

## Bundle Finance & Performance Committee 29 October 2020

- 1 FP20/121 Apologies for absence  
*Helen Wilkinson*
- 2 FP20/122 Declaration of Interests
- 3 09:30 - FP20/123 Draft minutes of the previous meeting held on 30.9.20 and summary action plan  
FP20.123a FPC Draft minutes 30.9.20 v.02.docx  
FP20.123b Summary action log.doc
- 4 09:50 - FP20/124 Diagnostic and Treatment Centre pre strategic outline case  
*Gill Harris*  
*Gavin Macdonald / Andrew Kent in attendance*  
*Recommendation:*  
*The Committee is asked to review the presented options and confirm intentions for progress to development of Strategic Outline case and development of a DTC business case project*  
FP20.124 Diagnostic Treatment Centre pre-SOC version v 6.pdf
- 5 10:20 - FP20/125 Robotic Surgery business case  
*Mark Wilkinson*  
*Recommendation*  
*The F&P Committee is asked to approve the recommendation laid out in the attached paper that:*  
  - The plans described here in are supported.*
  - The Health Board (HB) progress to securing a lease arrangement (7 year with break out option at the end of year 3), for Robotic Assisted Surgery (RAS) technology to be provided at YG.*
  - That RAS will support urology services in the first instance, with view to maximizing opportunities for other specialties in due course.*
  - That the HB remains committed to the All Wales RAS programme and will ensure that this lease agreement is managed in line with the All Wales programme rollout plan.*FP20.125a Robotic Assisted Surgery Cover sheet V2.docx  
FP20.125b Robotic Assisted Surgery V8 post ET review.docx
- 6 for assurance
- 7 10:40 - FP20/126 Winter Plan 2020/21  
*Gill Harris*  
*Gavin Macdonald*  
*Recommendation*  
*The Committee is asked to note the work being done to strengthen delivery over winter 2020-21, alongside the Covid-19 pandemic response, which includes bed capacity modelling, and potential schemes developed by the health communities, in partnership with Local Authorities in order to support delivery over winter.*  
FP20.126a BCU Winter Resilience Plan.docx  
FP20.126b BCUHB overarching Winter Resilience Plan template\_draft v 0.07\_CB.docx  
FP20.126c Winter plan slides.pptx
- 8 11:00 - FP20/127 Quarter 2 monitoring report  
*Mark Wilkinson*  
*Recommendation*  
*The Committee is asked to note the report*  
FP20.127a Q2PMR for FP Committee - September 2020.docx  
FP20.127b BCU Quarter Two Plan Monitoring Report - September 2020 FINAL.pdf
- 8.1 11:15 - FP20/127.1 Q3/4 Plan 'Annex D' supporting Minimum Data Set  
*Mark Wilkinson*  
*Recommendation*  
*It is recommend that F&P Committee:*  
  - Receive this report and the assurance that our Q3/4 plan is underpinned by a completed 'Annex D' which is a supporting technical Minimum Data Set (MDS) to accompany our plan*
  - Provide necessary scrutiny to the full Annex D minimum dataset profiles which underpin our Q3/4 plan prior to presenting the summary narrative and action plan to board in November for approval.*FP20.127.1a Q3\_4 Plan 'Annex D' supporting Minimum Data Set.docx  
FP20.127.1b Q3\_4 Plan 'Annex D' supporting Minimum Data Set FINAL.pdf
- 9 11:25 - Comfort break
- 10 11:35 - FP20/128 Quality and Performance report

Mark Wilkinson

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*

FP20.128a QaP.docx

FP20.128b QaP Report FP - September 2020 FINAL.pdf

11 11:55 - FP20/129 Orthopaedics business case update

Mark Wilkinson

Recommendation

*It is recommended that the Committee notes :*

- *the rationale for the potential revision of the current orthopaedic case, including the contextual drivers for change.*
- *the engagement strategy undertaken with the clinical teams and the subsequent option appraisal conducted.*
- *the alternative model clinically agreed and proposed following full consideration of the emerging Diagnostic & Treatment Centre (DTC) model.*
- *the proposed timescale for the completion of a revised orthopaedic business case.*

FP20.129.1 Orthopaedic Briefing Paper 23.10.20 v3.docx

12 12:15 - FP20/130 Unscheduled Care and Building Better Care update

Gavin Macdonald

*Presentation to be provided by Stephen Harrhy Board Director / Chief Ambulance Service Commissioner Cwm Taf Morgannwg University Health Board*

Recommendation

*The Committee is asked to note the Unscheduled Care performance for September 2020 across BCUHB and for each Health Community*

FP20.130 USC REPORT v1.0.docx

FP20.130b Stephen Harrhy presentation\_Unscheduled Care.pptx

14 12:30 - Break

15 13:00 - FP20/131 Finance Report Month 6

Sue Hill

Recommendation

*The Committee is asked to note the report*

FP20.131 Finance Report M06.docx

15.1 13:25 - FP20/132 Financial Governance Cell – Update on Controlled Self-Assessment

Sue Hill

Recommendation

*The Committee is asked to:*

- Note the collaborative work undertaken through the Financial Governance Cell*
- Note the Areas of Good Practice and the Lessons Learned suggestions from the Governance Cell.*
- Consider the next steps (Draft Action Plan) and the future role of the Governance Cell.*

FP20.132 Financial governance update report Oct 20 v1.0.pdf

15.2 13:40 - FP20/134 Q3/4 finance update

Sue Hill

Recommendation

*The Committee is asked to note the financial impact of the agreed revisions to the operational plan submitted to WG on the 19th October and the affordability of the plan and the funding risk.*

FP20.134 Quarter 3-4 Plan\_finance update.docx

15.3 14:00 - FP20/135 Financial Plan and budget setting 2021/22

Sue Hill

Recommendation

*The Committee is asked to note the approach to budget setting for 2021/22*

FP20.135a Budget Setting Framework and Timetable 2021\_22.docx

FP20.135b ANNEX 1 Budget Setting Framework and Timetable for 2021\_22.DOCX

16 14:15 - FP20/136 Capital Programme report Month 6

Mark Wilkinson

Neil Bradshaw in attendance

Recommendation

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

FP20.136a Capital Programme M6 report.docx

FP20.136b App 1 Capital Governance Structure - August 2020.pptx

20 for decision

21 FP20/137 Business Cases / Contracts for approval

- 21.1 14:30 - FP20/137.1 BCU Symphony / National WEDS (Welsh Emergency Department System) revenue business case  
*Chris Stockport*  
*Recommendation*  
*The Committee is asked to approve the BCU Symphony / National WEDS Revenue Business Case to allow a phased implementation of the BCU Symphony in West and East Emergency Departments and all Minor Injury Units (MIU) in BCU, in readiness for the fully integrated WEDS solution (which includes Central Emergency Department).*  
FP20.137.1 BCU Symphony National WEDS Revenue BC v5.2.1 October 2020.docx
- 21.2 14:50 - FP20/137.2 North Denbighshire Community Hospital  
*Mark Wilkinson*  
FP20.137.2a NDCHBC template.docx  
FP20.137.2b NDCHBC FBC Draft 0.20.docx  
FP20.137.2c NDCHBC Appendix A Health Impact Assessment NDCH Rhyl.doc  
FP20.137.2d NDCHBC Appendix B Equality Impact Assessment EQUIA Screening (parts A and B) NDCH v06.docx  
FP20.137.2e NDCHBC APPENDIX C - Benefits Plan v17.docx  
FP20.137.2f NDCHBC Appendix D - Financial Case.pdf  
FP20.137.2g NDCHBC Appendix E - Economic.pdf  
FP20.137.2h NDCHBC Appendix F - NDCH FBC Programme Rev C Opt 2AA 24.09.20.pdf  
FP20.137.2i Appendix G - NDCH Risk Register 201021.pdf  
FP20.137.2j NDCHBC appendix H - Governance Framework.docx
- 21.3 15:10 - Comfort break
- 24 15:20 - for information
- 24.0 FP20/138 Shared Services Partnership Committee quarterly assurance report (1st July 2020 – 30th September 2020)  
*Sue Hill*  
*Recommendation*  
*The Committee is asked to note the report*  
FP20.138a NHS WALES SHARED SERVICES PARTNERSHIP SUMMARY PERFORMANCE REPORT.docx  
FP20.138b Appendix 1 NHS WALES SHARED SERVICES PARTNERSHIP SUMMARY PERFORMANCE REPORT.docx  
FP20.138c Appendix 2 NHS WALES SHARED SERVICES PARTNERSHIP SUMMARY PERFORMANCE REPORT.docx
- 24.1 FP20/139 Cross Border Block Contracts Update  
*Sue Hill*  
*Recommendation:*  
*The Committee is asked to:*
  - *Note the level of delivery within the Health Board managed Cross Border Block Contract arrangements up to Month 5*
  - *Note the year on year activity reductions within the Health Board managed Cross Border Block Contract arrangements up to Month 5*
  - *Note the level of delivery within the material WHSSC managed Cross Border Block Contract arrangements up to Month 5*
  - *Note the latest position regarding Block contract arrangements for the period months 7 to 12*FP20.139 Block Contract Update report.docx
- 24.2 FP20/140 Monthly monitoring reports - Month 6 and 5  
*Sue Hill*  
*Recommendation:*  
*Note the contents of the report that has been made to the Welsh Government about the Health Board's financial position at Months 5 and 6 2020/21.*  
FP20.140a Monitoring Return Month 6 cover sheet.docx  
FP20.140b MR Report M06 2021 updated 14.10.20.doc  
FP20.140c Monitoring Return Month 5 cover sheet.docx  
FP20.140d MR Report M05 2021.doc
- 24.3 FP20/141 Summary of Private business to be reported in public  
*The Committee is asked to note the report*  
FP20.141 Private session items reported in public v1.0.docx
- 25 FP20/142 Issues of significance to inform the Chair's assurance report

26 15:20 - FP20/143 Date of next meeting 22.12.20

27 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 30.9.20**  
**via Webex**

**Present:**

Mark Polin	BCUHB Chairman / Committee Chair
John Cunliffe	Independent Member / Committee Vice Chair
Eifion Jones	Independent Member

**In Attendance:**

Andrew Doughton	Wales Audit representative – to observe
Arpan Guha	Deputy Medical Director
Sue Green	Executive Director Workforce and Organisational Development (OD)
Gill Harris	Acting Chief Executive
Sue Hill (SH)	Acting Executive Director of Finance
Andrew Kent (AK)	Interim Head of Planned Care Improvement ( <i>part meeting</i> )
Gavin Macdonald (GH)	Interim Chief Operating Officer ( <i>part meeting</i> )
Llinos Roberts	Executive Business Manager to Chairman
Emma Wilkins	Deputy Director, Financial Delivery Unit (FDU)
Mark Wilkinson (MW)	Executive Director Planning and Performance ( <i>part meeting</i> )
Diane Davies	Corporate Governance Manager (Committee Secretariat)

Agenda item	Action by
<b>FP20/113 Apologies for absence</b>  Received from David Fearnley (for whom Arpan Guha deputised) and Helen Wilkinson	
<b>FP20/114 Declarations of Interest</b>  None received	
<b>FP20/115 Draft minutes of the previous meeting held on 27.8.20 and summary action log</b>  It was agreed that the minutes were an accurate record and the summary action log would be addressed at the next meeting.  In respect of the briefing notes provided to members, it was noted that: <ul style="list-style-type: none"> <li>the booking process efficiency programme timeline encompassed 1.10.20 to the end of quarter 3.</li> </ul>	

- the Acting Chief Executive would join the Chairman in meeting with the Secondary Care Medical Director to discuss Urology services
- the Acting Executive Director of Finance assured that Welsh Government (WG) were aware of BCU's loss of income relating to non-contracted activity (NCA) due to the Covid19 pandemic.

### **FP20/116 Planned Care update including Diagnostic and Treatment Centre**

*The Interim Head of Planned Care Improvement joined the meeting and provided a powerpoint presentation.*

**FP20/116.1** The challenges were highlighted as: planned care had been significantly disrupted due to the Covid pandemic, long waits over 36 weeks had increased to over 30,000 and activity was at 37% of last year's level for Inpatient/Day cases. It was noted that should the current activity runrate remain, patients with long waiting times could increase to 60,000 by March 2021. Turn around times in theatres had improved although theatre and ward capacity had decreased due to Covid guidance. Essential services were still being maintained but at reduced activity; the recommencement of services within a reduced footfall was taking longer than expected and whilst WG had introduced a risk stratification approach, only guidance on stage 4 had been provided to date.

**FP20/116.2** The actions highlighted comprised of: essential service being maintained with weekly/monthly monitoring to ensure compliance and increase to meet demand, risk stratification for stage 4 and planned had been implemented, "Once for North Wales" approach for high risk specialties was being implemented, recommencement of routine services was being planned, with an expected increase in September. Out Patient Department activity for Cancer was almost back to pre-covid levels, routine referrals were slower, virtual clinics were being planned for further roll out, See On Symptoms (SOS) and Patient initiated Follow up (PIFU) toolkits were also complete and being rolled out and it was noted that the Orthopaedic network plan was being implemented, although the strategic business case required significant review.

**FP20/116.3** In respect of progress to date it was noted that essential service was being maintained, risk stratification was being implemented for stage 4 and planned, a Task and Finish group to cover IT governance and Patient Administration System to measure risk stratification was in place and there had been clinical engagement in respect of the new approach. In terms of Once for North Wales for P2/3 patients the live dates were reported as : Endoscopy & Ophthalmology (August), General surgery (August/September), Orthopaedics (August/September) and the Outpatient department (OPD) programmes - SOS/PIFU were now business as usual. Virtual clinics required a further push due to roll out issues. Progress was also noted regarding a review of diagnostic extra capacity for endoscopy and CT, applying this to a diagnostic and treatment centre approach as an option, options for non-operative pathways/primary care and field hospital usage and that BCU's Winter plan was key along with a working relationship with unscheduled care

**FP20/116.4** Risks were highlighted as: screening programmes re-start increased the risk for endoscopy/breast/diagnostics, increased routine referrals, Winter plan requires close integration 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 an improved communication strategy, reduced capacity will entail patients waiting much longer within P4 risk stratification, non-operative pathways may require investment and upscaling. A full review of the risk register would be required in August/September to incorporate new risks.

**FP20/116.5** The Interim Head of Planned Care Improvement drew attention to the increased forecasts highlighted in the presentation, advising that post Covid19 plans could only aspire to 60% of previous planning. Theatre utilisation was highlighted including the drop in activity which had been due to staff annual leave and non-availability of Spire hospital capacity. The Committee recognised the importance of staff taking leave at this time, which for many had been delayed during previous months in the response to Covid19. It was confirmed that whilst there had been an improvement in September it would not bounce back to pre Covid19 levels. It was understood that the West area was being affected by bed availability and there was work being done in the worse affected East area to improve flow and protect ring fencing.

**FP20/116.7** The Interim Head of Planned Care Improvement emphasised the scale of the unprecedented issues ahead and that potential recovery would be on a timescale of years, not months - which was a widely shared opinion in other areas across Wales. It was for this reason that he was putting forward an alternative concept of developing a Diagnostic and Treatment Centre (DTC) model amidst 5 different options outlined for consideration. He advised that work was ongoing to address financial costing, clinical engagement and high level clinical specification. It was his opinion that there would likely be a need for 2 DTCs due to the size of North Wales (1 x East and 1 x West). These could provide a one stop centre that included a diagnostic centre, oscopy unit and daycase surgery/ polyclinic which would also address the interface between primary and secondary care. This would also have a significant effect within BCU's primary care services. The presentation outlined the potential services provided and also the patient pathway from GP referral to receiving a procedure. He advised it would be important for the DTC to be daycase focussed and not include beds which required more complex procedures and aftercare by appropriate staffing. The workforce mix required to support DTCs would require significant exploration dependent on the services needed.

*The Interim Chief Operating Officer joined the meeting*

**FP20/116.8** Further details of the services were outlined in the paper including a potential Elective Orthopaedic Centre. It was noted that an update on the Orthopaedics Business Case being developed would be brought to the next meeting given the potential approach being outlined.

**FP20/116.9** The 5 options outlined in the paper were:

Option 1 – Business as Usual

Option 2 – 3 x session days and 7 day working, all sites

Option 3 - Diagnostic and Treatment Centres including theatres

Option 4 – Diagnostic Centre – Outpatient department and Diagnostics only

Option 5 – Diagnostic and Treatment Centre that has limited theatre capacity to clear backlogs and service transformation is undertaken to instigate covid light daycase centres.

It was also noted that a high level financial analysis and a SWOT analysis had been provided for each option within the report

**FP20/116.11** A discussion ensued. The Interim Chief Operating Officer stated the importance of critical thinking. He supported development of DTCs as a credible option which could also take into consideration patient's concerns regarding C19 risks that were affecting attendances. The Acting Chief Executive alluded to national discussions which were ongoing and reported that WG was keen to explore different options to resolve the shortfall. She stated she was following this up to see what other approaches were being put forward across Wales.

**FP20/116.12** Workforce considerations were discussed. In respect of the Deputy Medical Director's observations regarding diagnostic capacity, the Interim Head of Planned Care Improvement advised that there was further high level outline work to do before safe staffing levels could be ascertained in conjunction with the clinical specification. The Acting Chief Executive was very supportive of the potential opportunities to attract and retain staff. The Executive Director of Workforce & OD stated that BCU needed to address delivering care in a modern way which would be important within a clinical model that could address skills and training over a 3/5 year timeline and workforce would be an integral part of the development team. She highlighted the need to maintain 'Super Green' status and form a package that also supported improvements within Emergency Departments and patient flow; integrating different parts of BCU's services and ensuring alignment with investment decisions.

**FP20/116.13** The Chairman questioned what would be required strategically and the need to involve WG in terms of investment. He sought assurance that developments would be incorporated in BCU's Estate strategy. The Acting Chief Executive also drew attention to the need to incorporate risk considerations regarding surgical specialties and others who contributed to Orthopaedic services.

*The Executive Director Planning and Performance joined the meeting*

**FP20/116.14** The Committee stated that Option 1 (Business as Usual) was not acceptable, given that the numbers of patients waiting more than 36 weeks was increasing each month, and sought assurance that an interim solution would be moved forward at pace. The Interim Head of Planned Care Improvement advised of a variety of interim measures that were being put in place to address the three thousand patient gap per month and provided assurance that this was being built into the quarterly plan. The Chairman was keen to expedite solutions quickly and invited the Wales Audit representative to comment on his observations.

**FP20/116.15** Potential locations were discussed, following which funding was questioned. The Acting Executive Director of Finance emphasised the need to ensure expertise was provided to write the necessary business cases to support developments. In response to the Chairman she advised that potential revenue and capital funding would need to be clearly outlined in order to provide clarity of the

<p>scope of the proposal to WG. The Deputy Director FDU advised caution in respect of potential WG capital availability due to existing commitments.</p> <p><b>FP20/116.16</b> It was understood that the next report would provide greater detail on finance, including addressing the Chairman's question as to whether part of the existing £40m Planned Care budget could be repurposed.</p> <p><b>It was resolved that</b> the Committee agreed</p> <ul style="list-style-type: none"> <li>the paper be shared at the upcoming Board workshop, supported by the Interim Chief Operating Officer</li> <li>the Interim Head of Planned Care Improvement provide a briefing note to the members clarifying what steps would be taking place and assets required to provide an interim solution to the widening gap.</li> <li>an update on progress of the Orthopaedic Business case (including risks) be provided at the next meeting. It was noted that the business case would also need to be reviewed against DTC development.</li> <li>business cases be developed to support the proposals</li> </ul>	<p>GH</p> <p>AK</p> <p>MW</p> <p>MW/SH</p>
<p><b>FP20117 Finance Report - Month 5</b></p> <p><b>FP20/117.1</b> The Acting Executive Director of Finance presented this report. It was noted that the £31m in-month deficit / £44.4m year to date deficit, was an adverse variance of £27.7m compared to the Month 5 plan. Whilst the reported position had deteriorated significantly, this was due to the agreed change to the income assumptions, as only income notified by WG was now included in the financial position and this was broadly in line with the income risk reported at the previous Committee meeting.</p> <p><b>FP20/117.2</b> The Acting Executive Director of Finance advised that WG had issued guidance on £83.1m sustainability funding to be made available to BCU and what the allocation was to be used for. She referenced the detail and agreed to share this with members following the meeting. She advised that following work to understand the impact on the end of year forecast, there was the potential to deliver a position under the £40m deficit plan, but she reminded the committee of the continued volatility around the impact of Covid19.</p> <p><b>FP20/117.3</b> In response to the Committee, she confirmed that the forecast deficit position currently included savings of £14.9m and that the table on page 4 of the report illustrated the revised forecast position and the variable cost elements which were informing that forecast.</p> <p><b>FP20/117.4</b> The Chairman requested that Appendix 1 of the report provide separate detail of expenditure around Covid19 and Divisional costs in order that members could ensure they could identify divisions not aligning with their budgets. The Acting Executive Director of Finance agreed to address this within the next report along with</p>	<p>SH</p> <p>SH</p>

the inclusion of a table tracking expenditure against the additional WG allocation for monitoring purposes.

**FP20/117.5** The Committee was concerned that due to the present circumstances potential financial issues were mounting for the future and therefore reminded of the importance of a continued focus on savings. The financial implications on budgets to respond to the Minister's statement on additional beds to be provided during the Winter Season was also questioned. The Acting Executive Director of Finance stated that current budgets included usage of field hospitals, however month 6 would provide greater clarity on this issue. She also stated that WG would be providing additional funding for specific programmes leading to year end. A discussion ensued on potential field hospital utilisation and related workforce shortfall issues which the Acting Chief Executive advised was being monitored closely by the Executive Team. The Deputy Director ~ FDU questioned the impact of consequential losses against the field hospitals and the Acting Executive Director of Finance stated that this was being worked through with the Field Hospital partners and WG.

**It was resolved that** the Committee noted the report

#### **FP20/118 Savings report**

**FP20/118.1** The Acting Executive Director of Finance presented the report. Following a considerable reduction in the number and value of schemes between March and June, the number of schemes had risen by 7 and the value of the programme had risen by £1.7m to £13.9m. The Improvement Group schemes for medicines, digital and estates had all moved into divisional schemes for delivery. It was noted that all savings schemes were subject to a risk assessment process in line with WG guidance. Whilst £7.41m of the current programme was assessed as amber or green. £6.49m worth of schemes were classified as red RAG status and required further work to ensure progression into delivery. The Acting Executive Director of Finance stated that due to the current circumstances, there was a need for realism as to what could be delivered in year.

**FP20/118.2** In terms of pipeline schemes, the Executive Team were looking at options which ensured delivering safely and a team was in place to support this. The Acting Executive Director of Finance stated that a report on the Recovery Director's recommendations would be brought to the October meeting. She also advised that digital investment would be required to support some schemes.

**FP20/118.3** The Committee was keen to understand progress on Programme Management Office resource within the next report, including the separate skill mix capability and capacity to support the two areas of financial recovery & service improvement.

**FP20/118.4** It was also clarified that the £1m Estates savings scheme had been transferred into the relevant division, following progression of the scheme..

**FP20/118.5** The Chairman was concerned that the Q3&4 plan being provided to the Strategy, Partnership and Population Health Committee and Board workshop the next day did not have financial alignment and therefore affordability could not be assessed.

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SH

<p><b>FP20/118.6</b> A discussion ensued on Value Based Healthcare (VBHC), in which the Acting Executive Director of Finance advised that the Head of VBHC had returned to post following a period supporting the Covid19 response. She stated that clinical pathways were being developed with this approach. The Executive Director of Workforce and OD concurred and cited the work on DTCs as an excellent example of integrating VBHC into new developments. She commented that greater awareness of VBHC principles being applied needed to be drawn out in papers submitted by executives, which the Chairman endorsed, and that it needed to be more integrated into the organisation rather than the responsibility of a specific team. It was agreed that the next Finance report include a VBHC update.</p> <p><b>FP20/118.7</b> The Wales Audit representative remarked that the organisation appeared to have reverted back to type, driving the focus on cost control &amp; avoidance rather than looking to the longer term. The Acting Chief Executive welcomed the comments made. She stated that significant progress was being moved forward, particularly in respect of digital improvements, progressing business cases to support productivity and ensuring the right supportive workforce supported improvements. BCU was ambitious in moving forward in a different way to achieve strategic direction.</p> <p><b>It was resolved that</b> the Committee noted</p> <ul style="list-style-type: none"> <li>the increase in the value of the savings programme of £1.7m since the June review, giving a programme value of £13.9m, and the latest forecast delivery of £14.9m</li> <li>the urgent action required to finalise the development and risk assessment of existing PIDs</li> <li>the need for further savings schemes to be developed in order to reduce to projected shortfall against the Board's financial plan requirements</li> <li>the development of a proposal for resourcing and delivery of the PMO and Service Improvement functions which would be presented to the Committee in October</li> </ul> <p>agreed</p> <ul style="list-style-type: none"> <li>further detail be provided at the October meeting on the recommendations made by the Interim Recovery Director as outlined in the report and             <ul style="list-style-type: none"> <li>review of 19/20 non-recurring savings to identify repeat opportunities</li> <li>Grip and control measures which delivered significant benefit in 19/20 and could provide rapid impact</li> </ul> </li> <li>inclusion of a VBH report within the next Finance report</li> </ul>	<p>SH</p> <p>SH SH</p>
<p><b>FP20/119 Issues of significance to inform the Chair's assurance report</b></p> <p>To be agreed outside the meeting</p>	
<p><b>FP20/120 Date of next meeting</b></p> <p>29.10.20</p>	

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
<b>Actions from 24.10.19 meeting:</b>				
Sue Hill	<b>FP19/236 Finance Academy</b> Forecasting Best Practice Guide A plan to implement the guidance would be provided In December	<del>December meeting (11.12.19)</del> 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  Deferred to January meeting	Jan-2020 February 2020   March 2020  22.4.20 25.6.20 19.10.20  18.1.21
<b>Actions from 27.8.20 meeting:</b>				
Sue Hill	<b>Matters arising FP20/93.2</b> In respect of FP20/77 the Committee was pleased to note that Covid19 Block contract updates It was agreed that future reports would also provide further detail of the services provided	19.10.20	This information will be included in future external contracts updates and block contracts are a standing item on the Committee agenda while the contractual arrangement continues with NHSE.	Action to be closed
Mark Polin	<b>FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR)</b>	11.9.20	23.9.20 Circulated to members	Action to be closed



	<b>Acute Urology Services</b> The Chairman had requested a report to be prepared by the Medical Director Secondary Care which he undertook to share with members on receipt.			
David Fearnley Arpan Guha	<b>FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR)</b> <b>Acute Urology Services</b> The Executive Medical Director also undertook to raise the issue of robotic surgery progress at the next All Wales Medical Directors meeting and feedback to the members.	19.10.20	10.9.20 DF : Next meeting for the All Wales Medical Directors will be held on 2.10.20 – new interim Executive Medical Director will feedback following the meeting.  19.10.20 Arpan Guha attended an All Wales Medical Director (MD) group meeting with CMO/Wales in attendance. Our approach, as described in the urology business case was discussed. This received broad support from the Chief Medical Officer and all the Welsh MDs.	Action to be closed
Sally Baxter	<b>FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR)</b> <b>FP20/94.</b> Provide member briefings be provided in respect of : <b>AN19.1</b> Review current process for booking and allocation to ensure it is fit for purpose and consistently applied across North Wales <b>AN25.2</b> 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	7.9.20	Member briefings re AN19.1 and AN25.2 circulated to members 23.9.20	Action to be closed

	equity of access			
Mark Wilkinson	<b>FP20/95 Quality and Performance (QAP) report</b> <b>FP20/95.2</b> The Chairman asked that future reports avoided duplication and streamlined the format so that Board members could easily appreciate 'what was happening' in positive as well as negative areas and 'what was being done' to address these areas. The Deputy Chief Executive undertook to address this within the Executive Team.	19.10.20	22.10.20 Reporting formats are under constant review and feedback is always welcomed. The new Director of Performance will review our systems and processes including reports. As a result of the pandemic we stood down our narrative reports from operational leads – which historically provided the 'what is being done' aspect. This is being gradually reintroduced now as local ownership of performance commentaries is crucial. This month's report includes an unscheduled care commentary drafted by the Chief Operating Officer.	Action to be closed
Gill Harris	<b>FP20/95.3.</b> The Chairman requested that the Winter Resilience Plan report reflect improvements introduced through the response to Covid19 and how temporary hospitals would be used in respect of surge capacity	11.9.20	The local health communities have developed draft Winter Resilience plans with colleagues from social care which include details on how they will manage surge over Q3/Q4. The three plans are currently being aggregated up to form a BCUHB Winter Resilience plan which will be presented to Board in October 2020.	Action to be closed
Gill Harris	<b>FP20/96 Planned Care update including RTT and essential services</b> <b>FP20/96.5.</b> It was agreed that a report be presented to the next meeting along with greater detail on the development of a diagnostics and treatment centre – see below re meeting date	11.9.20	Significant work has been undertaken on the concept of diagnostic and treatment centre. We are currently building a service specification and stakeholder engagement, a task and finish group has had one meeting. A paper is being prepared for Octobers F&P  Agenda item 29.10.20	Action to be closed

Mark Polin	<b>FP20/96 Planned Care update including RTT and essential services</b> <b>FP20/96.5.</b> The Chairman stressed the Board's significant concern in this area and undertook to consider whether a Committee meeting be held in September to hasten a solution	7.9.20	Committee scheduled 30.9.20	Action to be closed
Gill Harris	<b>FP20/96 Planned Care update including RTT and essential services</b> Orthopaedics business case to be provided within the October RTT report.		A number of meeting have been undertaken with the clinicians and the orthopaedic network manager, we are working to a November deadline, therefore wish to present the business case in December  30.9.20 Update to be provided to 29.10.20 meeting  Agenda item 29.10.20	10.12.20  19.10.20  Action to be closed
Neil Bradshaw	<b>FP20/98 Capital Programme</b> <b>FP20/98.4</b> Brief the Acting Executive Director of Finance re the Supply Chain Provider to the Royal Alex development.	4.9.20	Action completed	Action to be closed
Sue Green / Neil Bradshaw	<b>FP20/98 Capital Programme</b> <b>FP20/98.5</b> Discuss proposals to address electric charging point commuting cost recovery for staff	14.9.20	11.09.20 – Meeting between Sue Green and Neil Bradshaw scheduled 23.9.20	Action to be closed
Sue Hill	<b>FP20/99.5 Finance report</b> <b>FP20/99.5</b> Clarify the largest budget variance of £2.5m	14.9.20	Member briefing circulated 22.9.20	Action to be closed
Sue Hill	<b>FP20/99 Finance report</b> <b>FP20/99.6</b> The Acting Executive Director of Finance agreed to	31.8.20	Circulated on behalf of the Chairman 7.9.20	Action to be closed

	share with the Chairman and Committee members the change of accountable officer letter to WG			
Sue Hill	<p><b>Covid19 Financial governance FP20/100.4</b> In respect of rising expenditure, it was agreed that further detail would be provided in the next report to the Committee, including demonstrating a reconciliation of the additional pay costs.</p> <p>Agreed future Finance reports would include the Covid19 expenditure within their monthly position reporting, in line with other Health Boards in Wales.</p>	<p>19.10.20</p> <p>19.10.20</p>	<p>This will be included in the next paper which is on the agenda in October</p> <p>This has now been actioned</p>	<p>Action to be closed</p> <p>Action to be closed</p>
Sue Hill	<b>FP20/74.5</b> The Acting Director of Finance agreed to clarify the anomaly in respect of Ysbyty Gwynedd expenditure on Covid-19 (Appendix A) following the meeting.	23.9.20	Briefing note circulated to members 21.10.20	Action to be closed
Sue Hill	<p><b>FP20/101 Staff Lottery</b></p> <ul style="list-style-type: none"> <li>Undertake a comparative with another staff lottery operating within a South Wales Health Board and report back.</li> <li>Provide a revised paper at</li> </ul>	19.10.20	Agenda item 29.10.20	Action to be closed

	the 29.10.20 Committee meeting, addressing the concerns raised and to include more detail of how the lottery would be implemented and operated, along with evidence of sufficient potential staff support.			
Mark Wilkinson	<b>FP20/102 Committee Annual report 2019/20</b> Arrange for a review of the Health Board's Performance Management framework to be addressed as a priority in 2020/21		22.10.20 A timescale for this work to develop a framework for 2021/22 has been included in the Q3 and Q4 plan. Work in 2020/21 is more advanced supported by the Interim Director of Governance. Accountability review meeting dates are being scheduled for the rest of this year.	Action to be closed
Sue Hill / Diane Davies	<b>FP20/102 Committee Annual report 2019/20</b> Update the draft report and submit to the Audit Committee	9.9.20	Submitted 9.9.20	Action to be closed
<b>Actions from 29.9.20 meeting:</b>				
Mark Wilkinson	<b>FP20/116.8</b> Provide update on Orthopaedics Business Case progress (including risks) to next meeting	19.10.20	Agenda item 29.10.20	Action to be closed
Gavin Macdonald	<b>FP20/116 Planned Care</b> Submit FP20/116 paper to Board workshop and attend to support at the meeting	8.10.20	Actioned	Action to be closed
Andrew Kent	<b>FP20/116</b> Provide paper describing actions being undertaken to address interim solution	19.10.20	Circulated to members 22.10.20	Action to be closed

Sue Hill	<b>FP20/117.2 Finance report</b> Circulate allocation table to members	30.10.20	30.9.20 Circulated to members via email	Action to be closed
Sue Hill	<b>FP20/117.2 Finance report</b> Separate C19 expenditure column to be added within App 1 to enable more effective divisional budget monitoring	19.10.20	Actioned within Month 6 Finance report	Action to be closed
Sue Hill	<b>FP118.2 Savings report</b> Provide update on Recovery Director recommendations to next meeting	19.10.20	Agenda item – private session	Action to be closed
Sue Hill	<b>FP20/118.4 Savings report</b> Include update on PMO capacity and capability resource within next report	19.10.20	It was agreed that the Savings report is taken bimonthly therefore it will be on the next F&P Committee agenda (22.12.20).	10.12.20
Sue Hill	<b>FP20/118.8 Savings report</b> Include Value Based healthcare report within the next Finance report	19.10.20	Actioned in Finance report for 29.10.20 meeting	Action to be closed

21.10.20

<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance committee 29/10/2020</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Diagnostic and Treatment centre pre-Strategic Outline Case						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Gill Harris CEO						
<b>Awdur yr Adroddiad Report Author:</b>	Andrew Kent- Interim head of planned care transformation						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Gavin MacDonald and Gill Harris						
<b>Atodiadau Appendices:</b>	Appendix 1 – Graphic of DTC model Appendix 2 – DTC Service Specification Appendix 3 – Comparative summary of DTC options in light of NHS England report “Diagnostics: Recovery and Renewal” Appendix 4 – Summary of estimated backlog treatment costs Appendix 5 – Analysis of potential timelines for DTC delivery						
<b>Argymhelliad / Recommendation:</b>							
F&P are asked to review presented options and confirm intentions for progress to development of Strategic Outline case and development of a DTC business case project.							
Please tick as appropriate							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input checked="" type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
<p>The COVID19 pandemic has had a significant impact on planned care service as previously reported. Length of times for patients have increased across all the pathways, particularly diagnostics and treatments at stage 4. Referrals for routines have yet to reach pre-COVID levels and many outpatient services are just re-starting with limited capacity. When these levels increase, it will compound the issue.</p> <p>In August, the Finance and Performance committee requested a paper to explore strategies to reduce backlogs and to discuss and agree the principles and possible options going forward. This paper develops the emergent options into the format of a potential SOC; provides updated high level costs; and comments on the wider strategic context. This paper should also be considered alongside the accompanying paper presented to the committee meeting of 29 October which sets out proposals for an interim solution to waiting list backlogs.</p>							
<b>Cefndir / Background:</b>							
The country is facing a similar dilemma and a number of strategies are emerging nationally, including the guidance from the National planned care programme, that suggest the way forward is to provide carved out/ring fenced elective capacity, that could be considered as COVID light as							

possible. To ensure this occurs, any facility needs to separate from unscheduled care and provide an environment that is as safe as possible to both patients and staff.

