648	79,598	950
Other North Wales	364	2,706	3,017	3,022	10,618	11,461	842
Field Hospitals	25,037	(539)	1,043	735	26,280	26,280	0
Commissioner Contracts	17,951	17,816	16,890	17,659	72,225	70,316	(1,910)
Provider Income	(1,170)	(1,252)	(1,195)	(1,211)	(7,238)	(4,827)	2,410
Total Area Teams	94,160	68,532	71,354	75,222	305,698	309,218	3,520
SECONDARY CARE							
Ysbyty Gwynedd	8,248	8,076	8,561	8,942	33,550	33,820	270
Ysbyty Glan Clwyd	10,151	10,259	10,480	10,557	41,556	41,445	(111)
Ysbyty Maelor Wrexham	9,054	8,930	9,199	9,185	35,721	36,214	492
North Wales Hospital Services	8,520	8,074	8,807	8,826	33,790	34,227	436
Womens	3,404	3,514	3,264	3,516	13,387	13,697	310
Total Secondary Care	39,377	38,853	40,310	41,026	158,004	159,402	1,397
Total Mental Health & LDS	10,920	10,773	11,349	11,295	44,128	44,337	209
CORPORATE							
Chief Executive	213	209	225	257	689	904	214
Chief Operating Officer	0	0	233	164	831	873	42
Estates & Facilities	4,729	4,564	4,631	4,610	17,923	18,533	610
Utilities & Rates	1,508	1,409	1,482	1,414	5,500	5,812	312
Executive Director of Finance	739	761	750	734	2,955	2,984	29
Executive Director of Nursing & Midwifery	1,074	1,041	973	952	3,924	3,837	(86)
Executive Medical Director	1,760	1,839	1,725	1,748	6,851	7,097	246
Executive Director of Workforce & OD	1,068	1,157	1,619	1,218	4,235	5,063	828
Director of Planning & Performance	159	229	200	203	859	804	(55)
Executive Director of Public Health	135	88	67	93	462	383	(79)
Director of Corporate Services	0	0	0	0	0	0	(0)
Office to the Board	162	98	93	61	375	341	(34)
Director of Therapies	54	28	30	19	124	105	(19)
Executive Director of Primary Care & Comm Services	66	64	74	74	338	277	(61)
Director of Turnaround	98	98	110	8	492	315	(178)
Total Corporate	11,765	11,585	12,211	11,555	45,558	47,328	1,770
Total Other Budgets incl. Reserves	1,897	2,059	1,352	4,316	16,469	9,624	(6,845)
TOTAL	**3,404**	**3,329**	**3,317**	**3,338**	**13,333**	**13,383**	**50**

Appendix 2 – COVID-19 Expenditure and Breakdown of Income

Significant additional expenditure has been incurred as a result of COVID-19, including pay costs, spend on the establishment of the Field Hospitals, beds, equipment and consumable items (medical, surgical, cleaning, etc). Total spend in July was £7.1m, £46.9m for the year to date.

Type	M01 £000	M02 £000	M03 £000	M04 £000	Total £000
Other Income	(30)	30	0	0	0
Total Income	**(30)**	**30**	**0**	**0**	**0**
Additional Clinical Services	170	357	683	532	1,742
Administrative & Clerical	166	427	417	374	1,384
Allied Health Professionals	22	50	57	116	245
Estates & Ancillary	(15)	36	166	148	335
Healthcare Scientists	10	34	15	10	69
Medical and Dental	437	648	1,255	1,523	3,863
Nursing and Midwifery Registered	313	383	1,729	1,592	4,018
Professional Scientific & Technical	0	18	43	73	134
Total Pay	**1,103**	**1,953**	**4,365**	**4,368**	**11,789**
Primary Care	(10)	21	42	395	448
Primary Care Drugs	0	0	0	0	0
Secondary Care Drugs	129	61	38	89	318
Clinical Services & Supplies	1,129	580	387	120	2,216
General Services & Supplies	589	378	444	160	1,572
Healthcare Services Provided by Other NHS Bodies	0	10	5	5	20
Continuing Care and Funded Nursing Care	338	655	712	1,128	2,833
Establishment & Transport Expenses	66	92	52	25	234
Premises and Fixed Plan	25,352	(522)	1,420	585	26,835
Other Non-Pay	133	480	(212)	189	589
Total Non-Pay	**27,725**	**1,754**	**2,889**	**2,696**	**35,064**
Total	**28,798**	**3,737**	**7,254**	**7,064**	**46,853**

Appendix 2 – COVID-19 Expenditure and Breakdown of Income

Type	M01 £000	M02 £000	M03 £000	M04 £000	Total £000
Field Hospitals	25,041	(539)	1,043	735	26,280
Area Teams	607	947	1,852	2,228	5,635
Secondary Care	2,133	2,033	2,811	2,940	9,917
Mental Health	289	427	788	641	2,145
Corporate	728	868	759	441	2,796
Other Budgets	0	0	1	79	80
Total	**28,798**	**3,737**	**7,254**	**7,064**	**46,853**

Month 4 COVID-19 Expenditure Detail

Type	Description	West Area £000	Centre Area £000	East Area £000	Field Hospitals £000	Ysbyty Gwynedd £000	Ysbyty Glan Clwyd £000	Ysbyty Wrexham Maelor £000	North Wales Hospital Services £000	Womens £000	Mental Health £000	Corporate £000	Other Budgets £000	Grand Total £000
Pay	Additional Clinical Services	43	78	82	21	132	96	139	(3)	1	71	(128)	0	532
	Administrative & Clerical	1	(1)	0	27	12	(20)	1	0	0	7	347	0	374
	Allied Health Professionals	54	41	19	2	0	0	0	0	0	0	0	0	116
	Estates & Ancilliary	0	3	0	10	0	0	0	0	0	0	135	0	148
	Healthcare Scientists	0	0	0	0	1	0	0	9	0	0	0	0	10
	Medical and Dental	14	11	156	10	501	177	356	23	133	127	15	0	1,523
	Nursing and Midwifery Registered	142	129	133	31	268	211	265	22	238	142	11	0	1,592
	Professional Scientific & Technical	8	51	0	0	5	5	1	0	0	0	3	0	73
Total Pay		**262**	**312**	**390**	**101**	**919**	**469**	**762**	**51**	**372**	**347**	**383**	**0**	**4,368**
Non-Pay	Primary Care	222	65	108	0	0	0	0	0	0	0	0	0	395
	Secondary Care Drugs	0	5	0	10	0	39	30	5	0	0	0	0	89
	Clinical Services & Supplies	(59)	15	9	27	36	10	40	20	3	7	12	0	120
	General Services & Supplies	(2)	21	21	26	15	52	29	(4)	1	4	(3)	0	160
	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	5	0	0	0	5
	Continuing Care and Funded Nursing Care	352	343	186	0	0	0	0	0	0	247	0	0	1,128
	Establishment & Transport Expenses	1	2	2	11	(8)	3	1	(1)	1	1	12	0	25
	Premises and Fixed Plan	(125)	18	9	560	9	24	40	5	1	14	30	0	585
	Other Non-Pay	1	12	57	0	4	5	0	3	0	21	7	79	189
Total Non-Pay		**390**	**481**	**392**	**634**	**56**	**133**	**140**	**28**	**11**	**294**	**58**	**79**	**2,696**
Total		**652**	**793**	**782**	**735**	**975**	**602**	**902**	**79**	**383**	**641**	**441**	**79**	**7,064**

Appendix 2 – COVID-19 Expenditure and Breakdown of Income

Anticipated income for COVID-19, split between allocated, received and assumed is shown below.

Year to Date					
Category of Expenditure	**Total Cost £m**	**Total Income £m**	**Allocated Income £m**	**Of Which Received £m**	**Assumed Income £m**
Pay costs	11.6	(11.6)	(5.4)	(5.4)	**(6.2)**
Non-pay costs	11.5	(11.5)	(2.9)	(2.5)	**(8.6)**
Field Hospital commissioning costs	23.6	(23.6)	(23.6)	(12.1)	**0.0**
Test Trace Protect (TTP) costs	0.2	(0.2)			**(0.2)**
Lost income	5.4	(5.4)			**(5.4)**
FRG identifed savings (£27.8m)	9.3	(0.3)			**(0.3)**
Savings plans identified at M04 (£14.2m)	(3.0)				
Undelivered savings (£17.2m)	5.7				
Elective underspend	(10.0)				
Slippage on planned investments (incl. Clusters)	(1.7)				
Total	**52.6**	**(52.6)**	**(31.9)**	**(20.0)**	**(20.7)**

2020/21 Forecast					
Category of Expenditure	**Total Cost £m**	**Total Income £m**	**Allocated Income £m**	**Of Which Received £m**	**Assumed Income £m**
Pay costs	23.1	(23.1)	(5.4)	(5.4)	**(17.7)**
Non-pay costs	40.3	(40.3)	(4.8)	(3.5)	**(35.5)**
Field Hospital commissioning costs	23.6	(23.6)	(23.6)	(12.1)	**0.0**
Test Trace Protect (TTP) costs	14.5	(14.5)	(11.2)		**(3.3)**
Lost income	13.9	(13.9)			**(13.9)**
FRG identifed savings (£27.8m)	27.8	(9.2)			**(9.2)**
Savings plans identified at M04 (£14.2m)	(14.2)				
Undelivered savings (£17.2m)	17.2				
Elective underspend	(19.3)				
Slippage on planned investments (incl. Clusters)	(2.3)				
Total	**124.6**	**(124.6)**	**(45.0)**	**(21.0)**	**(79.6)**

The full year forecast for 2020/21 assumes income of £124.6m. Of this, £45.0m has been notified to the Health Board, leaving a risk of £79.6m.

Appendix 2 – COVID-19 Expenditure and Breakdown of Income

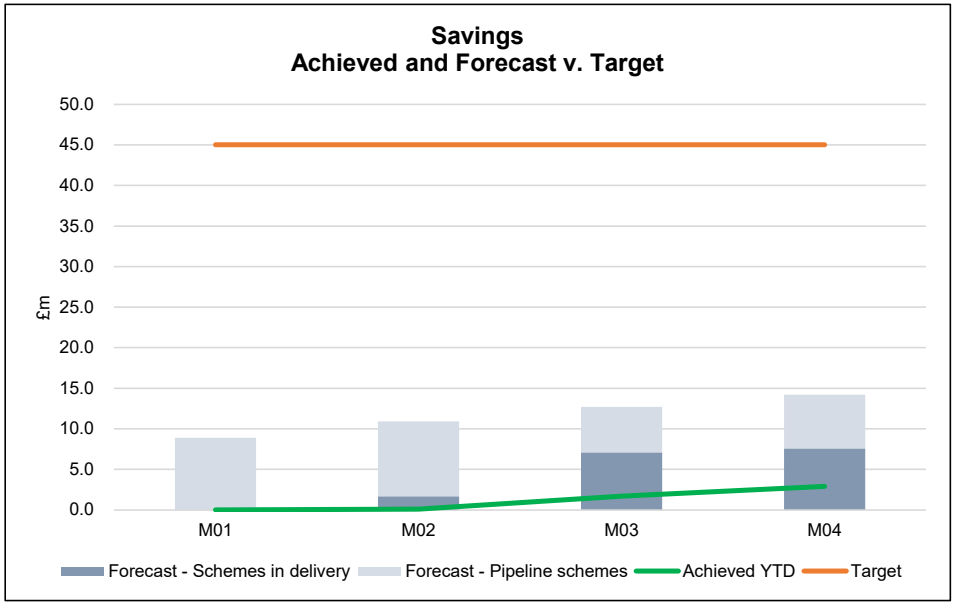
Notes:

- Savings have been split between the plans identified by the FRG at the start of the year and prior to the pandemic, a total of £27.8m, and the remaining £17.2m of savings required, but where no plans had been identified.
- Savings targets are pro-rata for the YTD figures.
- All achieved/forecast savings have been allocated to savings identified at the start of the year.
- Elective underspend and slippage on investments used to offset non-delivery of savings.

Appendix 3 – Savings

The financial plan for 2020/21 is based on delivering savings of £45.0m, equating to 3.6% of recurrent base budget (excluding ring-fenced budgets). Savings of £1.2m are reported in Month 4, increasing the overall year to date delivery to £2.9m. The Month 4 figure includes some retrospective savings for schemes not identified in Month 3. The year to date delivery is a £12.0m shortfall against the target, which has been included as a cost of COVID-19.

The total in-year forecast for savings, including pipeline, has increased by £1.5m from last month to £14.2m, of which £11.2m is recurrent. This leaves a shortfall of £30.8m against the full year savings target.



In addition to this forecast, schemes that remain in the pipeline amount to £6.6m. Work is progressing to fully develop these schemes and move them into amber and green over the next two months. The full year effect of pipeline schemes, totalling £9.4m, is an estimate at this stage and requires further validation. Critical areas such as workforce will depend upon the ability to deploy sufficient support and resource to re-instate the Improvement Group work programme that was operating in 2019/20 and this forms the basis of the estimates. The Executive Team is currently considering options and capacity requirements for the savings delivery and PMO function to be re-established. This will ensure that there is dedicated capacity available to not only drive the schemes currently identified, but also to develop further opportunities for both in-year savings and the 2021/22 programme.

Appendix 3 – Savings

	Savings Target £000	Year to Date YTD Savings Target £000	Year to Date Savings Delivered £000	Year to Date Variance £000	Forecast Recurring Forecast £000	Forecast Non-Recurring Forecast £000	Forecast Total Forecast £000	Forecast FYE £000	Variance £000
SCHEMES IN DELIVERY									
Ysbyty Gwynedd	4,167	1,389	326	(1,063)	332	308	640	683	**(3,526)**
Ysbyty Glan Clwyd	5,079	1,693	38	(1,655)	38	0	38	111	**(5,041)**
Ysbyty Wrexham Maelor	4,414	1,471	193	(1,279)	142	307	449	252	**(3,966)**
North Wales Managed Services	4,300	1,433	173	(1,260)	463	10	473	575	**(3,828)**
Womens Services	1,733	578	37	(541)	152	0	152	174	**(1,581)**
Secondary Care	**19,692**	**6,564**	**766**	**(5,798)**	**1,127**	**625**	**1,751**	**1,796**	**(17,941)**
Area - West	4,402	1,467	489	(978)	1,412	275	1,687	1,462	**(2,716)**
Area - Centre	6,408	2,136	537	(1,599)	1,681	0	1,681	1,775	**(4,727)**
Area - East	6,464	2,155	591	(1,564)	158	1,142	1,300	158	**(5,164)**
Area - Other	607	202	0	(202)	0	0	0	0	**(607)**
Contracts	1,000	333	0	(333)	0	0	0	0	**(1,000)**
Area Teams	**18,881**	**6,294**	**1,617**	**(4,677)**	**3,251**	**1,417**	**4,667**	**3,395**	**(14,213)**
MHLD	1000	0	420	420	1,000	0	1,000	1,000	**0**
Corporate	5,426	1,809	93	(1,715)	109	42	151	109	**(5,275)**
Total Schemes in Delivery	**45,000**	**14,667**	**2,896**	**(11,771)**	**5,486**	**2,084**	**7,570**	**6,300**	**(37,429)**

PIPELINE SCHEMES									
Ysbyty Gwynedd					257	0	257	151	
Ysbyty Glan Clwyd					353	0	353	360	
Ysbyty Wrexham Maelor					201	138	338	208	
North Wales Managed Services					74	0	74	178	
Womens Services					0	0	0	0	
Secondary Care					**885**	**138**	**1,023**	**897**	
Area - West					65	0	65	65	
Area - Centre					1,180	0	1,180	1,215	
Area - East					19	15	34	33	
Area - Other					0	0	0	0	
Contracts					0	0	0	0	
Area Teams					**1,264**	**15**	**1,279**	**1,313**	
MHLD					0	0	0	0	
Corporate					189	758	947	592	
Total Divisional Pipeline Schemes					**2,338**	**910**	**3,249**	**2,803**	
Medicines Management IG					150	0	150	150	
Procurement IG					2,000	0	2,000	2,000	
Workforce IG					1,236	0	1,236	4,438	
Total Improvement Group Holding Schemes					**3,386**	**0**	**3,386**	**6,588**	
Total Pipeline Schemes					**5,725**	**910**	**6,635**	**9,391**	

Total Programme	**45,000**				**11,211**	**2,994**	**14,205**	**15,691**	**(30,794)**

Appendix 4 – Income

Most of the Health Board's funding is from the Welsh Government allocation through the Revenue Resource Limit (RRL). Confirmed allocations to date are £1,545.9m, with further anticipated allocations in year of £136.1m, a total forecast Revenue Resource Limit (RRL) of £1,682.0m for the year.

Description	£m
Allocations Received	
Total Confirmed Funding	1,545.9
Sub-total Allocations Received	1,545.9
Allocations Anticipated	
Covid-19 costs	110.2
Substance Misuse	5.5
Mental Health Service Improvement Fund	3.0
IM&T Refresh Programme	1.9
Community Cardiology Scheme	1.8
Prevention and Early Year Funding for 2019-20	1.3
MSK Orthopaedic Services	1.2
WHSSC annual requirement for 0.8% inflation uplift	1.1
Vocational Training	1.0
Outpatients Transformational Fund Bid	0.8
Consultant Clinical Excellence Awards	0.5
SpRs	0.4
Mental Health Individual Placement Support (IPS)	0.4
WAST Emergency Services Mobile Communications Programme (ESMCP)	0.3
A Healthier Wales - Rehabiliation, Reablement and Recovery	0.2
Community Cardiology Scheme	0.2
Delivery Plan Palliative Care	0.2
Suicide Prevention	0.1
Capital Adjustment	6.0
Sub-total Allocations Anticipated	**136.1**
Total Allocations as at Month 4	**1,682.0**

Appendix 4 – Income

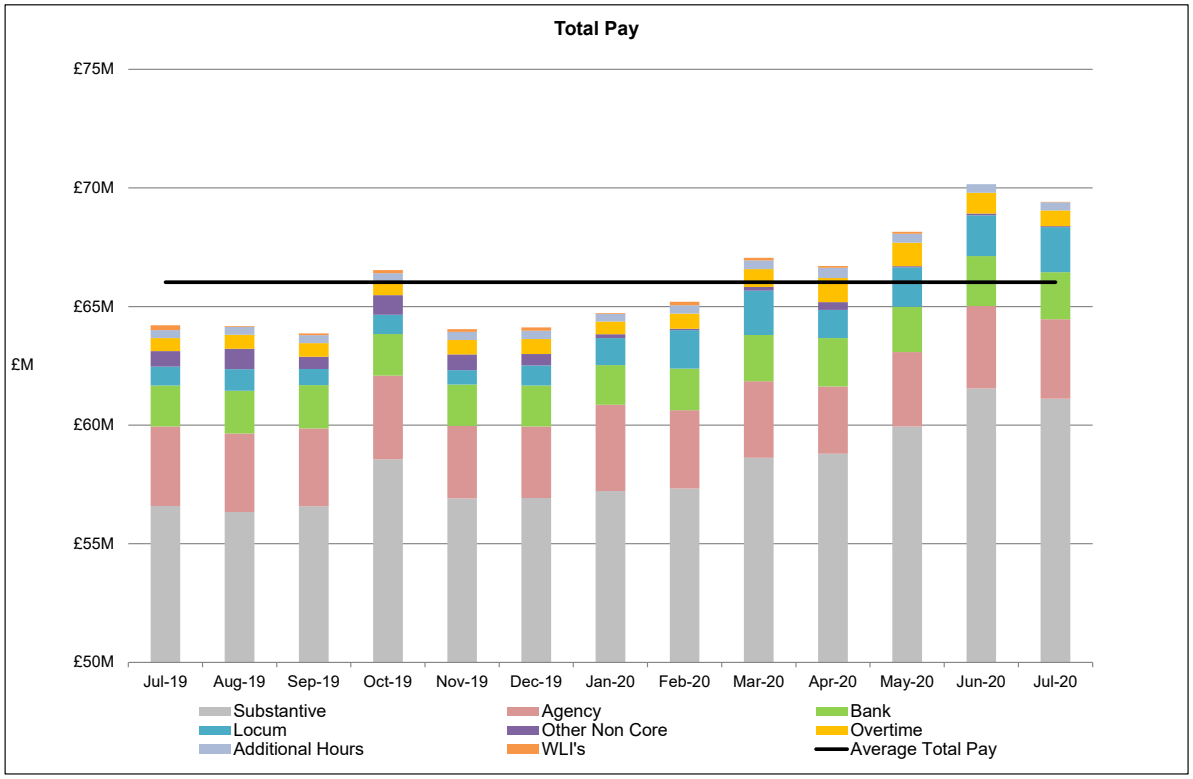
Miscellaneous income is showing a year to date shortfall of £5.8m, of which £5.4m is due to the impact of the pandemic on some of the Health Board's income streams. This has been included as a cost of COVID-19.

Loss of Income to Month 4	Total £m
Dental Patient Charge Revenue	2.3
Non-contracted activity (NCAs)	2.4
Other	0.7
Total Income	**5.4**

Appendix 5 – Expenditure

Pay Expenditure

Health Board pay costs in July are £67.3m, a decrease of £0.8m from last month. Month 4 spend includes £4.4m of pay costs directly related to COVID-19, the same as last month, with variable pay costs of £8.3m (12.3% of pay), which is £0.3m lower than in June. Overall, pay is under spent against budget (£2.7m year to date).



Appendix 5 – Expenditure

	Actual				Cumulative		
	M01 £m	M02 £m	M03 £m	M04 £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Administrative & Clerical	8.6	8.8	8.8	8.6	37.1	34.8	(2.3)
Medical & Dental	15.2	15.6	15.5	16.1	60.1	62.4	2.3
Nursing & Midwifery Registered	20.6	20.8	21.2	20.6	87.8	83.2	(4.6)
Additional Clinical Services	9.4	9.5	9.8	9.3	35.6	38.0	2.4
Add Prof Scientific & Technical	3.1	3.1	3.0	3.0	12.9	12.2	(0.7)
Allied Health Professionals	3.8	3.8	4.0	4.0	15.1	15.6	0.5
Healthcare Scientists	1.1	1.2	1.2	1.2	4.8	4.7	(0.1)
Estates & Ancillary	3.2	3.2	3.4	3.3	13.5	13.1	(0.4)
Students	0.0	0.1	1.2	1.2	2.3	2.5	0.2
Health Board Total	**65.0**	**66.1**	**68.1**	**67.3**	**269.2**	**266.5**	(2.7)
Primary care	1.7	2.1	2.0	2.1	6.4	7.9	1.5
Total Pay	**66.7**	**68.2**	**70.1**	**69.4**	**275.6**	**274.4**	(1.2)

Variable Pay	M01 £m	M02 £m	M03 £m	M04 £m	Total £m
Agency	2.8	3.1	3.5	3.3	12.7
Overtime	1.0	1.0	0.9	0.7	3.6
Locum	1.2	1.7	1.7	1.9	6.5
WLIs	0.1	0.1	0.0	0.0	0.2
Bank	2.1	1.9	2.1	2.0	8.1
Other Non Core	0.3	0.0	0.1	0.0	0.4
Additional Hours	0.4	0.4	0.3	0.4	1.5
Total	**7.9**	**8.2**	**8.6**	**8.3**	**33.0**

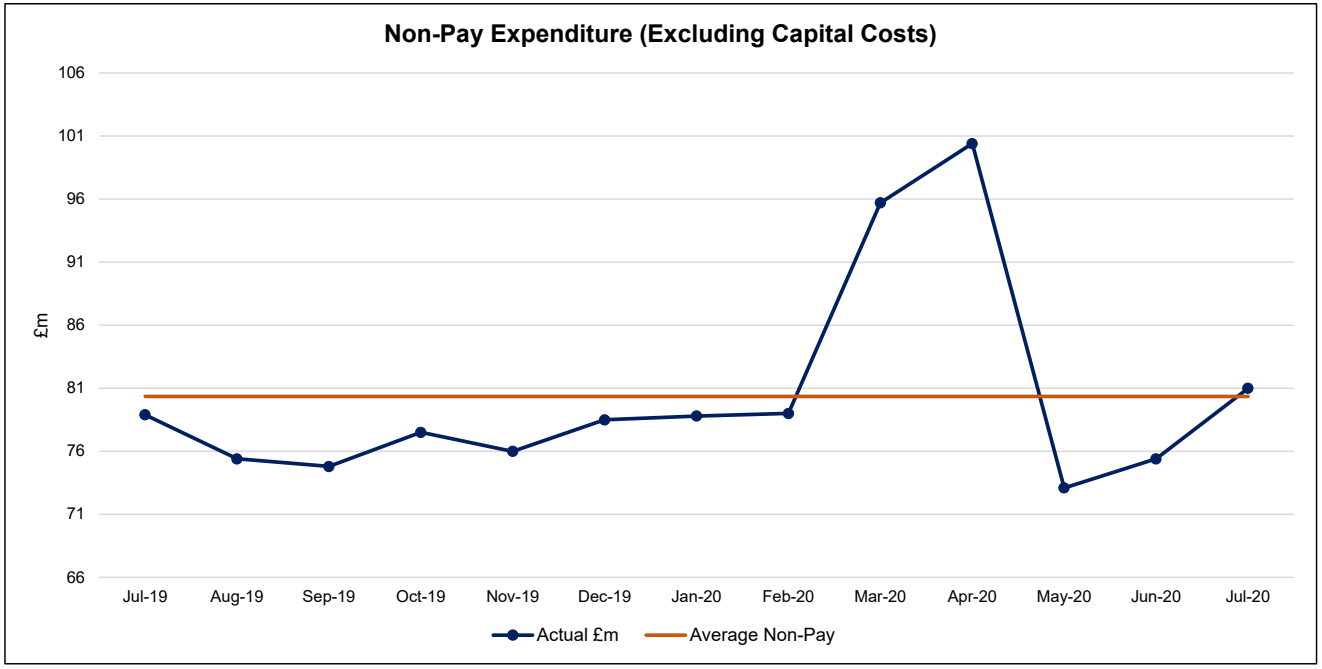
Areas of note are:

- Medical and Dental pay has increased by £0.8m from last month, with £0.3m of the increase relating to COVID-19. This includes some backdated payments to doctors for work during the height of the pandemic. In addition, there have been increases in agency (£0.1m) and locum costs (£0.2m).
- All other pay categories showed reduced costs compared to Month 3. Overtime costs are down by £0.2m and bank costs by £0.1m.
- Agency costs for Month 4 are £3.3m (4.8% of pay), a decrease of £0.1m from last month. Agency spend related to COVID-19 in July was £0.9m, compared to £0.5m in June. Medical agency costs have increased by £0.1m to an in-month spend of £1.6m. Nurse agency costs totalled £1.2m for the month, the same as in June. Other agency costs fell by £0.2m to £0.5m for July and mainly arise from Admin and Clerical (£0.3m) and Allied Health Professionals (£0.2m).

Appendix 5 – Expenditure

Non-Pay Expenditure

Costs this month are £8.0m higher than in June at £85.7m, with a year to date under spend of £3.1m. Month 4 non-pay costs include £2.7m directly related to COVID-19 (£35.1m year to date).



Appendix 5 – Expenditure

	Actual				Cumulative		
	M01	M02	M03	M04	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m	£m	£m
Primary Care	17.2	17.5	15.9	17.6	70.2	68.2	(2.0)
Primary Care Drugs	8.9	8.6	10.5	11.0	36.1	39.0	2.9
Secondary Care Drugs	5.4	5.0	5.5	5.8	23.4	21.7	(1.7)
Clinical Supplies	4.8	3.6	4.2	4.6	21.9	17.2	(4.7)
General Supplies	2.7	2.6	2.1	4.7	12.7	12.1	(0.6)
Healthcare Services Provided by Other NHS Bodies	22.7	22.7	21.5	22.3	90.7	89.2	(1.5)
Continuing Care and Funded Nursing Care	8.4	8.2	9.1	9.0	35.9	34.7	(1.2)
Other	30.3	4.9	6.6	6.0	42.1	47.8	5.7
Non-pay costs	**100.4**	**73.1**	**75.4**	**81.0**	**333.0**	**329.9**	(3.1)
Cost of Capital	2.4	2.4	2.3	4.7	11.8	11.8	0.0
Total non-pay including cost of capital	**102.8**	**75.5**	**77.7**	**85.7**	**344.8**	**341.7**	(3.1)

The main areas of significance this month are:

- **Primary Care**: Expenditure in July has returned to the same level as at the start of the year, following an adjustment in June arising from the quarterly review of General Dental Services (GDS) and the reduced patient charge income that is expected this year.
- **Primary Care drugs:** GP prescribing and dispensing costs are a significant concern in 2020/21. The rolling average annual cost continues on an upward trend. As a result, costs are £0.5m higher than reported last month. A detailed analysis of the position is included in Appendix 7.
- **General Supplies:** Spend against Intermediated Care Funding (ICF) has increased significantly this month, as plans are developed and implemented. This has contributed £2.9m to the increase in expenditure.
- **Healthcare Services Provided by Other NHS Bodies**: Due to the agreement to maintain payments to other NHS organisations via block contracts, most contractual payments are fixed, despite those organisations only undertaking very low levels of activity on behalf of the Health Board.
- **Continuing Healthcare (CHC)**: Expenditure in July has decreased by £0.1m compared to June. COVID-19 related costs of £1.1m were incurred in Month 4, to give a year to date spend of £2.8m. Efforts to review placements and packages, particularly for those patients discharged due to COVID-19, continue. Excluding COVID-19 costs, CHC expenditure is £0.2m more than last month. The increase relates to a number of new high cost Mental Health placements, in addition to an in-month increase in package costs.
- **Cost of Capital**: Additional Capital funding that has been received for numerous schemes, including COVID-19 requirements, has led to a £2.4m increase in depreciation costs this month. These costs are fully funded.

Appendix 6 – Financial Risks and Opportunities

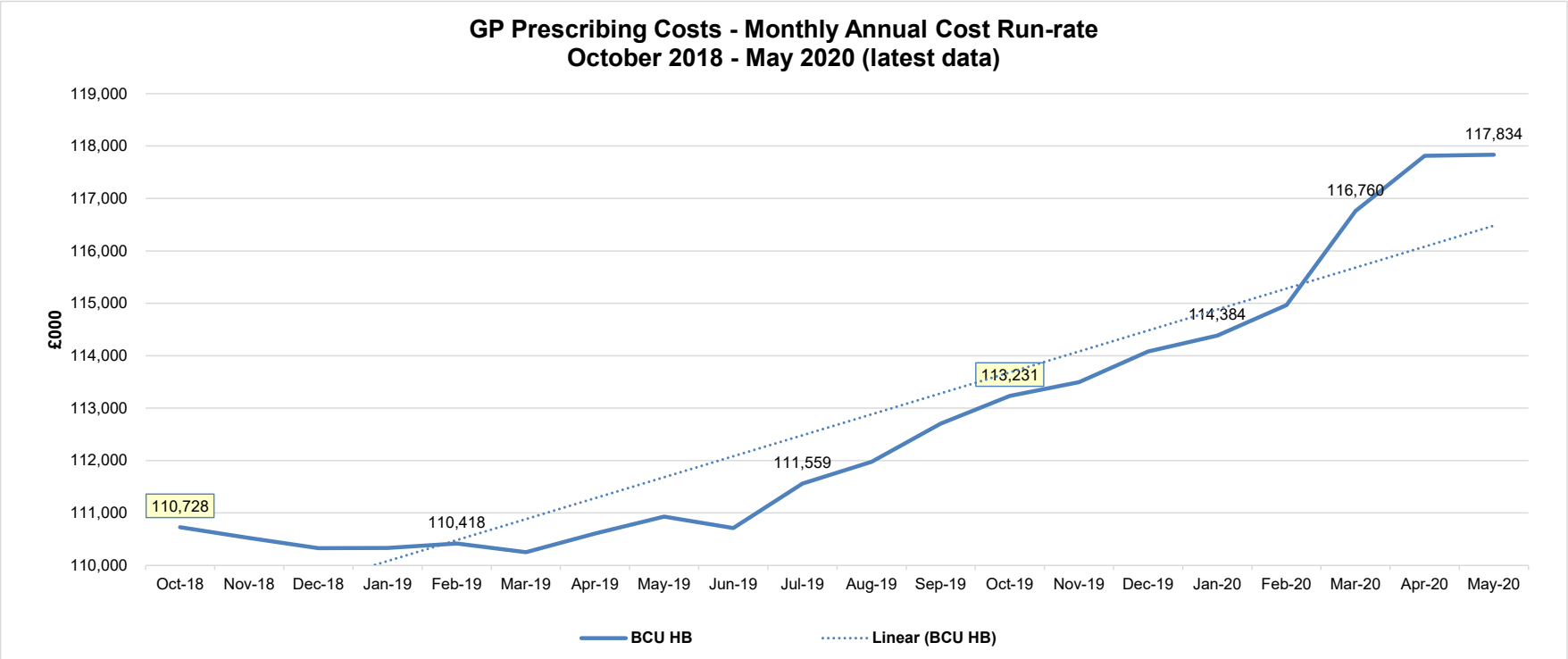
	Issue	Description	£m	Key Decision Point & Summary Mitigation	Risk Owner
1	**Opportunity:** Red Pipeline Savings Schemes	– Red rated savings schemes that total £6.6m are currently held in pipeline and are due to start delivering over the next two months.	(6.6)	– Work is progressing to move these schemes into amber / green in the coming months. It is expected that all current schemes will be amber or green by the end of September:	Sue Hill, Acting Executive Director of Finance
2	**Risk:** WG COVID-19 Funding	– Income has been anticipated for the estimated cost of COVID-19 for 2020/21, less funding already received. Welsh Government has not yet confirmed that this will all be funded and so it is a significant risk to the financial position. The operational plan is still being developed and so all costs are only indicative at this stage.		– The finance team are reviewing expenditure and savings against the original plan to clearly identity which costs have been funded by WG and which categories are unfunded. This will support discussion about the level of risk and what mitigating steps can be taken to reduce the income risk for the remaining months of the year.	Sue Hill, Acting Executive Director of Finance
3	**Risk:** Welsh Risk Pool (WRP) Risk Share	– The projected increased cost of the Welsh Risk Pool (WRP) Risk Share is a risk to the Health Board's forecast for 2020/21.	2.5	– The cost is being monitored and all-Wales discussions taking place through Deputy Director of Finance meetings.	Sue Hill, Acting Executive Director of Finance
4	**Risk:** Junior Doctor Monitoring	– There was a significant test legal case focusing on how NHS organisations should address monitoring for junior doctors.		– It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.	Sue Green, Executive Director of Workforce & Organisational Development
5	**Risk:** Holiday Pay	– NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement are ongoing and the outcome of the Supreme Court appeal is awaited.		– The Health Board is monitoring the situation and will respond appropriately to any legal decision.	Sue Green, Executive Director of Workforce & Organisational Development

Appendix 7 – Prescribing Analysis

Primary Care Prescribing data (activity and costs) is received two months in arrears and is managed through Shared Services.

Based upon the latest available data, the range in forecast outturn expenditure for BCU is between £118m and £126m. This would lead to an over spend in the range of £5m to £13m.

The Month 4 Financial Position is based upon the highest and most prudent approach, which is supported by the underlying growth trend in the rolling 12-month annualised costs, as shown in the following chart.



Prescribing costs are typically driven by three key elements:

Appendix 7 – Prescribing Analysis

- The number of prescribing days in each month. The average cost per prescribing day across the Health Board is £0.5m.
- The number of items prescribed and the make-up of those items in terms of generic or branded drugs.
- The cost of each drug, recognising that reimbursement tariffs to pharmacists are set nationally at UK level.

Across the Health Board the average cost per prescribing day over the last three month period increased by 6.3%.

Following the release of the May 2020 data, the below table shows the all-Wales costs and usage to May 2019/20 compared to the costs and usage to May 2020/21.

Health Board	2019/20		2020/21		Movement 2019/20 to 2020/21		% Movement Amount	% Movement Items
	£000	Items	£000	Items	£000	Items	%	%
Cwm Taf	14,208	2,186	15,304	2,151	**1,096**	-35	7.7%	-1.6%
Betsi Cadwaladr	18,742	2,940	19,817	2,879	**1,074**	-61	5.7%	-2.1%
Aneurin Bevan	16,740	2,697	17,758	2,636	**1,018**	-61	6.1%	-2.3%
Swansea Bay	11,188	1,729	11,879	1,693	**691**	-36	6.2%	-2.1%
Hywel Dda	11,765	1,735	12,415	1,698	**650**	-37	5.5%	-2.1%
Cardiff & Vale	12,414	1,718	12,950	1,645	**537**	-73	4.3%	-4.2%
Powys	3,913	581	4,211	575	**299**	-6	7.6%	-1.1%
Total	**56,020**	**8,460**	**59,213**	**8,247**	**3,195**	**-213**	**5.7%**	**-2.5%**

This shows that there has been an comparative increase in GP Prescribing costs of £5.4m in the first two months of 2020/21 across NHS Wales, and that whilst there is a reduction of more than 300,000 items prescribed (2.3%), the increased cost must be largely due to price changes (typically Category M drugs or No Cheaper Stock Obtainable (NCSO)). After allowing for the reduction in items, the overall cost increase is 6%.

If this trend continues, this could result in a full year cost increase for the Health Board of £6.5m and up to £32.0m across NHS Wales.

NCSO

The table below highlights the top-10 most significant increases in NCSO drugs for the Health Board, comparing the tariff prices in May 2019 and May 2020, along with an assessment of the additional cost impact of these price increases in the actual April and May 2020 prescribing position:

Appendix 7 – Prescribing Analysis

Drug	May 2019 Price (pre NSCO) £	May 2020 Price (post NCSO) £	Increase %	Cost Impact (M01 & M02) £000
Cyanocobalamin	12.49	14.17	113%	300.0
Gabapentin	4.94	11.58	234%	194.0
Mirtazapine	1.00	2.36	236%	43.0
Mometasone	1.66	4.80	289%	26.0
Perindopril	2.49	4.71	189%	23.0
Ranitidine (150mg)	0.92	5.80	630%	16.0
Ranitidine (300mg)	1.12	5.85	522%	11.0
Sertraline (50mg)	1.09	8.09	742%	11.0
Sertraline (100mg)	1.47	14.44	982%	11.0
Tolterodine	1.94	16.76	864%	10.0
Total				**645.0**

In the first two months of the financial year, these top-10 NCSO increases have resulted in a cost increase of £0.6m.

At an average of £0.3m per month, should these NCSO concession tariff rates remain in place for the full financial year, the additional cost impact is estimated at £4.0m, which would suggest that NCSO accounts for 62% of the overall potential £6.5m estimated cost increase for 2020/21.

Further Prescribing Analysis Overview

In addition to the NCSO impact, the Pharmacy & Medicines Management business information analysis team has highlighted the following key 2020/21 cost pressures per month.

Appendix 7 – Prescribing Analysis

Issue	Description	Pressure per Month £000	Time Limit
Direct Oral Anticoagulants (DOACS)	GPs switching existing Warfarin patients to DOACS. This is the preferred option for patients with cardiac disease based on safety data.	150	End of the financial year
General Prescribing	Underlying growth in monthly costs not accounted for by DOACS.	100	Ongoing
June Cat M Price Increase	In recent years, Category M drugs have seen a continued rise in Tariff rates.	200	Elevated costs - September 2020 at least
Total		**450**	

On a positive note, comparing the May 2020 prescribing data to the April 2020 data for BCU shows a slight reduction in unit cost:

The overall cost per item has reduced in May compared to April, with each Area as follows:

- Cost per Item West £6.45 (-1.24% reduction)
- Cost per Item Centre £6.83 (-1.63% reduction)
- Cost per Item East £7.12 (-0.55% reduction)
- **Cost per Item BCU wide £6.84 (-1.13% reduction)**

The overall number of items per prescribing day increased in May (70,630) compared to April (70,374 / +0.4%):

- Change in Items Per Prescribing Day West +1.4% (increase)
- Change in Items Per Prescribing Day Centre -2.3% (reduction)
- Change in Items per Prescribing Day East +1.1% (increase)
- **Change in Items BCU wide + 0.4% (increase)**

The Medicines Management Teams continue to work locally and nationally to identify and deliver savings and mitigations to cover the cost pressures; however, this remains a significant risk to the Health Board financial position.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **27.8.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Finance Report Month 3 2020/21**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Eric Gardiner, Finance Director - Provider Services
Craffu blaenorol: **Prior Scrutiny:**	Acting Executive Director of Finance
Atodiadau **Appendices:**	Appendix 1: Summary of Position by Division Appendix 2: Covid-19 Impact Appendix 3: Savings Appendix 4: Welsh Government Allocations Appendix 5: Expenditure Appendix 6: Financial Risks and Opportunities

Argymhelliad / Recommendation:

It is asked that the report is noted.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the financial performance of the Health Board as at June 2020 and reflects the financial impact of the continuing response to the Covid-19 pandemic.

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m and is based on delivering savings of £45m. The plan did not take into account the impact of Covid-19, and therefore it will change throughout the year. It is likely that spending will be higher than planned due to the pandemic response and savings delivery will be significantly reduced as the Health Board prioritises the clinical and operational response to the pandemic, particularly in the early months of the year.

Due to the uncertainty around the costs of Covid-19 and the number of unknown variables, forecasting a position for 2020/21 will be extremely difficult. The Health Board is currently anticipating that the plan of a £40m deficit will be achieved. This is based on the assumption that all Covid-19 costs will be funded by Welsh Government although this remains a significant risk to the financial plan.

Asesiad / Assessment:

1.0 Strategy Implications

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

2.0 Options considered

Not applicable – report is for assurance only.

3.0 Financial Implications

3.1 Summary

Current Month		Year to Date		Full Year Forecast	
Plan	£3.3m Deficit	Plan	£10.m Deficit	Plan	£40.0m Deficit
Actual	£3.3m Deficit	Actual	£10.0m Deficit	Forecast	£40.0m Deficit
Variance	Balanced	Variance	Balanced	Variance	Balanced

Achievement Against Key Targets

Revenue Resource Limit	✓	Public Sector Payment Policy (PSPP)	✗
Savings & Recovery Plans	✗	Revenue Cash Balance	✓
Capital Resource Limit	✓	Medium Term Plan	✗

3.2 Revenue Position

	Actual			Cumulative		
	M01 £m	M02 £m	M03 £m	Budget £m	Actual £m	Variance £m
Revenue Resource Limit	(154.7)	(128.5)	(133.2)	(416.4)	(416.4)	0.0
Miscellaneous Income	(9.7)	(9.8)	(9.3)	(33.0)	(28.8)	4.2
Health Board Pay Expenditure	65.0	66.1	68.1	200.5	199.2	(1.3)
Non-Pay Expenditure	102.8	75.5	77.7	258.9	256.0	(2.9)
Total	**3.4**	**3.3**	**3.3**	**10.0**	**10.0**	**0.0**

- Overview (Appendix 1): The £3.3m in-month deficit, £10.0m year to date deficit, is in line with the plan for Month 3. This position assumes that all Covid-19 costs incurred by the Health Board are fully funded. The value of Welsh Government funding available for Covid-19 has not yet been confirmed and this is therefore a significant risk to the financial position.

- Impact of Covid-19 (Appendix 2): The cost of Covid-19 for the year to date is £44.7m (£7.8m in Month 3), of which Intermediate Care Fund (ICF) and Cluster monies have funded £1.3m. £17.5m of Welsh Government income has been received to date with a further £25.9m of anticipated funding, to give a nil impact on the position.

	M01 £m	M02 £m	M03 £m	YTD £m
Covid-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	39.8
Lost income	1.2	1.4	1.2	3.8
Non delivery of savings	3.7	3.6	2.0	9.3
Elective underspend	(2.4)	(2.8)	(2.2)	(7.4)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.8)
Total Covid-19 costs	**31.1**	**5.8**	**7.8**	**44.7**
ICF funding	(0.3)	(0.7)	0.0	(1.0)
Cluster funding	0.0	0.0	(0.3)	(0.3)
WG funding - anticpated & received	(30.8)	(5.1)	(7.5)	(43.4)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**

WG funding received	(17.5)
WG funding anticipated	(25.9)
Total	**(43.4)**

Significant additional non-pay expenditure has been incurred as a result of Covid-19, including spend on the establishment of the Field Hospitals, beds, equipment and consumable items (medical, surgical, cleaning, etc). Spend in June was £7.3m. Offsetting underspends are seen in Elective Care, where activity has significantly reduced as part of the pandemic response, with limited planned activity in June leading to cost reductions of £2.2m. In addition, there has been £0.5m slippage against some investments planned for 2020/21.

- Savings (Appendix 3): The financial plan for 2020/21 is based on delivering savings of £45.0m, equating to 3.6% of budget. Savings of £1.6m are reported in Month 3, increasing the overall delivery to £1.7m for Quarter 1. The Month 3 figure includes some retrospective savings for schemes not identified in Month 2. The year to date delivery is a £9.3m shortfall against the target, which has been included as a cost of Covid-19. The total in-year forecast for savings, including pipeline, has increased by £1.8m from last month to £12.7m, of which £9.5m is recurrent. This leaves a shortfall of £32.3m against the full year savings target. In addition, schemes that remain in the pipeline amount to £5.6m. Work is progressing to fully develop these schemes and move them into amber and green over the next three months. The full year effect of pipeline schemes, totalling £9.0m, is an estimate and requires further validation. Critical areas such as workforce will depend upon the ability to deploy sufficient support and resource to re-instate the Improvement Group work programme that was operating in 2019/20 and this forms the basis of the estimates. The Executive Team is currently considering options and capacity requirements for the savings delivery and PMO function to be re-established. This will ensure that there is dedicated capacity available to not only drive the schemes currently identified, but also to develop further opportunities for both in-year savings and the 2021/22 programme.

- Forecast: Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year is extremely difficult. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

3.3 Income and Expenditure

- Income (Appendix 4): Most of the Health Board's funding is from the Welsh Government allocation through the Revenue Resource Limit (RRL). Confirmed allocations to date are £1,542.7m, with further anticipated allocations in year of £145.6m, a total forecast RRL of £1,688.3m for the year.

Miscellaneous income is showing a year to date shortfall of £4.3m, of which £3.8m is due to the impact of the pandemic on some of the Health Board's income streams. This has been included as a cost of Covid-19.

Loss of Income to Month 3	Total £m
Dental Patient Charge Revenue	1.8
Non-contracted activity (NCAs)	1.5
Private patient income	0.3
Other	0.2
Total Income	**3.8**

- Pay expenditure (Appendix 5): Health Board pay costs in June are £68.1m, an increase of £2.0m from last month and £5.2m above the 2019/20 average. Month 3 spend includes £4.4m of pay costs directly related to Covid-19, £2.4m higher than in May, which accounts for much of the increase.

  Areas of note are:
  - Covid-19 pay costs contain £1.1m for Band 3 and 4 student nurses (second and final year students respectively) who were recruited by the Health Board as a nursing initiative in response to the pandemic. The majority of these staff commenced in post in Month 2, but no costs were reported. Therefore, Month 3 includes two months costs for these posts.
  - Total variable pay in June was £8.9m, 12.2% of total pay. This is an increase of £0.4m on May and £0.9m above the average for 2019/20. Additional costs relate to agency (£0.4m) and bank (£0.2m).
  - Agency costs for Month 3 are £3.5m, 4.9% of total pay, an increase of £0.4m from last month. Agency spend related to Covid-19 in June was £0.5m, compared to £0.3m in May. Medical agency costs have increased by £0.1m to an in-month spend of £1.5m. Nurse agency costs totalled £1.2m for the month, £0.2m higher than in May. Other agency costs remained at £0.7m for June and mainly arise from Admin and Clerical (£0.4m) and Allied Health Professionals (£0.3m).

- Non-pay expenditure (Appendix 5): Costs this month are £2.2m higher than in May at £77.7m. Month 3 non-pay costs include £2.9m directly related to Covid-19 (£32.4m year to date).

  The main areas of significance this month are:
  - Primary Care: General Dental Services (GDS) Contractors received 80% of the agreed 2020/21 contract value in Quarter 1. Costs of the main dental contract have decreased by £0.8m in June, as the quarterly GDS figures have been reviewed and adjusted to reflect the 20% reduction in contract payments. GP Practices are continuing to offer services, albeit with limited face-to-face patient access, and therefore are receiving the usual core General Medical Services (GMS) contract payments in full.
  - Primary Care drugs: Costs have increased by £1.9m in the month and are a significant concern this year. The rolling average annual cost continues on an unprecedented upward trend and the first prescribing data for 2020/21 (April 2020) received this month showed a significant increase in the cost of items compared to 2019 levels. The actual costs for April were £0.6m higher than had been estimated, which has been adjusted in the Month 3 position. The April data has been used to update the average cost per prescribing day calculations, affecting the estimates for May and June reflected in the Month 3 position.
  - Healthcare Services Provided by Other NHS Bodies: Due to the agreement to maintain payments to other NHS organisations via block contracts, most contractual payments are fixed, despite those organisations only undertaking very low levels of activity on behalf of the Health Board. There has been a reduction in Month 3 spend of £0.9m due to the WHSCC contract

reporting an under spend from delayed developments and adjustments to some of the block contract payments.

- Continuing Healthcare (CHC): Expenditure in June has increased by £0.9m. This is due to patients being transferred into CHC placements to create capacity in acute settings because of Covid-19.
- Other non-pay expenditure: Spend has increased by £1.7m, with £1.2m arising from additional Covid-19 costs. There has also been a small increase in planned care activity, which has increased non-pay costs.

3.3 Balance Sheet

- Cash: The closing cash balance for June was £4.1m, which included £2.7m cash held for capital projects. The revenue cash balance of £1.4m was within the internal target set by the Health Board. The cash flow forecast is currently reporting a shortfall of £38.7m at the end of the year. The Health Board will consider all possible actions to minimise the level of Strategic Cash Assistance required, with current forecasts indicating that £32.7m will be required from Welsh Government to support payments.

- Capital: The Capital Resource Limit (CRL) for 2020/21 is £23.1m. Actual expenditure up to June was £3.3m, which was £1.3m ahead of plan. This is primarily due to Covid-19 expenditure.

- PSPP: The Health Board achieved the PSPP target to pay 95% of non-NHS invoices within 30 days.

4.0 Risk Analysis (Appendix 6)

There are four risks to the financial position and one opportunity.

5.0 Legal And Compliance

Not applicable.

6.0 Impact Assessment

Not applicable.

Appendix 1 – Summary of Position by Division

	M01 Actual £000	M02 Actual £000	M03 Actual £000	Cumulative Budget £000	Cumulative Actual £000	Variance £000
WG RESOURCE ALLOCATION	(154,715)	(128,474)	(133,260)	(416,448)	(416,448)	0
AREA TEAMS						
West Area	13,969	13,417	13,666	39,684	40,277	593
Central Area	18,101	17,247	18,204	51,844	52,811	967
East Area	19,908	19,137	19,730	56,875	57,885	1,010
Other North Wales	364	2,706	3,017	7,964	8,439	475
Field Hospitals	25,037	(539)	1,043	25,544	25,544	0
Commissioner Contracts	17,951	17,816	16,890	53,889	52,656	(1,232)
Provider Income	(1,170)	(1,252)	(1,195)	(5,113)	(3,617)	1,496
Total Area Teams	94,160	68,532	71,354	230,687	233,996	3,309
SECONDARY CARE						
Ysbyty Gwynedd	8,248	8,076	8,561	24,867	24,878	11
Ysbyty Glan Clwyd	10,151	10,259	10,480	31,129	30,890	(239)
Ysbyty Maelor Wrexham	9,054	8,930	9,199	26,634	27,029	395
North Wales Hospital Services	8,520	8,074	8,807	25,021	25,401	379
Womens	3,404	3,514	3,264	9,875	10,181	307
Total Secondary Care	39,377	38,853	40,310	117,527	118,379	852
Total Mental Health & LDS	10,920	10,773	11,349	32,682	33,042	360
CORPORATE						
Chief Executive	213	209	225	519	647	128
Chief Operating Officer	0	0	233	507	709	202
Estates & Facilities	4,729	4,564	4,631	13,688	13,923	235
Utilities & Rates	1,508	1,409	1,482	3,925	4,398	473
Executive Director of Finance	739	761	750	2,208	2,250	42
Executive Director of Nursing & Midwifery	1,074	1,041	973	2,853	2,882	30
Executive Medical Director	1,760	1,839	1,725	5,100	5,350	250
Executive Director of Workforce & OD	1,068	1,157	1,619	3,297	3,845	548
Director of Planning & Performance	159	229	200	640	601	(40)
Executive Director of Public Health	135	88	67	352	290	(62)
Director of Corporate Services	0	0	0	0	0	(0)
Office to the Board	162	98	93	305	279	(26)
Director of Therapies	54	28	30	102	86	(16)
Executive Director of Primary Care & Comm Services	66	64	74	253	203	(50)
Director of Turnaround	98	98	110	450	306	(143)
Total Corporate	11,765	11,585	12,211	34,199	35,769	1,571
Total Other Budgets incl. Reserves	1,897	2,059	1,352	11,354	5,308	(6,046)
TOTAL	**3,404**	**3,329**	**3,317**	**10,000**	**10,046**	**46**

Appendix 2 – Covid-19 Impact

Type	M01 £000	M02 £000	M03 £000	Total £000
Other Income	(30)	30	0	0
Total Income	**(30)**	**30**	**0**	**0**
Additional Clinical Services	170	357	683	1,210
Administrative & Clerical	166	427	417	1,010
Allied Health Professionals	22	50	57	129
Estates & Ancillary	(15)	36	166	187
Healthcare Scientists	10	34	15	59
Medical and Dental	437	648	1,255	2,340
Nursing and Midwifery Registered	313	383	1,729	2,426
Professional Scientific & Technical	0	18	43	61
Total Pay	**1,103**	**1,953**	**4,365**	**7,421**
Primary Care	(10)	21	42	53
Primary Care Drugs	0	0	0	0
Secondary Care Drugs	129	61	38	228
Clinical Services & Supplies	1,129	580	387	2,096
General Services & Supplies	589	378	444	1,411
Healthcare Services Provided by Other NHS Bodies	0	10	5	15
Continuing Care and Funded Nursing Care	338	655	712	1,705
Establishment & Transport Expenses	66	92	52	210
Premises and Fixed Plan	25,352	(522)	1,420	26,250
Other Non-Pay	133	480	(212)	400
Total Non-Pay	**27,725**	**1,754**	**2,889**	**32,368**
Total	**28,798**	**3,737**	**7,254**	**39,789**

Funded via ICF	**338**	**669**	**453**	**1,460**
Funded via Clusters	**0**	**0**	**316**	**316**
Funded by Welsh Government	**28,460**	**3,068**	**6,485**	**38,013**

Appendix 2 – Covid-19 Impact

Type	M01 £000	M02 £000	M03 £000	Total £000
Field Hospitals	25,041	(539)	1,043	25,545
Area Teams	607	947	1,852	3,407
Secondary Care	2,133	2,033	2,811	6,977
Mental Health	289	427	788	1,504
Corporate	728	868	759	2,355
Other Budgets	0	0	1	1
Total	**28,798**	**3,737**	**7,254**	**39,789**

Month 3 Covid-19 Expenditure Detail

Type	Description	West Area £000	Centre Area £000	East Area £000	Field Hospitals £000	Ysbyty Gwynedd £000	Ysbyty Glan Clwyd £000	Ysbyty Wrexham Maelor £000	North Wales Hospital Services £000	Womens £000	Mental Health £000	Corporate £000	Other Budgets £000	Grand Total £000
Pay	Additional Clinical Services	67,981	62,677	17,642	6,703	123,059	57,442	130,765	13,439	1,949	67,413	134,333	0	683,403
	Administrative & Clerical	6,183	24,768	0	47,719	22,818	9,016	0	2,165	0	17,573	285,157	1,275	416,676
	Allied Health Professionals	22,261	2,035	8,987	6,776	0	0	0	16,652	0	0	457	0	57,169
	Estates & Ancilliary	0	0	0	13,742	0	0	2,448	0	0	0	149,480	0	165,670
	Healthcare Scientists	0	0	0	0	1,064	0	0	14,024	0	0	0	0	15,089
	Medical and Dental	18,027	70,911	64,589	0	398,760	160,424	270,867	23,763	121,366	126,538	0	0	1,255,246
	Nursing and Midwifery Registered	130,698	165,365	156,554	32,753	292,114	301,844	249,508	36,307	59,733	289,138	15,382	0	1,729,395
	Professional Scientific & Technical	11,713	22,804	0	4,744	0	0	0	0	0	0	3,500	0	42,761
Total Pay		**256,864**	**348,560**	**247,773**	**112,438**	**837,815**	**528,726**	**653,588**	**106,352**	**183,048**	**500,661**	**588,310**	**1,275**	**4,365,409**
Non-Pay	Primary Care	560	6,890	34,393	0	0	0	0	0	0	0	0	0	41,843
	Primary Care Drugs	0	0	0	7	0	0	0	0	0	0	0	0	7
	Secondary Care Drugs	0	1,072	0	399	11,226	9,347	16,411	0	0	0	0	0	38,455
	Clinical Services & Supplies	70,566	8,182	2,111	36,522	47,179	61,199	105,885	22,989	12,384	3,052	16,977	0	387,046
	General Services & Supplies	15,391	80,390	25,341	23,928	17,411	(35,071)	72,292	33,101	1,357	22,839	187,293	0	444,272
	Healthcare Services Provided by Other NHS Bodies	0	0	0	0	0	0	0	0	4,944	0	0	0	4,944
	Continuing Care and Funded Nursing Care	156,250	118,655	199,693	0	0	0	0	0	0	237,802	0	0	712,400
	Establishment & Transport Expenses	2,451	3,171	912	19,205	7,887	2,377	30	2,075	0	1,995	12,027	0	52,130
	Premises and Fixed Plan	141,104	23,645	20,688	1,169,918	42,225	11,928	13,139	24,416	4,079	21,234	(52,642)	365	1,420,099
	Other Non-Pay	145	14,830	72,212	(319,708)	0	12,058	0	0	570	10	7,393	0	(212,491)
Total Non-Pay		**386,468**	**256,835**	**355,350**	**930,271**	**125,928**	**61,839**	**207,756**	**82,580**	**23,334**	**286,932**	**171,048**	**365**	**2,888,705**
Total		**643,331**	**605,394**	**603,123**	**1,042,709**	**963,743**	**590,565**	**861,344**	**188,932**	**206,382**	**787,593**	**759,358**	**1,640**	**7,254,113**

Appendix 3 – Savings

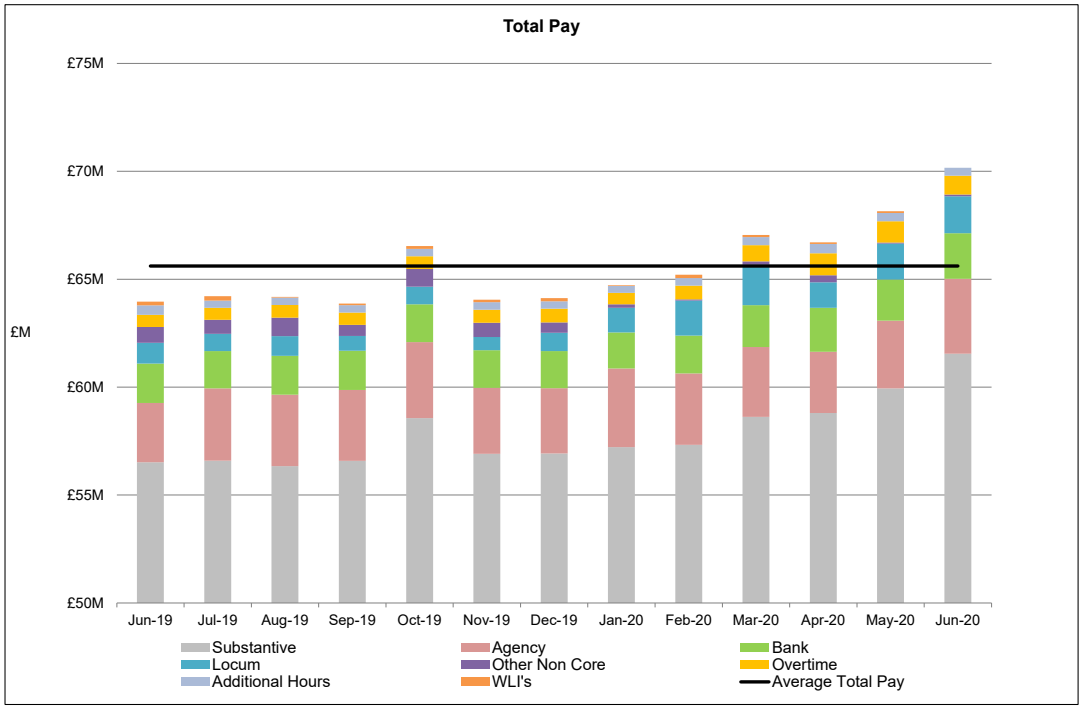
	Year to Date			Forecast			
	YTD Plan	YTD Actual	YTD Variance	Recurring Forecast	Non-Recurring Forecast	Total Forecast	Forecast FYE
	£000	£000	£000	£000	£000	£000	£000
SCHEMES IN DELIVERY							
Ysbyty Gwynedd	156	177	22	506	112	618	612
Ysbyty Glan Clwyd	0	0	0	0	0	0	0
Ysbyty Wrexham Maelor	120	113	(7)	225	414	639	225
North Wales Managed Services	48	106	58	387	10	397	455
Womens Services	24	24	(0)	161	0	161	183
Secondary Care	**348**	**420**	**72**	**1,279**	**536**	**1,815**	**1,475**
Area - West	209	127	(82)	950	275	1,225	1,000
Area - Centre	206	402	196	1,345	0	1,345	1,775
Area - East	496	498	2	0	1,603	1,603	0
Area - Other	0	0	0	0	0	0	0
Contracts	0	0	0	0	0	0	0
Area Teams	**911**	**1,027**	**116**	**2,295**	**1,878**	**4,173**	**2,775**
MHLD	250	232	(18)	1,000	0	1,000	1,343
Corporate	8	35	27	80	0	80	80
Total Schemes in Delivery	**1,516**	**1,714**	**197**	**4,654**	**2,414**	**7,068**	**5,674**
PIPELINE SCHEMES							
Ysbyty Gwynedd				0	0	0	0
Ysbyty Glan Clwyd				280	0	280	360
Ysbyty Wrexham Maelor				110	0	110	190
North Wales Managed Services				150	0	150	299
Womens Services				0	0	0	0
Secondary Care				**540**	**0**	**540**	**849**
Area - West				390	0	390	375
Area - Centre				200	0	200	470
Area - East				19	15	34	33
Area - Other				0	0	0	0
Contracts				0	0	0	0
Area Teams				**609**	**15**	**624**	**878**
MHLD				0	0	0	0
Corporate				189	800	989	592
Total Divisional Pipeline Schemes				**1,338**	**815**	**2,153**	**2,319**
Medicines Management IG				**233**	**0**	**233**	**233**
Procurement IG				**2,000**	**0**	**2,000**	**2,000**
Workforce IG				**1,236**	**0**	**1,236**	**4,438**
Total Improvement Group Holding Schemes				**3,469**	**0**	**3,469**	**6,670**
Total Pipeline Schemes				**4,807**	**815**	**5,622**	**8,990**
Total Programme				**9,461**	**3,229**	**12,689**	**14,664**

Appendix 4 – Welsh Government Allocations

Description	£m
Allocations Received	
Total Confirmed Funding	1,542.7
Sub-total Allocations Received	1,542.7
Allocations Anticipated	
Covid-19 costs	125.0
Substance Misuse	5.5
Mental Health Service Improvement Fund	3.0
IM&T Refresh Programme	1.9
GMS Contract - In House Access Funding	1.8
Drug Treatment Fund	1.6
Prevention and Early Year Funding for 2019-20	1.3
MSK Orthopaedic Services	1.2
Vocational Training	1.0
Outpatients Transformational Fund Bid	0.8
Single Cancer Pathway	0.6
Consultant Clinical Excellence Awards	0.5
SpRs	0.4
Mental Health Individual Placement Support (IPS)	0.4
Additional Pharmacy Funding 2019-20	0.3
WAST Emergency Services Mobile Communications Programme (ESMCP)	0.3
A Healthier Wales - Rehabiliation, Reablement and Recovery	0.2
Community Cardiology Scheme	0.2
Delivery Plan Palliative Care	0.2
Transfer from GMS Non Dispensing Prcatice Fees	0.2
Capital Adjustment	-0.8
Other	0.0
Sub-total Allocations Anticipated	**145.6**
Total Allocations as at Month 3	**1,688.3**

Appendix 5 – Expenditure

Pay Expenditure

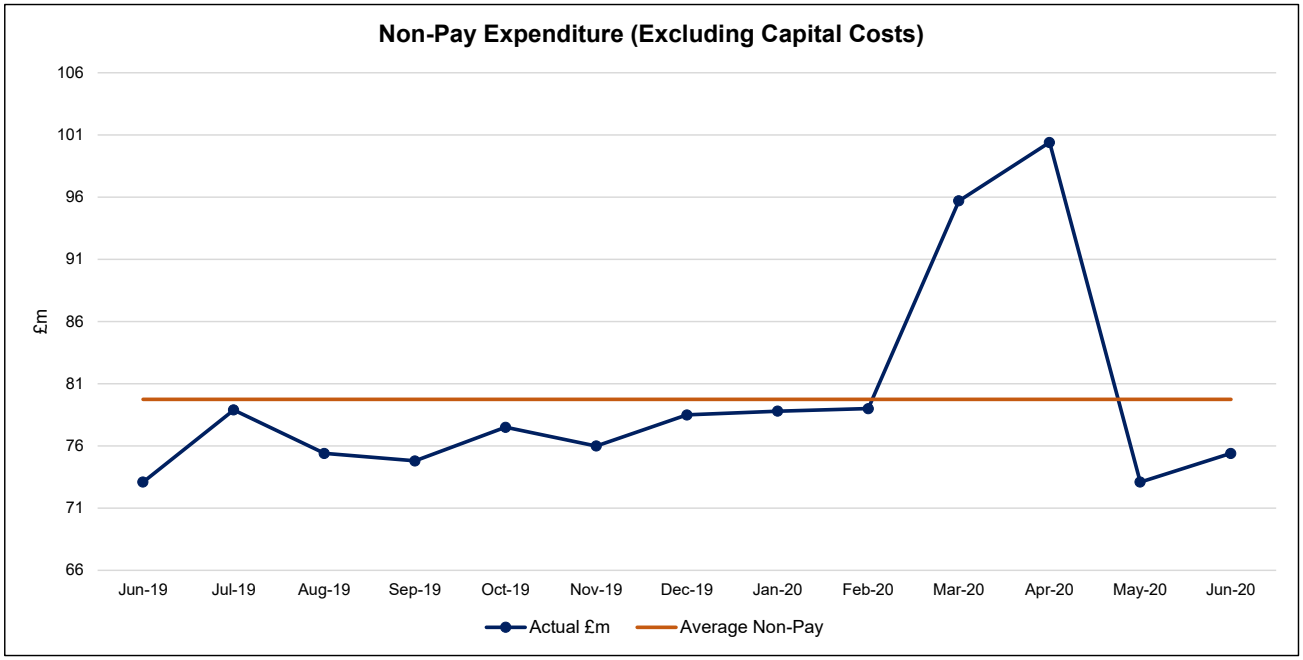


	Actual			Cumulative		
	M01	M02	M03	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m	£m
Administrative & Clerical	8.6	8.8	8.8	27.8	26.2	(1.6)
Medical & Dental	15.2	15.6	15.5	44.5	46.3	1.8
Nursing & Midwifery Registered	20.6	20.8	21.2	66.0	62.6	(3.4)
Additional Clinical Services	9.4	9.5	9.8	26.7	28.7	2.0
Add Prof Scientific & Technical	3.1	3.1	3.0	9.6	9.2	(0.4)
Allied Health Professionals	3.8	3.8	4.0	11.2	11.6	0.4
Healthcare Scientists	1.1	1.2	1.2	3.6	3.5	(0.1)
Estates & Ancillary	3.2	3.2	3.4	10.0	9.8	(0.2)
Students	0.0	0.1	1.2	1.1	1.3	0.2
Health Board Total	**65.0**	**66.1**	**68.1**	**200.5**	**199.2**	**(1.3)**
Primary care	1.7	2.1	2.0	4.8	5.8	1.0
Total Pay	**66.7**	**68.2**	**70.1**	**205.3**	**205.0**	**(0.3)**

Variable Pay	M01	M02	M03	Total
	£m	£m	£m	£m
Agency	2.8	3.1	3.5	9.4
Overtime	1.0	1.0	0.9	2.9
Locum	1.2	1.7	1.7	4.6
WLIs	0.1	0.1	0.0	0.2
Bank	2.1	1.9	2.1	6.1
Other Non Core	0.3	0.0	0.1	0.4
Additional Hours	0.4	0.4	0.3	1.1
Total	**7.9**	**8.2**	**8.6**	**24.7**

Appendix 5 – Expenditure

Non-Pay Expenditure



	Actual			Cumulative		
	M01 £m	M02 £m	M03 £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Primary Care	17.2	17.5	15.9	52.8	50.6	(2.2)
Primary Care Drugs	8.9	8.6	10.5	25.0	28.0	3.0
Secondary Care Drugs	5.4	5.0	5.5	17.0	15.9	(1.1)
Clinical Supplies	4.8	3.6	4.2	16.7	12.6	(4.1)
General Supplies	2.7	2.6	2.1	7.9	7.4	(0.5)
Healthcare Services Provided by Other NHS Bodies	22.7	22.7	21.5	67.8	66.9	(0.9)
Continuing Care and Funded Nursing Care	8.4	8.2	9.1	27.0	25.7	(1.3)
Other	30.3	4.9	6.6	37.6	41.8	4.2
Non-pay costs	**100.4**	**73.1**	**75.4**	**251.8**	**248.9**	(2.9)
Cost of Capital	2.4	2.4	2.3	7.1	7.1	0.0
Total non-pay including cost of capital	**102.8**	**75.5**	**77.7**	**258.9**	**256.0**	(2.9)

Appendix 6 – Financial Risks and Opportunities

	Issue	Description	£m	Key Decision Point & Summary Mitigation	Risk Owner
1	**Opportunity:** Red Pipeline Savings Schemes	– Red rated savings schemes that total £5.6m are currently held in pipeline and are due to start delivering over the next three months.	(5.6)	– Red rated savings schemes that total £5.6m are currently held in pipeline and are due to start delivering over the next three months.	Sue Hill, Acting Executive Director of Finance
2	**Risk:** WG Covid-19 Funding	– Income has been anticipated for the estimated cost of Covid-19 for 2020/21, less funding already received. Welsh Government has not yet confirmed that this will all be funded and so it is a significant risk to the financial position. The operational plan is still being developed and so all costs are only indicative at this stage.		– This reflects a review of all schemes that were in the pipeline programme when the Recovery Programme was suspended, which has identified those schemes which can be mobilised rapidly to generate savings this year.	Sue Hill, Acting Executive Director of Finance
3	**Risk:** Welsh Risk Pool (WRP) Risk Share	– The projected increased cost of the Welsh Risk Pool (WRP) Risk Share is a risk to the Health Board's forecast for 2020/21.	0.1	– The cost is being monitored and all-Wales discussions taking place through Deputy Director of Finance meetings.	Sue Hill, Acting Executive Director of Finance
4	**Risk:** Junior Doctor Monitoring	– There was a significant test legal case focusing on how NHS organisations should address monitoring for junior doctors.		– It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.	Sue Green, Executive Director of Workforce & Organisational Development
5	**Risk:** Holiday Pay	– NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement are ongoing and the outcome of the Supreme Court appeal is awaited.		– The Health Board is monitoring the situation.	Sue Green, Executive Director of Workforce & Organisational Development

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **27.8.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Interim report on Covid 19 Financial Governance**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Nigel McCann, Chief Finance Officer, Chair of Governance Cell
Craffu blaenorol: **Prior Scrutiny:**	Sue Hill, Acting Executive Director of Finance
Atodiadau **Appendices:**	Appendix A – COVID Expenditure Summary Analysis Appendix B – WG letter and Guidance extract of 30th March 2020 Appendix C – Acting Director of Finance letter of 3rd April 2020

Argymhelliad / Recommendation:

The Committee is asked to:

a) *Note the early self-assessment against the key Welsh Government Principles.*
b) *Note that that the formal "Lessons Learned Report" from the Governance Cell will be issued for discussion at the October Committee Meeting.*

Please tick as appropriate

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

Sefyllfa / Situation:

This briefing paper is intended as a precursor to the "Lessons Learned" report from the Finance Governance Self-Assessment Group, and at this stage it provides the Committee with an update against the Health Board compliance with the key Principles set out by the Welsh Government on the 30 March 2020 (ref AG/SE/SB).