As of the end of September 2020, the number of “all over 36 week waiters” has increased to over 40,000 and the total diagnostic waits currently stand at over 14,000, of which 8,515 are radiology. Taking the quarter 1 average increase and applying this to a “no change” scenario, presents a risk of reaching over 80,000 over 36 week waiters by the end of March 2021.

## **Asesiad / Assessment & Analysis**

### **Strategy Implications**

This paper aligns a number of current business cases in process, namely the endoscopy, Ophthalmology, orthopaedic and Radiology cases. It aligns with the national planned care strategic approach of providing facilities that would be minimised from disruption and provides COVID low burden for patients and staff

### **Options considered**

- Once for North Wales (option 5)
- Business cases listed above

### **Financial Implications**

There are significant financial implications both capital and direct treatment costs described in the paper. It does not take into account any lease costing of the modular health units. Please note these are minimum financial costs and would be expected to rise (direct treatment costs) if the backlog increases.

### **Risk Analysis**

Long waiters and clinical harm, post COVID planned care activity.

### **Legal and Compliance**

We would need to comply with procurement rules and financial regulations, which would be explored as part of the next steps, if accepted.

### **Impact Assessment**

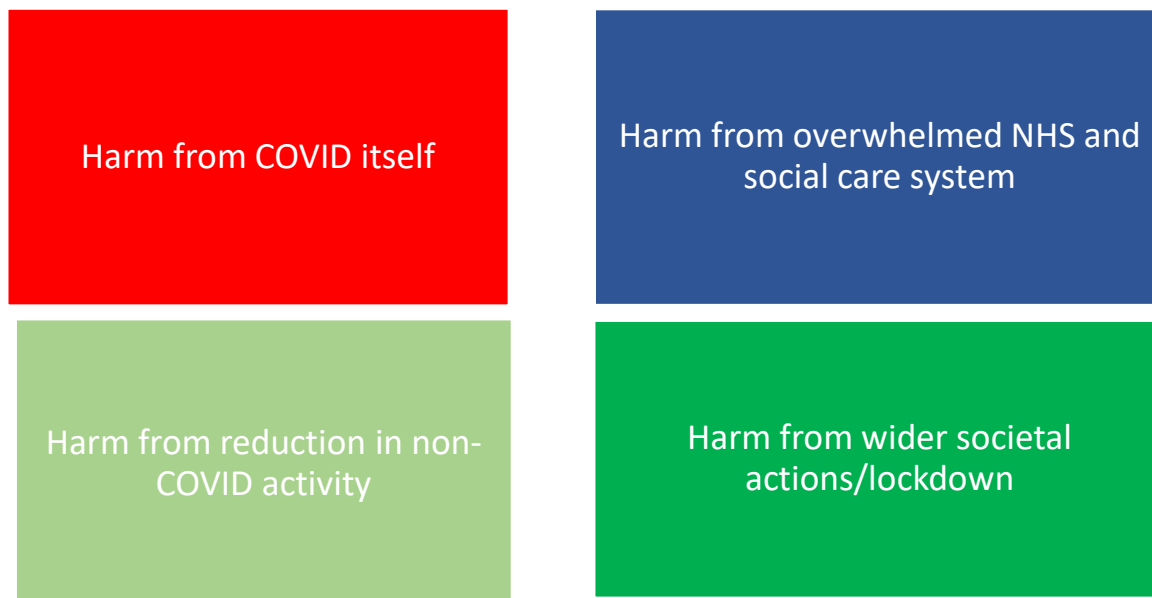
Not yet undertaken

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## 1. Introduction

The impact of COVID-19 on the communities we serve is demonstrated within the quadrant model shared by Welsh Government below.



This paper is a follow up to the discussion document presented to the Finance and Performance Committee on 30 September 2020 and focusses primarily on the harm from reduction in non-COVID activity described above. This followed a number of clinical engagement events earlier in the year, as part of a concerted effort to define clinical and operational responses to the specific challenges presented by the COVID-19 pandemic. The focus of this approach centred on maintaining levels of elective care, and options for use of existing elective capacity.

During the COVID-19 pandemic, the potential option to designate one or two acute sites for elective activity only was considered to be too great a risk to deliver within the required timescales. Therefore “Option 5 - Once for North Wales” was developed for key specialties. This ensured an approach to ameliorating inequalities of access, and reducing some of the significant variations in waiting times across the sites/localities. It recognised that this approach did not deliver any additional capacity.

Detailed below is a proposal for a structured programme of work to develop the proposal for a transformational project for diagnostic and treatment services. The initial paper presented to the Finance and Performance Committee outlined the options under consideration, also setting out the key areas of potential for service development and transformation.

The specific focus of the initial paper was on out-patient, day case and ambulatory care. However, it recognised the wider implications for delivery of in-patient care,

considering the opportunities for service transformation within the context of wider Health Board strategy and its existing programme of service developments.

In order to further develop the concepts and options described in the initial paper this document provides an additional opportunity for discussion and feedback. This will form the basis for the work required to develop the required business case, using established models of best practice.

## 2. Approach

Subject to comment and approval, the proposed approach to the development of this transformational project will utilise the established three key stages in the development of a project business case. These are the Strategic Outline Case (SOC); the Outline Business Case (OBC); and the Full Business Case (FBC). The Health Board will prepare these elements using the agreed standards and format for business cases, as set out in the NHS Wales Infrastructure Investment Guidance (see comments and information provided in section 3.3. below)

This paper will outline the key issues for consideration within the development of the Strategic Outline Case, to support the development of a formal document. It will also provide an indicative timeline (and possible scenarios) for business case development and implementation.

## 3. Development of the Strategic Outline Case

The main components of the Strategic Outline Case are intended to establish the strategic context, make a robust case for change and provide a suggested way forward (rather than a definitive preferred option). As part of the work to develop a SOC document, the following sections will consider content for the following areas:

- 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 explores the suggested way forward – or how best to deliver the objectives of the scheme;
- The Commercial Case - this assesses the ability of the market place to deliver the required goods and services, and summarises the organisation's commercial strategy;
- The Financial Case - this gives outline estimates of the capital and revenue implications of the scheme, and a view of affordability.

### **3.1. The Strategic Case**

The Health Board has already published key strategy documents such as “Living Healthier, Staying Well” (March 2018) and an accompanying updated Estates Strategy (February 2019).

Living Healthier, Staying Well (LHSW) sets out how health, wellbeing and healthcare might look in ten years' time and describes current plans along with implications for how resources are allocated and how staff prioritise their time. The strategy is based on three overlapping major programmes within the overall portfolio:

- Improving health and reducing inequalities
- Care closer to home
- Excellent hospital care

Key elements of the LHSW strategy for ensuring excellent hospital care have a focus on:

*“looking at how we deploy our workforce and using modern approaches including integrated teams of different professionals like therapists, advanced nurse practitioners and doctors; and finding new ways to deliver services”<sup>1</sup>*

The Health Board's Estate Strategy supports the strategic aims of LHSW and sets out a goal to ensure that:

*“the estate is aligned to our clinical and enabling strategies and supports transformation plans”<sup>2</sup>*

The development of the proposal described below should be considered within the context of the Health Board's agreed strategic aims to develop new ways of delivering services, with an estates strategy aligned to support transformation plans. It further aligns with the key priority agreed by the board to continue to provide care under 'essential' services whilst supporting the safe stepping up of planned care.

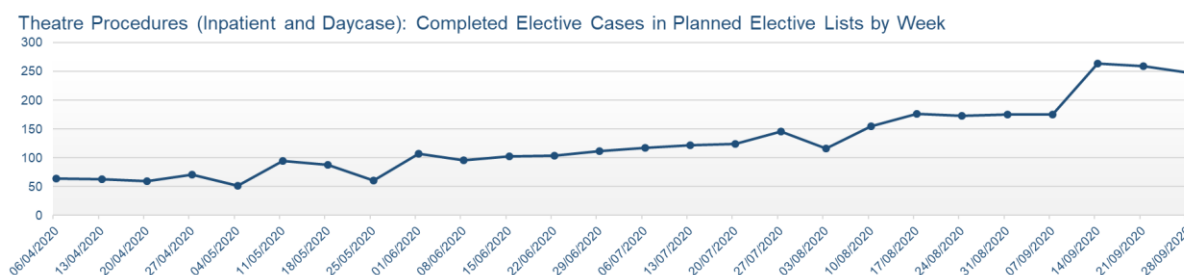
The development of options for a transformational approach to support the above strategic objectives has also been driven by recognised operational challenges. The COVID19 pandemic and the legacy of long waiters at the end of 2019/20 has left the organisation with a significant clinical risk. Whilst not unique to this organisation, the size of activity required to be undertaken and the previous backlog does present a challenging environment.

As of the end of September 2020, the number of “all over 36 week waiters” has increased to over 40,000 and the total diagnostic waits currently stand at over 14,000, of which 8,515 are radiology. Taking the quarter 1 average increase and applying this to a “no change” scenario, presents a risk of reaching over 80,000 over 36 week waiters by the end of March 2021. The run rate of in-patient and day case procedures, shown below, signals the “new normal” after COVID with late August delivering 250 cases per week, compared to the March position of 500 per week, a reduction of 50%.

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<sup>1</sup> “Living Healthier, Staying Well”, BCUHB, March 2018

<sup>2</sup> Estates Strategy (version 6), BCUHB, February 2019



As part of this planning, we have undertaken a harm risk analysis across our current waiting lists. Working on the assumption that 3 -4% of cancers are only picked up after they are escalated via a more routine appointment, this demonstrates a significant and growing clinical risk across the HB.

Our analysis suggests that a total of 2,699 stage 4 patients who have been classified as P2/3 who need definitive treatment in the next 3 months will not be treated and are therefore at risk of developing some form of consequential harm. A further 1,623 from our routine waiting list will fall into this category based upon the 4% assumption. This will increase to 2,583 if our growth rate continues as per current trajectory. A similar analysis of our stage 1 patients demonstrates a risk of harm to 337 patients. These figures exclude our most challenging speciality of orthopaedics. Clearly this will increase if there is a subsequent need to reduce planned care as a result of the pandemic or we are unable to manage the backlog.

To address this problem mid to long term a potential option has been developed based on a diagnostic and treatment centre strategic approach that would “carve out” Outpatients, Day case, Oscopies and other key ambulatory services. (e.g. Cardiac services). This would provide long term resilience to the organisation by enabling the treatment of highly vulnerable patients without interruption from pressures in unscheduled care and further COVID-19 surges. By increasing available capacity within a ‘COVID light environment, it would also help retain clinical activity (and associated resources) within Wales. This would provide a tangible economic benefit and significantly reduce reliance on other external providers including English capacity and the Independent sector.

Many organisations across the U.K. have introduced diagnostic and treatment centres. South Wales have recently adopted this approach, predominantly for cancer services.

These centres provide outpatient, diagnostic and day case surgical capacity. Usually located away from an acute hospital site to provide ring fenced ambulatory care. Many different models exist; however, a two centre approach is considered amongst the possible viable options. A task and finish group has commenced to look at the clinical specification and significant clinical engagement has been undertaken to invite feedback on the concept.

It is acknowledged that delivery of this strategy could take between two and three years. Therefore, short to mid-term solutions for the delivery of planned care are underway. These include introducing smaller modular builds of theatres plus wards,

to commence backlog clearance. This would provide the organisation with a viable short-term solution.

The two centres would provide a low COVID-19 burden and a new service model for ambulatory care for the population of North Wales. The approach “future proofs” capacity for potential cancer patients and those that are regarded high risk but ambulatory. An example of the two centre model is attached at **Appendix 1**.

The challenges and potential solutions being considered will need to be evaluated with reference to the recent national report, “Diagnostics: Recovery and Renewal” (Professor Sir Mike Richards, NHS England, October 2020).

The report states that:

*“The COVID-19 pandemic has further amplified the need for radical change in the provision of diagnostic services, but has also provided an opportunity for change.”<sup>3</sup>*

The report identifies the following key actions:

- Acute and elective diagnostics should be separated wherever possible to increase efficiency.
- Acute diagnostic services (for A&E and inpatient care) should be improved so that patients who require CT scanning or ultrasound from A&E can be imaged without delay.
- Inpatients needing CT or MRI should be able to be scanned on the day of request.
- Community diagnostic hubs should be established away from acute hospital sites and kept as clear of COVID-19 as possible.
- Diagnostic services should be organised so that as far as possible patients only have to attend once and, where appropriate, they should be tested for COVID-19 before diagnostic tests are undertaken.
- Community phlebotomy services will be improved, so that all patients can have blood samples taken close to their homes, at a minimum of six days a week, without needing to access acute hospital sites.

The summary recommendations of this report are highly relevant to the development of the Health Board’s plans and will be a key point of reference for the appraisal of service options.

The key investment objectives of the project are summarised as follows:

1. To reduce the risks from disruption to service delivery and diagnostic capacity
2. To reduce harm to patients by providing early diagnostic and treatment to suspected cancers and vague symptoms

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<sup>3</sup> “Diagnostics: Recovery and Renewal”, NHS England, October 2020

3. Provide further capacity for In-patient activity by providing Day case procedures elsewhere
4. Provide faster/same day access to diagnostic tests
5. Deliver sustainable improvements in day case access and treatment times
6. Provide “ring fenced” elective capacity and deliver pathways that protect patients and staff from COVID-19.
7. Eliminate the backlog of patients waiting over 36 weeks for day case
8. Support development of new roles and improve recruitment and retention
9. Reduce reliance on external providers
10. Deliver socio-economic benefits to the North Wales economy
11. To provide a sustainable strategic platform which will support a coherent, timely and cost effective approach to addressing the underlying known system pressures through a complimentary range of short, intermediate and longer term measures.

A set of specific measurables that contribute to each of these high level objectives, including baseline measurements, will be developed pending approval to develop the OBC.

### **3.2 The Economic Case**

The critical success factors are being considered as part of the work by the Task and Finish group and a proposed list is provided below:

- CSF1: business needs – how well the option satisfies the existing and future business needs of the organisation.
- CSF2: strategic fit – how well the option provides holistic fit and synergy with other key elements of national, regional and local strategies.
- CSF3: 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) – assists in improving overall VFM (economy, efficiency and effectiveness) and socio-economic benefits.
- CSF4: 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). The organisation’s ability to engender acceptance by staff.
- CSF5: supply side capacity and capability – the ability of the market place and potential suppliers to deliver the required services and deliverables.
- CSF6: potential affordability – the organisation’s ability to fund the required level of expenditure – namely, the capital and revenue consequences associated with the proposed investment.

The discussion paper presented to the Finance and Performance Committee set out a number of options for approaches to address service pressures, reduce day case backlogs and deliver services in line with emerging national guidance which

recommends carved out/ring fenced elective capacity, that could be considered as 'COVID light' as possible.

To ensure this occurs, any facility needs to separate from unscheduled care and provide an environment that is as safe as possible to both patients and staff. The challenge the organisation faces is that its current facilities all have busy unscheduled care services, including A&E departments, which means it, is impossible to carve out pure elective capacity on the same site, which would be free from disruption. With this in mind the options proposed for discussion were:

1. Business as usual post-COVID
2. Three session days and 7 day working -all sites
3. Diagnostic and treatment centre – including theatres
4. Diagnostic centre – Outpatient and diagnostics only
5. Diagnostic and treatment Centre that has limited theatre capacity to clear backlogs and service transformation is undertaken to instigate COVID light Day case pathways within the current DGH's
6. Diagnostic and treatment centre incorporating the proposals within the existing Orthopaedics business case project. An option developed since the discussion at the F&P Committee on 30/9/20.

A summary of the review of the above options is provided in the following table:

Option	Initial Finding
1. Business as usual post-COVID	<p>Even if the COVID measures are lifted and no further interruption to planned care delivery, the backlogs will at best stay static. Previously the organisation outsourced significant activity. This may not be available to the organisation as they too have backlogs that require clearing for their own population.</p> <p>The national contract with Spire at Wrexham has been reviewed and it is known that capacity will decrease from November/December. It is unclear, at the time of writing, how much capacity RJAH will offer the organisation but this is limited to orthopaedics. Unfortunately, the backlogs are now significant across most specialties. It is clear this option is not viable and will not deliver safe effective care to our population.</p>
2. Three session days and 7 day working -all sites	<p>Model is dependent on the good will of staff working extra shifts or changing working patterns to work out of hours for a considerable period. Recovery could take 4-5 years to achieve reduction in backlog.</p> <p>To support this option extra staff would be required and discussions with clinicians around changing their job plans to weekend working or employing</p>

	<p>extra locums for mid-term contracts. The disadvantage is that we would be providing extra staff costs but no guarantee of capacity for them to operate in, with a risk of not getting value for money from their contracts. Further discussions would be required on whether this would be consolidated on one, two or all three sites. There would be additional costs associated with increased bed capacity to make this model viable and the model would not address the underlying capacity and demand pressures within the system.</p> <p>All three sites have unscheduled activity, disruption due to these pressures is likely to occur, and sustained planned care activity would be unlikely.</p>
3. Diagnostic and treatment centre – including theatres	<p>Many organisations across the U.K. have introduced diagnostic and treatment centres. South Wales have recently adopted this approach, predominantly for cancer services.</p> <p>These centres provide Outpatient, diagnostic and day case surgical capacity. Usually located away from an acute hospital site to provide ring fenced ambulatory care. A task and finish group has been established to look at the clinical specification (see <b>Appendix 2</b>). Significant clinical engagement has been undertaken to receive reaction to the concept.</p> <p>Initial capacity modelling suggests that two centres are required. One being East/Centre the other being Centre/West, as illustrated in Appendix B. Site location is yet to be considered, as we are ensuring the clinical specification is correct which will allow the floorplan to be developed, which in turn will allow the geographical location to be identified.</p> <p>The task and finish group support the modular building approach, similar to the theatres placed at Wrexham over the last few years. The modular units can be provided for outpatients, diagnostics, oscopies and theatres.</p>
4. Diagnostic centre – Outpatient and diagnostics only	<p>This option would be the same process except without the theatres and could be seen as a reduced cost option. The challenge with this is that theatres would become the bottleneck. Patients would be treated through to diagnostics and then may be held due to the lack of theatres. Cancellations due to no beds and the current restrictions within the day case units due to surge and COVID peaks would still be a risk. Leaving</p>



	patients vulnerable at the stage 4. This model does not enable backlog clearance.
5. Diagnostic and treatment Centre that has limited theatre capacity to clear backlogs and service transformation is undertaken to instigate COVID light Day case pathways within the current DGH's	This option provides all the benefits of option 3, but again at a lower cost, with the disadvantages that recurring activity would be undertaken at the DGH's, however it does provide the organisation with "buffer capacity" that could be switched on and off after clearing the backlogs, comparable to an outsourcing model. Although attractive, it does not provide all patients with a one-stop approach but could be seen as a compromise position. These could be purchased or leased and allows the ability to have them removed after the 2-3 year duration.
6. Diagnostic and treatment centre incorporating the proposals within the existing Orthopaedics business case project	This option was proposed following the discussion at the F&P Committee on 30/9/20. It is an expansion of the model described at option 3. The orthopaedics business case is currently being reviewed. The proposal here would be to align the implementation with the DTC component. Assessment of how the projects will be aligned will need to be developed at part of the Business Case process for this entire option.

### 3.2.1 Outline capacity required for option 3

To be able to estimate the costs and size of the building required for option 3, a high-level analysis using assumptions based on the previous year's activity was undertaken; no productivity assumptions have been made.

**Outpatients:** Using this modelling approach it is estimated that 45 outpatient rooms would be required if a two centre approach, or 90 if a one-centre approach.

**Oscopy:** is estimated to be 24 rooms on each site to undertake an "Oscopy unit" this would future proof a growing diagnostic and procedure and takes into account all services that would be utilising it, as described in the option.

**Theatre capacity:** A number of options are available for the theatre capacity, which are tabled below; the more potentially more economical option is to undertake backlog clearance at the diagnostic sites, over a three-year period. This would bring the need to 2 to 3 theatres over a 2-3 year period. To move all recurring activity, it would mean 9.8 (10) theatres split across two sites. These options are appraised below.

	Theatres required (normal recurring activity)	theatres required to clear backlog - 1 year	theatres required to clear backlog - 2 year	theatres required to clear backlog - 3 years	recurring +1 year backlog clearance	recurring +2 year backlog clearance	recurring + 3 year backlog clearance
2 sessions per day 5x week	12.2	7.6	3.8	2.5	19.8	16.0	14.7
2 sessions per week 6 days	10.1	6.3	3.1	2.1	16.4	13.3	12.2
<b>3 sessions per week x 5 days</b>	<b>8.1</b>	<b>5.1</b>	<b>2.5</b>	<b>1.7</b>	<b>13.2</b>	<b>10.7</b>	<b>9.8</b>
3 sessions per week over 6 days	6.7	4.2	2.1	1.4	10.9	8.8	8.1

A key task for the Task and Finish group – as part of the work to complete a SOC will be to confirm the project objectives and critical success factors, and complete a final review of the options within that context. Further consideration will also be given to an analysis of how main components of the listed options align with the key actions and recommendation set out in the “Diagnostics: Recovery and Renewal” report recently published by NHS England.

The summary at **Appendix 3** sets out an illustrative summary comparison (of recommendations on service delivery models) based on current information. It should be noted that the national report also includes recommendations on equipment and facilities; workforce; digitisation and connectivity; and delivery.

### 3.3 The Commercial case

The details of the commercial case will be confirmed subject to the final review of the option appraisal described above.

In term of timelines for delivery, initial work has taken place to model a number of possible scenarios. The table shown below assumes a scenario where current guidelines and processes are followed in full (i.e. a 3-stage business case process), with appointment of contractors from the framework.

In this instance, the estimated times for the production of business cases and construction are based on previous experience in the Health Board and elsewhere in Welsh Government. The total estimated time to completion is 5 years 9 months.

Milestone	Target Date
Completion of Strategic Outline Case (SOC)	January 2021
Completion of Outline Business Case (OBC)	March 2022
Completion of Full Business Case (FBC)	May 2023
Completion and Handover	July 2026

Further details of this estimated timeline and scenarios are shown at Appendix 5. It also includes information on two further scenarios which seek to shorten the process by a number of mitigating measures.

The second scenario shortens the process, through assumptions about accelerated governance/approvals, producing a combined OBC/FBC and the use of modular construction. The estimated time to completion is 3 years 4 months (multi-storey build) or 2 years 8 months (single storey build).

The third scenario shortens the process further, by assuming the use of single-tender waivers to speed up appointments and accelerated working. The estimated time to completion is 2 years 7 months (multi-storey build) or 2 years 3 months (single storey build).

Further information on the assumptions used for the scenarios above are included at Appendix 5.

Further analysis will be required as part of the business case process to determine options for the potential location of the DTC facilities. This will include assessment of whether they can be accommodated within the existing estate or whether further land purchase(s) will be necessary.

### 3.4. The Financial Case

The purpose of this section is to set out the indicative financial implications of the preferred option (as set out in the economic case section) and the proposed deal (as described in the commercial case section). The detailed analysis of the financial case, including affordability, takes place at OBC stage.

Subject to completion of the SOC, the initial high level financial analysis is set out below.

The estimated outline costs linked to the various options are listed below. Since the presentation of the initial estimates to the F&P Committee meeting of 30/9/20, further work has been undertaken to develop and refine these opening estimates. The outcome of this work to date is therefore reflected in the table below. Note that the capital costs for Option 6 includes an element of the £10m already factored into the current Orthopaedics business case, which is presently being reviewed.

<b>Option</b>	<b>Session</b>	<b>Theatres</b>	<b>Capital Cost (£m)</b>	<b>E&amp;F Cost p.a.(£m)</b>
Option 1 – Business as Usual	BAU	BAU	BAU	BAU
Option 2 - Three session days and 7 day working -all sites	3 sessions x 7 days x 3 years	BAU	tbc	tbc
Option 3– backlog + recurring + Out-patient + endoscopy + theatres	3 sessions x 5 days x 3 years	10	98.6	2.0

Option 4 - Diagnostic centre – Outpatient and diagnostics only	3 sessions x 5 days x 3 years	-	73.8m	1.6
Option 5 -DTC and treatment Centre that has limited theatre capacity to clear backlogs. Service transformation for COVID light DC pathways in current DGH's	3 sessions x 5 days x 3 years	3	81.2	1.7
Option 6 - Diagnostic and treatment centre incorporating the proposals within the existing Orthopaedics business case project	3 sessions x 5 days x 3 years	12	112.8	2.2
Notes: All costs are current as at Sept 2020 (PUBSEC 250) Costs allow for 3 storey modular construction Enabling includes allowance for substructures, structural frame, plant room and engineering supply and externals Costs exclude land costs and legal fees				

Since the discussion at the F&P committee on 30/9/20, further work has been to done to give estimated costs of equivalent leasing arrangements for the capital elements described above. This is set out in the following table.

<b>Option</b>	<b>Enable &amp; Clear (£m)</b>	<b>Lease* (£m)</b>
Option 1 – Business as Usual	N/A	N/A
Option 2 - Three session days and 7 day working -all sites	N/A	N/A
Option 3– backlog + recurring + Out-patient + endoscopy + theatres	30.5	91.6
Option 4 - Diagnostic centre – Outpatient and diagnostics only	24.7	70.1
Option 5 -DTC and treatment Centre that has limited theatre capacity to clear backlogs. Service transformation for COVID light DC pathways in current DGH's	26.5	76.6
Option 6 - Diagnostic and treatment centre incorporating the proposals within the existing Orthopaedics business case project	34.5	103.8

\*Estimates based on 5 year term

## High-level revenue financial analysis

The assumptions made for the direct treatment costs is that all out-patient activity will be lifted and placed into the diagnostic centre and the same for any recurring theatre activity, therefore the increase cost will be the backlog clearance. The theatre direct treatment costs are summarised at **Appendix 4** and show an indicative cost of £15.3m. This cost is the minimum and will increase as backlogs increase based on Q3/4 capacity plans. The implications for Endoscopy and Radiology are being worked through via the diagnostic and endoscopy business cases.

### 4. The Management Case

One of the key components of the further development of the DTC model (and associated business case process) will be to examine the impact and risks of the project.

This will need to include an assessment of how the scheme aligns and compliments related business cases already under review or in development; the challenges around workforce in terms of the scale of the development, the implications for delivering a significant step change in activity levels (and the financial implications for delivering this type of transformative change).

Analysis of the potential socio-economic impact is also required to provide a robust evidence base of the benefits that the programme can provide.

The health board will also need to consider the resources that it may wish to commit to support the successful development of the business case. This will be an important consideration given the transformative nature and scale of the proposal and the relevance to other business plans and strategic aims.

Furthermore, the work to develop this proposal may require further detailed consideration of wider plans and service configuration to ensure the successful delivery of longer-term strategic aims and objectives.

### 5. Next Steps and Finalisation of the Strategic Outline Case

This paper presents the detail of progress made to date, and the development of material to support a Strategic Outline Case.

Key immediate tasks for completion to ensure the completion of a robust SOC include:

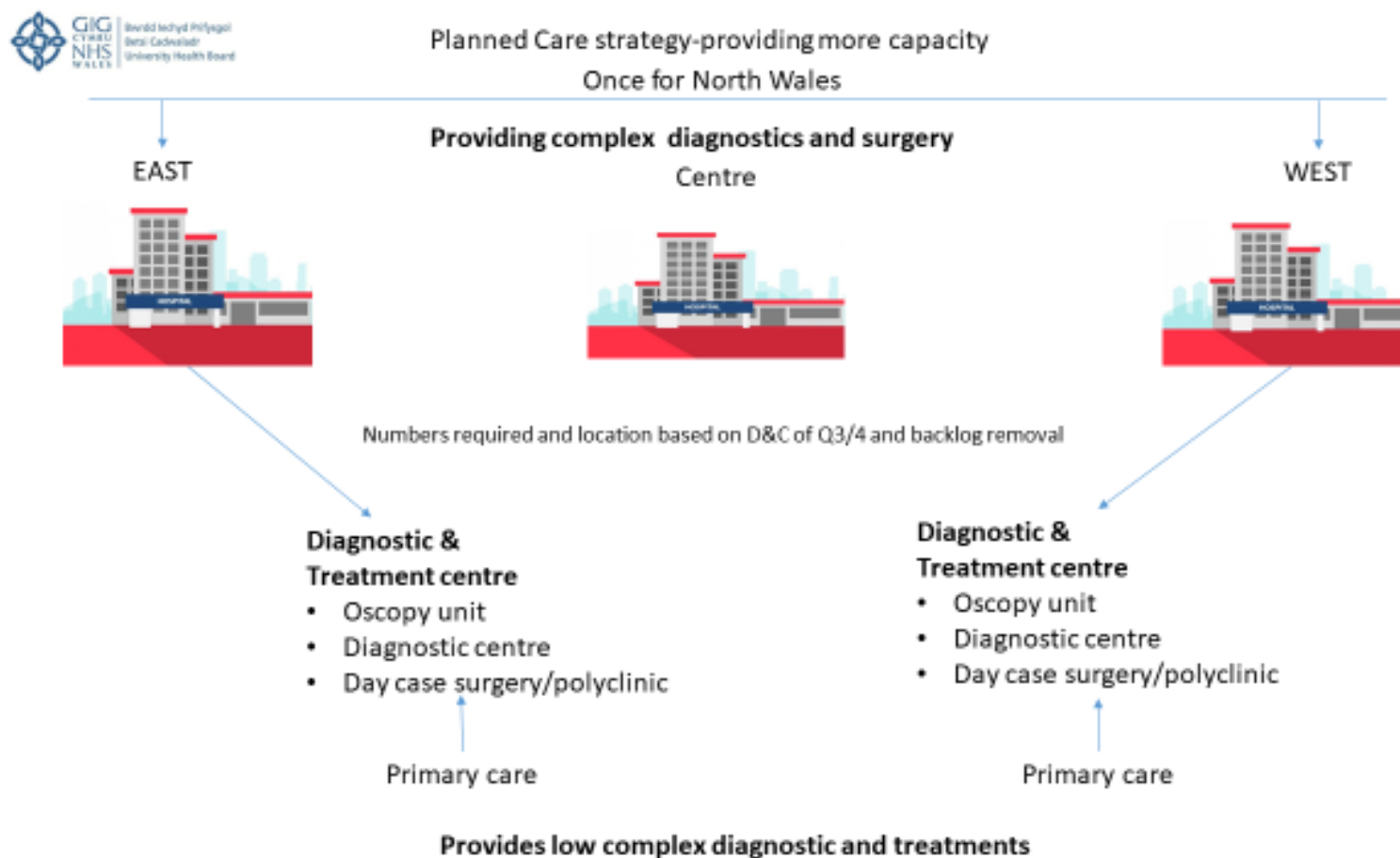
- Confirmation of any updated costings for the high level financial analysis
- Review of project objectives and critical success factors to enable confirmation of the SOC Economic Case
- Capture of any further clinical feedback on emergent models
- Identification of resources to support the development of the business case process, in view of the scale and complexity of the work required
- Review of milestones with key organisation leads

- Consideration of alignment with agreed short/interim term measures being implemented by the health board to address waiting list backlogs.
- Continued engagement with Welsh Office around development of the project
- Development of communication and stakeholder engagement plan

## 6. Summary and Recommendations

Members of the F&P Committee are asked to:

- i. Note the development of the analysis of options and actions to develop a SOC
- ii. Review and consider the financial estimates included with each option
- iii. Review proposed draft timelines and scenarios (Appendix 5)
- iv. Consider resources to develop the business case process



## Service specification of diagnostic treatment centre (28/8/2020)

### OPD- 1 stop pathway approach

Specific specialties that require diagnostics & one stop basis

#### 1. Cancer

- Max/fax
- ENT/audiology
- Obs/gynae
- Breast
- Dermatology
- Urology
- Respiratory medicine
- Oncology

#### 2. Non cancer services

- Orthopaedics
- Ophthalmology ARMD IVT service
- Rheumatology (TBC)
- ? *Therapies (gyms) OT*

Cardiology- HF/stress echo  
respiratory centre (TBC)

### Oscopy suite

Endoscopy  
Bronchoscopy  
Cystoscopy  
Hysteroscopy

### Pre-operative assessment

### Diagnostic

Radiology  
Plain film  
CT  
Ultrasound  
Audiology TBC  
Neurophysiology  
Phlebotomy  
Pharmacy  
Other support CSSD (TBC)  
Near patient testing

### Theatres/OPROC

Day case all specialties  
described  
Ambulatory orthopaedics  
ODTC



Diagnostic and treatment Centre



**Example of Summary Analysis of DTC long list options against key actions and recommendations of “Diagnostics: Recovery and Renewal” Report (NHS England, October 2020).**

<b>NHS England Report</b>	<b>BCUHB DTC Long List Options</b>					
<b>Diagnostics: Recovery and Renewal – Service Delivery Model</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
New pathways to diagnosis should be established, building on those already developed as part of the initial phase of the response to COVID19, with virtual consultations and community diagnostics promoted to keep visits to acute hospital sites to a minimum.	?	?	Y	Y	Y	Y
New pathways should separate emergency/acute and elective diagnostics wherever possible to improve efficiency and reduce delays for patients.	?	?	Y	Y	?	Y
Emergency/acute diagnostic services should enable patients to be imaged in A&E without delay and for inpatients to be imaged or to undergo endoscopy on the day of request.	?	?	Y	?	?	Y
Community diagnostic hubs should be rapidly established to provide COVID-19 minimal, highly productive elective diagnostic centres for cancer, cardiac, respiratory and other conditions. For patients with suspected cancer, these should incorporate the rapid diagnostic centre service model.	?	?	Y	?	Y	Y
During recovery, triage tools should be used to prioritise patients according to likelihood of having serious disease. FIT levels for patients with possible bowel cancer and NT-proBNP for heart failure are examples.	Y	Y	Y	Y	Y	Y
Commissioners working with acute trusts and pathology services should ensure that phlebotomy services are easily and safely accessible within the community six days a week.	?	?	Y	Y	Y	Y
New diagnostic technologies should be rapidly evaluated – e.g. near patient virus testing for COVID-19, advanced genomic technologies, artificial intelligence in imaging and endoscopy and wearables.	Y	Y	Y	Y	Y	Y
<b>Option summary</b> 1. Business as usual post-COVID 2. Three session days and 7 day working -all sites 3. Diagnostic and treatment centre – including theatres 4. Diagnostic centre – Outpatient and diagnostics only 5. Diagnostic and treatment Centre that has limited theatre capacity to clear backlogs and service transformation is undertaken to instigate COVID light Day case pathways within the current DGH's 6. Diagnostic and treatment centre incorporating the proposals within the existing Orthopaedics business case project						

**Summary of Estimated Direct Treatment Costs**  
**Day case Backlog Cases Longer Than 36 week Wait**

Specialty	Backlog Cases @ 31st Aug 20	Cost @ WLI Rates	Estimated Cost
Max Fax	557	1,281	713,785
ENT	1,368	1,243	1,699,740
Breast Surgery	93	1,593	148,180
Gynaecology	322	1,141	367,288
Obstetrics	-	1,243	-
Trauma & Orthopaedics	4,582	1,418	6,496,894
Urology	930	1,083	1,007,218
Ophthalmology	5,760	860	4,952,291
<b>Grand Total</b>	<b>13,612</b>		<b>15,385,396</b>

**Notes**

Cost includes consultant surgeon (with Pre-op), Anaesthetist, theatre staff & consumables, HSDU, POAC and Day case ward.

No OPD costs included

In conclusion, option 3 has the potential to cost £75.5m, capital and direct treatment costs

Option 5 has the potential to cost £ 22.5m capital and direct treatment costs.

Other business cases as described earlier would contribute to this overall costing, however experts within the organisation have indicated that these are the **minimum** likely costs.

## D&amp;TC Programme – Draft timelines

From	To	Duration (Weeks)	Task	Comments
19.10.2020	22.01.2021	14	SOC Completion	Based on achieving: F&P Committee: 22.12.2020 (10.12.2020) Health Board: 21.01.2021 (11.01.2021)
22.01.2021	16.04.2021	12	WG scrutiny and approval	Normal time for scrutiny and approval
19.04.2021	25.06.2021	10	Appointments of Supply Chain Partner, Cost Advisor, Project Manager	Normal time for appointments from the mandated frameworks for this scale of project
28.06.2021	10.12.2021	24	OBC Development	Based on previous projects
13.12.2021	04.03.2022	12	WG scrutiny and approval	Normal time for scrutiny and approval
07.03.2022	03.03.2023	52	FBC Development	Based on previous projects
06.03.2023	26.05.2023	12	WG scrutiny and approval	Normal time for scrutiny and approval
29.05.2023	29.05.2026	156	Build	Based on benchmarking information from WG
01.06.2026	24.07.2026	8	Commissioning	
<b>Total Weeks</b>		<b>300</b>		
<b>Approx.:</b>		<b>5 years 9 months</b>		

Potential Mitigation A				
From	To	Duration (Weeks)	Task	Comments
19.10.2020	31.12.2020	11	SOC Completion - submit to WG end December 2020	Accelerated SOC submission - requires internal agreement
04.01.2021	29.01.2021	4	WG scrutiny and approval	Accelerated approval - requires WG agreement
01.02.2021	09.04.2021	10	Appointments of Supply Chain Partner, Cost Advisor, Project Manager	No change
12.04.2021	08.04.2022	52	Combine OBC / FBC	Requires WG approval. No break point in decision-making before undertaking detailed design work
11.04.2022	13.05.2022	4	WG scrutiny and approval	Accelerated approval - requires WG agreement
<b>16.05.2022</b>	<b>10.11.2023</b>	<b>78</b>	<b>Build: multi-storey</b>	<b>Based on a Modular Build. Land required - 5.6 acres</b>
<b>13.11.2023</b>	<b>08.02.2024</b>	<b>4</b>	<b>Commissioning</b>	<b>Accelerated</b>
<b>16.05.2022</b>	<b>12.05.2023</b>	<b>52</b>	<b>Build: Single storey</b>	<b>Based on a Modular Build. Land required - 5.6 acres</b>
<b>15.05.2023</b>	<b>09.06.2023</b>	<b>4</b>	<b>Commissioning</b>	<b>Accelerated</b>
<b>Total Weeks</b>		<b>163</b>	<b>(78 week build, multi-storey)</b>	
<b>Approx.:</b>		<b>3 years 4 months</b>		
<b>Total Weeks</b>		<b>137</b>	<b>(52 week build single storey)</b>	
<b>Approx.:</b>		<b>2 years 8 months</b>		

Potential Mitigation B				
From	To	Duration (Weeks)	Task	Comments
19.10.2020	31.12.2020	11	SOC Completion - submit to WG end December 2020	Accelerated SOC submission - requires internal agreement
04.01.2021	29.01.2021	4	WG scrutiny and approval	Accelerated approval - requires WG agreement
01.02.2021	12.02.2021	2	Appoint Contractor, Cost Advisor, Project Manager	Requires WG/HB to agree single tender waivers/not using the framework
15.02.2021	11.02.2022	52	Combine OBC / FBC	Requires WG agreement
14.02.2022	11.03.2022	4	WG scrutiny and approval	Accelerated approval
<b>14.03.2022</b>	<b>05.05.2023</b>	<b>60</b>	<b>Build: multi-storey modular: working accelerated</b>	<b>Requires agreement to accelerated working and the resulting cost premium.</b>
<b>08.05.2023</b>	<b>02.06.2023</b>	<b>4</b>	<b>Commissioning</b>	<b>Accelerated</b>
<b>14.03.2022</b>	<b>16.12.2022</b>	<b>40</b>	<b>Build: Single storey modular: 24/7 working</b>	<b>Requires agreement to accelerated working and the resulting cost premium.</b>
<b>19.12.2022</b>	<b>20.01.2023</b>	<b>5</b>	<b>Commissioning</b>	<b>Accelerated</b>
<b>Total</b>		<b>137</b>	<b>(60 week build multi-storey)</b>	
<b>Approx.:</b>		<b>2 years 7 months</b>		
<b>Total</b>		<b>118</b>	<b>(40 week build single storey)</b>	
<b>Approx.:</b>		<b>2 years 3 months</b>		

## **DTC Draft Timelines - Explanatory Note**

The timelines above outline three scenarios for how long it would take from here to have operational DTCs

The first scenario assumes that the current guidelines and processes are followed in full - for example a 3-stage business case process (SOC, OBC, FBC), and appointment of contractors from the framework. The estimated times for the production of business cases and construction are based on previous experience in the Health Board and elsewhere in Welsh Government. The estimated time to completion is 5 years 9 months.

The second scenario shortens the process, through assumptions about accelerated governance/approvals, producing a combined OBC/FBC and the use of modular construction. Two sub-options are shown, one where there is sufficient land to allow a single-storey construction, and one where multi-storey construction is required. The estimated time to completion is 3 years 4 months (multi-storey build) or 2 years 8 months (single storey build).

The third scenario shortens the process further, by assuming the use of single-tender waivers to speed up appointments and accelerated working. Again 2 sub-options are shown, as above. This is likely to incur a cost-premium (which has not been estimated). The estimated time to completion is 2 years 7 months (multi-storey build) or 2 years 3 months (single storey build).

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	<b>Finance and Performance Committee</b> <b>29.10.20</b>		
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public		
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	<b>Interim Robotic Assisted Surgery (RAS) solution for North Wales</b>		
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Mark Wilkinson		
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Meinir Williams; Dr Kate Clark; Kamala Williams; Jemma Orlik/Adrian Butlin		
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	<b>Committee</b>	<b>Date papers due</b>	<b>Date of meeting</b>
	Secondary Care Group	28 <sup>th</sup> September	1 <sup>st</sup> October 2020
	Planned Care Improvement Group	1 <sup>st</sup> October	2 <sup>nd</sup> October 2020
	Health Board Review Team (HBRT)	29 <sup>th</sup> September	6 <sup>th</sup> October 2020
	Executive Team	16 <sup>th</sup> October	21 <sup>st</sup> October 2020
<b>Atodiadau</b> <b>Appendices:</b>	None		
<b>Argymhelliad / Recommendation:</b>			
<p>The F&amp;P Committee is asked to approve the recommendation laid out in the attached paper that:</p> <ul style="list-style-type: none"> <li>• The plans described her in are supported.</li> <li>• The HB progress to securing a lease arrangement (7 year with break out option at the end of year3), for Robotic Assisted Surgery (RAS) technology to be provided at YG.</li> <li>• That RAS will support urology services in the first instance, with view to maximizing opportunities for other specialties in due course.</li> <li>• That the HB remains committed to the All Wales RAS programme and will ensure that this lease agreement is managed in line with the All Wales programme rollout plan.</li> </ul>			
Please tick as appropriate			
<b>Ar gyfer</b> <b>penderfyniad</b> <b>/cymeradwyaeth</b> <b>For Decision/</b> <b>Approval</b>	<b>X</b>	<b>Ar gyfer</b> <b>Trafodaeth</b> <b>For</b> <b>Discussion</b>	<b>Ar gyfer</b> <b>sicrwydd</b> <b>For</b> <b>Assurance</b>
			<b>Er</b> <b>gwybodaeth</b> <b>For</b> <b>Information</b>
<b>Sefyllfa / Situation:</b>			

In order to develop a safe and sustainable North Wales Urology service, recruiting and retaining high caliber clinical staff is essential. In June 2020 the UHB managed to recruit one high caliber urology cancer surgeon who has successfully re introduced cystectomy surgery into North Wales. In August this year, the UHB have recruited a further 2 high caliber surgeons, both skilled in cancer surgery and robotic assisted surgery (RAS). In order to secure their start dates and retain our surgeon appointed in June, access to RAS technology in North Wales is essential.

This business case describes how RAS can be introduced quickly and cost effectively. How we can avoid the high risk strategy of reliance on access to NHSE services; does not compromise the HBs commitment and engagement with the All Wales RAS procurement programme, and provides an opportunity to deliver cost savings in years 4 -7 should the HB choose to continue beyond year 3 of this proposal.

### **Cefndir / Background:**

Prior to Covid-19, the North Wales Urology service had been subject to a strategic review with the intention to agree a service model that would deliver high quality, sustainable urology services for the population.

The most recent clinical aspiration for the service model includes comprehensive urology cancer delivered at Ysbyty Gwynedd - which supports the complex pelvic cancer work already being delivered there; single site complex stone service to continue to be delivered at Wrexham Maelor; all supported by robotic assisted technology (RAS). The clinical teams believed that a comprehensive service model as described would attract high caliber urology Consultants and wider workforce which will lead to established and sustained, comprehensive urology cancer surgery in North Wales.

There is little doubt that securing RAS into North Wales is key to the delivery of the clinical aspiration.

Access to RAS through our historic pre Covid pathways and contracts has been challenging due to NHS England providers protecting their limited capacity for their local population. This has meant that we have been unable to secure care for some of our most clinically high risk patients. Despite significant efforts to secure services as far afield as London and South Wales, little or no capacity has been secured.

Following the recruitment of a high caliber urology cancer surgeon in June, the HB has now re started complex cystectomy surgery at Ysbyty Gwynedd in Bangor. This has meant that as of October all patients who had waiting significant periods for their treatment have now had their surgery and all are recovering well.

Access to prostatectomy and nephrectomy surgery remains a challenge. There are currently 19 patients waiting for nephrectomies with the HB only able to secure surgery for 17. This capacity is at the Royal Free in London. The team continue to attempt to secure surgery for prostatectomy.

This puts into context the importance of securing sustainable services in North Wales. The proposal set out in this Business Case provides that opportunity.



## Asesiad / Assessment & Analysis

### Strategy Implications

The Health Board's commitment to the continuation of Acute Urology services in North Wales is of strategic significance not only for patients who require care for urological conditions but also to safeguard the provision of other interdependent specialties. Establishment of Robotic Assisted Surgery (RAS) in North Wales has been identified as a priority, necessary to sustain delivery of Acute Urology services by supporting the recruitment and retention of key medical personnel.

Whilst the main driver for the development of a RAS service in North Wales at this time is to safeguard the provision of urology services it will address the current North Wales inequality of access to RAS compared to the rest of Wales and the UK.

The detailed strategic implications can be read in **section 1** of the enclosed business case.

### Options considered

Several options have been considered by the clinical group established to develop this business case.

The options considered are described in **section 3** of this business case.

### Financial Implications

The financial case is detailed in **section 4** of the attached business case

### Risk Analysis

The risk of the HB not recruiting and retaining high calibre urology clinicians is set out in the attached business case. The ability to mitigate this risk is inextricably linked to introduction of RAS technology into North Wales.

A comprehensive risk register will form part of the implementation plan should this business case be approved through the governance structure defined.

### Legal and Compliance

A negotiated notice period with existing contract with NHS England is required. However, this contract has failed to secure timely surgery for North Wales patients since Covid-19.

<b>Division / Area / Department</b>	<b>North Wales Urology Service</b>
<b>Development or Scheme Title</b>	<b>Interim RAS solution for North Wales</b>
<b>Author/s</b>	<b>Meinir Williams: Kamal Williams: Jemma Orlik: Dr Kate Clark</b>
<b>Executive Sponsor</b>	<b>Mark Wilkinson – Exec Director Planning and Performances</b>
<b>Version</b>	<b>V</b>
<b>Date</b>	<b>22/10/2020</b>

<b>1.0</b>	<b>The Strategic Case</b>
<b>1.1</b>	<p><b>Introduction</b></p> <p>Prior to Covid-19, the North Wales Urology service had been subject to a strategic review with the intention to agree a service model that would deliver high quality, sustainable urology services for the population.</p> <p>The most recent clinical aspiration for the service model includes comprehensive urology cancer delivered at Ysbyty Gwynedd - which supports the complex pelvic cancer work already being delivered there; single site complex stone service to continue to be delivered at Wrexham Maelor; all supported by robotic assisted technology (RAS). The clinical teams believed that a comprehensive service model as described would attract high caliber urology Consultants and wider workforce which will lead to established and sustained, comprehensive urology cancer surgery in North Wales.</p> <p>There is little doubt that securing RAS into North Wales is key to the delivery of the clinical aspiration.</p> <p>In March 2017 the Health Board drafted a Business Justification Case (BJC) which progressed through a series of groups and committees and in Q3 2018 it was presented to Executive Management Team. In early 2019 the BJC was refreshed to reflect Executive feedback and was due to be represented in Q2 2019/20. However, by this time the HB had expressed an intent to be part of the all Wales commissioning programme designed to deliver a once for Wales approach to Colorectal Robotic Assisted Surgery (RAS) which the HB believed would address the limited access to RAS for the people of North Wales.</p> <p>Soon after the decision to work to the all Wales timeframes Covid-19 changed everything that had gone before, and as the HBs acute sites prepared its staff and systems for what was anticipated, all bar for emergency surgery was put on hold.</p> <p>As we emerged from the initial peak, and turned attention to restarting essential surgical activity, the impact felt by our highest risk urology patients can be quantified by extensive waits, narrowing of optimum time to treatment leading to deterioration in patient outcomes, quality of life and life expectancy. Attempts to access historical pathways into NHS England (NHSE) for procedures such as prostatectomies, cystectomies and partial nephrectomies have been significantly compromised with</p>

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NHSE partners protecting their limited capacity for their own, local population. The HB has found little recourse with our NHSE partners as historical contracts were, for the majority, based on 'per patient', often through IPFR or informal arrangements which, in the face of Covid-19 lacked resilience or guarantee of care when North Wales patients most needed it.

As part of the HBs work to restart Essential Services, a Strategic Planned Care Programme group has been established led by the Executive Nurse Director/Interim CEO and Executive Medical Director. They, in turn are supported by the Chief Operating Officer and Director of Planned Care. Together the group set to identifying the patient cohorts with the highest clinical risks and most likely to suffer harm. Urology fell firmly into this category in terms of the number, length of wait and clinical acuity of patients across North Wales.

A sub group established to quickly developed and implement a Urology action plan have made significant progress working in developing and delivering a sustainable service model similar to that described in the 2018 Clinical Strategy BJC. The group, though operationally supported by senior management, has been largely clinically driven by four key Consultants from across the HB. These 4 individuals have invested time, emotion and energy in galvanizing clinical opinion and secured much needed 'buy in' of colleagues within and outside of urology. This has meant that for the first time in almost a generation there is a single coherent clinical voice driving the vision for the North Wales Urology service.

The power of this voice cast across the UK has attracted and secured three high caliber urology Consultants. One already in post - and early in September he performed the first cystectomy case in North Wales for almost 3 years. A further 4 cases have since been performed resulting in no patients waiting for cystectomy surgery – a position the HB has not been in for many years. These patients experienced protracted waiting times for their cancer surgery, causing increased stress and anxiety through an already troubled time. This service re start has been a significant step both for North Wales citizens and the HB.

The 3 new surgeons have a significant cancer surgery pedigree, and all are trained to in RAS. Adding this to the single urology cancer surgeon already employed by the HB has the potential to create a urology service that will deliver high quality, safe, timely cancer surgery to the sickest, highest risk patients, close to home and supported by local BCUHB teams. Cancer surveillance will be delivered locally by local teams and the substantive workforce means that the HB moves closer to the overall capacity required for all urological conditions.

However, the vision can only be realized by provision of consistent and reliable access to RAS, which ensures that the surgeons maintain their skills and expertise, and provides improved patient care, outcomes and experience; maximizes use of resource and brings North Wales in line with the rest of Wales and the UK.

This business case describes how RAS can be introduced quickly and cost effectively. How we can avoid the high risk strategy of reliance on access to NHSE services; does not compromise the HBs commitment and engagement with the All Wales RAS procurement programme, and provides an opportunity to deliver cost savings in years 4 -7 should the HB choose to continue beyond year 3 of this proposal.

1.2	<p><b>Strategic Context</b></p> <p>The Health Board's commitment to the continuation of Acute Urology services in North Wales is of strategic significance not only for patients who require care for urological conditions but also to safeguard the provision of other interdependent specialties. Establishment of Robotic Assisted Surgery (RAS) in North Wales has been identified as a priority, necessary to sustain delivery of Acute Urology services by supporting the recruitment and retention of key medical personnel.</p> <p>Whilst the main driver for the development of a RAS service in North Wales at this time is to safeguard the provision of urology services it will address the current North Wales inequality of access to RAS compared to the rest of Wales and the UK.</p> <p>The HB remains fully commitment to the All Wales RAS procurement programme, therefore this business case describes a lease option as opposed to previous intent to outright purchase a robot. A capital purchase option has been discounted partly due to the risk this may pose to the HBs commitment to the All Wales RAS procurement programme, but also on the grounds of affordability and expected life span of a robot.</p> <p>The clinical and operational team are in support of seeking to secure a 3 year lease option of the robot which brings the HB in line with the estimated roll out of the All Wales programme.</p> <p>This paper describes a proposed lease arrangement with associated revenue and capital cost implications. The detailed financial breakdown is described in section 4.</p>
1.3	<p><b>Organisational Overview</b></p> <p>BCUHB was established on 1st October 2009 and is the largest health organisation in Wales. 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. 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.</p> <p>BCUHB employs approximately 16,400 staff and has an annual revenue budget of approximately £1.5 billion.</p> <p>North Wales is divided into three "Areas", which operationally manage primary and community services (including community hospitals and dental services) and work with local hospital services to ensure the delivery of effective healthcare. The Areas are established within geographical boundaries across North Wales – East, Centre and West. Each Area is serviced by one District General Hospital namely Wrexham Maelor Hospital (WRX) in the East; Ysbyty Glan Clwyd (YGC) in the Centre, and Ysbyty Gwynedd (YG) in the West.</p>



#### 1.4 Relevant National and Local Strategies

##### 1.4.1 Living Healthier Staying Well

BJC has been developed as a key part of the BCU Health Board's vision for its *Acute Hospital Care* programme within the "Living Healthier Staying Well".

##### Annual Operating Plan 2019/20

1.4.2 The Planned Care Annual Operating Plan (AOP) for 2019/20 makes reference to the development of a BJC for RAS to support the urology specialty, to respond to changes in patient needs, demand, workforce and technology. The AOP notes that the intention to utilize RAS to develop a specialist pelvic cancer service for North Wales encompassing gynecology and colorectal cancer surgery – however this development will form part of the All Wales RAS colorectal procurement programme

##### 1.4.3 Cancer Delivery Plans

The Welsh Government's *Together for Health - Cancer Delivery Plan - A Delivery Plan up to 2016 for NHS Wales and Its Partners* requires Health Boards and Trusts to work together, either through the Cancer Networks or Welsh Health Specialised Services Committee (WHSCC), to plan for the prompt and equitable introduction of new technologies. One of the required actions to "Delivering Fast and Effective Treatment and Care" is to identify mechanisms to plan and deliver equitable access to new diagnostic and treatment procedures in line with evidence. Support for the implementation of robotics within BCUHB will enable the organisation to collaboratively lead clinical and laboratory research in this field and provide the patients of North Wales the same opportunity to Robotic Surgery as currently provided in South Wales and elsewhere in the UK. More recently, the *Cancer Delivery Plan for Wales 2016 – 2020 repeatedly refers to "equitable access" to care*, reinforcing the message of the previous plan.

1.4.4	<p><b>National Cancer Standards</b></p> <p>The Cancer Delivery Plans reference meeting national quality standards introduced in 2005 (WHC (2005) 051) Cancer Services in Wales – Publication of National Cancer Standards and the implication for Commissioner and Providers, through the Cancer Networks). The 2016 – 2020 plan notes:</p> <p><i>Referral to treatment times are an important measure of quality, not just productivity, as all patients should start treatment within 62 days of being aware they are suspected of having cancer to give them the best possible outcomes.</i></p>
1.4.5	<p><b>National Institute for Health and Care Excellence</b></p> <p>The National Institute for Clinical Effectiveness (NICE), now the National Institute for Health and Care Excellence, published revised guidelines for the treatment and management of prostate cancer (NICE 2014). This guideline indicated that RAS techniques should be considered for the management of localised prostate cancers.</p>
1.4.6	<p><b>North Wales Review of Urology Services</b></p> <p>The current service model for Acute Urology services in North Wales has not been sustainable due to difficulties in the recruitment and retention of key clinical staff. The service has recently been subject to review and a preferred service model identified.</p>
1.4.7	<p><b>National Urology Implementation Plan</b></p> <p>The purpose of the National Urology Implementation Plan is to improve patient experience and deliver sustainable services. The plan builds on a series of developments in Wales to provide a balanced service change for implementation by Health Boards across Wales.</p> <p>The plan requires Health Boards to understand and measure demand, capacity and activity in Urology and establish a patient experience measure for Urology services in Wales.</p> <p>The three primary drivers for service change will be:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Clinical Value Prioritisation</b> - making sure that only the right patients are managed in secondary care.</li> <li><input type="checkbox"/> <b>Integrated Care</b> - establishing collaborative care groups (between hospital, community and primary care) and empowering patients to manage their health.</li> <li><input type="checkbox"/> <b>Best in Class</b> - measuring value for money and benchmarking against top performing organisations.</li> </ul> <p>The plan has been developed by the National Planned Care Programme Board after stakeholder consultation with advice and recommendations from the planned care reference groups that involves patients and the third sector. It contains thirteen key actions for Health Boards to implement.</p> <p>The plan is issued as a Welsh Health Circular (WHC/2016/017). Health Boards' delivery against the plan is reviewed at each meeting of the Welsh Urology Board.</p>

## The Case for Change

The development of RAS will enable BCUHB to deliver a range of benefits to patients in North Wales (and potentially others within neighboring Health Boards); improve the clinical and physical environment for surgeons and provide increased opportunities for training and collaborative clinical research. While improving care for patients, the improvements for the surgeons would also impact positively on recruitment and retention rates. The proposal will result in improvements in a number of areas including:

- **Service sustainability - address recruitment and retention issues in the North Wales urology service including future training opportunities.**
  - Urological surgeons in the UK are now exclusively trained in robot assisted laparoscopic pelvic surgery so potential candidates are unlikely to apply for a post which does not offer access to a robot. The Health Board prior to this year advertised several times for two consultant urologist posts with no suitable candidates. It is clear that BCUHB will not be able to develop a safe and sustainable urology service capable of delivering the majority of urological procedures in North Wales without a full complement of permanent medical staff in place. Establishing RAS in North Wales presents an opportunity to develop a training programme that will further enhancing potential to recruit and retain high caliber staff.
  -
- **Enhanced quality of surgery**
  - Enhanced surgical precision is enabled because the image is three dimensional as in open surgery but unlike laparoscopic surgery, the instruments move with 7 degrees of movement, which is more than the human hand. Conventional laparoscopic surgery is restricted to 2 degrees of movements. Movements are scaled down to remove tremor and enhance accuracy. Improved handling speeds up the performance of complex surgical procedures in hard to access areas such as the pelvis and retro peritoneum.
- **Shorter learning curve**
  - It has been demonstrated in Urology with regards to radical prostatectomy that those with minimal laparoscopic skills can develop Robotic Surgery. The learning curve from open to Robotic Surgery is estimated to be less than 40 cases. The reduced learning curve also applies to Gynaecology and rectal surgery, making this surgery easier and safer.
- **Surgical time**
  - Robotic assisted surgery is generally faster and safer than laparoscopic surgery. Laparoscopic surgery has a long learning curve and tasks such as suturing take time to accomplish satisfactorily. The difficulty in learning skills may result in increased complication and poor adoption. The use of robotic assisted surgery minimizes these risks.
  -
- **Reduced hospital stay and readmission rates**
  - Whilst minimal access surgery has clear advantages over open surgery with regard to hospital stay recovery and reduced complications, evidence suggests that this is reduced even further for robotic assisted surgery. It is anticipated that the length of stay for an open radical prostatectomy patient will reduce from 4.1 days to 1 day with the use of robotic assisted surgery. In the future where RAS could be made available to other specialties, an example of the wider



opportunities for improved quality, patient experience and outcomes is in the case of gynaecology, radical hysterectomy with pelvic lymphadenectomy currently carried out as an open procedure with patients staying in hospital 5 days on average, can be done robotically with an overnight stay.

- **Enhanced working environment**

- Surgery using robots is more ergonomically sound for the surgeon, has reduced operating times and reduced incidence of repetitive strain injury resulting in less surgeon fatigue thereby increasing productivity and efficiency.

- **Patient return to normal activity**

- The use of robotic assisted surgery enables patients to return to normal levels of activity at a far faster rate than with open surgery.

- **Enhanced quality of life outcomes**

- Evidence suggests that the use of robotic assisted surgery reduces the rates of post-operative complications such as incontinence and erectile dysfunction. This improves the patients' quality of life and reduces the cost of treatment of complications.

- **Reduce reliance on other NHS providers**

- BCUHB historically held contracts with three English providers for robotic assisted surgery. Due to Covid-19 and other challenges access to RAS in NHSE in 19/20 has not been possible. The risk of contracting with an English provider presents a number of risks – the English commissioners of the service can unilaterally change service configuration. Whilst notice will be given it may prove difficult to find an alternative provider. Using an English provider can also result in additional costs to the Health Board over and above the cost of the surgical procedure itself for example, extended length of stay, ancillary treatment or diagnostics. There is also a risk of a material increase in tariff, as has been recently experienced for cardiac procedures, which the Health Board will not be able to avoid. Recent experience of access to services in the North West of England is that patients referred for care via the traditional process have not accepted by the provider but not listed for procedures. The HB has since needed to seek alternative providers for patients with unacceptably long waiting times.

The BJC had been developed as a key part of the BCU Health Board's vision for its *Acute Hospital Care* programme within the "Living Healthier Staying Well" system wide BCUHB Health Strategy. This programme incorporates service areas which may be considered fragile / under extreme pressure, and require rapid solution to facilitate developing services for the longer term. Urology has been identified as one of the highest risk specialties as part of the Essential Services restart programme.

The BJC addressed the requirement to support the sustainability of clinical services connected with pelvic cancer, specifically urology. Focusing on the implementation of robotic surgery, the proposed scheme is in line with a number of the Health Board's Strategic Goals including:

- Improving health and well-being for all and reducing health inequalities
- Improving the safety and outcomes of care to match the NHS's best
- Using resources wisely, transforming service through innovation and research
- Supporting, training and developing our staff to excel



## Patient and Public Expectation

The BJC has also been developed in response to patient and public demand. In July 2013, the Petitions Committee of the National Assembly for Wales received the following petition:

### **P-04-494 Robotic assisted laparoscopic prostatectomy must be made available to men in Wales now**

#### **Petition wording:**

*Robotic assisted laparoscopic prostatectomy is the 21st Century Gold standard. Wales as a nation must be at the forefront in offering this standard. We, the undersigned, are appalled by the fact that men in Wales with prostate cancer cannot be offered robotic surgery in Wales, yet in England ALL men have this choice with at least 40 locations offering this treatment and with men from Wales having to pay thousands of pounds to access this capability in these English NHS facilities (typically between £13-15,000). Clearly, many men in Wales cannot afford this. We call on the National Assembly for Wales to urge the Welsh Government together with the National Health Service of Wales to resolve this totally unfair predicament and serious lack of essential resource within our NHS in Wales without delay. It is vital that this technology, this 21st Century Gold Standard is offered to men in Wales. It simply cannot be right that such technology is available elsewhere and that men from Wales have to pay to avail themselves of it in an NHS facility in England.*

In a response to the Chair of the Petitions Committee, Mark Drakeford, then Minister for Health and Social Services, confirmed that the Welsh Government recognized that technology has a major role to play in the future of the NHS in Wales and noted that the Health Technologies Fund had funded a robotic surgery system at the University Hospital of Wales.

Patient groups in North Wales have also been active in their support for robotic surgery in North Wales, with an active campaign established to raise awareness and provide support for the potential development. This drive is also supported by cancer charities, for example, Prostate Cancer UK. In the document, "Prostate Cancer UK Policy Position on Robotic Surgery", the charity stated "we believe all men should be able to make an informed choice about whether they wish to undergo robot-assisted surgery or not" and:

We want

- All men to be able to access robotic surgery when it is the right choice for them
- Robots to be made more available across the UK
- All men to have access to a surgeon who is trained to use the equipment

While these demands are specifically linked to prostate cancer, they could be equally applied to other areas of pelvic cancers, with access, availability and training common themes to other specialties.

As part of the development of this BJC, the North Wales Cancer Patient Forum was asked to provide a user perspective on the development of a robotic assisted surgical service in North Wales. The Forum is a voluntary group of people affected by cancer and works in positive partnerships with BCUHB and a range of other

	<p>organisations to provide a service user perspective of cancer services at a local and national level. The topic elicited great interest and generated considerable discussion within the Forum and positive views included the following:</p> <p><b>Prostate Cancer Patient:</b> <i>The issue is not one of survival but return to a quality of life in a short time frame and living beyond the cancer episode as fit and healthy as possible.....</i></p> <p><b>North Wales Prostate Cancer Support Group representative:</b> <i>I am very much in favor of robotic surgery as after having a prostatectomy I suffered both incontinence and still have erectile dysfunction 8 years on. These side effects are greatly reduced by robotic surgery and in the procuring of this equipment this should be the deciding factor in my opinion.....</i></p>
2.1	<p><b>Existing Arrangements, Issues and Risks</b></p> <p>Currently the only access arrangements to RAS for North Wales patients relies on outsourcing into NHSE or seek support from South Wales HBs. The risks associated with this arrangement has been well described here-in, and remains to be an unsafe and unsustainable arrangement.</p> <p>With limited or lack of access to RAS, clinical teams are opting for alternative treatment plans which - though clinically safe, may not be the best option to maximize patient outcomes and experience. Clinicians are reporting that patients too are choosing alternative pathways as a journey to London or the North West of England for major surgery is felt not to be the best holistic path for them.</p> <p>The introduction of RAS for urology in North Wales, does not impact on existing urology on call services, routine urology care such as many procedures through Urology Day Units, diagnostics such as scoping procedures or surveillance, therefore there is no impact for the majority of patients accessing urology care in North Wales. There will be an impact for a small number of patients who may need to travel to Ysbyty Glan Clwyd for Day Case Surgery as we realign theatre capacity to accommodate the cancer work in the West. Further work is being done to quantify the impact but is envisaged to be a small number of patients. This proposal does however, significantly improve access, care and outcomes for urology cancer patients who currently have to travel to England for treatment which, since Covid has come with great uncertainty.</p> <p>Review of the current waiting lists shows that there are 36 patients waiting for prostatectomy surgery and 9 patients waiting nephrectomies. The current HB contracts for these procedures are held at Arrowpark and UCLH, London. Arrow Park have been unable to offer dates for patients referred to their service, and UCLH are currently reviewing 3 patients waiting nephrectomy surgery with view to offering surgery dates in the next 4 weeks. There is, as yet no clear plan for the remaining 6 patients. The teams continue to monitor and liaise with providers in the hope of securing capacity soon.</p> <p>The UCLH contract ends in March 2021, and it is proposed that the HB maintain this contract to the end of its term.</p> <p>This business case describes the cost and service model for the North Wales urology service, and though it recognizes the opportunity RAS offers for colorectal and gynaecology - should the HB seek to realise the opportunity for these specialties separate business cases will be required.</p>

	It is envisaged that the development of RAS as described here-in will compliment any future HB plans to establish Diagnostic and Treatment centres in North Wales.
2.3	<p><b>Objectives and Benefits</b></p> <p><b>Main Objectives</b></p> <p>This section describes the main objectives and benefits associated with the implementation of the project. The benefits derived from the project investment objectives can be seen below and are summarized as benefit criteria.</p> <p>The investment objectives for the project are as follows:</p> <p><b><i>Investment Objective 1</i></b></p> <p>To provide safe and sustainable services in response to current and future health needs of the population</p> <ul style="list-style-type: none"> <li>- Improved recruitment and retention opportunities and rates</li> <li>- Improved patient outcomes through less invasive trauma, blood loss and associated transfusions</li> <li>- Reduced complication rates</li> </ul> <p><b><i>Investment Objective 2</i></b></p> <p>To increase the range of services available locally, thereby reducing reliance on referral to England for treatment</p> <ul style="list-style-type: none"> <li>- Improve access for patients and allow care closer to home</li> <li>- Retain services in North Wales (and reduce referrals to external NHS providers)</li> <li>- Provide equity of access to treatment in line with South Wales and England</li> <li>- Increase patient choice</li> <li>- Potential to attract activity from other geographical areas (opportunity to provide a potential source of income in the longer term)</li> </ul> <p><b><i>Investment Objective 3</i></b></p> <p>To improve patient experience by delivering best practice surgical techniques for patients requiring radical urology cancer surgery</p> <ul style="list-style-type: none"> <li>- Reduced recovery time for patients with less pain and quicker return to normal activities</li> <li>- Enable the best practice surgical technique for patient requiring radical cancer surgery</li> <li>- Improve patient functional outcomes e.g. improved continence and nerve sparing (and subsequent erectile function)</li> <li>- Improved cancer staging</li> </ul> <p><b><i>Investment Objective 4</i></b></p> <p>To improve surgeon experience by delivering best practice surgical techniques for patients requiring radical urology cancer surgery.</p> <ul style="list-style-type: none"> <li>- Improved opportunities for recruitment by providing modern and appropriately equipped facilities for clinicians</li> <li>- Improved ergonomics and reduced operating times leading to less operator Fatigue and strain e.g. currently only one laparoscopic prostatectomy can be carried out in a day, while robotic assisted surgery can accommodate two or three of these procedures in a day</li> <li>- Reduction in medical agency expenditure</li> </ul> <p><b><i>Investment Objective 5</i></b></p>

- To improve performance against a range of local and national targets
- Decrease cancer waiting times (e.g. 62 day target for patients requiring surgical management)
  - Deliver specialist urology cancer services in North Wales
  - Reduced length of stay in an acute setting – patients are home quicker Following safer surgery
  - Improve the utilization of operating department facilities and theatre efficiencies

Benefits are expressed as follows:

- **CRB:** Cash releasing Benefits (e.g. avoided costs)
- **Non CRB:** Non cash releasing Benefits (e.g. staff time saved)
- **QB:** Quantifiable Benefits (e.g. achievement of targets)
- **Non QB:** Non Quantifiable or Qualitative Benefits (e.g. improvement in staff morale)

The following table summarizes the benefits arising from each of the investment objectives:

Investment Objective	Stakeholder Group	Benefit	Category
1. To provide safe and sustainable services in response to current and future health needs of the population	Patients	Continued delivery of acute surgery across BCUHB	Non QB
	BCUHB	Improved recruitment and retention rates	QB
	Staff/Patients	Improved patient outcomes	Non QB
	Patients		QB
	Patients/BCUHB	Reduced complication rates	QB
2. To increase the range of services available locally, thereby reducing reliance on outsourcing to deliver care	Patients	Improved access for patients	Non QB
	BCUHB		Non QB
		Retain services and reduce outsourcing (Potential for future CRB)	
	Patients/Staff		Non QB
	Patients	Provide an equitable service	Non QB
	BCUHB	Provide increased choice	Non QB
		Potential to attract activity and income from other health boards (Potential for future CRB)	

	3. To improve patient experience by delivering best practice surgical techniques for patients requiring radical cancer surgery	Patients	Reduced recovery time with less pain and quicker return to normal activities	Non CRB
		Patients/Staff	Provides best practice surgical technique to patients requiring radical urology cancer surgery	Non QB
		Patients	Improved quality of surgery reducing incidence	Non QB
		Patients	Improved patient functional outcomes (continence and nerve sparing)	Non QB
		Patients/Staff	Improved cancer staging	Non QB
	4. To improve surgeon experience by delivering best practice surgical techniques for patients requiring radical cancer surgery	Staff	Improved opportunities for recruitment by providing modern and appropriately equipped facilities for clinicians	QB
		Staff/BCUHB	Improved ergonomics and reduced operating times leading to less operator fatigue and strain e.g. increased numbers of procedures. Improved productivity and efficiency.	Non-CRB
		Staff/BCUHB		CRB
		BCUHB	Reduced surgeon time – fewer surgeons required for procedures	CRB
			Reduced medical agency expenditure	
	5. To improve performance and efficiency against a range of local and national targets	Patients/BCUHB	Decreased cancer waiting times (e.g. 62 day target)	Non QB
		Patients/BCUHB	Continued delivery of specialist cancer services	Non QB
		Patients/BCUHB	Reduced length of stay in an acute setting – patients are home quicker	Non-CRB