Cefndir / Background:

The Welsh Government issued Guidance to Chief Executives on the 30 March 2020 specifically in relation to Decision making and Financial Governance during the COVID (CV19) emergency period and response.

On the 3 April 2020, the Acting Executive Director of Finance shared this Welsh Government Guidance with all Directors and Divisions, clearly setting out the Financial Governance arrangements and controls that were being put in place and expected to be in place across the Divisions.

The Acting Executive Director of Finance established the Financial Governance Cell to review these arrangements.

Asesiad / Assessment & Analysis

1. Strategy Implications

This briefing paper is intended as a pre-cursor to the "Lessons Learned" report from the Finance Governance Self-Assessment Group, which is planned to report in September.

This paper is written to provide the Committee with a specific early summary of the Self-Assessment against the key Principles of Financial Governance set out in the Welsh Government Guidance of the 30th March 2020.

2. Options considered

This is a Briefing Paper to provide the Committee with an update on compliance with Welsh Government Guidance.

3. Financial Summary

Up to Month 4, the Health Board has reported COVID (CV19) related costs of £56million, with a forecast of £122million, across the following key Revenue, Capital and Charitable Funds elements.

Expenditure Type	At Month 4 £ million	Forecast £ million
Divisional Revenue expenditure (Pay & Non Pay)	20.9	50.2
Field Hospitals – set up and decommissioning	23.6	25.8
Field Hospitals – operational running costs	2.5	11.0
Track, Trace & Protect	0.2	14.5
Loss of Income (eg Dental or NHS Contracts)	5.5	13.9
Charitable Funds	0.4	1.2
Capital	2.6	5.1
Total across Revenue, Capital and Charitable Funds	**55.7**	**121.7**

Further analysis of the Revenue and the Capital expenditure is provided in Appendix A.

The Following Table sets out the ten key Governance Principles as set of in the Welsh Government letter of 30th March 2020 and the Self-Assessment against each:

WG Governance Principle	BCU Self-Assessment
Finance will not be a barrier to delivering the operational needs of the service in response to the COVID-19 pandemic but needs to be managed and monitored in a structured manner	- Formal guidance issued to all Directors and divisions by the DoF on the 3rd April. - Divisions used existing systems and processes (Oracle and ESR), ensuring effective and consistent continuity around business processes. - All divisions were allocated dedicated CV19 cost centres in order to separately and uniquely record and track all expenditure. - There have been no formally reported delays in the procurement of goods and services directly as a result of financial controls impeding an urgent order.
Funds will flow to and from NHS Wales' organisations in a timely manner	- Health Board continues to pay all NHS Contracts in accordance with this guidance.

Organisations are expected to work together to ensure that services are not disrupted during this period as a result of cross-border flows and commissioning	- NHS England Guidance issued in March 2020 and adopted by NHS Wales; Contract mechanisms and Payment by Results (PbR) suspended; block contracts mandated. - We continued to pay NHS providers, as set out in the NHS guidance. - There has been some service disruption as all NHS organisations have had to place restrictions on the level of routine elective activity undertaken. See previous note regarding £7.2 million of "lost" activity, which is outside of the direct control of the Health Board.
Requests for COVID-19 funding will be facilitated through a simplified process that balances financial governance and operational need	- Formal guidance issued to all Directors and divisions by the DoF on 3 April. - Revenue and Capital decision—making / funding request forms were issued by the DoF on 3 April to simplify CV19 purchases, although these were not completed for every CV19 purchase. - Accountable Officer letters have been sent to WG detailing financial impact and rationale for CV19 decisions
Organisations will track both the additional costs arising from COVID-19, and reductions in expenditure due to COVID-19 (i.e. reduced elective activity) in a structured and transparent manner	- All Divisions were allocated dedicated CV19 cost centres in order to separately and uniquely record and track all expenditure. - Detail of CV19 costs and financial impact is formally reported to Welsh Government Monthly via the Monitoring Return. - CV19 costs and financial implications are formally reported to the Board every month in the Health Board Finance report. - The CFOs produce monthly Finance Reports to their Divisions, which have specifically highlighted the Divisional-level CV19 costs.
Ensuring an appropriate scheme of delegation is in place and compliance with SFIs. This should include ensuring effective authorisation and signatory systems are in place to minimise any disruption	- The HB did not amend the existing SFIs, SOs or SORDs. - HECC and its sub-structured were formally documented in the (COVID-19 Command, Control & Co Ordination Framework), presented to Cabinet on (16th April 2020). - However as a point of Learning for the future, the HECC did not have a formal SORD in the HB Template. - Contracts for the two main Capital Schemes to create surge capacity in YGC were approved by the Chief Executive and Chairman.
Financial information should be collected in support of COVID-19 which is auditable and evidenced and supported by good documentation of key decisions	- All Divisions were allocated dedicated CV19 cost centres in order to record and track all expenditure. - Revenue and Capital decision-making / funding request forms were issued by the DoF on the 3rd April to simplify CV19 purchases, although these were not completed for every CV19 purchase. - The CFOs produce monthly Finance Reports to their Divisions, which have specifically highlighted the Divisional-level CV19 costs. - Command Structures maintained formal Decision Logs, which have been tested as part of the Governance Cell. - Where, through the Governance Cell, expenditure has been charged against the cost of CV19 which is not strictly CV19 related, this has been reversed and the costs charged back to

	the relevant Divisional Budgets, (at Month 3, this amounted to £0.2m).
Delegation limits and approvals should be documented and followed, having been approved by the Board. The arrangements should also be sufficiently robust and flexible to ensure that authorisation and decisions can take place in the absence of key staff.	- The HB did not change it's SFIs, SOs or SORDs - HECC and its sub-structured were formally documented in the (COVID-19 Command, Control & Co Ordination Framework), presented to Cabinet on (16th April 2020). - Key decisions were delegated to the relevant HECC workstream SROs, to support timely decisions making. - The HB did not implement a revised SORD as part of it pandemic response – the Emergency plan will be revised to include the implementation of a revised SORD.
No new revenue or capital business investments should be progressed unless related to the response to COVID-19, or otherwise expressly approved by Welsh Government.	- The Health Board Capital Discretionary plan for 20/21 was suspended, with all Capital Planning in Quarter 1 July focused on CV19 related schemes. - Revenue investments (eg Field Hospitals, TTP, Surge capacity, PPE) were all directly related to the CV19 response. - WG were notified about operational decisions with a significant financial impact.
From a governance perspective, organisations are also expected to ensure that any proposed service delivery solution in response to COVID-19 have appropriate NHS Indemnity arrangements and advice from Welsh Risk Pool as required	- NHS Wales Welsh Risk Pool issued the formal document "***Indemnity Arrangements During the Coronavirus Pandemic***" which states: - Under section 11 of the Coronavirus Act 2020, WG will provide indemnity for clinical negligence liabilities associated with COVID 19 **which are not already** covered by alternative indemnity arrangements. - Where a field hospital, reception centre or other facility is setup by the NHS, indemnity arrangements can be established. A lead body (Health Board) would become responsible for the indemnity of staff, volunteers and partners deployed to work at that location.

The Following Table compares the BCU approach to a sample of other NHS Wales organisations:

Controlled Question	BCU	Org A	Org B	Org C	Org D	Org E
Did the Organisation Change its SFIs and SOs	N	N	N	N	Y	Y
Did the command structure (HeCC or equivalent) have its own separate SORD	N	N	N	N	Y	Y
Did the Organisation set up a formal Governance Cell in April	Y	N	N	N	N	N
Did each Division have its own unique CV19 cost centre for tracking and monitoring of costs	Y	N	n/a	N	Y	Y
Did the Finance Department have a Business Continuity Plan pre-CV19	Y	N	Y	Y	Y	Y

4. Risk Analysis

The following COVID-19 specific Finance Risk (ID 3152) is logged:

Title	Description	Controls in place	Further action to achieve target risk score	Risk Rating (initial)
Covid 19 Pandemic may exceed funding available for Welsh Government	The total quantum for funding for addressing Covid-19 across Wales remains fluid and uncertain. There is a risk that the organisation's operational cost of addressing the pandemic cannot be contained within available funding resulting in a potential breach of the planned outturn for 2020-21.	1. Modelling of anticipated patient flows, and the resultant workforce, equipment and operational requirements is managed through Gold command; 2. Financial modelling and forecasting is co-ordinated on a regular basis; 3. Financial reporting to Welsh Government on local costs incurred as a result of Covid-19 to inform central and local scrutiny, feedback and decision-making; 4. Oversight arrangements in place at Board level and through the command structure. Exploring alternative funding sources 1. Local Health Board funding arrangements, including confirmed additional support from Welsh Government; 2. Funding arrangements through the Regional Partnership Board and Local Authority partners;	Risk will be managed at an executive level and reviewed and managed on a weekly basis. Covid-19 actual and forecast costs are submitted to WG each month as part of the regular Monitoring Return. Regular discussions are taking with WG regarding the level of funding required and it is discussed on a regular basis across the finance network in Wales.	25

5. Legal and Compliance

Section 3 summarises the Self-Assessment of Compliance against the key Principles set out by Welsh Government on the 30th March 2020.

6. Impact Assessment

This is a Briefing Paper to provide the Committee with an update on compliance with Welsh Government Guidance.

A formal "Lessons Learned" Paper will be presented to the Committee in October, however in the main the Lessons Learned are in relation to;

- Formalising the SORD for any future Emergency Control Centre(s), and sub-groups.
- Formalising and clarifying what must be reported to the Board versus what can be managed within such an Emergency Control Centre.
- Improved Communication Governance in relation to Policy changes (for example temporary pay related changes that were implemented during CV19).
- Continue to working closely with NWSSP Procurement to further tighten up the controls over purchase orders between £5,000 and the £25,000 Tender limits.

APPENDIX A - Analysis of Revenue Expenditure (Pay and Non-Pay)

EXPENDITURE ANALYSIS BY DIVISION						
BUDGET HEADING	**April £000's**	**May £000's**	**June £000's**	**July £000's**	**YTD £000's**	**FORECAST £000's**
AREA TEAMS						
West Area	172	463	641	652	1,928	5,200
Central Area	162	274	618	792	1,846	4,790
East Area	236	240	601	781	1,858	4,003
TOTAL AREA TEAMS	**570**	**977**	**1,860**	**2,225**	**5,632**	**13,993**
COMMISSIONER CONTRACTS	**-23**	**-13**	**336**	**100**	**400**	**1,200**
SECONDARY CARE						
Ysbyty Gwynedd	582	443	964	974	2,963	5,756
Ysbyty Glan Clwyd	590	765	591	602	2,547	6,828
Ysbyty Maelor Wrexham	584	658	861	902	3,005	6,420
North Wales Hospital Services	247	140	175	79	641	1,520
Women's	128	31	206	383	749	2,119
TOTAL SECONDARY CARE	**2,131**	**2,037**	**2,797**	**2,940**	**9,905**	**22,643**
TOTAL MENTAL HEALTH & LDS	**289**	**427**	**787**	**642**	**2,145**	**6,398**
TOTAL CORPORATE DEPARTMENTS	**621**	**1,257**	**507**	**441**	**2,826**	**5,939**
SUB-TOTAL DIVISIONAL COSTS	**3,589**	**4,685**	**6,287**	**6,347**	**20,908**	**50,174**
TRACK, TRACE & PROTECT	**3**	**5**	**47**	**170**	**225**	**14,530**
FIELD HOSPITALS	**25,062**	**-568**	**1,028**	**547**	**26,069**	**36,797**
TOTAL EXPENDITURE	**28,654**	**4,122**	**7,362**	**7,064**	**47,202**	**101,501**

Source : Month 4 Welsh Government Monitoring Return

APPENDIX A - Summary of Capital Expenditure by Scheme

EXPENDITURE ANALYSIS BY CAPITAL SCHEME		
Scheme	**Month 4 £000's**	**FORECAST £000's**
Partition-Emergency Department Wrexham Maelor	0	30,000
Reconfigure Ward 6-Glan Clwyd	158,607	304,925
Reconfigure Ward 10-Glan Clwyd	298,076	434,525
Satellite Renal Unit-Mold Hospital/Wrexham	0	32,000
Reconfigure Acton Ward-Wrexham Maelor	21,065	21,065
Reconfigure Onnen Ward-Wrexham Maelor	21,065	21,065
Reconfigure Pasteur Ward-Wrexham Maelor	24,532	75,000
Increase bed capacity-Eryri Hospital	10,260	19,000
Increase bed capacity-Ysbyty Penrhos Stanley	29,043	41,600
Increase bed capacity-Llandudno Hospital	36,237	45,500
Increase bed capacity-Bryn Beryl Hospital	13,430	25,500
Increase bed capacity-Dolgellau Hospital	23,442	33,500
Increase bed capacity-Alltwen Hospital	7,713	18,000
Flooring Erddig Ward-Wrexham Maelor	21,942	21,942
Flooring Arrivals Unit-Wrexham Maelor	21,942	21,942
Increase bed capacity-Ysbyty Gwynedd	68,302	202,000
Additional Oxygen & Medical Gas Supply-Wrexham Maelor, Glan Clwyd & YG	330,506	360,101
Increase bed capacity-Day Room Chirk Hospital	121,793	130,000
District Nurses Accommodation-Rhosllanerchrugog Health Centre	45,656	55,000
Increase bed capacity-Rehab Unit Wrexham Maelor	2,241	134,500
Install Hygienic Wall Cladding-Ysbyty Gwynedd	11,246	11,246
Install Intercom Access-Ysbyty Gwynedd	19,487	19,487
Alteration to Car Park-Glan Clwyd	0	9,081
Alteration to Car Park-Wrexham Maelor	15,923	16,883
Install Intercom Access-Wrexham Maelor	21,736	31,812
Upgrade Electrical Systems-Wrexham Maelor	28,965	32,940
Upgrade Flooring-Wrexham Maelor	55,106	71,206
Convert Areas to Covid Wards	0	60,000
Estates Total	**1,408,677**	**2,279,820**
Remote Access Software	0	0
Expand Network-Field Hospitals	0	0
27 Home Reporting Stations-Radiology	139,995	168,000
Additional Laptops & printers	150,169	150,169
3 Interactive Screens-Field Hospitals	17,561	17,561
IM&T Total	**307,725**	**335,730**
6 Mobile Xray Units-Glan Clwyd, Wrexham Maelor & Ysbyty Gwynedd	690,324	690,324
6 Portable Ultrasounds-Glan Clwyd, Wrexham Maelor & Ysbyty Gwynedd	(4,343)	0
7 Blood Gas Analysers-Glan Clwyd, Wrexham Maelor & Ysbyty Gwynedd	0	60,648
Portable Oxygen Analyser-Pharmacy Wrexham Maelor	6,024	6,024
6 Scanners- Labour Wards Wrexham Maelor, Glan Clwyd & Ysbyty Gwynedd	166,876	166,876
Ultrasound-Hebog Ward Ysbyty Gwynedd	21,843	21,843
18 Recovery Monitors	0	126,581
2 Lumify S4-1	0	11,998
58 Glidescopes	0	533,508
6 Ultrasounds 3 ED Glan Clwyd, 2 Respiratory Ysbyty Gwynedd & 1 ED YG	0	151,200
80 Monitors	0	650,328
Handheld Echo Ultrasound-Cardiology Glan Clwyd	0	6,000
Lumify C5-2	0	5,999
Ultrasound Vivid S70	0	53,492
Medical Devices Total	**880,724**	**2,484,821**
TOTAL EXPENDITURE	**2,597,126**	**5,100,371**

EXPENDITURE ANALYSIS BY SUBJECTIVE HEADING						
BUDGET HEADING	**April £000's**	**May £000's**	**June £000's**	**July £000's**	**YTD £000's**	**FORECAST £000's**
Administrative, Clerical & Board Members	12	258	186	126	582	5,046
Medical & Dental	341	650	994	1,086	3,070	8,079
Nursing & Midwifery Registered	299	354	1,154	804	2,610	7,840
Prof Scientific & Technical	0	0	49	73	122	266
Additional Clinical Services	168	279	1,184	1,198	2,829	8,200
Allied Health Professionals	22	47	58	119	246	1,259
Healthcare Scientists	3	26	4	1	34	120
Estates & Ancillary	0	35	152	136	323	1,044
Agency Staff (Across all Staff Groups)	278	333	541	867	2,020	5,790
SUB-TOTAL PAY	**1,122**	**1,982**	**4,323**	**4,409**	**11,835**	**37,644**
Field Hospitals (set up & decommissioning	25,037	-1,742	311	-1	23,605	25,824
CHC Early Discharge	338	655	712	715	2,420	4,827
Estates, Security & Facilities	538	594	395	250	1,777	4,843
Rent, Rates & Utilities	0	170	566	217	953	3,101
Medical & Surgical Equipment (M&SE)	999	449	381	179	2,008	4,518
IT &Telephony Costs	41	203	124	-14	354	717
Accommodation Costs	28	5	10	4	47	227
Additional costs in Primary Care	0	0	77	220	297	679
PPE	168	243	251	133	796	2,441
Drugs inc Medical Gases	120	58	40	84	303	1,517
Temporary LTA Arrangements	104	119	97	105	425	1,259
General non clinical, inc office equipment	54	912	223	282	1,471	3,307
Other Non- Pay	104	475	-147	480	912	10,597
SUB-TOTAL NON-PAY	**27,532**	**2,141**	**3,040**	**2,655**	**35,367**	**63,856**
TOTAL EXPENDITURE	**28,654**	**4,122**	**7,362**	**7,064**	**47,202**	**101,501**

Source : Month 4 Welsh Government Monitoring Return

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

To Chief Executives

Our Ref: AG/SE/SB

30 March 2020

Dear Colleagues

COVID-19 – Decision Making & Financial Guidance

I want to take this opportunity to thank you and your teams for your support and commitment during these unprecedented times. The challenges associated with COVID-19 are significant, and delivering the necessary solutions are the priority for us all.

In these exceptional and unprecedented circumstances, I recognise that organisations and teams are required to make potentially difficult decisions at pace. These decisions may at times be without a full evidence base, or be without the support of key individuals who would ordinarily support business as usual processes and advice.

In taking urgent and exceptional decisions in this challenging environment, I recognise that there is a disruption to our usual financial discipline and authorisation processes. However, this continues to be within the context of needing to ensure appropriate use of public money. It is vital therefore, that within this disrupted environment, individual and collective decision-making is effective and stands the test of scrutiny when our services and systems return to a normalised position in the future. Once we return to a normalised position, the NHS will be called to account for its stewardship of public funds.

Across Welsh Government, the First Minister has asked all departments of government to both prioritise resources to deal with the COVID-19 pandemic and to ensure those resources are deployed effectively on the actions that will make the biggest difference. It is within that context that I am writing this letter to you.

I would urge organisations to ensure that in making decisions at this time the following applies:

- Due consideration is given to regularity in relying on legal powers, propriety and meeting the standards of 'Managing Welsh Public Money', and value for money supported by an assessment of the realistic options available to you at the time

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- Decisions taken must be rational and justifiable with due consideration of all options and risk. If approval is required then it should be sought, and justification for decisions should be recorded, if not at the time then subsequently. Ultimately, we need to ensure the decisions we are taking are defendable to the patients and public we serve, and this should provide a clear and consistent test to our actions.

- Individuals and organisations should ensure that our decision making conduct is in line with Nolan Principles, and integrity is at the heart of what we do, with no conflict of interest affecting or appearing to affect decisions. If a decision is planned which is particularly novel, contentious, or repercussive, my officials are on hand to provide advice and guidance to inform any decision making.

- During emergencies such as these, organisations inevitably are more vulnerable to a risk of fraud, and unfortunately, some will try to take advantage of this situation for personal gain. That is why at times like these a continued focus on good governance and potential fraud is key.

- If you have any concerns in any aspects of your decision making process and revised governance arrangements, in addition to seeking advice of officials, you should ensure the continual involvement of Wales Audit Office in your activities to re-focus your decision making processes.

In keeping with the principles and spirit of this correspondence, and the indication set out by the Minister to step back from routine monitoring arrangements, our routine financial arrangements need to adapt on an interim basis. I therefore attach guidance to organisations on expectations from a financial management and reporting perspective at this time. This outlines the minimum expectation in this area, and aims to ensure a supportive and balanced focus in forthcoming months on ensuring core minimum requirements are in place to support all organisations at this challenging time.

Once again, thanks to you and your teams for everything that you do. My officials continue to be available to provide support on the issues I have outlined above. If there are any areas for further clarification or where additional advice and guidance is required, let me know.

Yours sincerely

Dr Andrew Goodall CBE

COVID-19 - Financial Guidance to NHS Wales' organisations

Given the immediate challenges presented by the COVID-19 pandemic, it is recognised that routine financial arrangements and disciplines are disrupted and need to adapt on an interim basis.

In this environment, there is a need to ensure that:

- There are clear and pragmatic financial arrangements in place which minimise any disruption to the system
- Business continuity arrangements are effective
- Frameworks to support effective decision making are clear
- Core financial assumptions and positions are clear and monitored, but with a light touch approach whilst maintaining sufficient clarity on minimum key measures

This guidance has been developed to support organisations and provide clarity on expectations for this disrupted period and until organisations return to business as usual arrangements.

Principles

This document has been developed with the following guiding principles:-

- Finance will not be a barrier to delivering the operational needs of the service in response to the COVID-19 pandemic but needs to be managed and monitored in a structured manner;
- Funds will flow to and from NHS Wales' organisations in a timely manner;
- Organisations are expected to work together to ensure that services are not disrupted during this period as a result of cross-border flows and commissioning;
- Requests for COVID-19 funding will be facilitated through a simplified process that balances financial governance and operational need; and
- Organisations will track both the additional costs arising from COVID-19, and reductions in expenditure due to COVID-19 (i.e. reduced elective activity) in a structured and transparent manner.

Financial Governance

The maintenance of financial control and stewardship of public funds will remain critical during the NHS Wales response to COVID-19. Chief Executives, Accountable Officers and Boards must continue to comply with their legal responsibilities and have regard to their duties as set out in Managing Welsh Public Money and other related guidance. Any financial mismanagement during this period should be managed in exactly the same way as at any other time.

NHS Wales organisations should undertake an urgent and timely review of financial governance arrangements to ensure decisions to commit resources in response to COVID-19 are robust and appropriate. Value for money is expected to remain a consideration when making decisions with a significant financial impact.

Specifically, organisations are expected to ensure that systems are in place to support decision-making at pace whilst maintaining appropriate controls and governance. This relates in particular to:

- Ensuring an appropriate scheme of delegation is in place and compliance with SFIs. This should include ensuring effective authorisation and signatory systems are in place to minimise any disruption
- Financial information should be collected in support of COVID-19 which is auditable and evidenced and supported by good documentation of key decisions

- Delegation limits and approvals should be documented and followed, having been approved by the Board. The arrangements should also be sufficiently robust and flexible to ensure that authorisation and decisions can take place in the absence of key staff.

No new revenue or capital business investments should be progressed unless related to the response to COVID-19 or otherwise expressly approved by Welsh Government.

From a governance perspective, organisations are also expected to ensure that any proposed service delivery solution in response to COVID-19 have appropriate NHS Indemnity arrangements and advice from Welsh Risk Pool as required.

Core Financial Systems & Processes

NHS Wales Shared Services Partnership has outlined the business continuity arrangements in respect of key financial processes including payroll, procurement and accounts payable. These systems are able to operate via remote working with limited disruption. The systems are, however, dependent upon the ongoing exercise of controls within NHS Wales' organisations. In particular, organisations are asked to ensure that purchase to pay arrangements are appropriately effective and timely, and any payroll adjustments are communicated at an early stage. This will ensure timely payments to suppliers and maintaining cash flow, and ensuring no impact on the pay of our staff.

Organisations should ensure that robust business continuity arrangements are in place covering core financial systems, monitoring and reporting. This should include ensuring procedures, and rules for key systems are available and accessible to all appropriate staff, in a common place (both hard copy and electronically) to support staff required to undertake roles outside of their normal duties.

Business continuity plans should be kept under constant review, tested to ensure they remain effective, shared with all staff members, and updated on a timely basis where required with clear and timely communication.

Standing Financial Instructions require clear quotations and tender processes, which in the current situation, may not be possible. In ensuring appropriate use of public money, where this is not possible any new arrangements must be clearly documented, and decision making justifiable in the context of future scrutiny and accountability.

Organisations should ensure that control is maintained over inventory and stocks which will be critical should supply chains be under pressure. Organisations should therefore consider whether more frequent stock checks are required, and have clear processes in relation to products in high demand and optimise product distribution to ensure the right items are available at the times for patient care.

If inventory is moved to other NHS organisations, then records will need to be kept of where these items are being sent to ensure that they are appropriately accounted for and are not lost or wasted.

NHS Wales' organisations are required to continue to pay suppliers and other NHS bodies (including NHS England providers) on a timely basis.

Counter Fraud

During emergencies and crises, organisations are inevitably more vulnerable to a risk of fraud. There is already emerging evidence of increased phishing e-mails and other fraudulent activity. There are particular risks around invoice and procurement fraud.

We would encourage organisations to remain vigilant to this heightened risk of fraud and to take the following actions:-

- Maintain basic and fundamental financial controls around authorisation and segregation of duties; and
- Engage with your local counter fraud service if you require any guidance or note any suspicious activity.

Revenue & Capital Allocations and Cash

NHS Wales organisations have received clear allocations for 2020/21, and all organisations should always utilise the funding available within their agreed allocation. It is anticipated that reductions in planned care activity as part of the response to COVID-19 will free up resources (finance and workforce) to be diverted to the COVID-19 response.

Welsh Government recognises the importance of liquidity and cash management at this time. The NHS Financial Management Team will prioritise the distribution of cash to support NHS Wales' organisations. Welsh Government will ensure that cash is paid to NHS Wales' organisations on a regular and timely basis to facilitate key financial activities such as payroll, procurement and accounts payable.

If additional allocations and/or requests for funding are approved through the processes outlined in this document, Welsh Government will communicate approval and issue the allocation in a timely manner, including converting into cash allocations on a timely basis.

It is acknowledged that organisations will incur additional costs in relation to COVID-19 and outline arrangements for monitoring and reimbursement below.

Ring-fenced Allocations (excluding DEL/AME Non Cash Depreciation)

During this period, it is recognised that there may be under-utilisation or re-direction of ring-fenced services for their traditional purpose with therefore a reduced expenditure level against the baseline ring-fenced allocation. During this period there will be no claw-back of ring-fenced allocations therefore any under-spend against the allocation is an appropriate offset against increased COVID-19 expenditure.

Cost Reimbursement – Revenue Costs

In many instances, the operational costs of the COVID-19 response will be met from within existing funding, as resources are re-directed from planned elective activity or other planned commitments. Further, costs of significant programmes and actions co-ordinated on a Once for Wales basis will be funded centrally as part of the national co-ordinated response.

Where an organisation has a need to incur specific additional costs associated with the local response, or where an organisation has a national leadership role, then Welsh Government will consider making additional revenue funding available. This will require a submission to Welsh Government explaining the nature of the additional cost, the likely timeframe it will be incurred and why it cannot be met from within the existing allocation. This will ensure an audit trail to support business critical decisions and support enabling allocation processes.

In order to facilitate a swift response, requests for funding support should be submitted to the central mailbox at NHSFinancialManagement@gov.wales

Implementation of identified actions and appropriate procurement should not be delayed whilst waiting for funding confirmation from Welsh Government.

Financial Reporting & Monitoring

Organisations need to ensure they will be able to track their financial position on an ongoing basis, and capture the impact of the COVID-19 pandemic. Welsh Government is revising existing monitoring arrangements to ensure routine monitoring is focussed on the bare minimum requirements to sustain clear financial reporting and integrity at this time. At a high level, this monitoring will describe the following:-

- Baseline position pre COVID-19 as per previous plans;
- Year to Date & Forecast outturn position
- Risks
- Allocation & Income assumptions (recognising that this is a fast changing environment)
- Cash flow & Capital assumptions
- Additional COVID-19 expenditure incurred; and
- Planned expenditure or investments that was not incurred due to COVID-19;

Organisations should build this approach into reporting and forecasts, and establish appropriate mechanisms to facilitate tracking of any additional expenditure in relation to COVID-19.

Welsh Government acknowledges that organisations' efforts will be wholly directed towards the COVID-19 response, which will affect the pursuit of savings and efficiencies at this time. It is recognised that delivering savings will not be prioritised unless they are supportive of the current situation and challenges. Organisations should review and identify which programmes will, and will not, be maintained or ceased, and progress to date documented and closed down to allow progress when the system returns to a normalised position. Organisations are expected to provide a clear assessment of their forecast outturn position having considered non-delivery of planned savings and the other variables outlined above.

Welsh Government is re-developing monitoring guidance for 2020-21, which will be issued in due course. This is being developed in line with the principles above and in the spirit of the challenges associated with COVID-19. Monitoring will therefore adopt a 'light-touch' approach with key areas of focus around COVID-19 reporting, and with sufficient flexibility for organisations to describe the financial impact of COVID-19 clearly. This will reflect both planned impacts on expenditure, and unplanned financial impacts of COVID-19.

Capital

The principles of ensuring clarity on assumed allocations, forecast expenditure, and COVID-19 impact outlined within this guidance applies to Capital in addition to Revenue expenditure. Capital support will be provided for:

- Testing equipment and facilities
- Inpatient facilities, to include compliance issues with existing isolation rooms and conversion to negative pressure where required
- Inpatient facilities, expansion of isolation rooms numbers to meet the requirements of WHC (2018) 033
- Critical care facilities and equipment
- Diagnostics

- Works and equipment required to cohort patents not requiring critical care, including those in non NHS owned facilities where required
- Digital equipment
- Other capital requirements not covered by the above as required

As per reimbursement of revenue costs, organisations are asked to outline where additional capital funding is required above approved Capital Resource Limits (CRLs) and Capital Expenditure Limits (CELs), organisations should make submissions to Welsh Government outlining the detail of the costs, and timeframe it will be occurred. Implementation of identified actions and appropriate procurement should not be delayed whilst waiting for funding confirmation from Welsh Government

Routine capital monitoring will be reflected in the revised Monitoring Returns; however, given the challenges of COVID-19, Capital Projects progress reports are not required until at least the end of Quarter 1, when the position will be reviewed.

Given the exceptional circumstances of the current situation, for 2019/20 due to the ongoing uncertainty about year-end deliveries for both COVID and non COVID equipment and delay in construction schemes CRLs/CELs will continue to be amended for one week after 31st March, with the intention of closing them on 8 April 2020.

Depreciation funding requirements above baseline, will be obtained via the Non Cash Estimate Exercise in early August and refined in November (the June exercise will not be undertaken in 2020/21).

Purchase of enhanced discharge support services / Partnership arrangements

Timely discharge and community care wrap around packages will be essential to release bed capacity within hospitals. Discharge to Recover and Assess packages are anticipated to be enhanced and will include community response team ('CRT') support, intermediate care beds (in a community hospital or care home) and domiciliary care.

Within existing partnership arrangements Welsh Government anticipates that additional costs will be incurred by both the local authorities involved and healthcare bodies. It is also envisaged that organisations collectively will be repurposing existing funding streams such as the Integrated Care Fund as an appropriate resourcing mechanism in these circumstances. Any additional planned expenditure which requires funding support should comply with the revenue cost reimbursement model outlined above within this guidance.

Cross-Border Flows

It is essential that NHS Wales organisations collaborate effectively and minimise any disruption on the system during this period. All Welsh commissioners are expected to deploy the same approach as English commissioners and agree block contract arrangements with English providers in line with NHS England guidance. The NHSE guidance reflects that this arrangement should be in place to 31 July 2020 but we anticipate that this period will be extended and organisations should ensure that they are able to respond swiftly to any extension. It is recognised that this arrangement may have a disproportionate impact on those organisations with a high reliance on English providers and who cannot re-deploy internal resources to offset this financial pressure. This will be considered directly with specific impacted organisations.

An approach to Long Term Agreements for quarter 1 during the COVID-19 pandemic period has been developed by Deputy Directors of Finance, which is endorsed by Welsh Government as both a pragmatic and sensible approach. It is vital that organisations ensure stability, and no disruption in the system at this time.

Actions being taken and led directly by Welsh Government on a system wide basis as part of the response to COVID-19 will be resourced directly with no anticipated impact on any individual organisation.

It is anticipated that Welsh organisations will have similar pragmatic reciprocal arrangements with English commissioners as appropriate on any activity for English residents treated in Welsh providers.

Primary Care Contractors

From 1 April, it is anticipated that Primary Care contractors are enabled to prioritise their workload according to what is necessary to prepare for and manage the outbreak, and therefore as a principle organisations should ensure that income will be protected as per existing contractual arrangements if other routine contracted work has to be substituted. Health Boards should plan to continue to make payments on this basis and ensure timely cash flow to independent contractors. Welsh Government will reimburse any additional costs in relation to COVID-19 as part of the reimbursement processes outlined in this guidance. Specific developments on a national basis may result in further guidance and support in relation to actions being taken by Primary Care contractors and this will be issued by policy leads in due course.

It is also intended that, during the outbreak, payments made under the Premises Cost Directions will be maintained. This will be in the event that premises are not able to open or where the use of premises is diverted away from GMS to support other COVID activities.

Summary

This guidance is intended to provide clear minimal expectations and be a supportive framework for organisations to consider what is or is not maintained in the current situation.

Given the pace and urgency of the current situation and environment, there may be additional areas for clarification that has not been addressed by this guidance. Any queries in relation to this can be directed at NHSFinancialManagement@gov.wales or directly with either Steve Elliott, Hywel Jones, Andrea Hughes, or Val Whiting in the first instance who will support you as required.

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

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Dyddiad / Date: 3rd April 2020

Dear Colleagues

RE: COVID-19; Financial Governance and Decision Making

I would like to take this opportunity to clarify the Financial Governance arrangements during these difficult and ever-changing times.

We have received formal guidance from Welsh Government (Ref AG/SE/SB) which I have enclosed for completeness, however there are a number of key aspects that I would emphasise and draw out.

Clearly we need to mobilise resources quickly and allow operational management to focus efforts on directly responding to the front-line demands, however the management and maintenance of financial control and stewardship of public funds remains critical during this period. Boards and all levels of management must continue to comply with their budget responsibilities and have regard to their duties as set out in Managing Welsh Public Money and other related guidance.

Any financial mismanagement during this period will be managed in exactly the same way as at any other time.

During this difficult time, there is a need to ensure that:

- There are clear and pragmatic financial arrangements in place which minimise any disruption to the system
- Business continuity arrangements are effective
- Finance will not be a barrier to delivering the operational needs of the service in response to the COVID-19 pandemic but needs to be managed and monitored in a structured manner
- Requests for COVID-19 funding will be facilitated through a simplified process that balances financial governance and operational need, with a clear framework to support investment decisions
- We track both the additional costs arising from COVID-19, and reductions in expenditure due to COVID-19 (i.e. reduced elective activity) in a structured and transparent manner

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Financial Governance

The Standing Financial Instructions (SFIs) and Standing Orders (SOs) still apply, as such we must all abide by the following principles:

- Up to £5,000 Oracle Requisition
- £5,000 to £25,000 Minimum 3 Quotes, then Oracle Requisition
- £25,000 to £118,000 Tender, or approved Single tender Waiver (click here)
- Above £118,000 OJEU Tender and possible Welsh Government Approval

Likewise, staff posts can only be appointed to, or increases in hours / sessions can and should only be agreed where there is a budgeted establishment in place.

Financial Systems

All non-payroll expenditure must still be managed through the Oracle Financial System. The Health Board continues to operate the No-PO-No-Pay Policy, and as such all expenditure must be initiated through an Oracle Requisition in advance of any contract or commitment is made.

Requisitions will continue to follow the Divisional Scheme of Delegation and Oracle Approval Hierarchy, and will only be processed into Purchase Orders by the NHS Procurement Team (NWSSP) once all necessary requisition approvals have been given. It is recognised that as operational or clinical budget managers re-focus their efforts to the front-line, it may be necessary to reduce or streamline the number of approvers required within the hierarchy. This will need to be managed locally, ensuring that the Chief Financial Officer (CFO) is fully sighted on any such changes, and wherever necessary the CFO will themselves be a senior-level approver, in line with the formal Operational Scheme of Delegations.

All staff payments continue to be managed through the ESR Payroll System. Recruitment activities continue to be managed through the Establishment Control system, although as with the aforementioned non-pay Oracle hierarchy, it may be necessary to review the number of approvers required at each stage; again ensuring that the CFO remains a key senior approver of all increases in hours or new appointments.
Where recruitment for specific COVID-19 posts requires fast-tracking, this must be processed using the necessary Payroll Documents (New Appointment Form), and must be approved by the relevant Director and CFO. This is being managed and coordinated through the local Workforce Hubs.

All supporting Systems, such as E-Roster, Bank and Agency systems will be maintained as normal.

Financial Decision-Making

The aforementioned systems are used for Revenue, Capital and Charitable Funds related expenditure, although Capital expenditure (through the Capital Programme, CPMT) and Charitable Funds expenditure (through the Charitable Funds Committee) also have their own clear routes for investment approval and decision-making.

As set out in the **Financial Governance** Section, the SFIs and SOs set out clear lines of approval for all investment and expenditure, across all sources of funding.

Where expenditure for specific COVID-19 activities requires fast-tracking, it is essential that the decision-making process is clearly and fully documented. To support this, a number of specific templates and toolkits have been developed, and are enclosed:

- Capital investment-decision control
- Revenue investment-decision control
- Voluntary Support plan

Whilst these documents can be used to clearly document any decision to invest resources to support the COVID-19 efforts, it is essential that the supporting System (Oracle, ESR, and Establishment Control) is then used to create the Purchase Order or Payroll Appointment Form.
The relevant Decision-Making Toolkit, must then be attached to the relevant Oracle Requisition or ESR Payroll Form as clear evidence of effective financial governance.

Funding Sources

NHS Wales Organisations have received clear allocations for 2020/21, and Welsh Government expect all organisations to utilise the funding available within their agreed allocation. It is anticipated that reductions in planned care activity as part of the response to COVID-19 will free up resources (finance and workforce) to be diverted to the COVID-19 response.

Costs of significant programmes and actions co-ordinated on a Once for Wales basis will be funded centrally as part of the national co-ordinated response.

Where there is a need to incur specific additional costs associated with the local response, the Welsh Government will consider making additional revenue funding available, however this will require a submission to Welsh Government clearly explaining the nature of the additional cost, the likely timeframe it will be incurred and why it cannot be met from within the existing allocation. This will ensure an audit trail to support business critical decisions and support enabling allocation processes.

In specific relation to traditional Ring Fenced Allocations, such as GDS Dental or Mental Health. It is recognised that there may be under-utilisation or re-direction of ring-fenced services for their traditional purpose with therefore a reduced expenditure level against the baseline ring-fenced allocation. During this period the Welsh Government will not

claw-back ring-fenced allocations therefore any under-spend against these allocations is considered an appropriate offset against increased COVID-19 expenditure.

Financial Reporting & Monitoring

We will, as always, need to clearly track the financial position on an ongoing basis, although the Welsh Government is revising existing monitoring arrangements to ensure routine monitoring is focussed on the bare minimum requirements to sustain clear financial reporting and integrity at this time.

Nevertheless it is essential that we clearly monitor and report;

- The additional costs of the COVID-19 response
- The cost reductions from reductions in planned and non-emergency care

The CFOs will continue to work across all Divisions to ensure that, through the Oracle Financial System and the ESR Payroll System that all such cost increases and decreases are fully tracked and reported.

Cross Border Flows

An approach to Long Term Agreements for Quarter 1 during the COVID-19 pandemic period has been endorsed by Welsh Government.

It is essential that NHS Wales organisations collaborate effectively and minimise any disruption on the system during this period. All Welsh commissioners are expected to deploy the same approach as English commissioners and agree block contract arrangements with English providers in line with NHS England guidance. The NHSE guidance reflects that this arrangement should be in place to 31 July 2020 but we anticipate that this period will be extended and organisations should ensure that they are able to respond swiftly to any extension.

Welsh Government has recognised that this arrangement may have a disproportionate impact on those organisations with a high reliance on English providers and who cannot re-deploy internal resources to offset this financial pressure.

Business Continuity

I am working with Shared Service colleagues to ensure that we continue to provide core and critical systems and services, including, but not limited to:

- Ensuring that we have systems (and staff) in place to continue to pay staff.
- Ensuring that we have system (and staff) in place to continue to procure new goods and services, particularly COVID-19 related supplies.
- Ensuring that we have systems (and staff) in place to pay our suppliers, and our Local Authority Partners and Care Home providers.

- Ensuring that we have systems in place to control and record all expenditure (Oracle Financials and ESR).
- Maintaining, if not increasing our Local Counter Fraud activities, particularly at a time when unfortunately fraudulent activities become more prevalent.

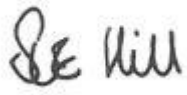
As the Control Centres and Hubs develop, there will be a need to issue further Financial Guidance and Policy in relation to evolving operational processes. For example, the development and commissioning of Field Hospitals is a significant undertaking within which there will be clear financial Guidelines and Controls.

In addition to these core systems and services, I along with my Senior Team are also putting in place our own resilience and back-up / cover arrangements, should a number of key individuals be unavailable for a period of time.

Should the COVID 19 situation change more rapidly, resulting in the need to review any or all of the above arrangements we will of course review the situation at that time and through the appropriate internal Governance channels.

I trust this, along with the supporting documents and toolkits, provides you with clear guidance and expectations around Financial Governance during this period, however if you have any questions, comments or thoughts in the meantime, please do not hesitate to contact me directly or any of the Senior Finance Team.

Yours sincerely



Sue Hill
Cyfarwyddwr Gweithredol Cyllid
Executive Director of Finance

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

Radiology

Nuclear Medicine Consolidation Strategic Outline Case

Background

- Clinical Utility
  - Physiological and Hybrid Imaging
  - Very sensitive method of imaging – highly sensitive and can be the only method of imaging certain diseases
  - MSK imaging (Gamma Camera)
  - Cancer Service – PET-CT & Routine Nuclear Medicine for Staging and treatment follow up
  - Paediatrics e.g. Renal Imaging required by tertiary centres
  - Complementary imaging for those unable to have IV contrast or MRI compatibility
  - Cardiac Imaging
- Services Supported
  - Paediatrics
  - Oncology
  - Inpatient / Outpatient
    - MSK – trauma / infection imaging
  - Neighbouring trusts e.g. RJAH (which does not have a facility)
  - Medicine – e.g. PE imaging
  - Cardiology – MPI imaging
  - Neuroendocrine Service
  - Organ Transplant services

Current Service & Deteriorating Sustainability

- National Shortage - Recruitment and Retention of Sub-Specialty trained Consultants and Radiographers increasingly difficult
- Compliance – Licencing Issues surrounding maintaining services
- Wales currently not providing equivalent access to patients compared to England for PET-CT (AWPET / WHSSC)
  - Under provision Linked to lack of PET-CT facilities
- Currently operating 3 Nuclear Medicine departments
- Three Gamma Cameras – all at 'end of life status' & under utilised /some routine Nuclear Medicine tests migrating to PET-CT
- PET-CT provided by 3rd Party on Mobile Unit
- WHSSC – regularly increasing funded indications – with growth in service accelerating
- Retirements and impacted recruitment means that services are now difficult to run with the remaining licenced consultants
- Expensive Imaging Equipment and Support Services

Need for Stability in Clinical Deliverability and Service Development / Evolution

- Whole Nuclear Medicine Service Including PET-CT reliant on an ARSAC licence issued to the Employer & to each Radiologist with Additional Training in NM/PET
  - Number of Licences in HB much reduced
  - Services cannot run without a Licenced Clinician
  - Recruitment /Retention/ Continuation of Current Services - Dependent on Centre of Excellence / Consolidated service
- PET-CT service growing – need to provide in house service
  - Capital purchase of PET-CT and infrastructure – allowing long term revenue savings
  - HB staff run own service (saving on revenue) – allowing for staff development / skill mix / optimised equipment use/
  - Full weekly service possible
  - Accessible to patients with disabilities / mobility / bariatric patients

Proposed Solutions

- Reduction to 2 Gamma Cameras – in alignment with evolution of patient pathways and transition of Gamma Camera work to PET-CT
- Fit for Purpose Imaging Unit – future proof / legislation compliance / clinical utility
- Consolidated Centre of Excellence:
  - 1 Nuclear Medicine Department –
    - 2 x Gamma Cameras(Back to Back)
    - 1 x PET-CT
  - Site Option Appraisal to be undertaken

Service Reconfiguration - Impact

- Provision of Centre of Excellence for Nuclear Medicine within BCUHB
- Likely to recruit and retain radiology trainees and consultants with NM Specialty
- Opportunity for revenue saving (Equipment /AML contract/ Staffing)
- Optimal Use of State of the Art Facility and Equipment
- Ability to expand service to include future indications by WHSSC / WG
- Ability to facilitate research trials for cancer patients currently unable to access novel research treatments in the region

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Nuclear Medicine Consolidation Strategic Outline Case**
Cyfarwyddwr Cyfrifol: Responsible Director:	Adrian Thomas, Executive Director Therapies and Health Science Mark Wilkinson, Executive Director Planning and Performance
Awdur yr Adroddiad Report Author:	Ian Howard, Assistant Director – Strategic and Business Analysis Pat Youds, Professional Lead, Radiography/Radiology Manager
Craffu blaenorol: Prior Scrutiny:	In line with the organisation's Procedure for Managing Capital Projects the Business Case has been endorsed by the Secondary Care Division, the Estates Improvement Group and the Executive Team.
Atodiadau Appendices:	The Business Case and its 11 appendices are attached.

Argymhelliad / Recommendation:

The Committee is asked to approve the Business Case for submission to the Board.
(Subject to Board approval the case will then be submitted to Welsh Government).

Please tick as appropriate

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

Sefyllfa / Situation:

This is a Strategic Outline Case, which is the first stage in the process of seeking capital from Welsh Government. Its purposes are to set out the case for change and outline a suggested way forward, rather than to propose a definitive preferred option. Capital and revenue figures are high level approximations based on a set of explicit assumptions. The key decisions, and definitive costings, are established at Outline Business Case/Full Business Case stage. SOC approval will release funding from Welsh Government to work up a fully costed proposal.

This case addresses the Nuclear Medicine Service provided by BCUHB. Currently the service is provided utilising three Gamma Cameras - one on each of the three main acute hospital sites - and one mobile PET-CT, which is located in Wrexham for two days a week. The case has the following objectives:

Investment Objective 1
To provide services which meet the strategic direction / requirements as detailed within the Health Board's plans, and key all-Wales strategies including the *Imaging Statement of Intent (2018)* and "*Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations*"
Investment Objective 2

To create and provide an environment that delivers safe and effective care whilst achieving key efficiency targets throughout the service, including meeting increased demand for PET services

Investment Objective 3

To maintain legal compliance through service redesign to attract and retain specialist licenced practitioners

Investment Objective 4

To deliver services that are affordable and represent value for money, maximising opportunities to deliver revenue savings whilst continuing to deliver and improve nuclear medicine services

Investment Objective 5

To avert current risk of service failure and provide a sustainable and reliable programme for the replacement of existing equipment

Cefndir / Background:

There are a series of issues with the current service configuration which make it unsustainable in the short and long term. There is an imminent threat to the delivery of this service due to staff shortages - in particular there may soon be insufficient holders of a licence from the Administration of Radioactive Substances Advisory Committee (ARSAC), which is required to deliver the service. In terms of the Gamma Cameras, all three are well past their planned lifespan and are increasingly unreliable and prone to breaking down. They also have relatively low technological capability compared to current models and not all cameras support the same examinations, resulting in a sub-optimal and inequitable service. Demand for the service is falling, and current and projected future demand could be accommodated by two machines. As regards PET, the number of sessions required is likely to increase. The current two day a week service is inflexible and there are a number of practical issues associated with the use of a mobile scanner - for example patients on trolleys cannot be accommodated, there are no toilet facilities, and there are regular problems with data transfer. There are very limited opportunities to participate in clinical trials, which is important in itself as well as being a factor in the recruitment and retention of staff.

Asesiad / Assessment & Analysis

Strategy Implications

The main strategic drivers for Radiology across Wales are summarised in the *Imaging Statement of Intent (2018)*, which identifies four key themes: increasing demand; workforce issues; ageing equipment; and the need for a networked approach to services, all of which apply to North Wales. In terms of PET, the key document is the 2018 report of the All Wales PET Advisory Group and the Welsh Scientific Advisory Committee "*Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations*." This report states that PET-CT has become a central diagnostic tool, and is significantly underutilised in Wales compared to the rest of the UK, which is itself behind the USA and Europe. The report recommends an expansion of the service in Wales, and WHSSC is currently developing a Strategic Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research. BCUHB are fully engaged with the development of the all-Wales business case, and this case is fully aligned with it.

The need for this development is highlighted in the Health Board's Operational Plan, and the key risks are identified in the Health Board's risk register.

Options considered

Various options have been considered, focusing on the location and scale of services to be provided and the merits of a permanent vs a mobile PET-CT, and the attached case includes a full option appraisal. The Community Health Council have been fully involved, and have confirmed that the engagement undertaken to date in evaluating these options has been appropriate. A possible solution is to reduce the number of sites providing a Gamma Camera service to two. However there is a strong argument in terms of service resilience and reduced revenue costs cost in favour of purchasing two new gamma cameras to replace the existing three, and co-locating them on a single site. There would be further resilience and revenue cost savings if these two cameras were co-located with a permanent fixed PET-CT. The service would then be run by the same radiographers and administrative staff. This would create a centre of excellence which will be able to accommodate the likely increase in demand for PET-CT, support research and provide a flexible and robust service. This is the preferred way forward.

It is important to be clear that the PET element of this preferred way forward is subject to agreement through the all-Wales PET-CT Strategic Board which is producing the Programme Business Case. It is understood that the all-Wales Programme Business Case will be produced in 2021. WHSCC, as commissioners of the service, have endorsed the following statement: "*Given the imperatives to resolve the wider issues with the Nuclear Medicine service in North Wales it would be unwise - as well as unnecessary - to delay this case until the all-Wales case is produced and approved. As with any business case the option appraisal in this SOC will be revisited at OBC/FBC stage, and the final preferred option will be consistent with the final all-Wales position. BCUHB is currently exploring with the Programme Board the possibility of reaching a clear position on the North Wales PET in advance of the publication of the all-Wales PBC, to avoid delaying the production of the OBC/FBC and so prolonging further the risk that the current service configuration poses to the Nuclear Medicine service."*

It is also important to note that this option appraisal addresses the number of sites that should provide the service, but does not identify the preferred site (or sites). This analysis will be undertaken as part of developing the OBC/FBC, and will require a further systematic engagement exercise.

Financial Implications

In terms of capital expenditure, the total costs will depend to a degree on the site selected. A high level estimate of the capital cost for the preferred way forward (2 new Gamma Cameras co-located with a permanent PET-CT) is between £10 million and £11 million. The revenue costs will also vary depending on the site selected. However the overall recurring saving from consolidating the service, stopping the lease of the mobile PET and maintaining only two Gamma Cameras is estimated at approximately £210,000 per annum.

Risk Analysis

The Project Board has identified the risks and counter-measures as follows:

Risk	Counter Measure	Risk Level
Projected revenue savings not achieved	▪ Savings achievement to be actively managed and reviewed at 6 month intervals for the first 2 years of implementation and variations reported. ▪ Recruitment to be strictly in line with planned staff skill mix within the business case.	10
Capital funding bid to WG not approved due to lack of strategic alignment	▪ Ensure the scheme is fully aligned with WHSSC and AWPET strategic direction. ▪ Scoping document shared with WG and initial meeting held to discuss intent and scope. ▪ Dialogue to be maintained in monthly WG meetings and discussions with WHSCC.	15
Unrealistic programme adopted given the priority of implementation	▪ Timescales within SOC reviewed July 2020 to reflect delay. ▪ Time allowances consistent with past business case processes.	9
Programme delay	▪ Delayed SOC to be submitted to first possible meetings for internal approval prior to submission to WG. ▪ Separate BJC to be developed for WMH gamma camera replacement given End of Life/Support Dec 2020.	25
OCP and HR related risks	▪ Consultation with staff and staff side representatives has commenced with HR representation. 1-2-1 discussions to take place. ▪ OCP to be applied in full if applicable to the final preferred option. Staff to be offered alternative opportunities where transfer isn't practical. ▪ Phased transfer to be considered.	9
Availability of suitable site for preferred option	▪ Availability to be discussed with the Hospital Director and Site Clinical Directors and included in development control plans. ▪ Option appraisal to be completed at the earliest opportunity. ▪ Initial feasibility investigations underway. ▪ All aspects to be documented and considered during site appraisal against weighted criteria.	9

High selected site abnormal costs	▪ Identifiable abnormals to be considered in the site selection wherever possible. ▪ Some allowances made within budget costs.	12
Existing mechanical and electrical infrastructure found to be inadequate or in a poor condition	▪ Some allowances made within SOC budget costs. ▪ Surveys and site investigations to be completed as soon as possible at OBC stage.	12
Effect of COVID 19 pandemic on project	▪ Considered by Project Board, capacity provided by 2 gamma cameras considered adequate. ▪ Air changes to be provided in ventilation design. ▪ Any additional Infection Prevention requirements to be considered in design.	10

Legal and Compliance

Subject to approval of the case by the Board and Welsh Government, a combined OBC/FBC will be produced. This will go through the same governance process as the SOC.

Impact Assessment

An Equality Impact Assessment has been carried out, and is enclosed as appendix I of the business case. It concludes that there is an impact on a small number of patients who would have to travel further, as a result of the consolidation of the service. However current service risks could lead to no service, and patients would have to travel to England. Patients with disabilities that prevent them from getting up stairs currently cannot access mobile PET-CT and have to travel to England and also experience delays to diagnosis.