		BCUHB	following safer surgery. Increased throughput	Non-CRB
		BCUHB	Improved utilization of operating department facilities and theatre efficiencies	Non QB
		BCUHB	Potential to reduced “downstream” costs e.g. continence nurse appointments,  Reduced re-admissions and less complications?	Non-CRB
	<p><b>Business Needs</b></p> <p>Robotic surgery is now an established technique for the treatment of uro-pelvic cancers in the UK. In the absence of RAS in North Wales BCUHB continues to offer both open and laparoscopic urological cancer surgical procedures. In 2015, following extensive discussions with the then Executive Medical Director (Professor Matt Makin) a robotic surgeon was successfully appointed by BCUHB, the surgeon remains in post and though has historically had access to robotic assisted procedures with an English NHS provider, since Covid this has been increasingly difficult which risk his ability to maintain competency. Implementation of RAS within the organisation would maximize the opportunities for developing services that this appointment and now other more recent appointments have brought.</p>			
3.0	<b>Options</b>			
3.1	<p>The options previously reviewed as part of the 2019 BJC are described below. These remained the possible solutions to the challenges faced by current services in North Wales. However working within the National context and reflecting the impact of Covid-19, the HB has failed to secure access to NHSE urology cancer capacity, and as such outsourcing can no longer be viewed as a safe or feasible option.</p> <p><b>Option 1     Do Nothing</b> Retain current service provision with outsourced activity commissioned from NHS providers in the North West of England.</p> <p>This option would retain the status quo with patient care delivered as now: within BCUHB and Robotic Surgery for a number of Urology procedures outsourced to NHS providers in the North West of England. The “Do Nothing” option would not allow BCUHB to provide a safe and sustainable service for our patients and for those patients requiring pelvic cancer surgery, the service would remain fragile with a real threat that the Health Board may not be able to sustain an acute urology service in North Wales. BCUHB would not be able to modernise its surgical services and support the delivery of best practice techniques. By not investing in robotic surgery, BCUHB would limit its ability to recruit and retain consultant and junior staff, and future recruitment is likely to be severely compromised. By relying on external</p>			

	<p>providers for services, BCUHB would have less control over its cancer waiting times performance. BCUHB is committed to investing in its own local services, allowing patients to be treated closer to their homes. However, patients would continue to have to travel distances out of North Wales to receive their care, limiting access and patient preference, and at significant cost to the Health Board in order to have their surgery.</p>
3.2	<p><b>Option 2 Stop outsourcing activity to NHS providers in the North West of England</b></p> <p>No longer outsource activity to current providers and aim to deliver services within BCUHB. This would mean that robotic assisted surgery would no longer be available to North Wales' patients.</p> <p>This option aims to deliver services within BCUHB, while stopping outsourcing activity to external providers. As with option 1, this option would not provide a safe and sustainable service and opportunities to further improve clinical outcomes for patients will not be realized. Improvements to efficiency and productivity will remain challenging and in order to meet patient demand, this option would require future investment in laparoscopic capacity (surgeons, theatre teams and equipment). Patients would not have the option of robotic assisted surgery. Staffing, recruitment and retention of trained laparoscopic surgeons will continue to present a challenge as the pool of laparoscopically trained surgeons is diminishing due to changes in training. In addition the Health Board will be in competition for applicants with other NHS providers able to offer robotic assisted surgery.</p>
3.3	<p><b>Option 3 Outsource advanced Pelvic Cancer Surgery to NHS providers in the North West of England</b></p> <p>No longer provide advanced pelvic cancer surgery within BCUHB.</p> <p>Increasing numbers of patients are seeking access to robotic assisted surgery. If BCUHB decides to outsource all such operations, it will be challenging to recruit and retain expertise for pelvic surgery in North Wales. Such surgeons will not only be required to perform complex pelvic procedures but also support the delivery of acute gynaecology, general and urological services. In order to maintain these essential services, BCUHB will have to spend more by relying on temporary agency locums. Over time, the outsourcing of advanced pelvic cancer surgery would seriously impact on the viability of acute care within the Health Board and reduce the numbers of consultant and junior staff level of posts available. This may also impact on the ability to recruit high caliber staff longer term, as they would be unable to fulfil their special interests.</p> <p>This option is not aligned with a key BCUHB principle of providing care as close as possible to patients' home and would o create inequity of care between North and South Wales. In addition, it is not clear whether there is capacity for this level of growth in the North West of England, given the limited capacity available for current levels of referrals.</p>
3.4	<p><b>Option 4a Implement RAS in BCUHB – Capital Option</b></p> <p>Implement robotic surgery within BCUHB funded by All Wales Strategic Capital.</p>
3.5	<p><b>Option 4b Implement RAS in BCUHB – Leasing Option</b></p> <p>Implement within BCUHB funded through a leasing arrangement i.e. revenue route.</p>

	<p>Investment to implement robotic surgery (funded either by capital or revenue) into BCUHB would enable the delivery of a range of strategic and clinical benefits linked to the investment objectives for the scheme. This would support the development of a safe and sustainable service, deliver a range improved outcomes for patients, and increase opportunities for providing services locally. This would improve both access and choice for patients. While improving patient experience, options 4a and 4b would also have a very positive impact on performance (cancer targets, length of stay etc.), in delivering more efficient and effective patient care. The implementation of robotic assisted surgery would significantly improve opportunities for recruitment and retention, demonstrating investment in modernization and support for best practice surgical techniques. Further development and growth of the uro-oncology, colorectal and gynaecology services would be facilitated with the establishment of a dedicated pelvic cancer team. The investment in robotic assisted surgery would also provide the ability to teach, train and attract trainee doctors, whilst maintaining and developing BCUHB as a pelvic cancer centre. BCUHB would be able to offer “cutting edge” health care and research for robotic assisted surgery on a par with the rest of the UK and Europe. Both options 4a and 4b would result in a net additional revenue cost to BCUHB. These additional costs require a funding source and provision for the additional costs will be required. There are opportunities to mitigate the costs through increased productivity and efficiency although this is likely to be non-cash releasing and in the longer term via income generation.</p>
3.6	<p><b>Appraisal of Options</b></p> <p><b>Option 1 Do Nothing</b>  Retain current service provision with outsourced activity commissioned from NHS providers in the North West of England.</p> <p><i>This is no longer an option either in the immediate, short or medium term post Covid due to limited capacity of all UK providers being protected for their own, local population. The HB has already experienced an inability to secure timely care for many high risk urology patients.</i></p> <p><b>Option 2 Stop outsourcing activity to NHS providers in the North West of England</b>  No longer outsource activity to current providers and aim to deliver services within BCUHB. This would mean that robotic assisted surgery would no longer be available to North Wales’ patients.</p> <p><i>Denying the North Wales population of access to RAS has been discounted from the outset. This would lead to significant inequality and compromise patient safety and outcomes.</i></p> <p><b>Option 3 Outsource advanced Pelvic Cancer Surgery to NHS providers in the North West of England</b>  No longer provide advanced pelvic cancer surgery within BCUHB.</p> <p><i>This is no longer an option either in the immediate, short or medium term post Covid due to limited capacity of all UK providers being protected for their own, local population. The HB has already experienced an inability to secure timely care for many high risk urology patients.</i></p>



	<p><b>Option 4a Implement RAS in BCUHB – Capital Option</b> Implement robotic surgery within BCUHB funded by All Wales Strategic Capital.</p> <p><i>This is no longer an option due to the HB's commitment to the All Wales RAS programme, and support of a 'Once for Wales' approach. It has also been demonstrated that outright purchase does not offer VFM given the capital outlay and life expectancy of a modern day robot, which means that a replacement programme would be required in 7 years.</i></p> <p><b>Option 4b Implement RAS in BCUHB – Leasing Option</b> Implement within BCUHB funded through a leasing arrangement i.e. revenue route.</p> <p><i>This option provides a balanced, sustainable, VFM solution to the challenges the HB is faced with today. It addresses the capacity gaps that urgently need to be filled to ensure patients who require time critical life saving urology surgery are offered it locally and in a safe, timely way. It avoids compromising the HBs role in the All Wales Programme and supports the recruitment and retention opportunities currently open to the HB.</i></p>
3.7	<p><b>Conclusion: Preferred Option</b></p> <p><b>Option 4b Implement RAS in BCUHB – Leasing Option</b> Implement within BCUHB funded through a leasing arrangement i.e. revenue route.</p> <p><b><i>Option 4b is the consensus preferred option of the Urology Clinical and Operational team. This option makes economic sense; does not rely on WG approval of capital funding; addresses the need for sustainability in North Wales and moves the HB closer to its strategic aspirations for Urology Services in North Wales. This option taking advantage of the 'no penalty 3 year contract break clause' also ensures that the HBs commitment to the All Wales RAS programme is complimented not compromised.</i></b></p>
3.8	<p><b>Full Description of the Proposed Change</b></p> <p>This proposal describes the leasing of a robot to support RAS for urology cases in the first instance.</p> <p>It is planned that the robot will be located at Ysbyty Gwynedd (YG) and will provide care to patients across North Wales. Locating at YG allows an opportunity to further develop the pelvic cancer work already established there. Urology major cancer work has already recommenced at YG with the first cystectomy case carried out earlier this month. YG will deliver a reduced amount of DC activity and focus on IP procedures.</p> <p>Theatre infrastructure, ward base, workforce and job plans have been aligned and no additions are required to implement this project should it be approved.</p> <p>Clinicians have agreed that job plans will allow for surgeons to work across North Wales and a clinical network arrangement has been agreed with colleagues in the North West of England, led by Mr Phillip Cornford – the details of the network</p>

	<p>arrangements are being worked up and will be presented to the HBs Clinical Advisory Group as part of the pathway approval process. This approach moves the HB into a North Wales Urology Service structure which is best suited to the delivery of the HBs 'option 5' for restart and delivery of Essential Services.</p> <p>Ysbyty Wrexham Maelor(YWM) will remain as the centre for complex stone work with their theatre and bed base remaining broadly as is. Again, there is no requirement for additional infrastructure or workforce.</p> <p>YGC will transition to an outpatient/day case service, with theatre capacity being utilized by the pan North Wales clinical teams. This means that YGC will provide for DC activity from East and West, adding to their local population. This in turn frees up operating capacity at YG and YWM to accommodate the cancer work in West and the complex stone work in East.</p> <p>A review of the decontamination service to support RAS has been carried out. The capital costs associated with the changes required to allow the HB to deliver in house decontamination is circa £135,000 (detailed within the financial breakdown).</p> <p>Outsourced decontamination service has been considered and the team identified the need for an additional 7 trays at a cost of £27,000 each (total capital cost of £189,000), would be required to offset the impact of protracted turnaround times. The cost of the trays alone is in excess of providing an in house decontamination capability, and so an outsourcing option has been discounted. The HDSU estate on the Ysbyty Gwynedd site has been assessed as part of the review, and requires no building or structural changes to accommodate the equipment needed. There is no revenue consequence of the in house service other than a marginal increase in electricity costs.</p> <p>Training needs assessments have been carried out and covered as part of the leasing agreement, and included within the lease costs. Additional training will be required for anaesthetic colleagues due to the unconventional positioning of patients whilst undergoing RAS i.e. patient is positioned head down.</p>
3.9	<p><b>EqIA of the Preferred Option</b></p> <p>TBC</p>
4.0	<p><b>The Financial Case</b></p>
	<p>The Robotic Business Case presents a pan-BCU service development for Urology in North Wales, based in YG using the 'Da Vinci Xi Single Console with Simulator'.</p> <p>Over the short- term, it is proposed that this is delivered via an operational lease arrangement, which seeks the re-allocation of revenue funding from contracting and requires further revenue investment by BCUHB (Years 1-7).</p> <p>The financial case indicates that the investment in RAS is projected to have an increase in recurrent revenue costs for the Health Board and an estimated requirement of <b>£2.438m over Years 1 - 3</b> (£4.898m over the 7-year period) inclusive of VAT. <i>It is proposed that RAS will commence in December 2020, with a 4m part year effect (PYE) in 20/21 (Year 0) of £0.284m.</i></p>

The main drivers for the net additional revenue costs are the annual lease payment (£0.56m per annum (1-3), then £0.408m per annum (4-7)) and associated consumables (£0.125m per annum). Provisions for additional instruments and patient travel are also included. *No additional revenue costs for decontamination are anticipated for the in-house model, following a recent site visit to review options.*

The case requires **£0.171m** capital funding (inclusive of VAT) to enable the in-house decontamination service set-up, which includes both equipment and minor works. BCUHB Discretionary Capital funding has been approved for this.

No charitable funding is sought in support of this business case.

In summary, it is assumed that the revenue for this service development is funded as follows:

- by the re-allocation of base funding from contracting of **£0.417m** per annum for repatriating prostatectomies (~60) from the Wirral (NB – 6 month notice period);
- assumed strategic assistance from Welsh Government for **£0.024m** of Capital Charges (Decontamination);
- noting, that an additional revenue investment is required to meet the shortfall of **£0.435m** Year 1 (£0.364m Year 2 and £0.313m Year 3). *Noting, PYE of £284,000 in 20/21 (this is included as worst case and is subject to block contract negotiations with the Wirral with regards repatriation of the funding in 20/21).*
- The funding shortfall is reduced in Years 4 – 7 as the cost of the lease decreases and the service becomes more affordable (Years 4-6 £0.197m and Year 7 £0.131m).

Please refer to the detailed table at the end of this section for a breakdown of the capital and revenue costs over the 7-year period, as well as the assumed funding source and opportunities with regards affordability.

#### Affordability and Benefits Realisation

The above funding shortfall can be met by cost avoidance opportunities from:

- Additional outsourced activity repatriation (currently estimated at £0.187m per annum), noting however that RTT is currently unfunded and of a non-recurrent nature.
- The reduction in Urology agency through improved recruitment. The premium agency cost savings only require agency reductions of 40% (£238k) in year 1, 28% (£167k) in year 2 and 10% (£116k) in year 3 for the robot revenue costs to be fully covered.
- Please note that the recent recruitment of two new urologists is dependent upon RAS being available at BCU. These recruitments would enable the removal of two mid-grade agency doctors from Ysbyty Gwynedd from January 2020, generating agency premium savings of circa £300k p.a.

The introduction of RAS should realise benefits by facilitating recruitment and retention, in turn reducing the reliance upon locum and agency staff. The following table captures the potential opportunity within the Urology specialty:

UROLOGY Medical Agency savings opportunity	YG	YGC	YWM	Total
	£000s	£000s	£000s	£000s
Total Agency Cost (19.20)	793	1,088	92	1,972
Total Agency Cost (As at M6 20.21)	295	332	0	626
Forecast FYE ( <i>Straight Line basis</i> )	589	663	0	1,253
Potential agency premium saving @ 50% (FYE)	295	332	0	626
Less Savings already committed via existing PIDs	32	0	10	42
Potential TARGET agency premium saving @ 50% (FYE)	263	332	0	594
Potential monthly equivalent TARGET	22	28	0	50

The Full Year Effect (FYE) medical agency costs for Urology forecasted in 2020/21 are **£1.253m** (YG £0.589m, YGC £0.663m and YWM £0m), which indicates the scale of potential agency cost premium (@50%) that could be saved over future years, equivalent to **£0.626m** per annum / £50,000 per month pan-BCU.

The above takes into account the existing medical agency saving targets already agreed for 2020/21 specifically linked to Urology, as the cost reductions (run rate) for these schemes are already accounted in BCU saving scheme PIDs and cannot be double counted. These total **£42k** FYE (£10k for YWM (scheme *YWM20010*), £32k FYE for YG (scheme *YG20008*) with the YGC scheme details yet to be finalised).

A new PID would be required for any additional 'run rate' savings anticipated in relation to RAS in Urology, which would need clear ownership and deliverables. **The above summarises the level of opportunity only, and any plans would need to be discussed and agreed with the relevant person(s) at each site.**

**Please note:** Medical agency cost premium is not funded, and these costs are captured as a cost pressure.

### Activity and Contracting

The financial modelling is currently based on activity of **134 cases** per annum (at 18/19 levels), the 19/20 activity has not been used due to the impact of COVID-19 in March and our ongoing inability to secure outsource capacity with NHSE:

Potential Robotic Activity (Annual)	Count (19/20)	Count (18/19)	Count (17/18)	Count (16/17)	4-yr AVERAGE
<b>Urology IN-HOUSE</b>					
Open Partial Nephrectomies	3	2	8	7	5
Open Radical Cystectomies	0	0	0	7	2
Radical prostatectomies - Laparoscopic	26	35	26	27	29
Radical prostatectomies - Open	2	2	6	4	4
	31	39	40	45	39
<b>Urology OUTSOURCED</b>					
Radical prostatectomies - Robotic	84	95	93	59	83
Robotic Cystectomies	3				
<b>Total activity</b>	<b>118</b>	<b>134</b>	<b>133</b>	<b>104</b>	<b>122</b>
	-12%	1%	28%		

Please note, that a new contract for Nephrectomies has commenced with the Royal Free (RFH) London in April 2020 (delayed due to COVID19), and is managed via WHSSC on a cost per case basis. There are currently 19 patients on the waiting list in total and 17 have already been referred to RFH. *PbR tariff rates range between £5,545 - £14,533 dependent upon the nature and complexity of the case. If all these 19 patients are to be treated here over the remaining 5m of 20.21, the potential additional outsourcing costs for these cases ranges between £105,355 and £276,127.*

There have also been 26 cases referred (of 45 on the waiting list) to UCLH for prostatectomies, via direct engagement between BCUHB and UCLH. Further details are yet to be confirmed with no activity charged to date. *PbR tariff rates average £4,454 for radical prostatectomies. If all these 45 patients are to be treated here over the remaining 5m of 20.21, the potential additional outsourcing costs for these cases is estimated at £200,430.*

No allowance has been made within the case for the repatriation of this new activity.

The following table captures the key contracting information for current and new providers for decision making purposes:

Provider Name	Service Provision	Current contract Arrangement	Estimated annual volume	Notice period required to terminate service
Wirral Hospitals NHS Foundation Trust	Prostatectomies	Block	60	6 months
University College London Hospitals (UCLH)	Prostatectomies	SLA Cost per case	26 referrals to date (Oct 20)	2 weeks
	Cystectomies	SLA Cost per case	N/A	2 weeks
Royal Free Hospital (RFH)	Nephrectomies	Via WHSCC contract and re-charged to BCUHB on a cost per case basis	17 referrals to date (Oct 20)	N/A BCU can just stop sending patients

There are a number of important considerations as follows:

- the minimum notice period and to whom this is directed (with view to ensure adequate notice is given in order to maintain a positive relationship with providers should their assistance be required in future);
- the exact logistics and governance of how this would work with patients already sent to providers would have to be worked out with the contracting and operational teams;
- wider interdependencies and the impact of any early termination of contracts upon existing contracting relationships for other specialty contracts to ensure no issues arise going forth.

**Note:** The re-allocation of base funding from contracting assumed as part-funding for RAS in BCUHB (£0.417m per annum) is for the historical contract in the North West and repatriation of prostatectomies (60) from the Wirral (£0.417m). There is no assurance that any of this funding can be repatriated during the 4 months from December 20 – March 2021, due to the block contract nature with 6m notice period and on-going C-19 pandemic arrangements. Contract negotiations would need to be expedited following any BCUHB decision in relation to RAS.

#### Key supporting information:

- The operating lease is based on an indicative cost from Intuitive (the supplier) of a 7 year lease with a 'one time exit option' at the end of Month 36 (Yr. 3);
- The operating lease includes the following:
  - *Initial engineer set-up;*
  - *The 'firefly system package' inc 4 endoscopes (2 x 0 degree and 2 x 30 degree);*
  - *All relevant software and systems;*
  - *Annual service and maintenance;*
  - *Emergency parts and replacements;*
  - *Training for staff. NB - Surgeon 'wet-lab' training is not included.*
- Procurement arrangements are ongoing with framework details, market options, specifications and supplier quotations to be confirmed. This in turn will facilitate a more detailed financial analysis. A direct award approach is the preferred procurement path.
- A 2-year rental option was considered, but not favoured for Business Case purposes;
- *Please note* – there has been ministerial approval given to the set-up of an All-Wales robotic assisted surgery (RAS) procurement project, with a project team established, which has clinical and management representation from BCUHB. The first virtual meeting was planned at the end of September 2020 with an update of programme details, roles, responsibilities and timelines;
- It has been confirmed that the robot can be accommodated within an existing suitable theatre on site, which will be available for other surgical work when the robot is not in use. A recent successful demonstration day was held in YG theatres.

#### Financial assumptions and supporting notes:

- A contingency provision of 20% has been made in Year 1 to cover the costs of training (including backfill cover), service and maintenance costs of decontamination equipment and other unplanned costs (note, this is reduced to 10% in Years 2-7);
- There are no foreseen minor works or capital requirements for Theatres;
- There are no foreseen additional revenue costs associated with the provision of decontamination in-house (with the throughput to be managed within existing CSSD resources);
- Should the business case be successful the Health Board will actively seek out opportunities to increase RAS utilisation and income generation. However, at this stage no additional income is projected;
- The equivalent capital purchase value is £1.689m excluding VAT with an assumed asset life of 7 years;
- The operating lease payments will be made on a monthly basis. Payments can be made on a quarterly or annual basis but at no preferential rate;
- Please note, that IFRS 16 – Lease Accounting is expected to have an impact on the NHS's disclosure of leases from 1<sup>st</sup> April 2021 (delayed implementation from 1<sup>st</sup> January 2019). This is likely to significantly affect the balance sheet and income statement treatment of the RAS lease. We do not have the

necessary information as yet to enable a revised costing to be undertaken in support of this change;

- A residual value of 'nil' is assumed for the decontamination capital equipment with a 7-year asset life and no impairment is anticipated during the lifecycle;
- All capital costs are captured inclusive of VAT @ 20%, assuming no VAT recovery.

Financial risks:

- The cost of consumables is based on the supplier forecasting cost reductions equivalent to 33% per case from November 2020 onwards;
- No consumable costs have been included for the Nephrectomy cases recently contracted with the Royal Free (RFH) nor the additional Prostatectomy activity with UCLH (~19+45 cases would be equivalent to ~£59,584 per annum). It is not anticipated that this activity would repatriate at this stage;
- There is a risk that the contingency at 20% may be insufficient in Year 1. Procurement input, service model, capacity plan and theatre scheduling are key to determining if any such additional costs are anticipated;
- If a decision was made to outsource decontamination (rather than in-house provision) then an additional 7 x scopes and trays would be required over and above the set-up package (as replacements and emergencies), at a cost of £27,600 each totalling an additional ~£0.193m capital requirement. The revenue costs of outsourcing this service and associated travel would also need to be considered;
- The business case focuses solely upon Urology activity, which will occupy only 25 - 30% of the capacity of the robot. This presents a significant risk of 'service creep', as other specialties may seek to utilise the spare RAS capacity. The business case does not reflect any capital or revenue requirements for any such increased activity levels (beyond 18/19 levels) nor any changes in the range of robotic assisted procedures. This would attract additional revenue costs for training, consumables and decontamination, and potentially capital for additional scopes and trays. **It is imperative that any introduction of new specialties to RAS must be supported by a separate business case;**
- Should RAS not be made available in North Wales, any increased demand for Urology would need to be sourced outside of North Wales at a premium cost in addition to current contracting arrangements (cost of 'Do Nothing').

**The indicative financial analysis is illustrated on the following page:**

ADDITIONAL COST SUMMARY - As at 16.10.20																
PHASING (Operating Lease):																
20/21 (4m PYE): Year 0																
21/22: Year 1																
22/23: Year 2																
23/24: Year 3																
24/25: Year 4																
25/26: Year 5																
26/27: Year 6																
27/28 (8m PYE): Year 7																
TOTAL 7yr (inc VAT)																
TOTAL 3yr (inc VAT)																
TOTAL 3yr (EXC. vat)																
CAPITAL: In-house provision of decontamination: Equipment and works (inc. VAT)																
REVENUE:																
Annual Lease Payment (inc VAT)																
Additional Robotic consumables																
Additional cost of Instrument Trays (x5)																
Additional cost of pan-BCU Travel																
Transitional Cost (Contingency @20% Yr 1, and 10% on-going thereafter)																
Capital Charges																
REVENUE Costs (less Capital Charges)																
TOTAL estimated CAPITAL and REVENUE																
FUNDED BY (BCUHB):																
CAPITAL: BCU Discretionary Capital (already Approved)																
REVENUE:																
Contracting repatriation - Resource re-allocation (100% of contract from 1/4/21)																
Capital Charges - WG funding (assumed strategic assistance)																
Income generation																
TOTAL Funding																
Funding shortfall																
FUNDING SHORTFALL OPPORTUNITIES (BCUHB INTERNAL):																
REVENUE:																
Cost avoidance (RTT / additional outsourcing)																
Cash Releasing - Run Rate: (minimum required urology agency savings as a percentage of maximum potential agency savings Yr1 = 40%, YR 2 = 28%, YR3 = £20%)																
TOTAL Opportunity																
NET COST AFTER OPPORTUNITY																



5.0	<b>Governance and Project Management</b>																					
5.1	<b>Approval Route</b> <table><tr><th>Committee</th><th>Date papers due</th><th>Date of meeting</th></tr><tr><td>Secondary Care Group</td><td>28<sup>th</sup> September</td><td>1<sup>st</sup> October 2020</td></tr><tr><td>Planned Care Improvement Group</td><td>1<sup>st</sup> October</td><td>2<sup>nd</sup> October 2020</td></tr><tr><td>Health Board Review Team (HBRT)</td><td>29<sup>th</sup> September</td><td>6<sup>th</sup> October 2020</td></tr><tr><td>Executive Team</td><td>16<sup>th</sup> October</td><td>21<sup>st</sup> October 2020</td></tr><tr><td>F&amp;P</td><td>22<sup>nd</sup> October</td><td>29<sup>th</sup> October 2020</td></tr><tr><td>BCU Board</td><td>1<sup>st</sup> November</td><td>12<sup>th</sup> November 2020</td></tr></table>	Committee	Date papers due	Date of meeting	Secondary Care Group	28 <sup>th</sup> September	1 <sup>st</sup> October 2020	Planned Care Improvement Group	1 <sup>st</sup> October	2 <sup>nd</sup> October 2020	Health Board Review Team (HBRT)	29 <sup>th</sup> September	6 <sup>th</sup> October 2020	Executive Team	16 <sup>th</sup> October	21 <sup>st</sup> October 2020	F&P	22 <sup>nd</sup> October	29 <sup>th</sup> October 2020	BCU Board	1 <sup>st</sup> November	12 <sup>th</sup> November 2020
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BCU Board	1 <sup>st</sup> November	12 <sup>th</sup> November 2020																				
5.2	<b>Governance, Project Management, Implementation and Monitoring</b> <ul style="list-style-type: none"><li>• This project will be implemented through the Urology task and finish group as a sub set of the Planned Care Strategic Group.</li><li>• Ongoing monitoring of the service will be overseen by the Urology Clinical Advisory Group reporting through to the Secondary Care Management Group and to the Chief Operating Officer.</li><li>• Pathways and processes will be overseen, quality assured and approved by the HB Clinical Advisory Group under its new, revised remit post Covid</li><li>• Named BCU Clinician (Mr Kingsley Ekweume) is leading the programme development, supported by the Clinical Lead from the Liverpool network (Mr. Phil Cornford). Arrangements are already in place for the North Wales service to work within a support network model which will provide peer review and quality monitoring of outcomes. This governance arrangement will report directly into the HB Clinical Advisory Group as noted above.</li></ul>																					
5.3	<b>Implementation Timeline</b> <p>Should this case be approved through the route noted in section 6.1 - with F&amp;P committee sign off on October 29<sup>th</sup>; followed by Board approval on 12<sup>th</sup> November, it is anticipated that implementation will take between 6 and 12 weeks depending on external influencing factors such as impact of Covid-19 on HB operating pressures and supply chain.</p> <p>Indicative timeframes for contracting arrangements through direct award could be completed by early December. This could allow for an indicative delivery and installation date of mid to late December. Staff training and formal commissioning of the pathways could be completed through January which is in line with the start anticipated start dates of the new Consultants.</p> <p>Full impact of the new service is likely to be seen in February, though there is a degree of urgency in startup due to the increasing number of patients waiting prostatectomy surgery, and limited or no access to NHS England capacity.</p> <p>One of the new Consultants is currently operating with RAS, he along with the UHBs existing RAS trained Urology Consultant means that we will be well placed to safely</p>																					

	<p>scale up productivity of the service and quickly address the current waiting list once the service is fully operational.</p> <p>As noted, this timeline is caveated given the current operating climate with Covid-19. Uncertainty of operational demand and risk to supply chain will undoubtedly affect implementation of the timeframes, and this will be balanced with the need to address the clinical risk of patient harm as a result of no access to RAS.</p>
5.4	<p><b>Post Implementation Review</b></p> <p>TBC</p>
6.0	<p><b>Conclusions and Recommendations</b></p> <p>The introduction of RAS into BCUHB will allow a strengthened service model to emerge, linked to the development of a dedicated pelvic cancer team, with clinicians working collaboratively. BCUHB will be able to offer robotic assisted interventions to patients within urology, colorectal and gynaecology (cancer and benign conditions) based on an integrated and sustainable model and consolidated by the All Wales RAS programme when the time comes for the North Wales rollout.</p> <p>Currently, resections that involve surgeons from different specialties are taking place during weekly scheduled theatres lists. The provision of RAS will allow the organisation to strengthen these arrangements, providing surgeons from the three interdependent specialties with more opportunities to work collaboratively, and ensuring that this new approach is embedded into every day practice. It is considered that this development will also impact positively on the sustainability of the wider acute secondary care service.</p> <p>While delivering the benefits of robotic surgery to the patients of North Wales, implementation will enable BCUHB to develop and lead a collaborative approach to clinical research and allow North Wales to play a key role in the All Wales RAS programme.</p> <p>As robotic surgery continues to grow across the UK, Europe and worldwide, there will be an increased requirement for training and mentors. The implementation of a successful robotics programme will also ensure that BCUHB is in a position to attract the top trainees and future surgeons from across the UK and beyond. This will ensure the quality of practice moving forward continues to deliver the high standards of care experienced by patients within North Wales.</p> <p>It is the recommendation of this paper that:</p> <ul style="list-style-type: none"> <li>• The plans described here in are supported.</li> <li>• That the HB progress to securing a lease arrangement (7 year with break out option at the end of year3), for robotic technology to be provided at YG.</li> <li>• That RAS will support urology services in the first instance, with view to maximizing opportunities for other specialties in due course.</li> <li>• That the HB remains committed to the All Wales RAS programme and will ensure that this lease agreement is managed in line with the All Wales programme rollout plan.</li> </ul>
7.0	<p><b>Declarations</b></p> <p><input type="checkbox"/> 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</p>

- ☐ 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 Managers have signed below to confirm

**Signed by:**




.....  
**Area/Corporate/Secondary  
 Care Director**

.....  
**Area/Secondary Care  
 Nurse Director**

.....  
**Area/Secondary Care  
 Medical Director**

**Ade Butlin**

**E signature added 16:22  
 22.10.2020**



.....  
**Chief Finance Officer**

.....  
**Director / Asst. Director  
 (Other Area/Corporate  
 if required)**

.....  
**Director / Asst. Director  
 (Other Area/Corporate  
 if required)**



<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>				
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public				
<b>Teitl yr Adroddiad Report Title:</b>	Winter Resilience Report				
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Gavin MacDonald, Interim Chief Operating Officer				
<b>Awdur yr Adroddiad Report Author:</b>	Meinir Williams, Director of Unscheduled Care Claire Brennan, Head of Office, Executive Director of Nursing				
<b>Craffu blaenorol: Prior Scrutiny:</b>	BCUHB Executive Team SPPH Committee – 1.10.2020 Board Workshop – 15.10.2020				
<b>Atodiadau Appendices:</b>	A number of supporting documents are referenced in the Plan and will be available as appendices				
<b>Argymhelliad / Recommendation:</b>					
The Committee is asked to note the work being done to strengthen delivery over winter 2020-21, alongside the Covid-19 pandemic response, which includes bed capacity modelling, and potential schemes developed by the health communities, in partnership with Local Authorities in order to support delivery over winter.					
Please tick as appropriate					
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>	<b>X</b>	<b>Ar gyfer sicrwydd For Assurance</b>	<b>Er gwybodaeth For Information</b>
<b>Sefyllfa / Situation:</b>					
The Winter Resilience Plan 2020-21 has been developed in line with the Health Board's Q3-Q4 plans, and reflects on learning from winter 2018-19 as well as from the first wave of the Covid-19 pandemic response. The Plan describes operational, practical and strategic co-ordination to manage increased demand and seasonal pressures across the Health Board's resources. The Plan is also informed by the six goals of urgent and emergency care and the Welsh Government Winter Protection Plan.					
<b>Cefndir / Background:</b>					
Winter typically results in an increase in demand from seasonally affected conditions, an increased risk relating to infection prevention and control outbreaks, and the potential risk of influenza. However, this winter, there are the added challenges and impact of Covid-19. The purpose of the Winter Resilience Plan is to provide assurance to the Health Board of the overall effectiveness of winter planning, alongside the additional challenges of Covid-19 and the whole system's ability to meet forecasted activity during the winter period whilst maintaining patient safety at all times. The Plan is supported by local health community plans for winter, which include details of local operational and escalation plans and schemes to support demand developed in collaboration with Local Authority partners. The Plan should be read in conjunction with other winter plans developed by partner organisations i.e. WAST, Local authorities and the Health and Care Recovery Group Plan.					

## Asesiad / Assessment & Analysis

### Strategy Implications

The Winter Resilience Plan is aligned to the Health Board's Q3-Q4 plans.

### Options considered

N/A

### Financial Implications

This plan has been developed, with a number of schemes requiring separate funding. Given the quantum of the estimated costs and how dependent this is on workforce recruitment, a review of all schemes across health and social care is required to prioritise the schemes and to determine what is deliverable and within what timeframe.

### Risk Analysis

The risks associated with the delivery of the Winter Resilience Plan are set out within the Plan, and a Winter Resilience Plan Risk Register is being developed, which includes risk scoring and mitigations.

### Legal and Compliance

No legal implications are reported. Standard reporting on key metrics from unscheduled care and planned care will continue through the established governance and reporting routes, and an evaluation of winter will be undertaken in Spring 2021.

### Impact Assessment

Impact assessments will be undertaken to identify any impact on clinical quality, equality and data protection.

# Betsi Cadwaladr University Health Board Winter Resilience Plan 2020-21

Draft v0.07

The following have reviewed and or commented to the Winter Resilience Plan;

Assistant Area Director – Children's Services  
Associate Director of Nursing, Infection Prevention  
Clinical Team Leader – Implementation Lead, WAST  
Critical Care and Trauma Network Lead  
Critical Care Lead for BCUHB / Consultant Anaesthetics and Intensive Care  
Director of Midwifery & Women's Services  
Director of Unscheduled Care  
Directorate General Manager – NW Managed Clinical Services  
General Manager and Business Lead, Women's Services  
Head of Occupational Health & Wellbeing  
Head of Planned Care Improvement  
Head of Regional Collaboration  
Head of Quality & Governance, Pathology  
Health Board Workshop comments incorporated  
Immunisation Co-ordinator  
Interim Chief Operating Officer  
Interim Deputy Director, Mental Health & Learning Disability Services  
Managing Director Ysbyty Glan Clwyd  
Programme Management Office – Manager  
Senior Information Analyst  
Service Manager for Cellular Pathology  
Strategy, Partnership & Population Health Committee comments incorporated  
Workforce Optimisation Advisor

#### Reporting Arrangements

30/09/2020 Executive Team  
01/10/2020 Strategy, Partnership & Population Health Committee  
07/10/2020 EMG  
15/10/2020 Board Workshop  
19/10/2020 Welsh Government  
29/10/2020 Finance & Performance Committee  
12/11/2020 BCUHB Health Board public meeting

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## 1. Executive Summary

Winter typically results in an increase in demand from seasonally affected conditions, an increased risk relating to infection prevention and control outbreaks, and the potential risk of influenza. However, this winter, there are the added challenges and impact of Covid-19. The Betsi Cadwaladr University Health Board (BCUHB) Winter Resilience Plan (the Plan) is supported by local health community plans for winter, which include details of local operational and escalation plans. This Winter Plan is developed in line with the Health Board's Q3–Q4 plans, and is informed by the six goals for urgent and emergency care<sup>1</sup> and the Welsh Government Winter Protection Plan 2021-21<sup>2</sup> that focuses on prevention against four main areas of harm.