Nuclear Medicine Consolidation

Strategic Outline Case (SOC)

Finance and Performance Committee

August 2020

VERSION HISTORY

Version	Date Issued	Brief Summary of Change	Owner's Name
Draft V0.01	11.09.2019	Initial draft document	Project Team
Draft V0.02	05.10.2019	Amendments following review by Service	Project Team
Draft V0.03	09.10.2019	Amendments following review by Service	Project Team
Draft V0.04	14.10.2019	Consolidation of comments received	Project Team
Draft V0.05	15.10.2019	Review Investment Objectives / Options	Project Team
Draft V0.06	05.11.2019	Rationalised text	Project Team
Draft V0.07	11.11.2019	Amendments following receipt of comments	Project Team
Draft V0.08	11.11.2019	Amendments following receipt of comments	Project Team
Draft V0.09	19.11.2019	Consolidation of comments received: issued for further review	Project Team
Draft V0.10	22.11.2019	Further amendments following comments received	Project Team
Draft V0.11	26.11.2019	Format / draft Executive Summary	Project Team
Draft V0.12	16.12.2019	Capital costs included	Project Manager
Draft V0.13	10.01.2020	Further amendments / format	Project Team
Draft V0.14	03.02.2020	Further amendments/format following scrutiny by the Assistant Director Strategic & Business Analysis scrutiny	Project Team
Draft V0.15	17.02.2020	Amendments by Assistant Director Strategic & Business Analysis	Project Team
Draft V0.16	17.02.2020	Amendments by Assistant Director Strategic & Business Analysis	Project Team
Draft V0.17	19.02.2020	Amendments by Assistant Director Strategic & Business Analysis	Project Team
Draft V0.18	19.02.2020	Amendments by Assistant Director Strategic & Business Analysis	Project Team
Draft V0.19	10.05.2020	Format	BC Manager
Draft V0.20	15.07.2020	Update to capital cost range, timeline and risks	Project Manager
Draft V0.21	22.07.2020	Amendments by Assistant Director Strategic & Business Analysis	Project Team
Draft V0.22	24.07.2020	Amendments following feedback from the Director of Planning & Performance	Project Team
Draft V0.23	19.08.2020	Cover change for F&P	Project Team

Contents

Appendices

1. Executive Summary

1.1 Introduction

This case addresses the Nuclear Medicine Service provided by BCUHB. Currently the service is provided utilising three Gamma Cameras - one on each of the three main acute hospital sites - and one mobile PET-CT, which is located in Wrexham for two days a week. There are a series of issues with this service configuration which make it unsustainable in the short and long term - in particular: difficulties in staffing three separate services; obsolete equipment; falling demand for the Gamma Camera service, and increasing demand for PET-CT. There is an opportunity to improve the quality of the service, make it more resilient and reduce revenue costs. The preferred way forward at this stage in the development of the business case is to consolidate services in a single Centre of Excellence for Nuclear Medicine at one of the three acute sites. The Centre would consist of two Gamma Cameras and one permanent fixed PET-CT, and would be housed by a combination of new building and refurbishment work. The Gamma Camera and PET-CT service would be run by the same radiographers and administrative staff. The estimated capital cost of this proposal is in a range between £10 million and £11 million. There is an estimated recurring revenue saving of approximately £210,000 to provide the same level of service as is provided now. There would also be a lower additional marginal cost per case for any future investment by WHSSC in the expansion of PET-CT than would be achieved by expanding the current mobile service.

1.2 Summary of the Case

Nuclear medicine is a specialised form of imaging involving the administration of small amounts of intravenously injected radioactive pharmaceuticals or radionuclides to patients. Both Gamma Cameras and PET cameras (or scanners) produce images of injected radioactivity distributed through the body. The images produced depend on which tracers are used. Tracers have specific uses and target different processes that need to be examined. Generally gamma cameras image lower energy radioactivity and cannot readily image the higher energies. This is appropriate for the range of tests done with the gamma camera, such as bone scans, heart perfusion scans, kidney scans and thyroid function. PET scans image the higher energy radiation. They are mainly used as a primary diagnostic test and in treatment planning for certain indications in cancer, but are also increasingly used in diagnosing neurological conditions and cardiac disease.

The main strategic drivers for Radiology across Wales are summarised in the *Imaging Statement of Intent (2018)*, which identifies four key themes: increasing demand; workforce issues; ageing equipment; and the need for a networked approach to services, all of which apply to North Wales. In terms of PET, the key document is the 2018 report of the All Wales PET Advisory Group and the Welsh Scientific Advisory Committee "*Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations*." This report states that PET-CT has become a central diagnostic tool, and is significantly underutilised in Wales compared to the rest of the UK, which is itself behind the USA and Europe. The report recommends an expansion of the service in Wales, and WHSSC is currently developing a Strategic Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research. BCUHB are fully engaged with the development of the all-Wales business case, and this case is fully aligned with it.

In BCUHB the nuclear medicine service is currently provided from three Gamma Cameras - one on each of the three main acute hospital sites - and one mobile PET-CT, which is located in Wrexham two days a week. There is an imminent threat to the delivery of this service due to staff shortages - in particular there may soon be insufficient holders of a licence from the Administration of Radioactive Substances Advisory Committee (ARSAC), which is required to deliver the service. In terms of the Gamma Cameras, all three are well past their planned lifespan and are increasingly unreliable and prone to breaking down. They also have relatively low technological capability compared to current models and not all cameras support the same examinations, resulting in a sub-optimal and inequitable service. Demand for the service is falling, and current and projected future demand could be accommodated by two machines. As regards PET, the number of sessions required is likely to increase in line with the Advisory Group's recommendations. The current two day a week service is inflexible and there are a number of practical issues associated with the use of a mobile scanner - for example patients on trolleys cannot be accommodated, there are no toilet facilities, and there are regular problems with data transfer. There are very limited opportunities to participate in clinical trials, which is important in itself as well as being a factor in the recruitment and retention of staff. In terms of the COVID-19 pandemic, this has highlighted the risks of relying on a mobile service provided by a third party, as mobile PET-CTs were requisitioned in the UK for operational use at the Nightingale Hospitals.

Based on this analysis of the issues, the following key objectives for the project have been identified:

Investment Objective 1
To provide services which meet the strategic direction / requirements as detailed within the Health Board's plans, and key all-Wales strategies including the *Imaging Statement of Intent (2018)* and "*Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations*"
Investment Objective 2
To create and provide an environment that delivers safe and effective care whilst achieving key efficiency targets throughout the service, including meeting increased demand for PET services
Investment Objective 3
To maintain legal compliance through service redesign to attract and retain specialist (ARSAC) licenced practitioners
Investment Objective 4
To deliver services that are affordable and represent value for money, maximising opportunities to deliver revenue savings whilst continuing to deliver and improve nuclear medicine services
Investment Objective 5
To avert current risk of service failure and provide a sustainable and reliable programme for the replacement of existing equipment

A range of options to meet these objectives have been considered, focusing on the location and scale of services to be provided and the merits of a permanent vs a mobile PET-CT. The Community Health Council have been fully involved, and have confirmed that the engagement undertaken to date in evaluating these options has been appropriate. A possible solution is to reduce the number of sites providing a Gamma

Camera service to two. However there is a strong argument in terms of service resilience and reduced revenue costs cost in favour of purchasing two new gamma cameras to replace the existing three, and co-locating them on a single site. There would be further resilience and revenue cost savings if these two cameras were co-located with a permanent fixed PET-CT. The service would then be run by the same radiographers and administrative staff. This would create a centre of excellence which will be able to accommodate the likely increase in demand for PET-CT, support research and provide a flexible and robust service. This is the preferred way forward.

It is important to be clear that the PET element of this preferred way forward is subject to agreement through the all-Wales PET-CT Strategic Board which is producing the Programme Business Case. It is understood that the all-Wales Programme Business Case will be produced in 2021. WHSCC, as commissioners of the service, have endorsed the following statement: "*Given the imperatives to resolve the wider issues with the Nuclear Medicine service in North Wales it would be unwise - as well as unnecessary - to delay this case until the all-Wales case is produced and approved. As with any business case the option appraisal in this SOC will be revisited at OBC/FBC stage, and the final preferred option will be consistent with the final all-Wales position. BCUHB is currently exploring with the Programme Board the possibility of reaching a clear position on the North Wales PET in advance of the publication of the all-Wales PBC, to avoid delaying the production of the OBC/FBC and so prolonging further the risk that the current service configuration poses to the Nuclear Medicine service."*

It is also important to note that this option appraisal addresses the number of sites that should provide the service, but does not identify the preferred site (or sites). This analysis will be undertaken as part of developing the OBC/FBC, and will require a further systematic engagement exercise.

In terms of capital expenditure, the total costs will depend to a degree on the site selected. A high level estimate of the capital cost for the preferred way forward (2 new Gamma Cameras co-located with a permanent PET-CT) is between £10 million and £11 million. The revenue costs will also vary depending on the site selected. However the overall recurring saving from consolidating the service, stopping the lease of the mobile PET and maintaining only two Gamma Cameras is estimated at approximately £210,000 per annum.

2. Structure and Contents of the Document

This case has been prepared using the agreed standards and format for business cases, as set out in the NHS Wales Infrastructure Investment Guidance, the format being the *Five Case Model* which comprises the following key components:

- The **Strategic Case:** this sets out the strategic fit and case for change, together with the supporting investment objectives for the scheme
- The **Economic Case:** this demonstrates that the organisation has selected a preferred option which optimizes public value for money
- The **Commercial Case**: this outlines that the preferred option will result in a viable procurement and well-structured deal
- The **Financial Case:** this demonstrates that the preferred option will result in a fundable and affordable deal
- The **Management Case:** this demonstrates that the scheme is achievable and can be delivered successfully in accordance with accepted best practice

There are normally three key stages in the development of a project business case, these are:

- the Strategic Outline Case (SOC)
- the Outline Business Case (OBC)
- the Full Business Case (FBC)

This SOC:

- Establishes the strategic context
- Makes a robust case for change
- Provides a suggested way forward, rather than a definitive preferred option

Subject to this SOC being approved, the intention is to produce a combined OBC / FBC which will:

- Identify the option which optimises value for money
- Prepare the scheme for procurement
- Set out the negotiated commercial and contractual arrangements for the deal
- Put in place the necessary funding and management arrangements for the successful delivery of the scheme
- Demonstrate that the scheme is *unequivocally* affordable

It is anticipated that the OBC / FBC will be submitted to Welsh Government in November 2021 and the scheme will become fully operational in November 2023.

3. The Strategic Case

3.1 Introduction

The purposes of this section are: to explain how the scope of the proposed scheme fits within the existing organisational strategies; and to provide a compelling case for change, in terms of the existing and future operational needs of the service.

Part A: The Strategic Context

3.2 Organisational Overview

Betsi Cadwaladr University Health Board (BCUHB) was established on 1st October 2009. It provides a full range of primary, community, acute and mental health services for a population of approximately 700,000 across North Wales and some parts of North Powys and North-West England. BCUHB is responsible for the operation of over 90 health centres, clinics, community health team bases and mental health units, 19 community hospitals and three acute hospitals. The Health Board employs approximately 16,500 staff and has an annual revenue budget of approximately £1.4 billion.

3.3 Alignment to Existing Policies and Strategies

This section of the business case outlines how the project fits with the existing policies and strategies of the organisation, and of NHS Wales as a whole.

3.3.1 Overall Radiology Policies and Strategies

Radiology is a key diagnostic and interventional service used to help diagnose, monitor and treat disease and injuries. As such is it, and will remain, a core service provided by the Health Board. Nationally, the main strategic drivers for Radiology as a whole are summarised in various documents - notably the *Imaging Statement of Intent (2018)* and the Auditor General for Wales report *Radiology Services in Wales, November 2018* (enclosed as Appendices A and B). There are four broad strategic national themes that are relevant to this case: increasing demand; workforce issues; ageing equipment; and the need for a co-ordinated approach to service change across Wales.

In terms of increasing demand and workforce, to quote the *Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations, "*current services are under increasing pressure with major growth in demand as a result of more effective clinical pathways, increasing numbers of older people, increasing cancer incidence, improved technology, new techniques and workforce pressures resulting in delays to patients accessing the appropriate imaging services for their needs. The demand for imaging, both image acquisition (scanning) and prompt clinical interpretation and reporting significantly outstrips current capacity across all types of imaging, compromising high-quality patient care and incurring unnecessary delays in care pathways." This case seeks to address the future demand for the Nuclear Medicine service in North Wales and to reduce workforce pressures.

As regards ageing equipment, the WAO have concluded that across Wales, "ageing and underutilised equipment are making it harder for health boards to meet demand." One of its recommendations is to "ensure that there is a national coordinated approach to address equipment needs, with sufficient funding for the replacement of equipment and purchase of new technology to meet increasing demand and technology advances." This case proposes to resolve issues with both ageing and underutilised equipment.

The *Imaging Statement of Intent* emphasises the need for a networked approach to services: “imaging service will be strengthened as part of a co-ordinated and networked approach to their planning and delivery. We will review service models and clinical pathways to provide optimal imaging services for the adult population of Wales.” As is outlined further below (para: 3.3.2), this project is fully aligned with the co-ordinated approach across Wales, and seeks to establish a single Nuclear Medicine service in North Wales.

3.3.2 **Nuclear Medicine**

This business case focuses on the future of Nuclear Medicine services - both Gamma Camera and PET. The key policy document related to PET is the 2018 report of the All Wales PET Advisory Group and the Welsh Scientific Advisory Committee “*Positron Emission Tomography (PET) in Wales: Overview and Strategic Recommendations*” (Appendix C). The report states that PET-CT has become a central diagnostic tool in the management of patients with cancer, and that its role in cancer and other diseases continues to evolve. It points out that in the UK the development of PET services has been slow compared to the United States and other European countries, and that the Wales lags significantly behind the other 3 devolved nations, in terms of funded indications for PET scans, development of PET scanning infrastructure, specialist workforce, and research opportunities. The report outlines the strategic vision for the development of PET services, and makes the following recommendations that are relevant to this case:

1. The All Wales PET Advisory Group (AWPET), a subgroup of the Welsh Scientific Advisory Committee, should recommend to Welsh Health Specialised Services an expanded indication list for PET scanning based on best available evidence. There should be provision for increased growth and appropriate funding. In future AWPET should continuously review evidence based best practice clinical pathways incorporating PET scanning in Wales.

2. WHSSC should be commissioned to produce a Strategic Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.

3. Constitution of a Welsh PET innovation strategy to develop research, clinical, technological, and industrial collaboration within a formal framework. This will encompass horizon-scanning and development of subjects such as PET in radiotherapy planning, and in novel malignant and non-malignant indications.

The PET element of this business case is fully aligned to the work being done by the PET-CT Strategic Board to develop the all-Wales Programme Business Case for PET-CT (recommendation 2). The following exposition of this alignment has been endorsed by WHSCC:

- *The drivers for this case are the same as those outlined in the Programme Brief for the all-Wales programme (enclosed as Appendix D).*
- *BCUHB is represented on the PET-CT Strategic Board by Dr. Elias who is joint chair of the clinical model sub-group.*
- *As the case develops to OBC/FBC, there will continue to be full alignment with the all-Wales work. For example, the level of future PET activity will be determined by WHSSC, informed by the all-Wales modelling and capacity work currently being undertaken to inform the all-Wales Programme Business Case.*

At the time of drafting this case, it is understood that the all-Wales Programme Business Case will be produced in 2021. Given the imperatives to resolve the wider issues with the Nuclear Medicine service in North Wales, outlined elsewhere in the document, it would be unwise - as well as unnecessary - to delay this case until the all-Wales case is produced and approved. The key strategic judgement that is required for the preferred option to be finalised is whether the all-Wales case will recommend that a permanent static PET-CT scanner should be located in North Wales. The judgement in the option appraisal for this SOC (para 4.4) is that a permanent static PET-CT scanner in North Wales is preferred as this seems to be clearly the best (including most cost-effective) way to meet projected future demand for the service, and to facilitate service integration. However, as with any business case, this option appraisal will be revisited at OBC/FBC stage and the final preferred option will be consistent with the final all-Wales position.

In terms of BCUHB's plans and governance, the need for this development is highlighted in the Health Board's Operational Plan, and the key risks are identified in the Health Board's risk register.

Part B: The Case for Change

3.4 Investment Objectives

Given the strategic context outlined above, and the specific case of need outlined in section 3.6, this project's objectives are as follows:

Investment Objective 1
To provide services which meet the strategic direction / requirements as detailed within the Health Board's plans, and key all-Wales strategies including the *Imaging Statement of Intent (2018)* and "*Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations*"
Investment Objective 2
To create and provide an environment that delivers safe and effective care whilst achieving key efficiency targets throughout the service, including meeting increased demand for PET services
Investment Objective 3
To maintain legal compliance through service redesign to attract and retain specialist (ARSAC) licenced practitioners
Investment Objective 4
To deliver services that are affordable and represent value for money, maximising opportunities to deliver revenue savings whilst continuing to deliver and improve nuclear medicine services
Investment Objective 5
To avert current risk of service failure and provide a sustainable and reliable programme for the replacement of existing equipment

The benefits criteria related to these objectives are outlined in para 3.8.

3.5 Existing Arrangements for Nuclear Medicine in North Wales

The nature of the service

Nuclear medicine is a specialised form of imaging involving the administration of small amounts of intravenously injected radioactive pharmaceuticals or radionuclides to patients. Both Gamma Cameras and PET cameras (or scanners) produce images of injected radioactivity distributed through the body. The images produced depend on which tracers are used. Tracers have specific uses and target different processes that need to be examined. Generally gamma cameras image lower energy radioactivity and cannot readily image the higher energies. This is appropriate for the range of tests done with the gamma camera, such as bone scans, heart perfusion scans, kidney scans and thyroid function. PET scans image the higher energy radiation. They are mainly used as a primary diagnostic test and in treatment planning for certain indications in cancer. PET CT scans can provide greater staging certainty, increasing the likelihood of the correct therapeutic treatment option being chosen and reducing the use of sometimes unnecessary surgical approaches with high morbidity risks. PET CT has been shown to change proposed treatment in around 40% of cases. Stage certainty improves accuracy of cancer datasets which in turn allow outcomes to be more accurately attributed and understood. There is increasing use of PET CT in non-oncology indications with the recent adoption of inflammatory and infective indications. They are increasingly used in diagnosing neurological conditions and cardiac disease.

PET CT access is governed in Wales by WHSCC Policy CP50. PET CT referrals need to fall within a restricted range of funded indications determined by WHSSC with any other cases only accepted if IPFR (Individual Patient Funding Requests) funding is made available.

North Wales service provision

In North Wales there are nuclear medicine services with a gamma camera room and supporting rooms, along with radio pharmacies on each of the 3 DGH sites in North Wales (Bangor, Glan Clwyd and Wrexham).

In terms of PET, there is a commercially leased mobile and staffed PET CT at Wrexham for 2 days of the week. Patients from the north of Powys are also referred to the mobile PET CT, having previously travelled to Cardiff. At present the existing referral restrictions outlined above mean that demand is being met within the 2 days the leased PET CT is onsite at WMH. The PET service is commissioned by WHSSC.

3.6 Business Needs / Benefits of the Scheme

This section describes the issues associated with the existing service which this business case seeks to address.

3.6.1 Difficulties in recruiting and retaining key staff for Nuclear Medicine Service as a whole, which threaten the continuation of the service

There are some significant workforce issues which apply to the service as a whole and threaten its continued provision. This problem is the main driver for the urgency of the scheme. Both the *Imaging Statement of Intent* and the WAO report *Radiology Services in Wales* refer to major difficulties across the UK in recruiting and retaining radiologists, radiographers, radio pharmacists and other nuclear medicine staff. The issues with the fragmented nature of the service, out-of-date equipment and inability to conduct research, outlined in full below, mean that there are particular problems in North Wales. For example two radiology trainees, who did a 6th year specialising in nuclear medicine, have recently left BCUHB to work in specialist centres in Cardiff and

Manchester. There is concern that with the existing service model further staff could leave, particularly with other organisations with Nuclear Medicine Centres of Excellence actively trying to attract staff.

Provision of nuclear medicine services is dependent on consultants who have completed a 6th year on top of their specialist training and provide ongoing evidence of competence to be awarded and retain a licence from the Administration of Radioactive Substances Advisory Committee (ARSAC). The Health Board is required to have an ARSAC licence holder on each site with Nuclear Medicine services to maintain legal compliance - the service is not able to operate otherwise. However, the number of licence holders within the service is reducing with retirement and in the mid-term there will only be two existing ARSAC certificate holders remaining in North Wales. Recent attempts to recruit consultants to the current service model have failed. Given the legal requirement for a licence holder to spend time on, and be familiar with, the site for which they provide specialist cover, any less than three ARSAC certificate holders (one per DGH site) would result in onerous travel between sites and the loss of clinical capacity if the current service configuration is maintained.

In addition to this fundamental concern, the fragmented service model does not promote a high quality integrated workforce. The opportunities for integration rely upon pan BCUHB study events where attendance is restricted by the need to keep the local service running. Opportunities for service development, innovation, learning and improving team integration are limited.

3.6.2. **Gamma Camera Service**
In addition to the workforce issues outlined above, there are a number of specific issues associated with the existing gamma camera service:

Lack of reliability due to age: Gamma cameras have a planned lifespan of approximately 7 years before replacement should take place to avoid image quality, performance, maintenance, software upgrade and part availability issues. All of the gamma cameras are beyond this planned lifespan - the existing WMH gamma camera was installed in 2007, YGC's in 2006 and YG's in 2011.

The original manufacturers are currently maintaining the WMH gamma camera but this is the last of its type in the UK still in clinical use and it has had a significant number of breakdowns and spare parts are becoming difficult to source. In 2018/2019 £28k was paid at WMH to extend the life of the software alone for just one year to enable it to continue to operate but this contract may not be extendable for further years. The ingenuity of a specialist 3rd party contracted company is being relied on until parts are no longer available for maintaining the gamma camera at YGC but this company does not have the technical experience to support the WMH camera when the original manufacturer is unable to offer a further service contract. A 3rd party company is also maintaining the YG gamma camera.

The growing unreliability of the gamma cameras also increases the risk that patients could be injected with a radionuclide and then not be scanned which means they have been irradiated for no benefit. These events are classed as reportable radiation incidents and have to be reported to Health Inspectorate Wales (HIW).

Without planned replacement the difficulty in sourcing spare parts will eventually lead to equipment failure and the need to complete one or more unplanned replacements, without prior notice. This would result in appointment cancellations, the need to divert

patients at short notice to another site and loss of service during a long procurement lead time for the equipment and enabling works which for planned replacements takes place while the old scanner remains in use.

Low technological capability: The age of the 3 gamma cameras means that they have low technological capability when compared to current models and the type and complexity of scans that the YGC gamma camera in particular can complete is limited. Throughput is also restricted with current models having lower scanning times as well as lower radiation doses.

Fragmented service: The service is fragmented across the 3 sites with associated communication and co-ordination issues. The different licenses on each site results in a service where not all the studies can be performed on each site, resulting in an inconsistent and inequitable service. Appointment bookings are being made by the 3 teams on each separate site in an inefficient manner and the fragmentation reduces the ability to provide a quality service to patients.

In-equality of access: The different gamma cameras also mean that some examinations such as Myocardial Perfusion Imaging (MPIs) are performed differently on patients and there is a lack of consistency and equity in service provision.

Lack of resilience: Having only 1 gamma camera on each site means that in the event of a breakdown patients have to travel to another site or have their appointment cancelled. The need to provide staffing 'cross cover' across the 3 sites for resilience necessitates travel during valuable clinical time and incurs travel costs. The different specifications and technological capabilities of the 3 gamma cameras means that it is difficult in practice to provide this 'cross cover' of staff for the 3 sites as not all staff are able to gain familiarity with and experience on each gamma camera.

Limited staff competencies: The variations is scanner capabilities contribute to differing skill sets amongst the workforce. This subsequently contributes to scheduling difficulties.

Over capacity to meet current and projected demand: while the general trend in Radiology is one of increasing demand, the demand for Gamma Camera services is in decline and predicted to decline further. The number of patients receiving the service has reduced from approximately 3,700 in 2016/17 to 3,500 in 2019/20, and none of the three cameras are fully utilised, with the workload of each gamma camera below the recommendations of Royal College of Radiologists. The current and projected levels of activity can be accommodated by two machines. It is therefore inefficient to maintain three separate services, and service consolidation could release significant cash savings.

3.6.3 **PET**

There are a number of specific issues associated with the current use of the commercially leased and staffed PET CT mobile:

Capacity: As outlined earlier in the document, the need to expand PET services throughout Wales is articulated in the 2018 report of the All Wales PET Advisory Group and the Welsh Scientific Advisory Committee - "*Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations*." (Appendix C). The all-Wales PET-CT Strategic Board is working to develop a demand and capacity model for

Wales as part of the all-Wales Programme Business Case for PET-CT. This will inform the future level of service commissioned by WHSSC.

Flexibility: In addition to the shortfall in the total capacity in North Wales, the time-sensitive nature of scans means that the scanner only being available for 2 days a week creates a further problem. It is a requirement of the existing commissioning route that patients are scanned within 10 working days. This is likely to be shortened to accommodate the requirements of the Single Cancer Pathway. This is a very tight window to scan and report PET CT patients, particularly when trying to accommodate breakdowns and failure of the injected FDG (Fluorodeoxyglucose) delivery, does not allow patients to be scanned in time. Treatment is either delayed or takes place without the appropriate staging which may mean that it is also inappropriate.

Practicality: Patients and staff have to go out in all weathers to access/egress the mobile.

Data transfer: A frequent operational issue is the failure of data transfer from the mobile via a data cable to PACS for reporting which results in having to manually import studies from DVD which is slow and delays reporting.

Accessibility: The mobile does not provide equitable access as the more poorly patients on trollies or beds can't be accommodated on the mobile and either do not receive the service or have to travel to Wigan which delays treatment.

Lack of space: The mobile has room for 2 patients to rest before scanning which limits the potential throughput.

Lack of facilities: There are no toilets on the mobile van, patients deciding that they need the toilet before scanning have to come back off the mobile and into the main building, this results in further delays and inefficiencies.

Lack of opportunity to develop staff: As the mobile is a staffed leased service the BCUHB nuclear medicine radiographers do not have the opportunity to undertake hands on PET scanning and develop scanning skills further.

Lack of ability to participate in clinical trials/research: The capacity issues of the mobile service and the specific needs of research trials means a number of studies are ineligible to open in BCUHB. This reduces BCUHB's reputation as a research organisation and denies local patients access to trial participation. This also has a negative effect on retention and recruitment of skilled staff.

Revenue cost: The cost of leasing the staffed mobile is likely to be relatively high per patient compared to a fixed site PET.

3.7 Potential Scope

This section describes the potential scope for the project.

Given that staffing issues are a major driver for the project, and a common set of staff are able to run a PET service and a Gamma Camera service, this project looks at Nuclear Medicine as a whole. It explores the location of the services, as supporting Gamma Cameras in three locations is placing pressure on staffing and diluting the service. It also examines the scale of future services, to take account of the increasing demand for PET and reducing demand for Gamma Cameras. The limitations as a

result of having a mobile PET means that the potential for having a permanent static PET is also explored.

3.8 Main Benefits Criteria

This section describes the main outcomes and benefits associated with the implementation of the potential scope in relation to business needs. Satisfying the potential scope for this investment will deliver the following high-level strategic and operational benefits. By investment objectives, these are as follows:

Investment Objective 1	Main Benefits Criteria
To provide services which meet the strategic direction / requirements as detailed within the Health Board's plans, and key all-Wales strategies including the *Imaging Statement of Intent (2018)* and "*Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations*"	Compliance with: ▪ 10 day turn-round for PET CT patients (WHSCC Standard) ▪ Single Cancer Pathway requirements ▪ Future proofing of increased capacity requirements

Investment Objective 2	Main Benefits Criteria
To create an environment that delivers safe and effective care whilst achieving key efficiency targets throughout the service i.e.: meet increased demand for PET indications	▪ Provide fit for purpose accommodation ▪ Modern technology with increased reliability is installed ▪ Enable non-ambulatory PET patients to be scanned and not sent to Wigan ▪ Reduce variation in service delivery ▪ Enhance radiographic skills ▪ Increase participation in research

Investment Objective 3	Main Benefits Criteria
To maintain legal compliance through service development to attract and retain specialist (ARSAC) licenced practitioners	Support regulatory compliance by: ▪ Maximising chance of retention of staff ▪ Maximising potential for recruitment ▪ Minimising risk of reportable radiation incidents arising from failure of a single camera.

Investment Objective 4	Main Benefits Criteria
To deliver services that are affordable and represent value for money, maximising opportunities to deliver revenue savings whilst continuing to deliver and improve nuclear medicine services	▪ Appropriate radiographic staffing requirement ▪ Introduces the correct skill mix ▪ Reduction in cost per case Provides opportunity for income generation through: ▪ Participation in research trials ▪ Offer of specialist scanning services to other Health Boards /Trusts

Investment Objective 5	Main Benefits Criteria
To avert risk of service failure and provide a sustainable and reliable programme for the replacement of existing equipment	▪ Avoid unplanned equipment replacement ▪ Provide a flexible booking schedule and ability to provide for service growth ▪ Offer later appointments to patients who have to travel further distances mitigating FDG supply issues ▪ Improved resilience

The specific metrics for the main benefits criteria will be fully developed in the OBC/FBC.

3.9 Main Risks

The main business and service risks associated with achieving the project's outcomes, and the proposed mitigations, are as follows:

Risk	Counter Measure	Risk Level
Projected revenue savings not achieved	▪ Savings achievement to be actively managed and reviewed at 6 month intervals for the first 2 years of implementation and variations reported. ▪ Recruitment to be strictly in line with planned staff skill mix within the business case.	10
Capital funding bid to WG not approved due to lack of strategic alignment	▪ Ensure the scheme is fully aligned with WHSSC and AWPET strategic direction. ▪ Scoping document shared with WG and initial meeting held to discuss intent and scope. ▪ Dialogue to be maintained in monthly WG meetings and discussions with WHSCC.	15
Unrealistic programme adopted given the priority of implementation	▪ Timescales within SOC reviewed July 2020 to reflect delay. ▪ Time allowances consistent with past business case processes.	9
Programme delay	▪ Delayed SOC to be submitted to first possible meetings for internal approval prior to submission to WG. ▪ Separate BJC to be developed for WMH gamma camera replacement given End of Life/Support Dec 2020.	25
OCP and HR related risks	▪ Consultation with staff and staff side representatives has commenced with HR representation. 1-2-1 discussions to take place. ▪ OCP to be applied in full if applicable to the final preferred option. Staff to be offered alternative opportunities where transfer isn't practical. ▪ Phased transfer to be considered.	9

Availability of suitable site for preferred option	▪ Availability to be discussed with the Hospital Director and Site Clinical Directors and included in development control plans. ▪ Option appraisal to be completed at the earliest opportunity. ▪ Initial feasibility investigations underway. ▪ All aspects to be documented and considered during site appraisal against weighted criteria.	9
High selected site abnormal costs	▪ Identifiable abnormals to be considered in the site selection wherever possible. ▪ Some allowances made within budget costs.	12
Existing mechanical and electrical infrastructure found to be inadequate or in a poor condition	▪ Some allowances made within SOC budget costs. ▪ Surveys and site investigations to be completed as soon as possible at OBC stage.	12
Effect of COVID 19 pandemic on project	▪ Considered by Project Board, capacity provided by 2 gamma cameras considered adequate. ▪ Air changes to be provided in ventilation design. ▪ Any additional Infection Prevention requirements to be considered in design.	10

3.10 **Constraints and Dependencies**

a. The following constraints have been identified:

- The availability of the sites which will be included in an option appraisal at OBC/FBC stage
- The ability to retain staff and recruit to new staff posts

b. The following dependencies have been identified:

- The project is dependent on capital funding from Welsh Government

To note: The project is not dependent on the ongoing TRAMS (Transforming Access to Medicine) reconfiguration of pharmacy services across Wales and assurance has been provided that the production of radionuclide injections by radio-pharmacy will be maintained.

4. The Economic Case

4.1 Introduction

The purposes of the Economic Case are to identify and appraise the options for the delivery of the project, and to recommend the option which is likely to offer the best Value for Money (VfM). This is achieved in two steps: first, by identifying and appraising a wide range of realistic and possible option (the long list); and second, by identifying and appraising a reduced number of possible options in further details (the short list).

4.2 Critical Success Factors

The Critical Success Factors (CSF) for the project are as follows:

- **CSF 1: Business Needs**: how well the option satisfies the existing and future business needs of the organisation
- **CSF 2: Strategic Fit**: how well the option provides holistic fit and synergy with other key elements of national, regional and local strategies.
- **CSF 3: Benefits Optimisation**: how well the option optimises the potential return on expenditure; business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation) and assists in improving overall Value for Money (VfM) (economy, efficiency and effectiveness).
- **CSF 4: Potential Achievability**: the organisation's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks and the need for supporting skills (capacity and capability). Also the organisation's ability to engender acceptance by staff.
- **CSF 5: Supply-side Capacity and Capability**: the ability of the market place and potential suppliers to deliver the required services and deliverables.
- **CSF 6: Potential Affordability**: the organisation's ability to fund the required level of expenditure, namely the capital and revenue consequences associated with the proposed investment.

4.3 The Long-listed Options

The long list of options was generated using the options framework, which systematically works through the available choices for what (scope), how (service solutions), who (service delivery), when (implementation), and funding. This process results in options either being discounted, carried forward for further consideration in the short list or identified as a preferred choice. The options framework for this project is as follows:

Options		Finding
1.0	**Scope**	
1.1	**Business as Usual**: Continue with current arrangements for service delivery for the Nuclear Medicine service	**Discounted:** it would not address the service risks and issues outlined in the strategic case. This option is retained as a comparator against which to assess whether other options offer value for money
1.2	**Do Minimum**: limit the scope of the business case to address the Gamma Camera service only	**Discounted:** this would not result in the potential benefits of integrating the Gamma Camera and PET services, in terms of staffing or physical location. It would not address the limitations of the current PET service

1.3	**Intermediate**: limit the scope of the business case to address the PET only	**Discounted:** this would not address the fundamental staffing and equipment issues related to the Gamma Camera service.
1.4	**Maximum**: Consider the Nuclear Medicine service as a whole – i.e. Gamma Camera and PET	**Preferred:** this would allow the case to address all of the issues with the service. It would allow exploration of the benefits of fully integrating the Nuclear Medicine service as a whole and creating a centre of excellence.
2.0 Service Solution		
2.1	**Business as usual**: Continue with current arrangements for service delivery with incremental investment as and when required to replace obsolete equipment	**Discounted**: - it would not address the service risks outlined in the strategic case including ARSAC licence holder risk - does not develop PET CT services which remain dependant on 3rd party provision - expensive equipment continues to be used inefficiently (3 departments continue to operate along with 3 supporting radio pharmacies) - retained as a comparator against which to assess whether other options offer value for money
2.2	Replace 2 of the 3 gamma cameras, reducing service provision to two sites. No change to the PET service.	**Possible**: it would reduce, but not eliminate, the risks related to staffing and equipment failure. It would not address the issues related to PET.
2.3	Co-locate 2 new gamma cameras on the same site as the commercially leased and staffed mobile PET CT scanner.	**Possible:** - allows the service to operate from a single site (rather than 3) and consolidation of specialist staff & equipment - does not address the limitation of a mobile PET service
2.4	Co-locate 2 gamma cameras on the same site as the commercially leased mobile PET CT scanner but staffed by BCU staff.	**Discounted:** - allows the service to operate from a single site (rather than 3) and consolidation of specialist staff, equipment and disinvestment in aseptic services - consolidation of staff is greater than option 2.3, as the PET scanner is staffed by BCUHB employees - does not address the limitations of a mobile PET service - probably more expensive than a permanent PET, particularly if the number of PET sessions commissioned by WHSSC increases
2.5	Co-locate 2 gamma cameras on the same site and in the same building as a permanent, static PET CT scanner	**Preferred**: - Would meet all benefits criteria along with service efficiency, improved service

	staffed by BCUHB staff to form a Specialist Nuclear Medicine Centre	quality, requirements of national strategic policy - addresses service delivery and ARSAC risks - future proof PET services across N. Wales - allows consolidation of specialist staff, equipment and rational disinvestment in aseptic services and scanning equipment - promotes a centre of excellence for recruitment and retention - greater opportunities for revenue savings - greater opportunities for research
3.0	**Service Delivery**	
3.1	In-house	**Preferred:** In line with WG Policy
3.2	Outsource	**Possible:** some of the service solutions include leasing a staffed mobile PET, which could be described as partially outsourcing the service
4.0	**Implementation**	
4.1	Big Bang/Single Phase Implementation	**Possible:** the creation of a single centre of excellence could be achieved as a single implementation. However it would involve both a significant service change for the Gamma Camera service (from 3 sites to 1) and for PET at the same time, with concentrated capital expenditure.
4.2	Phased	**Preferred:** for the reasons outlined above
5.0	**Funding**	
5.1	Private Funding	**Discounted** as unaffordable
5.2	Public Funding	**Preferred**

4.4 Short-listed Options

The *preferred* and *possible* options identified in the table above have been carried forward onto the short list for further appraisal and evaluation. All the options that were discounted as impracticable have been excluded at this stage. On the basis of this analysis, the recommended short list for further appraisal within the OBC/FBC is as follows:

Option 1: Business as usual (included as a benchmark): Continue with current arrangements for service delivery with incremental investment as and when available to replace obsolete equipment.
Option 2: Replace 2 of the 3 gamma cameras and deliver the gamma camera service on two sites. No change to the PET service.
Option 3: Co-locate 2 gamma cameras on the same single site as a mobile PET CT scanner - the Nuclear Medicine service would therefore be provided on a single site.
Option 4: Co-locate 2 gamma cameras on the same site, and in the same building, as a permanent static PET CT scanner, staffed by BCUHB staff to form a Specialist Nuclear Medicine Centre. The potential flow of patients through this department is enclosed as Appendix E. This is the preferred way forward.

The work on creating and appraising options has been developed with extensive stakeholder engagement. The project team have identified a number of internal and external stakeholders whose opinion on the proposals have been sought.

- **Internal Stakeholders:**
  - Nuclear medicine and PET CT referrers
  - Radiology staff working in nuclear medicine
  - Radiology service
  - Hospital management teams and Board
  - Staff side

- **External Stakeholders**
  - Current and former service users from North Wales, and communities potentially affected in Mid Wales
  - North Wales Community Health Council
  - 3rd Sector organisations
  - Powys CHC

The engagement strategy for the project has involved a number of meetings with the various stakeholder groups with presentations and question and answer sessions. Meetings have been held across all three BCUHB regions at different times of day and evening in accessible facilities. Sessions have been held with current and former service users, and with representatives from the Cancer Network Patients' forum. Members of radiology staff on the project team have also attended clinical advisory groups to discuss the proposals. In parallel with the meetings, people who have recently attended for nuclear medicine or PET CT examinations have been invited to take part in a survey to gain their views. As people from North Powys have PET CT scans in Wrexham their views have also be obtained. Concurrently meetings have been held across BCUHB with referrers, radiology staff and senior management. The CHC have been fully involved with the approach from the outset, and have confirmed that the engagement undertaken to date has been appropriate. We have also shared the information and facilitated discussion with Powys CHC.

It is important to note that at this stage the case does not identify the preferred single site (as in options 3 and 4) or two sites (as in option 2). This analysis will be undertaken as part of developing the OBC/FBC, and will require a further systematic engagement exercise.

5. The Commercial Case

5.1 Introduction

This section of the SOC outlines the proposed deal in relation to the preferred way forward, as outlined in the economic case and provides a very high level, preliminary view. Detailed analysis will take place at OBC stage.

5.2 Required Services

The current anticipated nett departmental or construction cost is below £4m so it is intended that the construction works will be procured via Sell to Wales with support from NHS Wales SSP. NWSSP-SES typically provide support to BCUHB for the larger equipment procurements from NHS Supplies frameworks.

5.3 Potential for Risk Transfer

This section provides an initial assessment of how the associated risks might be apportioned between BCUHB and the contractor. The general principle is to ensure that risks should be passed to *the party best able to manage them*, subject to value for money. The table below outlines the potential allocation of risk, which is the standard distribution at this stage in the development of a scheme.

Risk Category		Potential Allocation		
		Public	Private	Shared
1.	Design Risk			√
2.	Construction and Development Risk			√
3.	Transition and Implementation Risk	√		
4.	Availability and Performance Risk			√
5.	Operating Risk	√		
6.	Variability of Revenue Risks	√		
7.	Termination Risks			√
8.	Technology and Obsolescence Risks			√
9.	Control Risks	√		
10.	Residual Value Risks	√		
11.	Financing Risks	√		
12.	Legislative Risks	√		
13.	Other Project Risks	√		

5.4 Personnel Implications (including TUPE)

It is anticipated that the TUPE (Transfer of Undertakings (Protection of Employment) Regulations 1981) will not apply to this investment as outlined above.

5.5 Procurement Strategy and Implementation Timescales

With an anticipated nett departmental or construction cost of below £4m these works will not be procured via the Designed for Life: Building for Wales major capital framework which applies to schemes over this level. An outline design for the department or construction works to support the OBC/FBC will be completed by the multi-disciplinary design team from the existing BCUHB consultant framework and prepared for tender issue via Sell to Wales by the cost advisers on the same framework.

A clinical evaluation of gamma cameras and PET CT systems available to the UK market will be completed by evaluation teams to inform the typical 60% this element forms with the remaining 40% being the technical and commercial responses returned by suppliers in response to BCUHB specifications. BCUHB is normally supported through this process by NWSSP-SES and Procurement Services with the equipment being procured via existing NHS Supplies frameworks.

6. The Financial Case

6.1 Introduction

The purpose of this section is to set out the indicative financial implications of the preferred way forward (as set out in the economic case section).

The detailed analysis of the financial case, including the final conclusion about affordability, will take place at OBC/FBC stage.

6.2 Capital Costs

The estimated total cost of the preferred way forward is between £10 and £11 million at PUBSEC Index 248, and the cost forms are enclosed as Appendix F.

The preferred way forward is also the option with the highest capital cost, so this is the best estimate of the maximum capital cost of the scheme.

The cost includes the purchase of two new Gamma Cameras as well as a PET-CT scanner, at a combined equipment cost of approximately £3.4 million. It should be noted that the Gamma Camera in Wrexham is on BCUHB's list of equipment requiring urgent replacement. If early funding is available this camera could (and should, given the current risks) be purchased prior to the completion of the OBC/FBC, as Gamma Cameras can be relocated if necessary.

6.3 Impact on the Organisation's Income and Expenditure Account

The revenue analysis below compares the current costs with a preliminary analysis of the preferred way forward. Overall, this project delivers recurring revenue savings, currently estimated at £210,000.

The main reasons for this are as follows:

- The number of gamma cameras goes down from three to two, reducing equipment running costs
- Staffing efficiencies can be achieved by consolidating the gamma camera service onto a single site. The same staff can also run the PET-CT service. This means that there only needs to be a small increase in the number of staff employed to allow the Health Board to run the PET-CT service, while there are substantial savings from ending the contract for the current mobile service.

The scale of saving fluctuates during the first four years, depending on when maintenance costs are incurred (it is assumed that there are no maintenance costs in the first year after the 2 Gamma Cameras and the PET-CT are purchased).

The cash flow projection based on current information is detailed below:

	20/21	21/22	22/23	23/24	Recurrent
	Year 1	Year 2	Year 3	Year 4	Year 5
	£000's	£000's	£000's	£000's	£000's
Projected Costs					
Capital Costs	72	1,514	3,931	4,930	0
Revenue Costs	1,362	1,362	1,364	1,107	1,207
Depreciation	10	227	788	1,492	1,492
Total Costs	**1,444**	**3,103**	**6,083**	**7,529**	**2,699**
Proposed Funding Stream					
WG Capital	72	1,514	3,931	4,930	0
WG Funding Depreciation Charge	10	227	788	1,492	1,492
Existing Revenue Funding	1,417	1,417	1,417	1,417	1,417
Total Funding Stream	**1,499**	**3,158**	**6,136**	**7,839**	**2,909**
Saving	(55)	(55)	(53)	(310)	(210)

** Years 5 and 6 will be the same as year 4. In year 7 the centralisation/excess travel costs cease, giving the recurring position.

Further detail about the revenue calculations are enclosed in Appendix G.

It should also be noted that while it is envisaged that the level of PET activity will increase, and one of the drivers of this case is to accommodate that increase in the most cost-effective way, the analysis at this stage is a like-for-like comparison assuming no change in current activity. However it is important to understand that the marginal cost per case of any increased activity will be significantly lower under the preferred way forward than through the current service configuration. This will be explored further in the OBC/FBC. The OBC/FBC will also explore the potential to increase income by offering capacity for neighbouring organisations and undertaking research.

Given that there is a net revenue saving for current levels of activity, and any additional activity will be commissioned via WHSSC, this case is affordable.

7. The Management Case

7.1 Introduction

This section of the SOC addresses the achievability of the scheme. Its purpose is to set out the actions that will be required to ensure the successful delivery of the scheme.

7.2 Project Management Arrangements

The project management arrangements for capital projects are outlined in the *Procedure Manual for Managing Capital Projects*, which was adopted by the Health Board in May 2015 (updated October 2018).

The project will be managed in accordance with PRINCE 2 project management methodology to enable a well-planned and smooth transition to the new service models. There will be a strong focus on the delivery of the objectives and benefits.

The Senior Responsible Officer (SRO) for the project is Adrian Thomas, Executive Director of Therapies and Health Sciences.

7.3 Target Milestones

The target milestones for the project are as follows:

Milestones	Target Date
Submit SOC to Welsh Government	September 2020
Receipt of SOC approval by Welsh Government	January 2021
Submit combined OBC / FBC to Welsh Government	November 2021
Receipt of OBC / FBC approval by Welsh Government	April 2022
Completion and Handover	November 2023

7.4 Use of Special Advisers

Special advisers will be used as required, procured via the BCUHB Framework supported by NWSSP

8. Conclusion and Recommendation

This Business Case is recommended for approval.

List of Acronyms

Acronym	Definition
ARSAC	Administration of Radioactive Substances Advisory Committee
AWPET	All Wales PET Advisory Group
BCUHB	Betsi Cadwaladr University Health Board
BJC	Business Justification Case
CHC	Community Health Council
CSF	Critical Success Factors
CT	Computed Tomography
DGH	District General Hospital
EqIA	Equality Impact Assessment
EMG	Executive Management Group
GMP	Guaranteed Maximum Price
HIA	Health Impact Assessment
HIW	Health Inspectorate Wales
IPFR	Individual Patient Funding Request
IR(ME)R 2017	Ionising Radiation Medical Exposure Regulations
MRI	Magnetic Resonance Imaging
NWSSP	NHS Wales Shared Services Partnership
PET	Positron Emission Tomography
PET CT	Positron Emission Tomography Computed Tomography
TUPE	Transfer of Undertakings (Protection of Employment) Regulations
VfM	Value for Money
WG	Welsh Government
WHSSC	Welsh Health Specialised Services Committee
WMH / YMW	Wrexham Maelor Hospital
YG	Ysbyty Gwynedd
YGC	Ysbyty Glan Clwyd

Imaging Statement of Intent

This *Statement of Intent* addresses the current challenges in diagnostic and therapeutic imaging in the Welsh National Health Service. It signals the Welsh Government's commitment to adopt a new strategic approach to the development of high quality, effective and sustainable imaging services for NHS Wales that address the needs of the population, respond to current and future policy direction and ensure long term sustainability. The Statement is consistent with the Welsh Government ambitions outlined in Taking Wales Forward: Healthy and Active as well as recommendations made in Parliamentary Review of Health and Social Care in Wales by increasing investment in facilities to reduce waiting times; exploiting digital technologies to help speed up the diagnosis of illness. To achieve this we require a coordinated approach to diagnostic processes such as imaging. Central to our ambition are alternatively configured service models for imaging, including where it is provided, how it is staffed, how it is accessed, workforce development, informatics and information support, thriving research and innovation, and appropriate investment in equipment. We will establish a nationally coordinated, prudent imaging implementation plan to support the provision of imaging services across Wales that are sustainable and provide the best outcomes for Welsh patients.

Diagnostic imaging services provide a significant role in the investigation of disease, helping determine patient management through accurate diagnosis. This is predominantly provided in Radiology Departments (X-Ray) in hospitals with different imaging modalities which include radiographs (x-rays), Ultrasound, CT, MRI and Nuclear Medicine. Highly skilled professionals, mainly Radiographers and Radiologists, undertake and interpret the imaging studies respectively. Imaging investigations need to be carried out in a timely fashion, appropriate for the patient and their medical management. The imaging study then needs to be interpreted and reported promptly to maximise its impact on the patient's care *as* informed by the Welsh Radiology Reporting Standards. These imaging techniques are also used to guide targeted intervention such as liver biopsy, spinal injections and aorta repair (EVAR – endovascular aneurysm repair).

Imaging is a key component in the delivery of prudent health services to the population of Wales and a key enabler to Welsh Government health delivery plans including cancer and stroke. Innovative, state-of-the-art imaging facilities in Wales have established a strong international reputation, including Cardiff University's Brain Research Imaging Centre (CUBRIC) and the Wales Research and Diagnostic Positron Emission Tomography Imaging Centre (PETIC). Exciting new initiatives provide opportunities to enhance this reputation and fully exploit the clinical, research and economic potential of Wales' thriving life sciences sector.

Imaging services are provided by a wide range of different specialty and professional groups and account for a significant proportion of the NHS budget. As demonstrated by a recent Welsh Audit Office review, current services are under increasing pressure with major growth in demand as a result of more effective clinical pathways, increasing numbers of older people, increasing cancer incidence, improved

technology, new techniques and workforce pressures resulting in delays to patients accessing the appropriate imaging services for their needs.

As demonstrated by the Royal College of Radiologists annual census, the number of Magnetic Resonance Imaging (MRI) and CT scans performed is increasing by over 10% each year yet failing to keep pace with the growth in demand. The increased demand on imaging services come from varied sources: National Institute for Health and Care Excellence (NICE) recommendations, increased number of attendances, increased diversity of investigations, increasing access to diagnostic services, and the developing requirements of interventional radiology. Imaging is also associated with many benefits, for example, minimally invasive interventional radiology procedures have transformed aortic repair with reduced morbidity, mortality and hospital stay, compared to open surgical procedure, and treatment of patients hitherto excluded due to high general anaesthetic risk.

The demand for imaging, both image acquisition (scanning) and prompt clinical interpretation and reporting significantly outstrips current capacity across all types of imaging, compromising high-quality patient care and incurring unnecessary delays in care pathways. Capacity issues are exacerbated by difficulties in recruiting to consultant radiologist, radiographer and sonographer vacancies; the level of difficulty varies according to geographical location. Clinical imaging remains a popular specialty for medical trainees but training capacity does not match current workforce deficits.

Wales has seven radiologists per 100,000 population, compared to a European average of 12, and the 160 whole time equivalent consultant workforce in Wales has the oldest demographic in the United Kingdom; based on a retirement age of 62 years, 26% are anticipated to retire by 2020. The situation for radiographers and sonographers is no better; both professions are on the UK shortage occupations list. Similar challenges exist for other professionals such as cardiologists who spend increasing amounts of their time undertaking diagnostic imaging.

The imaging service in Wales is currently being sustained by outsourcing image reporting to the private sector, at a projected cost of at least £11 million over the next three years, and a heavy reliance on locum appointments, placing additional pressure on NHS resources. Delays in reporting are a major issue; despite an average turnaround of less than ten days, there is unacceptable variation with delays in some reporting of six months or more. In a recent consultation by the Royal College of Radiologists, Wales was the worst area of the UK with respect to access of images in an external picture archiving and communication system, with 83% of respondents reporting difficulty. The provision of clinically appropriate imaging services in Wales is unsustainable without significant change.

There are major opportunities to reconfigure the service model in a way that improves care pathways, is sustainable and cost-effective. This will involve increased primary care access to imaging, improved demand management and the creation of a national imaging network that is integral to a whole system approach to care pathway development and management in NHS Wales. Reconfiguration will require national targeted investment in imaging and a significant proportion of this will be recovered from the introduction of more efficient pathways, earlier diagnosis

at the appropriate stage of the pathway, reduced waste and savings in other service areas, including through reduced outsourcing.

Key Priorities

1. Public Involvement and Engagement

The public are central to healthcare in Wales and should be at the heart of imaging service development. Facilitating meaningful public involvement and engagement will allow the public, patients and professionals to work together as equal partners to co-produce imaging services for Wales that make a real difference. Co-production will promote a values based approach that focuses on achieving the outcomes that matter to the population of Wales, rather than being over-focused on the service delivery process.

Active public involvement and engagement will be facilitated by providing members of the public access to the support necessary to enable them to be involved.

ACTIONS

- **NHS Wales to develop meaningful linkages with the public to facilitate co-production of imaging services.**

2. Workforce Development

A significant element of the solution to addressing the large workforce shortfalls described above is the establishment of a NHS Wales Imaging Academy sited in South Wales that has an all Wales remit and significantly improves training capacity. The Academy will innovatively facilitate enhanced capacity for training and combine training with regional service provision to address the major but uneven recruitment challenges across Wales. A dedicated building will house state of the art facilities for teaching knowledge and practical skills and provide supervised interpretation of imaging from all NHS Wales Health Boards and Trusts.

Initially, the Academy will focus on training radiologists to perform tasks that only a radiologist can competently undertake, but rapidly extend this to radiographers and other professionals who will be critical to ensuring a sustainable imaging workforce for the future. Development of extended roles for other staff groups, especially radiographer reporting, will increase capacity in a cost-effective and sustainable manner working within the reporting team. Work will also be undertaken to drive skill mix change within the support workforce, including developing and training radiography assistant practitioners. The Academy will be a greenhouse for a prudent multidisciplinary integrated workforce and education.

In parallel with the work of the Academy, a strategic approach will be developed and implemented to increase skills and capacity within other critical imaging workforce groups, for example, breast clinicians, cardiac clinical physiologists and clinical scientists, cardiologists, medical physicists, physiotherapists, podiatrists, nurses and midwives. Development of an optimally configured future imaging workforce to

deliver the agreed service model will be supported by the *Train/Work/Live in Wales* initiative.

ACTIONS

- **The NHS Wales Imaging Academy will be established to develop a sustainable and flexible imaging workforce to deliver a modern, responsive diagnostic imaging service for Wales.**

- **Health Education and Improvement Wales will facilitate the development of an integrated workforce training strategy for Radiologists, Radiographers, Sonographers, Advanced Practitioners, Assistant Practitioners and other Imaging Healthcare Professionals in Wales.**

- **Welsh Government, in conjunction with NHS organisations, will establish funding models to allow the delivery of a national approach to workforce training that is appropriate for modern, flexible training combined with regional service provision.**

3. Equipment

Reliable, safe and modern imaging equipment is a pre-requisite for an effective and sustainable imaging service. Fit for purpose equipment is expensive, its value rapidly depreciates and its lifetime varies dependent upon its use, technological advances, maintenance and changes in clinical practice. On average, imaging equipment has an expected asset life of eight years. 2014 data published by the OECD in 2016 showed that Wales had ten CT and eight MRI scanners per million population compared with eight and seven for the UK as a whole and an average of 16.7 and 11.7 for France, Germany and Spain. In addition to the shortfall in the number of MRI and CT scanners in Wales compared to other high income countries, there is a need to invest in technologies such as Cardiac CT and MR, and Hybrid Positron Emission Tomography (PET) imaging with either CT or MRI imaging facilities.

In order to strategically plan, identify and address the imaging equipment needs of NHS Wales, a co-ordinated national approach will be established. This will include the identification, evaluation and, when appropriate, prioritisation and adoption of new technologies, and imaging equipment for specialties outside radiology such as cardiology. The national approach will also ensure that necessary complementary workforce developments are progressed in parallel with the evolving equipment infrastructure.

Planning will be based on the needs of the population through scrutiny of data that allows objective appraisal of what is required. Configuration of imaging equipment will be undertaken in a manner that is optimal for Wales as a whole and based on the principles of facilitating equitable access to and timely reporting of imaging wherever an individual lives. This will require a collaborative, regional approach towards demand and capacity planning and resourcing.

ACTIONS

- **Welsh Government will continue to support the development of a prioritised and sustainable capital replacement programme.**
- **NHS Wales will establish a co-ordinated approach to identifying, evaluating, prioritising and adopting new imaging technologies across NHS Wales.**
- **NHS Wales will ensure that regional utilisation and workforce considerations are central to equipment procurement decisions.**

4. Quality

A strong focus on improving the quality and safety of imaging services will be central to future provision. This will be contributed to by access to appropriate equipment and training and education programmes for staff but changes to the way we work will be vital to drive the transformative change required. Following the principles of prudent healthcare, future imaging services will ensure the public, patients and professionals work together as equal partners through co-production; care for those with the greatest health need first, making the most effective use of all skills and resources; do only what is needed, no more, no less, and do no harm; and reduce inappropriate variation using evidence based practices consistently and transparently.

A values based approach that is driven by health outcomes that really matter requires the development of a service model that is regularly updated as new knowledge emerges and through constant evaluation and monitoring, including benchmarking. The routine use of appropriate patient reported experience and outcomes measures will improve quality and place an emphasis on demonstrating the value of services delivered.

ACTIONS

- **NHS Wales will develop an evidence-based, data-driven and outcomes focused quality improvement framework that is based on the principles of prudent healthcare.**
- **NHS Wales, working with Welsh Government, will commission and evaluate research to support efficient and prudent use of imaging modalities and clinical imaging pathways.**

5. Services

As sophisticated imaging has become more central to the delivery of more effective prudent healthcare, the range of services has diversified and increased. They are now routinely provided both within and outside radiology/radiography departments, in primary and secondary care settings and are integral to many clinical pathways.

Further work is now required to ensure that imaging services are networked and delivered by the most appropriate people working at the top of their licence, in the most appropriate place as a fundamental element of an integrated and prudent healthcare system. It is vital that imaging experts are centrally involved in the data and evidence driven planning and delivery of all clinical services that rely on imaging and that care pathways are co-produced with all relevant stakeholders, not least the public and primary care providers.

Imaging service will be strengthened as part of a co-ordinated and networked approach to their planning and delivery. We will review service models and clinical pathways to provide optimal imaging services for the adult population of Wales. This will include a greater focus on primary care and expansion of the potential imaging workforce, with development of a strong mixed healthcare professional workforce. Services for such an approach include:

- Cardiac imaging – rapidly expanding service requirement including echocardiography, cardiac MRI and CT
- Interventional Radiology - including management of acute life threatening haemorrhage and the delivery of minimally invasive therapies
- Neuroradiology – includes early diagnostics of stroke and interventional services for minimally invasive therapies such as clot retrieval in stroke
- Nuclear Medicine – including the continuing development of PET-CT services in Wales
- Screening – Imaging is a substantial part of *Breast Test Wales*, *Bowel Screening Wales*, *Wales Abdominal Aortic Screening Programme* and *Antenatal Screening Wales*.

a. Antenatal Imaging and Imaging for Children

Antenatal screening is delivered by Welsh Health Boards in line with agreed policy and standards set by the managed clinical network (*Antenatal Screening Wales*). Equity of access to a high quality, timely and evidence-based service is key to ensuring consistency across Wales for our pregnant population. Sonography capacity has been a limiting factor to roll out some of the UK National Screening Committee recommendation in a timely way such as combined screening for Down's Syndrome Screening. This is now fully rolled out and the external quality assurance undertaken demonstrates the high quality that the sonography service delivers to in Wales.

Obstetric and Doppler ultrasound services are heavily pressured and vital to reduce stillbirth rates and meet guidelines for foetal monitoring. These services will be reviewed and rationalised through a quality assurance programme.

Paediatric radiology is a distinct sub-specialty. A sustainable neonatal and paediatric imaging and interventional radiology service model for children in Wales will be developed, including the provision of a fully staffed out of hours service. A tiered model will be developed where networked centres share images and reports. The level 1 site will be at the Children's Hospital for Wales, supported by the provision of in hours remote and on site image reporting and second opinion at level

2 sites. Paediatric Services for the population of North Wales will continue to be supported by Alder Hey Children's hospital Liverpool.

c. Imaging in Primary Care

Improved access to imaging through primary care services will reduce missed and delayed diagnosis and improve the efficiency, clinical and cost-effectiveness of many current care pathways. For example, Wales has the worst survival outcome for many cancers compared with similar health systems across three continents of the western world. Several contributing reasons include limited access to diagnostic tests, lengthy diagnostic pathways and a 'gatekeeper' approach from clinicians to protect the limited resource. A programme of work will be developed to support health boards across Wales to deliver key policy commitments to detect cancer earlier. The work programme will be based on models shown to be successful in other countries (e.g. Denmark) and promote a cultural shift in current approaches to cancer diagnosis across both primary and secondary care; ensuring they are aligned with the Welsh Government's vision detailed in the Cancer Delivery Plan 2016-2020. New ways of working to achieve earlier diagnosis will include: improving the diagnostic pathway; piloting new approaches to support earlier diagnosis; empowering radiologists to pro-actively move patients through the diagnostic pathway; developing and strengthening the professional relationship between primary care practitioners and secondary care diagnostic teams; and strengthening the role of the radiologist as a core clinician in multidisciplinary teams.

ACTIONS

- **NHS Wales will develop a regionally networked approach for the delivery of imaging for the population of Wales to ensure equitable access.**
- **NHS Wales organisations, will develop strategic plans for the delivery of imaging services to maximise workforce and imaging capacity utilization.**
- **Integrated service delivery plans for imaging will be delivered across Wales.**

6. Informatics and Information

Effective and high quality informatics systems and information are critical to the delivery of a world-leading, sustainable, effective and efficient imaging service. *Informed Health and Care: A digital Health and Social Care Strategy for Wales (2015)* clearly outlines the vision of improving access to information and introducing new ways of delivering care with digital technologies at the heart of Welsh Government's plans for NHS Wales. Images taken locally will be made available nationally with an interoperable picture archiving and communication system facilitating the drive to common standards and image sharing across Wales. This will make information available at the point of care, reduce unnecessary repeat imaging, allow safer transfer of care, reduce unnecessary delays and provide more efficient care pathways.

A common user interface based on nationally agreed standards with an integrated, once for Wales secure IT infrastructure across NHS Wales will be developed to allow electronic requesting, vetting, processing and reporting. Improved systems and data analytics based on common international standards will enable improved understanding of business demand, provide validated data for service modelling, benchmarking and improve demand management.

A new set of performance indicators will be developed to widen the range of performance information collated and used to deliver and improve the quality and consistency of imaging services. This will include routine measurement and monitoring of the demands on imaging services, the capacity of the services to respond to pressures and reduce risks. Standardisation of measurement will be agreed and adopted across Wales, and clear targets will be set for NHS Wales to achieve. The Welsh reporting standards for radiology services will be revised to ensure they are appropriate for these purposes, for internal and external benchmarking and to inform local and national service developments.

ACTIONS

- **Welsh Government will support the drive to a Once for Wales imaging platform based on agreed national standards across NHS Wales.**
- **NHS Wales will implement state-of-the-art business support informatics and radiology systems that can capture and report data in a consistent way to deliver a modern imaging service.**
- **Welsh Government will revise performance indicators to reflect and support the development and maintenance of a modern imaging service, including time to reporting, not just time to investigation.**

7. Research and Innovation

With its position at the cutting edge of medical science, imaging provides multiple opportunities for research and innovation through collaboration with various partners. There is a tradition of working with partners in the NHS, universities and industry to support high quality research studies, and to pursue new technologies with advances in equipment and techniques, including software development. Despite the opportunities and examples of research excellence in Wales, such as CUBRIC, the world-leading brain research imaging centre at Cardiff University, the potential of imaging research and innovation has not yet been fully realised in Wales. The NHS Wales Imaging Academy will act as a hub for research and innovation activity.

A strategic plan will be developed to ensure research and innovation opportunities are seized and Wales capitalises on its unique selling points. Central to the plan will be the ability to effectively support high quality research, to establish strong collaborations across sectors to undertake novel research and innovation that translates into clinical service change and to evaluate the true potential of new technologies including artificial intelligence/machine learning.

ACTIONS

- **Welsh Government will establish a strong research and academic base, with national and international collaboration, for imaging including radiology, radiography and medical physics in Wales.**

- **NHS Wales will provide effective imaging support for high quality service delivery and other research studies and innovation in Wales.**

8. Governance

A *National Imaging Network*, accountable to NHS Wales' Chief Executives, will be developed to co-ordinate imaging service development and provision for the Welsh Government and NHS Wales. This will include: provision of high quality training and education for the imaging workforce; leading the development of a sustainable Imaging Services Accreditation Scheme accredited imaging service across NHS Wales; advocating a nationally coordinated, locally delivered service; developing best practice guidance to reduce variation, improve patient outcomes and experiences; co-ordinating imaging research, development and innovation; supporting standardisation of imaging services, including NHS Benchmarking.

A high level advisory board will bring together chairs of working groups that will provide annual work programmes for imaging that feed into the IMTP process and also support the prudent healthcare agenda. The Medical Imaging Subcommittee will be configured to support the development and publication of best practice guidance to reduce variation, drive standardisation and improve patient experience and outcomes; provide horizon scanning, situational awareness and support research and development. The focus of both the National Imaging Network and Medical Imaging Subcommittee being on continuous improvement.

ACTIONS

- **Welsh Government to create a National Imaging Network, accountable to NHS Wales' Chief Executives, to co-ordinate imaging service development and provision for the Welsh Government and NHS Wales.**

- **Welsh Government to support the creation of a high level advisory board to the National Imaging Network.**

- **Medical Imaging Subcommittee will be reconfigured in order to support the imaging service improvement agenda.**

Next Steps

An imaging taskforce has been established to support the development of a national imaging implementation plan. The taskforce will be jointly chaired by Dr Rob Orford, Chief Scientific Adviser (Health), Welsh Government and Steve Moore, lead Chief

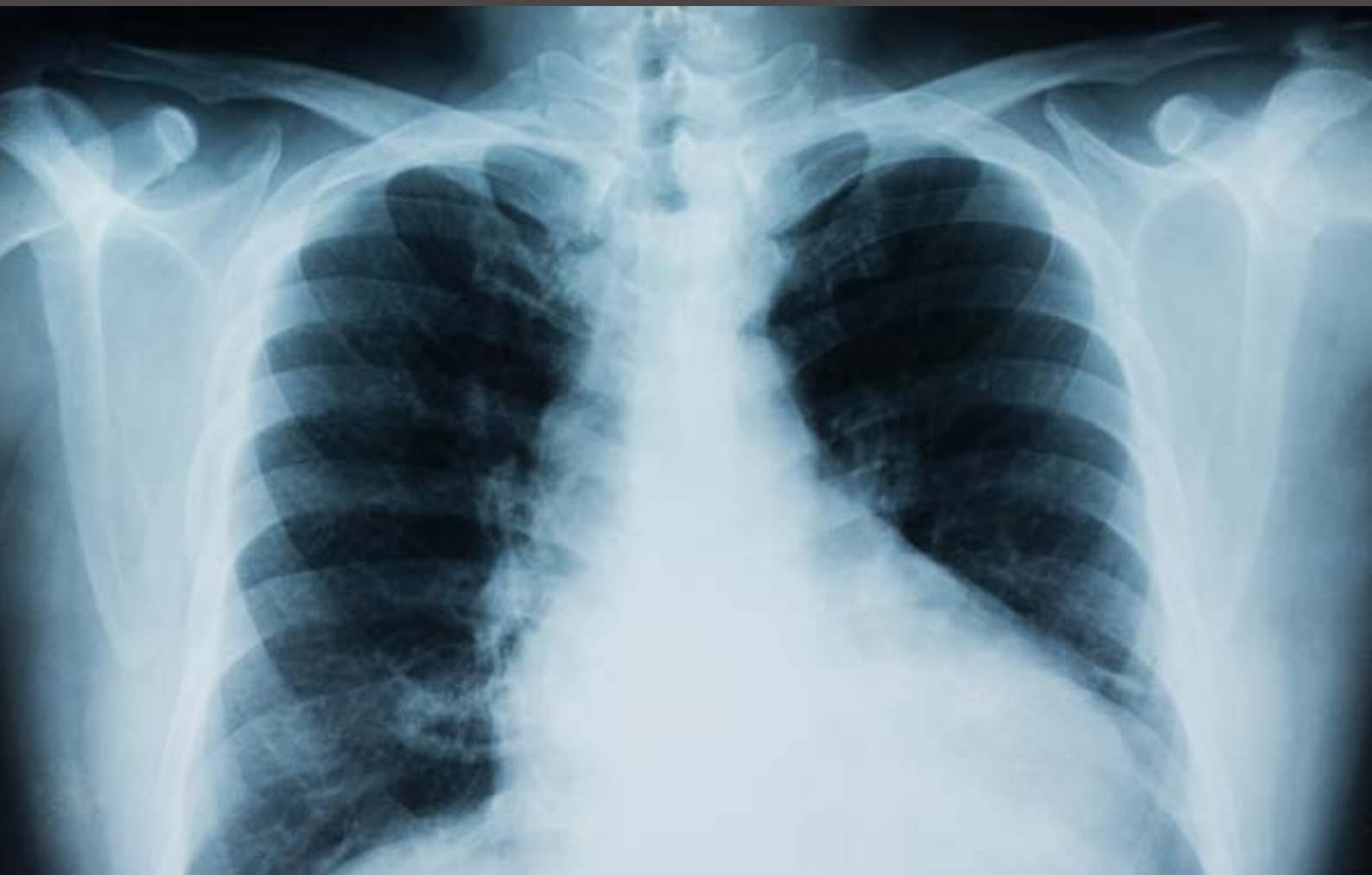
Executive for Imaging. The taskforce will engage with the public and other stakeholders and report back to Ministers in summer 2018. The implementation plan will be delivered together with the NHS in Wales, who have endorsed this Statement of Intent.

November 2018

Archwilydd Cyffredinol Cymru
Auditor General for Wales

Radiology Services in Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU



This report has been prepared for presentation to the National Assembly under the Government of Wales Act 1998 and 2006.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

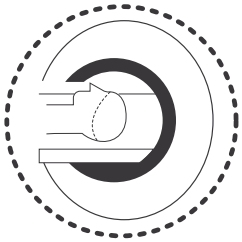
Summary report

Background

1 Radiology is a key diagnostic and interventional service used to help diagnose, monitor and treat disease and injuries.

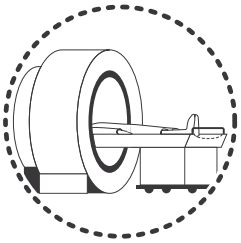
2 Hospital-based clinicians and general practitioners refer patients to radiology departments to undergo radiological examinations or to have images taken. Radiographers use sophisticated radiology equipment to produce differing types of images, depending on the issue being investigated. Exhibit 1 provides a summary of the key radiology techniques commonly used across the NHS.

Exhibit 1: key radiology imaging techniques



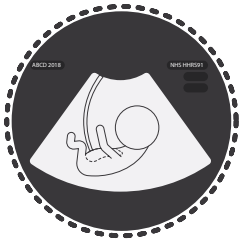
Computerised tomography (CT):

Uses X-rays and a computer to create detailed images of structures inside the body, including internal organs, blood vessels and bones. Patients lie on a bed that passes into a doughnut shaped scanner



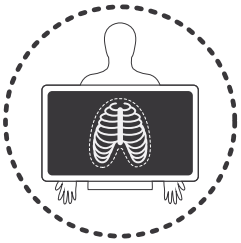
Magnetic resonance imaging (MRI):

Uses strong magnetic fields and radio waves to produce detailed images of the inside of the body. Can be used to examine almost any part of the body, including bones and joints, the heart and blood vessels, and internal organs, such as the liver. An MRI scanner is a large tube in which patients lie during the scan.



Ultrasound (US):

Uses high-frequency sound waves to create an image of a part of the inside of the body. Ultrasound probes gives off high-frequency sound waves. The sound waves bounce off different parts of the body, creating an "echo" that is picked up by the probe and turned into a moving image. This image is displayed on a monitor while the scan is carried out.



X-ray:

Uses radiation to pass through the body, the energy from X-rays is absorbed at different rates by parts of the body. X-rays are mainly used to look at bones and joints, but can also be used to detect problems affecting soft tissue, such as heart problems and tumours.

Source: NHS Choices

3 Following an examination, a clinical radiologist[1] will view the resulting image or images, and produce a report, which provides an interpretation. Radiologists play a key role in the clinical management of a patient's condition, advising on, and selecting the best imaging technique to enable diagnosis and minimise radiation exposure. Interventional radiologists have a more direct role in treating patients, using minimally invasive procedures, aided by radiology imaging, to diagnose and treat various diseases.

4 Many clinical decisions about the management of a patient cannot be made without a radiologist's input into the diagnosis. Where rapid diagnostic testing is in place, this enables clinical decisions to be made quickly.

5 **The Future Delivery of Diagnostic Imaging Services in Wales** (2009)[2] report set out that demand for some types of radiology examinations was increasing by between 10% and 15% per year.

6 In 2010, the National Imaging Programme Board was created at the request of NHS Chief Executives, as the primary source of advice, knowledge and expertise for the planning of diagnostic radiology services in Wales. The National Imaging Programme Board, through NHS Chief Executives was given delegated authority for developing and implementing a programme of strategic work for radiology, and for adopting all-Wales standards and protocols for radiology services across Wales. Since then, although progress has been made at a national level, a number of significant challenges are yet to be fully addressed.

7 It is widely accepted that there are ongoing difficulties in recruiting general and specialist radiology staff. There are also concerns about the capability of radiology information systems to support the delivery of services. In addition, radiology equipment is expensive to purchase and maintain. Waiting time performance in the past five years suggests that the current capacity of radiology services is not sustainable.

8 The Wales Audit Office report on **NHS Waiting Times for Elective Care in Wales** (January 2015)[3] showed that waiting time targets for diagnostic tests were not being met. Similarly, the Wales Audit Office report **A Review of Orthopaedic Services** (June 2015)[4], showed that the long waiting times for radiology examinations was contributing to long waits for overall orthopaedic treatment.

1 In this report, reference made to radiologists, includes consultant radiologists, middle-grade doctors, specialist registrars and junior doctors. Where there is any variation from this, the report content will specify what the variation is, for example, 'consultant radiologists'.

2 Welsh Assembly Government, The Future of Diagnostic Imaging Services in Wales, 2009

3 Wales Audit Office, NHS Waiting Times for Elective Care in Wales, January 2015

4 Wales Audit Office, Orthopaedic Services, June 2015

9 Given the challenges, the Auditor General commenced a review of radiology services at all health boards in Wales in late 2016. The work examined each health board's arrangements to meet demand for radiology examinations and made recommendations for service improvements. We excluded therapeutic radiology from the review. Appendix 1 provides the audit approach and methodology used for this work.

10 During 2016-17, the Wales Audit Office conducted a value-for-money examination of the NHS Wales Informatics Service[5]. The review considered the implementation of key NHS information systems, including the implementation of RADIS[6] across Wales. The report highlighted that frontline staff are dissatisfied with the functionality of RADIS.

11 This report summarises the key messages from the Auditor General's local work on radiology services, and refers to the findings set out in the Auditor General's separate report on the NHS Wales Informatics Service where relevant.

Key findings

12 Waiting time targets for radiology examinations are currently being met and our work has shown that radiology services are generally well managed. However, rising demand, difficulties with recruitment and retention of staff, outdated and insufficient scanning equipment, along with IT weaknesses are putting services under pressure and point to the need for clear and targeted action to ensure that radiology services are able to cope with future demand.

13 Our key findings are set out further in the paragraphs below.

Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results

14 Demand for radiology examinations is increasing each year, in particular for the most complex scanning techniques. The reasons for the increase in demand are numerous.

15 Where a GP or consultant decides that a patient is in need of a radiology examination, those referred as outpatients are added to a waiting list. Our review found that waiting lists are prioritised according to need, and all health boards review the appropriateness of the referral priority.

5 Wales Audit Office, Informatics systems in NHS Wales, January 2018

6 RADIS – Wales Radiology Information System.

16 Hospital inpatients with emergency health needs may need prompt access to radiology examinations. In normal working hours, hospitals set aside a small number of appointments to accommodate urgent inpatient cases. However, we found that out of hours access to radiology examinations for patients with urgent needs is variable. Whilst CT and X-ray examinations are available out of hours in most hospitals, MRI and US examinations are not.

17 There has been improvement in waiting time performance over the last five years, with a reduction in the number of patients waiting more than eight weeks for a radiology examination, supported by additional funding from the Welsh Government. Health boards have secured improvements in waiting times by outsourcing examinations to private sector mobile units and making use of unused capacity in other health boards.

18 Following a radiology examination, a report of the image is produced. Generally, reporting turnaround targets are met, however, some patients wait a long time for their results, and not all examinations are reported.

19 Whilst radiologists report most examinations, specially trained radiographers are able to report on less complex images. However, staff shortages were limiting health boards' ability to make greater use of radiographer reporting. As a result, health boards have relied on outsourcing reporting to help ensure timely turnaround of radiology reports.

Recruitment, retention and an ageing workforce are threatening the sustainability of the service and limiting health boards' ability to train staff

20 We found that all but one health board was struggling to recruit and retain radiologists and radiographers. Health boards have been increasingly reliant on using locum staff to bridge the gap caused by unfilled vacancies. At the same time, the radiology workforce is aging and at the time of our review, more than one third of radiologists and radiographers were aged 50 or over, and therefore, vacancy levels could increase without appropriate action.

21 To help address the reporting capacity shortfall, a National Academy has been set up to provide a training facility for trainee radiologists. The first cohort of trainees are due to commence training in September 2018.

22 We found that staffing shortages were limiting health boards' ability to train their staff, and all health boards were struggling to keep staff compliant with statutory and mandatory training modules.

Ageing and underutilised equipment are making it harder for health boards to meet demand and health boards do not have the staffing resources to extend opening hours

23 Comprehensive arrangements are required to ensure the maintenance and replacement of radiology equipment. Older imaging equipment is more expensive to maintain and has a greater risk of failure. At the time of our review, all health boards had equipment nearing the end of their lifespan. A capital replacement programme for radiology equipment requires significant funding, and as such, capital funding is provided on an all-Wales basis but not necessarily to the level needed to replace all out of date equipment. Since our review, the Welsh Government provided funding for additional radiology imaging equipment in 2016-2017 and 2017-18, and is working with health bodies to identify and prioritise further additional imaging investment over the period 2018-19 to 2020-21.

24 We found there was scope to increase the utilisation of scanning equipment in all health boards. However, additional radiology staffing would be required to achieve this. A further complication is that increasing operating hours would also lead to higher maintenance costs, and reduce equipment lifespans.

Wales-wide radiology IT system challenges and weaknesses in local IT infrastructures inhibit radiology services' efficiency

25 Our review found that the core radiology system, RADIS, was not fulfilling health boards' needs. Inadequacies in the system were causing difficulties for some health boards in planning and delivering radiology services and leading to inefficiencies. We also found that inadequacies in local IT infrastructures were also compounding inefficiencies.

26 At the time of our review, the absence of an e-referral system and weaknesses in Picture Archiving and Communications Systems (PACS) and voice recognition systems were creating inefficiencies in the planning and delivery of radiology services. However, since our review there has been phased implementation of electronic referrals as part of the wider rollout of the Welsh Clinical Portal.

Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services

27 We found that strategic and operational planning of radiology services need strengthening in most health boards. Only three health boards undertook demand and capacity modelling. At the time of our review, only one health board had a specific, detailed financial plan for radiology.

28 Performance data and audit results help health boards to monitor and evaluate the performance of radiology services. However, we found that most health boards had opportunities to widen the range of radiology performance measures reported to their Boards and Committees. In addition, currently there is no standard radiology activity measurement. Health boards do not record radiology activity consistently across Wales. This makes it difficult to provide true comparisons of activity and performance between health boards.

29 Our review found that the operational management and accountability arrangements for radiology services were clear and appropriate. We found that nearly all health boards are taking positive steps to reduce inappropriate referrals, but signposting to local referral guidance could be improved. However, since our review, access to national referral guidance has improved.

30 Our review also found that not all health boards had an executive lead for radiology that was a member of the Board. The absence of an executive lead for radiology attending board meetings at some health boards may mean the opportunity to highlight and monitor emerging issues is missed.

31 Given the nature of some of the issues facing radiology services, action taken alone by health boards will not be enough to ensure the future sustainability of radiology services. National strategic planning is required to address the challenges facing radiology services. Since we reviewed radiology services across Wales, the Welsh Government established an Imaging Taskforce to develop and deliver a high-level **Imaging Statement of Intent**[7]. The aim of the Imaging Statement of Intent (the Statement of Intent) is to address the challenges facing diagnostic radiology services in Wales. In developing the Statement of Intent, the Imaging Taskforce took account of the findings from our local work. The Statement of Intent was published in March 2018. It contains a number of actions for NHS Wales to address.

7 Welsh Government, Imaging Statement of Intent, March 2018.

Key challenges and recommendations

32 The findings from our work identify a number of key challenges that face health boards, and require action both locally and nationally by NHS Wales, or locally by some or all health boards. These are set out in Exhibit 2.

Exhibit 2: key challenges that need to be addressed nationally and locally

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Workforce		
• Ensure that the level of trainee radiologists and radiographers is sufficient to address recruitment challenges and increasing demand.	✓	
• Ensure that opportunities to maximise the contributions that support staff and other professions can make to radiology services are identified and secured.		✓
• Ensure that health boards have radiology workforce plans, which identify the capacity and skill mix required to sustainably meet current and future radiology demand in a timely and safe way.		✓
Equipment		
• Ensure that there is a national coordinated approach to address equipment needs, with sufficient funding for the replacement of equipment and purchase of new technology to meet increasing demand and technology advances.	✓	
• Ensure that health boards have equipment replacement programmes, which set out priorities, requirements and associated costs.		✓

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Demand		
• Ensure that regional levels of current and future demand are known, to enable planning for additional capacity to be coordinated across regions.	✓	
• Ensure that health boards know the current and future demand for each referring specialties that takes account of changes, such as to patient pathways.		✓
• Ensure that health boards have action plans that detail how waiting times and reporting targets will be achieved in the short-term, and sustained in the future.		✓
• Ensure that health boards can demonstrate a value-based approach to radiology services by making better use of benchmarking information across Wales and the UK.		✓
ICT		
• Ensure that information systems are efficient and enable reliable management and performance information to be produced, and facilitate the appropriate sharing of patient information and images within and between health boards.	✓	
Management of services		
• Ensure that management accountability and strategic oversight is appropriate to drive service improvements.		✓
• Ensure that referral guidance provides sufficient information and is accessible to referring clinicians.		✓

Key challenges	National action required by NHS Wales	Local action required by some or all health boards
Quality		
• Ensure that common procedure codes are in place and used to ensure that workload is measured consistently with and between health boards.	✓	✓
• Ensure that common performance indicators are in place to drive the consistency of benchmarking and improvement of services.	✓	✓
• Ensure that appropriate and robust performance quality measures are in place, which includes the review of patient experiences and service quality reviews.		✓
• Ensure that appropriate monitoring arrangements are in place at board and committee level.		✓

Source: Wales Audit Office

33 Our local audit reports set out specific recommendations for health boards. All health boards have prepared management responses setting out the actions they are taking to address audit recommendations. Our local reports and the associated management responses are available on the Wales Audit Office website (www.audit.wales).

34 The challenges that require a national response align closely to the actions set out in the Statement of Intent. Consequently, we do not see value in repeating those actions in the form of recommendations here.

35 The Imaging Taskforce, in consultation with the public and stakeholders, is developing a national imaging implementation plan for NHS Wales to address the actions set out in the Statement of Intent. We therefore base our recommendations around ensuring that national implementation adequately addresses the challenges identified through our work and the Statement of Intent.

Recommendations

The national challenges facing radiology services across Wales are reflected in the Imaging Statement of Intent and appropriate action has been identified. However, delivery against these actions is reliant on a timely national imaging implementation plan being developed and acted upon.

R1 The Welsh Government, through the Imaging Taskforce, should ensure that the national imaging implementation plan addresses each of the actions set out in the Imaging Statement of Intent, and the key challenges highlighted in this report.

R2 The national implementation plan should include clear implementation dates to deliver action in the short to medium term, with clearly identified accountabilities for delivery.

R3 The Welsh Government should properly cost the implementation plan and ensure that the necessary resources are in place to support delivery.

R4 The Welsh Government should ensure the necessary arrangements are put in place to monitor delivery of the national implementation plan.

Part 1

Despite increasing demand, diagnostic radiology examination waiting time targets are currently largely being met, however, some patients wait a long time for their examination results

Demand for radiology imaging is increasing annually, and in particular for the most complex scans

1.1 The growing role of radiology in clinical care has led to increasing demand for radiological examinations. A number of factors drives the increase in demand. This includes demographic changes, new clinical guidelines, lower thresholds for referral, and advances in technology and understanding about how the features of disease present themselves on diagnostic images.

1.2 In Wales, the total number of diagnostic radiology examinations undertaken per year increased by 9% between 2013-14 and 2016-17[8] (Exhibit 3). In addition, scans are becoming more complex. The biggest percentage rise in volume for radiological examinations has been for CT and MRI imaging due to an increase in their role in the early diagnosis of many diseases. Between 2013-14 and 2016-17, the number of CT scans undertaken per year increased by 33% and the number of MRI scans increased by 28% (Exhibit 3). MRI and CT examinations are complex and can include multiple images, and therefore, per patient examination, are more labour-intensive for radiologists interpreting images than other examinations, such as X-rays.

Exhibit 3: increase in demand for CT, MRI, US and X-ray imaging between 2013-14 and 2016-17

	2013-14	2014-15	2015-16	2016-17	Percentage increase 2013-14 to 2016-17
CT	235,861	256,935	284,672	313,947	33%
MRI	97,929	109,506	119,066	126,335	29%
Plain film X-ray	1,291,395	1,279,348	1,299,609	1,281,067	-1%
Total ultrasound	409,363	419,378	444,540	468,361	14%
All others	120,532	143,956	144,203	153,941	28%
Total examinations	2,155,080	2,209,123	2,292,090	2,343,651	9%

Source: NHS Benchmarking Network

8 These figures are based on data provided by five health boards who participated in the NHS Benchmarking Network review of radiology services. Hywel Dda University Health Board and Powys Teaching Health Board did not participate.

1.3 The increase in demand for radiology examinations is not unique to Wales. In England between 2013 and 2016 the number of CT examinations increased by 33% and MRI examinations by 31%, equating to a mean annual growth of just over 10%[9].

Patients on waiting lists are prioritised according to clinical urgency, and emergency access for radiology examinations in normal working hours is good, but emergency access out of hours is variable

1.4 While most radiology departments offer some form of open access to patients referred to the department as outpatients, the extent of access varies and typically is limited to X-rays only. Where open access is not available, patients are placed on a waiting list. The referral should specify the degree of urgency. This ensures that the patients with the most critical needs are seen first. The referrer assigns the urgency.

1.5 All health boards operate three priority levels for outpatients: urgent, urgent suspected cancer and routine. Urgent referrals are prioritised and seen as soon as they can be accommodated.

1.6 In all health boards, radiologists or appropriately trained advanced practice radiographers review the priority of the referral using the clinical information provided by referrers. The priority of the referral may be amended following review. This system ensures waiting lists are based on clinical priority.

1.7 However, only two health boards operate a centralised waiting list within the health board. Five health boards have separate radiology waiting lists in different parts of the organisation. By maintaining more than one waiting list, health boards are failing to manage demand on an organisation-wide basis, with the result that some patients may wait longer than they would have if they had been on a single waiting list.

1.8 Inpatients with emergency health needs may need prompt access to a radiology examination both within and outside of normal working hours. During normal working hours, all health boards told us they set aside a small number of appointments to accommodate emergency inpatient referrals, based on historic demand. However, the unpredictable nature of emergency demand means that sometimes, too much or too little time is allowed in the appointment timetable.

9 NHS England, Diagnostic Imaging Dataset (accessed 24 August 2017).

1.9 Out of hours provision is based on staff working on call rotas. At the time of our review, access to out of hours examinations for inpatients with urgent healthcare needs was variable across health boards. CT scans and X-rays were available out of hours at the majority of hospital sites, and at least one hospital site at each health board provided cover. However, out of hours MRI scans and US scans were not available in three health boards.

The percentage of patients waiting more than eight weeks for an examination has fallen in the last five years, waiting time performance has been helped by securing additional scanning capacity from the private sector

1.10 All NHS bodies in Wales are required to comply with the Welsh Government diagnostic waiting times target which states that no patients should wait more than eight weeks to receive their diagnostic test[10].

1.11 Since 2009, waiting times for radiology examinations have also formed part of the referral to treatment target[11], where the referral for radiology has been made as part of the patient pathway. Health boards in Wales are required to ensure that 95% of all patients waiting for elective treatment receive their treatment within 26 weeks from the point at which the referral was received. For many of these patients, diagnostic tests help decide which treatment is the best option.

1.12 In March 2018, there were no patients waiting more than eight weeks for a diagnostic radiology examination at three health boards. However, there were patients waiting more than eight weeks for a radiology examination at Aneurin Bevan, Betsi Cadwaladr and Cardiff and Vale University Health Boards, and Powys Teaching Health Board[12]. Exhibit 4 provides the number of patients that had been waiting more than eight weeks at the time of our review, and in March 2013 and March 2018.

10 The diagnostic waiting time target applies to all radiology examinations including MRI, CT, and non-obstetric US, fluoroscopy, barium enema, and nuclear medicine. The Welsh Government target does not include X-rays.

11 Welsh Health Circular (2007) 014 – Access 2009 – Referral to Treatment Time Measurement, Welsh Health Circular (2007) 051 – 2009 Access – Delivering a 26 Week Patient Pathway – Integrated Delivery and Implementation Plan and Welsh Health Circular (2007) 075 – 2009 Access Project – Supplementary Guidance for Implementing 26-Week Patient Pathways.

12 Abertawe Bro Morgannwg, Betsi Cadwaladr, Hywel Dda University Health Boards and Powys Teaching Health Board. Powys Teaching Health Board provides plain X-ray and US examinations only, other imaging and interventional procedures are commissioned from a range of providers in neighbouring health boards in Wales and NHS trusts in England.

Exhibit 4: all-Wales waiting times for CT, MRI and non-obstetric US scans[1]

		Total number of patients waiting for an examination					
		Up to 8 weeks	Over 8 weeks and up to 14 weeks	Over 14 weeks and up to 24 weeks	Over 24 weeks	Total waiting	Percentage of patients waiting more than 8 weeks
CT scan	March 2013	6,777	159	61	5	7,002	3%
	August 2016[2]	7,301	63	51	11	7,426	2%
	March 2018	8,054	9	1	1	8,065	0%
MRI scan	March 2013	11,087	2,520	2,241	278	16,126	31%
	August 2016[2]	11,662	913	66	163	12,804	9%
	March 2018	10,662	121	59	62	10,904	2%
Non-obstetric US scan	March 2013	19,454	3,110	867	7	23,438	17%
	August 2016[2]	18,944	1,999	626	133	21,702	13%
	March 2018	20,097	13	0	0	20,110	0%

Notes:

1 Waiting time targets do not apply to X-rays as most health boards provide open access for X-ray examinations.

2 Waiting time data reported in our local reports.

Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

1.13 Exhibit 4 shows that waiting time performance has improved over the last five years, although there have been fluctuations in performance (Appendix 2). Generally, the month 12 performance has shown an improvement compared to the full year's performance in general. The improvement is a result of a concerted effort by health boards to meet waiting time targets, often funded with additional Welsh Government monies. Whilst the waiting time target applies all year around, performance monitoring tends to focus on the year-end performance as opposed to performance during the year.

1.14 Health boards have achieved reductions in waiting times for radiology examinations over the last five years by securing additional scanning capacity by outsourcing imaging to private sector mobile CT and MRI units, and utilising unused capacity in other health boards. In 2014, the Welsh Government provided £840,000 to radiology services across Wales to reduce the backlog of patients waiting more than eight weeks for an MRI examination[13]. Since then, health boards have funded initiatives to keep waiting times within the eight-week target by outsourcing examinations and increasing radiology opening hours.

Whilst average reporting turnaround targets were largely being met, some patients waited more than six months for results, and health boards were unable to make full use of their reporting capacity

1.15 A report outlining the interpretation of the image must be produced following a radiology examination. This report is then used to make further decisions about the ongoing care of the patient.

1.16 All examinations must be reported and provided to the referring clinician within a timeframe appropriate to the patient's clinical condition. The Welsh Reporting Standards for Radiology Services 2011 were produced in order to clarify previous guidance and regulations[14]. The Standards range from same-day to ten working days.

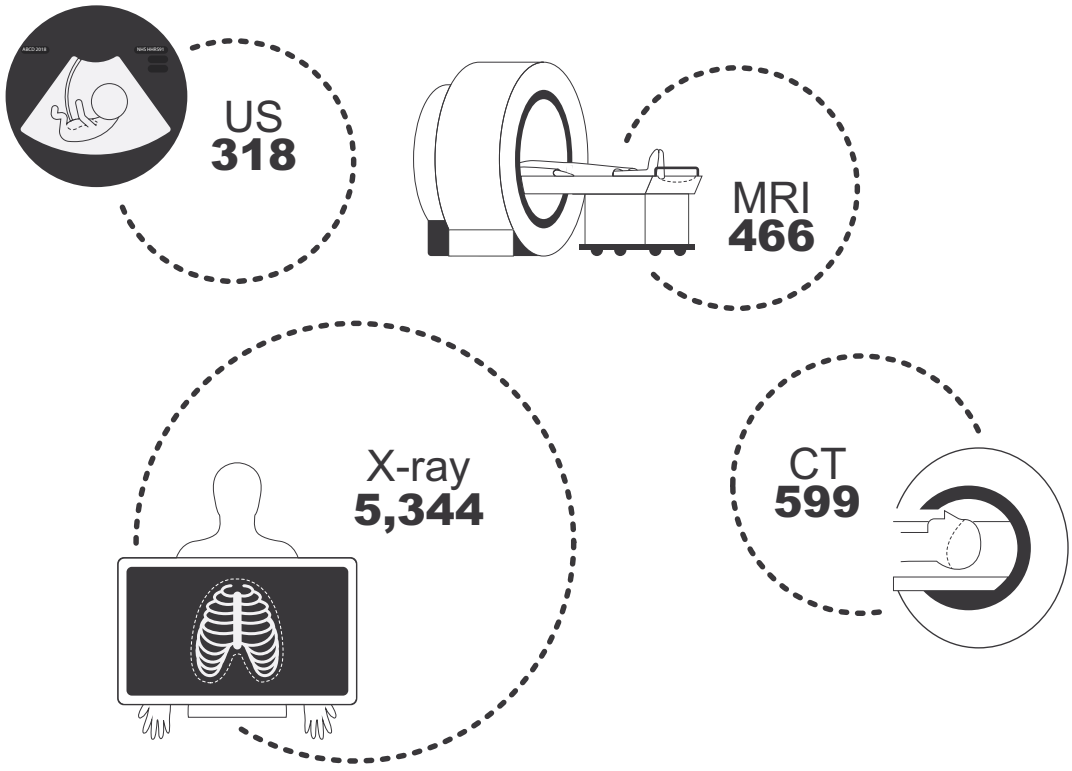
13 In January 2014, 41% (7,179) of patients waiting for an MRI had been waiting more than eight weeks, 1,463 patients had waited more than 24 weeks.

14 Produced by the Medical Imaging Sub-committee (a sub-group of the Welsh Scientific Advisory Committee). The Reporting Standards for Radiology Services 2011 set out that radiology should aim to provide reporting turnaround times appropriate to the type of referral as follows: urgent – immediately/same working day; inpatient – within one working day; accident and emergency – within one working day; GP – within three working days; and outpatient – within ten working days.

1.17 We asked health boards to provide the average and longest reporting times and the number of unreported examinations for CT, MRI, US and X-ray imaging by hospital. The type of referral (for example urgent, inpatient, GP) is not routinely available. The average reporting time between 1 April 2015 and 31 March 2016 for each type of scan was 10 days or less at all but one of the hospitals participating in the review[15]. However, local audit work found that some patients wait a long time for their scan to be reported. At the time of the audit, the longest report turnaround time was over six months. Exhibit 5 shows the number of unreported examinations at the end of March 2016. Whilst these represent less than 1% of the total examinations undertaken, they nonetheless show that a notable number of examinations have delayed reporting or are not reported at all, with associated quality of care risks to patients from delayed diagnosis and treatment.

Exhibit 5: number of examinations not reported as at 31 March 2016 across Wales[1]

Total for hospitals participating in the review



Note:

1 Unreported examinations include those examinations that remain unreported more than 10 days since the examination date. The figures exclude Cardiff and Vale University Health Board and Powys Teaching Health Board.

Source: Wales Audit Office, Hospital Site Survey

15 One hospital told us that the average reporting time for X-rays was 16 days.

1.18 Whilst radiologists report most images, specially trained radiographers provide additional reporting capacity. Extended practice radiographers (EPRs) receive training to interpret and report some types of images, typically less complex scans, such as X-rays, and sonographers report US scans.

1.19 Whilst all health boards, with the exception of Powys Teaching Health Board, have invested in EPRs, at the time of our review shortages in the radiology workforce across Wales was making it difficult for health boards to utilise EPR reporting skills. Our review found that resourcing constraints in the radiologist workforce meant that opportunities to train and support EPRs were limited. Similarly, radiographer shortages has resulted in health boards being unable to release EPRs from undertaking examinations, to enable them to report images, resulting in reduced reporting capacity within health boards.

1.20 Radiologist staffing shortages and the resulting reduction in EPR reporting capacity led to the introduction in November 2014 of a national contract to provide additional, outsourced reporting capacity from the private sector. Radiology Reporting Online Limited was awarded a contract to provide reporting capacity across Wales. The contract was initially for a two-year period, with an option to extend the contract for an additional year. The contract value was £1.5 million (excluding VAT) for the initial two-year period. However, increasing demand, particularly for CT and MRI reporting, resulted in the service being used significantly more than predicted with the actual spend across the initial two-year contract being £3.5 million excluding VAT. The contract was subsequently extended until November 2019, at a cost of £11 million over the three-year extension. At the time of our review, outsourced reporting capacity bridged the gap created by staff shortages, but is not a sustainable solution for the long-term.

Part 2

Workforce challenges are threatening the sustainability of the service and limiting health boards' ability to train and appraise staff

All but one health board is struggling to recruit and retain radiology staff, resulting in a reliance on locums

2.1 Radiologist, radiographer and sonographer vacancy levels compound the ability to meet increasing demand for radiology examinations. On 31 March 2016, there were 112 full time equivalent (FTE) vacancies within radiology departments across four health boards in Wales (Exhibit 6).

Exhibit 6: number of radiology staff vacancies in Wales as at 31 March 2016[1]

	Radiologists	Radiographers/ sonographers	Other radiology staff[3]
Number of FTE vacancies	22	58	32
FTE vacancies as a percentage of the FTE establishment[2]	15%	9%	6%

Notes:

1 The figures are based on four health boards. Cardiff and Vale, Cwm Taf University Health Boards and Powys Teaching Health Board did not provide their vacancy levels.

2 The FTE staffing establishment is the level of staff that the Health Board has determined it needs to provide services and for which funding has been made available.

3 Other radiology staff includes staff such as nurses, scientific and technical staff, healthcare support workers and administrative staff.

Source: Wales Audit Office, Hospital Site Survey

2.2 Whilst vacancy levels were reasonably consistent across the health boards providing data, there were particularly high radiologist vacancy levels at Hywel Dda University Health Board with 42% of FTE establishment posts vacant. The relatively high vacancy rate for radiologists shown in Exhibit 6 creates particular challenges. Many radiologists specialise in a particular area, meaning that the loss of a single radiologist can have a big impact on a radiology department. For instance, at the time of our review there were two interventional radiologist posts in Cwm Taf University Health Board, however, only one was filled. The vacancy put the interventional radiology service under considerable pressure and resulted in restricted out of hours interventional radiology cover. Across Wales, there is a shortfall of consultant radiologists in interventional, breast, paediatric and nuclear radiology specialties. The level of radiologist vacancies is not unique to Wales. Across the UK, the number of unfilled consultant radiologist posts in 2016 was 9%, compared with 13% in Wales[16].

2.3 Whilst vacancy levels were high at the time of the audit, the age profile of staff working in radiology services creates further challenges in terms of retirement and succession planning. As at June 2018, 38% of consultant radiologists and 34% of radiographers and sonographers in Wales were aged 50 or over (Exhibit 7).

Exhibit 7: number and percentage of consultant radiologists and radiographers in Wales by age group as at June 2018

	Age					
	Under 39	**40–44**	**45–49**	**50–54**	**55–59**	**60+**
Consultant radiologists[1]	27	36	41	23	15	26
	(16%)	(21%)	(24%)	(14%)	(9%)	(15%)
Radiographers[2]	535	98	84	147	133	86
	(49%)	(9%)	(8%)	(14%)	(12%)	(8%)

Notes:

1 NHS workforce definition: staff with consultant grade code or job role working in radiology – note this includes both diagnostic and therapeutic radiologists.

2 NHS workforce definition: Staff bands 5–9 with a diagnostic radiography occupation code (S*F).

Source: NHS Wales Workforce, Education and Development Services, NHS workforce census data for June 2018

16 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2016 Report, 2017.

2.4 For the period 2016-2021, consultant workforce attrition due to retirement is likely to be higher in Wales than in any other part of the UK. Around 30% of consultants in Wales are expected to retire, compared to 22% for the UK as a whole (based on an assumed retirement age of 60)[16].

2.5 At the time of our review, all health boards, other than Cardiff & Vale University Health Board, told us that they found recruiting both radiologists and radiographers challenging. More than one health board told us that some adverts for radiology posts had received no suitably qualified applicants.

2.6 Our review found that health boards across Wales were making use of locum staff to bridge staffing gaps, although this was not successful in covering all the vacant posts with 35 FTE locums recruited compared to 112 FTE vacancies[17].

2.7 NHS Wales has experienced particular challenges in securing sufficient trainee radiologists and then retaining those staff in Wales. In 2015, compared to other parts of the UK, Wales had the lowest proportion of trainees to consultant radiologists; 25% in Wales compared to 38% across the UK[16], and NHS Wales has previously lost two out of every five trainees to England or countries outside of the UK[18].

2.8 In response to the challenges facing the radiology workforce, the National Imaging Programme Board developed a business case for a National Imaging Academy for Wales (the Academy) to be based in Bridgend. The Academy is a collaboration between health boards to provide a bespoke training facility for at least 20 trainee radiologists a year, with trainees splitting their time between the Academy and clinical placements in hospitals across South Wales. The Welsh Government has funded initial set up costs, and the health boards will meet the annual running costs. Initially, the Academy will train radiologists; however, later will also train enhanced practice radiographers, sonographers and other imaging professionals to report images.

16 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2016 Report, 2017.

17 The FTE of locums is based on the average FTE of locum use between 1 Oct 2015 and 31 March 2016, and FTE vacancy levels at 31 March 2016. Includes all staff groups, and is based on five health boards, Wales Audit Office, Hospital Site Survey.

18 NHS Wales, NHS Wales Health Collaborative Diagnostic Services Modernisation Programme, December 2015.

2.9 The Academy combines training and provides a reporting facility across Wales. The Academy is intended to address the recruitment challenges experienced across Wales, and may help to reduce the reliance on outsourced reporting in future years. However, whilst the Academy opened in 2018, it will take a number of years before the first trainees have completed their training. The first cohort of trainees have been recruited, and the full cohort of 22 trainers have been appointed to the Academy.

2.10 Whilst in the long-term the Academy should increase the number of trained radiologists in Wales, our local work found that radiology services were also planning to amend their staffing models to increase their reporting capacity. Health boards were planning to train more radiographers and other appropriate staff groups, such as cardiologists, to report examinations. Using a different staff mix to report examinations will help to reduce health boards' reliance on radiologists. In addition, we found that health boards were reviewing the skill mix of their staff to explore opportunities to make more use of non-professional grades, such as assistant practitioners, to help provide additional capacity for imaging (whilst working under supervision) to help bridge radiographer staffing shortages.

Operational pressures and staffing constraints are limiting health boards' ability to train staff

2.11 Annual staff appraisals and continuing professional development (CPD) reviews are an important part of ensuring that the quality of radiology services is maintained and that staff training needs are properly addressed. We asked health boards to provide us with the percentage of staff that had received an appraisal and a CPD review. Across Wales, at least 75% of radiologists, radiographers and other radiology staff had received an appraisal or a CPD in 2015-2016.

2.12 However, not all staff are compliant with statutory and training modules[19]. In 2015-2016, there was variation in the percentage compliance rates between staff groups and modules across health boards. One health board told us that only 48% of radiographers were compliant with Moving and Handling Training, and another health board told us that only 33% of radiographers were up to date with Information Compliance Training. Some health boards told us that they had been unable to maintain compliance with mandatory training and were struggling to achieve higher rates of annual appraisals and CPD reviews due to staffing constraints. Non-compliance with statutory and mandatory training could present a risk to staff members, patients and ultimately health boards.

19 The statutory and mandatory training modules are set out in the UK Core Skills and Training Framework. They are: Equality, Diversity and Human Rights; Health, Safety and Welfare; Fire Safety; Infection Prevention and Control; Moving and Handling; Safeguarding Adults; Safeguarding Children; Resuscitation; and Information Governance.

Part 3

Ageing and underutilised equipment is making it harder for health boards to meet demand, and health boards do not have the staffing resources to extend opening hours

3.1 Health boards must ensure their radiology equipment capacity and specifications meet increasing demand and advances in both clinical practice and technical sophistication.

All health boards have equipment nearing the end of their lifespan

3.2 Comprehensive arrangements are required for the maintenance and replacement of radiology imaging equipment. Older imaging equipment has a higher risk of failure and maintenance costs increase. Image quality also declines with age. Radiology equipment more than ten years old is typically considered to no longer be state of the art and technical advances render the equipment obsolete[20]. In addition, the lifespan of radiology imaging equipment shortens with increased use.

3.3 In November 2015, NHS Wales estimated that 87% of imaging department scanners would require replacement by 2017[21]. We asked health boards to provide us with the age of their CT, MRI and US scanners as at September 2016 (Exhibit 8).

Exhibit 8: age of CT, MRI and US imaging equipment across Wales as at September 2016[1]

		CT	MRI	US
Median scanner age (years):		5	7	4
Number of scanners:	aged up to 6 years	17	9	105
	aged between 6 and 10 years	6	7	9
	aged over 10 years	1	2	1
	total	**24**	**18**	**115**

Note:

1 Based on equipment in five health boards for CT and MRI scanners, and six for US scanners. Aneurin Bevan University Health Board did not provide data. Powys Teaching Health Board has US scanners, but no CT or MRI scanners.

Source: Wales Audit Office, Radiology Equipment Age Survey; and European Society of Radiology

20 The European Society of Radiology advocates that equipment aged: up to five years old reflects the current state of technology, and can be upgraded; between six and ten years old is fit to use if properly maintained, but require replacement strategies to be in place; and 11 or more years old requires replacement.

21 Diagnostic Service Programme NHS Wales, All Wales Gantry (MRI, CT, Gamma Camera and Ultrasound) Usage/Capacity, November 2015.

3.4 In September 2016, 17% of US scanners in Wales were six or more years old. However, 29% of CT scanners and 50% of MRI scanners were six or more years old. Our review identified two 13 year-old MRI scanners, and one 11 year-old CT scanner. Staff at all health boards identified ageing radiology equipment in need of replacement. One health board told us about an ageing CT scanner which regularly broke down (approximately every eight weeks). As the only CT scanner in that hospital, the regular disruption was affecting the care of critically ill patients and resulting in the cancellation of outpatient appointments. Since our local work, the CT scanner has been replaced.

3.5 It is essential that health boards have equipment replacement plans to identify how and when imaging equipment will be replaced. Our review found that whilst six health boards has a radiology equipment plan, all health boards were struggling to identify finances to replace and purchase additional radiology equipment.

3.6 MRI and CT scanners cost upwards of £800,000. Historically, health boards have relied on capital funding from the Welsh Government to buy replacement and additional radiology imaging equipment. In 2014, the Welsh Government provided funding for £8.5 million between five health boards to purchase new and replacement CT, MRI and mammography equipment.

3.7 At the end of 2016, the Welsh Government announced £16 million of funding to provide additional and replace out of date radiology imaging equipment. The funding was allocated across all health boards and Velindre NHS Trust for CT, MRI, mammography, US and X-ray equipment.

3.8 Since our review, the Welsh Government has provided a further £9 million for imaging equipment in health bodies, and to support the development of the Imaging Academy. The Welsh Government is working with NHS organisations to identify and prioritise further additional imaging investment over the period 2018-19 to 2020-21.

3.9 When replacing aging equipment, it is essential that health boards adequately plan for the installation of the new equipment. CT and MRI scanners are large, and the cost of installation can be as much as the cost of the scanner. Where a new scanner is required to replace existing equipment, the downtime can be considerable. In addition, where the new scanner is in addition to existing scanners, an extra room may be required to house the scanner, and this can cause considerable disruption and be costly. In 2016, two of the CT scanners financed by the Welsh Government in 2014 remained in storage because the health boards who were receiving them had struggled to identify finances to modify their buildings to install the equipment. Since our review, the two CT scanners have been put to use.

3.10 The Statement of Intent recognises that a national coordinated approach is needed to plan, identify and address imaging equipment needs. The Statement of Intent sets out that planning is required on a regional level with additional scanners providing extra capacity for regions, rather than a single health board. In 2016, the Welsh Government announced an additional £6 million for a Diagnostic Hub at the Royal Glamorgan Hospital (Cwm Taf University Health Board) which included funding for a replacement CT scanner and an additional MRI and CT scanner, to serve the needs of the South Wales area. The Diagnostic Hub opened in February 2018, and Cwm Taf University Health Board have reported that it provides additional capacity of approximately 7,200 MRI scans and 6,600 CT scans a year. A Regional Planning and Delivery Group established in October 2017, is overseeing the Diagnostic Hub and rollout of wider regional solutions across the South Central and East Wales region.

Whilst there are opportunities to increase imaging capacity with existing equipment by increasing the operating hours, this would have a significant impact on resourcing

3.11 One way for health boards to shorten waiting times for radiological examinations, particularly diagnostic radiography scans is to maximise the opening hours, and thus increase the number of available appointments. The longer the operating hours, the more patients can be seen; however, there are additional costs associated with this.

3.12 In 2014, NHS Wales undertook a review of the operating hours of CT, MRI and US scanners in Wales (Exhibit 9).

Exhibit 9: percentage usage of CT, MRI and US scanners in 2014, averaged across Wales, 2014

Type of scanner	Average number of operating hours per scanner per day		Percentage usage of equipment[1]
	Monday to Friday	Saturday to Sunday	
CT	8.7	0.7	52%
MRI	10.6	2.1	67%
US	7.7	0.0	46%

Note:

1 Based on the planned operating hours as a percentage of potential operating hours (seven days a week and 12 hours a day).

Source: NHS Wales, All-Wales Gantry Usage/Capacity Report, November 2015. Data based on the operating hours in 2014

3.13 In 2014, if all CT, MRI and US scanners across Wales had operated 12 hours a day and seven days a week, we estimate that it may have been possible to undertake at least an extra 1,340 CT examinations, 1,110 MRI examinations and 4,630 US examinations a week[22].

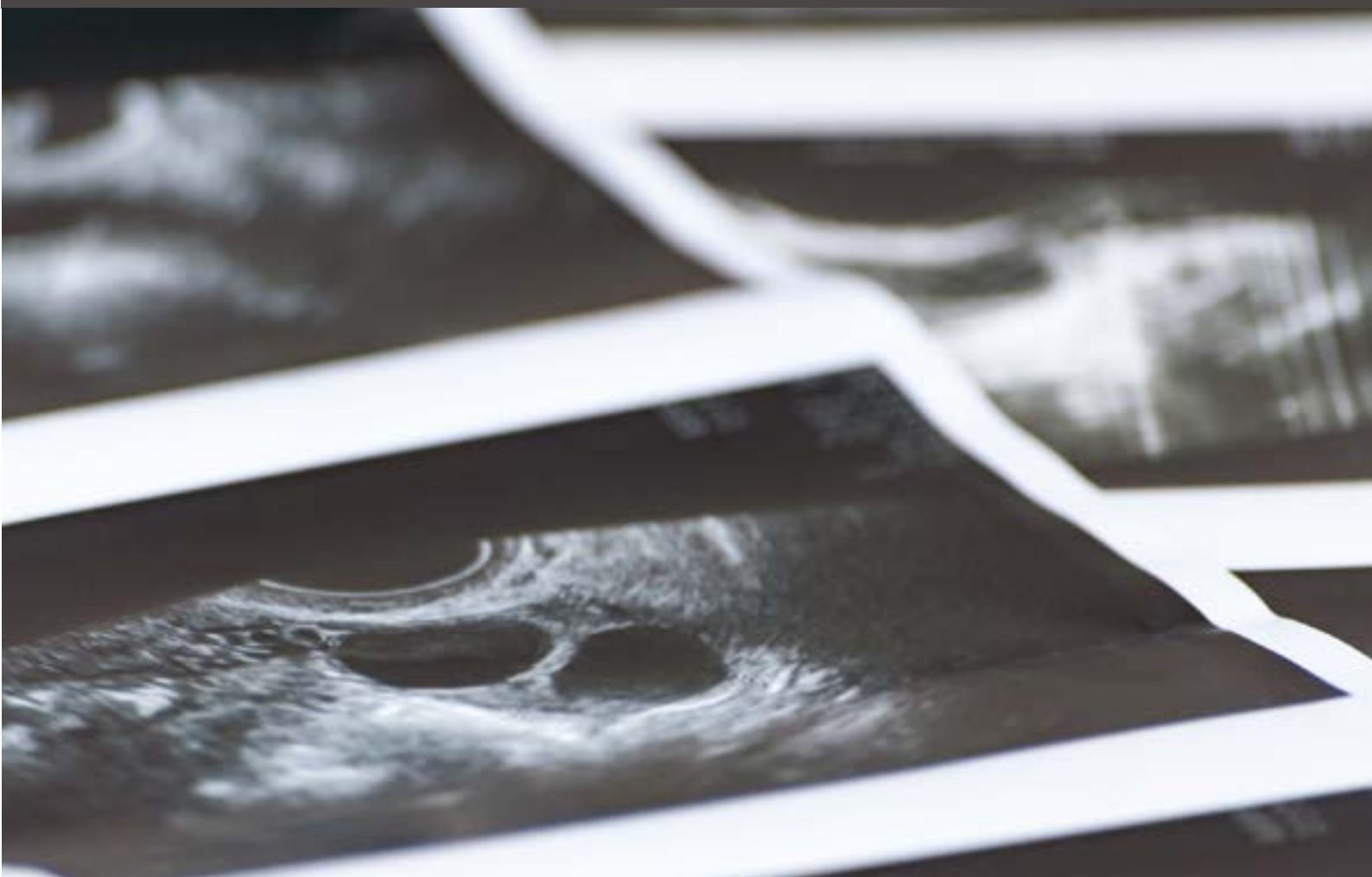
3.14 Since then, health boards have increased the number of operating hours of CT and MRI examinations on weekdays and weekends. Health boards have achieved the increase in operating hours largely by staff undertaking shift work. However, at the time of our review, only one health board was providing CT and MRI examinations for at least 12 hours a day over seven days a week at each hospital site. The standard operating hours across the other health boards varied. Out of 17 hospital sites surveyed, on weekdays, only seven provided CT examinations for 12 or more hours a day, and 10 provided MRI examinations for 12 or more hours a day. On weekends, only two hospital sites provided CT examinations for 12 hours a day and the same number provided MRI examinations for 12 hours a day (the same two hospitals). None of the hospitals provided US services 12 hours a day on weekdays or weekends, and only one hospital provided US examinations as standard on weekends.

22 The time an examination takes depends on the nature of the examination required. CT examinations can take between 10 and 45 minutes, MRI examinations between 15 and 90 minutes, and US examinations between 15 and 30 minutes. Therefore, our estimation is based on a CT examination length of 45 minutes, 90 minutes for MRIs and 30 minutes for a US examination.

3.15 However, extending operating hours is not a simple option for increasing capacity. Extending operating hours would require additional staff, meaning additional cost, and at a time when health boards are already finding it challenging to fill existing vacancies (paragraph 2.2). In addition, higher rates of equipment use results in shortened equipment lifespans, and potentially higher maintenance costs (paragraph 3.2).

Part 4

Wales-wide radiology IT system challenges and weaknesses in local IT infrastructure inhibit radiology services' efficiency



The core radiology management system is not serving health boards' needs, and this is further impeded by weaknesses in local IT infrastructures

4.1 Having effective ICT systems plays a central role in delivering efficient radiology services. In Wales, the Radiology Information System (RADIS) is a national system developed and run by NHS Wales Informatics Service. All health boards use RADIS. RADIS supports the scheduling of radiology investigations, provides a clinical record of scans received by patients and allows health boards to generate reports and statistics on performance. Other systems link to RADIS to provide additional functionality; these different systems must integrate with each other to ensure that information easily transfers and updates between systems.

4.2 Our review found that across Wales, health boards had mixed views on RADIS. Despite RADIS 2 being rolled out in 2005, at the time of our review three health boards were running separate instances[23] of RADIS, and a further two health boards were using a mixture of RADIS and alternative core radiology systems. Having numerous instances of RADIS or alternative systems, is a consequence of NHS reorganisation during the latter half of the 2000s. Hospitals that were part of separate organisations are now part of the same health board, but the separate infrastructure remains in place in some areas. Work is ongoing to provide a single instance of RADIS in all health boards.

4.3 Having separate instances of RADIS is time consuming for clinicians and makes it difficult to plan and deliver services across the whole health board. For example, if a patient has a scan in one hospital, another hospital in the same health board will not have a record of it. Having multiple instances of RADIS also makes it difficult to retrieve management information, as this has to be done separately for each instance and then consolidated into one report manually.

23 An 'instance' refers to a separate database that is specific to a particular location. It is used in order to differentiate from 'versions', which refer to updates and upgrades. For example, two hospitals could have the same version of RADIS, ie they are both equally up to date, but they would still have separate instances because staff in one hospital would not be able to access the records held in the other. Separate instances mean that clinicians cannot access patient information across administrative or geographical boundaries.

4.4 Whilst, some health boards told us they felt that RADIS is adequate in terms of patient scheduling, clinical reporting and management reporting, other health boards expressed doubts in the reliability of the reports produced, and said that they were unable to create bespoke reports in-house. In addition, health boards expressed concerns that RADIS does not integrate with other systems in use by health boards, meaning that changes to information in RADIS had to be updated manually in other systems.

The current absence of a fully functional e-referral system and weaknesses in picture archiving systems and voice recognition systems are creating inefficiencies in the service

4.5 In addition to the core radiology system, other systems are required for each stage of the patient journey, including electronic referrals, archiving of images and providing a record of the report.

4.6 Electronic requesting systems can enable clinicians referring patients for diagnostic imaging to request and receive updates and the outcomes of radiology requests quickly. At the time of our review, the functionality of request software was generally limited to providing a template for a request, which then has to be emailed to the radiology service. The absence of an e-referral system across Wales means that the vast majority of referrals are paper based. Paper based referrals can be problematic, creating more administration because all referral forms have to be scanned and there is the risk that sections are not fully completed or legible.

4.7 Once the examination has been undertaken, radiologists create a report to record their interpretation of the image. When reporting on images, radiologists can choose to use voice-activated dictation systems to record their report. Across Wales, health boards were generally dissatisfied with voice-activation dictation systems. Whilst some health boards used the dictation software built into RADIS, others were using alternative systems. Staff in some health boards indicated that IT network weaknesses meant that dictation systems were prone to freezing and timing out. The consequence of dictation software timing out is that all reports dictated in a session are lost and need to be repeated, leading to frustration and inefficient working.

4.8 All images must be archived. Picture Archiving and Communications Systems (PACS) acquire and archive radiology images, and enables the safe distribution of the image to other health professionals[24]. The report of the image (stored on RADIS) and the scan image (stored on PACS) together comprise the clinical record of the image. Whilst we found that health boards were generally satisfied with their PACS, there was variation in accessibility to PACS images. All health boards told us that radiologists and other hospital staff working within the health board could access images. However, not all radiologists can access PACS images remotely out of hours, and access for GPs and other NHS staff working in other locations was limited.

4.9 Work is ongoing to roll out the full functionality of the Welsh Clinical Portal across Wales. The Welsh Clinical Portal is a digital workspace, which allows the sharing of medical information between professionals securely. When fully functional, the system will provide an electronic platform for sharing information across Wales, including test results and allow electronic patient referrals. The system is being rolled out in a phased approach, with health boards implementing the different elements of the system in a timeframe that is manageable for the individual organisation. The Welsh Government has formed a Welsh Technical Standards Board to support the creation and maintenance of a catalogue of standards and requirements to enable integration and interoperability across all health and care systems in a consistent and secure manner.

4.10 The Statement of Intent has set out a vision for high quality radiology informatics systems to be developed with a secure IT infrastructure that operates across Wales. The vision is for systems that allow electronic referrals, review, processing and reporting through standardised software and that are interoperable, to allow the safe transfer of care between hospitals and allow imaging sharing across Wales.

24 A third party, Fujifilm, provides PACS. Fujifilm supplies hardware and software to health boards for the provision of PACS services, including voice recognition and full disaster recovery solutions. Each health board provides the necessary infrastructure to run those services, including networks and server space.

Part 5

Radiology services are well managed operationally but there is scope to strengthen board level scrutiny and the strategic planning of services

Most health boards need to strengthen strategic and operational planning

5.1 Health boards should clearly set out their strategy for meeting current and future demand for radiology services. Service changes and developments in the wider organisation should inform radiology operational plans. Almost all clinical specialties rely heavily on radiology to help diagnose, treat or monitor disease or injury. When health boards are planning service changes that may lead to an increase to the number of patients referred for radiology imaging, they must ensure that they adequately consider the impact on radiology departments.

5.2 At the time of our review, only three health boards undertook demand and capacity modelling. Across Wales, our review found that there was variation in the degree to which radiology teams were involved in decisions about service changes that affected radiology services.

5.3 Each radiology service should have an agreed documented annual operational delivery plan. The operational plan(s) should clearly identify service demand, the workforce and equipment capacity required to meet this demand as well as the finances available and required to deliver the service safely, efficiently and effectively. Our review found that whilst one health board had a five-year strategic plan, four health boards did not. Four health boards did not have operational plans, and two health boards had neither a strategic nor an operational plan. Not all health boards had clearly set out their workforce needs. Only one health board had a specific, detailed financial plan for radiology, with other health boards financial planning being informed by the previous year's expenditure. Our local work found financial expenditure in four health boards exceeded the budgeted expenditure, which may be a symptom of the absence of adequate financial planning.

Nearly all health boards are taking positive steps to reduce inappropriate referrals, however, signposting to local referral guidance could be improved

5.4 GPs and consultants refer patients to radiology. Ensuring that patients are referred for the most appropriate diagnostic investigation depends on clear guidance and standards. Each inappropriate investigative image performed is, in effect, an example of valuable NHS resources being wasted. Encouragingly, all health boards told us that they return inappropriate referrals to consultants with an explanation for the refusal. In addition, six health boards regularly undertake audits to highlight patterns of inappropriate referrals.

5.5 All health boards use the Royal College of Radiologists' iRefer[25] guidance although at the time of our review, some consultants told us they found it difficult to access iRefer guidance. Since our review, iRefer has been made available via the NHS Wales e-library, providing access to all Welsh NHS professionals.

5.6 Most health boards had also developed supplementary local guidance. Although in the sample of consultants we interviewed many said that they were unaware of local guidance highlighting a need for better signposting and awareness raising in respect of these documents.

All health boards review the clinical performance of their radiology service, although there are opportunities to increase the range of reviews undertaken

5.7 Radiology services must ensure that clinical performance always meets the appropriate standards for patient treatment and care. They need to comply with the **National Diagnostic Imaging Framework**[26] and monitor clinical performance to ensure compliance. Radiology services must ensure that their practices are safe and comply with the Ionising Radiation Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017.

5.8 At the time of our review, all health boards had good arrangements in place to learn from incidents, errors and complaints, and the reporting of incidents is encouraged. All health boards had a regular programme of audits to assess service quality, however, there were opportunities for all health boards to increase the range of audits they undertook (Exhibit 10).

25 iRefer is a radiological investigation guidelines tool from The Royal College of Radiologists.

26 Welsh Government, National Diagnostic Imaging Framework, 2009

Exhibit 10: number of health boards undertaking regular audits of quality and clinical performance

	Number of health boards undertaking regular audits[1]
Appropriateness of referrals	6
Appropriateness or urgent and/or out of hours referrals	5
Quality of written requests	5
Demand levels by time of day/day of week	4
Demand levels by GPs/hospitals	6
Accuracy of reporting	7
Reporting turnaround times	6
Lost and late reports	3

Note:

1. Health boards were asked to indicate whether they undertake the audits listed in the review.

Source: Wales Audit Office, Health Board Survey

5.9 Whilst five health boards regularly undertook patient experience surveys, the other two health boards did not and should review arrangements to learn from patient experiences.

5.10 The Imaging Services Accreditation Scheme (ISAS) is a patient-focused accreditation scheme that helps imaging services to manage the quality of their services and make continuous improvements. In Wales, the National Imaging Programme Board is overseeing the introduction of ISAS. However, progress at individual health bodies has been limited by a lack of staff resources to enable coordination of the work associated with the accreditation process. Since our review, Betsi Cadwaladr University Health Board commenced a two-year pilot exercise to attain ISAS accreditation. The exercise will be used to identify how best to roll out ISAS across Wales.

In most health boards we identified opportunities to widen the range of operational performance measures reported

5.11 Effective monitoring and scrutiny of radiology service performance is important in assessing if the service is delivering its organisational goals and objectives, and identifying the need for remedial action. Health boards should use performance data and audit results to monitor and evaluate the performance of their radiology departments. Performance monitoring and review should take place at all levels within the organisation, from operational level to board level.

5.12 Our review found that whilst all health boards regularly review performance information about their radiology services, there was variation in the range of performance information reported. All health boards regularly viewed radiology waiting times data and incidents data. Most health boards regularly reviewed a range of workforce performance measures on appraisal and compliance with training rates, sickness levels, and planned versus actual staffing levels. However, not all health boards reported key information such as capacity versus demand and reporting turnaround times. All heath boards had scope to further develop the range of performance measures to support business reports by reviewing existing measures and identifying gaps.

5.13 Five[27] health boards in Wales are members of the radiology NHS Benchmarking Network (NHSBN). The NHSBN undertakes an annual radiology survey of approximately 85 radiology departments across the UK. The survey collects data and allows participants to compare a range of measures relating to staffing and activity levels. Despite the range of information available, the use of benchmarking comparative data in business reports was limited across health boards.

5.14 One of the challenges for health boards when comparing their performance with other health boards is the absence of a standardised radiology activity measurement. When measuring radiology activity, care is needed to ensure that comparisons are like for like. A single image may count as one unit of activity. However, where a patient receives complex or multiple images this may count as one or more units of activities depending on a health board's view.

27 Hywel Dda University Health Board told us it does not participate in the network because it does not have the administrative capacity to complete data collection returns. Powys Teaching Health Board does not participate because comparative data for the health board is limited due to the differences in the radiology service.