Research shows that keeping patients in hospital for longer than necessary can be detrimental to health outcomes and keeping patients in an Emergency Department (ED) for longer than the maximum 4 hour wait, will have a significant negative impact on their outcomes. In order to ensure patients move from ED to the appropriate service or ward, flow must be maintained throughout the hospital and into the community/home setting.

The actions for winter 2020-21 focus on preventing harm by ensuring patients only stay in hospital for the appropriate amount of time in order to manage their acute phase of care and the facilitation of fast, safe discharges to the most appropriate environment for their on-going needs.

The purpose of the Winter Resilience Plan is to provide assurance to the Health Board of the overall effectiveness of winter planning, alongside the additional challenges of Covid-19 and the whole system ability to meet forecasted activity during the winter period whilst maintaining patient safety at all times.

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<sup>1</sup> Transforming Urgent and Emergency Care EASC 8 Sept 2020

<sup>2</sup> Winter Protection Plan 2020-21, Welsh Government 15 Sept 2020

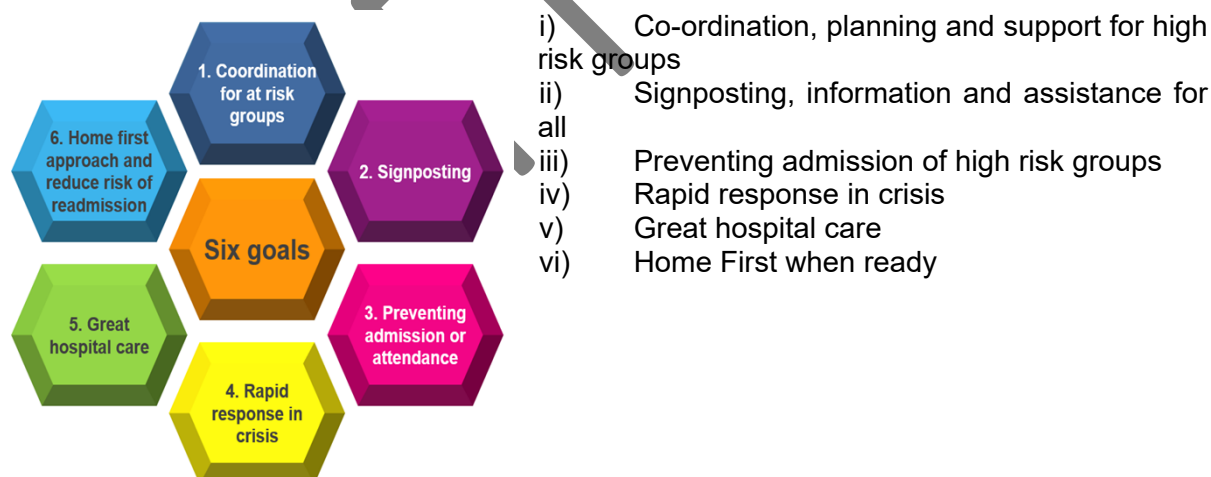
## 2. Introduction

Winter pressure is a well-recognised national issue for the NHS and presents significant challenge for the health and social care system with a typical increase in presentations to EDs and admissions to hospital, which subsequently affects system capacity and flow. This requires a whole system response to effectively support admission avoidance where the needs of the patient can be met in the community. There is a need for effective and optimal management of length of stay in hospital and timely discharge to an appropriate place, ideally the patient's usual place of residence. Any 'surges' in demand can manifest as overcrowding in ED and assessment units. This renders the 95% 4-hour ED standard difficult to achieve and impacts on quality and experience for patients and staff.

When flow across the hospital slows, ED becomes overcrowded and breaches occur. Patients can end up in the wrong beds and being cared for by the wrong clinical team resulting in longer lengths of stay, escalation beds opened and ambulance delays. This in turn slows the system outside the hospital. These are symptoms of a health and social care system under pressure. Overcrowding is unsafe and affects both quality of care and patient experience. Therefore, ED overcrowding is a gauge of whole-system capacity and resilience and as such should be avoided through whole-system planning and actions.

This Winter Resilience Plan describes the arrangements for operational, practical and strategic co-ordination to manage increased demand across the Health Board's resources. The Plan builds upon lessons learnt from 2019-20 as well as learning from Covid-19 pandemic, which will inform the system changes to ensure resilience across the health and social care system over the winter months. This includes new ways of working internally and with partners to avoid admissions where possible and reduce the number of prolonged admissions.

The Plan is underpinned by the six goals of urgent and emergency care principles;



The BCUHB Winter Resilience Plan sets out the Health Boards response to meet additional demand over winter months, however, work continues in partnership with WAST, Local Authorities and third sector organisations and the Plan should be read in conjunction with any such plans developed by partner organisations.

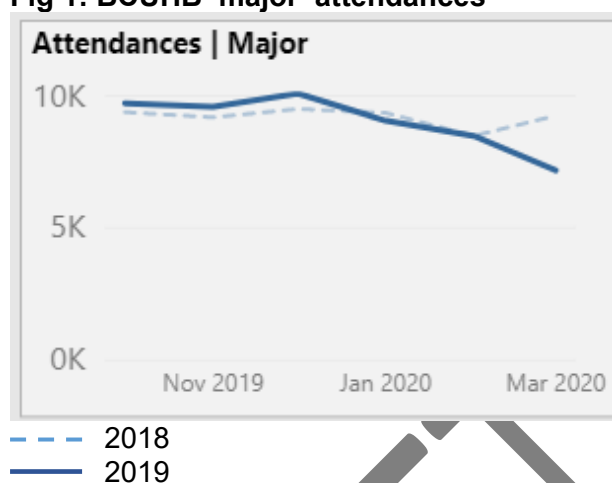
The Regional Partnership Board (RPB) is co-ordinating a Health and Care Recovery Group winter plan response in line with WG requirements, which is informed by the three BCUHB local health community plans.

### 3. Lessons Learned from Winter 2019-20, COVID-19 & Operational Control Centres

#### 3.1 Learning from Winter 2019-20

Throughout December 2019 EDs across the UK experienced unprecedented increased demand and an increase in the number of patients presenting to ED triaged as 'majors'. BCUHB exceeded 10,000 patients categorised as 'major' for the first time as shown in fig 1 below, which was an increase of 600 patients categorised as major, compared to the previous year. December 2019 also saw an increase in over 400 attendances compared to December 2018. This increased demand of higher acuity patients was a key driver in the deterioration in performance of the tier 1 targets.

**Fig 1: BCUHB 'major' attendances**



The increased demand and extreme challenges for BCUHB resulted in a combined performance in December 2019 of 66.32% against an internal trajectory of 72%. Performance improved slightly in January 2020 to 68.7% before returning to 66.4% in February 2020. Internal trajectories for the Tier 1 targets were re-forecasted in November to realign them to actual performance, with a shorter stretch.

An increase in flu cases in 2019, with 276 confirmed cases in December, was a key driver for the increased number of patients spending longer than 12 hours in ED due to increased need for cubicles. This was alongside a significant increase in other types of respiratory illnesses in both adults and children.

Staff sickness and high levels of non-filled bank and agency shifts throughout December 2019 and particularly over the Christmas and New Year period was also significant, leading to the closure of a number of community beds.

The BCUHB Winter Resilience Plan for 2019-20 focused on the delivery of schemes within seven key themes as set out below. To support delivery of the Winter Resilience Plan, Welsh Government (WG) allocated £5.740m winter funding in two separate allocations, for the Health Board (£2.126m) and the NW Regional Partnership Board (£3.614m). A single Winter Resilience Plan was submitted to WG across the North Wales region.

The Winter Resilience Plan was developed with a total of 75 schemes under seven themes:

i) Optimising cross organisational and sector working	12 schemes
ii) Urgent primary care/out of hours' resilience	30 schemes
iii) Preventing unnecessary conveyance and admission to hospital	14 schemes
iv) Discharge to assess/recover	8 schemes
v) Community step down capacity	4 schemes
vi) An enhanced focus on the respiratory pathway	4 schemes
vii) An enhanced focus on the frailty pathway	3 schemes

Some schemes cross cut two themes and most schemes from the BCUHB allocation were implemented across two or three areas. Key highlights of schemes were noted re as follows;

- 'Tuag Adref' / Homeward Bound project focused on 'pulling' patients out of the acute hospital to reduce bed days and avoid admissions
- Wrexham Home First model saw the opening of an additional 8 community beds to support discharges from the acute hospitals at Wrexham and Chester.
- Community in-reach project implemented working with Community Resource Teams to support discharges.
- Enhancements to the community pharmacy roles for non-medical and independent prescribing supported an increase in the number of patients seen.
- Additional pharmacist roles appointed which supported transcribing discharge prescriptions within ED and across wards for medically fit patients. As well as an enhanced COPD home visiting service which supporting the review of COPD patients experiencing exacerbations in the community.
- Additional clinician posts in EDs supported safe and timely assessment and treatment of patients to support urgent care demand.

Whilst a number of the schemes ceased at the end of March due to funding, some schemes have continued either with funding or at a cost pressure. Details of learning from winter 2019-20 and schemes developed for each area are set out within each local health community plans for winter 2020-21.

Unscheduled Care performance targets and improvement programmes were put on hold both nationally and locally in line with the expectations set out by the Health Minister in a letter dated 13<sup>th</sup> March, to prepare for and manage the Covid-19 response. Throughout March the EDs focused their efforts on developing and implementing plans in response to the predicted Covid-19 surge.

### 3.2 Performance 2018-19 / 2019-20

Following a review of key performance data for 2019-20 compared to 2018-19, the following is highlighted;

The 4 hour ED performance for winter months from October 2019 to January 2020 was broadly comparable to the same period the previous year. The February 2020 position worsened compared to 2019, before the impact of Covid-19 in March 2020 which saw a continued improvement in this performance target for several months during lockdown, which was largely attributable to the significant decrease in the number of ED attendances. The number of 12 hour delays was higher in November and December 2019 than the same months the previous year and whilst this improved, the number of delays remained higher than 2018 until the pandemic in March 2020. Delays over 24 hours were also worse in December 2019, January and February 2020 in comparison to 2018-19 before significantly improving from March 2020.

The number of ambulance conveyances was lower during the winter months of 2019-20 compared to 2018-19 with a significant drop in April 2020 during lockdown. The number of ambulance handover delays >60 minutes was significantly worse for the 3 months between November 2019 to January 2020 than the same period the previous year. There was less variation between the number of delays for 15-60 minute handover delays in comparison to the previous year which remained more consistent in between November 2019 and February 2020. The <15 minute ambulance handover delays performance was worse during November 2019 to March 2020 than the same period in 2018-19.

December 2019 saw an additional 415 attendances compared to the previous year and as mentioned previously the number of admissions triaged as majors peaked at 10,090, an additional 586 attendances compared to December 2018.

The number of discharges was broadly similar in comparison for the months of November and December 2019 but fell in January 2020, remaining less than the previous year for subsequent months.

The number of patients with a length of stay >21 days remained higher for the months of December 2019 through to March 2020 compared to the previous year.

### 3.3 Covid-19 learning

The Health Board has undertaken a review of lessons learnt across a range of services and processes following the first wave of Covid-19. This includes but is not limited to; the numbers of tests done, number of patients treated and discharged, number of additional beds opened, increased oxygen capacity and support from volunteers. The following five high level themes were identified from the review;

- i) clinical processes;
- ii) environment and equipment;
- iii) information management & technology;
- iv) workforce;
- v) communication

Review of impact across these areas will help understand and share learning to inform Q3-Q4 plans and help shape and embed new ways of working to develop future innovative ways of working that improve and sustain delivery of services particularly over the coming winter months.

The response to Covid-19 pandemic saw the commissioning of three temporary Enfys hospitals across North Wales in Bangor, Llandudno and Deeside, creating additional bed capacity including piped oxygen at the Deeside and Llandudno sites. This was achieved as a result of significant planning and co-ordination from staff deployed from a number of areas. The primary purpose of the Enfys hospitals is for additional surge capacity, however, alternative options are currently being considered for the optimum utilisation of the Enfys hospitals over the forthcoming winter months should this surge capacity not be required as was the case during the first wave.

In addition, the following was also achieved in response to Covid-19;

- An additional 724 acute beds were created and 371 community beds
- Health Emergency Control Centre (HECC) was established on 10<sup>th</sup> March 2020 until 10<sup>th</sup> July 2020 supported by 55 staff overall
- Oxygen capacity was increased on acute sites from 7,860l/min to 11,000l/min
- 1,800 volunteers offering support
- An additional 708 users were trained on WPAS and WCP patient administration systems

A consistent and emerging theme from the review of Covid-19 was the overwhelming response from staff across all disciplines and sectors, many of whom went the 'extra mile' in ensuring services were sustained as well as adapting to new ways of working within pressurised environments to support patients and other staff despite the potential risks.

The following areas of development were highlighted following the response to Covid-19;

- Health economy working with colleagues in Local Authorities has been positive with local control centres developed in partnership and input into care homes, which will continue.
- Improved communications between staff delivering services outside hospital and strengthened working relationships across traditional boundaries, with an increased level of knowledge amongst cluster staff of available services including third sector provision.
- Improved partnership working has supported the use of venues for primary and community services.
- Development of a community pharmacy escalation tool as an effective resource for staff to support local community pharmacies / dispensing practices requiring urgent support.
- Delivery of virtual / telephone appointments and consultations implemented across a range of services including within primary care, CAMHS, outpatient appointments
- Pharmacy on call system established
- Drug 'click and collect' service implemented
- Clinical pathways: evidenced based and supporting clinicians with decision making
- Clinical effectiveness: Monitoring impact through pre-defined quality metrics
- Clinically led: engaging with clinicians to drive improvement and embed good practice
- Staff empowerment: Staff health and well-being centres, daily updates, visibility of leaders, workforce re-deployment strategies. The presence of clinical psychologists to provide staff drop-in sessions to support staff welfare has had positive feedback.
- Digital technology developments to supporting more staff to work remotely / flexibly and increased access to a range of devices to support clinical and admin staff, improve access to systems and intelligence including real time data.

### 3.4 Critical Care learning from Covid-19

The Critical Care response to the demands of COVID-19 involved significant cross-site planning and delivery of clinical care, in collaboration with Respiratory Medicine, and supported by the Welsh Critical Care and Trauma Network (WCCTN). A formal debrief process, collating lessons learned, has been undertaken by the WCCTN Clinical Lead for North Wales<sup>3</sup>. The review highlights that the first wave did not hit all hospitals equally across Wales, with some being hit early and hard, surging close to surge limits, whilst others hit much later in the wave with a slower, longer wave with others barely hit at all. It also acknowledges that in advance of a second wave, combined with seasonal flu, it is important to prepare for all scenarios. The document stated that whilst there were things that could have been done better, it acknowledged the significant overall response of staff to this crisis including non-ITU staff.

In comparison with South and Southeast Wales, Critical Care services in North Wales appear to have been relatively fortunate with regard to demands associated with the spring wave of Covid-19. Some essential services activity requiring post-intervention Critical Care support has continued, and there have been no cancellations of planned surgery across BCUHB because of lack of Critical Care capacity since April 2020.

As a higher risk acute inpatient area, expansion of critical care footprint was required to separate Covid-19 and non-Covid-19 patients and to meet an overall increase in anticipated demand. This involved opening additional beds in existing critical care wards and / or converting alternative areas on each site i.e. theatre recovery, where appropriate. During

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<sup>3</sup> Lessons learned from the first wave of Covid-19 pandemic, NWCTC; August 2020



the first wave, use of inter-hospital transfer enabled site decompression and maximal site Critical Care occupancy was 15 patients (Covid-19 and non-Covid-19).

Local BCUHB review of critical care learning was divided into the following categories; *Staff; Stuff; Space; System* and *Skills*, which highlighted many positives alongside areas for improvement. The summary key highlights include;

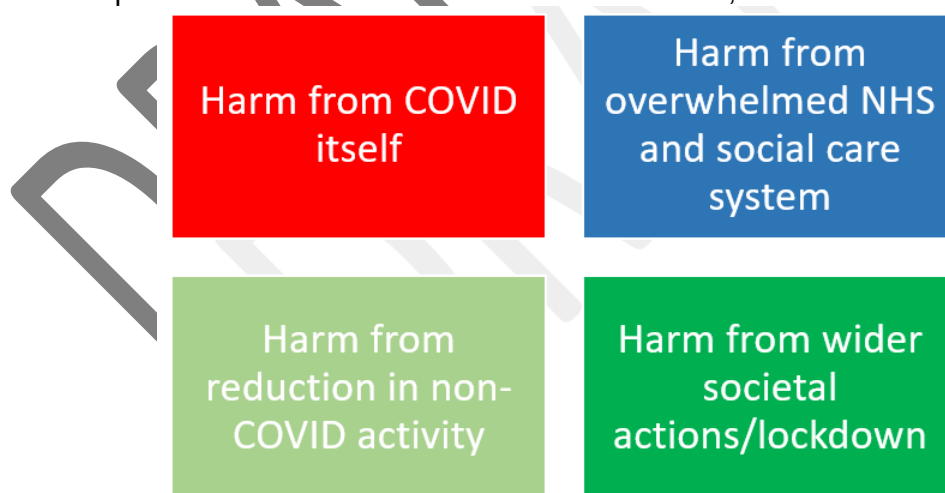
- Effective team management and appreciation for physiotherapy proning teams and their skill sets.
- Staff deployed from other areas were less well understood and inefficiently utilised and supported within critical care.
- Communication between dispersed cohort areas was further hindered by barriers imposed by Personal Protective Equipment (PPE), which caused difficulties in building a cohesive team during shifts.
- PPE was always available but some models were temporarily out of stock and it was felt that fit-testing should have been more readily available along with the availability of hoods which would have provided a second-choice of face protection for staff at all times.
- Concern about PPE provision was detrimental to staff confidence, particularly when out of date stock and the threat of PPE re-use was raised.
- There was a view of a lack of leadership from senior management and the role of the HECC was not felt to be visible to clinical staff.

### 3.5 Learning from Operational Control Centres

Local debrief sessions have taken place within each health community to review the local operational control centres established during the initial phases of the response to Covid-19, utilising feedback from those directly involved in either the setting up or operational management of the Control Centre, through to the Senior Responsible Officers who were responding to operational matters occurring.

## 4. Outcome Measures

In line with WG the Winter Protection plan the Health Board plans will be developed with the intention to prevent harm as set out in the four areas below;



The following outcome measures have been identified;

- No patient will wait in an ambulance more than 3 hours
- No patient will wait in an Emergency Department more than 48 hours
- No patient will develop a Health Care Acquired Infection (HCAI) as a result of poor flow
- No patient will stay in an acute hospital bed when they are medically ready for discharge

## 5. Demand & Capacity Requirements

The Health Board developed capacity and demand projections to account for winter pressures and Covid-19 related demand over the next six months. Capacity and demand are expressed in terms of general, acute and community overnight hospital beds for ease of comparison.

### 5.1 Bed demand

Health Board bed demand planning has been made on the basis of the *Swansea University Reasonable Worst Case Scenario*<sup>4</sup> (RWC) modelling, with contingencies in place in the event that a 'high' Covid-19 scenario is reached in any part of North Wales, as described in WG correspondence dated 24<sup>th</sup> June 2020.

In addition, the bed demand model anticipates we will experience emergency demand in line with the historic average. Essential surgical activity is included in the model, plus additional high priority surgical activity that would need to be done in the event of a prolonged period of Covid-19 related demand.

### 5.2 Bed capacity

Bed capacity is defined as funded general and acute overnight beds at the end of August 2020 (i.e. acute hospital beds excluding day case beds), to align with the bed demand model. In addition to funded beds there are a number of unfunded beds that will be brought on stream as escalation or surge capacity. Escalation beds are beds that are occasionally opened in acute hospitals to accommodate temporary increases in demand, and surge beds are beds created for unusual or rare demand events like the Covid-19 pandemic. In addition to the acute hospital general and acute overnight beds, there are 72 unfunded surge beds at YGC that are exclusively for Covid-19 related CPAP that could be deployed if required. This capacity is not included in the analysis below.

Capacity is modelled at 85% midnight occupancy, to allow for essential anticipated operating flexibility in bed use.

### 5.3 Analysis

Graphs are attached on the following pages which illustrate bed capacity, & predicted emergency and Covid-19 related bed demand across acute and community, in line with the Swansea University modelling for both BCUHB wide and per Health Community. Graphs on the left indicate the position with no solutions applied, thereby indicating;

- Non-covid demand remains at historic levels
- Covid demand follows the Swansea model
- Elective Activity remains around 90%
- Bed occupancy is 85%
- 5% reduction in bed capacity due to covid restrictions

The graphs on the right hand side include the following solutions applied;

- Potential reduction in non-covid occupancy (1.3 times covid occupancy)
- Acute surge beds
- Community surge beds
- Enfys hospitals (not currently shown)
- Reduction in elective activity (not currently shown)

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<sup>4</sup> Technical Advisory Group, Swansea University RWC model scenario



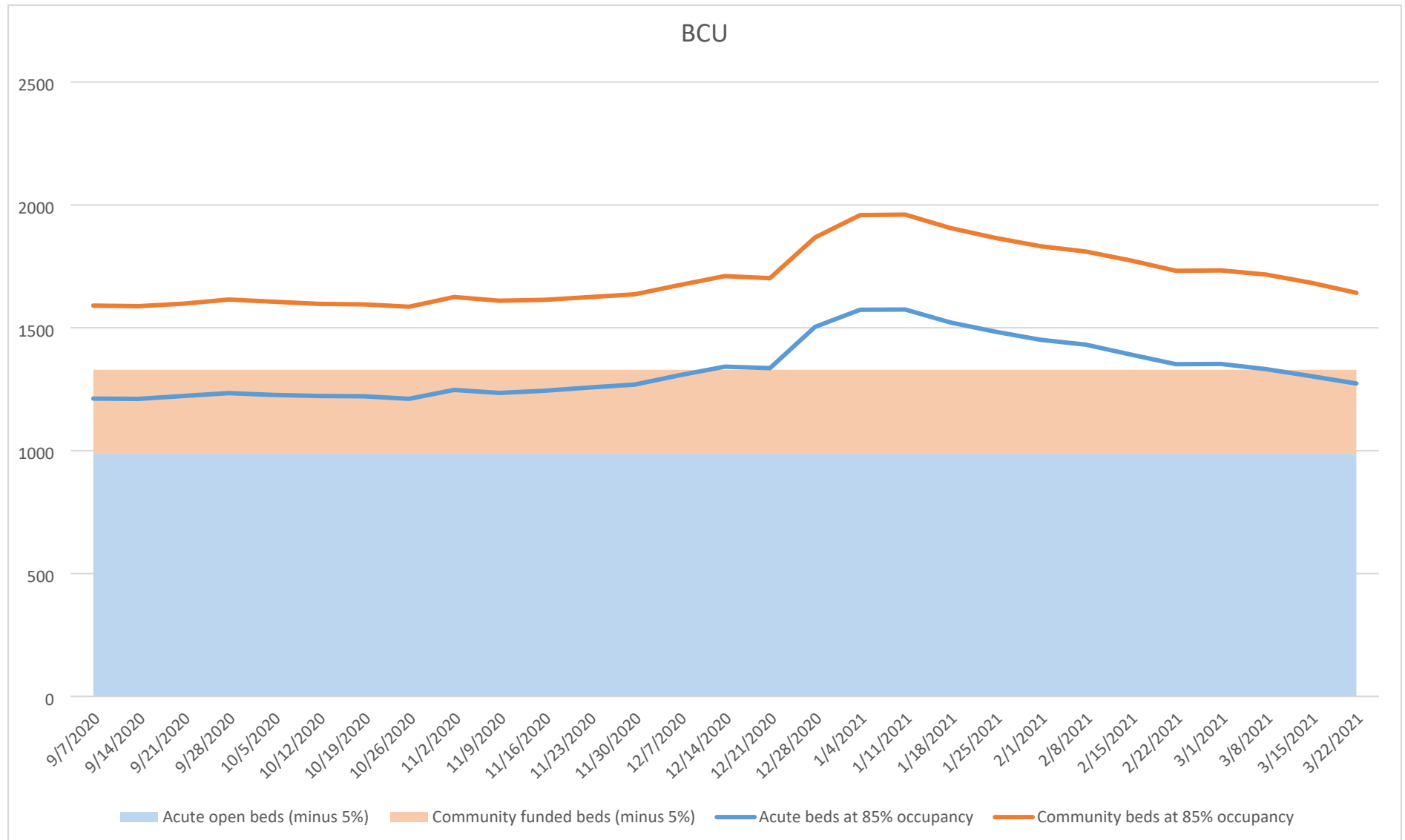
The graphs demonstrate that the East Health Community has the greatest predicted disease burden and has the greatest pressure on its bed stock, even after additional capacity and admission avoidance schemes are played into the system. This indicates that as a minimum the East HC will need the support of Enfys hospitals or similar capacity in order to sustain services throughout winter. The Central Health Community is in a similar position but to a lesser extent and is likely to require fewer Enfys hospital surge capacity when compared to the East. The West Health Community reflects the best position in terms of its capacity and demand where its surge planning is sufficient to sustain until January but insufficient from mid-January into March 2021.

Operationally, 100% occupancy is not be feasible or sustainable at a BCUHB level, because we would need to control and limit patient movement for infection prevention control reasons, and some empty beds are inevitable due to carve out for different admission pathways (red, green, specialty specific, elective and emergency pathways). Significant planning and coordination will be required at BCUHB level to maximise bed utilisation, as we know from the first Covid-19 wave, spikes and surges in hospital related demand impact across Wales at different times.

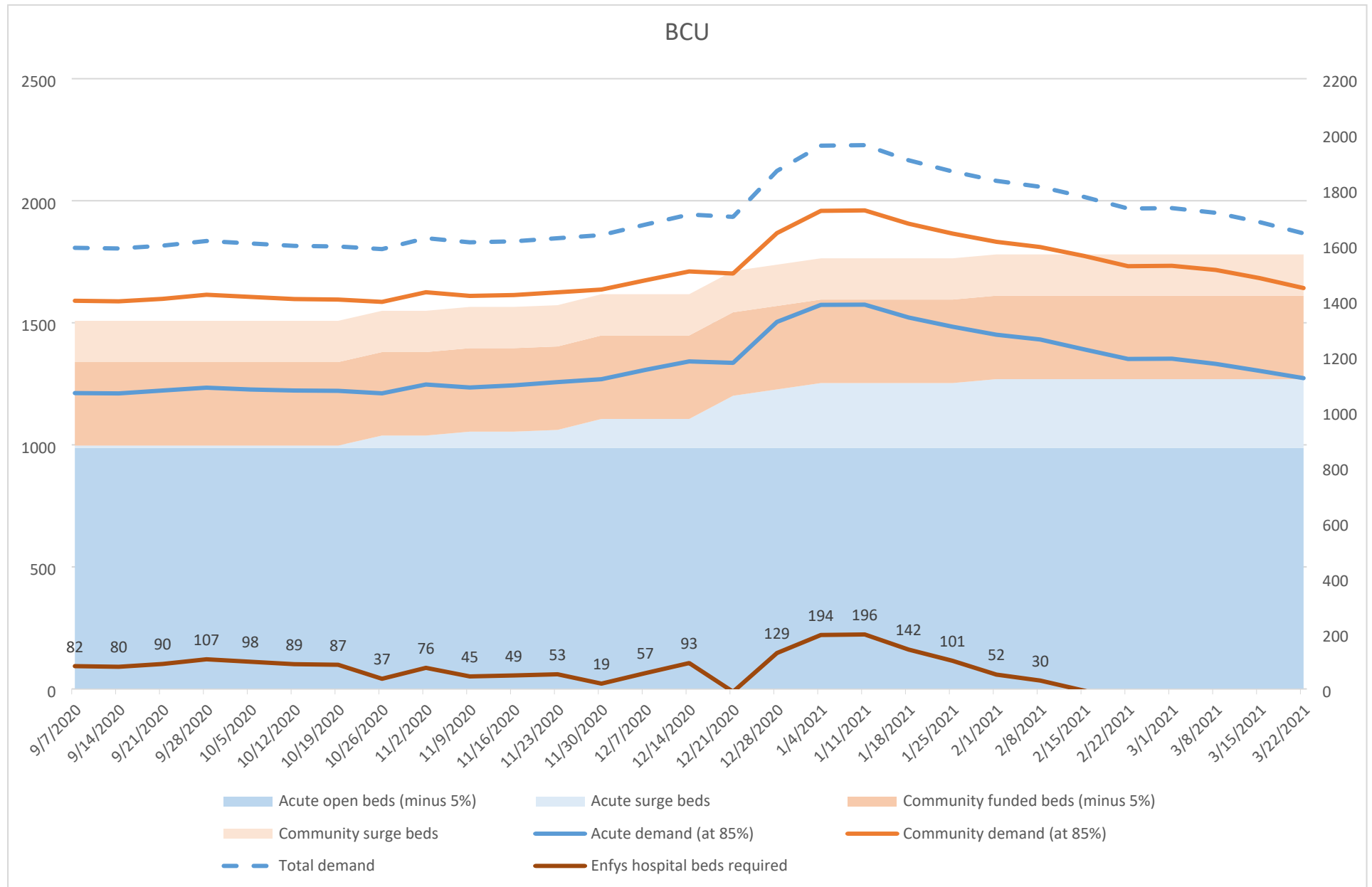
The capacity demand graphs demonstrate the capacity requirement calculated 85% bed occupancy respectively

At 85% it is clear that we require Enfys hospital capacity to be mobilised as soon as is practicable. The greatest demand for Enfys hospital capacity peaks in the middle of January where we will require 196 additional beds, this means that mobilising of 1 Enfys hospital will be sufficient. As depicted in

# Graphs illustrating Bed Modelling at 85% occupancy (without solutions)



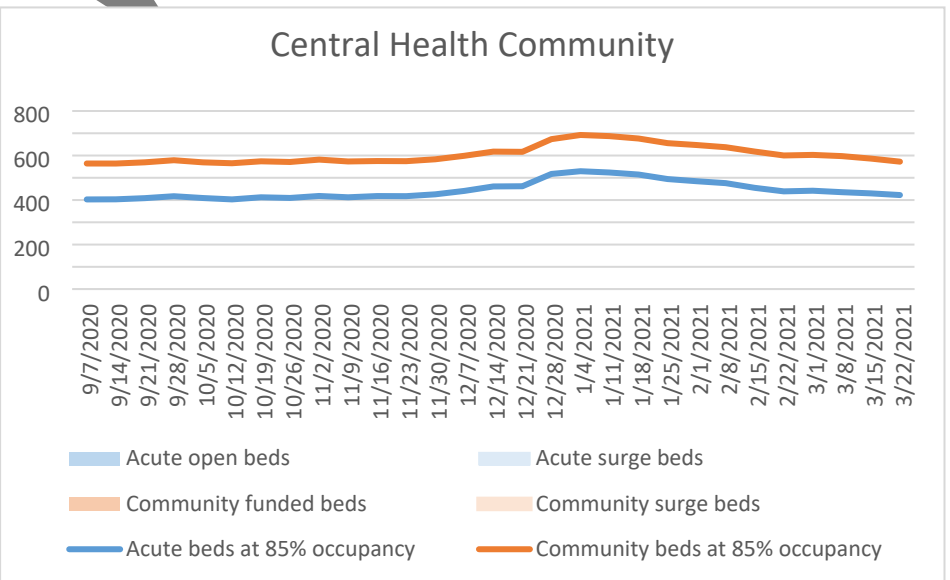
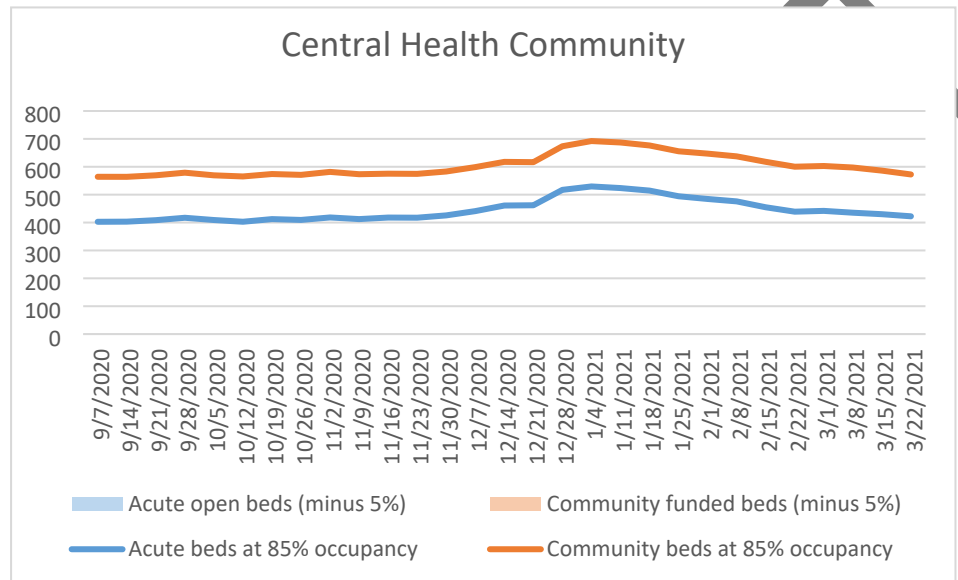
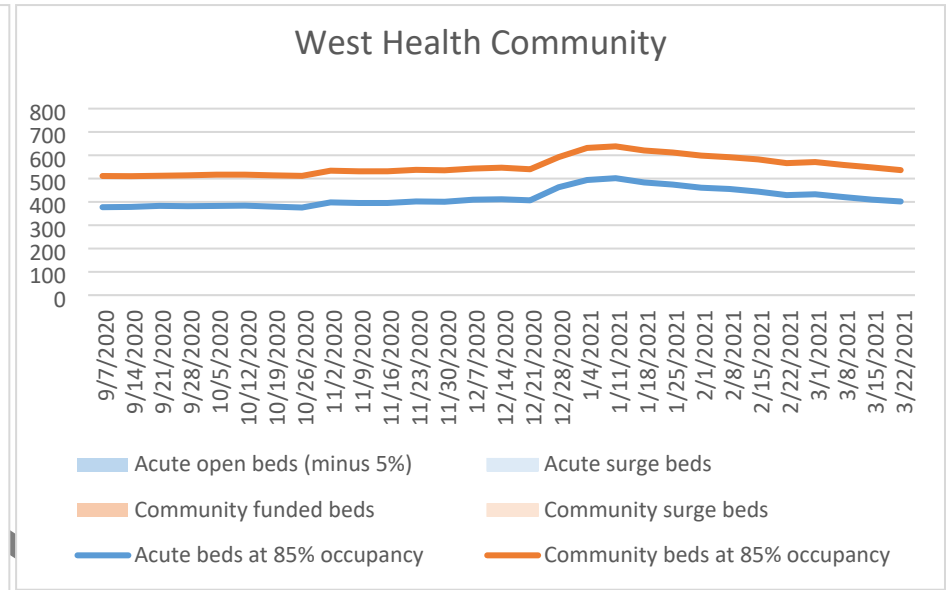
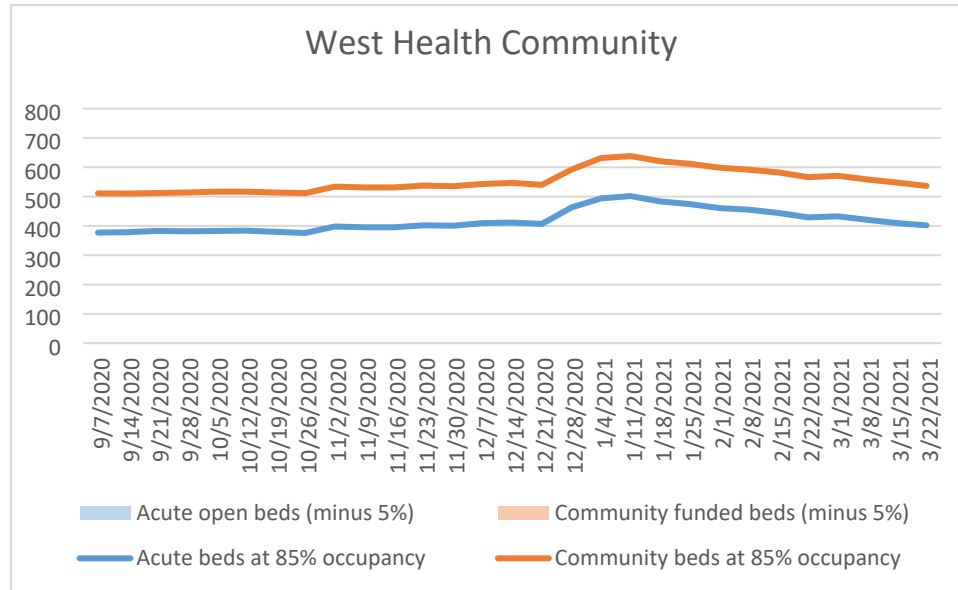
Graphs illustrating Bed Modelling at 85% occupancy (with solutions & including Enfy's Hospitals)



## Graphs illustrating Bed Modelling at 85% occupancy

### Without solutions

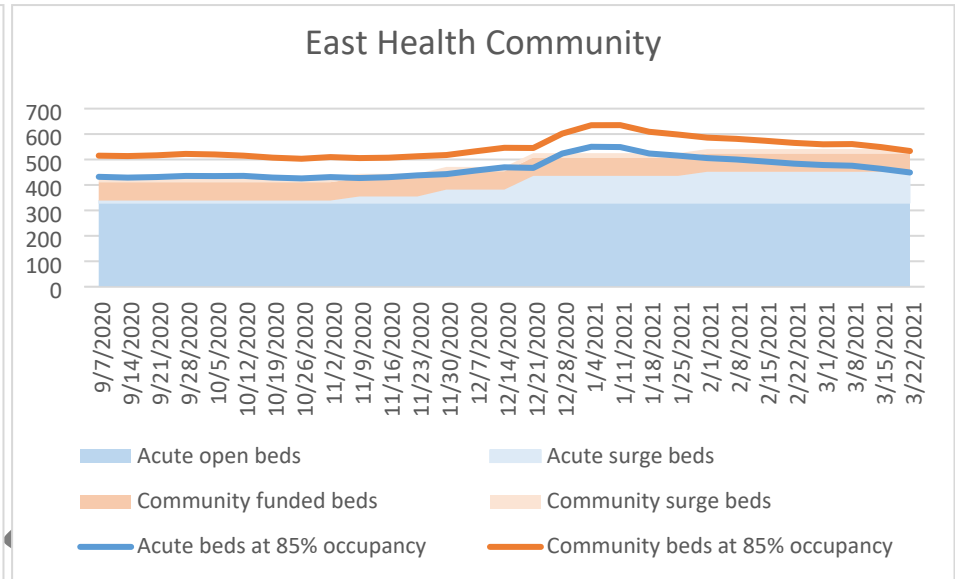
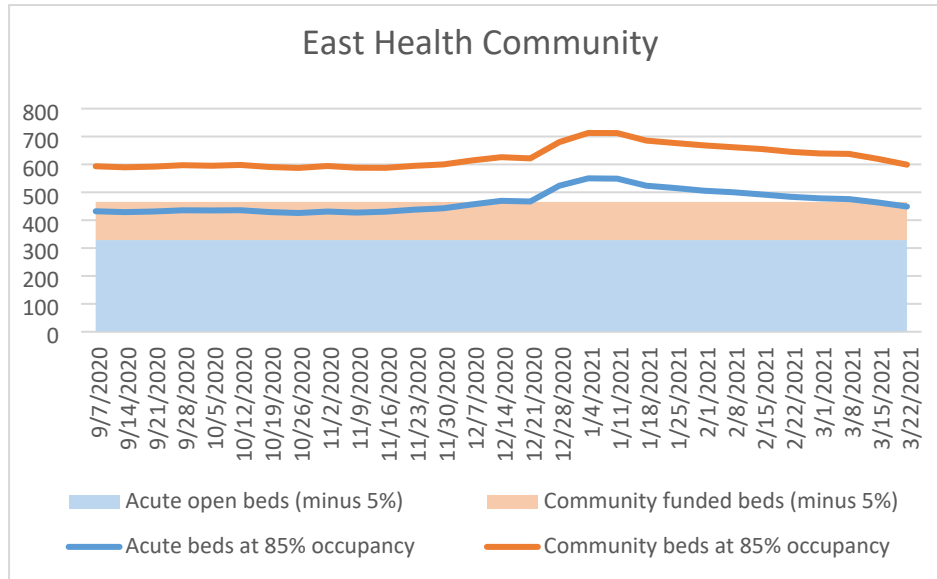
### With Solutions



# Graphs illustrating Bed Modelling at 85% occupancy

Without solutions

With Solutions



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## 5.4 Essential Services (Acute Hospitals only)

Prior to the Covid-19 outbreak, there was significant inequity of access for patients across BCUHB, and performance monitored at site level. However, this did not intuitively promote collaboration, and to some degree, the health community focus provided a distraction from pan-BCU working. Each site encountered variations in Covid-19 activity with varying capabilities to provide planned care capacity, influenced by workforce limitations (vacancies, redeployment and sickness), critical care capacity as well as the required infection prevention measures.