5.15 In the absence of standard activity count, the medical classification system, the Systematised Nomenclature of Medicine Clinical Terms (SNOMEDCT), has enabled some activity measurement. SNOMEDCT in an international classification system that allows clinical data to be recorded in a consistent way, as it uses a standardised set of clinical terminology and codes. NHS England is adopting SNOMEDCT as the universal classification and terminology for all health organisations and for all aspects of health. In Wales, SNOMEDCT has only been adopted in radiology and a small number of other specialties. SNOMEDCT automatically applies multiplication for some activities depending on the coding applied. However, comparisons of activity between radiology departments has to be treated with caution as any count of activity is reliant on organisations recording activity using SNOMEDCT consistently. At the time of the audit that was not the case in Wales, meaning that even with SNOMEDCT in place, there were still difficulties in obtaining meaningful comparisons of activity.

5.16 The Statement of Intent indicated that improving radiology informatics systems must incorporate common international procedure codes to improve benchmarking of radiology services. In addition, the Statement of Intent has set out that a common set of performance indicators will be developed to broaden the range of information collated to drive the improvement of quality and consistency of radiology services.

In most health boards, operational management and accountability arrangements are clear

5.17 Effective leadership and clear lines of accountability are vital components of any healthcare service. Radiology is a complex service, which comprises radiologists, radiographers and nursing staff working together to produce and interpret images. For a health board to deliver effective radiology services, it needs leadership, and an operational and professional management structure with clear lines of accountability.

5.18 Radiology team structures and lines of accountability differ in each health board. Generally, our review found that the operational management and accountability arrangements were clear.

Health boards could do more to proactively make their boards aware of the issues effecting radiology services

5.19 Our review found that there was variation across health boards in the degree to which radiology services are represented at board level. Not all health boards had an executive lead for radiology that was a member of the Board. However, our local work found that service managers were invited to provide updates on radiology issues and risks at board committees (and board meetings where appropriate). Whilst this ensures that risks and challenges are highlighted to Boards and Committees when required, the absence of an executive lead for radiology attending board meetings at some health boards may mean the opportunity to highlight and monitor emerging issues is missed.

5.20 The Welsh Government has published a Statement of Intent in response to challenges being faced by radiology services.

5.21 The Welsh Government's Future Delivery of Diagnostic Imaging Services in Wales and the National Diagnostic Imaging Framework provided a set of measures to be taken forward at local, regional and national level to improve radiology services. The National Imaging Programme Board was established in 2010 to take action at an all-Wales level, and comprises clinical and management representatives from organisations involved in the delivery of imaging services in NHS Wales.

5.22 The National Imaging Programme Board was given delegated authority for developing and implementing a programme of strategic work for radiology through to 2016, and for adopting all-Wales standards and protocols for imaging services in NHS Wales. Although the National Imaging Programme Board has made progress, most notably the progress made in setting up the Academy, there remain significant challenges that require strategic input from the Welsh Government.

5.23 In March 2018, the Cabinet Secretary for Health and Social Services published a high-level Imaging Statement of Intent for radiology services. The Imaging Taskforce is developing a national implementation plan to address the actions set out in the Statement of Intent, and the Taskforce is due to report back to the Cabinet Secretary in summer 2018.

5.24 The Statement of Intent addresses many of the challenges identified through our local audit work and summarised in this report, including:

a Workforce (paragraphs 2.8 to 2.10)

b Equipment (paragraph 3.9)

c Information systems (paragraph 4.10)

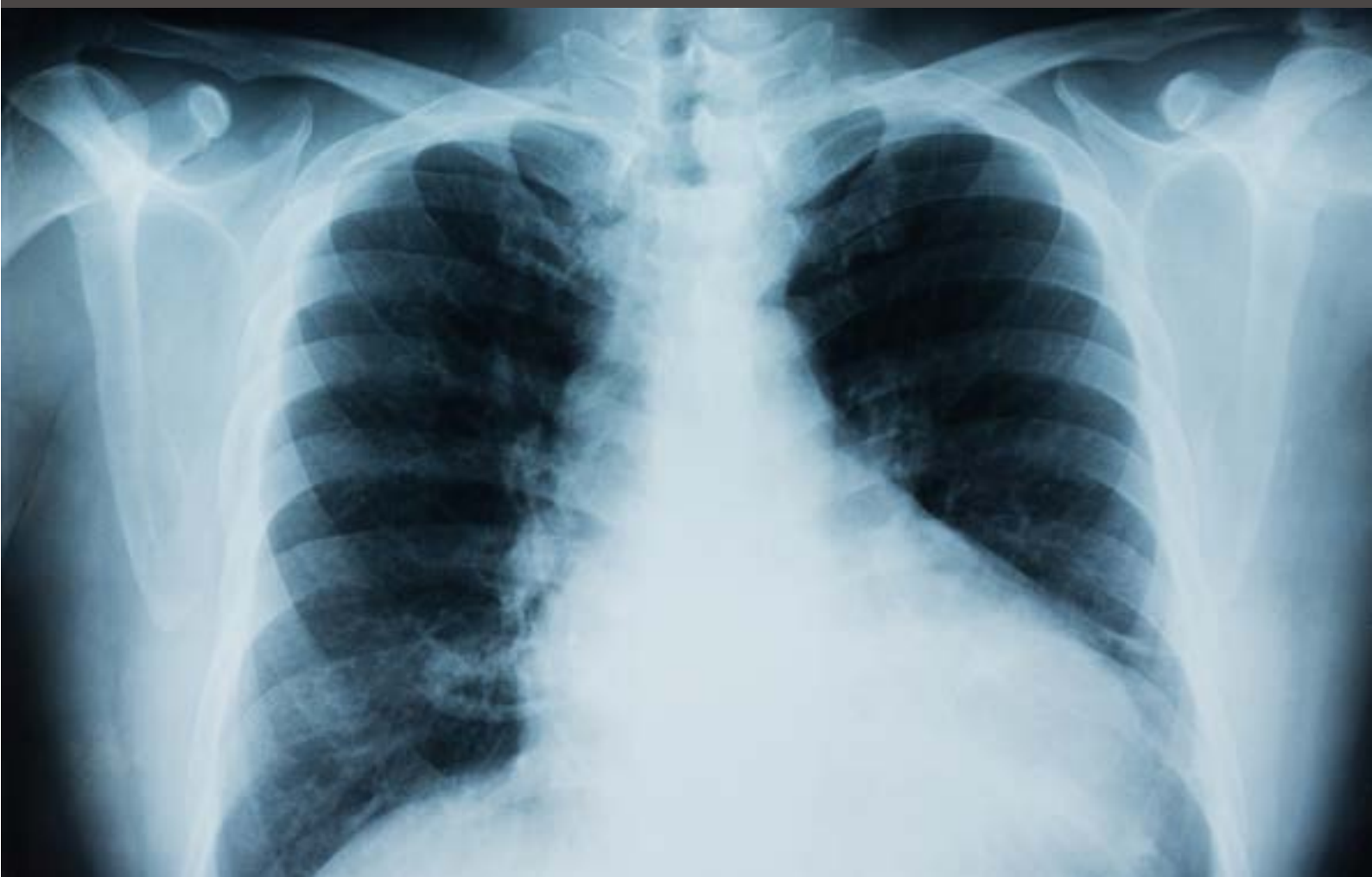
d Consistent activity recording (paragraph 5.16)

e Performance indicators (paragraph 5.16)

Appendices

Appendix 1 – Methodology

Appendix 2 – Five-year waiting times trends



Appendix 1 – Methodology

We undertook our review of radiology services at all major hospital sites that provide a range of radiology imaging, including CT and MRI examinations. In Powys Teaching Health Board, we undertook the review at the six hospitals providing X-ray and US examinations[28]. Exhibit 11 provides the hospital sites included in the review.

Exhibit 11: hospital sites that were included in our review

Health Board	Hospital sites included in the review
Abertawe Bro Morgannwg University Health Board	• Morriston Hospital • Neath Port Talbot Hospital • Princess of Wales Hospital • Singleton Hospital
Aneurin Bevan University Health Board	• Nevill Hall Hospital • Royal Gwent Hospital
Betsi Cadwaladr University Health Board	• Glan Clwyd Hospital • Wrexham Maelor Hospital • Ysbyty Gwynedd
Cardiff and Vale University Health Board	• University Hospital Llandough • University Hospital of Wales
Cwm Taf University Health Board	• Prince Charles Hospital • Royal Glamorgan Hospital
Hywel Dda University Health Board	• Bronglais General Hospital • Glangwili General Hospital • Prince Philip Hospital • Withybush General Hospital

28 Powys Teaching Health Board commissions other imaging and interventional procedures, such as MRI and CT scans as well as X-ray and US reporting from a range of providers in neighbouring health boards in Wales and NHS trusts in England. Commissioning arrangements are through service level agreements which cover a range of services including professional support for the radiographers, radiation protection and IT services to archive and share images with health professionals.

Health Board	Hospital sites included in the review
Powys Teaching Health Board	• Brecon War Memorial Hospital • Llandrindod Wells County War Memorial Hospital • Machynlleth Community Hospital • Montgomery County Infirmary • Victoria Memorial Hospital • Ystradgynlais Community Hospital

Our methodology is provided in Exhibit 12.

Exhibit 12: audit approach

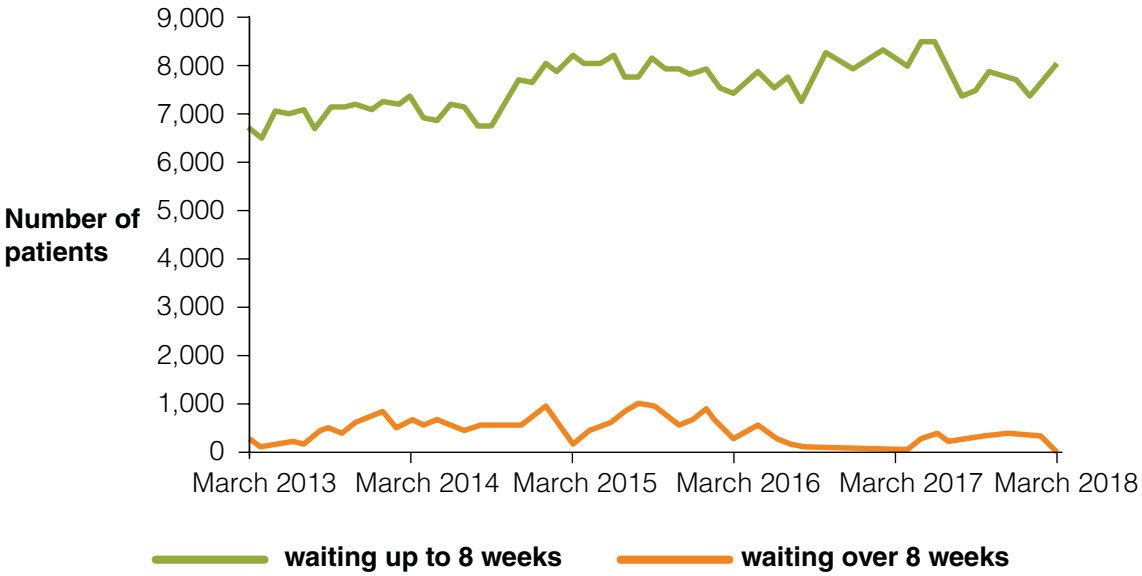
Method	Detail
Information and data collection	We used health board and hospital-site level data collection forms to capture data and information on radiology services. We also utilised data and information from a number of other sources, including: • NHS Benchmarking Network radiology 2015 and 2016 data collection (data collection period 2 May to 8 July 2016); • The All Wales Equipment Capacity Report, NHS Wales Health Collaborative (December 2015); • Stats Wales: Radiology Diagnostic Waiting Times; and • National Reporting and Learning System (NRLS) data: Patient safety incidents.

Method	Detail
Document request	We requested and reviewed documents from each health board, including: • terms of reference and membership of health boards' main radiology groups, together with a sample of minutes from the previous meetings; • examples of condition pathway documents (for stroke, cancer or heart disease) illustrating radiology service provision requirements; • relevant radiology papers to board and committees along with operational papers including safety reports; • examples of each health boards' main radiology service performance reports or performance scorecards from the past six months; • the most recent financial reports showing progress towards the savings/cost improvement plan; • health boards' radiology equipment replacement plans; • health boards' radiology risk registers; • guidance provided to hospital referrers and GPs on expectations when referring patients to the service; and • examples of any work carried out by health boards over the past two years to measure radiology patient experience.
Interviews	We interviewed staff at each health board including: • the Radiology Directorate Manager; • the Radiology Clinical Director; and • a sample of consultants selected by health boards from Surgery, Medicine, Accident and Emergency and Anaesthetics specialties.
Focus groups	We carried out focus groups at each health board of: • Radiographer Senior Leads at each main hospital site; and • GP Locality Leads.

Appendix 2 – Five-year waiting times trends

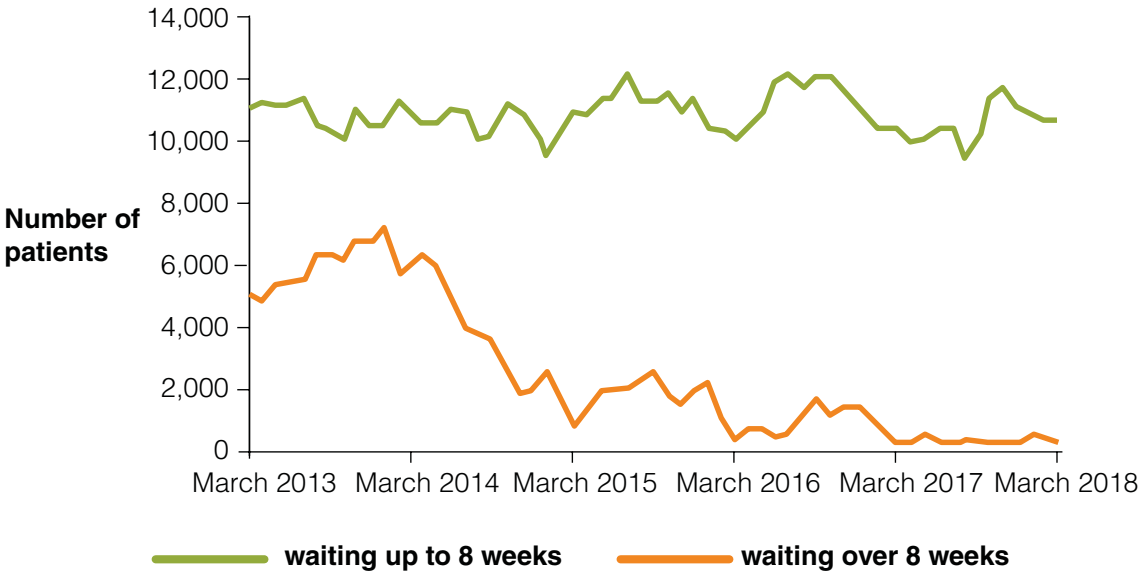
Exhibits 13, 14 and 15 provide the numbers of patients waiting up to eight weeks and more than eight weeks for CT, MRI and US examinations between March 2013 and March 2018.

Exhibit 13: all-Wales CT waiting times trend March 2013 to March 2018



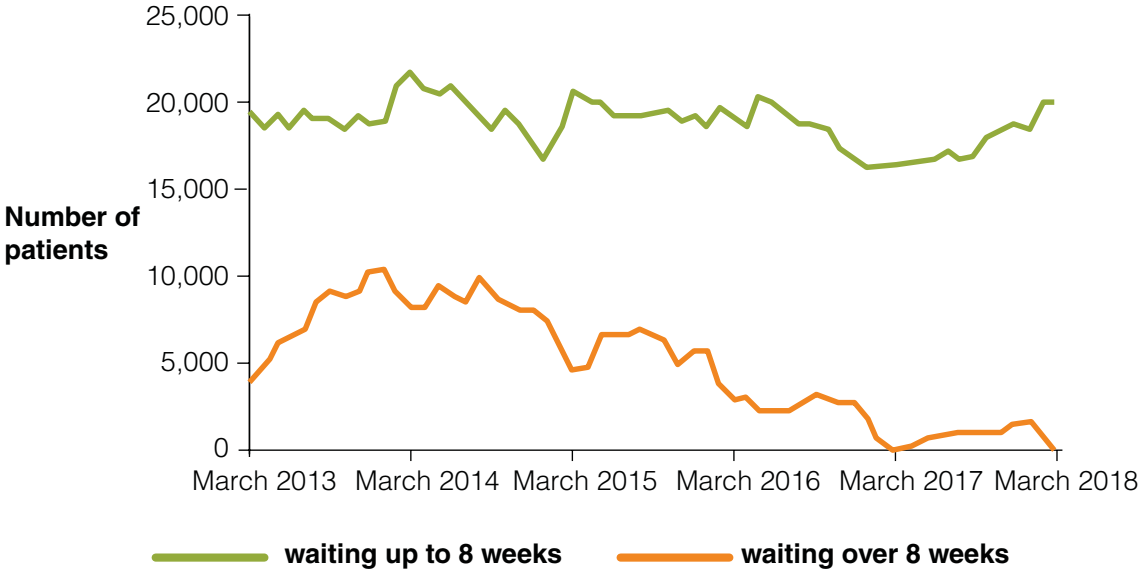
Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

Exhibit 14: all-Wales MRI waiting times trend March 2013 to March 2018



Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

Exhibit 15: all-Wales non-obstetric US waiting times trend March 2013 to March 2018



Source: Diagnostic and Therapy Services Waiting Times, Stats Wales, May 2018

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Positron Emisssion Tomography (PET) in Wales

Overview and Strategic Recommendations

All Wales PET Advisory Group (AWPET)
Welsh Scientific Advisory Committee

November 2018

Contents

1. Introduction

1.1. Positron Emission Tomography (PET, PET-CT) has become a central diagnostic tool in the management of patients with cancer. Its role in cancer and in other diseases continues to evolve. Although it is a relatively expensive investigation, when used appropriately, PET can increase the value of healthcare overall. PET can significantly improve clinical decision making particularly with respect to the appropriate use of complex, morbid, and expensive specialist treatments. There is an increasing body of high quality evidence demonstrating the contribution of PET to improved patient outcomes in a number of areas. There is also excitement in the clinical and research communities about the possible uses of PET in a rapidly growing number of new indications.

1.2. In the UK the development of PET services has been slow, compared with the United States and other European countries. The development of PET in Wales lags significantly behind the rest of the UK home nations, in terms of funded indications for PET scans, development of PET infrastructure, specialist workforce, and research opportunities.

1.3. It is estimated that Wales is currently performing approximately 40% of the PET scans per head of population compared to England. NHS Wales has a list of funded indications for PET which is limited compared to England and Scotland. In its 2005 strategy document *PET-CT in the UK: a strategy for development and introduction of a leading edge technology within routine clinical practice*, the Royal College of Radiologists working party recommended: 'Initially, one PET-CT per 1.5 million population is planned to reflect the current role in cancer management.' In 2018, Wales has a single fixed-site PET-CT scanner in Cardiff (PETIC) and 1-2 days per week use of a mobile unit in Wrexham. Patients from South West Wales must travel to Cardiff for their PET scans.

1.4. Meanwhile, in the rest of the UK, PET has moved out of specialist tertiary centres and has become a routine part of the equipment in the nuclear medicine departments of teaching hospitals and large District General Hospitals.

1.5. This document outlines necessary background information as regards PET imaging, the current position as regards provision in Wales, and sets out options and recommendations for development of PET services in Wales.

Summary of Recommendations

Recommendation 1.

- **A robust process is required for accepting and funding an expanded indication list, based on the best available evidence, as recommended by AWPET, with provision for ongoing growth of funded indications. AW-PET, a subgroup of Welsh Scientific Advisory Committee and advisory group for Welsh Health Specialised Services, should continue to review and recommend best practise evidence based PET-CT practise, for clinical pathways, in Wales.**

Recommendation 2.

- **Welsh Government should request an Outline Business Case, to be developed by Cardiff University, so that a formal decision on the replacement of the end-of-life machine at PETIC can be made in the near future. Cardiff University should work closely with Cardiff and Vale University Health Board in producing the OBC and planning any machine replacement work. Work may also need to be undertaken with Cardiff University, C&VUHB and ABMUHB Health Board to ensure any transition period during machine replacement is considered and robust transitional pathways are in place e.g. mobile scanning capacity. Welsh Government would need to keep up-to-date of progress made in all of these areas on a regular basis by leads from each organisation.**

Recommendation 3.

- **WHSSC should be commissioned to produce a Strategic Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.**

Recommendation 4.

- **The licensing of PETIC with regards to production and supply of radiopharmaceuticals is reviewed as part of the planning of the radiopharmaceutical supply chain for an expansion of PET facilities in Wales.**

Recommendation 5.

- **Constitution of a Welsh PET innovation strategy to develop research, clinical, technological, and industrial collaboration within a formal framework. This will encompass horizon-scanning and development of subjects such as PET in radiotherapy planning, and in novel malignant and non-malignant indications.**

2. Background

2.1. Radioisotopes, Radiopharmaceuticals, production and distribution

2.1.1. PET imaging uses short-lived radioactive atoms (radioisotopes) combined into biologically useful tracers (radiopharmaceuticals) to obtain functional images of the body. PET can provide anatomically useful information about specific physiological processes. This complements the information obtained from standard CT and MRI scans. The best known use of PET is in the staging of cancers, for example:

- To locate primary tumours and metastases which may not be apparent on standard imaging.
- To determine whether lumps seen on CT or MRI are likely to be benign or malignant.
- In the assessment of response of cancer to chemotherapy and radiotherapy (i.e. whether there is there any residual disease requiring further treatment).

2.1.2. Production of radiopharmaceuticals requires a specialist particle accelerator (cyclotron) to make the radioisotope, and specialised radiopharmaceutical production facilities to integrate this into a biologically useful tracer.

2.1.3. The commissioning and running of a PET cyclotron and radiochemistry facility is expensive and requires highly specialist staff. When PETIC was opened in 2010 this was at a cost of £18m, the majority of which (at least £13m) was accounted for by the building of the cyclotron and radiochemistry facilities. Based on the recent new PET-CT facility in Exeter the cost of a static machine and associated infrastructure, without a cyclotron, is approximately £7m

2.1.4. The majority of standalone PET facilities do not have a cyclotron, and source their tracers from external suppliers. This is a considerably simpler model which works well for most types of PET scans, though it imposes some constraints on the use of short-lived tracers (see 2.1.6.)

2.1.5. The most commonly used tracer in PET is FDG. FDG is glucose which has been "radiolabelled" with fluorine 18 (^{18}F). ^{18}F has a half-life of 109 minutes. That is to say that the amount of activity of a sample ^{18}F decays by a half approximately once every two hours. The half-life of ^{18}F is long enough to permit remote supply to a standalone PET scanner from another radioisotope or radiopharmaceutical manufacturing centre.

2.1.6. Some of the other isotopes used routinely or experimentally in PET have considerably shorter half-lives than ^{18}F, and as such, are only practically useful in a centre with a short transport time from a cyclotron manufacturing facility. There are therefore some fundamental constraints with respect to the location and function of PET units. PETIC is able to manufacture many of these non-^{18}F radiotracers.

2.2. Physiological mechanism of action and rationale

2.2.1. FDG is a glucose analogue and its pattern of uptake in the body allows the creation of a "map" of glucose metabolism which can be read by a PET scanner. FDG is preferentially taken up in cancer cells, which exhibit increased glucose metabolism, and this shows up on a PET scan. This technique enables the detection of both primary and secondary cancer which might be invisible or ambiguous on CT or MRI.

2.2.2. FDG PET is more sensitive than either CT or MRI in the detection of cancer and results in more accurate staging. When used appropriately PET typically changes management in around 30-40% of patients. This permits more confident **Intensification** of treatment where benefit is

likely, and **De-intensification** of treatment and reduction in treatment morbidity where benefit is unlikely.

2.3. Licensing and commercial supply of radiopharmaceuticals in Wales

2.3.1. PETIC, and the mobile unit in Wrexham are able to receive radiopharmaceuticals labelled with ^{18}F from a number of commercial cyclotron production facilities in England.

2.3.2. PETIC is also able to produce FDG for its own supply under the Specials manufacturing license held by Cardiff University.

2.3.3. Only holders of a Marketing Authorisation for FDG are able to provide the radiopharmaceutical to secondary centres. Whilst PETIC is able to produce its own supply of FDG, it does not hold a Marketing Authorisation to supply FDG to other centres.

2.3.4. This means that under the current licensing arrangements, any new PET units in Wales would have to obtain their FDG from English commercial suppliers rather than from PETIC.

2.3.5. Whilst PETIC is unable to supply FDG, it produces a range of other tracers for research use. Cardiff University excels in neuroscience, and these tracers have tended to focus on neurological applications. PETIC is also supplying these tracers, for research purposes, to a range of institutions in England.

2.4. PET imaging facilities

2.4.1. A PET facility can be one of three main types:

1. A **production and scanning facility**
    - with cyclotron, radiochemistry, dispensing room, scanner, uptake rooms, dedicated toilet and reporting facilities. This is the facility at PETIC.
2. A **scanning only facility**
    - No cyclotron or radiochemistry, relies on delivered ^{18}F radiopharmaceuticals, dispensing room, uptake rooms, dedicated toilet, scanner.
3. A **mobile scanning facility**.
    - A commercial company visits the hospital with a scanner on the back of a lorry for several days each week. The unit also contains a dispensing room and uptake rooms. This is the facility at Wrexham.

2.5. The PET scan process: timing and basic infrastructure requirements

2.5.1. Following injection of a radiopharmaceutical, patients typically need to wait until the tracer has distributed and been "taken up" into organs. The patient is radioactive during this time and dedicated shielded rooms are required where the patient can wait whilst the radiopharmaceutical circulates through the body.

2.5.2. For FDG, the "uptake" time after injection is typically 60-90 minutes. On the current scanners available in Wales, imaging the whole body then usually takes about 25-30 minutes.

2.5.3. A PET facility must adhere to stringent statutory Radiation Protection legislation, in order to ensure safe management of radiopharmaceuticals, including protection of patients, staff, public and the environment.

2.5.4. Radiation shielding is required, and a fixed facility is generally purpose-built rather than simply repurposing existing unshielded rooms. The facility also needs to have suitable arrangements for disposal of radioactive human waste and contaminated clinical materials.

2.6. The ongoing development of PET scanner technology and the implications for commissioning

2.6.1. PET is a general technique. The technology to harness the possibilities of PET are constantly developing. This is a crucial point.

2.6.2. The first commercially available PET scanner reached the market in 2001. Since that time, the technology available, with respect to radiological imaging and computing, has developed almost beyond recognition.

2.6.3. A clinical PET scanner will have a planned lifespan of approximately 10 years before scheduled decommissioning and replacement. A 10 year old scanner will not be replaced like-for-like because the original technology will have become, in significant part, obsolete. Replacements should therefore be regarded as new technology for old technology. This has implications for revenue, since a new system is likely to have the capability to do more things than an old system, and therefore the service will also likely need to develop in order to exploit this.

2.6.4. Extension of PET scanner working life much past a planned replacement point has a number of implications, including:

- Decreased reliability
- Obsolescence: potentially reduced manufacturer support, problems sourcing spare parts, and compatibility issues.
- Decreased performance and functionality compared with contemporary PET-CT. Typically this is seen in terms of scan sensitivity, resolution, and speed of patient throughput.

2.7. The Current Status of PET scanners in Wales

2.7.1. As of June 2018, Wales has 1 radiopharmaceutical production and scanning facility at PETIC in Cardiff which opened in 2010, plus 1 mobile scanning facility for 1-2 days a week in Wrexham which started in 2015.

2.7.2. The scanner at PETIC in Cardiff was purchased in 2008 and is now in need of replacement as parts become more difficult to source and reliability issues increase. The mobile scanner in Wrexham is provided by a commercial company and will be kept current.

2.8. Current Activity levels and Commissioning arrangements

2.8.1. Funding for FDG PET Oncology services in Wales is provided centrally by Welsh Health Specialised Services Committee (WHSSC) rather than by individual health boards. The currently commissioned indications for FDG PET imaging in Wales are set out in Specialised Services Policy: CP50 Positron Emission Tomography (PET).

2.8.2. Data in Table 1 show the growth in PET activity in both PETIC and North Wales since 2010. In 2017-18 PETIC performed a total of 2318 FDG PET Oncology scans and North Wales 763. This equates to a total of 3,081 scans per annum for the whole of Wales which is equivalent to 1,034 scans per million population.

2.8.3. In Wales overall (PETIC and North Wales) under the current commissioning policy CP50, approximately 3,585 scans are forecast for 2018/19.

2.8.4. As part of the current WHSSC ICP development process for 2019-22 a total of 8 new indications have been proposed, including 4 non-oncological indications. If these are funded then this will further increase activity for all-Wales in 2019-20 by adding a further 500 PET

scans. Therefore the predicted total number of scans in Wales for 2019/20 (PETIC and North Wales) will be 4,371 if these new indications are funded or 3,871 if not (Table 1).

Table 1 Recent activity and forecast growth in PET-CT activity

	PETIC		North Wales	
Year	**Total NHS scans**	**Growth (%)**	**Total NHS scans**	**Growth (%)**
2010-11	675	n/a	n/a	n/a
2011-12	1285	90%	n/a	n/a
2012-13	1417	10%	n/a	n/a
2013-14	1619	14%	n/a	n/a
2014-15	1920	19%	n/a	n/a
2015-16	2119	10%	794	n/a
2016-17	2263	7%	784	-1%
2017-18	2318	2%	763	-3%
2018-19 (Apr to Sep)	*1332 (*full year estimate 2851)	*23%	*367 (*full year estimate 734)	*-4%
Forecast for 2019-20 (no new indications)	3137	10%	734	0%
2019-20 (with new indications)	3520	23%	851	16%

*These data include new indications agreed in the WHSSC 2018-21 ICP that were introduced into the PET policy in May 2018

2.8.5. PET referrals are initially sent to the two Welsh centres. If the referrals fall within WHSCC policy then these are accepted. The PET gatekeepers have limited latitude to include "other" cases, which can only be accepted if IPFR funding is granted.

2.8.6. PETIC also provides an FDG Non-Oncology service for the Epilepsy team at Cardiff and Vale UHB. This is funded centrally and the Epilepsy service directly commission around 25 PET scans per annum from PETIC.

2.8.7. A very small number of patients travel from Wales to London for Non-FDG scans using Ga DOTA for neuroendocrine tumours. This activity will be repatriated to Cardiff over the course of 2019.

2.9. PETIC

2.9.1. PETIC was commissioned in 2010, with 2 principal aims:

- To provide a state of the art clinical diagnostic service.
- To provide research facilities to the burgeoning Welsh life science industry, researchers throughout Wales, and also the GW4 consortium.

2.9.2. Whilst this document focuses on the strategic development of the Welsh PET clinical service, any developments must take into account the complementary R&D aim of PETIC.

3. PET utilisation in UK, Europe, and the developed world

3.1. Comparison of number of PET scans within the UK

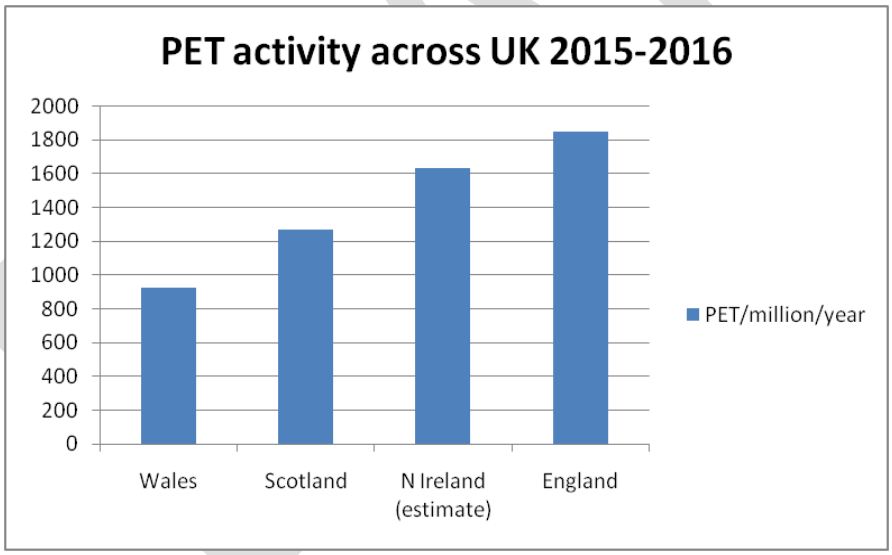
3.1.1. The range of funded indications for PET scans in Wales are much more limited than those funded in England or Scotland.

3.1.2. For the year 2015/2016 Table 2 and Figure 1 give a breakdown of PET scanning activities per million population per year for the UK devolved nations.

Table 2

Nation	Number of PET scans per million population (2015/16)
Wales	922
Scotland	1269
Northern Ireland (estimated)	1631
England	1849

Figure 1

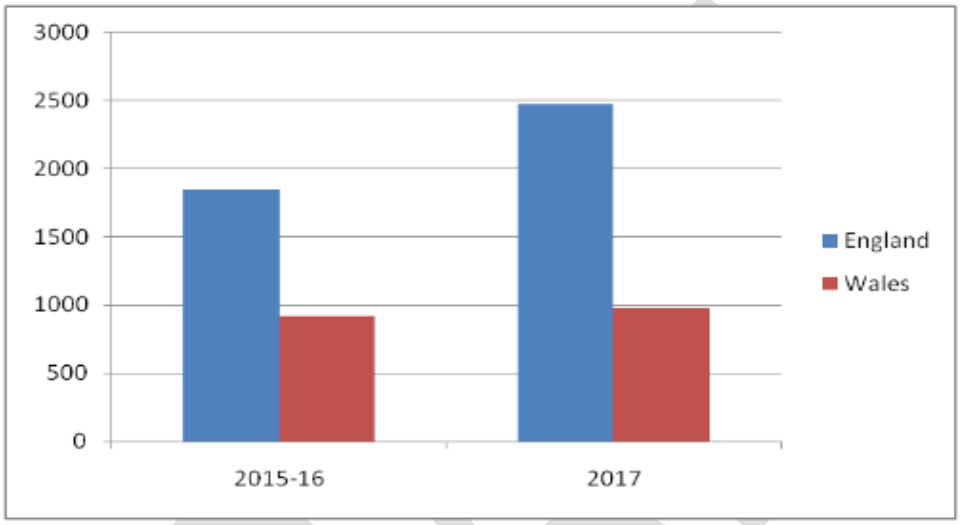


3.1.3. It is clear that the numbers of PET scans per head of population in Wales is significantly less than in the rest of the United Kingdom. An updated comparison demonstrates a widening disparity between Wales and England subsequent to 2015-6. For the calendar year 2017, Wales performed approximately 40% of the PET scans per head of population when compared to England (Table 3 and Figure 2).

Table 2

	Number of PET scans per million population	
Nation	**2015/2016**	**2017**
England	1849	2470
Wales	922	973

Figure 2



The graph and table above give recent estimates of PET activities in England and Wales. Figures given are for the periods April 2015-April 2016 and the calendar year 2017 respectively. The figures are all expressed as scans per million population per year.

Whilst there has been some growth within current indications in Wales (approx. 6% per annum), there has been a massively greater increase within England (approx. 34%). The reasons for the much greater English growth in the absence of altered indications is not entirely clear. In Wales, there is a consistent and close application of the policy with only 3 radiologists acting as gatekeepers and applying the commissioning policy. In Wales generally gatekeepers will not depart greatly from the commissioned indications. Another difference is that as the list of indications in England is much wider there are far more areas in which organic growth may occur.

3.2. Comparison of number of scanners within the UK

Table 4

Country	Fixed PET CT	Mobile PET CT	PET MR	Scanners per million
England	37	20	1	1.05
NI	2	0	0	1.10
Scotland	6	0	0	1.13
Wales	1	0.4	0	0.39

3.2.1. According the NCRI there are 1.05 PET scanners per million population in England. The 2005 UK recommendations suggests an allowance of approximately 1 scanner per million population.

3.2.2. It is clear that the number of scanners per head of population in Wales is significantly lower than the rest of the UK.

3.2.3. This metric does not account for issues of geographic accessibility.

3.3. International Comparisons

3.3.1. European comparisons of PET imaging per head of population between 2002-2014 demonstrate that the only parts of Europe currently undertaking a similar level of PET imaging to Wales were the Balkan states and some eastern European countries

3.3.2. In terms of numbers of PET scanners, the EU average was 1.71 scanners per million population in 2016, compared to 1.05 for England, and 0.39 for Wales. Amongst the EU nations, only Romania and Cyprus have lower PET infrastructure provision than Wales.

3.3.3. Australia has around 2.75 scanners per million. In Canada in 2015, there were 1.42 scanners per million.

4. Impact of the Limitations of the current Welsh PET service

4.1. Lack of access to PET scans will result in inaccurate staging of some patients with cancer in situations where this will make a critical difference to clinical management.

4.2. Patients who do not have a PET scan may be assigned a lower cancer stage compared to patients who have a PET scan as part of their initial diagnostic work up. This will have a number of consequences:

- Inaccurate prognostication, with personal implications for patient hopes and expectations.
- Apparent survival rates and outcomes of patients with low stage cancers will be reduced due to patients who actually have higher stage disease being inaccurately assigned to a lower stage.
- Inappropriate treatments, in particular surgery.

4.3. Increasing the range of funded, evidence-based indications for PET (in line with the rest of the UK), should improve patient outcomes by reducing stage-inappropriate morbid, and costly cancer treatments.

4.4. There is at present an awkward situation for those Welsh patients who receive cancer treatments from NHS England where routinely funded PET examinations are requested which will not be funded by NHS Wales.

4.5. Non-cancer PET investigations currently represent a small proportion of overall PET work. This is anticipated to increase, and will become important in the management of an increasing number of serious non-cancer conditions.

4.6. The current lack of access to PET results in lack of development of Welsh expertise in its use in diagnostic, clinical and research settings.

4.7. The current lack of access to PET in Wales also results in lack of development opportunities in Radiotherapy, where PET is becoming a key tool in accurate tumour localisation and response assessment.

5. Constraints on the ability of the current Welsh PET service to service future need

5.1. With the expansion of the funded indication list for PET in Wales in May 2018 the current Welsh PET infrastructure will reach capacity in the next 12 months. This is could affect waiting times and resilience until the Welsh PET infrastructure can be developed.

5.2. The ability of patients from south west, and west Wales to access PET is geographically limited.

5.3. Lack of PET facilities affects the ability of Wales to recruit radiologists specialising in Nuclear Medicine. This has implications for the sustainability of nuclear medicine services in Wales in general.

6. Strategic Vision for Welsh PET services

6.1. Priorities

The following section describes in very broad terms a strategic plan for PET development for Wales

6.1.1. The short and medium term aims should be regarded as remedial in addressing the current shortfall in PET provision in Wales whilst the long term aim is more visionary.

6.1.2. As a priority NHS Wales should review evidence for expansion of indications with particular focus on indications that are already commissioned elsewhere in the UK. It is vital to understand the variation in access, scanning rates and commissioning assumptions across the UK. It is also important to developed a phased investment plan that supports resource allocation, research investment, local service planning and if possible the mitigation of geographical inequalities. Training needs and workforce planning will follow and an accelerated but phased introduction is realistically deliverable. Procurement and cost can be defined and all other agendas such as R&D developed.

6.2. Short Term: Review of funded indications

Regularly review the evidence for expansion of indications with particular focus on indications that are already commissioned elsewhere in the UK

6.2.1. The initial steps to achieve this are already in place. An expert all-Wales PET advisory group (AWPET) has been set up as a collaboration between WHSSC, clinical oncology, clinical radiology, medical physics. This is a subgroup of the Welsh Scientific Advisory Committee (WSAC.) AWPET has performed gap analyses looking at funded indications and PET activity between the 4 home nations.

6.2.2. AWPET has also instituted a transparent and rigorous process for assessing and recommending new indications for PET, following submissions from clinical specialist groups. A first round of this process was run in 2017, and the specific recommendations of AWPET for an expansion of the Welsh PET indications list have been accepted by WHSSC.

6.2.3. It should be noted that whilst this process largely follows the NHS England indications list, it is independent and still critically reviews each indication. Recommendation for Welsh funding is not automatically assumed just because an indication is on the list in England. Likewise, the process also provides Wales with a means for assessment of indications which may not be routinely funded in England.

Recommendation 1

- **A robust process is required for accepting and funding an expanded indication list, based on the best available evidence, as recommended by AWPET, with provision for ongoing growth of funded indications. AWPET, a subgroup of Welsh Scientific Advisory Committee and advisory group for Welsh Health Specialised Services, should continue to review and recommend best practise evidence based PET-CT practise, for clinical pathways, in Wales.**

6.2.4. The present arrangements have failed to meet this requirement adequately or efficiently. This is evidenced by the delay in agreeing funding for an expansion of indications in 2017/18 and the growing gap between provision in NHS Wales and NHS England despite this expansion.

6.2.5. The Welsh Government Imaging Statement of Intent (2018) states that NHS Wales will establish a co-ordinated approach to identifying, evaluating, prioritising and adopting new imaging technologies across NHS Wales. It is essential that PET scanning is included within this strategy.

6.3. Short Term: Replacement of PET-CT infrastructure in Wales

6.3.1. Working with Cardiff University, Welsh Government should make a strategic decision, based upon and subject to the analysis of a Business case, on replacing the end-of-life machine in PETIC.

Recommendation 2

- **Welsh Government should request an Outline Business Case, to be developed by Cardiff University, so that a formal decision on the replacement of the end-of-life machine at PETIC can be made in the near future. Cardiff University should work closely with Cardiff and Vale University Health Board in producing the OBC and planning any machine replacement work. Work may also need to be undertaken with Cardiff University, C&VUHB and ABMUHB Health Board to ensure any transition period between machine replacement is considered and robust transitional pathways are in place e.g. mobile scanning capacity. Welsh Government would need to keep up-to-date of progress made in all of these areas on a regular basis by leads from each organisation.**

6.4. Medium Term: Development of PET-CT infrastructure in Wales

6.4.1. PET services for patients across Wales should keep pace with the evidence base for the clinical and cost-effectiveness of the technique. There is an urgent need to increase basic PET-CT capacity and access across Wales to avoid a progressive degradation of the service as demand inevitably grows.

6.4.2. Current infrastructure will be inadequate to easily service an expanded Welsh PET-CT indication list. Assuming the English projections of 14% pa growth in PET demand, current Welsh infrastructure will become inadequate in the next few years irrespective of an expanded indications list.

6.4.3. Geographic access is an issue, particularly for patients from West Wales. The mobile unit in North Wales is available two days per week, which can cause inefficiency and scheduling problems.

6.4.4. New units should be planned to take into account the requirements of PET-CT for modern radiotherapy planning and trials at the three Welsh radiotherapy centres. In addition, provision must be made to cover the work of the fixed site PET-CT scanner at PETIC as it nears its planned replacement date, which will require it to be out of service for a period of around 6 weeks.

6.4.5. This will require a central, unified, all-Wales development scheme, not abrogated to individual Health Boards. Local initiative is the current situation and it has signally failed. A formal Programme Business Case will be required. A road map to guide PET-CT equipment procurement linked to the number of scans required should be produced as part of this work.

6.4.6. Any scheme will have to take into account the

- manufacture and supply of isotopes, and the licensing of PETIC in this respect
- the number and location of fixed-site units, and transitional arrangements using mobile units
- Staffing and revenue requirements
- The functionality of fixed site PET-CT with respect to:
  - General diagnostic capabilities, capacity
  - Radiotherapy planning
  - Likely future indications, especially screening and non-malignant imaging
  - R&D

Recommendation 3

- **WHSSC should be commissioned to produce a Strategic Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.**

Recommendation 4

- **The licensing of PETIC with regards to production and supply of radiopharmaceuticals is reviewed as part of the planning of the radiopharmaceutical supply chain for an expansion of PET facilities in Wales.**

Recommendation 5.

- **Constitution of a Welsh PET innovation strategy to develop research, clinical, technological, and industrial collaboration within a formal framework. This will encompass horizon-scanning and development of subjects such as PET in radiotherapy planning, and in novel malignant and non-malignant indications.**

6.5. Long Term: A world class Welsh PET-CT service, tailored to Welsh needs

6.5.1. A world class Welsh PET-CT service, tailored to Welsh needs.

This service should:

- Satisfy the needs of the Welsh population, as measured against contemporary national and international standards.

- Be sustainable in terms of HR training, expertise, and recruitment.
- Be sustainable in terms of infrastructure capital and revenue.
- Be dynamic, self-critical, and strategically fit for future service needs.
- Be ambitious, and not automatically be assumed to follow England's lead. Wales should actively participate in the development of PET-CT in the UK, and should look to best practice and innovation elsewhere in Europe and the world for opportunities to lead and innovate.
- Harness and develop existing Welsh expertise in R&D with clinical, academic, and industrial collaboration.

Cydweithrediad Iechyd GIG Cymru
NHS Wales Health Collaborative

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Positron Emission Tomography (PET) in Wales

Programme Brief

DOCUMENT CONTROL

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Positron Emission Tomography(PET) in Wales – Overview and Strategic Recommendations November 2018 All Wales PET Advisory Group (AWPET), Welsh Scientific Advisory Committee (WSAC)	
WHSSC Specialised Services Commissioning Policy, CP50a: Positron Emission Tomography (2019)	
WHSSC Specialised Services Service Specification, CP50b: Positron Emission Tomography (2019) – in development	

Sign Off

Name	Position	Organisation	Date
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CONTENTS

1 Introduction

1.1 Positron Emission Tomography (PET) has become a central diagnostic tool in the management of cancer and other non-cancer conditions. Its role and the evidence base continues to evolve. Although it is a relatively expensive investigation, when used appropriately PET can increase the value of healthcare overall, supporting the principles of prudent healthcare[1]. PET can significantly improve clinical decision making, particularly with respect to the appropriate use of complex and expensive specialist treatments. There is an increasing body of high quality evidence demonstrating the value of PET to improved patient outcomes in a number of areas. There is also excitement in both the clinical and research communities about the use of PET in a rapidly growing number of new indications and new radiopharmaceuticals. The latest scanners combine both the functional information of PET and the structural information of Computed Tomography (CT) into one machine, resulting in a fused and detailed PET-CT scan.

1.2 In the UK, the development of PET services has been slow compared with other European countries[2]. The development of PET in Wales lags significantly behind the other 3 devolved nations, in terms of funded indications for PET scans, development of PET scanning infrastructure, specialist workforce, and research opportunities.

1.3 It is estimated that Wales is currently performing approximately 40% of the PET scans per head of population compared to England[3]. NHS Wales has a list of funded indications for PET-CT which is limited compared to England and Scotland. In the 2005 strategy document PET-CT in the UK: a strategy for development and introduction of a leading edge technology within routine clinical practice, the Royal College of Radiologists working party recommended:

- *'Initially, one PET-CT per 1.5 million population is planned to reflect the current role in cancer management.'*

Currently Wales has a single fixed-site PET-CT scanner in Cardiff (PETIC) and 2 days per week use of a mobile unit in Wrexham. Patients from South West Wales must travel to Cardiff for their PET scans.

1.4 In Wales in 2018-19, PETIC performed 2,667 FDG PET-CT scans and North Wales 771. This equates to a total of 3,438 scans per annum

[1] http://www.prudenthealthcare.org.uk/wp-content/uploads/2016/02/Securing-Health-and-Wellbeing-for-Future-Generations1.pdf
[2] http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_co_exam&lang=en
[3] https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostic-imaging-dataset/

for the whole of Wales and is equivalent to 909 scans per million population. Demand for PET-CT continues to grow and it has been estimated that the total number of scans performed in Wales in 2019/20 could be 4,371 (1,467 per million population) if the revised WHSSC commissioning policy[4] is fully implemented.

1.5 Meanwhile, in the rest of the UK, PET-CT has moved out of specialist tertiary centres to become a routine part of the equipment in the nuclear medicine departments of teaching hospitals and large District General Hospitals.

2 Background & Context

In November 2018, the All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee (WSAC) produced a report "*Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations".*

This document (Appendix 1) provided the strategic vision for Welsh PET Services and outlined, in broad terms, a strategic plan for PET development in Wales.

The five key recommendations outlined within the document were:

- **Recommendation 1**
  The All Wales PET Advisory Group (AWPET), a subgroup of the Welsh Scientific Advisory Committee (and an advisory group to WHSSC), should continue to recommend to WHSSC an expanded indication list for PET scanning based on best available evidence. There should be provision for increased growth and appropriate funding. In future AWPET should continuously review evidence based best practice clinical pathways incorporating PET scanning in Wales.

The aim could be to move towards those indications recommended in the RCR/RCP UK recommendations of 2016[5] and those recommended in clinical guidelines published by NICE[6].

- **Recommendation 2**
  Welsh Government should require an outline business case (OBC) for the replacement of the end of life machine at PETIC. The OBC should be developed by Cardiff University in conjunction with Cardiff

[4] Specialised Services Commissioning Policy: CP50a. Positron Emission Tomography (2019). Welsh Health Specialised Services Committee (insert hyperlink)
[5] https://www.rcr.ac.uk/publication/evidence-based-indications-use-pet-ct-united-kingdom-2016
[6] https://www.nice.org.uk/guidance/published?type=apg,csg,cg,mpg,ph,sg,sc

and Vale UHB with a degree of urgency. Robust transitional pathways will need to be in place during machine replacement, and this will require collaboration between Cardiff University, Cardiff and Vale UHB and Swansea Bay UHB. Welsh Government should require regular updates during transition

- **Recommendation 3**
  WHSSC should be commissioned to produce a Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.

The strategy should aim to provide equitable access to PET imaging for all patients throughout Wales and for centres to work together to harmonise implementation of WHSCCs commissioning policy as well as similar scanning acquisition protocols and reporting guidance.

- **Recommendation 4**
  The licensing of PETIC with regards to production and supply of radiopharmaceuticals is reviewed as part of the planning of the radiopharmaceutical supply chain for an expansion of PET facilities in Wales.

- **Recommendation 5**
  Constitution of a Welsh PET innovation strategy to develop research, clinical, technological, and industrial collaboration within a formal framework. This will encompass horizon-scanning and development of subjects such as PET in radiotherapy planning, and in novel malignant and non-malignant indications.

On 28th March 2019, the Director General, Health and Social Service/NHS Wales Chief Executive, Welsh Government, wrote to the Chair of the AWPET Advisory Group, endorsing the recommendations made in the report and outlining the expectations for NHS Wales to collaborate on their implementation.

Since there was recognition that additional capital investment was required, to enable the broader service to be developed and made equitable for people across Wales. The Director General requested that WHSCC develop a Programme Business Case with support from the National Imaging Network, to guide the development of future service provision for the whole of Wales.

3 Purpose of Document

This Programme Brief outlines the programme structure and approach that will be adopted by WHSCC to develop an all Wales Programme Business case for Positron Emission Tomography Programme (PET-CTP) and outlines what is expected to be achieved in terms of benefits, outcomes, scope and objectives against clearly defined milestones and timescales.

At this stage, the content that has been provided within the Programme Brief is high level, but once approved, it will be used as the basis for the development of more detailed planning documents.

Formal approval of the programme brief will mean:

- The Senior Responsible Officer (SRO), following consultation with All Wales Chief Executives/Welsh Government confirms that it meets business requirements.
- The PET-CT Programme Board commits to supporting the SRO with delivery of the programme's objectives including the provision of the required resources from the constituent management bodies.

4 Programme Management Approach/Principles and Standards

4.1 Programme Management Approach

The delivery approach that has been adopted by the Efficiency through Technology Fund Group will be **Managing Successful Programmes™ (MSP)**, as it represents proven programme management good practice in successfully delivering transformational change, drawn from experiences of both public and private sector organisations.

4.2 Programme Management Principles

The principles that will be observed by the work undertaken by the PET-CT Programme Board are:

- Remaining aligned with corporate strategy
- Leading change
- Envisioning and communicating a better future
- Focusing on patient benefits such as improving outcomes, clearer benefits and service efficiencies
- Adding value

- Designing and delivering coherent capability
- Learning from experience

5 Programme Definition

5.1 Vision

"The aim of this work is to ensure the population of Wales have equitable access to high quality PET-CT scanning facilities in line with best practice across the UK and Europe"

5.2 Aims

The aims of this programme are to:

- plan an infrastructure of high quality PET-CT scanning facilities across Wales which meets the growing demand and is compliant with the WHSSC PET service specification[7]
- ensure that the agreed infrastructure takes into account the sometimes competing priorities of patient access, cost, workforce capacity, training and research
- ensure that the agreed infrastructure provides resilience and a culture of excellence through co-operative working between providers
- support PETIC in developing a business continuity plan during recommissioning of its facilities within the next 12 months.

5.3 Objectives

The PET-CT Programme Board will provide an effective mechanism for implementation of service change in line with the recommendations outlined in the PET in Wales Report published by AWPET in November 2018. The purpose of the programme will be to develop a Programme Business Case setting out a phased approach to deliver the overall PET service change (including the necessary infrastructure) across NHS Wales – seeking endorsement of the approach from Welsh Government.

5.4 Scope

The scope of the programme will include:

- All Health Boards across NHS Wales
- Velindre NHS Trust
- Cardiff University

[7] Specialised Services Service Specification: CP50b. Positron Emission Tomography (2019). Welsh Health Specialised Services Committee (in development) (insert hyperlink)

- PET providers in NHS England commissioned by WHSSC
- National imaging Network and Welsh Government
- Wales Cancer Network and other relevant specialist groups or organisations (e.g. Royal College of Radiologists)
- Collaboration with:
    - Consultant Radiologists
    - Nuclear Medicine
    - Cancer MDTs and non-cancer MDTs
    - Planning and Estates departments.

5.5 Key Benefits

A Benefits Management Strategy will be developed to refine and model benefits in more detail, determine methods for measuring them and ensure there is a process for tracking their realisation following implementation of the agreed objectives.

5.6 Constraints

The key constraints for the programme of work are:

- Challenging timescales for completion of the work
- Availability of key Human resource to deliver the programme of work due to existing work commitments
- Undefined financial models

5.7 Dependencies

It is recognised that this programme of work will need to link to relevant strategic developments in NHS Wales, for example the Imaging Statement of Intent for NHS Wales[8] and development of the Single Cancer Pathway for NHS Wales[9].

6 Programme Governance

6.1 Governance Framework

The Governance Framework that will be developed will ensure that:

- governance, decision-making and escalation routes are transparent
- decisions, including investment decisions, are better informed
- lines of accountability are clear, as are limits of authority and delegations

[8] https://gov.wales/written-statement-statement-intent-diagnostic-imaging-services
[9] http://www.walescanet.wales.nhs.uk/single-cancer-pathway

- efforts are focused on delivering results rather than on processes
- standards and processes are simple and clear
- strategic oversight and governance of the programme is maintained
- the whole contributes towards a clear and consistent vision
- there is adequate design assurance (business and technical)
- risks and interdependencies are identified and managed
- SROs, and programme and project teams, are clear about their roles and responsibilities for delivering outcomes and what they are being asked to achieve
- there is clear ownership of and accountability for delivering benefits
- Programme and Project Management (PPM) knowledge and best practice can be readily shared
- PPM capability is developed and relevant behaviours become embedded and
- the need for support or resources can be identified at an early stage.

6.2 Programme Structure

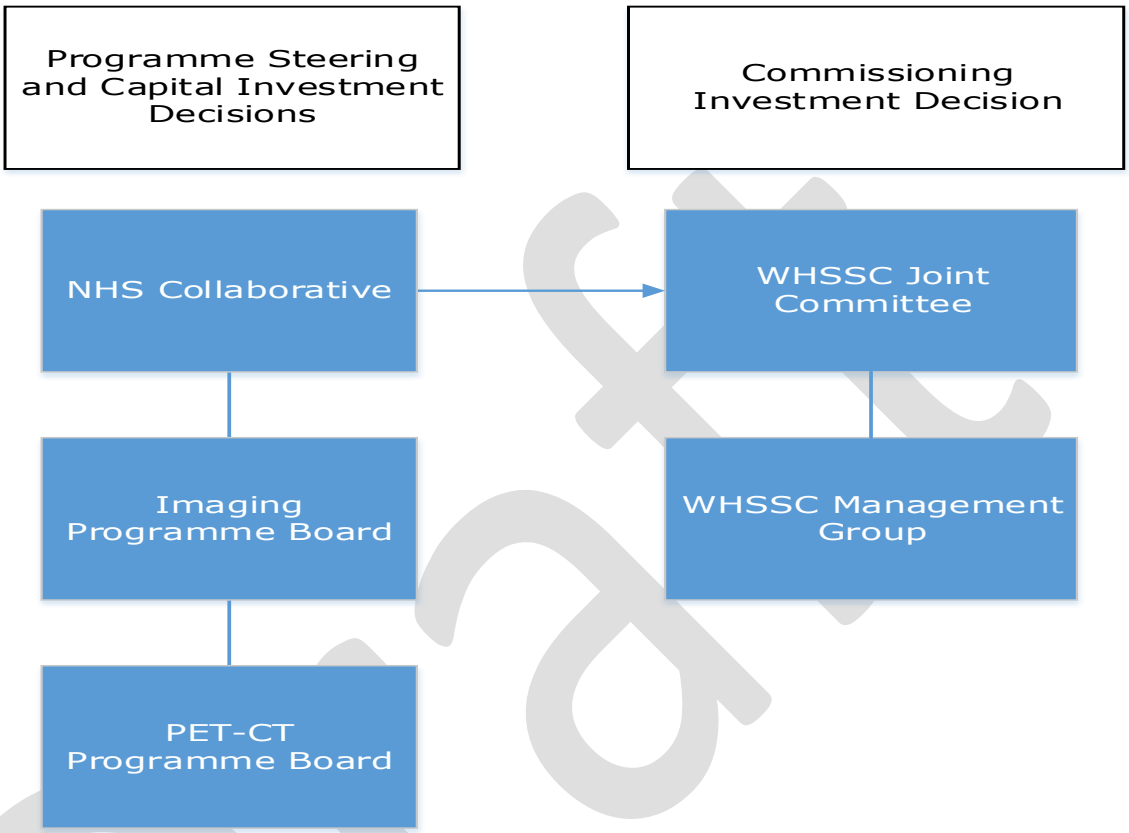
As this programme is being run by WHSSC, the integrity of the WHSSC governance structure and process will need to be maintained. Commissioning investment decisions are made by WHSSC Joint Committee with the appropriate scrutiny through the WHSSC Management Group.

In developing this Programme Brief WHSSC has formed a strategic partnership with the National Imaging Board and links directly to the governance structure of the National Imaging Programme Strategy Board (see Appendix 2). This Board is the overarching Board that that will report to the Health Board and Velindre chief executive officers.

One of the outputs from the programme will be additional PET-CT scanners and associated estates infrastructure and hence a capital requirement. WHSSC do not have a capital allocation and have no mechanism to manage capital, this firmly sits within the remit of Health Boards. This programme will therefore develop a programme business case with supporting business justification cases from Health Boards so that capital can be secured from the All Wales Capital Programme and will form part of the capital allocation to the relevant Health Board or institution.

The suggested structure to enable the PET-CT Programme Board to effectively develop and deliver the "new capability" is outlined in figure 1.

Figure 1: PET-CT Programme Board Structure



a) Sponsoring Group

The key role of the Sponsoring Group is to ensure the programme remains aligned with the strategic objectives for NHS Wales and resolve any conflicts arising from directional/policy changes or overlap with interfacing programmes or initiatives – the PBC will be a live document. Its role is also to approve any investment decisions and sign off final delivery and closure of the programme. The NHS Wales Chief Executives Group will be performing this role.

b) Senior Responsible Owner (SRO)

The SRO role is concerned with the leadership, direction and ultimate accountability for delivery of the programme and management of risk. Sian Lewis, Managing Director of WHSCC, will be the SRO for this programme.

c) PET-CT Programme Board

The board's role is to drive the programme forward, manage the risks and ensure the outcomes are delivered. It reports to the SRO, who chairs the board, members of the board are individually accountable to the SRO for their area of responsibility within the programme. Key responsibilities are to:

- define acceptable risk thresholds for the overall programme and projects within it
- ensure the programme delivers its objectives on time, within budget and to the required quality standard
- resolve strategic issues between projects
- ensure the integrity of benefits profiles and the benefits realisation plan
- provide assurance for operational stability through transition.

It is recognised that clear and effective organisation is critical to programme success and it is recommended that the following roles are members of the PET-CT Programme Board:-

Name	**Role**
Dr Sian Lewis	Senior Responsible Officer (SRO)
Dr Andrew Champion	Programme Director (Deputy SRO)
Dr Martin Rolles	AWPET Representative
Dr Mike Bourne	Cardiff and Value University Health Board
Dr Mark Elias	Betsi Cadwaladr University Health Board
Prof Chris Marshall	Wales Research and Diagnostic Positron Emission Tomography Imaging Centre
Mr Rhidian Hurle	NWIS Representative
Sian Harrop-Griffiths	Swansea Bay University Health Board Representative
Nicola Prygodciza	Aneurin Bevan University Health Board
Jane Fitzpatrick	National Imaging Network Representative
Julie Keegan	Cwm Taf Morgannwg University Health Board
Abigail Harris	Cardiff and Value University Health Board
Keith Jones	Hywel Dda University Health Board
Hayley Thomas	Powys Teaching Health Board
Carl James	Velindre NHS Trust
Mark Osland	Senior Finance Representative
Ian Gunney	Capital Planning Welsh Government
Matthew Prettyjohns	Health Economist – Advisor only and non-voting member
Paul Williams	Programme Manager
Julie Sumner	Head of Communications - Cwm Taf Morgannwg University Health Board

d) Programme Board – Purpose

Established and chaired by the SRO, and coordinated and supported by the Programme Manager, the prime purpose of the Programme Board is to:

- drive the programme forward to deliver the outcomes and benefits
- provide assurance that the Programme meets needs of stakeholders
- resolve dependencies with other projects and areas of work
- provide resource and specific commitment to support delivery
- take ownership for ensuring resolution of risks.

The Programme Board reports to the SRO, and whilst the SRO may delegate responsibilities and action to members of the Programme Board, its existence does not dilute the SRO's accountabilities and decision making authority.

e) Responsibilities of the Programme Board

Members of the Programme Board are individually accountable to the Senior Responsible Officer (SRO) for their areas of responsibility and delivery within the programme as follows:

- Defining the acceptable risk profile and risk thresholds for the programme and its constituent projects.
- Ensuring the programme delivers within its agreed parameters (e.g. cost, organisational impact, rate/scales of adoption, expected/actual benefits realisation).
- Resolving strategic and directional issues between projects, which need the input and agreement of senior stakeholders to ensure the progress of the programme.
- Ensuring the integrity of benefits profiles and benefits realisation plans and ensuring that there is no double-counting of benefits.
- Providing assurance for operational stability and effectiveness through the programme delivery cycle.

Each member of the Programme Board will provide and commit to the SRO for some or all of the following as appropriate for the area they represent:

- Understanding and managing the impact of change.
- Benefits estimates and achievement.

- Owning the resolution of risks and issues that the programme faces.
- Resolving dependencies with other pieces of work, whether change or business operations.
- Representing local strategy as expressed in, for example, medium-term plans and operational blueprints.
- Supporting the application of and compliance with operating standards.
- Making resource available for planning and delivery purposes.

f) Programme Manager

The Programme Manager is responsible for establishing the programme arrangements, governance and the delivery of new capabilities or outcomes. This role is accountable to the SRO/Programme Director and WHSSC Assistant Director (Evidence Evaluation). The programme manager for the PET-CT Programme will be appointed in Sep/Oct 2019 as a 12-month fixed term contract / secondment (1.0WTE) funded by Welsh Government as part of their commitment to implement the Imaging Statement of Intent.

g) Stakeholder Engagement

Once development of the Programme has reached a suitable stage a Stakeholder Engagement Strategy will be developed which includes, the stakeholder map, how stakeholders will be identified, consulted, involved and engaged and how their expectations will be managed.

The stakeholders will also have a role in quality assurance and scrutiny of the programme, particularly with respect to business stability, staff relations and customer expectations.

7 Stakeholder Engagement and Communication

A key output for the PET-CT Programme (PET-CTP) will be to develop a Stakeholder Engagement and Communications Strategy. This will review the stakeholder map and set out what their communication needs will be and how they will be met. A detailed communications plan will also be developed by the PET-CTP to set out what will be done, by whom and when in order to meet those needs.

There is a clear requirement for all members of PET-CTP and working groups to act as conduits for their constituent areas of service in feeding up any suggestions, issues or concerns from staff and reporting back information from the meetings they attend connected to the programme.

In addition, the PET-CTP will liaise closely with the Partnership Forum to ensure staff-side is kept up to date with the programme's activities if appropriate.

8 Assurance and Controls

8.1 Risks and Issues

Once development of the Programme has reached a suitable stage, a Risk Management Strategy will be developed for the Programme which will outline how risks and issues (around the non-delivery of the benefits) will be identified and managed.

The Programme Manager will work with key leads to detail potential risks and issues in the Programme Plan.

8.2 Financial Implications

There are no financial consequences at this stage in the development.

8.3 Acceptance Criteria

Once development of the Programme has reached a suitable stage, the Programme Manager will work with key staff and leads across NHS Wales to agree the key criteria which will define the successful completion of the programme.

8.4 Assumptions

- All programme deliverables must be delivered within timeframe, financial envelope and to the standard agreed.
- Key personnel will be available for their roles throughout the developmental phase.
- Areas of key dependency will be progressed in parallel to the development of the PET-CTP work programme.

8.5 Supporting documents

A suite of supporting documents will be developed as the programme develops recording the progress of the programme against plan.

Appendix 1 – PET in Wales Overview and Strategic Recommendations

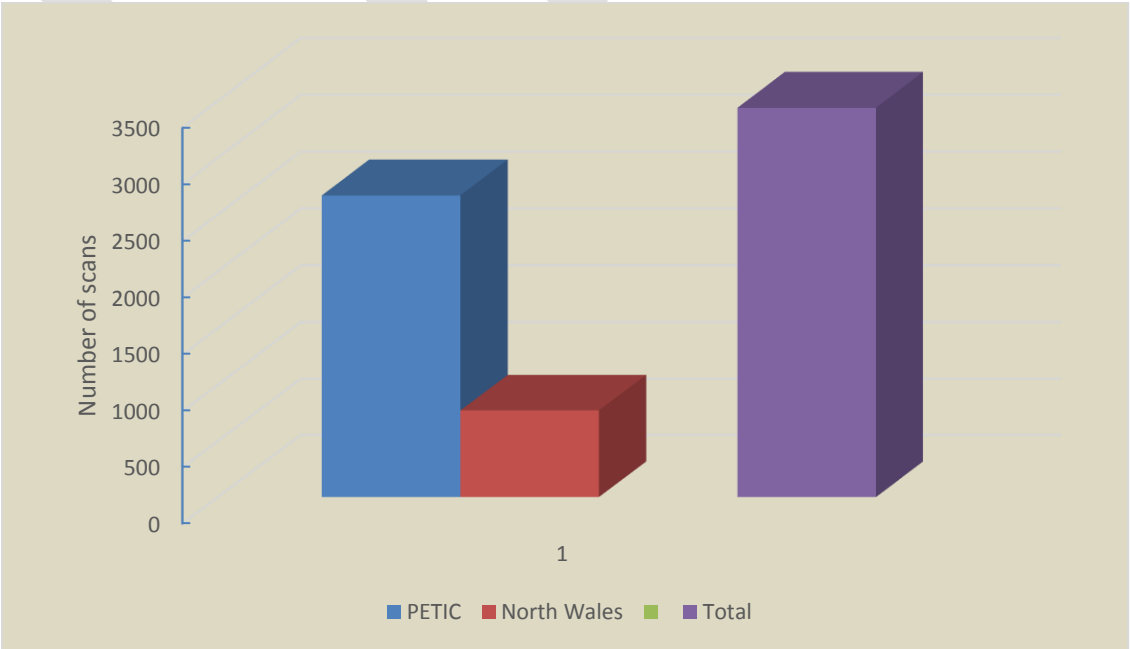
In April 2019, the All Wales PET Advisory Group recommended the development of an all Wales PET-CT strategy that would describe the PET-CT service in Wales over the next ten years.

PET-CT has become a central diagnostic tool in the management of cancer and other non-cancer conditions. Its role and the evidence base continues to evolve. Although it is a relatively expensive investigation, when used appropriately PET can increase the value of healthcare overall and support the principles of prudent healthcare. PET can significantly improve clinical decision making, particularly with respect to the appropriate use of complex and expensive specialist treatments.

It is estimated that Wales is currently performing approximately 40% of the PET scans per head of population compared to England. NHS Wales has a list of funded indications for PET-CT which is limited compared to England and Scotland. Currently Wales has one single fixed-site PET-CT scanner in Cardiff (PETIC) and 2 days per week use of a mobile unit in Wrexham. Patients from South West Wales must travel to Cardiff for their PET scans.

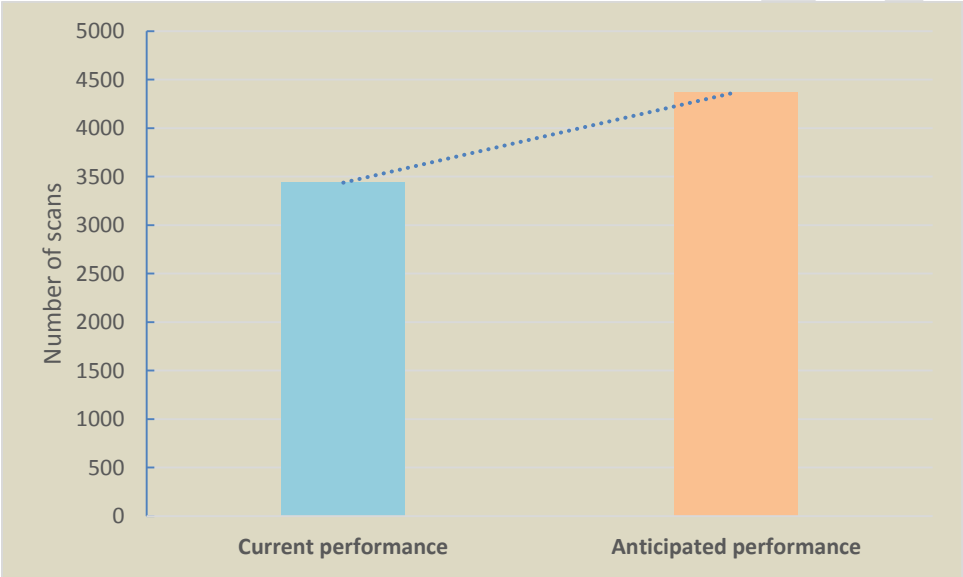
Wales in 2018-19, PETIC performed 2,667 FDG PET-CT scans and North Wales 771 (Figure 1). This equates to a total of 3,438 scans per annum for the whole of Wales and is equivalent to 909 scans per million population.

FIGURE 1 – Total number of PET scans performed in Wales (2018-19)



Demand for PET-CT continues to grow and it has been estimated that the total number of scans performed in Wales in 2019/20 could be 4,371 (1,467 per million population) if the revised WHSSC commissioning policy is fully implemented. This represents a 21% increase in activity compared to 2018-19 (Figure 2).

FIGURE 2: Current performance (2018-19) versus anticipated performance (2019-20)



In November 2018, AWPET and the Welsh Scientific Advisory Committee (WSAC) published a report – 'Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations. A Strategic Plan for PET development in Wales'.

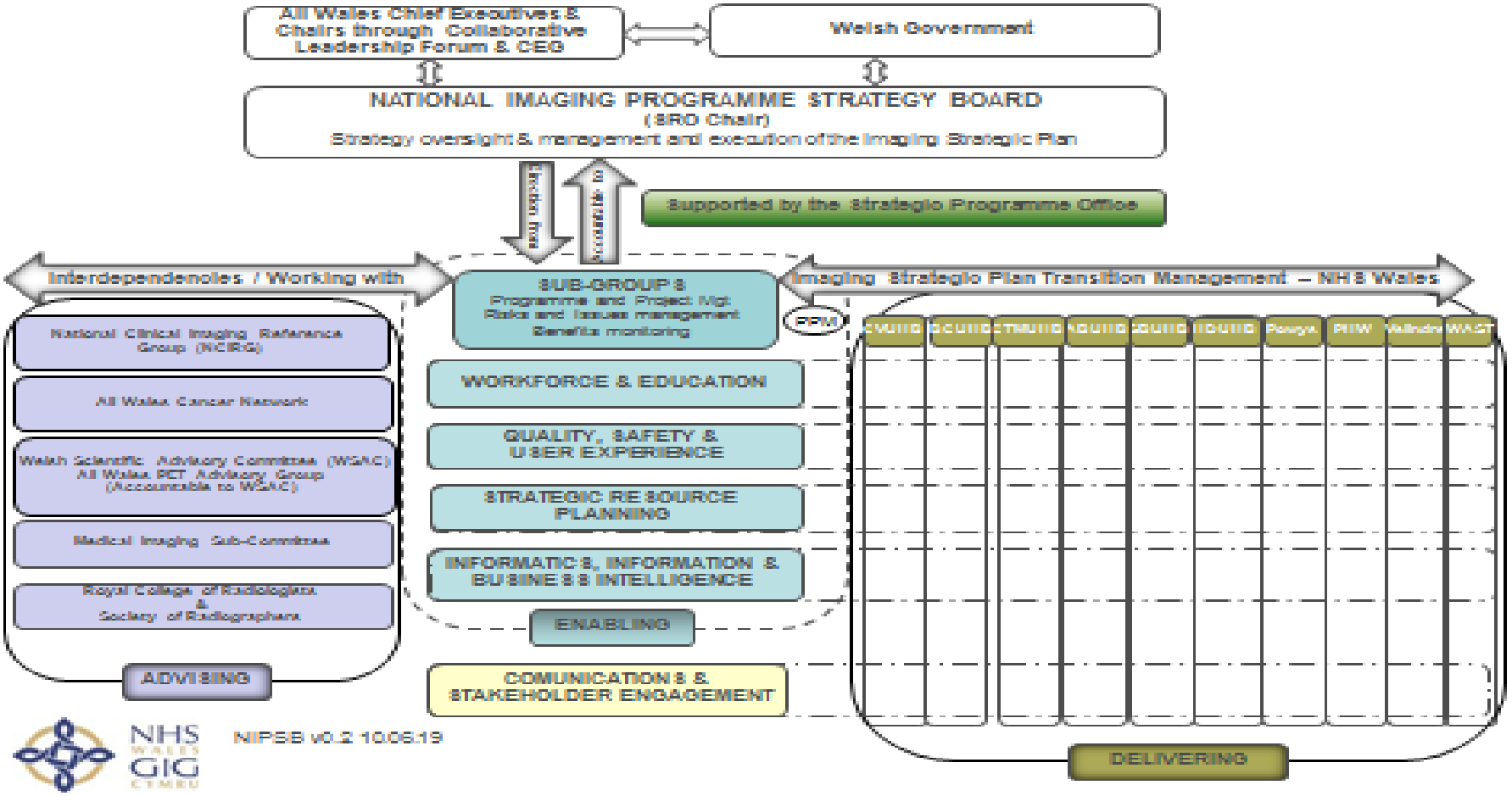
As part of this report five key recommendations were outlined:

1) To recommend to WHSSC an expansion of the indication list for PET scanning based on best available evidence. There should be provision for increased growth and appropriate funding.
2) PETIC to develop an outline business case (OBC) for the replacement of the end of life machine at PETIC. Robust transitional pathways will need to be in place during machine replacement.
3) WHSSC should be commissioned to produce a Programme Business Case for PET-CT capacity in Wales that considers increased demand projections, estates, staffing requirements and research.
4) The licensing of PETIC with regards to production and supply of radiopharmaceuticals is reviewed as part of the planning of the

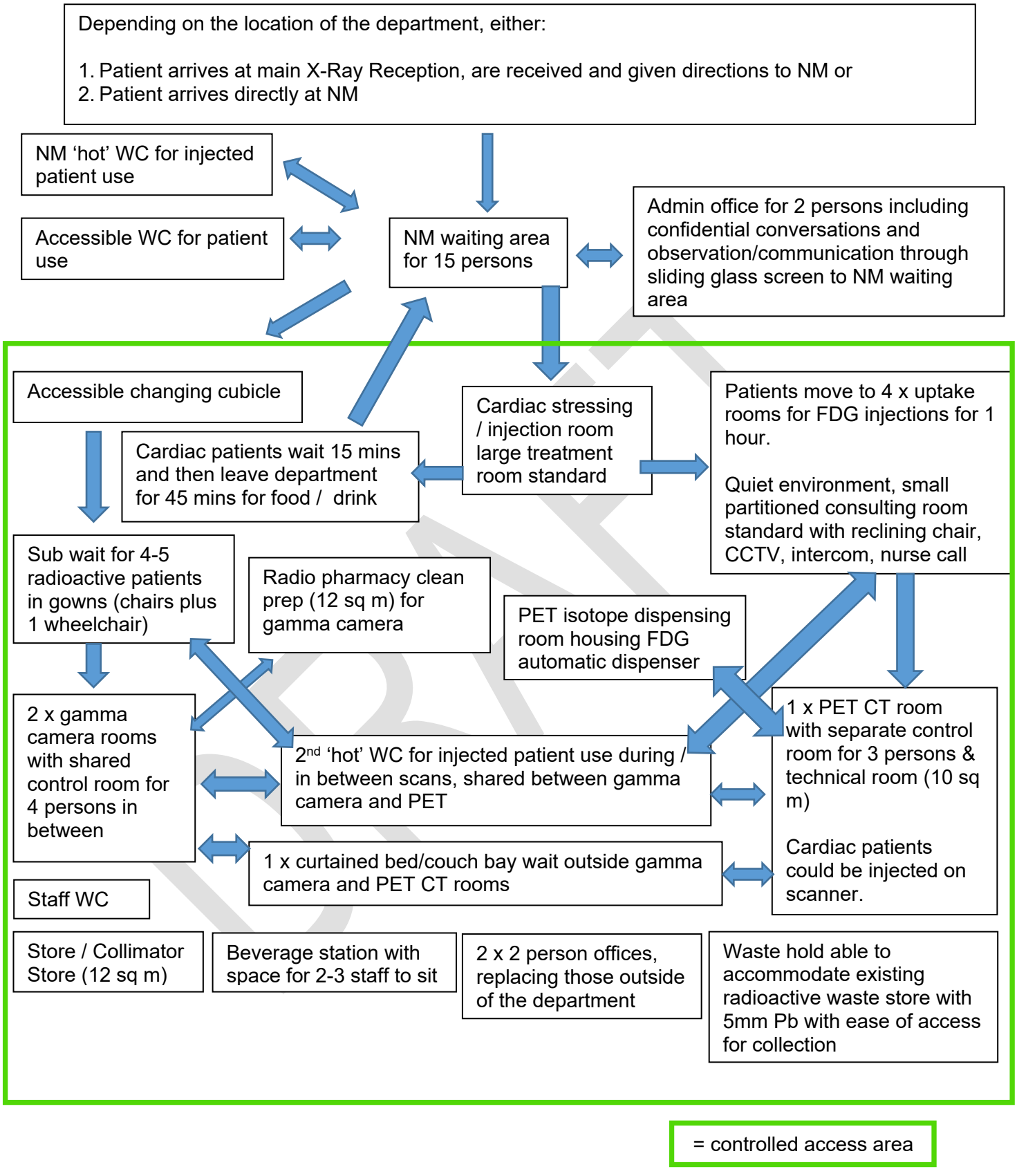
radiopharmaceutical supply chain for an expansion of PET facilities in Wales.

5) Constitution of a Welsh PET innovation strategy to develop research, clinical, technological, and industrial collaboration within a formal framework. This will encompass horizon-scanning and development of subjects such as PET in radiotherapy planning, and in novel malignant and non-malignant indications.

Appendix 2 – National Imaging Programme Governance Structure



Appendix E: Patient Flow Diagram



PET & NM co-located Department Patient Flow V2. 09.05.19. LL

Betsi Cadwaladr University Hospital
Nuclear Medicine Consolidation Project

Strategic Outline Case

Costs at Reporting Level of PUBSEC 248

24 June 2020

CONTENTS

STRATEGIC BUSINESS CASE

Health Board: BCUHB
SCHEME: Nuclear Medicine Consolidation Project
PHASE : **SOC**

Issue date: 24 June 2020

OUTLINE BUSINESS CASE COST FORMS — NOTES

A) BASIS OF CALCULATIONS:

a) Areas:

i) Drawn Areas etc (Departmental & Communications Space) areas are based on Liz Lloyd email dated 11.10.19

b) Costs :

i) All Costs based on £/m2 rates with allowance for on costs.
ii) The Provisional Location Factor Adjustment of 0.97 has been used.
iii) Costs are at PUBSEC index 248.

c) On Costs (Form OB3)

i) Calculation based upon build-up for abnormals

d) Equipment Costs - Based on % at this stage

e) Fees calculations based on % basis

f) Non-Works Costs based upon build up .

g) Value Added Tax calculated at a 'Standard Rate' of 20% on ALL. VAT Reclaim has been applied at 100% on Professional Fees.

k) Inflation -

The anticipated construction duration (< two years) of this Project means that the 'VOP' (Variation of Price) provisions of the DfL Framework WILL NOT apply.

j) Within the cash flow expenditure year 1. 2020/21 includes for the replacement of the WMH gamma camera

STRATEGIC OUTLINE CASE **COST FORM SO1**

Health Board: BCUHB

SCHEME: Nuclear Medicine Consolidation Project

PHASE : **SOC**

CAPITAL COST SUMMARY

		Cost Exc. VAT £	VAT £	Cost Incl. VAT £
1.	Works Cost (OBC)	3,553,100	710,620	4,263,720
2.	Fees	738,334	147,667	886,001
3.	Non-works Costs	32,000	6,400	38,400
4.	Equipment Costs (14%)	3,353,503	670,701	4,024,203
5.	Contingency (15% items 1 to 4)	1,151,541	230,308	1,381,849
6.	**Forecast Project Out-turn Cost (Pre VAT Recovery)**	**8,828,477**	**1,765,695**	**10,594,173**
7.	Less Recoverable VAT (OBC)		147,667	147,667
8.	**Forecast Project Out-turn Cost (VAT Recovery)**	**8,828,477**	**1,618,029**	**10,446,506**

Proposed Contract Period: TBC Months *Excluding Early Works & Substation*
Proposed Starting Date: TBC (m/y)
Proposed Completion Date: TBC (m/y)

	Year	1	2	3	4	Total
	Financial Year	20/21	21/22	22/23	23/24	
Works Cost			218,950	2,333,905	1,000,245	3,553,100
Fees		71,540	380,633	143,080	143,080	738,334
Non-works Costs				32,000		32,000
Equipment Costs			704,000		2,649,503	3,353,503
Contingencies			21,895	790,752	338,894	1,151,541
VAT		14,308	265,096	659,947	826,344	1,765,696
Sub total		**85,848**	**1,590,574**	**3,959,685**	**4,958,067**	10,594,173
Recoverable VAT		14,308	76,127	28,616	28,616	147,667
Total		**71,540**	**1,514,447**	**3,931,069**	**4,929,450**	10,446,506

This form completed by : BCUHB

Telephone No :

Address :

Date : 24 June 2020

Authorised by :

Reference : Health Board - BCUHB

STRATEGIC OUTLINE CASE **COST FORM SO2**

Health Board: BCUHB
SCHEME: Nuclear Medicine Consolidation Project
PHASE : SOC

CAPITAL COST : WORKS AND EQUIPMENT

Functional Content	Function Units/ Space Requirements (1)	Space Allowance		N/A/C (Note 2)		Cost Allowance HCI Version 2.0 (*PUBSEC 248*)	Equipment Cost (£)		
		m²	£/m²	N/A/C	Major / Minor	£			
Functional unit		617	3,000			1,851,000			
On Costs (excluding Fee)						1,702,100			
Equipment									
PET CT									1,600,000
2 x gamma camera									1,300,000
dose dispenser									120,503
injector									33,000
processing software									150,000
Group 2 and 3 items									150,000
Less abatement for transferred Equipment if applicable - Included									Included
Departmental Costs and Equipment Costs* to Summary (Form OB1)						£ 3,553,100	£		£3,353,503

STRATEGIC OUTLINE CASE **COST FORM SO3**

Health Board: BCUHB

SCHEME: Nuclear Medicine Consolidation Project

PHASE : SOC

CAPITAL COSTS: ON-COSTS

			Estimated Cost (exc. VAT)	Percentage of Departmental Cost
1.	Communications	£		%
	a. Space			
	b. Lifts		£	
2.	"External" Building Works (1)			
	a. Drainage			
	b. Roads, paths, parking (reduced part			
	c. Site layout, walls, fencing, gates			
	d. Builder's work for engineering services outside buildings		£	
3.	"External" Engineering Works (1)			
	a. Steam, condensate, heating, hot water and gas supply mains			
	b. Cold water mains and storage			
	c. Electricity mains, sub-stations, stand-by generating plant			
	d. Calorifiers and associated plant			
	e. Miscellaneous services (services in the road)		£	
4.	Auxiliary Buildings		£	
5.	Other on-costs and abnormals (2)			
	a. Link glazed corridor	300,000		
	b. Rooftop Plantroom	225,000		
	c. Varying ground conditions	70,000		
	d. Diverting/reinstating existing services	30,000		
	e. External lighting and landscaping	35,000		
	f. Electrical cable connections for the 3 scanners, AHUs and building	64,500		
	g. Substation	80,000		
	h. Generator	450,000		
	i. UPS/IPS N+1	68,000		
	j. BMS panel and connections to existing	50,000		
	k. 600x600 LED ceiling combined emergency lighting panels	63,600		
	l. L1 Fire alarm system	inc		
	m. Nurse call system	inc		
	n. AHU	inc		
	o. Radiant panel wet heating system	66,000		
	p. Duplex medigas pump	100,000		
	q. 8 x AC 6kw splitter units	100,000		
			£ 1,702,100	
	Total On-Costs to Summary SO1		£ 1,702,100	

STRATEGIC OUTLINE CASE **COST FORM SO4**

Health Board: BCUHB
SCHEME: Nuclear Medicine Consolidation Project
PHASE : SOC Cost/m² Basis

CAPITAL COSTS: FEES AND NON-WORKS COSTS

		£	Percentage of Works Cost (Net of Loc Fact Adj) %
1.	Fees (including "in-house" resource costs)		
	Trust/Health Board:		
a	Project Manager		3.00%
b	Health Board Cost Advisor		2.00%
c	Architect		6.16%
d	Civil and Structural Engineer		5.04%
e	Building Services Engineer		
f	Planning Supervisor		1.88%
g	Director and Inhouse Sponsor		1.00%
h	Supervisor		1.50%
i	Other (List and Describe)		
	Audit		0.20%
	Trust/Health Board Total	£	
	Total Fees to Summary (SO1)	£	20.78%

		£	% of Works Cost
2.	Non-Works Costs		
a	Statutory and local authority charges	12,000	
b	Planning and Building Control fees		
c	Other (list and describe)		
d	Surveys	20,000	
e	Decant		
	Non-Works Costs to Summary (OB1)	£ 32,000	£ 0.90%

OUTLINE BUSINESS CASE **COST FORM SO5**

Health Board: BCUHB

SCHEME: Nuclear Medicine Consolidation Project

PHASE : STAGE SOC

Proposed start on site: May 2022
Proposed completion date: October 2023

Year		1	2	3	4	Total
Financial year		20/21	21/22	22/23	23/24	
Works Cost			218,950	2,333,905	1,000,245	3,553,100
Fees		71,540	380,633	143,080	143,080	738,334
Non-works Costs				32,000		32,000
Equipment Costs			704,000		2,649,503	3,353,503
Contingencies			21,895	790,752	338,894	1,151,541
VAT		14,308	265,096	659,947	826,344	1,765,696
Sub-total		**85,848**	**1,590,574**	**3,959,685**	**4,958,067**	10,594,173
Less: Reclaimable VAT		14,308	76,127	28,616	28,616	147,667
TOTAL		**71,540**	**1,514,447**	**3,931,069**	**4,929,450**	10,446,506

	20/21	21/22	22/23	23/24	Recurrent
	Year 1	Year 2	Year 3	Year 4	Year 5
	£000's	£000's	£000's	£000's	£000's
Projected Costs					
Capital Costs	72	1,514	3,931	4,930	0
Revenue Costs	1,362	1,362	1,364	1,107	1,207
Depreciation	10	227	788	1,492	1,492
Total Costs	**1,444**	**3,103**	**6,083**	**7,529**	**2,699**
Proposed Funding Stream					
WG Capital	72	1,514	3,931	4,930	0
WG Funding Depreciation Charge	10	227	788	1,492	1,492
Existing Revenue Funding	1,417	1,417	1,417	1,417	1,417
Total Funding Stream	**1,499**	**3,158**	**6,136**	**7,839**	**2,909**
Saving	**(55)**	**(55)**	**(53)**	**(310)**	**(210)**

	19/20	20/21	21/22	22/23	23/24	Recurrent
	Year 0	Year 1	Year 2	Year 3	Year 4	Year 7**
Available funding						
Existing revenue stream	1,417,228	1,417,228	1,417,228	1,417,228	1,417,228	1,417,228
Costs						
Pay						
Principal Lead		-	-		55,985	55,985
Band 7 Physicist		-	-		23,483	23,483
Consultant reporting sessions		-	-		62,000	62,000
Radiographer & support staffing		448,312	448,312	448,312	383,447	383,447
Centralisation protection/Excess travel reserve		-	-		29,962	-
Pay sub-total		**448,312**	**448,312**	**448,312**	**554,877**	**524,915**

Non-Pay						
PET maintenance		-	-	-	67,365	202,096
NM Maintenance		75,796	75,796	78,000	156,000	156,000
NM Software Support		30,678	30,678	30,678	30,678	30,678
PET Consumables		-	-		10,641	10,641
PET Pharmaceuticals		-	-		210,000	210,000
Christies PET scans		-	-		9,100	9,100
PET Delivery & Transport		-	-		33,696	33,696
Non pay & training			-		10,000	5,000
Utilities increase - lighting and heating & cleaning		-	-		25,000	25,000
External PET Contract		806,997	806,997	806,997	-	-
Non-Pay sub-total		**913,471**	**913,471**	**915,675**	**552,480**	**682,211**

Total		**1,361,783**	**1,361,783**	**1,363,987**	**1,107,356**	**1,207,126**

Change		**- 55,445**	**- 55,445**	**- 53,241**	**- 309,872**	**- 210,102**

***Year 0 is 2019/20. Figures do NOT include inflationary uplift.**

****** Years 5 and 6 will be the same as year 4. In year 7 the centralisation/excess travel costs cease, giving the recurring position.**

Existing Costs Full Year (£)

	£	£
NM Existing Staffing	394,136	
NM Maintenance	137,082	
NM Software Licenses	24,837	
Total Cost Nuclear Medicine		556,055
PET Existing Staffing	54,176	
PET Mobile Lease	806,997	
Total Cost PET CT		861,173
Grand Total		**1,417,228**

Summary	
	Revenue
NM Maintenance	- 137,082
NM Software Licences	- 24,837
NM Existing Staffing	- 394,136
Total Cost of Nuclear Medicine	
PET Medical	- 45,091
Admin Support	- 9,085
PET CT Forecast for 1	- 806,997
Total Cost PET CT	
Grand Total	

Nuclear Medicine Consolidation Risk Register
Version 3, 15.07.20

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Grey shading in the Risk No. column on the left hand side indicates that the risk has been amended since the last version was issued

Risk No.	Ownership (Dept/CPG)	Date added	Type	Risk Description	Comments	Classification			Risk Implications				Risk Counter Measures or Mitigation
						Likelihood	Potential impact	Risk exposure score	Time	Cost	Quality	Operational	
1	Project Director	11.10.19.	Rev	Projected revenue savings not achieved	Business case predicated on achieving revenue savings through the consolidation onto 1 site with a capital PET solution within the preferred option. Detailed scrutiny of proposed staff mix for preferred option carried out and savings identified. To be presented to Secondary Care, F&P and Executive meetings for review.	2	5	10		X		X	Savings achievement to be reviewed at 6 month intervals for the first 2 years of implementation and variations reported. Recruitment to be strictly in line with planned staff skill mix within the business case.
2	Project Director	11.10.19.	Cap	Capital funding bid to WG not approved	No alternative source of capital funding. Significant level of capital investment but preferred option reduces the number of gamma cameras from 3 to 2. Capital funding shortages across Wales following Covid 19 contingency measures.	3	5	15	X	X	X	X	In line with WHSSC and AWPET strategic direction. Scoping document shared with WG and initial meeting held to discuss intent and scope. SOC requested at the earliest opportunity. Dialogue to be maintained in monthly WG meetings.
3	Project Team	11.10.19.	Cap	Unrealistic programme adopted given the priority of implementation	e.g. to pre-empt equipment failure or staff attrition. WMH gamma camera reaches End of Life and End of Support Dec 2020. Existing significant delay to SOC approval process during Covid 19 measures.	3	3	9	X	X	X	X	Timescales within SOC reviewed July 2020 to reflect delay. Time allowances consistent with past business case processes.
4	Project Director	11.10.19.	Cap	Programme delay	As a result of; delayed approval of capital funding bid, procurement issues, staff transfer/recruitment/retention, decant, construction related issues. Delayed approval of capital funding bid could lead to loss of equipment, existing post holders including ARSAC licence holders and an inability to recruit to vacant posts.	5	5	25	X	X		X	Delayed SOC to be submitted to first possible meetings for internal approval prior to submission to WG. Separate BJC to be developed for WMH gamma camera replacement given End of Life/Support Dec 2020.
5	Project Director	11.10.19.	Op	OCP and HR related risks		3	3	9	X	X	X	X	Initial consultation with staff and staff side representatives completed with HR representation. 1-2-1 discussions to take place when needed. OCP to be applied in full. Staff to be offered alternative opportunities where transfer isn't practical. Phased transfer to be considered.
6	Project Manager	11.10.19.	Cap	Project appointments not yet in place	In line with the Capital Manual, follows funding approval	3	2	6			X		Project Board membership already reviewed and established. Terms of Reference agreed. Project Director appointments agreed, SRO appointment to be reviewed at Director level.
7	Project Manager	11.10.19.	Cap	Project governance documents not yet in place	In line with the Capital Manual, follows funding approval	2	2	4			X		Meeting discussions recorded. Risk register to be reviewed and accepted by Project Team. Programme to be developed.
8	Project Manager	11.10.19.	Cap	Availability of site for preferred option	Site selection to be completed following SOC submission. No deliverable site next to main YG Radiology department, other identified sites are currently available but BCU strategic intent may change.	3	3	9	X	X		X	Availability to be discussed with each Hospital Director and Site Clinical Director and included in any Development Control Plans. Site selection to be completed at the earliest opportunity.
9	Project Manager	11.10.19.	Cap	Suitability of site	i.e. in terms of topography, existing use, adjacencies, availability of mechanical and electrical connections	3	3	9	X	X	X	X	High level initial feasibility review carried out pending OBC and funding availability for fees. All aspects to be documented and considered during site appraisal against weighted criteria.
10	Project Manager	11.10.19.	Cap	Late design changes or failure to finalise and sign off design		3	3	9	X	X	X	X	Design to be signed off by all lead users at key milestones within the design stage. Project Director to approve stage reports.
11	Project Manager	11.10.19.	Cap	Breach of regulatory and statutory requirements during design and construction phases		3	3	9	X	X	X	X	Designers risk assessments prepared. CDM Advisor appointed and Pre Construction Information prepared. Appointed contractor to submit Construction Phase Plan.
12	Project Manager	11.10.19.	Cap	Need to deviate from HTM/HBN guidance during design and construction phases	i.e. as a result of being unable due to other constraints. No derogations requested to date.	3	3	9	X	X	X	X	Experienced design team in place. Design and build contract to be let with responsibility remaining with the contractor. Appointed Principal Designer to review the design and construction process.
13	Lead User	11.10.19.	Op	Model of care changes and service requirements not captured within the business case, building design or on an equipment list	e.g. design fails to allow for short and mid term capacity requirements	3	3	9	X	X	X	X	Lead users to develop an operational policy and carry out capacity modelling for checking against the outline design and anticipated patient flow.
14	Project Director	11.10.19.	Cap	Equipment selection process flawed	Specifications to be prepared by Evaluation Team. Process supported by SSP-SES to include presentations, site visits, scoring and pricing.	3	3	9	X		X		Membership of Evaluation Team to be agreed by Project Team. Suppliers to be provided with equal opportunity. Process, rationale and scoring to be documented and in line with SSP-SES and procurement guidance and standing orders.
15	Finance Representative	11.10.19.	Cap	Original VAT reclaim assumption isn't realised	Could apply to professional fees and refurbished areas	2	2	4		X			BCUHB VAT Advisor to request HMRC assessment
16	Project Director	13.12.19.	Cap	Stakeholder support not forthcoming	i.e. CHC, WHSSC or AWPET	3	3	9	X	X	X	X	AWPET representation in place, communication to be maintained on progress. WHSSC have indicated their support for the SOC. Engagement with the CHC ongoing, confirmation of support received, no public consultation required.
17	Project Director	15.07.20.	Cap	Delay to one phase causes delay to subsequent phase	Risk to capital expenditure profile and programme for later phase	3	3	9	X	X			Realistic timescales to be adopted and reviewed at regular intervals.
18	Project Manager	15.07.20.	Cap	High selected site abnormal costs	i.e. one off costs such as poor ground conditions, requirement for a new power supply etc.	4	3	12	X	X			Identifiable abnormals to be considered in the site selection wherever possible. Some allowances made within budget costs.
19	Project Manager	15.07.20.	Cap	Existing mechanical and electrical infrastructure found to be inadequate or in a poor condition	Where connections are needed as it would be impractical to provide an alternative e.g. medigas	4	3	12	X	X	X		Some allowances made within SOC budget costs. Surveys and site investigations to be completed as soon as possible at OBC stage.
20	Project Director	15.07.20.	Op / Cap	Effect of coronovirus pandemic on project	In terms of deliverability, possible changes to service model and capacity as a result of cleaning regimes	5	2	10	X			X	Considered by Project Board, capacity provided by 2 gamma cameras considered adequate. Air changes to be provided in ventilation design. Any additional Infection Prevention requirements to be considered in design.

Legend:

Likelihood

Rare	1	2.50%
Unlikely	2	5.00%
Possible	3	20.00%
Likely	4	55.00%
Almost certain	5	75.00%

Impact

Insignificant	1
Minor	2
Moderate	3
Major	4
Catastrophic	5

Score

Low risk	1-5
Medium risk	6-14
High risk	15-25

Operational implication risk type
Capital or Project risk type
Revenue implication risk type

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Ruthin Clinic Relocation Risk Register - Removed Risks

Risk No.	Ownership (Dept/CPG)	Date removed	Type	Risk Description	Comments	Classification			Risk Implications				Risk Counter Measures or Mitigation	Risk Cost Allowance
						Likelihood	Potential impact	Risk exposure score	Time	Cost	Quality	Operational		
													UNALLOCATED RISK (INC VAT)	

Legend:

Likelihood

Rare	1	2.50%
Unlikely	2	5.00%
Possible	3	20.00%
Likely	4	55.00%
Almost certain	5	75.00%

Impact

Insignificant	1
Minor	2
Moderate	3
Major	4
Catastrophic	5

Score

Low risk	1-5
Medium risk	6-14
High risk	15-25

Local Area Team	LAT
Operational Estates Department (Central, Estates & Facilities)	Op Est
Estate Development Team (Central), Planning	Cap Dev
Primary Care Support Unit	PCSU
Ruthin Clinic GP Practice	GP
BCU Informatics Team	Inform
Operational implication risk type	Op
Capital or Project risk type	Capital
Revenue implication risk type	Rev

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

EQUALITY IMPACT ASSESSMENT FORMS

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	Consolidation of the BCU Nuclear Medicine Service
Date form completed:	8th November 2019

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	The reconfiguration of the nuclear medicine service to provide a sustainable service within North Wales that provides high quality general nuclear medicine imaging and a fixed PET CT scanner service.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Nuclear Medicine department undertakes and interprets images acquired following the patient being given a small amount of radionuclelide that is then taken up by the tissues and scanned to diagnose and determine the severity of a variety of diseases and disorders. There is a nuclear medicine scanner on each of the DGH sites WXM, YGC & YG and a mobile PETCT service visits the Maelor 2 days per week. The PETCT service is funded by WHSSC and covers the populations of BCU and North Powys It would be more cost effective for the health board to purchase our own PET-CT scanner, which could then be used 5 days of the week. The nuclear medicine scanners are not fully utilised and two are now in need of replacement due to their age. In addition, the Health Board has other big challenges in making sure that there are expert licence holders to look after the way the service is run and enough qualified staff at any one time at each hospital to run the service. Making sure there is a reliable delivery of radionuclides available from the centres in England that produce it is also a big factor. The service needs to be modernised and its future protected so the Health Board is considering how to restructure it to provide the best service to patients and solve the problems above. This could mean creating a specialist centre of excellence where having all the clinical staff and scanners together could speed up scanning and diagnosis. This EQIA is being done to support the proposed model of a centre of excellence
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree	Ultimately, this project will need BCU board approval. The SRO is the Director of Therapies and Healthcare sciences and there is a project board in place that reports to the radiology senior management team

Part A Form 1: Preparation

	or approve any changes you identify are necessary?	
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	The project is related to the need to be compliant with a variety of ionising radiation regulations listed below Ionising Radiation Regulations 2017 (IRR17) The Ionising Radiation (Medical Exposures) Regulations 2017 (The Environmental Permitting (England and Wales) Regulations 2016, as amended 2018) Transport of radioactive substances (The Carriage of Dangerous Goods and Transportable Pressure Equipment Regulations 2009, amended 2019) WHSCC are responsible for the commissioning of PETCT Used in many of the cancer pathways
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Radiology referrers to nuclear medicine and PETCT Radiology staff working in Nuclear Medicine All BCU Patients who would require either a nuclear medicine All BCU and North Powys patients who require a PETCT scan A plan for engagement has been agreed and implemented. There have been engagement sessions held with referrers, radiology staff and members of the public at sessions across North Wales and Powys.

Part A Form 1: Preparation

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Failure to reconfigure the service would lead to an unsustainable service and a high risk that the service could no longer be delivered in North Wales and patients would then need to travel to England to access services. The success of the project depends upon capital funding from WG and development of suitable accommodation on the preferred DGH site
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	Currently patients for PETCT have to access a mobile lorry. Patients with mobility difficulties are not able to access the PETCT in Wrexham and have to travel to England to a static facility for their scan.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

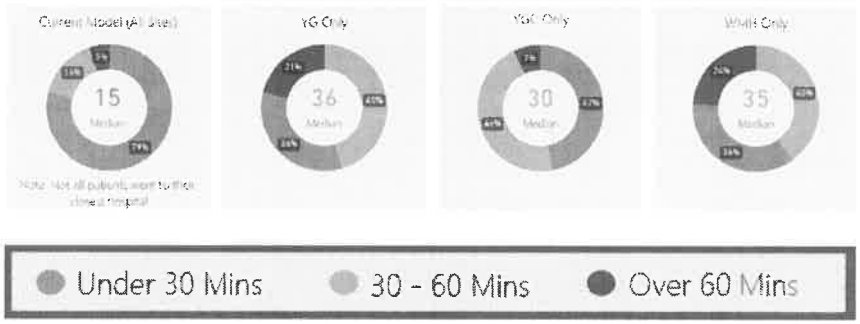
Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	Yes		x		The change in service affects all ages as patients of all ages are referred for nuclear medicine. However, the change to a single centre will not change referral pathways from referrers. Developing the centre will give opportunities to consider the environment for paediatric patients Having wider availability of PETCT through the week will facilitate flexibility of appointments which may help patients who have other needs to be considered when timing appointments e.g. dementia	
Disability (think about different types of impairment	Yes		+ve		The current PETCT service is provided on a lorry, which has limited space and access. This means that patients who have limited mobility or require the use of a hoist etc. need	

and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)					to be sent to centres in England to access scanning in a static centre who are able to support their needs. Unfortunately, this causes delays in securing space on the scanner and having the images returned for reporting. The proposal will mitigate this situation and will therefore support timely pathways for cancer patients.	
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		No			Irrespective of gender all patients requiring nuclear medicine/PETCT will continue to be referred as currently	
Pregnancy and maternity		No			There will be no impact as patients who are pregnant or breastfeeding already have special precautions in place as required by the Ionising Radiation (Medical Exposure) Regulations 2017 with respect to radiation protection. For each patient a benefit risk assessment is required by the regulations on an individual basis. Where comforters and carers attend with patients the department the regulations apply in ensuring radiation	

					safety. Facilities for baby changing are available in the department and breast feeding is supported	
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.		No			Referral to nuclear medicine is based on clinical need and not dependent on the ethnicity of the patient being referred.	
Religion, belief and non-belief		No			Referral to nuclear medicine is based on clinical need and not dependent upon the religion, belief or non-belief of the patient being referred.	
Sex (men and women)		No			Referral to nuclear medicine is based on clinical need and not dependent upon the sex of the patient being referred.	
Sexual orientation (Lesbian, Gay and Bisexual)		No			Referral to nuclear medicine is based on clinical need and not dependent upon the sexual orientation of the patient being referred.	

Marriage and civil Partnership (Marital status)		No			Referral to nuclear medicine is based on clinical need and not dependent upon the marital status of the patient being referred.	
Low-income households	Yes			-ve	Dependent upon the final location of the centre some patients will need to travel further to access nuclear medicine. The total number of nuclear medicine scans per year approximately 4000. **Travel** The figure below shows current travel time and the revised time depending upon the final site. Currently not all tests are done on all three sites thus some patients will currently travel.  PETCT patients all currently travel to Wrexham thus the potential number of patients who need to travel would be	Where patient's meet the relevant criteria they can access hospital transport to mitigate the cost

					similar to that currently irrespective of the final location of the service. However failure to change the service would result in service failure and a larger detriment to patients with all having to travel to England for both nuclear medicine and PETCT	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	No			None		

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	Yes		X		Members of the nuclear medicine team are Welsh speaking and the radiology department have staff across all modalities who can support the use of Welsh Language. The current PETCT service is provided by an English provider – staff on the mobile are from England and not able to speak Welsh although we do have welsh speaking staff who support the service.	
Treating the Welsh		No				

language no less favourably than the English language						

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	 Nuclear medicine events.docx Above is a list of the organisations who were invited by the BCU engagement team to the public meetings. There were also invites sent out to the public in North Powys by the PowysTHB engagement team
Have any themes emerged? Describe them here.	Members of the public and patients who attended the engagement sessions were very supportive of the move to a single centre of excellence and felt it was an appropriate approach. It was suggested that those people who are reliant on others to drive them to appointments or public transport may struggle, particularly if the appointment is early morning and they live a long way from the site. Existing parking limitations at hospitals was highlighted and it was suggested dedicated parking spaces for nuclear medicine patients could help.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	As part of the design of the centre consideration will be given to parking particularly with respect to PETCT appointments. Having a static PETCT service will allow for more flexibility of appointments. Currently patients have often left home to travel for their PET and it has had to be cancelled as the isotope has failed QA. We will

	be able to schedule patients to avoid this type of situation.

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	The reconfiguration of the nuclear medicine service to provide a sustainable service within North Wales that provides high quality general nuclear medicine imaging and a fixed PET CT scanner service.

2. Brief Aims and Objectives: (Copy from Form 1)	To co-locate the nuclear medicine services and create a fix PETCT service at one location

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes x	No
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance?	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x	
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language? The impact is on a small number of patients who would have to travel further. However current service risks could lead to no service and patients would all have to travel to England. Patients with disabilities that prevent them from getting up steps currently cannot access mobile PETCT and have to travel to England and also experience delays to diagnosis		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes x		
	Record Details: Access to transport for small numbers of patients which can be supported by hospital transport. Consideration of car parking e.g. identified space for PETCT patients.		
6. Are monitoring arrangements in place so that you can	Yes	No x	
	How is it being monitored?		

Part B Form 5: Summary of Key Findings and Actions

measure what actually happens after you implement your policy or proposal?	Who is responsible?	Patient experience feedback will be obtained from patients when the service starts This will be led by the Principal Radiographer Nuclear Medicine
	What information is being used?	E.g. will you be using existing reports, data etc. or do you need to gather your own information?
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	EQIA to be reviewed once service has been implemented

7. Where will your policy or proposal be forwarded for approval?	The project will be taken to board and then Welsh Government for approval

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be**	Name	Title/Role
	Helen Hughes	Head of Quality & Governance Radiology

Part B Form 5: Summary of Key Findings and Actions

undertaken as a group activity	Pat Youds	Professional Head of Radiography
	Dr Mark Elias	Consultant Radiologist and PETCT clinical lead
	David Jones	Principal Radiographer Nuclear Medicine
Senior sign off prior to committee approval:	(PAT YOUDS)	Professional Lead, Radiography & Radiology Manager.
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	None identified		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	The implementation of the programme will look at access to parking on site.	Project team	During site development

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
			plan production on Chosen site
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	Access to hospital transport is already available for some groups of patients.		
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.	Failure to consolidate the service will continue to impact on recruitment and if we are unable to attract licence holders the service will legally not be able to continue. Continuing to deliver a mobile PETCT maintains the current disadvantages to disabled patients		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Consideration will be given to access to parking.		

Part B Form 5: Summary of Key Findings and Actions

SUBSTANTIAL CHANGE PROTOCOL
APPENDIX 1: TEMPLATE FOR SUBMISSION

PROPOSALS FOR NHS SERVICE DEVELOPMENT OR VARIATION	
BCU HB Lead Manager and Contact Details	Pat Youds, Professional Lead, Radiography pat.youds@wales.nhs.uk
Description of service and proposal for development or variation *Including likely timescale for implementation*	There is a major national shortage of Consultant Radiologists in the UK which is having a significant impact on the delivery of specialist imaging services. In the case of Nuclear Medicine/PET CT imaging, this service is unable to function without radiologist expertise and, specifically, the holding of specialist licences issued by the DoH to allow the administration of radio-active pharmaceuticals to patients – only medical doctors can hold this licence for which considerable additional training is required. It is very likely that, with retirement, BCU will only have 2 such licence holders in about three years' time and, unless individuals can be retained, this specialist imaging service in North Wales will be lost. This has already happened in many parts of the UK with radiologists moving to specialist centres that have PET CT. With these concerns in mind, Radiology submitted a scoping document in March '19 to the BCU Executive Management Group regarding possibilities for reconfiguration of Nuclear Medicine/PET CT services in North Wales - this was considered favourably and Radiology was asked to develop a business case in which reconfiguration options are evaluated for the nuclear medicine gamma camera service currently based on the 3 DGH sites coupled with additional PET CT capacity. These proposals are set out in the scoping document which is embedded below. The preferred site for the co-located service of both Nuclear Medicine and PET CT (Option 3) has yet to be decided - this will be determined by the 'Options Appraisal' process but it is recognised that there are constraints related to the logistics of transporting radio-pharmaceuticals with a very short useable radioactivity life. The activity determines whether an examination can proceed or not – the cyclotrons required to provide the PET CT radio-pharmaceuticals cost many millions so it is not financially viable for BCUHB to have its own. The scoping document was also submitted by BCU to Welsh Government, following which both parties met in September to discuss next steps. WG have requested for a 'Strategic Outline Case' (SOC) to be submitted as soon as possible and before year end. It is, therefore, planned for the SOC to be submitted for consideration by the Secondary Care Management Group at the end of November, this being the initial stage in the BCU approval process. Subject to WG approval, funding and the outcome of the options appraisal, the project duration is estimated at being between 1 and 2 years - a phased implementation programme could be adopted. Radiology is aware of other schemes planned for North Wales, e.g. Wrexham re-development - discussions with Estate colleagues have and will continue to take place.

	Scoping document Reconfiguration of
Reason for change / evidence base *Including fit with strategic direction*	• to recruit and retain specialist staff, particularly Consultant Radiologists/ARSAC certificate holders (statutory/non-negotiable requirement for service delivery) • to improve the quality and effectiveness of the Nuclear Medicine service that also meets the increasing demand for PET-CT funded indications. • to improve the delivery of the service by achieving possible efficiencies within the gamma camera provision and greater throughput overall • to 'invest to save' and achieve both PET-CT and gamma camera service revenue savings • avert service failure through the replacement of at least 2 of the obsolete gamma cameras
Patient group(s) likely to be affected and potential numbers, proportion of relevant patient group or population	The age range for patients having Nuclear Medicine scans ranges from neonates to the elderly with total patient numbers amounting to an average of 3,700 across North Wales, the detail being in the table below. Far more outpatient scans are performed than inpatient, the split being 85% out-patients and 15% in-patients – a significant percentage of this latter group could have their scans as out-patients as the scans are non-urgent..

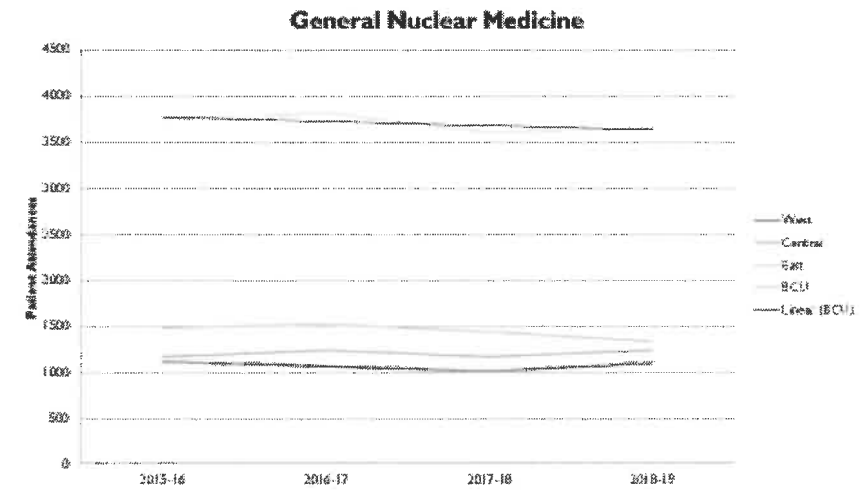
	General NM- West			General NM- Central			General NM- East		
Period	**OP**	**IP**	**Total**	**OP**	**IP**	**Total**	**OP**	**IP**	**Total**
2015-16	984	123	1107	1021	138	1159	1265	206	1471
2016-17	921	134	1055	1100	140	1240	1337	183	1520
2017-18	883	123	1006	1024	138	1162	1258	172	1430
2018-19	950	139	1089	1086	148	1234	1140	190	1330

Patients from North Wales having PET CT scans were in the region of 780 in 2018/19 which, with the recent new indications permitted in Wales, is expected to increase to around 1000 in 2019/20.

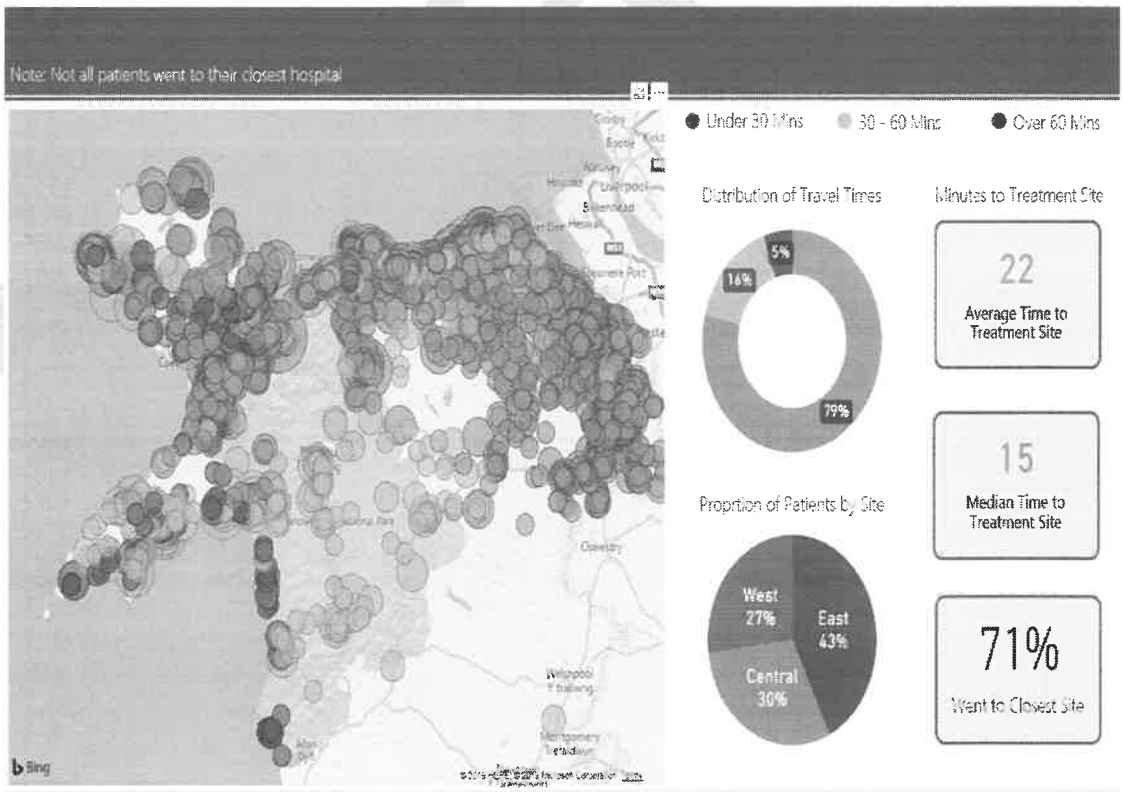
	PET/CT- East		
Period	**OP**	**IP**	**Total**
2015-16	353	1	354
2016-17	775	3	778
2017-18	756	2	758
2018-19	773	5	778

The number of patients required to travel further will depend on the future reconfiguration of the service but there is an overall decrease in the patients requiring Nuclear Medicine scans (currently provided on 3 sites) and an increase in those requiring PET CT(can only be provided on one site).
In bringing the referral criteria for PET CT scanning in Wales to be the same as England, there will be a substantial increase in demand for this specialist imaging.

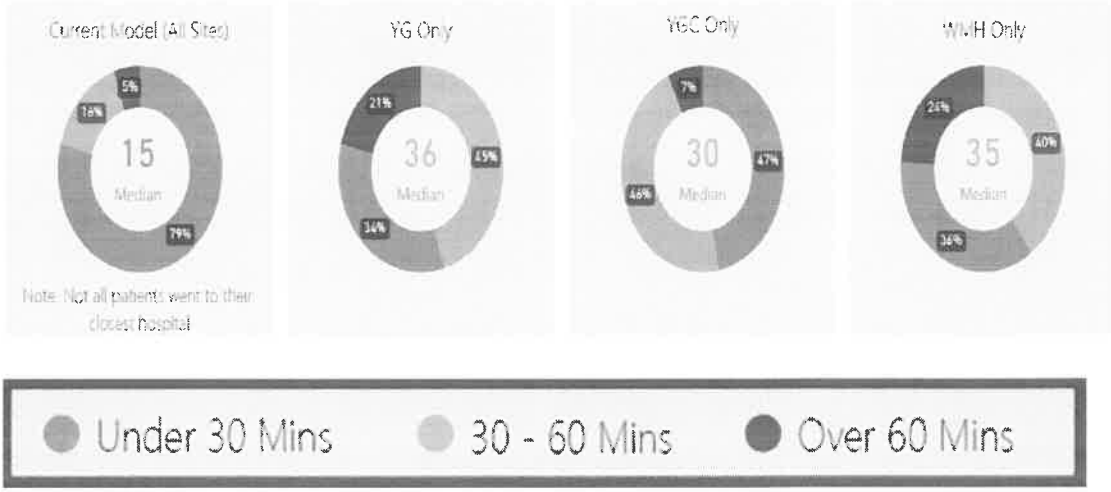
Workload



The current Nuclear Medicine Service travel times can be seen in the following graph with the median time currently being 15 minutes, the majority of patients currently going to Wrexham Maelor.

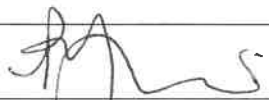


In calculating the median travel times should the service be consolidated to one site, this changes from 15 minutes to either 30 (YGC), 35 (YM) or 40 (YG)

	 With a consolidated service, the number of patients having to travel more than an hour to a single site of service will increase by 2% if located at YGC, 16% if at YG or 19% if at Wrexham. However, this also needs to be balanced against the distances that the specialist PET CT radio-isotope has to travel to the patient/scanner, and also the road networks – currently this comes from Keele, Preston and London. Also, should the N. Wales service be lost from North Wales, travelling times to, for example, North West England, will be greater for all patients.
IMPACT ASSESSMENT	
Equality and Human Rights consideration *Are there any likely implications; has EqIA screening been undertaken*	An Equality Impact Assessment along with a Health Impact Assessment is currently being completed.
Any broader impact on patients and families/ carers	A site appraisal for the options which change the current configuration will be completed and existing patient postcode data will be mapped to understand the impact.
Impact on communities – include identification of specific communities affected	This is still unknown at this point pending the site appraisal

Impact on other NHS services and/or other statutory or third sector services	Reconfiguration would release valuable functional space within Radiology and achieve revenue savings. There is no impact on Radio Pharmacy who have confirmed they could continue to support the service on all 3 DGH sites.
Any safety, quality or sustainability implications	The proposals would ensure the sustainability of the service, increase quality and maintain compliance.
Financial implications	Revenue savings associated with a purchased PET CT and co-location of a reduced number of gamma cameras
Describe any involvement undertaken or planned	Following a meeting with CHC representatives in Wrexham in December 2018 to discuss the concerns about the Nuclear Medicine and PET CT service in BCUHB, and a follow-up written briefing to the CHC in March 2019, there has been extensive discussion with BCUHB's 'Engagement Team' to help identify who Radiology should engage with regarding the possibility of consolidating the service, and how. This discussion resulted in invitations being sent out to a total of 112 patient/population representative bodies/organisations including, amongst many others, CHCs, County Councils, Voluntary Service Councils, Carers Trust, Welsh Ambulance, Community Transport, Cancer Forum, British Heart Foundation, Macmillan, Deafblind, Hearing Loss, Alzheimers, Stroke, British Heart Foundation, Disability Access Group, Grwp Cynhefin, Age Connects, Centre for Sight and Sound, local Hospices, Multiple Sclerosis and North Wales Police. Radiology attended the September CHC meeting at Parc Menai to update on business case progress and its engagement strategy with stakeholders. A presentation prepared by Radiology that outlined concerns for the future viability of the Nuclear Medicine/PET CT service was delivered to: • Clinicians and Managers who refer patients for scans and/or have a responsibility for their care e.g. Medical Directors, Hospital Managers • Staff involved in service delivery, e.g. radiologists, radiographers, radio-pharmacy, medical physics, Workforce & OD and Trade Unions. • Patient representatives including former patients and CHC representatives. In addition, Radiology have discussed the concerns and proposals at: • Clinical Advisory Groups • Cancer Steering Group. The meetings with patient and service representatives were held during October in each of the population areas served by the BCU Nuclear Medicine/PET CT service, i.e. West, Central, East and, further to local CHC comments, Powys. Meeting times spanned morning, afternoon and evening to

	help ensure maximum attendance. **Feedback** Other than the staff meeting, attendance was low but quality discussions took place on all sites. All parties valued the availability of a North Wales service and a 'centre of excellence' was seen as a positive move for patients, even with increased travel time, which would also encourage the recruitment and retention of specialist staff. There was a general view that, whilst the public would be prepared to accept consolidating the service onto one site as the right thing to do if the service is to remain sustainable, some people will be unhappy if they have to travel further for their appointment and that the Health Board would need to consider how this can be made easier for patients. It was suggested that those people who are reliant on others to drive them to appointments or public transport may struggle, particularly if the appointment is early morning and they live a long way from the site. Existing parking limitations at hospitals were highlighted and it was suggested dedicated parking spaces for nuclear medicine patients could help. Some staff expressed preference for a 2 site model as this would have less impact on patients and staff whereas the doctors who refer patients for scans likened Nuclear Medicine and PET CT to other specialised services in BCU that have had to change to ensure viability and assurance of quality e.g. cardiac angiography at YGC, oesophageal surgery at YM, gynaecological surgery at YG, complex vascular surgery at YGC. Powys commented about how appreciative they were of the PET CT service in Wrexham which meant that patients did not have to travel to Cardiff or Stoke and that, although a service based at Wrexham would involve no change to their current provision, Glan Clwyd was still a better option to their alternatives. All groups recognised the issues related to the delivery of the specialist isotopes for PET CT and how distance/ road networks are critical to their being enough radioactivity to allow the scans to be undertaken. **Future Engagement** Radiology will take every opportunity to talk to stakeholders about its concerns about the future of this particular imaging service and the suggestions to retain an improved service in North Wales. A survey of BCU Nuclear Medicine/PET CT patients is about to be undertaken and feedback is awaited from Hywel Dda about any engagement required in the North of this Health Board – Powys patients from Machynlleth in particular get referred to Bronglais.
Any known sensitivities or controversial implications	Possible increased travel distances for some gamma camera patients to reach a specialist nuclear medicine centre

How would the service development or variation be monitored	KPIs would include: • Patient satisfaction survey • Staff satisfaction survey • Ability to accommodate additional PET CT indications • Increased flexibility • Ability to meet RTT • Financial savings in radiographic staff costs through skill mix • Financial savings in radiopharmaceutical costs • Improved recruitment and retention • Ability to income generate
Signed	
Date	26/11/19

Llywodraeth Cymru
Welsh Government

Welsh Government Integrated Assurance

Risk Potential Assessment Form (RPA)

(IAH-RPA)

Version 2.0 – March 2019

INTRODUCTION

About OGC Gateway™:

Programmes and projects provide an important vehicle for the efficient and timely delivery of government aims. Good and effective management and control of programmes and projects is therefore essential to the successful delivery of government objectives. The Welsh Government Assurance Process (consistent with the OGC Gateway) is the responsibility of the Integrated Assurance Hub (IAH) and authorised to deliver assurance under accredited licence from the Infrastructure and Projects Authority (IPA), which is part of the UK's Cabinet Office. This process is designed to provide independent guidance to Senior Responsible Owners (SROs), programme and project teams and to the departments who commission their work, on how best to ensure that their programmes and projects are successful.

The OGC Gateway Process examines programmes and projects at 'key decision points' in their lifecycle, and looks ahead to provide assurance that they can progress successfully to the next stage. The OGC Gateway Process is regarded as best practice in central civil government throughout the UK, and applicable to a wide range of programmes and projects, including:

- policy development and implementation
- organisational change and other change initiatives
- acquisition programmes and projects
- property/construction developments
- IT-enabled business change
- procurements using or establishing framework arrangements

Value of the OGC Gateway Process

OGC Gateway Reviews deliver a 'peer review', in which independent practitioners from outside the programme/project use their experience and expertise to examine the progress and likelihood of successful delivery of the programme or project. They are used to provide a valuable additional perspective on the issues facing the programme/project team, an external challenge to the robustness of plans and processes, and support to SROs in the discharge of their responsibilities to achieve their business aims, by helping to ensure:

- the best available skills and experience are deployed on the programme/project
- all the stakeholders covered by the programme/project fully understand the programme/project status and the issues involved
- there is assurance that the programme/project can progress to the next stage of development or implementation and is well managed in order to provide value for money on a whole life basis
- achievement of more realistic time and cost targets for programmes and projects
- improvement of knowledge and skills among government staff through participation in Reviews
- provision of advice and guidance to programme and project teams by fellow practitioners.