Each site has invested in their health community to build relationships and develop pathways to support patient experience. This relationship building will continue to encourage future pathways focusing on 'care closer to home', delivering care in the local community wherever possible, and ensuring that hospitals deliver services that should only be delivered in an acute setting. This will be balanced with equity of access for all people living within the jurisdiction of the Health Board.

The Planned Care Transformation Group requested an option appraisal<sup>5</sup> to give direction on what approach should be followed to allow the continuing delivery of essential and planned elective care in the short and medium term, whilst continuing to operate within a Covid-19 and post-Covid-19 environment, ensuring that additional measures are required to safeguard staff and patients.

Guidance has been provided by national, international and professional bodies to support clinical decision-making and delivery of all components of healthcare, and this includes specific reference to Planned Care. Combining all these factors resulted in a new approach to delivering Planned Care that would:

- Protect planned capacity, virtual working and non-face to face delivery, including more community based activity
- Be able to maximise throughput given the imposed limitations of the Covid-19 restrictions
- Be able to factor in patient restrictions such as pre-operative isolation and rapid testing
- Be able to reduce the risk for both patients and staff from further Covid-19 infections by reducing potential cross infection
- Deal with phase two and three of the planned care recovery
- Be able to respond to further surges of non-Covid-19 emergency and elective activity
- Be able to work alongside unscheduled care.

From the options appraisal, Option 5 included a hybrid of three other options as follows:

- Each site uses its available capacity providing essential services locally where appropriate
- A risk management approach is applied to patients waiting for access to stage 1 or stage 4 to ensure that the highest priority patients are offered appointments at the soonest opportunity
- A review of services considered the highest priority, either due to risk of potential harm to patients waiting or insufficient resource to meet its needs.

Option 5 supports the Health Board's strategic intent and provides a platform to capitalise on the current progress made in the development and delivery of consistent clinical pathways. A system and process based on quality outcome measures and patient experience enables the Health Board to demonstrate improvements aligned to the strategic intent. This work also supports the pre-Covid-19 plans relating to the digitally enabled clinical strategy.

The successful delivery of Option 5 relies upon robust operational plans and a willingness to explore different ways of working, and this has already been demonstrated through the Clinical Advisory Group and the secondary care senior management team. This is being supported through changes to performance monitoring and the governance structure.

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<sup>5</sup> Options Appraisal for delivery of Essential Services with consideration of Unscheduled care pathways

## 5.5 Elective Care

Elective care continues to be delivered in association with essential services. During Q3/Q4, the focus will continue on delivering the P2/P3 risk stratification. Plans are being drawn together on reviewing all P4 (routine) waiting lists to understand how they can be supported in a non-surgical pathway. A different approach to delivering ambulatory surgery is also being reviewed in Q3/Q4 to support delivery mid-term.

The re-start of services continues and the risks associated to this are being mitigated as they arise. The interdependencies of unscheduled care and planned care are essential this winter due to the consequences of the Covid-19 pandemic.

## 6. Community Services

The Community Services Transformation programme, funded through the Welsh Government Transformation Fund, is a programme of work, which draws together partners from across primary care, community health, social care and the third sector, in order to better, and more fully integrate health and social care on a locality footprint. In seeking to integrate health and social care, as its principle aim, the programme seeks to transform service delivery by increasing capacity and capability within the community to respond to population need. To help them achieve this aim, Area Teams are working closely with colleagues in Social Care to implement detailed Transformation Plans, which respond to key pressure points within the Area, as well as contribute to the delivery of the overarching regional plan.

The Community Services Transformation programme underpins a number of key strategic priority areas for the Health Board and its partners as set out below:

### 6.1 Care Closer to Home:

An intended outcome for the Community Services Transformation programme is the shift in the locus of care from acute into the community, through an increase in capacity and capability of primary care, community health and social care teams to deliver the needs of the local population within their own homes and communities. With time, individuals will be able to access a greater range of services and support within their communities, supported by a strong, highly-skilled and motivated workforce able to meet their needs.

Building on the positive progress already made with regards to the development of Community Resource Teams (CRTs) work is being undertaken to expand their scope and purpose. Within the Community Services Transformation 'place-based/ locality' model, CRTs are being further developed, to enable them to become the operational delivery method for integrated health and social care within a given locality. To support this, work is underway to better understand the skills mix and competencies required to work in this new way, as well as to give these locality teams greater and/ or more devolved decision making powers.

The development of new workforce models, and the role of independent providers in supporting community healthcare is being trailed in the West, with home carer's undertaking observations on behalf of GPs in one area in Gwynedd. The development of such models of care are central to enabling Care Closer to Home to be delivered. Moreover, in Conwy and Denbighshire, important work is being undertaken in order to reduce staffing pressures and improve co-ordination of care, through the introduction of a scheduling system within CRTs.

Furthermore, work is being undertaken to understand the impact that Covid-19 has had on the way in which health and social care services are delivered within the community, as well as how CRTs support and engage with people in the community. This information is being used to help support and develop our community workforce, to enable them to continue to deliver Care Closer to Home in these unprecedented and challenging times.

The programme recognises digital technology as a key enabler to delivering Care Closer to Home, and as such is working collaboratively with the Welsh Co-operative Centre and the Welsh Government's 'Attend Anywhere' initiative, to help address issues of digital exclusion and digital poverty across the region, and provide citizens with the means to engage with health and social care via virtual/ digital technology. The programme has already purchased 356 iPads and is in the process of purchasing additional devices, which are being provided to people within the community on a short-term loan basis, to enable them to participate in online GP consultations, Secondary Care Clinics, Social Care assessments, etc. where required. The iPads can also be used for people at risk of social isolation, and/ or to improve well-being. Longer-term, the intention is to identify opportunities to use digital technology to support people with new and existing long-term conditions to successfully manage their health at home.

## 6.2 Admission Avoidance

By shifting health and social care services into the community, and increasing capacity within the community to respond to people's needs in an integrated and seamless way, the Community Services Transformation programme aims to have a positive impact on pressures faced within acute services, by developing community-based service responses, which help to avoid hospital admissions. For example, work is being undertaken in the East Area to develop more effective and seamless integrated step-up / step-down pathways, as a way of increasing community capacity and ensuring the availability of community services for frail older people as an alternative to an acute hospital admission. It is fully anticipated that in bolstering the community's ability to respond to increasingly complex health and social care needs, in a timeless and responsive manner, the programme of work being undertaken as part of Community Services Transformation, will positively impact on ED attendances, and acute hospital admissions.

## 6.3 Discharge 2 Assess and Recover

The Community Services Transformation Programme is engaging with the NHS Delivery Unit's 'Right-Sizing Community Services for Discharge' programme, which seeks to map current capacity within community health and social care services, in order to facilitate a timely discharge from hospital. When completed, the programme will be in a position to use the findings to evaluate current and future service models and develop a programme of change to respond to areas of identified gaps within the community. This will include ensuring that there is sufficient capacity within the community to support people to Discharge 2 Assess and Recover.

Workforce will be a key enabler for the successful implementation of Discharge 2 Assess and Recover pathways across North Wales. Therefore, the work being undertaken as part of the Community Services Transformation programme to understand the skill mix and competencies required to deliver effective and integrated health and social care in the community, is critical to this programme of work.

## 6.4 Frailty

Whilst in the medium-to-long term, the focus of the Community Services Transformation programme is upon integrated health and social care support from cradle to grave, in the short-term, and given current pinch-points within the system, the focus has initially been on developing integrated and transformational ways of working for older people, including those on a 'frailty pathway'. Community services and service responses are being put in place that enable older and frail people to receive a greater proportion of their care and support within their own homes and/ or communities.

A number of schemes set out in local health community plans focus on protecting this vulnerable cohort of patients, including improving frailty pathways;

- Frailty bed base within Acute Medical Unit to provide assessment and quick turn-around of patients
- Improving frailty pathways



- an outreach community service to care homes and other vulnerable patients
- frailty assessment units at the front door, including ADT and senior decision maker and the potential to re-profile therapy support to provide Technical Instructor and Occupational Therapy support for rapid follow up care to the ward

## 6.5 Other Vulnerable Groups

Whilst the initial focus of the Community Services Transformation programme is on meeting the needs of older people within their locality, the lessons learnt will enable partners to move forward with the development of a total-population approach, supporting people from cradle to grave.

## 7. Enfys Hospitals

Surge capacity remains the top priority for Enfy hospitals and the local surge plans do not currently take account of any of the temporary hospital capacity. Demand and capacity modelling suggests that surge plans within our hospitals would broadly be able to respond to demand in both low and medium Covid-19 scenarios. It is only the high Covid-19 scenario where there would be significant impact likely to require large-scale capacity within the temporary hospitals. The potential impact is greater on both Ysbyty Wrexham Maelor and Ysbyty Glan Clwyd / Abergele.

There is an ongoing requirement to confirm the need to continue to hold the three temporary hospitals in a state of readiness as the pandemic progresses, so that they are held in readiness but not needed. Other opportunities to use the facilities for the coming winter months continue to be explored.

Updated models are available although the formal planning expectation remains unchanged. To date the initial analysis of these new models would support a decision that the full capacity of all three temporary hospitals would not be required.

## 8. Critical Care

The Health Board is committed to prioritising patients with Covid-19 and those receiving essential services, which is a key principle in line with national and Health Board recommendations, whilst ensuring the separate flow of patients on elective and non-elective pathways for those patients directly affected by Covid-19 and those unaffected.

BCUHB Critical Care services face further surge in COVID-19 demands with a number of vulnerabilities. Although BCUHB has among the highest number of annual critical care episodes in Wales (around 2100 per year under ordinary circumstances), it has among the lowest number of critical care beds per unit population (Table 1; 5.4 per 100,000) in Wales (vs 5.9 per 100,000), the UK (vs. 6.6 per 100,000), and Europe (vs. 11.5 per 100,000). The critical care capacity per site including surge capacity is set out in Table 1 below<sup>6</sup>;

**Table 1. Critical Care capacity**

Commissioned beds	Level 3	Level 2	Total	Additional Surge capacity	Total capacity Level 3
Ysbyty Gwynedd	6	5	11	9	20
Ysbyty Glan Clwyd	8*	5	13	9	22
Ysbyty Maelor Wrexham	5	7	12	8	20
Total	19*	17	36*	26	62

\* 8<sup>th</sup> bed newly funded following WG Task and Finish Group Report, July 2019.

<sup>6</sup> Critical Care Response to first wave and preparation for second wave of Covid-19

Without increasing core critical care nursing numbers, the maximum number of ventilated patients that could be cared for according to FICM guidelines for critical care in BCUHB is 62 (20 at Ysbyty Gwynedd, 22 at Ysbyty Glan Clwyd, 20 at Ysbyty Wrexham Maelor).

It is notable that during peak surge at the Royal Gwent early in April, ratios of critical care nurse to patient ratios (with considerable numbers of support staff) extended to 1:3 for brief periods, which could not have been sustained for a significant period.

### FICM Bridging Guidance for Workforce

Critical Care bed capacity	Critical Care nurse: patient ratio	Support staff**	Critical Care consultant: patient ratio***	Trainee/ACCP: patient ratio****	Pharmacist: patient ratio
Approaching baseline L3 capacity	1:1	normal HCA establishment	1:10	1:15 'senior' 1:15 'junior'	1:10*
2x baseline L3 capacity	1:2	1 non-critical care nurse AND 1 HCA	1:20*	1:15 'senior' 1:15 'junior'	1:20*

The BCUHB Critical Care and Critical Illness Delivery Group and Service Improvement Group have highlighted a number of planning principles for 2020-21 and identified the following requirements:

- A system-wide approach to Critical Care flow and occupancy: consistency in Critical Care admission criteria and pathways, and a zero tolerance approach to delayed transfer of care
- Workforce to meet heightened overall demand associated with care of patients directly affected by Covid-19 and those not, to address the supervision requirements of those working within segregated areas, and to preserve the critical care skills of supporting staff who may be required through further activation of surge plans. WG advise workforce increase in the short- to medium- term to increase Critical Care capacity by 50%.
- Specific staffing needs relating to rehabilitation and recovery of those affected by Covid-19, taking into account starting position for allied health professional staffing
- Preservation of staff well-being (with reference to PPE/ IPC, and risk of burn-out. associated with protracted and/or significant increase in demand).

### 7.1 Critical Care Workforce

Taking into account;

- The increased overall demand for Critical Care services as a result of ongoing Covid-19 related activity;
- The potential for autumn and winter surge
- The re-establishment of essential services requiring Critical Care support
- A potential rise in non-elective demand due to deferred presentation,
- The loss of clinical staff through sickness and shielding and
- Challenges associated with Covid-19 and non- Covid-19 segregation.

The following recommendations have been identified;

- Offer rotational elements of job plans to clinical staff who have fulfilled an “escalation” role
- Create fixed-term contracts to enable nominal secondments to critical care
- Provide an educational programme for such “reserve” staff (and enable release to attend)
- Address additional Critical Care elements identified in the Health Board Economy Plans 2020-21, in particular expansion of core critical care nurse staffing numbers (recognising the need for additional senior supervision and to accommodate for staff absence), provision of

clinical psychology posts on all three sites, allied health professional needs in relation to rehabilitation, the development of advanced critical care practitioners, and dedicated management support for Critical Care at a pan-BCUHB level

## 7.2 Equipment

The Health Board has increased supplies of essential Critical Care equipment, including for ventilation and haemofiltration, to ensure there are sufficient supplies to meet the anticipated increased demand of (Level 3) critical care patients in line with modelling. This has resulted in an increase in critical care ventilators from 38 to 120 as well as additional supplies of other ventilation devices that include NIV, CPAP capability. Receipt of full orders has been subject to delays across the national supply chain and the full orders of critical care ventilators will be received by October 2020.

An additional 9 haemofiltration machines have also been ordered, as well as additional water filtration points installed to a number of critical care beds and acute bedded areas to support access to haemo-dialysis within and outside of critical care areas to provide greater system resilience and meet the anticipated demand for critical care patients requiring renal replacement therapy. Stock holding of renal replacement fluids is currently being reviewed at a national level to consider access to additional centralised stock in the event of a second wave. The BCUHB critical care pharmacy group are also conducting a local review of stock holding of these products for contingency purposes.

## 7.3 Pharmacy

A BCUHB wide critical care pharmacy group was established at the start of the first wave, involving ITU pharmacists, pharmacy procurement and aseptic technical services, which will manage critical care medicines. Continued local and national surveillance of these critical care medicines exists that will enable an agile response to surges in demand. In the event of a national shortage, a mutual aid agreement exists between all health boards across Wales to mobilise critical care medicines to the place of highest need.

BCUHB Pharmacy Technical Services has access to bulk intermediate products of critical care medicines to allow rapid upscale of the production of 'ready to use' presentations (using a newly validated syringe filler) to support potential increased demand. In addition, the Temporary Medicine Unit in South Wales will be accessible for a national provision of aseptically prepared products.

## 9. Respiratory Medicine

The winter months typically see an increased demand for respiratory admissions which will be further impacted by a potential second Covid-19 surge during 2020-21. Following the first Covid-19 surge it has been identified that not all Covid-19 patients require respiratory input and cohort wards will be managed as general medical wards with speciality input as needed.

Each acute site is developing respiratory plans that include proposals to manage respiratory ventilation wards and the specialist respiratory bed base, including plans for red and green beds for respiratory patients to allow expert care for all Covid-19 patients. Medical and nursing workforce plans are being developed to include respiratory physicians to provide 24/7 support for respiratory patients and increased specialist nurse input into the service to support both attendance and admission avoidance for asthma, NIV and lung cancer patients.

Plans are being finalised across the sites for out of hours cover for ventilation wards as part of the Covid-19 surge plan.

Within the community, a number of alternative pathways for COPD / respiratory conditions are already well established and are being reviewed following Covid-19. Work is also underway to develop additional multi-disciplinary pathways for respiratory conditions encompassing urgent

advice, diagnostics and review, including reviewing and reinstating relevant pathways developed during Covid-19. These are included within local health community plans. Urgent care pathways are also being developed for speciality in-reach as part of the Same Day Emergency Care (SDEC) development.

All Wales Respiratory Guidelines will be implemented via the COPD discharge bundle to enable increased co-ordination and resources for Respiratory 'Hospital at home' with enhanced Early Supported Discharge and Pulmonary Rehabilitation. This will also include locality-based monthly MDTs to support respiratory patients at home with Specialist Respiratory Nurse co-ordination to support admission avoidance.

Respiratory Physician support is being sourced as part of Consultant Connect to provide respiratory advice to GPs.

## 10. Site Escalation Processes

In preparation for winter, unscheduled care site escalation processes, comprising Escalation Levels 1 – 4 (see fig 1), have been developed and are being embedded to clarify the processes at different levels of escalation in line with the National Emergency Pressures Escalation and De-escalation Plan<sup>7</sup>. The standardisation of escalation levels aims to improve patient flow through the hospital, by reducing delays both into and within Emergency Departments as well as reducing delays in discharges. These standardised processes are being embedded and will provide up to date, whole system situation reports (SITREPs) for each site to feed into a rhythm of meetings throughout the day/week, to assist planning regarding predictions of pressures including during out of hours. This will also increase clinical safety and reduce level of risk through shared processes and improve unscheduled care performance.

Further work is underway to further develop the SITREP daily template to incorporate community capacity to ensure a whole system approach is captured.

This purpose of the escalation processes is to ensure;

1. The acute sites across North Wales have a standardised approach to escalating unscheduled care pressures 24/7 (through Level 1 to 4)
2. Key individuals within the multi-disciplinary team each have clear actions according to the site position throughout the day and that individual roles and responsibilities are documented and shared widely to minimise duplication e.g. signed off action cards (examples of action cards are included within appendices)
3. Clarity for clinical site management teams for which team members to involve depending on situation report.
4. Ensure standardisation of a fit-for-purpose safety huddle / mini safety huddle agenda throughout the day with relevant, up to date and accurate information to inform decision making. Agree wider health economy input into rhythm of the day e.g. area team
5. SAFER principles reviewed and monitored as part of the rhythm of the day e.g. board rounds, ward rounds, early discharge
6. Consistent situation reporting across North Wales aggregated to a North Wales position

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<sup>7</sup> National Emergency Pressures Escalation and De-escalation plan, March 2014



**Fig 1. Unscheduled Care Escalation Levels**

<p><b>Triggers – Escalation Plan Level 1</b></p> <p><b>Steady State</b></p> <p><b>HEALTHBOARD – 4 CORE TRIGGERS APPLICABLE:</b></p> <ul style="list-style-type: none"> <li>• Emergency admissions are within predicted levels match available capacity</li> <li>• Emergency Access performance 95% being maintained</li> <li>• Available resuscitation and trolley capacity in A&amp;E</li> <li>• Ambulance patients – transfers of care within 15 minutes</li> <li>• Beds available in assessment units</li> <li>• Predicted and known capacity to accommodate emergency and elective admissions (including community beds)</li> <li>• Available CCU &amp; ITU capacity</li> <li>• No additional beds opened</li> <li>• Elective lists proceeding as scheduled</li> <li>• No assistance being provided to other sites/health boards</li> <li>• No known external factors to impact upon capacity</li> <li>• Consider 24 and 48 hour weather forecasts (hot and cold)</li> </ul>	<p><b>Triggers – Escalation Plan Level 3</b></p> <p><b>Amber High: Severe Pressure</b></p> <p><b>HEALTHBOARD – 4 CORE TRIGGERS APPLICABLE:</b></p> <ul style="list-style-type: none"> <li>• Emergency admissions are exceeding predicted levels and available capacity</li> <li>• &gt;8 hours breaches have occurred</li> <li>• Unable to provide resuscitation facility</li> <li>• Ambulance patients – transfers of care &gt; 30 minutes but less than 60 minutes</li> <li>• Patients waiting more than 2 hour for first contact with assessing clinician (majors minors)</li> <li>• Limited ability to create CCU and ITU capacity (refer to Critical Care Escalation protocol)</li> <li>• Discharges and transfers less than predicted and will impact significantly on capacity</li> <li>• All available staffed adult capacity in use, including ring fenced beds</li> <li>• Planned commissioned additional activity in use</li> <li>• Routine electives cancelled</li> <li>• Divert within the Health Board in place</li> </ul>
<p><b>Triggers – Escalation Plan Level 2</b></p> <p><b>Amber Low: Moderate Pressure</b></p> <p><b>HEALTHBOARD – 4 CORE TRIGGERS APPLICABLE:</b></p> <ul style="list-style-type: none"> <li>• Emergency admissions are likely to exceed predicted levels and available capacity</li> <li>• &gt;4 hours breaches have occurred (excluding clinical exception)</li> <li>• Ability to provide resuscitation capacity</li> <li>• Ambulance patients – transfers of care &gt; 15 minutes but less than 30 minutes</li> <li>• Patients waiting more than 1 hour for first contact with assessing clinician (majors minors)</li> <li>• No acute beds available within the next 30 minutes</li> <li>• CCU &amp; ITU delayed transfers of care identified</li> <li>• Patients being admitted or transferred to an outlying specialty</li> <li>• Unplanned bed closures i.e. infection outbreak</li> <li>• Routine electives under review</li> <li>• Midday status remains at Yellow</li> </ul>	<p><b>Triggers – Escalation Plan Level 4</b></p> <p><b>Red: Extreme Pressure</b></p> <p><b>HEALTHBOARD – 4 CORE TRIGGERS APPLICABLE:</b></p> <ul style="list-style-type: none"> <li>• Emergency admissions have significantly exceeded predicted levels and available capacity</li> <li>• &gt;12 hours breaches have occurred</li> <li>• A&amp;E capacity unable to meet further demand</li> <li>• Ambulance patients – transfers of care &gt; 60 minutes</li> <li>• Patients waiting more than 4 hour for first contact with assessing clinician (majors minors)</li> <li>• No transfers or discharges taking place</li> <li>• No CCU or ITU capacity available</li> <li>• All planned admissions have been cancelled</li> <li>• Unplanned uncommissioned additional capacity in use</li> <li>• No divert to neighbouring Health Boards in place</li> </ul>

### 10.1 Ambulance Handover

During times of increased pressure within the emergency care system, there is a potential for delays in the transfer of care from one provider to another. This can result in significant delays in the overall system that can adversely impact on patient experience and operational performance.

In addition to the site escalation levels, draft ambulance escalation levels and ambulance handover operating procedures<sup>8</sup> are under development with a view to provide standardised guidance for all members of staff on the management of Ambulance Handovers between BCUHB and WAST. This guidance will set out clear lines of responsibilities and standards to ensure service delivery as well as accurate and safe handover of patients from the ambulance staff to BCUHB staff which aim to;

- ensure patients are received by the organisation in a timely manner with accurate recording of trolley clear times.
- improve the patient experience
- reduce the risk of poor care and clinical safety issues for the patient; and
- support the Ambulance Trust in providing a more efficient and effective response to calls within the community
- reduce the performance risks to providers involved in the urgent care pathway

<sup>8</sup> DRAFT Ambulance Handover Standard Operating Procedures, May 2019

## 10.2 Frequent Attenders

Work is also ongoing to support and reduce the number of frequent attenders through the following recommendations;

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

## 10.3 SICAT

Demand in the ambulance service is high all year round but more so over the winter period. Collaboration between WAST and BCUHB saw the implementation of SICAT (Single Integrated Clinical Assessment and Triage) working from the Clinical Contact Centre (CCC) in North Wales.

Experienced General Practitioners (GPs) work alongside WAST Advanced Paramedic Practitioner (APP), providing extensive experience and knowledge in clinical decision making and risk assessment skills that are vital for this role.

The benefits of developing this proactive team, within a defined Enfys model, offers clear benefits. Where clinically appropriate, patients who can care for themselves will be provided with information, advice and reassurance to enable self-care. Where possible patients will have their problem dealt with over the phone by a suitably qualified clinician and those requiring further care or advice will be referred to the relevant service that has the appropriate skills and resources to meet their needs. To date, SICAT have dealt with over 10,000 calls, saved over 6,400 Emergency Department attendances and over 7,800 ambulance usage.

## 11. Phone First programme / 111 North Wales Implementation

The Health Board is committed to the national roll out of Phone First programme for urgent and unscheduled care. We are currently working closely with the national implementation group and Cardiff and Vale Health Board as the pathfinder Health Board with their CaV 24/7 service.

This proposal to establish a 24/7 phone first approach focuses on supporting citizens to access the right services first time, every time and focuses predominantly on (but not limited to) lower acuity patients, mainly minor injury / minor illness categories, that could be managed elsewhere in the system and the essential requirement to reduce footfall to ensure safety. Thereby maximising use of the individual's time; improving the patient experience and outcomes; and utilising our resources effectively (delivering the principles of the quadruple aim). This important programme of work is linked to the EDQDF and Welsh Access Model (WAM) early adopter plans, Review and Restore plans for the EDs and the 111 roll out and builds on existing phone first systems already in place within the Health Board including GPOOHs, in-hours Primary Care pre-screening / triage and the SICAT service, all which have differing degrees of clinical triage.

The Central Health Community have already implemented a version of this model in relation to attendances at their minor injuries units, the plan is to further develop and roll out this pilot into the larger pan-BCUHB phone first service.

## 12. Pathology

BCUHB has a total of 130 adult fridge spaces across each of the 3 acute sites, a total of 7 freezer spaces are available at Ysbyty Gwynedd and Ysbyty Glan Clwyd, as well as a cold room at Ysbyty Wrexham Maelor to accommodate up to six patients or bariatric bed. There are two foetal fridge banks at Ysbyty Gwynedd. Mortuary contingency comprises 1 x 12-bed Nutwell unit (mobile), 1 x 12 bed container unit at Ysbyty Glan Clwyd ready for use, 1 x 12 bed small body container unit at Ysbyty Glan Clwyd, which is not yet modified nor approved for ergonomic working but could be used if needed with additional safety risk assessments. A business case is being prepared for additional permanent fridge and freezer storage. To simplify work flow in the fridge rooms, the mortuary spaces have been divided into normal and high risk but all spaces can be used as needed.

Mortuary forecast and resilience plans are updated daily and current capacity reported on a daily basis. The report covers each of the three main mortuary sites across BCUHB and lists the total capacity and daily vacancy at each site, including the temporary body storage facilities that are available. There is also the facility to transfer deceased across sites in BCUHB and utilise the body stores that are less busy, such as 12 spaces in Llandudno General Hospital if necessary. Mortuary facilities are also backed up by the Local Resilience Forum, which has been active in supporting the pandemic and maintains a record of all refrigerated body storage capacity across North Wales including hospitals and undertakers. In the event of a spike, a multi-agency response would be implemented between North Wales Police, undertakers, HM Coroner's office and BCUHB.

During winter 2019-20 mortuary capacity was reached on at least three occasions. This was responded to by requesting assistance from local undertakers who removed half a dozen deceased on each occasion to release capacity until the following day. Since then additional storage has been provided from the Cabinet Office, which will be available over the coming winter.

Workforce plans for Pathology are described in business continuity plans<sup>9,10</sup>, and includes cross training to support other disciplines if required. North Wales Managed Clinical Services (NWMCS) were able to support essential services earlier in the year, by retraining staff from other departments within NWMCS to provide additional resource depending on the demands of the service. Examples of this include; point of care testing (POCT) training and roll out of new equipment, phlebotomy, bereavement services and planning for excess deaths. There are contingency plans in place that describe actions to be taken if optimum staffing levels cannot be maintained. BCUHB Pathology will prioritise essential services as described in these plans.

Business continuity plans are also in place for other NWMCS, namely, Radiology, Audiology, Medical Physics and Neurophysiology, to ensure high clinical priority activity is maintained during the winter period. Plans can be progressively implemented subject to prevailing circumstances, and a directorate-wide communications process is in place to ensure rapid communication of information to ensure priority activity can continue to be met during the winter period.

## 13. Test, Trace, Protect

The Health Board, working with partners, is responsible for leading the delivery of the Test, Trace, Protect (TTP) service across North Wales, which is a significant new service in response to managing Covid-19 and is expected to be a requirement for a minimum of 18 months. Since go-live, the TTP service has conducted more than 20,000 antigen tests, more than 7,000 antibody tests and traced more than 1,800 index cases and 2,000 contacts. The service has responded to mass testing in care homes on a weekly basis, two outbreaks, targeted

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<sup>9</sup> Pathology Directorate: Cellular Pathology and Mortuary and Bereavement Services contingency plan

<sup>10</sup> Pathology Directorate: Blood Sciences & Transfusion contingency plan

community testing and dealt with a higher than Wales average of positive index cases. Going into autumn and an anticipated surge, the services that have been rapidly established with predominantly redeployed resources need to be established on a more stable footing.

The *WG Test Trace and Protect Strategy*<sup>11</sup> was first published on 13<sup>th</sup> May 2020 and updated on 4<sup>th</sup> June 2020. The *Test, Trace, Protect Strategy* is to enhance health surveillance in the community, undertake effective and extensive contact tracing, and support people to self-isolate where required to do so. This will mean asking people to report symptoms, testing anyone in the community who is showing symptoms of Covid-19, and tracing those they have come into close contact with. The Protect component of the strategy seeks to support the population, particularly the vulnerable when asked to isolate. Protect is a multiagency approach drawing on Health Board, Local Authority and third Sector partners to deliver the programme. Test, Trace, Protect is fundamental to helping us find a way to live with the disease until a vaccine or treatment is available.

Ahead of autumn there are clear priorities:

- **Protecting against the transmission of the virus by supporting contact tracing** – to prevent and protect spread of the disease amongst the population and to track the spread of coronavirus, understanding transmission dynamics and to ensure that testing can support targeted action through local outbreaks in communities or within businesses.
- **Delivering NHS Services** – to prevent, protect and deliver vital services and to support the safety of staff and patients.
- **Protecting vulnerable groups, closed settings and critical workers** – to safeguard and control infection in groups where there are greater risks.
- **Developing future delivery** – to utilise surveillance and new technologies to improve our understanding of the virus through the use of intelligence and to innovate new ways to test across the population.

WG want to build a resilient, flexible and sustainable delivery model, which will be responsive to current and future needs. Contact tracing combined with the other testing purposes could potentially require demand of as many as 20,000 tests a day across Wales. From this total, the contact tracing demand is estimated at 4,500 - 11,000 per day. Indicatively, North Wales accounts for 25% of this forecast.

Future capacity and testing strategy will be dependent on laboratory including staff, machines and reagent capacity, the spread of the disease (sensitivity and specificity vary with prevalence rates), this will encompass new incident cases and transmission rates in community (R), the prevalence of symptoms and the emerging evidence on how testing can best be deployed to prevent infection.

The Testing Plan builds upon the latest evidence and it is recognised that data and evidence is still evolving, where questions remain about the virus and our immune response. The testing plan will be iterative and continue to evolve as evidence emerges. The approach to testing is evolving rapidly, both for viral detection and for testing the protective immune responses to it.

Testing for SARS-CoV-2 has a number of purposes that it can be used for:

- Identifying Covid-19 cases to support contact tracing and thereby the spread of disease;
- diagnosing Covid-19 to help with treatment and care;
- population health surveillance, so that we can understand the spread of the disease; and
- business continuity, enabling people to return to work or education safely.

There are currently two different forms of testing in Wales.