The Welsh Government's Risk Potential Assessment Form (IAH-RPA) is designed to provide a standard set of high-level criteria for assessing the **risk potential** of a programme/project in a strategic context.

The RPA enables a conversation to be had about the risks and responsibilities that the SRO has for delivery and that the programme/project in respect of visibility, reporting and assurance in a wider portfolio management context. The RPA can also help the programme/project to identify areas where specific skills sets, commensurate with the level of complexity, may be required.

The OGC Gateway Process offers an independent assurance for all potential high and medium risk programmes/projects within Welsh Government and Wider Welsh public sector. In order to determine the applicability of an OGC Gateway Review, the RPA **must** be completed by the SRO for the programme/project.

The RPA form is in five sections :

- Section 1: (Programme/Project General Information): gathers some basic information about the programme/project
- Section 2: gathers a brief synopsis of the programme/project, its key objectives and the stage of the programme/project at the current time. This will provide context for the assessment by the IAH.

- Section 3: is designed to build on information provided in Section 2, by capturing a standard set of high-level criteria for further assessing the **risk potential** of a proposed programme/project. This section is also used to determine if an Assessment Meeting with the SRO is appropriate to discuss whether an OGC Gateway Assurance might be of value to the programme/project. At the end of each question within this section the SRO is required to make a self-assessment of the level of risk the programme/project carries. Further information and an explanatory note is required to support the self-assessment.
- Section 4: The SRO is required to provide an overall self-assessment of the level of risk the programme/project is at.
- Section 5: SRO sign off for the RPA form.

Completed forms must be sent directly for assessment to the Integrated Assurance Hub (IAH) Mailbox Assurance@gov.wales

SECTION 1 :	Programme/Project General Information
1. Is this a Portfolio/Programme or Project?	Project
2. Programme/Project name	Nuclear Medicine Consolidation
3. Your Division/Department	Radiology
4. Programme/Project Type	Capital
5. SRO Contact Details (to include telephone number, mobile number and e-mail address)	Adrian Thomas, Executive Director of Therapies & Health Sciences **Email**: Adrian.Thomas@wales.nhs.uk **Tel**: 01745 586468
6. Programme/Project Manager details (to include telephone number, mobile number and e-mail address)	**Project Manager:** Liz Lloyd **Email:** Liz.J.Lloyd@wales.nhs.uk **Tel:** 01745 448738
7. Primary contact point for administration of the OGC Gateway™ Review (to include telephone number, mobile number and e-mail address)	
8. Finance Officer details: Review (to include telephone number, mobile number and e-mail address) *(N.B. review costs will initially be met by the Integrated Assurance Hub but will be recouped via journal at the end of the review)*	
9. Date of previous Gateway Review if Applicable: p*lease include previous Gateway Product & IAH unique number).*	Click here to enter a date. Choose an item. AH/XX/XX

SECTION 2 : PROGRAMME / PROJECT DETAILS

Please provide a brief synopsis of the programme/project, the key objectives and at which stage the programme/project is currently at:

This Strategic Outline Case (SOC) addresses the proposal for the provision of nuclear medicine and PET CT within North Wales - which includes the provision of PET CT as a fixed service rather than using a mobile solution.

Radiology supports the organisation by providing almost all of the various types of imaging on the 3 DGH sites including CT, MR, ultrasound, interventional radiology and plain film. Additionally the service further provides availability of ultrasound across 6 community sites and plain film across 14 community hospitals in North Wales.

Ensuring sustainability of more specialist imaging services within BCUHB has already required a different approach in North Wales - for example: both elective and emergency cardiac angiography procedures are only undertaken in the cardiac catheterisation laboratories at the North Wales Cardiac Centre located at YGC. This service was repatriated from centres in the North West in 2006 but there are insufficient numbers of specialist staff and imaging systems to deliver the service on each DGH site in North Wales. Another example is complex vascular imaging moving in 2019 from three sites to a single site in support of developing a vascular theatre at YGC for aortic repair surgery.

Nuclear Medicine is a specialist form of imaging involving the administration of radioactive pharmaceuticals to patients. The service currently has a gamma camera room and supporting rooms along with radio-pharmacies on each of the DGH sites, along with a commercially leased mobile PET CT at Wrexham Maelor Hospital (WMH) for 2 days a week. Prior to the introduction of the mobile PET CT in October 2015 patients travelled to The Christie Hospital, Manchester, however, repatriation can only be sustained and supported if the service is delivered from a single site. This SOC outlines the proposed way forward to deliver this strategic change.

In considering this SOC, a nuclear medicine group has been established which has identified options to provide both nuclear medicine and PET CT in North Wales, the goal with the latter being the provision of a fixed service rather than using a mobile solution. The options, which include a single site, are aimed at achieving the following investment objectives:

Investment Objective 1
To provide services which meet the strategic direction / requirements as detailed within the Health Board's plans, and key all-Wales strategies including the *Imaging Statement of Intent (2018)* and "*Positron Emission Tomography (PET) in Wales – Overview and Strategic Recommendations*"
Investment Objective 2
To create and provide an environment that delivers safe and effective care whilst achieving key efficiency targets throughout the service, including meeting increased demand for PET services
Investment Objective 3
To maintain legal compliance through service redesign to attract and retain specialist (ARSAC) licenced practitioners
Investment Objective 4
To deliver services that are affordable and represent value for money, maximising opportunities to deliver revenue savings whilst continuing to deliver and improve nuclear medicine services
Investment Objective 5
To avert current risk of service failure and provide a sustainable and reliable programme for the replacement of existing equipment

SECTION 3: GUIDANCE
Section 3 of the RPA assesses the potential risk for the programmes/project. The overall RPA assessment process at this point is an **indicator** of risk potential and is not an exhaustive risk analysis model. However, it can be the starting point for a more exhaustive risk assessment of a programme/project. This section is made up of a series of five key short assessments, which will determine the basic and initial risk rating of the programme/project. These assessments are made using the knowledge and judgement of the SRO and programme/project team and should be considered in the light of a programme/project's strategic context. Each question requires an answer using the drop down boxes, a self-assessment of the level of risk and a short explanatory note of the reasoning for the self-assessment mark. This will provide further detail for the IAH and an audit trail of the considerations. After completion, the SRO should e-mail the RPA Form directly to the IAH for initial assessment. The IAH will then formally write to the SRO to notify them of the outcome. The initial assessment will normally be used throughout the life of the OGC Gateway Review process. However, and even though the score might decline during the programme/project lifecycle, should the programme/project's risk assessment increase, the higher assessment may take precedent. If you have further questions about the use or completion of this section, please contact the Integrated Assurance Hub on 0300 025 0149 or 0300 025 3901 or you can e-mail us on Assurance@gov.wales

SECTION 3.1 Strategic Alignment & Commitment	
3.1.1: Does the programme/project satisfy a ministerial commitment? If YES, please state who is the responsible minister(s)	Yes Vaughan Gethin
3.1.2: Does the programme/project cut across ministerial portfolios	No
3.1.3: Does the programme/project satisfy a major policy commitment? If YES, Which policy?	Yes ▪ Cancer Delivery Plan for Wales, 2016-2020 ▪ Single Cancer Pathway ▪ Imaging Statement of Intent (March 2018) ▪ All Wales PET Advisory Group (AWPET) and the Welsh Scientific Advisory Committee, *Positron Emission Tomography (PET) in Wales - Overview and Strategic Recommendations*, November 2018 ▪ *Positron Emission Tomography (PET) in Wales* Programme Brief ▪ Radiology Services in Wales, November 2018
3.1.4: Does the Programme/Project impact Key Organisational Objectives?	Critical link to delivery of key strategic objectives /targets
3.1.5: Does the Programme/Project impact Business Change?	Complex/Mulitple requirements
Strategic Alignment & Commitment – Self assessed risk rating	Low
Further information & explanatory note:	

SECTION 3.2: Financial/funding impact	
3.2.1: How much is the projected budget for the programme / project? *N.B. when completing this part of the form, please take into account the whole-life costs of the programme / project (as defined by HM Treasury Green Book)*	£5M and above

3.2.2: How long is the programme/project expected to run?	Over 2 Years
3.2.3: Is funding secured and in place for the entire lifecycle of the programme/project?	No
3.2.4: Does the programme/project receive external funding?	Yes - Capital Revenue
3.2.5: How is the Programme/Project budget managed?	Budget within delegations and local control
Financial/Funding Impact – Self assessed risk rating	Low
Further information & explanatory note: Self-assessed risk rating relates to revenue implications where potential savings have been identified	

SECTION 3.3 Stakeholder Engagement	
3.3.1: Has the Programme/Project identified all stakeholders?	Yes - All stakeholders identified and engaged
3.3.2: How complex is stakeholder management?	several stakeholders across organisations
3.3.3: Impact on resources	some resources in place
3.3.4: How many staff within the organisation will be affected by the programme/project?	10-25
3.3.5: Impact on Public	Low impact - Minister advised
Stakeholder Engagement: Self-Assessed Risk Rating	Medium
Further information & explanatory note:	

SECTION 3.4 Governance	
3.4.1: Has the programme/project undertaken a scoping exercise to ensure there is no duplication of work in any other part of the organisation?	Yes
3.4.2: Are the Programme/Project Governance arrangements in place?	Yes
3.4.3: Are the Programme/Projects Time & Quality Targets Achievable?	Yes
3.4.4: Has the Programmes/Projects benefits been identified?	Yes
3.4.5: Has the programme/project considered and implemented security standards in compliance with regulatory Acts e.g. GDPR?	Where applicable
3.4.6: Governance: Self Assessed Risk Rating	Low
Further information & explanatory note:	

SECTION 3.5 Programme/Project Dependencies	
3.5.1: Is the Programme or Project dependant on or connected to wider initiatives?	standalone programme/project with no dependency
3.5.2: Does the programme/project depend on key components, consent or approvals which are outside the organisations direct control?	key component of programme/project objective requires consent or approval from external organisation
3.5.3: Does the programme/project key objective require new IT systems and/or the need to develop interfaces with existing IT systems?	internal system upgrade

3.5.4: How complex are the commissioning / procurement arrangements for the programme / project	multiple suppliers required from existing commissioning framework
Programme/Project Dependencies – Self Assessed Risk Rating	Low
Further information & explanatory note:	

Section 4: Programme/Project overall self-assessment risk rating
Low

Section 5: SRO ENDORSEMENT	
I am satisfied that the Risk Potential Assessment provides an accurate reflection of the programme/project at this stage of development.	
Signed (Senior Responsible Owner)	Date
I will re-asses the programme/project if there is a significant change to the programme/project scope or budget or if significant changes emerge that may threaten successful delivery.	
Signed (Senior Responsible Owner)	Date

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Health Board Charity Staff Lottery**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Kirsty Thompson, Head of Fundraising
Craffu blaenorol: Prior Scrutiny:	Charitable Funds Committee – approved the business case on the 25th June 2020 Local Partnership Forum
Atodiadau Appendices:	Appendix 1: Staff Lottery Business Case

Argymhelliad / Recommendation:

The Committee is asked to approve the establishment of a Health Board staff lottery.

Please tick as appropriate

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

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the implementation of a Health Board Charity Staff Lottery.

Cefndir / Background:

In March 2019, a proposal to set up a Health Board Charity Staff Lottery was presented to the Charitable Funds Committee, where it was agreed in principle. A Staff Lottery will provide undesignated funds for the Health Board charity, Awyr Las, and it will help to increase engagement between staff and the charity. The net proceeds of the lottery, after running costs and prizes, will be used by Awyr Las to fund grants supporting the charity's priority areas and also services/departments that do not have their own funds.

The proposal was supported by the Charitable Funds Committee on the basis that a Staff Lottery scheme will provide the NHS Charity with 'undesignated' funds to support innovative strategic projects, which may not otherwise attract significant charitable support. The proposal was updated following delays due to COVID-19, with adjustments made to the implementation timeline. The revised Business Case was approved by the Charitable Funds Committee on 25th June 2020.

The Local Partnership Forum has supported the proposal on the condition that measures are put in place to prevent anyone from spending an unreasonable amount of money on the lottery. These conditions have been included in the business case. Public Health representatives have advised that each staff member should be allowed a maximum of two 'plays' (numbers) per week, so a maximum individual cost of £2 per week.

Asesiad / Assessment & Analysis

Strategy Implications

Awyr Las currently faces two significant challenges.

1. The vast majority of donations received are for specific wards/services/departments. This means that currently that there are not sufficient undesignated funds available to support new grant requests from services that do not have designated funds and also pay for the operational costs of the charity.
2. Health Board staff are not well informed about the charity and are not able to say what Awyr Las had supported in the last 12 months.

The most effective way of managing these challenges is to establish a Staff Lottery, which will:

- Potentially create matched funding for projects which may be part funded by charitable sources like Trusts and Foundations, therefore opening opportunities to new and different income streams
- Help promote giving to healthcare services in general and build affinity with the Awyr Las brand. A Staff Lottery has the potential to promote legacy giving and other fundraising streams.
- Potentially create opportunities to part fund wellbeing projects carried out in partnership with third sector groups to assist in the recovery and resilience building in the region post COVID-19

Options considered

The options considered as part of the Business Case were:

1. In house Staff Lottery
2. In house and External Operator - using an external provider to manage all aspects of the lottery except marketing and promotion.
3. External Operator – an external agency oversees all aspects of the lottery including the marketing and promotion

Option one has been selected as the preferred option. This is the cheapest option and will also allow the charities key messages to be promoted alongside the lottery.

Financial Implications

The planned costs and income up to 2023/24 are shown below:

	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000
Pay costs - 0.8WTE Band 6	12.5	38.4	39.1	39.9
Non-pay costs - Travel & IT	1.7	5.5	5.5	5.5
Promotional materials	1.7	5.0	5.0	5.0
Prizes	9.0	36.0	46.0	46.0
Total cost	24.9	84.9	95.6	96.4
Income from staff plays	-25.0	-100.0	-166.0	-208.0
Awyr Las budget	-15.9	-48.0	0.0	0.0
Total available for grants	-16.0	-63.1	-70.4	-111.6

Assumptions:

- The Band 6 post will commence December 2020. The lottery will commence January 2021.
- Pay inflation has been included at 2% per annum.

- Awyr Las funding is available from approved budgets to support the establishment of the lottery.
- Staff participation will be:
  Year 1 & 2: 12% staff participation
  Year 2: 20% staff participation
  Year 3: 25% staff participation

Risk Analysis

The risks of the preferred option are:

- Lack of capacity to carry out all tasks (mitigated by regular 1:1s with line manager)
- Lack of internal knowledge of lottery systems (mitigated by fundraising training budget)

Legal and Compliance

The Awyr Las Support Team has the necessary Small Society Lottery license required to carry out a lottery with an income of less than £250,000 per annum.

Impact Assessment

The Awyr Las Support Team Will ensure that the Staff Lottery is promoted bilingually, that it is promoted across all BCUHB sites and services, and that all data will be managed in line with BCUHB policy.

APPENDIX 1 Finance and Performance Committee 27.8.20

Awyr Las Covid-19 Second Phase Plan, June 2020, Appendix 1:
BCUHB Staff Lottery Business Case

Division / Area / Department	**Awyr Las, the North Wales NHS Charity**
Development or Scheme Title	**BCUHB Staff Lottery**
Author/s	**Kirsty Thomson, Head of Fundraising**
Executive Sponsor	**Sue Hill, Executive Director of Finance**
Version	**3**
Date	**12th June 2020**

1. Executive Summary

The Charitable Funds committee recommends the implementation of a BCUHB Staff Lottery, for the following reasons:

1. Support Strategic Priorities NHS Staff lotteries provide 'undesignated' funds (general funds that aren't given for a specific ward or department), which can be directed to supporting strategic priorities that are less likely to benefit from charitable funding
2. Opportunities to raise significant funds A well-promoted BCUHB Staff Lottery has the potential to generate over £1million in five years
3. Union and Staff support A proposal to set up a Staff Lottery was agreed in principle by the Local Partnership Forum in April 2019
4. Evidence of successful NHS Charity Staff Lotteries A recent survey of NHS Charities showed that 51% of those taking part already have an established lottery and the remaining charities are keen to establish one based on the success of existing staff lotteries in other NHS Charities
5. Mechanism to promote important messages Currently 40% of surveyed staff were unaware that Awyr Las was their NHS Charity. Key messages can be better shared through regular interactions with staff members if a Staff Lottery is in place
6. Funding for the administration of the Lottery is available The Awyr Las Support Team currently has a Band 6 vacancy. The Awyr Las Awyr Las Support Team will recruit a Part time (80%) Band 6 designated Staff Lottery Coordinator, to take overall responsibility for coordinating the BCUHB Staff Lottery, in its 2020/21 budget. From 2021/22 the coordinator role would be funded through the Staff Lottery. After costs, there would be a projected £50,000+ to fund charitable grants per annum from Year 1.
7. The potential demands on NHS Charities have never been greater As expectations of and challenges for the NHS grow, so too do the demands on all healthcare charities. Many of BCUHB's key partners, including national charities and local hospices, will have seen significant falls in income. The partnership working opportunities afforded through collaborations between Awyr Las and these strategic partners could help important third sector led patient wellbeing initiatives continue.

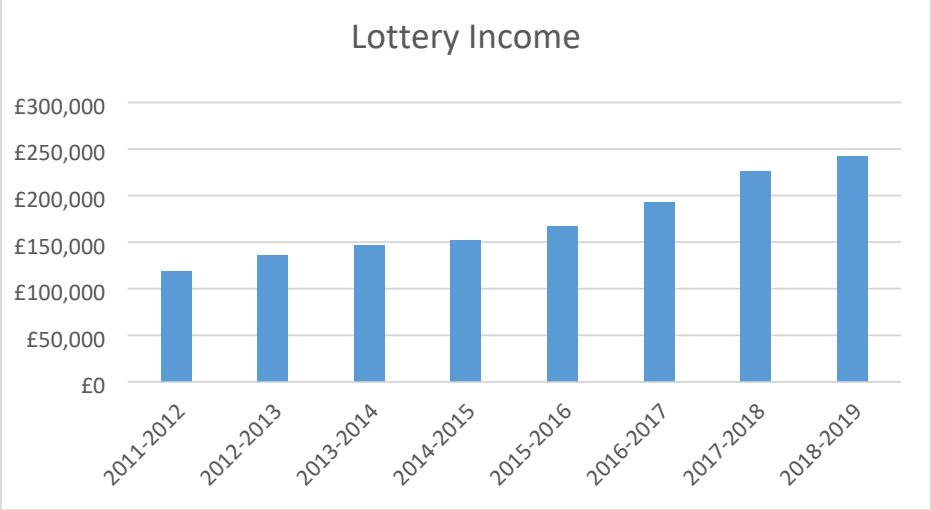
This paper sets out the need for a BCUHB Staff Lottery, provides options of managing a lottery and recommends that the Staff Lottery is managed in-house by the Awyr Las Support Team.

2.	**The Strategic Case**
2.1	Introduction In March 2019 a proposal to set up a BCUHB Staff Lottery was presented to the BCUHB Charitable Funds Committee. The Head of Fundraising then attended the Local Partnership Forum to present the case for a BCUHB Staff Lottery, which was supported on the condition that measures are put in place to prevent anyone from spending an unreasonable amount of money on the lottery. Concerns were raised around promoting gambling, and the Head of Fundraising was asked to ensure that this was considered when plans for a Staff Lottery were drawn up. The original proposal was supported by the Charitable Funds Committee on the basis that a Staff Lottery scheme will provide the NHS Charity with 'undesignated' funds to support innovative strategic projects, which may not otherwise attract significant charitable support. This proposal has been updated following the Covid-19 Initial Response Period, with adjustments made to the implementation timeline. This Business Case was approved by the Charitable Funds Committee on 25th June, 2020.
2.2	Strategic Context Awyr Las currently faces two significant challenges. 1. 94.2% of the donations Awyr Las received in 2017-18 were designated donations, whereby donors specified exactly which service or ward they wished to support. Donations of £92,590 were given to undesignated (also known as general) funds in 2017-18. This means that currently that there aren't sufficient undesignated funds available to: a) Support new grant requests from services that don't have designated funds b) Pay for the operational costs of the charity. 2. 40% of BCUHB staff that were recently polled were not aware that Awyr Las was their NHS charity and 80% were not able to say what Awyr Las had supported in the last 12 months. BCUHB staff are not well informed about the charity. The Awyr Las Support Team is establishing priority area appeals in order to generate funds to support priority services that do not have designated funds and the Team has developed plans to ensure that internal communications are improving. Nevertheless an additional funding stream is still required to increase the generation of undesignated funds and more needs to be done to increase BCUHB affinity to the charity. The most effective way of managing these challenges is to establish a BCUHB Staff Lottery. A Staff Lottery will:

	▪ Potentially create matched funding for projects which may be part funded by charitable sources like Trusts and Foundations, therefore opening opportunities to new and different income streams ▪ Help promote giving to healthcare services in general and build affinity with the Awyr Las brand. One Lottery provider uses the phrase 'people love prizes, prizes fuel engagement, and engagement drives income.' A Staff Lottery has the potential to promote legacy giving and other fundraising streams ▪ Potentially create opportunities to part fund wellbeing projects carried out in partnership with third sector groups to assist in the recovery and resilience building in the region post Covid-19
2.2.1	Organisational Overview The Awyr Las Support Team does not currently run a Staff Lottery Scheme. The Awyr Las Support Team does have the necessary Small Society Lottery license required to carry out a lottery with an income of less than £250,000 per annum. The Awyr Las Support Team currently has a Band 6 (80% P/T) vacancy in its 2020/21 budget. The new role holder will be responsible for coordinating the BCUHB Staff Lottery. From 2021/22 the coordinator role would be funded through the Staff Lottery. After costs, there would be a projected £50,000+ to fund charitable grants per annum from Year 1 (see section 4 for financial expectations). The Awyr Las Support Team is part of the BCUHB Finance Division. The Payroll Team and Communications Team would play a significant role in ensuring that the Staff Lottery runs smoothly.
2.2.2	Relevant National and Local Strategies A recent survey of 49 NHS Charities showed: ▪ 51% have an established lottery and the remaining charities are keen to establish one based on the success of existing staff lotteries in other NHS Charities ▪ 48% of those with a lottery run a staff only lottery which is not open to the public ▪ 25% of those with a lottery opened their lottery in the past 18 months ▪ 50% use external agencies to manage their lottery schemes and 50% run it internally. NHS Charities vary in how they use external agencies; some contract for the administration of the lottery only, and others use an external agency to manage all aspects of their lottery including the marketing and promotion of it. ▪ The average (median) Staff Lottery annual income was shown to be £30,000. The highest Staff Lottery annual income of the participating charities was £530,000 per annum. ▪ The greatest perceived barriers to growing a staff lottery were recruitment and resourcing.

	Public Health representatives and others have contributed to the planning of the Staff Lottery and have advised that one person should be allowed two ‘plays’ (numbers) per week only. N.B. One ‘play’ is £1, so all staff will be permitted to have two lottery numbers, totaling £2 per week only.
2.2	The Case for Change Evidence suggests that the introduction of a Staff Lottery can be overwhelmingly positive, not only because of the increase in income into a charity. One Fundraising Manager interviewed by the Head of Fundraising suggested that Staff Lotteries can be ‘unifying’ as colleagues feel part of a ‘collective’, and they also felt that the positive stories generated through staff ‘wins’ and Staff Lottery funded projects were ‘invaluable’. Strengths ▪ Existing strong working relationships between Workforce and Organisational Development, the Communications Team, the Board Secretary’s Office and the Awyr Las Support Team. A Staff Lottery Working Group can easily be set up to help establish the Staff Lottery ▪ Experienced database supervisor within the Awyr Las Support Team and BCUHB IT support who can oversee the introduction of technical aspects of the Staff Lottery scheme ▪ Awyr Las already has payroll fundraising programmes, so this scheme should be relatively simple to set up for the payroll team ▪ Positive messaging because of the benefits to staff (both through ‘wins’ and through charitable grants Weaknesses ▪ Internal communication channels are not robust, and will need to be improved in order to effectively share the message about the Staff Lottery ▪ Capacity in other teams to engage with the scheme and help deliver and promote the Staff Lottery ▪ Staff disinterest due to not being engaged Opportunities ▪ Offers for Peer to Peer Support and Mentoring from NHS Charities with existing Staff Lotteries mean that a support network is already in place ▪ Other NHS Charities in Wales have well established Staff Lottery Schemes, so it is not a new concept ▪ Positive stories, particularly as it is not an imposition on other local charities, as no other charity could hold a staff lottery for the NHS and this is a Staff only lottery for that purpose Threats

	▪ Negative press from local charities feeling that a Staff Lottery will take away from their own lotteries ▪ Negative comments from anti-gambling campaigners
2.2.1	Existing Arrangements The Awyr Las Support Team has a vacancy within the team currently. A permanent staff member will be required to coordinate the promotion and administration of a Staff Lottery. This is the case regardless of which Staff Lottery Management option is selected. The Head of Fundraising has budgeted for a part time (80%) Band 6 Fundraising Coordinator, a new role with the sole responsibility of coordinating the BCUHB Staff Lottery. The new staff member will be line managed by the Head of Fundraising and will work alongside the Fundraising Manager who is responsible for managing the Fundraising Team's supporter database. If the request to establish a Staff Lottery is successful, a pan-BCUHB multi-disciplinary Staff Lottery Working Group, led by the Head of Fundraising, would be established to ensure good governance and set up: ▪ Administration processes ▪ Prize giving (Terms and Conditions as well as insurances) ▪ Promotional plans & Sponsorship Opportunities ▪ Staff Lottery Grants Schemes
2.2.2	Issues and Risks with the Existing Arrangements – What is Wrong with the Status Quo Your NHS Charity, Awyr Las, is missing out on what should potentially be over £50,000+ in undesignated (i.e. it can fund any area of healthcare, not a specific ward or department) funds per year for charitable grants. The charity is also missing huge opportunities to share important key messages with the charity's most important stakeholders – BCUHB staff.
2.2.3	Scope of the Case A Staff Lottery will provide undesignated funds and it will help increase engagement with Awyr Las more generally. An example of the benefits of having a Staff Lottery can be seen in the Cardiff and Vale Healthcare Charity: *The Cardiff and Vale Staff Lottery was introduced in September 2005 to raise funds for the benefit of both staff and patients. The Staff Lottery now gives staff at the Cardiff and Vale University Health Board (CVHB) the chance to win £1,000 on each weekly draw. In addition, staff can win two Super Draws each year which include a brand new car in the*

	summer and a grand prize of £10,000 in January. Currently, there are 4720 plays (numbers) allocated each week in Cardiff and Vale. *All CVHB staff can join the lottery. Every penny in profit goes to charitable funds and all areas across CVHB could benefit from grants. The lottery programme is run using a fundraising database, Harlequin Software. Payroll lottery deductions are imported into the system and reconciled against every lottery member before each draw. In order to comply with audit recommendations, the weekly lottery draw is undertaken on the last Friday of each month. The four or five lucky winners are notified and details are placed on the intranet.* *CVHB is regulated by the local council. They hold a Small Society Lotteries licence and are required to submit lottery income returns after each draw. The graph below shows the last eight years of gross income from the CVHB Staff Lottery before costs.* 
2.2.4	Objectives and Benefits See section 2.2 for benefits and section 4 for financial objectives.
2.2.5	Constraints ▪ A new initiative like this will take time to embed ▪ A successful lottery requires a dedicated resource. A committed and focused Band 6 staff member is crucial to its success
2.2.6	Dependencies ▪ The Payroll team and Communications Team must be committed to supporting the development of the Staff Lottery ▪ Guaranteed funding for Year 1's annual prize payouts is a requirement
3.	**Options**

3.1	Criteria for Option Appraisal ▪ Cost & value for money ▪ Impact on reputation of the charity internally and externally ▪ Ability to promote key messages of the organisation as part of the Staff Lottery promotion
3.2	Longlist of Options 1. In house Staff Lottery – total fulfillment including website pages (using existing website); website & database interface (using recommended software and BCUHB IT support); database (using existing Harlequin software); BCUHB payroll support; producing own marketing materials (using in house printing service); recruiting volunteers to help promote it; providing own prizes; organising own sponsorship for specific special or additional prizes. 2. In house Staff Lottery – partial fulfillment, using an external provider to manage all aspects of the lottery except marketing and promotion. 3. External Operator – and external agency oversees all aspects of the lottery including the marketing and promotion The following lottery agencies could provide services for options two and three: Burden and Burden: https://www.burdenandburden.co.uk/ Make a Smile Lottery: https://www.makeasmilelottery.org.uk/ Zaffo: https://info.zaffo.com/ Sterling Lotteries: http://www.sterlinglotteries.co.uk/
3.3	Appraisal of Longlist and Creation of Shortlist of Options Less than 20% of participating charities in the Staff Lottery Survey managed their lotteries entirely in-house. The reasons cited for this was that this was not an option when they signed contracts with external providers, or they didn't have the capacity internally to oversee the administration of the lottery. The charities that took part in the study with the largest incomes from Staff Lotteries attributed the success of their lotteries to having dedicated internal support functions to promote the lottery. The minimum annual cost identified for option two was £600 for the web-functionality and a charge of 10p per £1 to administer the donations. With an anticipated income of £100,000 in Year 1, this cost would amount to £10,600. This annual cost could be reduced to £0 with option one.
3.4	Appraisal of Shortlisted Options

	Option one is the preferred option because it provides cost savings, and BCUHB has the software and expertise to run a Staff Lottery in house in the same way that CVHB do currently. A Band 6 would need to oversee the administration of the Staff Lottery as well as the promotion; it is expected that a full time staff member will have the capacity to do that.
3.4.1	Appraisal against Non-Financial Criteria Option 1 is the preferred option for the following reasons: ▪ Negative feedback from other charities about their experiences with external lottery agencies ▪ BCUHB directive to charities promoting services on BCUHB premises stating that third party fundraising agencies are not permitted to operate on BCUHB premises ▪ Upskilling existing workforce (including IT Support) to use different software and processes ▪ Ability to promote other key charity messages if the Lottery Coordinator is internal ▪ The Staff Lottery would be better embedded in all Awyr Las & BCUHB activity if the Lottery Coordinator is internal
3.4.2	Comparative Costs See section 4
3.4.3	Risk Appraisal Option 1: Risks ▪ Lack of capacity to carry out all tasks (mitigated by regular 1:1s with line manager) ▪ Lack of internal knowledge of lottery systems (mitigated by fundraising training budget) Option 2: Risks ▪ Lack of control due to external operators overseeing data (mitigated by regular meetings) ▪ No options to make systems bespoke, for example bilingual websites and information (mitigated by co-producing materials, though there may be an additional charge to this) Option 3: Risks ▪ Third party operators promoting the charity with little knowledge or training, and sometimes with little understanding of local services, communities or the Welsh language (mitigated by in depth training from Awyr Las Support Team Members and insistence on Welsh speakers only)
3.4.4	Conclusion – Preferred Option

	Option 1 is the preferred option. The primary reason for this is to ensure that other charity activity can be promoted alongside the Staff Lottery, and that the Staff Lottery recruitment and player retention service is of a consistent high standard.
3.5	Preferred Option Detailed Analysis
3.5.1	Full Description of the Proposed Change The introduction of a Staff Lottery managed in-house by the Awyr Las Support Team.
3.5.2	Impact on Activity and Performance The income from the Staff Lottery is expected to be raised in addition to the charity's regular income. The regular KPIs for Awyr Las Support Team staff will not change; an additional financial KPI to meet the proposed financial 5-year targets will be added.
3.5.3	Other Areas affected by the Proposal / Interdependencies / Assumptions ▪ It's assumed that Payroll, Communications, IT and Workforce and Organisational Development will all support with setting up processes and promoting the Staff Lottery ▪ It's assumed that the BCUHB Executive Team will encourage all staff to promote the Staff Lottery widely
3.5.4	EqIA of the Preferred Option The Awyr Las Support Team Will ensure that the Staff Lottery is promoted bilingually, that it is promoted across all BCUHB sites and services, and that all data will be managed in line with BCUHB policy.
4.	**The Financial Case**
4.1	Revenue Cost <u>Band 6 (Part time, 80%) Coordinator post per annum £38.4k (2021/22 cost)</u> Laptop, telephone and travel £5,000 Promotional materials £5,000 Harlequin software £500 *Annual cost not including annual prize giving: £48.9k* <u>2021/22 annual prize giving (pro rata 3 months for 2020/21)</u> £500 Weekly prize draw £26,000 £5,000 Introductory prize £5,000 £5,000 Christmas prizes £5,000 *Total annual prize giving: £36,000* ***Total revenue cost 2021/22: £84.9k***

	[£48k funded through the Awyr Las Support Team budget in 2020/21 (pro rata) and 2021/22 as budget is available due to a Band 6 vacancy. From 2022/23 all revenue costs will be funded through the Staff Lottery income] <u>2022/23 & 2023/24 annual prize giving</u> £500 Weekly prize draw £26,000 £10,000 Summer prizes £10,000 £10,000 Christmas prizes £10,000 *Total annual prize giving: £46,000* NOTE: ▪ *<u>Option 1</u>* 2021/22 costs: £84.9k for Band 6 post, promotion and annual prize giving ▪ *<u>Option 2</u>* 2021/22 costs: £84.9k for Band 6 post, promotion and annual prize giving + anticipated costs of £10,600 for software and support ▪ *<u>Option 3</u>* 2021/22 costs: £84.9k for Band 6 post, promotion and annual prize giving + anticipated costs of £40,600 for software, lottery recruitment and support Other NHS Charities have reported that a BCUHB member of staff would be required to promote the lottery and liaise with other BCUHB departments that are involved in promoting the lottery, for example communications. For this reason the Band 6 staff member would be required for all three options.
4.2	Capital Cost (If Any) N/A
4.3	Affordability and Source of Funding **The Awyr Las Band 6 vacancy budget will be used to fund the Band 6 staff member, set-up and ongoing marketing costs in 2020/21 and 2021/22. From 2022/23 the Band 6 post will be funded through the Staff Lottery income.** The lottery agencies that have been contacted have suggested that, with dedicated resource and budget for continuous promotion to boost retention alongside a commitment to promote the lottery from BCUHB's senior leadership team, BCUHB should expect to see the following staff population participation expectations in the first five years: 2020/21: 12% staff participation 2021/22: 12% staff participation 2022/23: 20% staff participation 2023/24: 25% staff participation 2024/25: 30% staff participation 2025/26: 35% staff participation

	Based on a staff population of 16,000 we can expect to raise the following through the Staff Lottery: 2020/21 & 2021/22 1,923 x £1 plays per week = £100,000 income 2022/23 3,200 x £1 plays per week = £166,400 2023/24 4,000 x £1 plays per week = £208,000 2024/25 4,800 x £1 plays per week = £249,600 2025/26 5,600 x £1 plays per week = £291,200
5.	**Governance and Project Management**
5.1	Approval Route ▪ Charitable Funds Committee January 2019 ▪ Awyr Las Trustees Meeting January 2020 ▪ Awyr Las Trustees Meeting June 2020 ▪ Final authorisation: 1) HBRT Committee 2) BCUHB Executive Committee 3) F&P Committee.
5.2	Project Management ▪ Led by the Head of Fundraising, Supported by the Fundraising Manager (Digital and Data). ▪ Working Group – with representation from across the Health Board – to meet (virtually) monthly from September 2020
5.3	Project Plan – Implementation Timeline ▪ Health Board Authorisation: July 2020 ▪ Recruitment: September 2020 ▪ Staff Lottery Official Launch December 2020
5.4	Post Implementation Review ▪ Staff Lottery to be a Charitable Funds Committee fixed agenda item from September 2020 ▪ Staff Lottery to become an Annual Trustees Meeting fixed agenda item from January 2021
6.	**Conclusions and Recommendations**
Following extensive research into giving trends and NHS Staff Lotteries across the UK, it is recommended that BCUHB launch a Staff Lottery by December 2020. It is expected that a well-promoted BCUHB Staff Lottery will generate in excess of £1million in its first 5 years. **The recommendation is for the Awyr Las Support Team to manage the lottery in-house in order to ensure that the charities key messages are promoted well alongside the lottery.**	
7.	**Declarations**

☑ The above information has been reviewed to ensure it is accurate and represents a true and fair view of the service to be provided, the benefits and the costs

☑ Where third parties have provided information this is in writing/e-mail format and they have confirmed it is correct to the best of their knowledge

☑ Where the business case has an impact on another Area/Division/Department the impact has been agreed with that Area/Division/Department in writing and the relevant Mangers have signed below to confirm

Signed by:

Kirsty Thomson	Rebecca Hughes	
……..	……	……
Kirsty Thomson, **Head of Fundraising**	**Rebecca Hughes** **Charity Accountant**	**Sue Hill** **Executive Director of Finance**

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Draft Committee Annual Report 2019/20
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Diane Davies, Corporate Governance Manager
Craffu blaenorol: Prior Scrutiny:	The Committee Annual Report has been scrutinised by the Committee Lead Executive.
Atodiadau Appendices:	1. Committee Annual Report 2019/20 2. Draft Cycle of Business 2020/21 3. Terms of Reference

Argymhelliad / Recommendation:

The Committee is asked to

- agree the overall and individual Committee objectives' RAG status ratings
- approve the Committee Annual Report 2019/20 for submission to the Audit Committee to be held on 17.9.20

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

The Committee is asked to approve the Committee Annual Report 2019/20

The Cycle of Business has been amended in line with discussions held at the previous meeting.

The Terms of Reference have been amended in line with discussion at the previous meeting and will be submitted to the Audit Committee on 17.8.20 for ratification

Cefndir / Background:

The Annual Report has been prepared on a BCU-wide template and will be submitted to the next meeting of the Audit Committee.

Asesiad / Assessment & Analysis

Strategy Implications
Strategies discussed during the period are noted within the report
Options considered
N/A
Financial Implications
N/A
Risk Analysis
Risks assigned to the Committee were discussed twice annually per the Committee's Cycle of Business.
Legal and Compliance
All Committees are required to produce an annual report which forms part of a composite report to the full Health Board. Due to the Covid-19 pandemic submission was delayed.
Impact Assessment
N/A

Finance & Performance Committee
DRAFT Annual report 2019-20

1. Title of Committee:

Finance and Performance Committee

2. Name and role of person submitting this report:

Ms Sue Hill, Acting Executive Director of Finance

3. Dates covered by this report:

01/04/2019-31/03/2020

4. Number of times the Committee met during this period:

The Committee was routinely scheduled to meet 12 times and otherwise as the Chair deemed necessary. During the reporting period, it met on 11 occasions. Attendance at meetings is detailed within the table below:

Members of the Committee	24.4.19	23.5.19	25.6.19	29.7.19	22.8.19	30.9.19	24.10.19	4.12.19	19.12.19	23.1.20	27.2.20	24.3.20 CNX
Independent Members												
Mr Mark Polin	P	P	P	P*	P	P*	P	P	P	P	P	
Mr John Cunliffe	P	P	P**	P	P	P	P	P	A	P	P	
Ms Helen Wilkinson	P	P	P	P	P	P	P	A	A	P	P	
Mrs Lyn Meadows	P	P	P**	P	◆	◆P	◆	◆	◆	◆	◆	
Mr Eifion Jones	◆	◆	◆	◆	P	P	A	A	P	P	A	
Mrs Jackie Hughes	◆	◆	◆	◆	◆	◆P	◆P	◆P	◆P	◆	◆	
Cllr Cheryl Carlisle	◆	◆	◆	◆	◆	◆ P*	◆P	◆	◆	◆	◆	

Formally In attendance (as per Terms of Reference)	24.4.19	23.5.19	25.6.19	29.7.19	22.8.19	30.9.19	24.10.19	4.12.19	19.12.19	23.1.20	27.2.20	24.3.20 CNX
Directors												
Mr Russ Favager Executive Director Finance	P	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Ms Sue Hill Acting Executive Director Finance	◆	P	P**	P	A	P	P	P	P	P	A	
Mrs Sue Green Executive Director Workforce &OD	P	P	P**	P	P	P	P	P	P	P	P	
Mr Mark Wilkinson Executive Director Planning & Performance	P	P	P**	P	P	P	A	P*	P*	P	P	
Dr Evan Moore Executive Medical Director	P	P*	P	A	◆	◆	◆	◆	◆	◆	◆	◆
Dr David Fearnley Executive Medical Director	◆	◆	◆	◆	A	P	A	P	P	P*	P	
Mrs Deborah Carter Acting Executive Director Nursing & Midwifery	P	P*	P	P*	P	P*	P*	A	◆P	◆	◆P	◆
Mr Geoff Lang Director of Turnaround	P	P	P**	◆	◆	◆	◆	◆	◆	◆	◆	◆
Mr Phil Burns Interim Recovery Director	◆	◆	◆	P	P	P	P	P	P	P	P*	
Mr Gary Doherty Chief Executive by invitation wef July	◆	◆	◆	A	A	P	P	P	A	A	◆	◆
Mrs Gill Harris Executive Director Nursing & Midwifery	◆	◆	◆	◆	◆	◆	◆	◆	A	P*	A	

Key:

P - Present

P* - Present for part meeting

A - Apologies submitted

X - Not present

◆ Not a member of the Committee at this time.

P** - part attendance due to membership of Savings Programme Group meeting held part concurrently

In addition to the above core membership, other Directors and Officers from the Health Board regularly attend meetings of the Committee. For a full list of attendance, please see the approved minutes which can be accessed on the Health Board's website via the following pages:- https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

5. Assurances the Committee is designed to provide:

The Committee is designed to provide assurance to the Board on the following key areas as set out in its Terms of Reference as follows:-

The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme and Workforce activity.

During the period that this Annual Report covers, the Committee operated in accordance with its terms of reference which were operative for the whole of the term this Annual Report covers. The Terms of Reference are appended at Appendix 1.

The work programmes, cycles of business and overall performance of each Committee/Group/Forum are reviewed by the Committee Business Management Group (CBMG) which meets quarterly. The CBMG oversees effective communication between Committees, avoiding duplication and ensuring all appropriate business is managed effectively and efficiently through the Health Board's Governance framework.

The Committee is required to publish its agenda and papers 7 days ahead of the meeting, and a breach log is maintained by the Office of the Board Secretary where there are exceptions to this requirement. During the reporting period there were 9 breaches of this nature in terms of individual papers not being available 7 days before the meeting.

6. Overall *RAG status against Committee's annual objectives / plan: RED/AMBER/GREEN

The summary below reflects the Committee's assessment of the degree to which it has met these objectives. The supporting narrative included alongside the assessment below describes this in more detail.

Objective as set out in Terms of Reference	**Assurance Status (RAG)***	**Supporting narrative** *(Please provide narrative against all red and amber including the rationale for the assurance status)*
• seek assurance on the Financial Planning process and consider Financial Plan proposals	A	The Committee received assurance and approved the planning and budget methodology, but the Health Board did not deliver the planned deficit.
• monitor financial performance and cash management against revenue budgets and statutory duties;	A	The Committee received relevant reports and improvements were made to the quality of reports during

		the year but the Health Board did not meet its statutory duties
• consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions;	G	The Committee received regular Capital reports and reviewed Business Cases for both capital and revenue projects; Capital was also considered and approved as part of the annual plan
• receive assurance with regard to the Health Board Turnaround programme progress and impact/pace of implementation of organisational savings plans.	A	The Committee received regular reports on the Turnaround programme but this was superceded by the Recovery programme from July 2019 and the Health Board did not deliver its savings target for the year
• receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.	G	The Committee received regular reports of this nature and the finance report includes analysis of divisional financial performance
• to determine any new awards in respect of Primary Care contracts	G	The committee considered all new Primary Care Contracts awarded during the year
• approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).	G	The Committee has not reviewed the Performance management Framework in the last twelve months – it was on the cycle of business but was deferred due to the Covid 19 pandemic and will be completed during 2020/21
• ensure detailed scrutiny of the performance and resources dimensions of the Integrated Quality and Performance Report (IQPR);	G	The IQPR is scrutinised at each Committee meeting and feedback is incorporated into future reports
• monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;	A	The Committee received regular dedicated reports access times during the year and this is also included in the IQPR but the Health Board did not deliver significant improvements against the previous year, which was in part due to Covid-19

• review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);	R	N/A – the Health Board submitted an annual plan to Welsh Government for 2020/21
• review and monitor performance against external contracts	G	The Committee receives regular reports on the performance of external contracts for healthcare services
• Receive assurance reports arising from Performance and Accountability Reviews of individual teams.	A	The financial performance of divisions is regularly reported but there has been limited distribution of reports on individual teams
• Receive assurance reports in respect of the Shared Services Partnership.	G	The Committee receives quarterly reports relating to NWSSP which are reviewed and where required, feedback is provided to the organisation

**Key:*

Red	*= the Committee did not receive assurance against the objective*
Amber	*= the Committee received assurance but it was not positive or the Committee were partly assured but further action is needed*
Green	*= the Committee received adequate assurance against the objective*

7. Main tasks completed / evidence considered by the Committee during this reporting period:

Finance

- Monthly Finance reports
- Draft unaudited Financial report month 12 2018/19
- Turnaround Programme savings reports
- External Contracts updates
- Financial review action plan
- Financial policies and processes
- Value Based Healthcare
- Financial Recovery Action Plan progress
- Finance Academy Forecasting best practice guide
- Resource allocation review
- Financial plan 2020-21 - planning framework and timetable for delivery
- Presentation: Financial Planning
- Non Pay Costs 2018/19
- Savings Programme Group (SPG) meeting updates
- Financial Recovery action plan
- Monthly Financial Recovery Group (FRG) reports

- Winter monies - Utilisation of Health Board and Regional Partnership Board monies
- Budget setting framework and timetable for 2020/21
- Financial plan update 2020/21
- Update on delivery of PWC recommendations

Planning & Performance

- Monthly 2019/20 annual plan progress monitoring reports
- Developing our Plan for 2020/23 - draft planning principles and outline timetable
- Completed planning profiles supporting July Board 2019/20 annual plan
- 2019/20 annual plan refresh
- Three year outlook and 2019/20 annual plan update
- Monthly Integrated Quality and Performance reports
- Performance summary
- Presentation : Excellent hospital care ~ Planned Care
- Countess of Chester hospital update
- Unscheduled Care and Building Better Care reports and SICAT presentation
- Proposal for outsourcing elective Orthopaedic work as part of the Orthopaedic plan
- Referral to Treatment (RTT) reports
- Update on Referral to Treatment improvement programme and year-end forecast
- Referral to Treatment 2019/20 development plan

Estates

- Monthly capital programme reports
- Discretionary capital programme 2019/20
- Policy for revenue business case development
- Partnership project - Satellite hospice at Ysbyty Penrhos Stanley – position paper and way forward
- Hafan Wen Substance Misuse Service DETOX contract
- Re-location of services from Mount Street clinic, Ruthin – business justification case
- Wrexham Maelor hospital continuity programme business case
- Redevelopment of the Ablett Unit at Ysbyty Glan Clwyd – procurement of external support
- Development of new isolation facilities – Critical Care Unit, Wrexham Maelor hospital
- Replacement of a CT scanner at Ysbyty Glan Clwyd business case
- Critical Care business case
- Bryn Beryl integrated Dementia & Adult Mental Health centre capital business case
- Procurement of local frameworks for construction works

Workforce

- Quarterly Workforce performance reports
- Strategic recruitment position and plans
- Retention update

Governance

- Draft minutes of previous meetings and summary action plans
- Review of Corporate Risk Assurance Framework – risks assigned to the Finance and Performance Committee
- Draft Finance and Performance Committee annual report 2018/19
- Cycle of Business 2019/20
- Shared Services Partnership Committee quarterly assurance reports

Private session

Finance

- PWC reports
- Review of operational plan investments 2019/20
- Non-recurrent RTT spending
- Financial Plan 2019/20
- Financial recovery management arrangements report
- Unfunded cost pressures
- Identifying the drivers of financial deficit approach
- Continuing Health Care support proposals
- Financial control
- Proposed interim arrangements for Continuing Health Care and Free Nursing Care fee changes for 2019/20
- Review of RTT expenditure Jan - March 2020
- Financial plan update 2020/21
- Financial recovery cost
- Drivers of the deficit
- Value for money assessment of the financial recovery programme
- WHC 2019/013 : 2019/20 monthly monitoring returns

Planning and Performance

- Board and committee monitoring of the 2019/20 annual plan
- Draft three year outlook and 2020/21 annual plan
- Outputs from health economy accountability review meetings
- Mental Health division delivery plan reports
- Wrexham Maelor hospital performance reports
- North Wales endoscopy service
- Proposals in respect of stroke services
- Referral to Treatment update
- RTT update : Eye care services
- Musculoskeletal and Orthopaedic service plan update
- Countess of Chester hospital update

Estates / business cases / contracts

- Ysbyty Glan Clwyd redevelopment
- Ysbyty Glan Clwyd park and ride service
- Digital dictation and speech recognition
- Outline business case for delivering an acute digital health record
- Supply chain partner for the proposed North Denbighshire community hospital update
- Land lease to Nightingale hospice
- Rowley's Drive SMS accommodation, Shotton

- National Infected Blood Inquiry embargo on destruction – storage impact
- Contractor requests for recommissioning of dental services
- Procurement services contract briefing papers:
    - Electrophoresis Managed Service Contract
    - Glycated Haemoglobin Managed Service Contract
    - Blood gas analyser managed service contract

Workforce

- Medical and Dental Agency Locum monthly report
- Nursing shift change proposals

Full details of the issues considered and discussed by the Committee in public session are documented within the agenda and minutes which are available on the Health Board's website and can be accessed from the following pages
https://bcuhb.nhs.wales/about-us/committees-and-advisory-groups/

8. Key risks and concerns identified by this Committee in-year which have been highlighted and addressed as part of the Chair's reports to the Board:

Meeting Date	Key risks including mitigating actions and milestones
24.4.19	• Significant risks to delivery of a revised financial plan and savings programme - support from PWC on review of annual plan, grip and control action plan, gearing up savings approaches and recovery. • Risk to RTT delivery and achievement of goals in unscheduled care/building better care – development of action plans to address ○ Orthopaedics capacity issues and impact on RTT and cost implications • Secondary Care expenditure profile to address RTT and urgent care performance.
23.5.19	• Risks to delivery of financial plan and savings programme - month 1 adverse variance against plan of £0.9m primarily from Mental Health and Secondary Care. - total saving schemes gap of £16.8m - support from PWC on re-planning, grip and control action plan, gearing up savings approaches and recovery. • Risk to RTT delivery – development of expenditure, funding and impact estimates. • Delivery of the Health Board's financial duties, specifically in relation to the control total of £25m deficit.
June – Sept 2019	• Operational issues within diagnostic and imaging were highlighted to the Executive Team to address • RTT delivery which could be impacted by unscheduled care pressures and level of finance and other recovery available. • Wrexham Maelor Hospital performance issues • Risks to delivery of financial plan and savings programme

	○ year to date adverse variance against initial plan of £3.0m – year to date £14.6m deficit ○ key areas for overspends were secondary care drugs (£1.4m), continuing healthcare (£0.7m), primary care prescribing (£0.5m) and other non-pay (3.2m) ○ total savings delivered were £6.6m against budgeted anticipated savings of £9.8m, a shortfall of £3.2m. • Financial recovery is being addressed by the Interim Recovery Director's newly introduced processes, planning activity and regular Divisional and Improvement Group meetings • The Financial Recovery Action Plan was agreed to be reassessed to ensure all actions were accurately recorded and closed appropriately.
Oct – Dec 2019	The Committee questioned whether the Corporate Risk Register adequately addressed the risks of: • Overall financial sustainability of the Health Board • Clinical performance and patient experience • Overarching delivery of the overall plan • The Chairman stated the need for the Finance Division to work towards accurate reporting by day 5 following month end in order that the organisation be informed as to the financial position at the earliest point in time and thus aid local senior leadership teams in place in regard to decision making which would be a critical success factor in comparison to previous years. • The Committee expressed concern with reliance upon improvements to digital systems and initiatives which were being affected by delays in national developments and / or infrastructure issues. BCU's developing digital strategy including current IT capability, issues and current plans would be reviewed in the Board's workshop programme and considered at the next Digital and Information Governance Committee meeting. • The Chief Executive stated the need for tighter RTT management and improvement in the number of patients treated. A micromanagement approach was in place to ensure scrutiny at individual patient level, however there were significant challenges in orthopaedics, general surgery, gynaecology, urology and endoscopy. The Committee was advised on 24.10.19 that there was a fair chance of meeting the November targets set with the exception of orthopaedics. • Following three months of consecutive improvement in financial performance, there had been a deterioration in month 8 which was £1.6m in excess of the control total plan. In respect of year to date, the Health Board was overspent by £27.1m, £8.8m higher than the control total plan and £3.8m over the original plan. The main over spending area was noted to be secondary care, while the non-delivery of savings, agency premium pay costs and prescribing cost

	pressures were the main causes of the over spend. Despite the downturn in performance in Month 8, the savings pipeline continued to hold a number of schemes that were forecast to deliver in the final quarter of the year. On the basis of the conversion and delivery of these schemes, the £35m forecast deficit was considered challenging but achievable. • It was also noted that the run rate needed to be below £2m per month from month 8 in order to achieve year-end target. The Committee expressed concern regarding deliverability given performance to date. • Concern was raised in respect of capability and capacity issues within the Finance Department's staffing structure which would be reviewed, an effective clamp down was due to be introduced in terms of non-clinical expenditure in January; the need for expenditure to be restrained with particular need for low level expenditure to be addressed was highlighted; and it was understood that the efficacy of BCU's Improvement Groups would also be reviewed. • It was noted that the Health Board had been advised to continue with increased planned care activity until the second week in January 2020 by WG, which would require the Health Board to spend at risk albeit that there was also a risk of clawback should activity be ceased. • The Committee discussed the critical issue of the deterioration in unscheduled and planned care performance during the winter period. Performance was worse than the previous year however, there had been an increase in demand and acuity of patients presenting.
Jan – Feb 2020	• The Chairman stated that the Board had noted the scale of deterioration which could not continue and that fundamental change needed to be undertaken. He clarified that the Executive Team needed to realistically assess the plan for the coming year, taking the opportunity to modify expectations for the change programme needed that would encompass important areas eg the ED review and RTT. • The Chairman emphasised that organisation design needed to address resistance to change and accountability across the Health Board. • Deterioration of progress within Planned Care • The Chairman sought assurance that Planned and Unscheduled care would be prioritised going forward, which the Chief Executive and Executive Director of Planning and Performance affirmed. • Finance Programme: It was noted that financial governance was being discussed by the Chair, Vice Chair, Chief Executive and Deputy Chief Executive. • Draft Annual Operational Plan 2020/21 to be developed at the Board workshop on 12.3.20

	• The in-month financial position reported an improvement in the run rate of £0.7m in Month 10. However, prescribing costs continued to increase and had a significant impact again in January i.e. £0.6m worse than expected. The in-month position was £1.6m in excess of the control total plan and £0.3m above the initial plan. In respect of year to date, the Health Board was overspent by £34.3m, £12.6m higher than control total plan and £5.1m over the original plan. • PWC recommendations had not been completed. Further narrative was requested to enable further consideration of the progress of actions. • In consideration of the risks assigned to the Committee on the Corporate risk register CRR06 Financial Stability and CRR12 Estates and Environment risk ratings were increased.
March	Cancelled meeting

9. Focus for the year ahead:

The primary focus of the Committee over the next twelve months will be progressing service improvements in the clinical and operational performance of the Health Board while managing the unprecedented implication of the Covid 19 pandemic across the Health Board. This will include but is not limited to the significant impact on clinical services across the Health Board, our patients and staff and the resulting financial consequences.

The Committee has established a Cycle of Business for the year ahead covering the breadth of its work, and primarily focussing on its key areas of risk, as defined in the Board's Corporate Risk and Assurance Framework. This is attached as Appendix 2.

Betsi Cadwaladr University Health Board
Terms of Reference and Operating Arrangements

FINANCE AND PERFORMANCE COMMITTEE

1. INTRODUCTION

1.1 The Board shall establish a committee to be known as Finance and Performance Committee (F&P). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Committee is to advise and assure the Board in discharging its responsibilities with regard to its current and forecast financial position and performance and delivery. This includes the Board's Capital Programme and Workforce activity.

3. DELEGATED POWERS

3.1 The Committee, in respect of its provision of advice and assurance will, and is authorised by the Board to: -

3.1.1 Financial Management

- seek assurance on the Financial Planning process and consider Financial Plan proposals
- monitor financial performance and cash management against revenue budgets and statutory duties;
- consider submissions to be made in respect of revenue or capital funding and the service implications of such changes including screening and review of financial aspects of business cases as appropriate for submission to Board in line with Standing Financial Instructions;
- monitor turnaround and transformation programmes' progress and impact/pace of implementation of organisational savings plans.
- receive quarterly assurance reports arising from performance reviews, including performance and accountability reviews of individual directorates, divisions and sites.
- to determine any new awards in respect of Primary Care contracts

3.1.2. Performance Management and accountability

- approve the Health Board's overall Performance Management Framework (to be reviewed on a three yearly basis or sooner if required).
- ensure detailed scrutiny of the performance and resources dimensions of the Quality and Performance Report (QAP);

- monitor performance and quality outcomes against Welsh Government targets including access times, efficiency measures and other performance improvement indicators, including local targets;
- review in year progress in implementing the financial and performance aspects of the Integrated Medium Term Plan (IMTP);
- review and monitor performance against external contracts
- receive assurance reports arising from Performance and Accountability Reviews of individual teams.
- Receive assurance reports in respect of the Shared Services Partnership.

3.1.3 Capital Expenditure and Working Capital

- approve and monitor progress of the Capital Programme.

3.1.4 Workforce

- Monitor performance against key workforce indicators as part of theQAP;

- Monitor the financial aspects of workforce planning to meet service needs in line with agreed strategic plans.

- Receive assurance reports in relation to workforce, to include job planning under Medical and Dental contracts for Consultants and Specialist and Associate Specialist (SAS) doctors and the application of rota management for junior doctors.

- To consider and determine any proposals from the Primary Care Panel (via the Executive Team) in relation to whether the Health Board should take on responsibility for certain GP Practices.

4. AUTHORITY

4.1 The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any:

- employee (and all employees are directed to cooperate with any legitimate request made by the Committee); and

- other committee, sub committee or group set up by the Board to assist it in the delivery of its functions.

4.2 May obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3 May consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business;

4.4 Will review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1 The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups carry out on its behalf specific aspects of Committee business.

6. MEMBERSHIP

6.1 Members

Four Independent Members of the Board

6.2 In attendance

Executive Director of Finance (Lead Director)
Chief Executive
Executive Medical Director
Executive Director of Workforce and Organisational Development
Executive Director of Planning & Performance
Executive Director Nursing and Midwifery

Other Directors/Officers will attend as required by the Committee Chair, as well any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

Trade Union Partners are welcome to attend the public session of the Committee

6.3 Member Appointments

6.3.1 The membership of the Committee shall be determined by the Chairman of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.3.2 Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chairman of the Board. Independent Members may be reappointed to the Committee up to a maximum period of 8 years.

6.4 Secretariat

Secretary – as determined by the Board Secretary.

6.5 Support to Committee Members

6.5.1 The Board Secretary, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1 Quorum

7.1.1 At least two Independent Members must be present to ensure the quorum of the Committee, this should include either the Chair or the Vice-Chair of the Committee. In the interests of effective governance it is expected that a minimum of two Executive Directors will also be in attendance.

7.2 Frequency of Meetings

7.2.1 Meetings shall be held at least 6 times per annum.

7.3 Withdrawal of individuals in attendance

7.3.1 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

8.3.1 joint planning and co-ordination of Board and Committee business; and

8.3.2 sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall:

9.1.1 report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report as well as the presentation of an annual report;

9.1.2 ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.2 The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

V5.01
Amendments agreed at Finance and Performance Committee 16.7.20
to be submitted to Audit Committee 17.9.20

Cycle of Business 2020/21

Agenda Item	~~APR~~	~~MAY~~	4.6	2.7	27.8	~~SEP~~	29.10	~~NOV~~	22.12	~~JAN~~	25.2	25.3
NB Consent items will be determined on a meeting by meeting basis												
Opening Business / Standing items												
Previous minutes and action plan	x	x	x	x	x	x	x	x	x	x	x	x
Declaration of any Interests	x	x	x	x	x	x	x	x	x	x	x	x
Finance and Planning												
Finance report	x	x	x	x	x	R	x	R	x	R	x	x
Financial plan 2020/21			x									
Financial plan 2021/22					-		x	x	x	x	x	x
Budget setting 2021/22							x	x	x	x	x	x
Financial planning	x	x	x	x	x	x	x	x	x	x	x	x
WG monthly monitoring return	x	x	x	x	x	R	x	R	x	R	x	x
Savings Programme							x				x	
External contracts update – for information		x		x				x Pres	x			X
Annual budget principles and management strategy									x			
Capital programme report	x	x	x	x	x	x	x	X	x	x	x	x
Approval of the draft annual discretionary capital allocation programme												x
Benefits Realisation / Gateway Reviews – *As arising & advised following business case submissions*	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘
Any Estates / Capital Business Cases for approval prior to Board ratification – *As arising*	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘
Performance and Contracting												
Quality and Performance report	x	x	x	x	x	R	x	R	x	R	x	x
2020/21 Annual Plan: monitoring of progress against actions for F&P		x	x	x	x	x	x	X	x	x	x	x
Operational plan monitoring							x		x		x	x

Agenda Item	APR	MAY	4.6	2.7	27.8	~~SEP~~	29.10	~~NOV~~	22.12	~~JAN~~	25.2	25.3
Unscheduled care and building better care update	x	x	x	x	x		x		x		x	
RTT report (Activity, Cost, Performance, Funding – For previous quarter)	x		x	x	x		x		x		x	
Workforce												
Workforce quarterly performance report (Previous quarter's data)		x			x			x	x			X
Review of corporate risks assigned to Finance & Performance Committee			x					x	x			
Agree CoB for coming year												x
Draft Committee annual report 2020/21 inc review of ToR	x											x
Policies (relating to area of responsibility)- as required			🕘	🕘	🕘		🕘		🕘		🕘	🕘
Shared Services Partnership Committee Assurance Report		x		x			x		x			x
Closing Business												
Summary of private Board business to be reported in public (Only for any prior month in private)	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘
Issues of significance to inform Chair's report	x	x	x	x	x	x	x	x		x	x	x
Private session												
Medical and Dental Agency Locums monthly reports	x	x	x	x	x	x	x	x		x	x	x
Health Economy Accountability Assurance Progress Reports – *For info*				~~x~~					x			x
Lease Transfers – *As arising*	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘	🕘
Carry forward to future years:												
<u>2020/21:</u> Review of Performance Management Framework (As required by ToR) *To be addressed in 3 year cycle)*							x					

🕘 = Items to be considered if arise
R= members to receive between meetings

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Monthly Monitoring Report – Month 4**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Eric Gardiner, Finance Director, Provider Services
Craffu blaenorol: Prior Scrutiny:	The submission made to Welsh Government required Chief Executive and Director of Finance sign off.
Atodiadau Appendices:	App 1 Monitoring report month 4

Argymhelliad / Recommendation:

Note the contents of the report that has been made to the Welsh Government about the Health Board's financial position for Month 4 of 2020/21.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

To report to the Committee the completion of monthly reporting to the Welsh Government for Month 4 of 2020/21.

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m and is based on delivering savings of £45m.

The plan did not take into account the impact of Covid-19, and therefore it will change throughout the year. In the first four months of the year, expenditure has been considerably higher than planned due to the pandemic response and we have already seen that savings delivery has been significantly impacted as the Health Board prioritised the clinical and operational response to the pandemic. The uncertainty about the potential resurgence of Covid-19 and the essential infection prevention measures which have been implemented means that the forecast expenditure is much higher than planned and savings delivery will be significantly reduced for the remainder of the year.

Asesiad / Assessment & Analysis

Strategy Implications:

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

Options considered
Not applicable – report is for information only.

Financial Implications:

1.1 In-month position

- The in-month position is a £3.3m deficit, which is in line with the plan for Month 4.

- This position assumes that all Covid-19 costs incurred by the Health Board are fully funded. The cost of Covid-19 in July is £9.2m, £2.4m of which has been funded via specific funding streams. Anticipated income from Welsh Government of £6.8m has been included in the position for the remainder of the cost.

- To date, the Health Board position has assumed that all Covid-19 costs would be fully funded by Welsh Government. Following discussions with Welsh Government, the Health Board will review its income assumptions around anticipated Covid-19 funding and discuss them at the Finance and Performance Committee in August, with a view to effecting any amendments in Month 5.

1.2 Year to Date Position

- At the end of Month 4, the Health Board is overspent by £13.3m, which is in line with the financial plan.

- The overall impact of Covid-19 on the year to date position is £52.6m, of which specific funding sources have funded £2.4m. £17.5m of Welsh Government income has been received to date and a further £32.7m funding anticipated in the position to fund these costs. The total amount of Welsh Government funding available has not yet been confirmed and is therefore a significant risk to the financial position.

	M01	M02	M03	M04	YTD
	£m	£m	£m	£m	£m
Covid-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	46.9
Lost income	1.2	1.4	1.2	1.6	5.4
Non delivery of savings	3.7	3.6	2.0	2.7	12.0
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(10.0)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(1.3)
Cluster funding	0.0	0.0	(0.3)	(0.1)	(0.4)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0
Total Covid-19 costs	**30.8**	**5.1**	**7.5**	**9.2**	**52.6**
Funding:					
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(1.6)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	(0.1)
WG - anticpated & received	(30.8)	(5.1)	(7.5)	(6.8)	(50.2)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

WG funding received	(17.5)
WG funding anticipated	(32.7)
Total	**(50.2)**

1.3 Forecast

- Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year remains extremely difficult. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

Risk Analysis:

- There are four risks to the financial position totalling £122.7m and one opportunity of £6.6m. These are detailed in Section 3 of the attached report.

Legal and Compliance:
Not applicable.

Impact Assessment:
Not applicable.

MONITORING RETURN

MONTH 4 2020/21

Sue Hill

Acting Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION & FORECAST

1.1 Financial Plan

- The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m and is based on delivering savings of £45m.

- The plan did not take into account the impact of Covid-19, and therefore it will change throughout the year. In the first four months of the year, expenditure has been considerably higher than planned due to the pandemic response and we have already seen that savings delivery has been significantly impacted as the Health Board prioritised the clinical and operational response to the pandemic. The uncertainty about the potential resurgence of Covid-19 and the essential infection prevention measures which have been implemented means that the forecast expenditure is much higher than planned and savings delivery will be significantly reduced for the remainder of the year.

1.2 In-month Position

- The in-month position is a £3.3m deficit, which is in line with the plan for Month 4.

- This position assumes that all Covid-19 costs incurred by the Health Board are fully funded. The cost of Covid-19 in July is £9.2m, £2.4m of which has been funded via specific funding streams. Anticipated income from Welsh Government of £6.8m has been included in the position for the remainder of the cost.

- To date, the Health Board position has assumed that all Covid-19 costs would be fully funded by Welsh Government. Following discussions with Welsh Government, the Health Board will review its income assumptions around anticipated Covid-19 funding and discuss them at the Finance and Performance Committee in August, with a view to effecting any amendments in Month 5.

1.3 Year to Date Position

- At the end of Month 4, the Health Board is overspent by £13.3m, which is in line with the financial plan.

- The overall impact of Covid-19 on the year to date position is £52.6m, of which specific funding sources have funded £2.4m. £17.5m of Welsh Government income has been received to date and a further £32.7m funding anticipated in the position to fund these costs. The total amount of Welsh Government funding available has not yet been confirmed and is therefore a significant risk to the financial position.

1. FINANCIAL POSITION & FORECAST

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Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(10.0)
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Cluster funding	0.0	0.0	(0.3)	(0.1)	(0.4)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0
Total Covid-19 costs	**30.8**	**5.1**	**7.5**	**9.2**	**52.6**
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Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	(0.1)
WG - anticpated & received	(30.8)	(5.1)	(7.5)	(6.8)	(50.2)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

WG funding received	(17.5)
WG funding anticipated	(32.7)
Total	**(50.2)**

1.4 Forecast

- Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year remains extremely difficult. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

2. UNDERLYING POSITION

2.1 Movement from Financial Plan (Table A)

- The underlying position brought forward from 2019/20 was a deficit of £57.7m, with an opening plan of £40m deficit.

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The below are risks to the Health Board's financial position for 2020/21.

	£m	Level	Explanation
Opportunities			
Red Pipeline Savings Schemes	6.6		Red rated savings schemes that total £6.6m are currently held in pipeline and are due to start delivering over the next three months.
Risks			
WG Covid-19 Funding	110.2		Income has been anticipated for the estimated cost of Covid-19 for 2020/21, less funding already received. Welsh Government has not yet confirmed that this will all be funded and so it is a significant risk to the financial position. The Health Board is working with Welsh Government regarding funding for the Covid-19 response. As the operational plan is developed, there will be greater confidence around the assumptions within the current forecast and any potential mitigating actions can be agreed.
Welsh Risk Pool Risk Share	2.5		The projected increased cost of the Welsh Risk Pool (WRP) Risk Share is a risk to the Health Board's forecast for 2020/21.
Hallett v Derby Hospitals NHS Foundation Trust			It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.
Flowers Judgement			NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement is ongoing and the outcome of the Supreme Court appeal is awaited.

4. INCOME & EXPENDITURE

4.1 Income (Table B)

- Income totals £149.5m for July.

- Confirmed allocations to date are £1,545.9m, with further anticipated allocations in year of £136.1m, a total forecast Revenue Resource Limit (RRL) of £1,682.0m for the year. £140.1m has been profiled into July, which is £6.8m higher than in June due to an increase in costs for Prescribing, Capital and spend against the Intermediate Care Fund (ICF).

- A reconciliation between the RRL phased into the position and an equal phasing is shown in the table below.

	Annual £m	Phased at M04 £m	4/12ths £m
RRL	(1,682.0)	(556.5)	(560.7)
Less funded Covid-19 costs	131.2	52.6	43.7
Non covid-19 budgets	(1,550.8)	**(503.9)**	(516.9)
Funding for specific purposes, e.g. Dementia / medical pay etc. - not phased in	39.1	0.0	13.0
	(1,511.7)	(503.9)	**(503.9)**

- The Health Board will review its income assumptions around anticipated Welsh Government Covid-19 funding, with a view to making any changes in Month 5.

- The impact of Covid-19 has resulted in lost income of £1.6m during July, which includes £0.6m of General Dental Services (GDS) patient income and £0.9m of English Non-Contracted Activity (NCA) income. The latter has a seasonal profile, with large increases in the summer months and is therefore forecast to show a significant loss over Quarter 2.

4.2 Expenditure (Table B)

- Expenditure totals £152.9m for Month 4, £6.9m higher than in Month 3.

- £7.1m expenditure is directly related to Covid-19, of which £4.4m is included in pay and £2.7m across non-pay expenditure categories. The latter includes spend of £0.7m relating to the three Field Hospitals.

- The impact of Covid-19 on the savings programme has resulted in planned savings of £2.7m not being achieved and this shortfall is included within non-pay. There has been an increase in elective care activity this month, but it is still at a much lower level than pre-Covid. There is therefore a reduction in planned care non-pay spend of £2.6m. In addition, there is slippage on a number of planned investments of £0.5m.

4. INCOME & EXPENDITURE

Primary Care	– Expenditure in July has returned to levels similar to that in April and May. – As noted in last month's report, June figures were lower than normal due to the quarterly review of GDS leading to some revisions and a correction of CHC costs.
Primary Care Drugs	– GP prescribing and dispensing costs are a risk of significant concern in 2020/21. The rolling average annual cost continues on an upward trend. As a result, costs are £0.5m higher than reported last month. – Based upon the latest available data, the forecast outturn expenditure for the Health Board is £126.0m. – The average cost per prescribing day across the Health Board is £0.5m. Over the last three-month period, this cost has increased by 6.3%. The May 2020 data received this month showed that the overall cost per item has reduced compared to April (by 1.1%), but the overall number of items per prescribing day increased (by 0.4%). – There has been an increase in GP Prescribing costs of £1.1m (5.7%) in the rolling twelve-month period for the Health Board (£5.4m or 6.0% across Wales). As there has been a reduction of 2.1% in the number of items prescribed, the increase in cost is due to price changes (typically Category M drugs or No Cheaper Stock Obtainable (NCSO)). If this trend continues, this could result in a full year cost increase for BCU of £6.5m. – The top-10 most significant increases in NCSO drugs for the Health Board over the first two months of available data have resulted in a cost increase of £0.6m. Should these NCSO concession tariff rates remain in place for the full financial year, the additional cost impact is estimated at £4.0m, which would suggest that NCSO accounts for 62% of the overall potential £6.5m estimated cost increase for 2020/21.
Provided Services - Pay	– Details are provided in Section 5.
Provider Services Non-Pay	– Expenditure has increased by £2.2m compared to Month 3. – Covid-19 expenditure of £0.8m is included within Provider Services Non-Pay in July, a decrease of £1.5m on last month. This is broken down as follows:

4. INCOME & EXPENDITURE

	<table><tr><th></th><th>£m</th></tr><tr><td>Clinical Services & Supplies</td><td>25</td></tr><tr><td>Establishment & Transport Expenses</td><td>20</td></tr><tr><td>General Services & Supplies</td><td>160</td></tr><tr><td>Other services</td><td>33</td></tr><tr><td>Premises and Fixed Plan</td><td>585</td></tr><tr><td></td><td>823</td></tr></table> – Spend against ICF funding has increased significantly this month, as plans are developed and implemented. This has contributed £2.9m to the increase in non-pay expenditure. – In addition, as noted in last month's report, June figures were lower than normal due to a correction of CHC costs.
Secondary Care Drugs	– Costs have continued to rise, increasing by another £0.3m compared to June. – Increases have been seen across a number of services, including Dermatology (£0.1m), Oncology (£0.04m) and related to Covid-19 (£0.1m).
Healthcare Services provided by other NHS Bodies	– Due to the national agreement to maintain payments to other NHS organisations via block contracts, costs are generally fixed, despite those organisations only undertaking very low levels of activity on behalf of the Health Board. – There has been a rise in spend compared to Month 3 of £0.7m. In June, WHSCC reported a significant under spend. In Month 4, they are still reporting an under spend for the month, primarily due to delayed developments, but this is at a reduced level.
Continuing Health Care (CHC) and Funded Nursing Care (FNC)	– Expenditure in July has decreased by £0.2m compared to June. However, as noted in last month's report, June figures were lower than normal due to a correction of CHC costs – Covid-19 related costs of £1.1m were incurred in Month 4, to give a year to date spend of £2.8m. Efforts to review placements and packages, particularly for those patients discharged due to Covid-19, continue. – Excluding Covid-19 costs, CHC expenditure is £0.2m more than last month. The increase relates to a number of new high cost Mental Health and LDS placements, in addition to an in-month increase in package costs.
Other Private and	– There has been no material change in spend. Expenditure relates

Voluntary Sector	to a variety of providers, including hospices and Mental Health organisations.
Joint Financing	– Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget.
Losses, Special Payments and Irrecoverable Debts	– Includes Redress, Clinical Negligence, Personal Injury and loss of property. – In Months 2 and 3 saw spend and then an adjustment for £0.3m of Covid-19 expenditure relating to charges anticipated from the hosts of the Field Hospitals for loss of their commercial income. Excluding this, costs have remained consistent across the year.
Capital	– As per the Non Cash Submission on the 7th August, the DEL depreciation increased by £5.5m of which includes £4.5m strategic depreciation. The increase reflected in the strategic element is as a result of additional capital funding that has been received for numerous capital schemes, including Covid-19 requirements. The overall increase in DEL depreciation is £1.1m. – AME depreciation is a forecast for the year based on donated capital expenditure.

4.3 Forecast (Table B)

- Pay costs are forecast to increase in September, which reflects the payment of the Doctors' and Dentists' Review Body (DDRB) pay award.

- Non-pay costs are forecast to increase significantly in March due to an increase in Test Trace Protect (TTP) costs and the decommissioning costs of two of the Field Hospitals and. The third Field Hospital is due to be decommissioned in November, reflected by a small increase in non-pay costs that month.

5. PAY EXPENDITURE

5.1 Pay (Table B2)

- Total pay costs in July are £69.4m, with Provided Services pay costs being £67.3m.

- Provided Services pay costs are £0.8m lower than in June. A total of £4.4m of pay costs were directly related to Covid-19, the same as last month. Primary Care pay costs at £2.1m have not changed significantly.

- Medical and Dental pay has increased by £0.8m from last month, with £0.3m of the increase relating to Covid-19. This includes some backdated payments to doctors for work during the height of the pandemic. In addition, there have been increases in agency (£0.1m) and locum costs (£0.2m).

- All other pay categories showed reduced costs compared to Month 3. Overtime costs are down by £0.2m and bank costs by £0.1m.

5.2 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 4 are £3.3m, representing 4.8% of total pay, a decrease of £0.1m on last month. Agency spend related to Covid-19 in June was £0.9m, compared to £0.5m in June.

- Medical agency costs have increased by £0.1m to an in-month spend of £1.6m. Of this, £0.4m related to Covid-19, which is £0.2m higher than in June.

- Nurse agency costs totalled £1.2m for the month, the same as in June. These costs include £0.1m relating to Covid-19.

- Other agency costs fell by £0.2m to £0.5m for July and mainly arise from Admin and Clerical (£0.3m) and Allied Health Professionals (£0.2m).

6. COVID-19 ANALYSIS

6.1 Covid-19 Actual Costs (Table B3)

- The total cost of Covid-19, including the Field Hospitals, is £9.2m for July.

- As requested by Welsh Government, some funding streams that have already been received are now to be used towards the costs of Covid-19 (Mental Health Service Improvement, Optimise Flow & Outcomes (ICF) and GMS (DES)). Where these had been previously classified as repurposing, they have been moved out of Table B3 and shown in Table A. All of the related costs remain in Table B3. Mental Health Service Improvement funding has been used to offset additional Mental Health pressures that have arisen due to the pandemic.

- A total of £2.4m of specific funding has been used to offset the cost of Covid-19, leaving a net cost of £6.8m. Income from Welsh Government to match this cost has been anticipated in the position.

	M04 £m
Specific Funding:	
Optimise Flow & Outcomes (ICF)	(1.6)
Mental Health Improvement Fund	(0.7)
GMS (DES)	(0.1)
Total	**(2.4)**

- In some areas, students have had more than one month paid during July, as they were due pay from previous months. The WTE in the report reflects the WTE paid rather than worked.

- As discussed with Welsh Government, there have been some adjustments in Month 4 to the coding of pay for the Field Hospitals relating to previous months. There has been a movement of some clinical staff from Student Nurses to Nursing and of some Admin and Clerical staff from bank to agency. There has also been a correction relating to rates overstated in Month 3.

- Test Trace Protect (TTP) costs have been included in accordance with Welsh Government guidance. Total cost in Month 4 was £0.2m.

6.2 Covid-19 Forecast Costs (Table B3)

- The forecast costs and expenditure relating to Covid-19 will be reviewed and revised as the Health Board develops and adjusts the plan.

6. COVID-19 ANALYSIS

- The assumptions behind the utilisation of the temporary Field Hospital capacity have been revised this month. The forecast position for the Field Hospitals reflects the following:
  - Decommission Bangor due to lack of oxygen provision. Handover assumed December 2020.
  - Deeside to have 25 beds open from mid-August to December 2020.
  - Venue Cymru and Deeside to be fully utilised from December 2020 to March 2021.
  - Staff redeployed to cover Field Hospitals, apart from Nursing and HCAs, which will be a mix of redeployed and new starters.

The table below summarises the bed number assumptions:

	M05	M06	M07	M08	M09	M10	M11	M12
Bangor	0	0	0	0	0	0	0	0
Venue Cymru	0	0	0	0	340	340	340	340
Deeside	25	25	25	25	420	420	420	420
Total	**25**	**25**	**25**	**25**	**760**	**760**	**760**	**760**

- Other specific assumptions made are:
  - The overall cost of Covid-19 to the Health Board will be fully funded by Welsh Government.
  - Savings delivery for the year will be reduced against the plan of £45m and indicative estimates are that this will be £7.6m, although there are £6.6m of red rated schemes in the pipeline, which it is anticipated will increase savings delivery this year to £14.2m.
  - Costs for decommissioning the field hospitals are currently estimated at £2.2m, with £0.6m incurred in November and the remaining £1.6m in March.
  - Elective under spends will continue for the rest of the year. Some elective work was undertaken in July. It is expected that activity will increase over future months, but full capacity will not be reached in 2020/21 due to the requirements of social distancing for staff and patients.

7. SAVINGS

7.1 Savings (Tables C – C3)

- Following the suspension of the Recovery Programme in March, the delivery of savings schemes in the early part of the financial year was severely impacted. Further review of savings has been undertaken in Month 4 and there is an increasing number of schemes that are now in delivery. Savings of £1.2m are reported in Month 4, increasing the year to date delivery to £2.8m. The Month 4 figure includes some retrospective savings reported for schemes that were not reported in Month 3. Schemes currently in delivery have a forecast in-year value in Table A of £7.4m. This includes delivery of £0.4m, year to date, for schemes where PIDs are currently under development and in line with guidance issued after the Month 3 return, the forecast for these schemes for months 5 to 12 has been included in the pipeline value. This amounts to £1.2m.

- The total in-year forecast for savings (including income generation and accountancy gains) including pipeline, has increased to £14.2m from the £12.7m reported in Month 3. Schemes that remain in the 2020/21 pipeline amount to £6.6m and work is progressing to move these into amber / green in the coming months. The expected movement is shown in the table below, with the aim of having all current schemes in amber / green by the end of September:

Amber/ Green Date	Forceast Annual Savings £000	Forecast FYE Savings £000
Aug-20	4,669	3,460
Sep-20	1,967	5,931
Total	**6,636**	**9,391**

- The Health Board is currently considering options and capacity requirements for the savings delivery and PMO function to be re-established. This will enable dedicated capacity to be re-instated to not only drive the schemes currently identified, but also to develop further opportunities for both in-year savings and the 2021/22 programme.

8. WELSH NHS ASSUMPTIONS

8.1 Income/Expenditure Assumptions (Table D)

- All Welsh NHS contracts have now been agreed and signed.

9. RESOURCE LIMITS

9.1 Resource Limits (Table E)

- The Health Board is anticipating income of £110.2m to fund the costs of Covid-19 for 2020/21. This funding has not been confirmed and is therefore listed as a significant risk to the financial position.

- The Health Board is anticipating funding of £1.1m required for the additional 0.8% nationally agreed inflation to fund the Block contracts with NHSE.

10. CASH

10.1 Cash Flow Forecast (Table G)

- The closing cash balance as the end of July was £3.1m, which includes £0.6m cash held for revenue expenditure and £2.5m cash held for capital projects.

- The Health Board is currently forecasting a shortfall of £37.3m at the end of the year. In order to maintain the opening revenue balance of £1.5m the total cash requirement for the year would increase to £38.7m. This assumes a nil capital cash balance.

- The total forecast cash requirement of £38.7m consists of £34.0m to support the forecast deficit position, £2.6m in respect of revenue working capital balances and £2.1m in respect of capital resource allocations that the Health Board did not request during 2019/20.

- As in previous years, the Health Board will consider all possible actions to minimise the level of Strategic Cash Assistance required to enable payments to continue through to the end of March. Current forecasts are that £6.0m of cash pressures can be managed internally and this will be reviewed as further opportunities arise.

- A full analysis of forecast revenue and capital cash movements during 2020/21 is provided below.

- Cash requirements currently exclude any pressures from in-year movements in provisions, as these will be updated following the provision commission exercise in November.

Revenue cash requirements 2020/21	**£000**
Forecast revenue deficit	(40,000)
Forecast revenue deficit to be managed internally	6,000
Working capital balances	(2,622)
Forecast revenue cash shortfall	**(36,622)**

Capital cash requirements 2020/21	**£000**
Forecast cash funding	
Opening capital balance	1,698
Approved Capital Resource Limit	23,930
Donated asset income	1,027
Disposal proceeds	150
Total forecast cash funding	**26,805**

10. CASH

Forecast cash spend	
Opening capital balance	(1,698)
Approved Capital Resource limit	(23,930)
Donated asset income	(1,027)
Disposal proceeds	(150)
Reduction in capital creditors (CRL not requested during 2019/20)	(2,109)
Total forecast cash spend	**(28,914)**
Forecast capital cash shortfall	**(2,109)**

Forecast total revenue and capital cash shortfall	**(38,731)**

11. PUBLIC SECTOR PAYMENT COMPLIANCE

11.1 PSPP (Table H)

- This table is not required this month.

12. CAPITAL

12.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2020/21 is £23.9m. Actual expenditure to the end of July was £5.4m, which was in line with the plan.

12.2 Capital Programme (Table J)

- The Capital Programme update is reported in Table J.

13. WELSH NHS DEBTORS

13.1 Welsh NHS Debtors (Table M)

- At the end July, the Health Board did not have any NHS Wales invoices over eleven weeks old requiring escalation in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales.

14. GMS & GDS

14.1 GMS (Table N)

- This table is not required this month.

14.2 GDS (Table O)

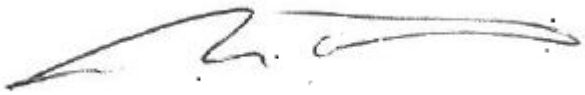
- This table is not required this month.

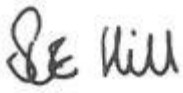
15. SUMMARY

15.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.

- The Month 4 Monitoring Return will be received by the Health Board's Finance and Performance Committee members on the 27th August.





Simon Dean
Interim Chief Executive

Sue Hill
Acting Executive Director of Finance

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Month 3 Monitoring Return Responses

Movement of Opening Financial Plan to Forecast Outturn (Table A) & Covid (Table B3) I have received confirmation that the following allocations made by WG were intended to fund additional Covid-19 costs. Please include these amounts on Table A on line 22 (WG Funding due to Covid-19), remove any "repurposing" from Table B3 - section D and ensure any associated costs are included in Table B3 - section A. **(Action Point 3.1)** Mental Health Service Improvement Fund 2020-21 - £744,000 – Mental Health allocations remain ring-fenced; however, it is recognised that this funding (representing the first six months) will be used to respond to Mental Health pressures arising from the pandemic. Please confirm in your narrative, that this funding is offsetting additional MH cost pressures that are recorded in Table B3. **(Action Point 3.1a)** TF Optimise Flow and Outcomes - £2,440,893 – if an element of this funding is being utilised with the Local Authority, then please ensure these payments are recorded on free text Line 95 (which we are now dedicating to 'Local Authority spend' – please use this narrative on the template) of Table B3. The balance of funding will be offsetting NHS Covid-19 costs recorded in Table B3. **(Action Point 3.1b)** All Wales Easter Bank Holiday DES (GMS) – £200,682 – any associated costs should be recorded in Table B3 and clarified in your narrative. **(Action Point 3.1c)** Contact Tracing - £11.2m – All Health Boards have received funding confirmation letters on the 6th July from the Policy Lead. As an organisation who is currently already including Anticipated Income to match all Covid-19 costs, we only need to seek specific clarification that you are including all known Contact Tracing costs in Table B3. This should include any payments made to the Local Authorities for reimbursement. Again, these should be shown on free text line 95 on Table B3 (use your narrative to provide a breakdown of what has been included on line 95). An equivalent amount of the total Contact Tracing costs can be anticipated as 'WG Funding due to Covid-19; up to the maximum allocated funding of £11.2m. **(Action Point 3.1d)**
Response Tables A and B3 have been amended to include this funding on Table A and remove any repurposing from Table B3. The narrative includes details of the specific funding brought into the position in Month 4. All related costs, including contract tracing, are included in Table B3.
Movement of Opening Financial Plan to Forecast Outturn (Table A) & Covid (Table B3) Thank you for completing the Dental and GMS tables earlier than required. I note you are reporting a overspend on your GMS Table and reflecting this additional pressure in Table A. Please can you review and confirm that you are not double counting any additional costs that relate to Covid-19, which are already included in Table B3 (for which you are assuming full funding), in this figure. Please contact me if you wish to discuss this issue. **(Action Point 3.2)**
Response

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

The GMS overspend does not include any double counting for Covid related expenditure. The All Wales Easter Bank Holiday DES had costs, but offset the allocation and did not contribute to the overspend reported in Table A.
Covid-19 (Table B3) - Action Point 3.3 I note the YTD amount you have reported as "Non delivery of Savings Assumed but not finalised at M1" is £9.314m but the equivalent amount on Table A amounts to £9.386m (being "Reversal of Planning Assumptions still to be finalised at Month 1" of £11.1m less Additional In Year Identified Savings – Forecast" of £1.714m). Please review this and ensure the monthly profile agrees in both tables.
Response These have been reviewed and now YTD agrees on both tables.
Covid-19 (Table B3) - Action Point 3.4 I note you have revised your future month's expenditure forecasts for Students (lines 33, 34 & 36) but I cannot see a similar revision in the WTE data. Please review this for your next submission.
Response The WTEs have been updated for Month 4.
Covid-19 (Table B3) - Action Point 3.5 I note you are now forecasting a cost reduction in Section C of this table for WHSSC contracts. Please confirm what this reduction relates to i.e. the original planning assumption regards investing additional funds with WHSSC has changed - explain why.
Response From the risk tables supplied by WHSSC the variation relates to underspends within both Welsh and English agreements Welsh variance is predominantly reduction in costs re ALAS and blood products – pass through costs. English variance mainly the Liverpool Heart and Chest block value being lower than budget.
Covid-19 (Table B3) - Action Point 3.6 Please provide further information of the item recorded on line 129 described as 'RPB ICF Funding Discharge Plan'.
Response This is the funding you refer to above as TF Optimise Flow and Outcomes, and the treatment has now been amended to reflect your requirements in action points 3.1/ 3.1b.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Covid-19 (Table B3) - Action Point 3.7

All Health Boards are being requested to confirm that they have undertaken a technical assessment of the accounting treatment of the Field Hospital costs, including those relating to Decommissioning, in terms of Revenue or Capital classification and as per that assessment, costs are accrued. This is particularly important if the period for which the Field Hospital is to be held is greater than 12 months. Health Boards should ensure that only those costs assessed as Revenue are included in Table B3, with Capital costs recorded in Table I. If revenue funding has been sought and received for costs now classified and recorded as Capital, then this must be declared in the submission.

Response

Decommissioning costs for all hospitals are included in our 20/21 forecasts, however these are not currently accrued for. The Technical Accounting Group are discussing the above in more detail.

Covid-19 (Table B3) - Action Point 3.8

I note that the Health Board has recorded retrospective savings delivery in June. Going forward, if schemes are delivering savings even though they are currently classified as a Red scheme, then that YTD delivery should be included in the Tracker as soon as it is realised (i.e. the YTD achievement is classified as Green). The narrative should then describe that the YTD achievement relates to a scheme which has a potentially greater value but that element does not currently meet the Green/Amber criteria (hence why there is no forecast value). Once the full scheme meets the Green/Amber criteria, the future month profile can be added to the Tracker. This will ensure that you correctly include savings that have been achieved to date, in the correct month, and that you continue to exclude future forecast delivery for Red schemes until they meet the Green/Amber criteria.

Response

This has been noted, as per the narrative.

Anticipated Allocations (Table E) – Action Point 3.9

I note you are anticipating £0.320m relating to “Additional Pharmacy Funding 2019-20”. I have been advised by my colleague, Julie Broughton, that this should be removed from future submissions.

Response

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This funding has been removed from our Month 4 Anticipated income.

Welsh Risk Pool – Action Point 3.10

I refer to the email dated 24th July, from Alison Ramsey (NWSSP). This states that the original share of the £13.799m pressure has changed and for your Health Board this is now £2,351,478. I trust this now eliminates the original risk value included in Table A2 of £0.130m. The email also

refers to a higher overall forecast outturn following an assessment at Month 3, although NWSSP state this will be treated as a Risk (with an opportunity relating to higher income to be received from the Health Boards) at Month 4. Therefore, Health Boards are expected to record their share of this revised assessment as a risk in Table A2. This potential additional pressure should not form part of the monthly Income and expenditure assumptions exercise with NWSSP (both organisations exclude, as currently only a risk).
Response The risk has been updated in accordance with the requirements.
Pay Analysis (Table B2) – Action Point 3.11 The full year forecast for Pay was to be provided at Month 3. Please ensure this is completed for the Month 4 submission.
Response Apologies for the oversight, the full year forecast for Pay has been completed for Month 4 Submission.
PSPP (Table H) – Action Point 3.12 Please ensure you complete the YTD columns on the 10-day section of this table.
Response The YTD column on the 10-day section of Table H has been updated and will be completed in future quarterly submissions.

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 27.8.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Monthly Monitoring Report – Month 3**
Cyfarwyddwr Cyfrifol: Responsible Director:	Mrs Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Eric Gardiner, Finance Director, Provider Services
Craffu blaenorol: Prior Scrutiny:	The submission made to Welsh Government required Chief Executive and Director of Finance sign off.
Atodiadau Appendices:	App1 Monitoring report month 3

Argymhelliad / Recommendation:

Note the contents of the report that has been made to the Welsh Government about the Health Board's financial position for Month 3 of 2020/21.

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

To report to the Committee the completion of monthly reporting to the Welsh Government for Month 3 of 2020/21.

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m and is based on delivering savings of £45m.

The plan does not take into account the impact of Covid-19, and therefore it will change throughout the year. It is likely that spending will be higher than planned due to the pandemic response and it is unlikely that savings delivery will be as high as originally planned, particularly in the early months of the year.

Asesiad / Assessment & Analysis

Strategy Implications:

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

Options considered
Not applicable – report is for information only.

Financial Implications:

1.1 In-month position

- The in-month position is a £3.3m deficit, which is in line with the plan for Month 3.
- This position assumes that all Covid-19 costs incurred by the Health Board are fully funded. The cost of Covid-19 in June is £7.8m, £0.3m of which has been funded via Cluster funding. Anticipated income from Welsh Government of £7.5m has been included in the position for the remainder of the cost.

1.2 Year to Date Position

- At the end of Month 3, the Health Board is overspent by £10.0m, which is in line with the financial plan.
- The overall impact of Covid-19 on the year to date position is £44.7m, of which Intermediate Care Fund (ICF) and Cluster monies have funded £1.3m. £17.5m of Welsh Government income has been received to date and a further £25.9m funding anticipated in the position to fund these costs. The total amount of Welsh Government funding available has not yet been confirmed and is therefore a significant risk to the financial position.

	M01 £m	M02 £m	M03 £m	YTD £m
Covid-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	39.8
Lost income	1.2	1.4	1.2	3.8
Non delivery of savings	3.7	3.6	2.0	9.3
Elective underspend	(2.4)	(2.8)	(2.2)	(7.4)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.8)
Total Covid-19 costs	**31.1**	**5.8**	**7.8**	**44.7**
ICF funding	(0.3)	(0.7)	0.0	(1.0)
Cluster funding	0.0	0.0	(0.3)	(0.3)
WG funding - anticpated & received	(30.8)	(5.1)	(7.5)	(43.4)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**

WG funding received	(17.5)
WG funding anticipated	(25.9)
Total	**(43.4)**

1.3 Forecast

- Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year remains extremely difficult. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

Risk Analysis:

- There are four risks to the financial position totalling £125.1m and one opportunity of £5.6m. These are detailed in Section 3 of the attached report.

Legal and Compliance:
Not applicable.

Impact Assessment:
Not applicable.

MONITORING RETURN

MONTH 3 2020/21

Sue Hill

Acting Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION & FORECAST

1.1 Financial Plan

- The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m and is based on delivering savings of £45m.

- The plan did not take into account the impact of Covid-19, and therefore it will change throughout the year. It is likely that spending will be higher than planned due to the pandemic response and savings delivery will be significantly reduced as the Health Board prioritises the clinical and operational response to the pandemic, particularly in the early months of the year.

1.2 In-month Position

- The in-month position is a £3.3m deficit, which is in line with the plan for Month 3.

- This position assumes that all Covid-19 costs incurred by the Health Board are fully funded. The cost of Covid-19 in June is £7.8m, £0.3m of which has been funded via Cluster funding. Anticipated income from Welsh Government of £7.5m has been included in the position for the remainder of the cost.

1.3 Year to Date Position

- At the end of Month 3, the Health Board is overspent by £10.0m, which is in line with the financial plan.

- The overall impact of Covid-19 on the year to date position is £44.7m, of which Intermediate Care Fund (ICF) and Cluster monies have funded £1.3m. £17.5m of Welsh Government income has been received to date and a further £25.9m funding anticipated in the position to fund these costs. The total amount of Welsh Government funding available has not yet been confirmed and is therefore a significant risk to the financial position.

1. FINANCIAL POSITION & FORECAST

	M01 £m	M02 £m	M03 £m	YTD £m
Covid-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	39.8
Lost income	1.2	1.4	1.2	3.8
Non delivery of savings	3.7	3.6	2.0	9.3
Elective underspend	(2.4)	(2.8)	(2.2)	(7.4)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.8)
Total Covid-19 costs	**31.1**	**5.8**	**7.8**	**44.7**
ICF funding	(0.3)	(0.7)	0.0	(1.0)
Cluster funding	0.0	0.0	(0.3)	(0.3)
WG funding - anticpated & received	(30.8)	(5.1)	(7.5)	(43.4)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**

WG funding received	(17.5)
WG funding anticipated	(25.9)
Total	**(43.4)**

1.4 Forecast

- Due to the uncertainty around the costs of Covid-19 for the rest of 2020/21, forecasting a position for the year remains extremely difficult. However, the Health Board is anticipating that it will achieve the £40m deficit at the end of the year, as per the financial plan, on the basis that all Covid-19 costs are fully funded by Welsh Government.

2. UNDERLYING POSITION

2.1 Movement from Financial Plan (Table A)

- The underlying position brought forward from 2019/20 was a deficit of £57.7m, with an opening plan of £40m deficit.

- Following the suspension of the Recovery Programme in March, the delivery of savings schemes in the early part of the financial year was severely impacted. Further review of savings has been undertaken in Month 3 and there is an increasing number of schemes which are now in delivery. Savings of £1.6m are reported in Month 3, increasing the overall delivery to £1.7m for Quarter 1. The Month 3 figure includes some retrospective savings reported for schemes that were not identified in Month 2. Schemes currently in delivery have a forecast in-year value of £7.1m.

- The total in-year forecast for savings, including pipeline, has increased to £12.7m from the £10.9m reported in Month 2. This reflects a review of all schemes that were in the pipeline programme when the Recovery Programme was suspended, which has identified those schemes which can be mobilised rapidly to generate savings this year. Schemes that remain in the 2020/21 pipeline amount to £5.6m and work is progressing to move these into amber / green over the next three months. The expected movement is shown in the table below:

Amber/Green Date	Forecast Annual Savings £000	Forecast FYE Savings £000
Jul-20	2,801	2,966
Aug-20	396	590
Sep-20	2,425	5,454
Total	**5,622**	**9,010**

- The Health Board is currently considering options and capacity requirements for the savings delivery and PMO function to be re-established. This will enable dedicated capacity to be re-instated to not only drive the schemes currently identified, but also to develop further opportunities for both in-year savings and the 2021/22 programme.

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The below are risks to the Health Board's financial position for 2020/21.

	£m	Level	Explanation
Opportunities			
Red Pipeline Savings Schemes	5.6		Red rated savings schemes that total £5.6m are currently held in pipeline and are due to start delivering over the next three months.
Risks			
WG Covid-19 Funding	125.0		Income has been anticipated for the estimated cost of Covid-19 for 2020/21, less funding already received. Welsh Government has not yet confirmed that this will all be funded and so it is a significant risk to the financial position. The Health Board is working with Welsh Government regarding funding for the Covid-19 response. As the operational plan is developed, there will be greater confidence around the assumptions within the current forecast and any potential mitigating actions can be agreed.
Welsh Risk Pool Risk Share	0.1		The projected increased cost of the Welsh Risk Pool (WRP) Risk Share is a risk to the Health Board's forecast for 2020/21.
Hallett v Derby Hospitals NHS Foundation Trust			It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.
Flowers Judgement			NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement is ongoing and the outcome of the Supreme Court appeal is awaited.

4. INCOME & EXPENDITURE

4.1 Income (Table B)

- Income totals £142.6m for June.

- Confirmed allocations to date are £1,542.7m, with further anticipated allocations in year of £145.6m, a total forecast Revenue Resource Limit (RRL) of £1,688.3m for the year. £133.3m has been profiled into June, which is £4.8m higher than in May due to an increase in costs for Covid-19 and Prescribing.

- A reconciliation between the RRL phased into the position and an equal phasing is shown in the table below.

	Annual £m	Phased at M03 £m	3/12ths £m
RRL	(1,688.3)	(416.4)	
Less Covid-19 costs	142.5	43.4	
Non covid-19 budgets	(1,545.8)	**(373.0)**	(386.5)
Funding for specific purposes, e.g. Dementia / medical pay etc. - not phased in	43.9		11.0
Other costs phased within divisions for specific area, e.g. ICF			2.5
			(373.0)

- The impact of Covid-19 has resulted in lost income of £1.2m during June, which includes £0.6m of General Dental Services (GDS) patient income and £0.5m of English Non-Contracted Activity (NCA) income.

4.2 Expenditure (Table B)

- Expenditure totals £146.0m for Month 3, £4.3m higher than in Month 2.

- £7.3m expenditure is directly related to Covid-19, of which £4.4m is included in pay and £2.9m across non-pay expenditure categories. The latter includes spend of £1.0m relating to set-up and running costs for the three Field Hospitals.

- The impact of Covid-19 on the savings programme has resulted in planned savings of £2.0m not being achieved and this shortfall is included within non-pay. Some elective care procedures are now starting to be undertaken, but at a much lower level than pre-Covid. There is therefore a reduction in planned care spend of £2.2m across a number of non-pay categories. In addition, there is slippage on a number of planned investments of £0.5m.

Primary Care	– Despite a reduction in patient contacts and activity due to Covid-19, costs will not reduce significantly. General Dental Services (GDS) Contractor's will receive 80% of the agreed 2020/21 contract value, but other contract payments (such as rates and pension) remain

	fully protected. GP Practices are continuing to offer services, albeit with limited face-to-face patient access, and therefore are receiving the usual core General Medical Services (GMS) contract payments in full. – Costs of the main Dental contract have decreased by £0.8m in June, as the quarterly GDS figures have been reviewed and adjusted to reflect the 20% reduction in contract payments. However, due to loss of patient income GDS is currently forecast to overspend by £2.4m. – It has been identified that £0.5m of CHC costs arising from the response to Covid-19 had been incorrectly allocated to the Primary Care category in Months 1 and 2. These have been moved to Continuing Health Care in Month 3.
Primary Care Drugs	– GP prescribing and dispensing costs are a risk of significant concern in 2020/21. The rolling average annual cost continues on an unprecedented upward trend and although the first Prescribing data for 2020/21 (April 2020) was received this month and showed a reduced level of increase compared to March 2020, the data showed a significant rise in the cost of items compared to 2019 levels. Although we anticipated an unusually high expenditure level for April 2020, the actual costs for April were £0.6m higher than had been estimated, which has been adjusted in the Month 3 position. The April data has been used to update the average cost per prescribing day calculations, impacting on the estimates for May and June, which have also been reflected in the Month 3 position. As a result, the overall Prescribing costs have increased by £1.9m from the May reported level.
Provided Services - Pay	– Details are provided in Section 5.
Provider Services Non-Pay	– Covid-19 expenditure of £2.3m is included within Provider Services Non-Pay in June, a rise of £1.4m on last month. This is broken down as follows:

	£m
Clinical Services & Supplies	387
Establishment & Transport Expenses	52
General Services & Supplies	444
Other services	28
Premises and Fixed Plan	1,420
	2,331

4. INCOME & EXPENDITURE

	– It has been identified that £0.5m of CHC costs arising from the response to Covid-19 had been incorrectly allocated to the Provider Services Non-Pay category in Months 1 and 2. These have been moved to Continuing Health Care in Month 3.
Secondary Care Drugs	– Costs are £0.5m higher than in Month 2. The main increases were seen in drugs for Haematology (£0.2m) and Cancer (£0.2m). There has also been a rise of £0.1m in Age-related Macular Degeneration (AMD) as the services starts to resume elective treatment.
Healthcare Services provided by other NHS Bodies	– Due to the national agreement to maintain payments to other NHS organisations via block contracts, costs are generally fixed, despite those organisations only undertaking very low levels of activity on behalf of the Health Board. – There has been a reduction in Month 3 spend of £1.1m due to WHSCC reporting an under spend. Some developments have been delayed and there have been adjustments to some of the block contract payments.
Continuing Health Care (CHC) and Funded Nursing Care (FNC)	– Expenditure in June has increased by £0.9m, which relates to the £1.0m adjustment to move Covid-19 related CHC costs from Months 1 and 2 to the correct heading. These costs arise from patients being moved into CHC placements to create capacity in acute settings. Additional Covid-19 related costs of £0.7m were incurred in Month 3, to give a year to date total of £1.7m. – Excluding these costs, CHC expenditure is £0.8m less than last month. Ongoing efforts to review placements and packages particularly for those patients discharged due to Covid-19 continue, which has reduced overall CHC patient numbers and costs. Part of the reduction in-month is due to delays experienced in moving patients into Care Home placements, due to the restrictions around Covid-19. However, this situation is expected to ease over the coming weeks and the Health Board anticipate that CHC patient numbers (and costs) will increase in the coming months.
Other Private and Voluntary Sector	– There has been no material change from Month 2. Expenditure relates to a variety of providers, including hospices and Mental Health organisations.
Joint Financing	– Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget.

Losses, Special Payments and Irrecoverable Debts	– Includes Redress, Clinical Negligence, Personal Injury and loss of property. – In Month 2, £0.3m of Covid-19 expenditure was included in this category, relating to charges anticipated from the hosts of the Field Hospitals for loss of their commercial income. Following discussions, these costs have been moved in Month 3 from Losses to Rent costs within Provider Services Non-Pay.
Capital	– Includes depreciation and impairment costs, which are fully funded.

4.3 Forecast (Table B)

- Pay costs are forecast to increase in September, which reflects the payment of the Doctors' and Dentists' Review Body (DDRB) pay award and also the anticipated opening of the Field Hospitals.

5. PAY EXPENDITURE

5.1 Pay (Table B2)

- Pay costs in June are £68.2m, with Provided Services pay costs totalling £70.1m.

- Provided Services pay costs are £2.0m higher than in May due to an increase in Covid-19 related pay of £2.4m. Total pay costs directly related to Covid-19 in June were £4.4m. Student costs have increased by £1.2m in June due to the employment of student nurses as part of the Covid-19 response.

- Primary Care pay costs have remained at £2.0m.

5.2 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 3 are £3.5m, representing 4.9% of total pay, an increase of £0.3m on last month. Agency spend related to Covid-19 in June was £0.5m, compared to £0.3m in May, accounting for most of the increase in overall agency spend.

- Medical agency costs have increased by £0.1m to an in-month spend of £1.5m. The additional costs incurred in June are all directly related to Covid-19 (total of £0.2m).

- Nurse agency costs totalled £1.2m for the month, £0.2m higher than in May. These costs include £0.1m relating to Covid-19.

- Other agency costs remained at £0.7m for June and mainly arise from Admin and Clerical (£0.4m, of which £0.2m relates to Covid-19) and Allied Health Professionals (£0.3m).

6. COVID-19 ANALYSIS

6.1 Covid-19 Actual Costs (Table B3)

- Expenditure related to Covid-19, including the Field Hospitals, is £7.3m in June. £0.3m of funding from Cluster funds has been used, leaving a net cost of £7.0m. In addition there is £1.2m of lost income and £2.0m of undelivered savings, offset by elective care savings of £2.2m. The overall impact of Covid-19 in June is therefore £7.5m and income from Welsh Government to match this cost has been anticipated in the position.

- Covid-19 pay costs have increased by £2.3m in Month 3, with £1.1m of this relating to students. Band 3 and 4 student nurses (second and final year status respectively) were recruited by the Health Board as a nursing initiative, centrally facilitated by workforce colleagues, in response to the Covid-19 pandemic. The majority of these staff commenced in post in Month 2, but no costs were reported. Therefore, Month 3 includes two months costs for these posts. European Development Funding (EDF) is anticipated in support, however details are yet to be confirmed. The cost of these posts has been charged to Covid-19.

- An additional £0.3m of costs have been incurred in the establishment of the Field Hospitals, taking the total cost to £23.6m. It is not expected that there will be any further set-up costs. Running costs for the Field Hospitals total £1.9m for the year to date (£0.7m in Month 3).

6.2 Covid-19 Forecast Costs (Table B3)

- The forecast costs and expenditure relating to Covid-19 will be reviewed and revised as the Health Board develops and adjusts the plan.

- Specific assumptions made are:

    - The overall cost of Covid-19 to the Health Board will be fully funded by Welsh Government.

    - Savings delivery for the year will be reduced against the plan of £45m and indicative estimates are that this will be £7.1m, although there are £5.6m of red rated schemes in the pipeline, which it is anticipated will increase savings delivery this year to £12.7m.

    - Costs for decommissioning the field hospitals are currently estimated at £2.2m, to be incurred in March.

    - Elective under spends will continue for the rest of the year. Some elective work was undertaken in May and June. It is expected that activity will increase over future months, but full capacity will not be reached in 2020/21 due to the

requirements of social distancing for staff and patients. The Health Board is continuing to use the local private hospital to support elective activity, the cost is estimated to be £0.9m and is included in the forecast from July.

7. WELSH NHS ASSUMPTIONS

7.1 Income/Expenditure Assumptions (Table D)

- All Welsh NHS contracts have now been agreed and signed.
- An adjustment to the WHSCC position was notified to the Health Board after the position had been closed. This is a timing difference and will be corrected in the Month 4 return.
- There will be a variance of £0.13m with Velindre, reflecting the WRP forecast outturn, which is being shown as a risk and therefore not included in our position.

8. RESOURCE LIMITS

8.1 Resource Limits (Table E)

- The Health Board has anticipated income of £125.9m to fund the costs of Covid-19 for 2020/21. This funding has not been confirmed and is therefore listed as a significant risk to the financial position.

- The Health Board has not included the anticipated funding required for the additional 0.8% nationally agreed inflation to fund the Block contracts with NHSE. The annual cost for BCU managed contracts for this will be approx. £0.5m. WHSSC have still to advise what the BCU element of their uplift will be.

9. CASH

9.1 Cash Flow Forecast (Table G)

- The closing cash balance at 30th June was £4.1m, which included £1.4m cash held for revenue expenditure and £2.7m cash held for capital projects.

- Table G – Monthly cash flow forecast currently forecasts a shortfall of £37.3m for the year. In order to maintain the opening revenue balance of £1.5m the total cash requirement for the year would increase to £38.7m. This assumes a nil capital cash balance at the end of March.

- The total forecast cash requirement of £38.7m consists of £34.0m to support the forecast deficit position as per Table B, £2.6m in respect of revenue working capital balances and £2.1m in respect of capital resource allocations that the Health Board did not request during 2019/20.

- As in previous years, the Health Board will consider all possible actions to minimise the level of Strategic Cash Assistance required to enable payments to continue through to the end of the year. Current forecasts are that £6.0m of cash pressures resulting from the 2020/21 deficit position can be managed internally and this will be reviewed as further opportunities arise.

- A full analysis of forecast revenue and capital cash movements during 2020/21 is provided below:

Revenue cash requirements	**£000**
Forecast revenue deficit	(40,000)
Forecast revenue deficit to be managed internally	6,000
Working capital balances	(2,622)
Forecast revenue cash shortfall	**(36,622)**

Capital cash requirements	**£000**
Forecast cash funding	
Opening capital balance	1,698
Approved Capital Resource limit	23,107
Donated asset income	800
Disposal proceeds	150
Total forecast cash funding	**25,755**

9. CASH

Forecast cash spend	
Opening capital balance	(1,698)
Approved Capital Resource limit	(23,107)
Donated asset income	(800)
Disposal proceeds	(150)
Reduction in capital creditors (CRL not requested during 2019/20)	(2,109)
Total forecast cash spend	**(27,864)**
Forecast capital cash shortfall	**(2,109)**

Forecast total revenue and capital cash shortfall	**(38,731)**

- Cash requirements currently exclude any pressures from in-year movements in provisions, as these will be updated following the provision commission exercise in November 2020.

10. PUBLIC SECTOR PAYMENT COMPLIANCE

10.1 PSPP (Table H)

- The Health Board achieved the PSPP target to pay 95% of valid invoices within 30 days of receipt in three of the four measures of compliance during Quarter 1.

- NHS invoices by number were below target at 92.0%, which equates to the Health Board paying 47 invoices later than the required 30 days. Whilst performance during April, when only 89.2% of invoices were paid within target, impacted adversely on this measure, the subsequent improved performance is expected to be maintained in coming months.

- Achievement in all categories of the 10-day measure was lower during Quarter 1 than the equivalent period in 2019/20. This was largely due to the Health Board transitioning to a new reporting methodology that measures performance in calendar days rather than working days, to ensure consistency with other NHS Wales organisations.

11. CAPITAL

11.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2020/21 is £23.1m. Actual expenditure up to June was £3.3m, which was £1.3m ahead of plan. This is primarily due to Covid-19 expenditure, which totals £1.6m and for where there was planned spend of £0.4m.

11.2 Capital Programme (Table J)

- The Capital Programme update is reported in Table J.

12. WELSH NHS DEBTORS

12.1 Welsh NHS Debtors (Table M)

- At the end June, the Health Board had four NHS Wales invoices outstanding over eleven weeks and which had been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales. The total outstanding value was £0.028m.

- Payment for one of these invoices was received prior to the Monitoring Return submission date and the Health Board has been advised that a further invoice will be paid shortly. The remaining two invoices both relate to accruals that were agreed as part of the year-end Agreement of Balances exercise.

13. GMS & GDS

13.1 GMS (Table N)

- At the end June, the Health Board reported a £0.2m over spend position against the ring-fenced General Medical Services (GMS) allocation. This is mainly due to the increasing costs of drugs reported through GMS Dispensing and Managed Practices, particularly in relation to locum GP costs. However, this is offset by slippage on Partnership Premium / Seniority payments and Enhanced Services. As at the 30th June, the Health Board is managing 16 practices and we are not aware of any further resignations at this stage in the financial year.

- Based on the Quarter 1 data, expenditure is currently forecast to overspend by £1.1m against the ring-fenced allocation of £134.6m and £0.8m against the current plan. However, we are expecting further contractual changes during the year, which may require the forecast to be amended.

	£000
Revenue Resource Allocation	134,587
Forecast out-turn	135,669
Forecast overspend	**1,082**

13.2 GDS (Table O)

- At the end June, the Health Board reported a £0.3m over spend position against the ring-fenced General Dental Services (GDS) allocation. The reason for the over spend was loss of the Patient Charge Revenue (PCR) exceeding the 20% contract reduction agreed across Wales.

- The Health Board was forecasting a breakeven position for 2020/21; however, following the confirmation from Welsh Government that they are continuing to provide contractual support to dentists for a further three months at 90% (ending 30th September) the forecast has now been amended to reflect this. The current forecast is £2.4m over spent for the year, which is again the difference between the anticipated PCR income reduction and the reduced contractual payments and is therefore a cost of Covid-19 within the GDS ring-fence.

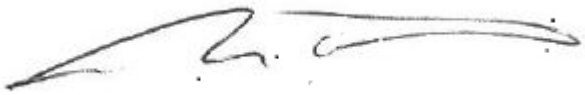
	£000
Revenue Resource Allocation	28,419
Forecast out-turn (net of dental service income)	30,770
Forecast overspend	**2,351**

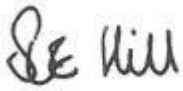
14. SUMMARY

14.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.

- The Month 3 Monitoring Return will be received by the Health Board's Finance and Performance Committee members during July 2020.





Simon Dean
Interim Chief Executive

Sue Hill
Acting Executive Director of Finance

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Month 2 Monitoring Return Responses

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 1.1a

Thank you for the explanation of the difference between the c/f underlying deficit position reported in the M12 MMR and that reported as the b/f position in your Month 1 submission. Whilst one element relates to timing differences between the MRs and the Opening Plan, there was also an element relating to the omitted assessment of the FYE of 19/20 cost pressures. I acknowledge your commitment to ensuring this takes place on a monthly basis going forward.

The FYE of recurring pressures is now reported as £6.170m; whilst I acknowledge the £0.980m relates to Prescribing, as discussed at meeting, please describe what areas of spend the balance of £5.190m relates to and provide a broad explanation to support of your methodology.

Response

The £0.980m relates to prescribing, which was included in the M12 return.

The £5.190m is within the 2020/21 financial plan and relates to the below:

FYE Cost Pressure	**£**
MIU extended hours in Community Hospitals	0.18
Commissioning and Contracting	2.02
Estates and Facilities non pay pressures	1.00
Microsoft 365 Roll out	0.50
Informatics WCCIS	0.41
Primary Care – DECLO	0.07
SICAT	0.60
Blood Products	0.41
Total	**5.19**

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 1.1b

Please provide details of the income that is described as ‘Non-Rec Support’, which has created a pressure.

Response

The £5.91m described as Non-Rec Support is non-recurring slippage of expenditure and investments in 2019/20, which enabled BCU to report a position of £49.12m overspend.

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 1.2

I acknowledge your responses to AP 1.2 and 1.4; please can you clarify if the New Cost Growth value of £34.8m includes the A4C uplift costs.

Response

We confirm the New Cost Growth of £34.8m includes estimates for pay inflation of which part is the A4C pay inflation.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 2.1

I wish to take this opportunity to provide additional clarity to all organisations, on the principles regarding the FYE of recurring savings.

All planned recurring saving schemes will have been assessed for their FYE i.e. the total savings value that would be delivered in a year if a scheme was operating at 100% for a full 12 months. The difference between your 'in year' delivery and the FYE delivery (known as the FYE adjustment) forms part of your planned c/f underlying position into 2021/22.

Those schemes that did not meet the Green or Amber criteria at Month 1, and included under "Planning Assumptions still to be finalised at Month 1", are automatically removed in the 'movements' section with the reversal matching the original planned assumption.

Any future amendment to the original planned delivery and FYE value of finalised schemes are to be recorded in the 'movements' section.

If a M1 finalised scheme has no 'in year' delivery, whether due to Covid-19 or other reasons, then an amendment should be made in the 'movements' section (line 14 or 15 as appropriate), to remove, in full, the original in year delivery and FYE planning assumption (i.e. this may deteriorate your overall forecast underlying position c/f into 2021/22).

If a M1 finalised scheme has a lower in year delivery value because the scheme has been delayed, whether due to Covid-19 or other reasons, then the original planned FYE value may still be valid. Therefore, you may not need to reflect an amendment in the FYE column on lines 14/15 (i.e. the delay has not changed the original FYE value assumption and therefore the delay has no impact on your original planned forecast underlying position c/f into 2021/22).

For organisations that are currently reporting partial non delivery of identified savings due to Covid-19; please confirm that this assessment included a review of the FYE value as this will enable us to understand the maturity of your forecast data.

If you have any queries about the reporting of your FYE of savings, please do not hesitate to get in touch.

Response

Thank you for the guidance. As you have recognised BCU did not declare any Month 1 savings as these had not quite converted to amber or green.

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 2.2

I acknowledge that you are now reporting the delivery of an element of your savings plan, with identified savings of £1.741m, which commenced this month. I refer to the above AP (2.1) to ensure the FYE value reflects an accurate assessment.

Response

We confirm the FYE value of the additional savings identified is calculated in accordance with the guidance.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 2.3/1.6

I acknowledge the reduction this month, in non-delivery of savings due to Covid-19 and your assertion that a detailed review of savings schemes will be completed by your next return. You state that you anticipate a movement from red rated schemes into amber or green and I hope this translates into a change at Month 3; however, if this is not the case, please include the timescales for doing so by scheme as part of your Month 3 narrative. Following on from my previous letter, any remaining red schemes should not be supporting your forecast outturn. These should be included in the Opportunities to achieve IMTP/AOP section of Table A2.

Response

We confirm that all remaining red schemes have been removed from Table A, and are now included in the Opportunities to achieve IMTP/AOP section of Table 2.

The narrative in the Month 3 report includes details of projected timescales for translation to green / amber for these remaining red schemes.

Risks (Table A2) – Action Point 2.4

Linked to AP 2.2 above, please confirm that an assessment against your forecast delivery of identified savings has been completed to support that you are currently reporting 'no' risk of non-delivery.

Response

The forecast of each scheme is reviewed on a monthly basis, and is as current and as accurate as possible. This is reflected in Table A. As such, we have assessed that it would not be appropriate to report a risk of non-delivery of schemes covered in Table A. The additional savings requirement will now be addressed through the IMTP/AOP section of Table 2 and will be updated monthly to reflect the latest forecast, thereby taking into account risks.

Risks (Table A2) – Action Point 2.5

I note that you have included the difference between the NWSSP WRP forecast outturn and your committed expenditure as a Risk (£0.130m). Whilst this is acceptable for the first half of the year, I would not however expect you to recognise the full value in Table D until it forms part of your outturn (i.e. the difference between what is included in your respective forecast outturns, should be shown as a variance, which in turn is explained by the risk).

Response

Table D has been amended in Month 3 for the WRP forecast outturn, as this is still being shown as a risk. There will therefore be a variance of £0.13m with Velindre.

Risks (Table A2) – Action Point 2.6

I note your response to AP 1.7 and your concerns around drugs and prescribing cost pressures, via the assessments in your financial plan, as well as the supporting MR narrative. Please advise what pro-active actions the HB is considering should the requirement to mitigate this

pressure become necessary.

Response

The cost pressure within GP Prescribing is predominately due to tariff price increases (agreed by the DoH) and this is due to supply issues, both of which are outside of the Health Board's control. To mitigate this during Covid-19 period, the Medicines Management Team will implement a temporary Local Enhanced Service with GP Practices which focuses on polypharmacy prescribing control and best prescribing practice for Frailty (to ensure the wellbeing of frail/shielding patients). A significant part of the temporary LES is focussed on direct control of prescribing in metrics defined by the AWMSG, particularly with respect to drugs of limited clinical value/less suitable for prescribing, 'special' drug procurement and drugs which are in the BLUE or RED categories and should not be prescribed in Primary care

From the 1st April 2021, the original Local Enhanced Clinical Effectiveness Service agreed with the LMC will commence, which focuses on the quality and the best use of medicines to obtain cost effect, value for money use of drugs in Primary Care. These 2 measures are seen to be the most effective way to try and mitigate some of the unprecedented drug tariff increases seen in 2020/21 and beyond.

Risks (Table A2) – Action Point 2.7

As discussed at our meeting, please make use Table A2 to reflect any risks or opportunities, particularly around your assumptions on the Covid-19 pressures reported in Table B3. This may be relevant regarding current assumptions around TTP or future capacity usage of Field Hospitals, for example.

Response

The forecast for Covid Expenditure is offset by anticipated WG funding. As forecasts are refined for TTP, activity for Field Hospitals or for any other reason, the anticipated funding is adjusted to reflect the change.

The risk to BCU is that the actual funding is lower than the anticipated funding, and this risk is identified in Table A2.

If BCU are required to fix the anticipated funding at a set level, the risk will then change to assumptions as to if our forecast is sufficient for the projected costs.

Covid-19 (Table B3) – Action Point 1.11

I refer to AP 1.11 relating to the release of resources from your Financial Recovery Programme and your response which stated this was noted and has been reviewed for Month 2. As there are no changes reported this month, it is not clear if the review was undertaken. Please provide an update and supporting information for any value reported at Month 3.

Response

This was reviewed for Month 2, and will continue to be reviewed on a monthly basis.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Covid-19 (Table B3) – Action Point 2.8

I refer to the Chief Dental Officer's letter of the 22 May 2020 notifying Health Boards that from 1 July to 30 September 2020 dental practices with NHS contracts will receive 90% of their Annual Contract Value. Please confirm that your data reflects this position and that your forecast for loss of patient charge income reflects the slightly increased activity being undertaken by practices from July.

Response

We confirm our data reflects the 90% Annual Contract Value up to the end of September. Our forecast of loss of patient charge revenue is currently 100% for Q1, however we will be updating our forecast for the rest of the year following a recent meeting with the CDO and WG representatives reflecting their views of the likely patient charge revenue for this year.

Covid-19 (Table B3) – Action Point 2.9

I note you are reporting decommissioning costs under 'Other' (line 91). For consistency, please include these costs on the 'Decommissioning' line (67) in future submissions.

Response

Decommissioning costs have been moved to line 67 for the Month 3 return.

Covid-19 (Table B3) – Action Point 2.10

Please explain why the WTE for Returning Healthcare Scientists was 2.4 in M1 (assume £3k reflects part month effect), zero in M2 but forecast to increase to 2.0 £13k pm for the rest of the year.

Response

This is for a Healthcare Scientist who is being paid on a timesheet basis.

Covid-19 (Table B3) – Action Point 2.11

Please explain your reasoning behind the phasing of the WHSSC Developments over the first quarter (£0.130m YTD). My baseline expectation is that the YTD would agree to the YTD development slippage position reported by WHSSC with the balance forecast over the remaining months.

Response

Thank you for the further explanation of this point. We will ensure the annual forecast is allocated correctly over future months.

Covid-19 (Table B3) – Action Point 2.12

The loss of income of the field hospital venues has been quantified as £3.5m. This is notably higher than forecasts of similar expenditure from other organisations. This value also includes

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

£0.3m of potential lost income in May when the facilities were not available for use and no losses would have been incurred that were the linked to the NHS. Please review this assumption and provide further explanation if not amended at Month 3.
Response The loss of income is still under debate and dispute, but was estimated based upon the best knowledge at the time in line with the prudence concept. Discussions have moved forward and the estimate adjusted and forecast further refined for Month 3.
Covid-19 (Table B3) – Action Point 2.13 I note the additional expenditure with the Private Sector on (line 60) and your narrative states this related to a local provider assisting with elective work. Please confirm that this arrangement is outside of the one between WHSSC and the Private Providers.
Response The arrangement is an extension to the existing WHSSC and the Private Providers contract.

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee 27.8.24**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Summary of business considered in private session to be reported in public**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director Finance
Awdur yr Adroddiad **Report Author:**	Diane Davies, Corporate Governance Manager
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the report

Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)

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

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Finance and Performance Committee considered the following matters in private session on 16.7.20

- 2019/20 monthly monitoring report
- Mental Health Rehabilitation business case update
- Wrexham Maelor hospital continuity programme– procurement of external support
- Procurement of Covid19 ventilation essential equipment
- Medical and Dental Agency Locum monthly report