- The RT-PCR (virus detection) test, which detects the presence of viral RNA.

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<sup>11</sup> Test, Trace, Protect Strategy; WG; June 2020



- The antibody test, which detects the antibody response to the SARS-CoV-2 virus, and is used primarily to determine whether a person has been previously infected and uses a range of sero-surveillance studies to better inform our understanding of the virus which will help to build an evidence base for us to develop a testing programme.

The current testing strategy initially focused on people in hospitals, care homes, and symptomatic critical workers. There is now a testing infrastructure that supports mass testing of symptomatic people across the population in support of the Test, Trace, Protect strategy. The population is asked to report symptoms and anyone in the community who is showing symptoms of Covid-19 will be tested. Contacts of positive cases are being traced when they have come into close contact, to control the spread of the disease. Testing is rapidly deployed to help manage outbreaks and clusters.

At present the north Wales region has access to:

- Mass Testing Centres (MTCs) – two; Llandudno and Deeside run by UK.GOV.
- Community Testing Units (CTUs) – four across the region; Ysbyty Alltwen, Ysbyty Gwynedd, Ysbyty Glan Clywd and Ysbyty Wrexham Maelor staffed and run by BCUHB.
- Mobile Testing Units (MTUs) – previously two units run by the military and now transitioned to a private provider, Mittie. These units will also support large scale testing during outbreaks in support of the CTU staff.
- Home Testing Kits (HTKs) – including access to a dedicated portal for care homes.
- Local Testing Units (LTUs) – two to be established in North Wales, each offering up to 250 tests per day. The location of these two units will be Bangor and Rhyl run by UK.GOV

Work is underway with partners to establish how we continue to work together to protect vulnerable people and communities:

- Supporting shielded individuals
- Signposting to and facilitating foodbanks
- Through good engagement and communications with individuals and families.

BCUHB is currently working with partners across north Wales to define and finalise the local Covid-19 Response & Prevention Plans. This aligns with the overall TTP service delivery.

## 14. Mental Health

In acknowledgement of the additional pressures facing healthcare services during winter and Covid-19 pandemic, the Mental Health Division in collaboration with Primary Care and Community Services have developed robust planning arrangements to allow services to meet increasing demand at the 'front door', shifting focus downstream on prevention and early intervention, building reliance at a community level. The Mental Health Winter Resilience Plan also seeks to address what are predominantly long-standing issues in our Mental Health Primary Care offer and ensure that services are psychosocially minded and that our staff feel supported, valued and empowered. Due to Covid-19 and the expected surge in demand for Mental Health support, this proposal would provide the opportunity to expedite the additional resource and intervention required.

GP services remain a highly visible part of the health system, which experiences significantly increased demand and pressure during the winter period. The Mental Health Division in partnership with the Primary Care and Community workstream seeks to develop a number of support mechanisms including investing in the roll out of the Mental Health practitioner model and community connector role to Clusters in order to improve Primary care resilience.

Implementation of the Mental Health model and connector role will provide Clusters with a more efficient way of managing the anticipated increased demand and release capacity. The Mental Health Service does not see seasonal fluctuations in demand to the same extent as other services although demand varies for other reasons, therefore roll out of the model will continue

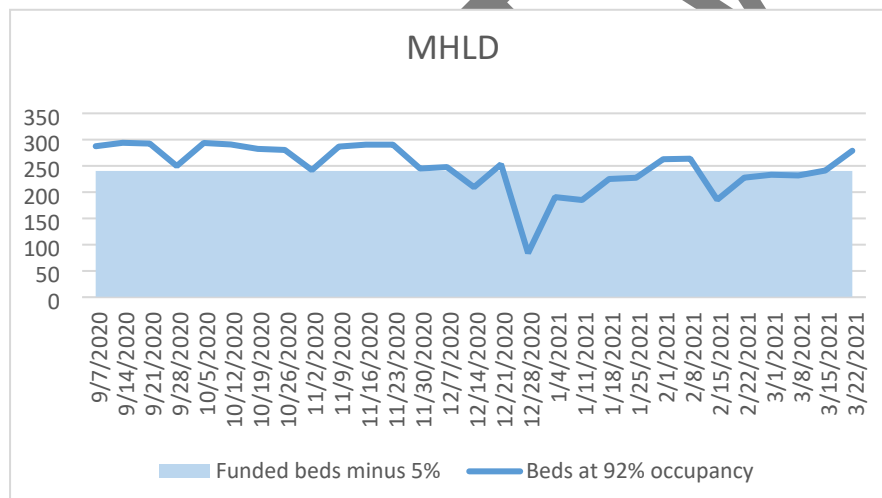
throughout the winter months with the focus on reducing number of people with mental health problem reaching crisis.

In order to connect to people differently and to increase availability of support services, it is proposed to increase the use of digitally enabled solutions in order to support a wider cohort of participants in a much more complex landscape but also to support people differently through the use of online Cognitive Behavioural Therapy (CBT) courses, 1:1 virtual counselling, webinars and group work. It is proposed to support the use of 'Attend Anywhere' with our Third Sector Partnerships in order to increase 'connectivity' across organisational silos that still exist.

The focus of the Mental Health Winter Resilience Plan is focused on prevention, early intervention with targeted sustainable solutions to improve resilience at the 'front door'. ICAN centres will continue to provide support and discussions are ongoing with lead clinicians and managers to finalise Mental Health pathways.

The Mental Health Winter Resilience Plan also focuses on supporting organisations that often meet the needs of the most marginalised people better than mainstream mental health services. However the Division also proposes to offer targeted preventative support for the 'less obvious' cohorts of the population during the Covid-19 pandemic. The Centre of Mental Health suggest there is an inherent risk of developing post-traumatic stress disorder (PTSD) after experiencing intensive care treatment for Covid-19 and therefore our plan will offer targeted, tailored mental health support to the families of people treated in ITU. Work is already underway to identify potential numbers affected.

The following graph illustrates typical bed demand based on historic occupancy figures and assumes the number of beds at 92% occupancy compared to current funded beds with a 5% reduction due to Covid-19 restrictions.



As part of the divisional arrangements going forward, Clinicians are working on clinical pathways and these discussions include a review of the arrangements within the inpatient units which should start to address bed capacity.

As part of the first phase of Covid-19, the mental health inpatient facilities were cohorted to maintain assessment wards, green clean wards and infected wards. In North Wales the Division moved to one inpatient facility to admit adult patients (<70) and one for older people (>70) where people were assessed and treated. If asymptomatic for 14 days and in need of longer admission, patients were moved to green units.

The Heddfan Unit in Ysbyty Wrexham Maelor was designated as the regional admission unit for people >70 years old across North Wales. Within the unit different areas were identified as Covid-19 positive; negative and assessment. The Section 136 suite remained in operation. The Ablett

Unit in Ysbyty Glan Clwyd became the regional admission unit for people <70 years old. The Sec 136 suite remained in operation but was identified as an isolation area. The Hergest Unit in Ysbyty Gwynedd was a treatment unit where patients were moved if asymptomatic for 14 days and still in need of admission. The Section 136 suite remained in operation.

The Cefni Unit and Bryn Hesketh Unit continued to host people suffering from neurodegenerative disorders, but new admissions were centralised to Heddfan unit. Coed Celyn unit in Wrexham, formerly used as inpatient rehabilitation unit, was cleared of patients who have been moved to either private facilities or community.

Three specific schemes are in development by the Mental Health teams which are designed to avoid acute exacerbations of mental illness and early intervention of mental distress. These schemes describe support into primary care settings with primary care support and Mental Health practitioner and connector roles as well as CPN support into care homes in each of the areas, aligned to Community Resource Teams in order to reduce crisis and transfer to the acute; and telephone triage pathways linked to the Phone First programme. The Q3-Q4 plans provide more detail of the short, medium and long-term critical milestones.

## 15. Women's Services

The maternity Covid-19 escalation and workforce continuity plans inform the overall winter preparation and resilience plan for the service. The plan ensures that essential maternity and related screening services in both the acute and community settings are managed on a North Wales network approach to achieve business continuity during periods of increased demand. The overall plan is underpinned by the use of digital enabling solutions to maximise connectivity, communications and supports virtual management of some of the adapted clinical pathways.

The health and safety of women, their families and staff is the service's first priority in the prevention and control of infection in our health care settings. As part of the winter / Covid-19 planning the service has adopted its estates across all three Community Areas and Acute sites to ensure that the care environments are safe for women and their babies to access.

The service has also developed clinical pathways based on the Royal College of Obstetricians and Gynaecologists (RCOG) Covid-19 specific guidance<sup>12</sup>. These pathways rely on routine SARS-COV-2 testing of all women who access hospital care during pregnancy, birth, and the postnatal period to ensure separate flow of women directly affected by Covid-19 to those unaffected. WG hospital guidance for maternity is being kept under review and will change as the pandemic status alters. The service continues to be responsive to any revised guidance and their safe application locally.

As part of the winter plan clinical outcomes and effectiveness will continue to be monitored via the national dashboards and formally reviewed at the Women's monthly Service Planning Group. The Service's Q3&4 plans provide more detail on the short, medium and long term critical milestones that include meeting Welsh Government targets.

## 16. Paediatrics

The BCUHB Winter Resilience Plan is an all age plan which includes the requirement to ensure that all children and adults have timely access and good quality care on their journey through services that meets all their needs. The plan seeks to address the high peak in demand seen every year in acute paediatrics as a consequence of the rise in viruses, particularly respiratory conditions, requiring admission and high dependency care.

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<sup>12</sup> Coronavirus (COVID-19), pregnancy and women's health

Children and young people (C&YP) whom attend EDs require timely assessment and intervention from a skilled workforce without being exposed to adult trauma and distress, the plan seeks to address the requirement to meet the needs of C&YP within EDs and increase the capacity and skill of the workforce required.

The plan also seeks to address the needs of young people in crisis and distress. The Covid-19 lockdown has had a significant impact on family life and the emotional wellbeing and mental health of young people, resulting in an increase in high risk behaviour, anxiety and the need for a crisis response from EDs, CAMHS and Paediatrics.

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## 17. Potential schemes for supporting delivery over winter

The following table provides details of the schemes that have been identified by each local health community to support increased demand over winter and are aligned to the 6 goals for urgent and emergency care.

	Goals	Outcome	Proposed Key Deliverables 2020-21	Scheme	Quantify Impact
1.	Co-ordination, planning and support for high risk groups	Planning and support to help high risk or vulnerable people and their carers to remain independent at home, preventing the need for urgent care	<p>Each cluster should enhance planning and protection for patients who are clinically extremely vulnerable (shielded) from Covid-19, identified through risk stratification / electronic frailty index / Patient Care Record / clusters</p> <p>Care home residents and patients with three or more chronic conditions will be prioritised in Q2. Each cluster should achieve 100% compliance with national enhanced service for care home residents</p> <p>Each cluster should achieve the influenza vaccination uptake target (60%) for at risk populations</p> <p>Support for children and young people with both chronic long term conditions, mental health challenges or acute illness by defined Paediatric pathway through hospital care; increased capacity within CAMHS liaison team, and increased outreach approach for children with long term conditions</p>	<p>Practices and clusters are prioritising reviews of registered patients with chronic conditions. MDT approach adopted for the most complex cases</p> <p>Practice/cluster virtual ward rounds of Care Homes. Full sign up to the Care Home DES</p> <p>SICAT/WAST telephone support for care home patients presenting with a change to their 'normal state'</p> <p>Mass vaccination events planned. Support from community pharmacy schemes</p> <p>Central schemes with increased children and young people workforce capacity</p>	<p>Reduce risk of acute exacerbations of chronic conditions e.g. COPD; Diabetes; CHD</p> <p>Holistic management offering increased patient confidence point of contact in crisis</p> <p>Proactive management of frailty and chronic conditions will avoid unnecessary clinical escalation with risk of hospital admission</p> <p>Reduced numbers of influenza cases = reduced demand on Primary and Acute care services during the winter period</p> <p>Avoid unnecessary admissions of children and young people with lifelong conditions hence reducing the risk of exposure to HAI; improve patient experience with clear pathway through acute care through to safe discharge.</p>

	Goals	Outcome	Proposed Key Deliverables 2020-21	Scheme	Quantify Impact
2.	Signposting, information and assistance for all	Information, advice or assistance to signpost people who want – or need - urgent support or treatment to the right place, first time.	<p>To support care in the right place and enable social distancing in ED, a 'phone first before attending ED' or 'phone and walk' concept targeted at patients who could be safely assessed elsewhere or through a planned approach will be developed and tested</p> <p>Out of hours urgent care pathways will be adapted for local use, and will be available to 111/Out of Hours primary care for urgent respiratory, dental and mental health crisis services pathways.</p> <p>Health Boards should deliver the 'Choose Pharmacy' system and common ailments service locally to enable patients to access an appropriate service for their minor ailments in a timely manner, and to receive NHS treatment from the community pharmacy, preventing the need for presentation at hospital</p>	<p>Service development plan for implementation of BCU 24/7 – (based on the CAV24/7 model) for presentation to Execs an onward to Board with target date of implementation by January 2021</p> <p>ICAN service to sustain through Winter with increased access where possible</p> <p>Acute care respiratory teams rota to be adjusted to allow access to senior decision maker up to 24/7 wherever possible</p> <p>Wholesale rollout of Consultant Connect</p> <p>Scope demand for development of urgent care treatment centre services in East</p> <p>Plans described within the Q3/4 action plan for increased use of Choose Pharmacy in East and West (full rollout already in place in Centre).</p>	<p>Improved patient experience and outcomes through access to the right service at the right time, first time/every time.</p> <p>Reduced ED attendances</p> <p>Delivery of live, comprehensive Directory of Services (DoS)</p> <p>Mental distress support to individuals in crisis – avoid acute exacerbation and/or progression into Mental illness crisis</p> <p>Better, safer outcomes and management of patient presenting with respiratory disease (with risk of associated Covid-19)</p> <p>Reduced demand on PC</p> <p>Improved patient experience through access to the right person with skills and knowledge best suited to their needs.</p>

	Goals	Outcome	Proposed Key Deliverables 2020-21	Scheme	Quantify Impact
3.	Preventing admission of high risk groups	Community alternatives to attendance at an Emergency Department and/or admission to acute hospital for people who need urgent care but would benefit from staying at, or as close as possible, to home.	<p>Consultant connect should be fully embedded in all health board areas to support the reduction of ambulance conveyance from care homes to hospital through the provision of specialist clinical advice and guidance</p> <p>Establishing frailty model within the 3 health communities which delivers rapid acute assessment, and speedy return to care closer to home for the most frail members of our communities</p> <p>Additional capacity for home ventilation with the support of a cardiac physiologist</p>	<p>Wholesale rollout of Consultant Connect, linked with WAST/SICAT and access extended to Care Homes and Community Hospitals</p> <p>Establish frailty services within the 3 health communities</p> <p>Enhance the care of patients requiring long term home ventilation. Reducing the risk of deterioration and requiring an acute hospital admission.</p>	<p>Avoid ED overcrowding leading to cross infection, patient harm and increased staff sickness</p> <p>Provide support with clinical decision making and care planning for patients suitable to manage outside of an acute setting</p> <p>Improved patient long term outcomes, Reduced risk of HAI Improved patient and family experience</p>
4.	Rapid response in Crisis	The fastest and best response at times of crisis for people who are in imminent danger of loss of life; are seriously ill or injured; or in mental health crisis.	10. Direct access pathways for respiratory, palliative care, stroke, STEMI and #NOF will be established and consistently delivered to support improved outcomes, and reduce unnecessary crowding and ambulance patient handover delays	<p>Paediatric direct access pathways to be implemented at all 3 acute sites</p> <p>Stroke improvement plan to be implemented at Ysbyty Gwynedd</p> <p>Respiratory pathway - cross reference to <b>scheme W&amp;C 2.2</b> above</p> <p>Continue to deliver the STEMI pathway as part of essential urgent care services</p>	<p>Improve patient experience and outcomes</p> <p>Reduce crowding in EDs</p> <p>Improved IPC management</p>

	Goals	Outcome	Proposed Key Deliverables 2020-21	Scheme	Quantify Impact
5.	Great Hospital Care	Optimal hospital based care for people who need short term, or ongoing, assessment/treatment for as long as it adds benefit	Given the requirement to conserve acute bed capacity during the pandemic, same day emergency care' (or Ambulatory Emergency Care) without need for an overnight stay will be rolled out across all acute hospitals with approx. 30% of medical take to be treated via AEC / SDEC, increasing the proportion of people typically Discharged on day of their attendance to around 90% where possible. Timely rehabilitation/reablement interventions must be consistently available to support rapid, sustainable discharge	<p>A sustainable flow model which includes direct access pathways which will ensure each site's ability to maintain a separate red/green patient flow</p> <p>SDEC pathway to be standardised across the three acute sites. This will include ambulatory care pathways.</p> <p>Comprehensive and deliverable surge plans for each health community, designed to meet the projected demand profiles as of 19/09/2020</p>	<p>Reduced demand on acute and community bed base</p> <p>Improved patient experience and outcomes</p> <p>Deliver principles of care closer to home</p> <p>Engaged workforce with new ways of working</p> <p>Maintain separation of Covid/Non-Covid demand</p>
6.	Home First when Ready	A home from hospital when ready approach, with proactive support to reduce chance of readmission	<p>HBs and LAs, working with the third sector and independent providers, should adopt a 'home first' approach to enable more people, who have attended an Emergency Department or have been admitted to hospital, to be assessed and recover in their own homes to avoid unnecessary long stays in hospital beds. This will be achieved through delivery of four 'discharge to recover and assess' active therapeutic pathways, embedded locally.</p> <p>HBs and LAs working with the third sector will increase the focus on the provision of rehabilitation, reablement and recovery, and ensure there is sufficient capacity to support the increasing number of</p>	<p>Delivery of 'Discharge to Recover and Assess' pathways in Centre. Extend the Home First reablement teams in East and West</p> <p>This includes access to step up/down beds and home therapies services.</p> <p>Establish Nurse/Therapy led ward at Llandudno Community Hospital (Tudno)</p>	<p>Reduced lead in time to discharge out of acute and community hospitals</p> <p>Reduce risk of bed blocking</p> <p>Improved patient experience</p> <p>Delivery of Home first principles and Care closer to home</p>



	Goals	Outcome	Proposed Key Deliverables 2020-21	Scheme	Quantify Impact
			people who will need support during the pandemic, with long term conditions, and frailty, who require support to prevent: <ul style="list-style-type: none"> <li>- permanent disability;</li> <li>- greater reliance on care and support;</li> <li>- avoidable readmissions to hospital;</li> <li>- delayed discharge from hospital</li> </ul>		

## 6.2 Prioritisation of Schemes

Prioritisation of costed schemes from each local health economy has been undertaken, based on costs versus system impact. All schemes are aligned to the WG 6 goals for urgent and emergency care with the following common themes across North Wales:

- Home First scheme
- Frailty Services
- Respiratory Pathways (to include Consultant Connect)
- Same Day Emergency Care (SDEC)
- Care Homes support schemes such as falls and chronic conditions management
- Specific Paediatric Pathways including enhanced support for CAMHS
- Flu vaccination and Pharmacy First schemes

Indicative costs for prioritised schemes is circa £9.927m, which includes schemes for which bids have been submitted to WG for AEC / SDEC, Phone First and Urgent Treatment Centres (24/7). Work is ongoing to allocate against Health Board allocation of Integrated Care Funds (ICF) and Regional Partnership Board monies.

## 18. Workforce Planning

As part of winter planning, workforce plans have been aligned to the clinical pathways for repurposing of capacity and capability to meet current and future changes in demand. This allows the Health Board to be able to mobilise to resource any additional capacity commissioned within the Health Board and supporting partners in health and social care to manage risks associated with outbreaks or clusters impacting upon staffing.

Significant work has been undertaken to develop workforce modelling to support assessment of priorities for deployment of staff in the event that additional winter capacity is required, or resources are impacted by infection/unavailability over the winter period. In addition, a workforce information dashboard has been developed to support a transparent mechanism for clinical teams to assess need and utilise resources in a safe way. Any decision to mobilise additional capacity would be balanced against the resources available in both the existing core workforce and additional flexible workforce. Work is continuing to develop and build upon the significant improvements made during Q1 & Q2 in the level of flexible workforce availability.

## 19. Infection Prevention & Control

BCUHB adheres to all national policies/guidance and updates in relation to Infection Prevention and Control (IPC) and public health requirements. To remove wherever possible the risk of nosocomial transmission between staff, patients and visitors, Public Health Wales (PHW) and BCUHB infection prevention and control measures are also implemented. This includes:

- Hand Decontamination and bare below the elbows
- The correct use of PP, level 1 and level 2, including donning and doffing and any necessary Fit Testing to FFP3 masks. There are also alternatives to respiratory protection including positive pressure hoods.
- Adherence to stringent decontamination and cleaning schedules which includes detergents, disinfectants, UV and HPV.
- Isolation and cohorting of potential and confirmed infectious patients, with strict bay/ward closures managed via the IPC team (IPCT). This includes care of those patients requiring aerosol generating procedures (AGPs)
- Minimising patient and staff movement is managed via Area, Site management teams, and IPCT, and this includes cohorting of staff to cohorted patients.
- There are regular reviews and agreements in place to manage single room facilities, negative pressure facilities, current and future bed spacing, air management systems, and where feasible to do so, screens and closed circuit ventilation systems are used.
- Promotion of PHW guidance is ongoing with regard to social distancing, hand washing and facial covering/mask via sanitation stations and subtle encouragement for the public.
- Designated clinical areas and pathways are established for suspected and positive patients to enable segregation for patients and staff.
- All admissions, discharges to care homes, community hospitals, tertiary centres and/or receiving provider care packages are screened for any circulating and suspected infections.
- Symptomatic staff testing is available with track and trace. Any clusters of infection in any inpatient area, also includes screening of staff where necessary to manage nosocomial infections like Covid-19.
- In line with BCUHB workforce guidance, risk assessments have been completed for at risk Black, Asian, Minority Ethnic (BAME) staff and those shielding to support safe return to work.
- Staff antibody testing is being implemented for Covid-19.

- PPE stock control measures continue, monitored by the PPE hub. Level 1 PPE stock available for ward/departments via internal top up and site/area based hub supplies level 2 PPE.
- Fit testers are undertaking accredited training to comply with HSE guidance. Full compliance anticipated October 2020.
- All ward environments have been risk assessed and environmental changes undertaken to support segregation, including doors installed in bays and along corridors. Sanitation stations available with the egress of all areas.
- Building on existing reporting systems a standardised approach to reporting Covid cases and investigation of hospital acquired Covid 19 infections has been agreed. Timely Make it Safe reviews are undertaken to determine early learning and alert of any significant mitigation required.
- Hospital Management Team have mandated that staff movement is monitored and a decision to move a patient for non-clinical reasons is deemed a significant event and reported via the incident reporting system and tracked by the hospital management team.
- Increased enhanced cleaning is undertaken on areas with increased footfall and infection rates.
- Waste and PPE stations are available for visitors
- Standard IPC measures are promoted continuously with safety walkabout undertaken by the IPCT and senior leadership team from the site to seek assurance regarding compliance.
- There is a daily review within the site safety huddle of infection prevention cases and concerns.

## 20. Staff Influenza and Covid 19 Vaccination Planning

A Seasonal Influenza Plan<sup>13</sup>, developed by the BCUHB Flu group has been agreed at the BCUHB Quality and Safety Group for implementation across the North Wales region based on information known to the time of publication. Due to the unusual nature of the forthcoming flu campaign, which will be affected by Covid-19 restrictions in terms of social distancing and the use of PPE, this year's campaign will take longer to deliver and adjustments may be required if a second wave of Covid-19 manifests itself. Further Flu Welsh Health Circulars are anticipated setting out the detail of how GP practices and community pharmacies will be able to access the additional stock procured by WG to vaccinate the extended groups 50-65 years of age commencing in late November.

The Flu Group is cognisant of the impending Covid-19 vaccination campaign plans. Flu and Covid-19 vaccination plans are entwined and interdependent on each other in terms of resources and provision.

In addition to the usual activities required to implement the Flu campaign, in 2020-21 the BCUHB Flu Plan specifically targets certain areas of work to maximise uptake by adopting a collaborative approach pan North Wales for example:

- **Care Home Staff Scheme** will see a community pharmacy buddy up with a care home to ensure easy access to the vaccine for staff working in an adult care home setting. This combined approach which includes an accreditation scheme for care homes to participate in, will encourage strong leadership to persuade staff to come forward for vaccination. Local authorities, contract officers and Continuing Health Care colleagues are all collaborating on this project to ensure a coordinated approach to ensure greater resilience in this sector. This work is considered to be exemplar in Wales.

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<sup>13</sup> BCUHB Seasonal Influenza Plan, August 2020

- **Carers:** Work is ongoing to support Carers to make themselves known to the GP practice and to raise awareness of their eligibility for the vaccine.
- **People with a Learning Disability (PWLD)** have all become eligible this year. Collaboration with multiagency colleagues supporting this vulnerable group has generated new innovative ideas to help this PWLD to access the vaccine in greater numbers than we have seen before.
- **Primary School Campaign:** School Nurse managers have ensured a robust scheme is in place to deliver the flu vaccine to all Primary School pupils in around 400 premises.
- **Communications and engagement colleagues** are working with more stakeholders this year to deliver a more tailored approach to target and support local groups with more information to raise awareness of the eligibility for the flu vaccine.
- **Those people who are morbidly obese** are receiving telephone contact from dietetic colleagues and also staff working on the National Exercise Referral Scheme to raise awareness of their eligibility.
- **Flu vaccine contingency stock:** For the first time, BCUHB obtained a significant contingency stock of flu vaccines due to concerns raised some months ago that there would be an increased demand for vaccination due to Covid-19 activity. The intention is to support the staff campaign, the Health Board managed GP practices and any other vaccine shortfall identified in the community.
- **Training to administer the flu vaccine** has become easier due to online module and a simplified competency assessment document developed to accommodate the absence of face to face training due to Covid-19 social distancing restrictions.

Planning and activity for the staff flu programme is well underway in parallel to the work for Covid-19 vaccination. As part of our planning for managing a joint Flu / Covid-19 vaccination programme this year, our flu vaccination model supports the vaccination of our staff for Covid-19 pending vaccine approval and implementation date. Each clinical site has a site-specific model and the staff flu vaccination campaign will commence on 28<sup>th</sup> September 2020 with peer vaccinators delivering the vaccination. This is supported by two mass vaccination centres that other staff can access via a booking system. Enrolment of vaccinators and training is currently ongoing to support a robust campaign.

## 21. Severe Weather

The Health Board has an Adverse Weather Policy<sup>14</sup> to ensure the special arrangements are in place to ensure the continuity of services during periods of severe weather and sets out how the plans to respond to actual or anticipated adverse (winter) weather to safely maintain services. The plan makes up part of our Business Continuity arrangements and is complementary to the Heatwave Plan and underpinned by the Major Emergency Plan. In order to support staff travelling to work in the event of severe weather, a contract is currently being reviewed with a Voluntary Agency '4x4 Response Wales', who for a fee, will collect staff from home and transport them to and from work. Co-ordination arrangements at an operational level are also being worked through so that any requests are made on a clinical and staffing basis.

The Health Board has very robust multi-agency arrangements in place across North Wales. If severe weather is predicted (snow causes the biggest issue), a Tactical Coordination Group (TCG) will be established and support can be requested from other agencies via the TCG. From historical snow incidences in the past, support has been received from RNLI, North Wales Police and Mountain Rescue.

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<sup>14</sup> BCUHB Adverse Weather Plan, March 2019

## 22. Staff Welfare

The Health Board recognise the additional stress and challenges that the pandemic has brought to the population and the toll this has taken on staff and with winter approaching there is added concern about how the NHS will cope over the coming months.. The Health Board also recognise that our staff are our biggest asset and that the safety and wellbeing of each and every staff member is of the utmost importance.

During the initial phase of the pandemic, the Staff Wellbeing and Support Service (SWSS) was established, supported by BCUHB clinical psychologists and psychological therapists who held drop-in sessions / telephone consultations for staff to provide support throughout Covid-19, which has received positive feedback. Due to the psychologists and therapists returning to the pre-Covid-19 roles, this service is not running at the same level currently and proposals have been submitted for a permanent and sustainable pan BCUHB service to be established.

BCUHB Occupational Health and Wellbeing are delivering a three pronged approach to stress management, based on the updated Staff Mental Health, Wellbeing and Stress Management Procedure<sup>15</sup> which aims to promote wellbeing within BCUHB. This includes;

- **Manager workshop** – focuses on how to “Remove Manage Reduce Stress in the Workplace” including recognising the signs of stress and provide information about tools available to carry out stress risk assessments and wellness action plans.
- **Employee workshop** – Wellbeing and You workshops for employees who are off work or present at work and struggle with stress, anxiety or depression.
- **Mental Wellbeing Champions** – for staff from each area to become mental wellbeing champions and attend enrolment sessions that will cover general information about mental health, learn mindfulness techniques, information about the role of champion/ sharing good practice and signposting information for mental health support.

There are also a wide range of available health and wellbeing supportive resources and tools to view or download from organisations across NHS Wales and Social Care Wales, to support staff in both emotional and physical wellbeing. The Samaritans has also launched a new confidential support line for NHS and social care workers in Wales

## 23. Finance

As set out in section 17.1, this plan has been developed with a number of schemes designed to create additional capacity where our predicted demand data highlights a need, and admission avoidance schemes to reduce the demand into our acute care sites. These schemes are above core funding and therefore require separate funding.

Given the quantum of the estimated costs mainly driven by the need for significant additions to our workforce, these schemes present a relative risk and are dependent on ability to recruit appropriate numbers and skill mix of staff described within the schemes above. Work is ongoing to refine funding streams to the divisional schemes identified and described in section 17.

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<sup>15</sup> BCUHB Staff Mental Health, WellBeing & Stress Management Procedure August 2019

## 24. Communications

Traditionally, Health Boards have managed their own winter campaigns independently, loosely based around the Choose Well theme. This year, however, WG will lead a new winter communications campaign under the Keep Wales Safe banner, however specific plans are awaited from WG. This will be coordinated centrally and the communications teams within each of the Health Boards will amplify that in their own areas and tailor specific messages to support their own services and communities where required. The full details of this year's campaign are still being drafted.

## 25. Risks

The Winter Resilience Plan risks fall into the following categories:

- Workforce capacity
- Environment and social distancing
- Bed spacing restrictions
- Personal Protective Equipment
- Delivering vaccination
- Financial
- Staff Covid-19 testing
- Patient transport
- Unscheduled Care attendances
- Planned Care – Essential and Elective Services

The workforce capacity and availability risks relate to the potential Covid-19 pressures, surge requirements and increased workload in both acute and community settings, compounded by the need for some staff to potentially shield or self-isolate. There is also a risk of increased staff demand if the Enfy's Hospitals are opened, and there will be a need to ensure sufficient bank staff availability, vacancies to be filled, and agreement to deploy staff across the organisation to areas of greatest need. A key mitigation for this will be the availability of Covid-19 staff testing to ensure staff are returned to work as soon as possible, however this in itself is a risk.

There has already been an impact on clinical and non-clinical areas due to social distancing, and this has and will continue to impact upon our ability to meet inpatient demand on the acute sites, a quicker use of surge beds and uptake of Enfy's Hospital beds.

The availability and PPE is also highlighted as a risk, given the current Covid-19 pandemic. This has the potential for staff and patients being at risk of contamination, exposure, and transmission.

Due to the limited staff and accommodation, there is a risk that we will be unable to deliver this year's influenza and Covid-19 vaccination campaign, and that this will impact both the public and staff.

Funding is seen as a significant risk during this winter, and lack of funding will have an impact on safe delivery of services, both from a staff and non-pay perspective, and WG will be key in mitigating this risk.

From an Unscheduled Care perspective, there are risks in relation to the Health Board's ability to deal with an increase in attendances, in addition to increased influenza and potential Covid-19 patients, as well as those who present with life-threatening conditions. This will cause a continued long length of stay within the ED, and put patients at risk of harm. The risk associated with planned care will emerge as the Q3/4 plan becomes available.



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14. BCUHB Seasonal Flu Plan 2020-21, August 2020
15. BCUHB Adverse Weather Plan, March 2019
16. BCUHB Staff Mental Health, Wellbeing and Stress Management Procedure; August 2019

## 27. Glossary

ADT	Assessment, Diagnostic and Treatment
APP	Advanced Paramedic Practitioner
BCUHB	Betsi Cadwaladr University Health Board
CCC	Clinical Contact Centre
CRT	Community Resource Team
CPAP	Continuous Positive Airway Pressure
CTU	Community Testing Units
CYP	Children and Young People
ED	Emergency Department
FICM	Faculty of Intensive Care Medicine
GP	General Practitioner
HECC	Health Emergency Control Centre
HTK	Home Testing Kits
IPC(T)	Infection, Prevention and Control (Team)
ITU	Intensive Treatment Unit
ICU	Intensive Care Unit
LTU	Local Testing Units (LTUs)
MTC	Mass Testing Centres
MTU	Mobile Testing Units
NIV	Non Invasive Ventilation
NWCTC	Welsh Critical Care and Trauma Network
PPE	Personal Protective Equipment
RWC(S)	Reasonable Worst Case Scenario
SiCAT	Single Integrated Clinical Assessment and Triage
TTP	Test, Trace, Protect
WAST	Welsh Ambulance Services Trust
WG	Welsh Government

# Winter Resilience Plan: Safe unscheduled care

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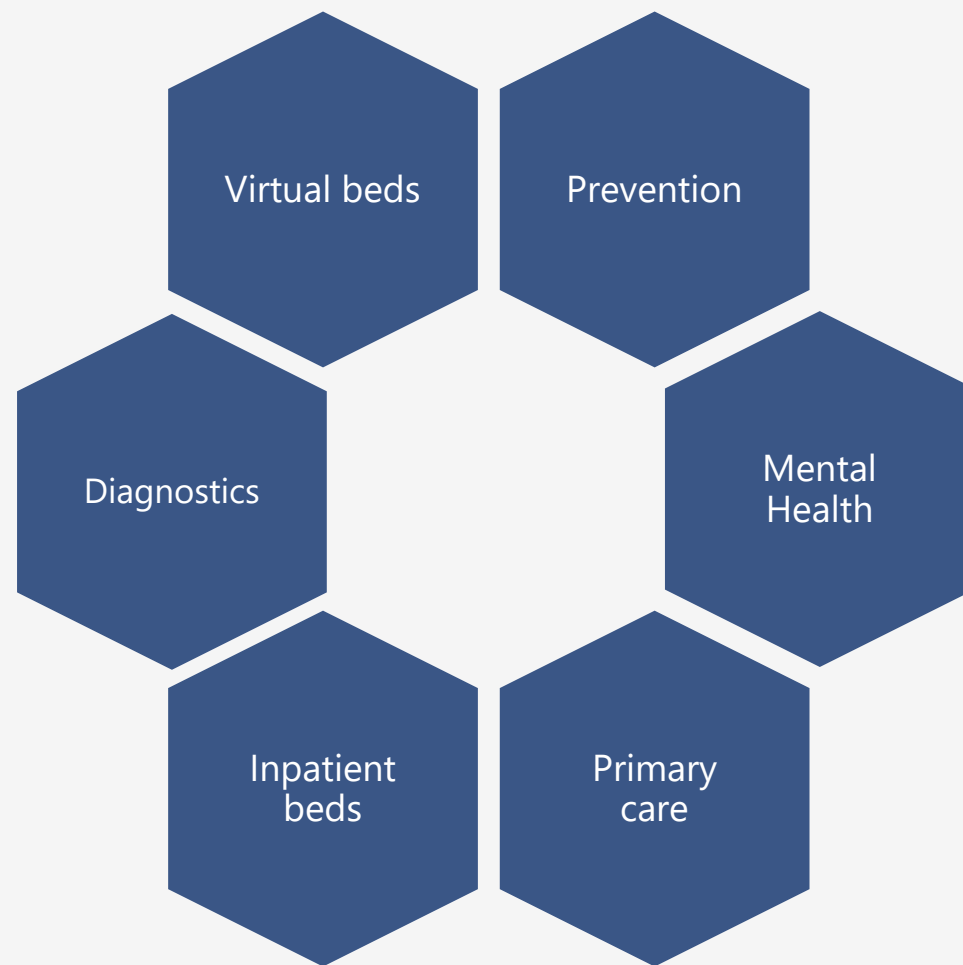
# Winter Resilience Planning

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- 2020-21 Winter Resilience Plan is a working document developed and aligned with Regional Partnership Board planning.
- Review of last winter and performance / impact of Covid
- Responds to bed modelling
- SITREP and site escalation plans
- Bed escalation numbers
- Number of priority (costed) schemes identified
- Local health community plans developed in each area with social care colleagues

# Surge Planning

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# Surge Planning

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## ASSUMPTIONS

Based on Swansea University modelling

Capacity and demand projections demonstrated without any solutions assumes;

Non-covid demand remains at historic levels

Covid demand follows the Swansea model

Elective Activity remains around 90%

Acute and community bed occupancy is 85%

5% reduction in bed capacity due to covid restrictions

## POSITION

Based on 85% occupancy, modelling suggests;

- Assumes acute and community and surge capacity if full.
- Currently bed deficit 37 – 87 beds across the health board.
- Significant bed pressures from 28<sup>th</sup> December 2020, peaking in January 2021 until the start of February 2021.
- The maximum number of beds required at the Enfy's hospitals using this model will be c. 200.

# Enfys Hospitals patient cohort / criteria

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## **Commissioning / Decommissioning**

Working through the commissioning and decommissioning options of 1 vs 3 Enfys hospital.

## **Clinically Agreed Clinical Model**

Discharge to recover then assess or palliative care in a person's existing care home.

Step down, rehabilitation of patients / North Wales Rehabilitation Facility.

## **Triggers**

Triggers agreed at site and Health Board level.

## **Workforce**

Working with workforce colleagues to identify the workforce models in line with the patient cohort.

# Winter Resilience Surge Schemes – Costings and Impact

	Pay £m	Non Pay £m	Total £m	Performance Impact				Quality
				Admission Avoidance	Reduce Length of Stay	Reduce Delayed Discharges	Reduce A&E attendances	
Home First expansion	0.30	0.50	0.80	✓		✓		
Frailty Pathway	0.30	0.20	0.50	✓				
Respiratory Pathway	0.77	0.00	0.77	✓	✓			
Paediatric Clinical Assessment	0.08	0.00	0.08	✓				
CAMHS Liaison	0.02	0.00	0.02				✓	
HDU / Critical Care expansion	0.16	0.00	0.16					✓
Falls Training for nursing homes	0.03	0.00	0.03	✓			✓	
Discharge / Flow Management / Pathways	1.13	0.00	1.13	✓	✓			
Medical Staffing to support Covid rotas	0.31	0.00	0.31					✓
Acute Intervention Team	0.02	0.00	0.02					✓
<b>Total</b>	<b>3.10</b>	<b>0.69</b>	<b>3.79</b>					



NHS  
WALES

Yrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board



<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Quarter Two Plan Monitoring Report						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Mark Wilkinson Executive Director of Planning & Performance						
<b>Awdur yr Adroddiad Report Author:</b>	Ed Williams, Head of Performance						
<b>Craffu blaenorol: Prior Scrutiny:</b>	This paper has been scrutinised and approved by the Executive Director of Planning and Performance.						
<b>Atodiadau Appendices:</b>	None						
<b>Argymhelliaid / Recommendation:</b>							
The Finance and Performance Committee is asked to note the report.							
Please tick as appropriate							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input checked="" type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
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.							
<b>Cefndir / Background:</b>							
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. Amber and red ratings are used for actions where there are risks to manage to secure delivery or where delivery was not achieved. For Red rated actions a short narrative is provided.							
<b>Asesiad / Assessment &amp; Analysis</b>							

**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.





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Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

Cyfarwyddiaeth Cynllunio & Perfformiad  
Planning & Performance Directorate

# Quarter 2 2020/21 Plan Monitoring Report

## September 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 to have delivered the actions set out in the plan by the 30<sup>th</sup> September 2020, with supporting narrative where delivery has not been achieved. This report provides an update from each Executive Director for the end of September 2020 actual position. The entire report is 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

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Scrutinising Board Committee	End of September 2020
AN1.1	Publish revised year 3 of Quality Improvement Strategy	Executive Director Nursing & Midwifery	30.09.2020	AP 040	QSE	<b>R</b>

#### AN1.1: Publish revised year 3 of Quality Improvement Strategy

The impact of the Covid-19 Pandemic has delayed work on the review of the Quality Improvement Strategy and the delivery timescale has now been extended. The review will be taken to the board in January 2021 with a view to launching the strategy from 1<sup>st</sup> April 2021.

### QP 02 Test, Trace, and Protect

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Scrutinising Board Committee	End of September 2020
AN2.1	Establish a timely testing programme for antibodies and antigens	Executive Director Of Public Health	30.09.2020	N/A	SPPH	P
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	P
AN2.3	Establish 'Protect' programme	Executive Director Of Public Health	30.09.2020	N/A	SPPH	P
AN2.4	Develop Test, Trace, and Protect	Executive Director Of Public Health	30.09.2020	N/A	SPPH	P

### QP 03: Promoting Health & Well-being

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN3.1	Review of Healthy Weight Services for children	Executive Director of Primary & Community Care	31.07.2020	AP 002	SPPH	<b>R</b>

#### AN3.1: Review of Healthy Weight Services for Children

Business case and options appraisal complete. Funding for preferred option has been confirmed as recurrent via BAHW monies. Recruitment to posts commenced in Sept/Oct 2020.

### QP 04: Achieve compliance with the Primary Care Operating Framework

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	P
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
AN4.3	Development of Locality 2020/21 Plans	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	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	P

### QP 05: Capture and embed proven technologies in primary care

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	P
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	P
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	P
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	P
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	P

### QP 06: Efficient and effective immunisation activities

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN6.1	Develop locality level flu immunisation delivery plans for 2021 <b><i>Linked to Action 3.5 &amp; 6.3</i></b>	Executive Director Primary & Community Care	31.08.2020	N/A	SPPH	P
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	P
AN6.3	Review uptake of childhood immunisations and implement catch up programmes as required <b><i>Linked to Action 3.5 &amp; 6.1</i></b>	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	P



### QP 07: Develop the Primary Care & Community Academy

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN7.1	Further develop the Advanced Paramedic Practitioner Pacesetter Project	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN7.2	Develop our version of Scottish <i>Project Joy</i> scheme for the recruitment of general practitioners & senior primary care clinicians	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	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	P
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	P
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	P

### QP 08: Implement General Medical Services Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	P
AN8.2	Commission revised care homes Directed Enhanced Service contract.	Executive Director Primary & Community Care	31.07.2020	N/A	F&P	P
AN8.3	Support General Practitioner practices with its <i>readiness for recovery</i> including provision of dedicated protected education time session and a recovery plan <i>toolkit</i> alongside Welsh Government Operational Guide	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	P
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

### QP 09: Implement Dental Services Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN9.1	Implement Welsh Government Dental Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
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	P
AN9.3	Implement the national 'buddy' system to inform contract reform	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R

### QP 10: Implement Community Pharmacy Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN10.1	Implement Welsh Government Community Pharmacy Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN10.2	Improve rapid access to palliative care drug	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	A

### QP 011: Implement Community Optometry Recovery Plan

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN11.1	Implement Welsh Government Optometry Recovery Plan	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
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	R
AN11.3	Address backlog of activity arising due to Covid.	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	P
AN11.4	Reinstate full access to urgent care pathway	Executive Director Primary & Community Care	30.09.2020	N/A	F&P	P

### QP 12: Develop primary care out of hours services and NHS 111

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN12.1	Implement agreed management structure for Out of Hours	Executive Director Primary & Community Care	31.07.2020	N/A	SPPH	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	P

AN9.3 - The Contract Reform programme is currently on hold during the escalation phases of COVID response.

Practices are completing ACORNS as required by current stage guidance. Where required practices are buddied with Contract Reform practices to provide support and guidance.

ACORN submission is being monitored and reported nationally, and support and guidance will be provided by the Health Board to practices who are not submitting to ensure that any issues are resolved.

AN11.2 - (line 82) This change is on basis that Diabetic Retinopathy pathway was to progress to CAG (Clinical Lead progression): to allow agreement for 1200, R1 patients to pass to Primary Care for data gathering and subsequent Ophthalmology virtual review.

### QP 13: Deliver safe Community Hospital services

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN13.1	Consolidation of Home First / Step Down pathways	Executive Director Primary & Community Care	31.07.2020	N/A	QSE	P
AN13.2	Consolidation of covid related protocols in Community Hospitals	Executive Director Primary & Community Care	31.07.2020	N/A	QSE	P
AN13.3	Maximising stroke rehabilitation services	Executive Director Primary & Community Care	30.09.2020	N/A	QSE	R
	<b>Linked to Action 28.5</b>					

### QP 14: Support Care Homes and reintroduce CHC

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	P
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	P
AN14.3	Care home testing	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P
AN14.4	Community Health Care Framework	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	R
AN14.5	Complete the governance and reporting arrangements for the Care Home Group	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P

### QP 16: Transform Community Services

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN16.1	Community Transformation Programme	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN16.2	Community Response Team working inclusive of third sector	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	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

### QP 17: Develop Community Resilience

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN17.1	<i>Complete baseline evidence collation for Right sizing Community Services</i>	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	A
AN17.2	Progress implementation of Phase 2 of the Digital Communities initiative	Executive Director Primary & Community Care	30.09.2020	N/A	SPPH	P



AN13.3 - Review of the ESD component of the Stroke Business Case with a view to implement pan BCU - linked to Q3/4 action for Executives to revisit the Stroke Business Case.

AN14.4 - Cannot be implemented as the CHC Framework publication is delayed by WG

AN16.1 - East transformation board approved reboot. Business case complete to secure ongoing funding through to March 2022

AN16.2 - CRT working closely with third sector however further work still to do to have a comprehensive approach.

AN16.3 - west action. Part of the Q3/4 plan. West piloting this on behalf of the other two areas and will review at end of Q4.

AN17.1 - Regionally led - Grant Thornton contracted to progress, DPIA just signed off. Delays starting as a result of internal process barriers.

### QP 18: Mental Health / Learning Disabilities (Part 1 of 2)

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN18.5	Commence implementation of the Primary Care Programme at pace.	Executive Medical Director	01.09.2020	N/A	SPPH	A

### QP 18: Mental Health / Learning Disabilities (Part 2)

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN18.6	Implementation of recommendations from the Psychological Therapies Review	Executive Director of Public Health	01.09.2020	N/A	SPPH	R
AN18.7	Re-establish the Rehabilitation Programme of work	Executive Director of Public Health	01.09.2020	N/A	SPPH	P
AN18.8	Begin roll out of Attend Anywhere virtual consultation platform across the division	Executive Director of Public Health	01.09.2020	N/A	F&P	P
AN18.9	Implementing division wider QI training plan	Executive Director of Public Health	01.09.2020	N/A	SPPH	A

### **AN18.5 Commence implementation of the Primary Care Programme at pace:**

Undertaking stakeholder engagement activities with the area teams , but no confirmed implementation date yet

### **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

### **AN18.9 Implementing division wider QI training plan:**

Discussions are ongoing with Elliot Blanchard to re commence the training plan . Meeting scheduled for the 30/09/20

### QP 19: Maximise Capacity within Each Site

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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
AN19.2	Delivery of OPD programme	Executive Director Nursing & Midwifery	30.07.2020	N/A	F&P	A
AN19.3	Utilisation of workforce dashboard to identify staffing resource	Executive Director of Workforce and OD	30.07.2020	N/A	F&P	P

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

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### QP 20: Develop a single risk stratification approach across the pathway of care

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN20.1	<b>Stage 1</b>	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	A
	Outpatient transformation project focused upon delivering virtual appointments wherever possible and only face to face where necessary					
AN20.2	<b>Stage 4</b>	Executive Director Nursing & Midwifery	30.07.2020	N/A	F&P	P
	Specialty specific risk stratification using P1-P4 categorisation as per essential services framework					
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	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	P

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

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### QP 21: Identification of highest priority services with risk based capacity shortfalls

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	P

### QP 22: Identification of areas for service review

Ref	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	R
AN22.2	Review of specialties identified where a pan BCU risk stratification approach may not on its own provide the necessary impact.					P

### QP 23: Identify the required metrics to monitor performance

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN23.1	a. Quality Outcome Measures of clinical pathways identified	Executive Medical Director	30.09.2020	N/A	QSE	R
	b. Pan BCU service metrics developed					R
	c. Effectiveness of implementation plans monitored & reviewed					R

### QP 24: Improve quality outcomes and patient experience

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN24.1	Identify clinical pathways requiring review or development	Executive Medical Director	30.07.2020	N/A	QSE	P
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	P
AN24.3	Develop pathways in line with the digitally enabled clinical services strategy	Executive Medical Director	30.07.2021	N/A	QSE	A
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	R
AN24.4	Ensure quality outcome measures are referenced and measurable	Executive Medical Director	30.07.2020	N/A	QSE	A
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	R



### **AN22.1 Review and refresh priority business cases e.g. Ophthalmology, Orthopaedics, Urology & Stroke**

The proposed diagnostic and treatment centres will impact will impact on these priority cases and it isn't possible at this stage to be clear about the extent as the DTC model is at an early stage. There are specific commitments in the Q3 and Q4 plan around orthopaedics, ophthalmology and stroke. On stroke services, we have decided to focus on the rehabilitation aspects of the previous case. Progress has been made on aspects of the urology case with the progression of a proposal to introduce Robotic Assisted Surgery.

### **AN23.1 Clinical Pathways**

There are a very large number of pathways, some of which are also being modified as the clinical situation regarding Covid-19 changes. These are being worked through, however due to the uncertainties of working with Covid-19 it would be difficult to say that all pathways [> 40 and counting] will be Green and by when.

### **AN24.3 Develop pathways inline with the digitally enabled clinical services strategy:**

No consistent representation from digital/informatics on CAG. Now included in amended TOR starting 02.10.20

### **AN24.4 Ensure quality outcome measures are referenced and measureable:**

Amended TOR include representation from performance. Clinical pathway template includes DPIA and clinical outcomes

### **AN24.5 Ensure patient reported outcome measures and patient reported experience measures are included and measured in pathway development:**

Not previously consistently included in pathways template. Very few specialties have validated PROMS/PREMs - Work required to define PROMs and PREMs aligned to national guidance. RECOMMENDATION: Completion date refresh to Dec 2020

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

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### QP 25: Provide care closer to home

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN25.1	Provide virtual appointments wherever possible	Executive Director Nursing & Midwifery	30.09.2020	N/A	F&P	P
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	A
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				A

### QP 26: Reduce health inequalities

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	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	P

### QP 27: Planned Care

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN27.1	Develop preferred service model for acute urology services	Executive Director Nursing & Midwifery	30.09.2020	AP 021	F&P	A
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
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
AN27.8	Implement year one plans for Endoscopy	Executive Director of Therapies & Health Sciences	30.07.2020	AP 025	F&P	R
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	R

### **AN27.6 - Transform eye care pathway to deliver more care closer to home delivered in partnership with local optometrists:**

Key clinical appointment has been made this month which will help lead the development of this service. The director of performance who lead on eye services has left on a secondment. Alyson Constantine Acute Site Director at Ysbyty Gwynedd has agreed to assume this responsibility.

### **AN27.7 - Systematic review and plans developed to address service sustainability for all planned care specialties (RTT):**

Work continues to develop Q3/4, activity plans, however due to the Covid-19 pandemic, significant disruption has occurred with planned care. A review of how services could be sustained through a diagnostic and treatment centre approach has been discussed at Finance and performance committee last month.

### **AN27.8 - Implement year one plans for Endoscopy:**

An endoscopy recovery plan is underway, which incorporates years 1-2. Currently once for north wales approach has been adopted and currently the organisation is out to tender for further capacity and an insourcing model.

### **AN27.9 - Systematic review and plans developed to address diagnostic service sustainability:**

Diagnostic services were disrupted due to Covid-19, risk stratification has been applied to all diagnostics and Essential diagnostic are now maintained. Further work is being undertaken to address the backlog including business cases for further CT and MRI capacity.

### QP 28: Unscheduled Care

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN28.1	<b>Demand:</b> Workforce shift to improve care closer to home (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 031	F&P	<b>R</b>
AN28.2	<b>Flow:</b> Emergency Medical Model (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 034	F&P	<b>A</b>
AN28.3	<b>Flow:</b> Management of Outliers (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 034	F&P	<b>P</b>
AN28.4	<b>Discharge:</b> Integrated health and social care (key priority for 2020/2021)	Executive Director Nursing & Midwifery	30.09.2020	AP 038	F&P	<b>P</b>
AN28.5	Stroke Services	Executive Director Nursing & Midwifery	30.09.2020	AP 039	F&P	<b>R</b>
	<b>Linked to Action 13.03</b>					

#### AN28.1 - Demand: Workforce shift to improve care closer to home (key priority for 2020/2021)

There have been some delays in progressing this at the pace intended due to COVID unfortunately, this is currently being reviewed in light of recent changes and learning as a result.

#### AN28.5 – Stroke Services (Linked to Action AN13.3)

Progress will be made in September to utilise video consultations where appropriate to increase capacity and support for stroke rehabilitation services.

### QP029: Workforce & Organisational Development

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	R
AN29.2	Ensure effective social partnership working as a key enabler for organisational development and transformation. Review the operation and management of social partnership relationships and processes and establish a programme for improvement across both medical and non-medical structures	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	SPPH	R
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	P

QP 30: Workforce Planning and Optimisation						
Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	P
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	P
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	R
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	R
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	R



## QP 31: Occupational Health Safety and Equality

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 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	R
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	P
AN30.3	Ensure ongoing effective management of training, equipment and supplies in line with emergency guidance	Executive Director, Workforce & Organisational Development	30.09.2020	N/A	QSE	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	P



### **AN29.1- Review the previous Workforce Improvement Group structure and establish a revised structure at Strategic, Tactical and Operational Levels:**

Operational Groups in place and tactical terms of reference drafted. Strategic Group and alignment now being informed by governance review underway. Taken forward for completion in Quarter 3

### **AN29.2 - Ensure effective social partnership working as a key enabler for organisational development and transformation. Review the operation and management of social partnership relationships and processes and establish a programme for improvement across both medical and non-medical structures:**

Medical and Non Medical structures mapped. Responsibilities for effective management of relationships at all levels linked to structure and governance review above and changes in executive leadership for medical staff. Taken forward in Quarter 3

### **AN30.3 - Ensure all key workforce indicators are in place and monitored robustly to support all surge and essential services delivery:**

Triggers for prioritised safe deployment of staff developed and to be agreed as part of surge planning. Workforce Planning performance indicators delayed due to work on outbreaks in August and again Sept and surge planning. Taken forward for Quarter 3.

### **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:**

Model developed and socialised. Capacity to support programme lead now being secured. Taken forward in Quarter 3

### **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:**

Initial revised plan was submitted but Covid related issues have consumed the capacity to move this action forward, most notably the Wrexham and Glan Clwyd Outbreaks that have been a major draw on Workforce resource over the period taken forward into Quarter 3.

**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:**

Robust risk assessment framework for COVID -19 in place and operational. Case for change for highest risks progress to Business Case review group. Security specification delayed but underway. Taken forward into Quarter 3.

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

Comprehensive improvement plan in place to ensure competent training and effective record keeping for PPE/Training in place. Links to work with HSE. Taken forward into Quarter 3.

### QP 32: Digital Health / IM&T

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN32.2	Seek approval for funding for Welsh Emergency Department System	Executive Medical Director	30.09.2020	N/A	F&P	<b>R</b>
AN32.3	Development of the digital health record	Executive Medical Director	30.09.2020	N/A	DIGC	<b>P</b>
AN32.5	Implementation of Digital dictation project	Executive Medical Director	31.08.2020	N/A	DIGC	<b>P</b>
AN32.7	Scale up Implementation of Office 365	Executive Medical Director	31.12.2020	N/A	DIGC	<b>A</b>
AN32.8	Implement COVID-19 hardware response	Executive Medical Director	31.01.2021	N/A	DIGC	<b>A</b>
AN32.11	Delivery of digital infrastructure rolling programme	Executive Medical Director		AP 058	DIGC	<b>A</b>
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	<b>A</b>

### **AN32.2 - Seek approval for funding for Welsh Emergency Department System:**

Pending review by the business case review team and scheduled for Finance & Performance Committee in October 2020.

### **AN32.7 - Scale up Implementation of Office 365:**

Resource being appointed and project governance established

### **AN32.8 – Implement COVID-19 hardware response:**

Procurement of 1,300 devices underway

### **AN32.11 - Delivery of digital infrastructure rolling programme:**

Usual rollout constrained by Covid-19 demand

### **AN21.12 – Provision of infrastructure and access to support care closer to home:**

Funding for 600 devices and short term resource funding agreed

### QP 33: Estates & Capital

Action Number	Action	Lead	Target Date	2019/20 AP Ref.	Board Committee	End of September 2020
AN33.1	Well-being hubs	Executive Director of Planning and Performance	30.09.2020	AP 064	SPPH	R
AN33.8	Complete reviews to initiate the following programmes:	Executive Director of Planning and Performance	30.09.2020	N/A	SPPH	R
	- Health economy programme business case					R
	- Relocation of services from Abergele					R
	- Rationalisation of Bryn y Neuadd					R

#### AN33.1: Well Being Hubs

This action remains relevant however has not been prioritised for Quarter 3 & 4 plan.

#### AN33.8: Complete Reviews to initiate Health Economy Programme Business Case, Relocation of Services from Abergele, Rationalisation of Bryn-y-Neuadd

This action remains relevant and will be part of the work-plan for the newly established Capital Investment Group. However it has not been prioritised for the Q3 & 4 plan

## 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](http://www.pbc.cymru.nhs.uk)  
[www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)
- Stats Wales [www.statswales.wales.gov.uk](http://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>



<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Q3/4 Plan 'Annex D' supporting Minimum Data Set					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Mark Wilkinson, Director of Planning and Performance					
<b>Awdur yr Adroddiad Report Author:</b>	John Darlington, Assistant Director, Corporate Planning					
<b>Craffu blaenorol: Prior Scrutiny:</b>	<p>The BCU Planning Workstream has overseen the development of the Q3/4 plan. The plan and supporting profiles have been developed by the planning workstream and scrutinised by Executive Team.</p> <p>Priorities for action have been shaped through our work with North Wales Regional Partnership Board, Health and Social Care Recovery Group. We have fully engaged with Community Health Council around our plans through service planning committee and continue to work closely with Stakeholder Reference Group partners around all our planning.</p>					
<b>Atodiadau Appendices:</b>	Appendix 1: Minimum DataSet (Annex D).					
<b>Argymhelliad / Recommendation:</b>						
<p>It is recommend that F&amp;P Committee:</p> <ul style="list-style-type: none"> <li>• Receive this report and the assurance that our Q3/4 plan is underpinned by a completed 'Annex D' which is a supporting technical Minimum Data Set (MDS) to accompany our plan</li> <li>• Provide necessary scrutiny to the full Annex D minimum dataset profiles which underpin our Q3/4 plan prior to presenting the summary narrative and action plan to board in November for approval.</li> <li>•</li> </ul>						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>	√	<b>Ar gyfer sicrwydd For Assurance</b>	√	<b>Er gwybodaeth For Information</b>
<b>Sefyllfa / Situation:</b>						
<p>This paper has been prepared to support the development of our quarter 3 &amp; 4 plan building on our priorities for action identified in quarter 2.</p> <p>This will ensure that robust delivery plans are in place to manage the care of our population throughout the winter period.</p>						

### **Cefndir / Background:**

The NHS planning Framework also set out a clear expectation for organisations for Q3/4 and as part of this, to complete a minimum data set, which is designed to underpin the narrative in our plan and used to inform the basis of Quarter 3/ Quarter 4 plans. This is referred to as Annex D.

A draft response was submitted to WG on 19<sup>th</sup> October by BCU Health Board, in response to the NHS Wales Operating Framework 2020-21 Quarter 3/4 and Andrew Goodall's letter of 24<sup>th</sup> September in respect of this. The letter recognised that whilst plans were required by Monday 19th October 2020, that this submission date is unlikely to be consistent with pre-planned committee and board meeting cycles. Our response on 19<sup>th</sup> October includes:

1. A summary narrative Q3/4 Plan
2. Q3/4 Action Plan
3. Winter Resilience Plan
4. Planning Framework 'Annex D' supporting Minimum Data Set

The summary narrative, action plans and winter resilience plan have been discussed at Board level workshops which have directed the development of our plans.

There is a need to ensure our plans have been considered via normal governance structures. This paper has been designed to support the requirement to undertake appropriate scrutiny and assurance to full board in an open and transparent manner. (The NHS Planning framework clarifies that arrangements which are specific to our organisation will need to be considered and agreed by Chairman, having taken advice from the Board Secretary.)

All plans remain in draft pending formal consideration by Board in November.

Completion of the Annex D has identified the need for new data collection requirements to support a clear baseline position for our plans for the rest of 2020/21 at a point in time, which allows future assessment in terms of progress or impact. The data sets are intended to support plans and allow clarity in assumptions, by supporting the triangulation of plans outlining areas of risk, challenge, and opportunity which we will need to address.

The following section outlines the key elements of our plan together with assumptions made as part of completing the Annex D profiles.

### **Asesiad / Assessment & Analysis**



## **Annex D Key Assumptions**

Health Board bed demand planning has been made on the basis of the Swansea University Reasonable Worst Case Scenario[1] (RWC) modelling, with contingencies in place in the event that a 'high' Covid-19 scenario is reached in any part of North Wales, as described in WG correspondence dated 24th June 2020.

In addition, the bed demand model anticipates we will experience emergency demand in line with the historic average. Essential surgical activity is included in the model, plus additional high priority surgical activity that would need to be done in the event of a prolonged period of Covid-19 related demand.

([1] Technical Advisory Group, Swansea University RWC model scenario)

### **Bed Plan**

Bed capacity is defined as funded general and acute overnight beds at the end of August 2020 (i.e. acute hospital beds excluding day case beds), to align with the bed demand model. In addition to funded beds there are a number of unfunded beds that will be brought on stream as escalation or surge capacity. Escalation beds are beds that are occasionally opened in acute hospitals to accommodate temporary increases in demand, and surge beds are beds created for unusual or rare demand events like the Covid-19 pandemic. In addition to the acute hospital general and acute overnight beds, there are 72 unfunded surge beds at YGC that are exclusively for Covid-19 related CPAP that could be deployed if required. This capacity is not included in our analysis.

Capacity is modelled at 85% midnight occupancy, to allow for essential anticipated operating flexibility in bed use.

### **Workforce**

BAME assessment - there is an internal target within the HB of 85% but no national target.

From May to September our registered nursing and midwifery workforce reduced. The Nursing establishment / bank usage data is drawn from our workforce systems. However it should be noted we have been asked to conjoin substantive staff and bank hours. Establishment and bank hours are an amalgamation of substantive FTEs plus bank hours worked converted to FTE equivalent for that month. We have therefore had to convert bank hours actually worked during the months of March & August (as Sept was not available at the time) into FTE.

A large proportion of the difference can be explained as fewer Bank Hours were worked in August lowering the overall FTE figure. However we do have in excess of 700 N&M vacancies. We are working closely with nursing colleagues implementing a nursing recruitment and retention action plan being overseen by a nursing recruitment and retention working group. We have increased the bank headcount by 94 additional bank N&M staff between March & September but this workforce is subject to fluctuation in terms availability and capacity, the calculation used works on bank hours not numbers registered to the bank (as this is less relevant if they only work infrequently). This gets reflected in the Establishment / bank WTE related to hours worked as above.

Our ultimate ambition is to achieve 100% COVID workforce risk assessments, however, to increase and achieve 85% initially.

## **Test, Trace, protect assumptions**

The expected infection rate – in numerical terms – was shared on Tuesday, 6th October. This information has been critical for us to be able to work with our partners across the region in order to prepare for what is ahead.

The antigen testing capacity is based on the following assumptions:

- CTUs – surge staffing can be secured
- MTUs – are mobilised and operate at capacity seven days per week
- LTSs – are established in the near future.
- UK.GOV general public sites continue to operate at reduced capacity and only 50% of the Deeside capacity is available for N Wales residents

We have not been able to establish NW lab capacity and discussion continues. The LHL capacity remains in flux.

POCT testing and capacity to be defined – ongoing request for information.

R rate to be updated by planning/ informatics team working with partners

Monthly index cases – figures provided last week per reference in point 1) above. There is nowhere in Annex D to identify capacity to deal with this demand. Currently there is not capacity to deal with this level of demand from November to February.

Antibody testing capacity is clear – this is subject to no further investment being made.

A decision needs to be made about the immediate priority of antibody testing.

All costs have been forecast by Finance team.

## **Core Activity**

Many of the indicators are new and considered to be developmental. Where we have identified 'data not available' this is consistent with position across all Health Boards across NHS Wales and therefore are in development pending discussion with WG.

Annex D profiles include core and impact of schemes to deliver increased levels of productivity this applies to inpatient, daycases, outpatients and diagnostic activity.

For eye care measure for example, we have reviewed compliance for new and follow up in Q1/2 and projected this forward for Q3/4. Position is not expected to recover to pre-Covid-19 levels in Q3 or 4 due to continued impact of second wave of pandemic upon planned care services.

NHS England definition of Ambulatory Sensitive Conditions has been used to understand the metric. Emergency referrals is 48% that of 2019/2020; it is assumed that activity will continue at this rate given current patient behaviour and ongoing covid-19 impact. The data is specifically on clinical coding diagnosis and as such is based on coding completeness – which is currently at 95% (agreed target) to July 2020 – so this means that we may miss some patients admitted after July if they have not yet been coded.

In respect to the number of tests relating to sexual health conditions (syphilis and chlamydia) and total number of tests by primary care and community clinics. We have included activity from the postal service which was developed and operational since May 2020 - additional 3600 tests have been completed to date and included in the MDS. Most clinics were closed over the pandemic period, with the health board services being provided from the DGHs.

The care Home DES was changed in Q1 20/21 and the total number of practices is changing, Not all practices have care home patients. As at March 2020 98/100 thereafter 89/95 have signed up to the new DES.

Referral numbers are GP only and differ with elective care section which includes all sources of referral.

For mental health, with the exception of line 59 which explicitly asks for CAMHS data all other entries are Adult and Older Person Mental Health services. (should this need to be changed we can provide combined figures but CAMHS and adult are managed and typically reported separately).

In mental health, we would not typically display or report on referrals to Part 1a and Part 1b. Part 1b is the result of a referral into Part 1a, therefore we have looked at referrals into Part 1 adult. Rationale for profile: As referral levels are returning to pre-covid levels its reasonable to refer to previous year referral levels as an assumption going forward. Whilst it is known that demand on Mental Health Services is experiencing an increase, the mechanism for referrals into MHM Part 1 is via General Practice and therefore also at risk of a potential decrease if COVID19 Phase 2 and/or winter pressures impact on GP Capacity and GP Practice access. We expect to see a continued increase into other MH services such as CALL and DAN helplines, SMS, third sector services etc.

For memory assessments, as with Part 1 we would not normally reflect referrals and assessments together. To comply with this new indicator we have reflected assessments as we deem the impact of COVID19 on our Memory assessment service to be significant and our response to it needs to be reflected. The FY and YTD data and the supporting data demonstrates that the number of assessments is significantly down compared to last year. Referrals into the service dropped in March and April but have been steadily increasing back to typical levels. Assessment numbers however have remained very low. This is in part due to the risk of COVID 19 on an already vulnerable group of people but also due to the response of the MHL Division in managing the crisis and redeploying staff to other areas of the service. Huge effort has been made by the staff to reinstate the service and most staff have returned to their substantive role and are planning and working through alternative or tailored methods of service delivery. The service are currently projecting a return to 85% capacity and this has been reflected in the profile. As with previous indicators the ongoing pandemic risks will be a factor.

In terms of the part 2 duty - % of total caseloads with a valid care and treatment plan (Row 61%) Whilst the service has an intent of bringing the number of patients with a valid care and treatment plan to not only its previous COVID levels but to improve on this, a cautious profile has been defined to accommodate the fragility of the service in the current climate.

Our cancer services team forecast referrals to increase in Q3&4 compared to Q1&2, however, remain below that seen last year for the rest of this year.

For outsourcing activity we have included average monthly volumes @ 30.9.20 based on core contract activity to month 5 (August). Profile for quarter 3 and 4 is based on pro-rata of months 1 to 5. Activity figures reported here relate to core longstanding 'business as usual' external contracts. No additional contracts have been agreed as yet for new outsourcing in 2020/21.

## **Screening services**

Screening services were paused between March and late July and some services only came back on line in September so data will be lacking and with introduction of FIT (Faecal Immunochemical Test) for Bowel Screening, comparing with 2019 is not reliable comparison. We have provided data for position in March 2020. (We won't have Immunisation data for September 2020 until end of October at the earliest and we don't report flu vaccination until October.) Immunisation 5 in 1 has been replaced by 6 in 1 since 2018. The 6-in-1 vaccine gives protection against these six serious diseases: diphtheria, tetanus, whooping cough (pertussis), polio, Hib disease (Haemophilus influenzae type b) and hepatitis B.

Our MDS also includes data for position as at March 2020 for all Flu Vaccination measures except staff (as we report overall staff and the MDS requests frontline only.)

## **Vaccination**

(Further guidance expected from WG in respect to completing this section)

## **Strategy Implications**

The Plan sets out how the Board will prioritise actions for the remainder of the financial year in order to minimise risk and harm by:

- Maintaining essential services and building up planned care
- Delivering safe and effective unscheduled care throughout the winter period
- Improving mental health services
- Keeping our people safe secure and healthy
- Using our resources effectively

In doing so, the Board will ensure that lessons learned to date from the pandemic are adopted, new ways of working embedded and strategic opportunities to enhance services for the future are progressed.

## **Options considered**

Options are being developed for the establishment of a diagnostic and treatment facility to improve productivity and support waiting list position are being developed.

## **Financial Implications**

The plan is aligned to the Health Board's total resource allocation which is £1,718.2m, including £156.2m of COVID specific funding.

## **Risk Analysis**

The plan has a particular focus upon the effective management of risk and the avoidance of harm. The potential for harm during the pandemic is particularly heightened and the Health Board has considered the 4 dimensions of harm arising from COVID.

Using this framework to view potential harm in developing the Plan has enabled key priority areas to be identified for immediate action, reflecting the urgency of the current situation whilst also focussing attention on critical strategic steps which need to be progressed at the same time.

### **Legal and Compliance**

The plan has been developed and submitted to WG on 19<sup>th</sup> October by BCU Health Board, in response to the NHS Wales Operating Framework 2020-21 Quarter 3/4 and Andrew Goodall's letter of 24<sup>th</sup> September in respect of this. The NHS planning Framework set out an expectation for organisations to complete a supporting minimum data set, which is designed to underpin the narrative in our plan and used to inform the basis of Quarter 3/ Quarter 4 plans. This is referred to as Annex D.

Annex D contains a suite of key performance indicators (KPIs) identified within the national planning framework and will inform our performance and reporting during this phase.

### **Impact Assessment**

The Plan has been developed in the context of the unique challenges facing public services and society at large arising from the pandemic. It reflects the particular challenges the Health Board has to address in delivering health services, whilst supporting and protecting our staff. It also recognises the work that is required in partnership to support vulnerable communities and protect the health and wellbeing of the population to support the principles of 'A Healthier Wales'

QUARTER 3 AND 4 PLANNING MINIMUM DATASET
SUMMARY OF CONTENTS

Organisation	Betsi Cadwaladr ULHB
--------------	----------------------

Checklist	Sections Complete (dropdown available)
BEDPLAN	Yes
WORKFORCE WTE	Yes
TEST TRACE PROTECT	Yes
CORE ACTIVITY	Yes
PUBLIC HEALTH	Yes
REVENUE PLAN	Yes
INCOME ASSUMPTIONS	Yes
NET EXPENDITURE	
FINANCE OTHER	Yes
CAPITAL	Yes
ASSET INVEST APPROVED	Yes

Comments
TTP Antigen: Insufficient time to provide full profile breakdown.



## Betsi Cadwaladr ULHB

Please fill in the lightly yellow shaded cells with WTEs

This section is intended to capture the organisations workforce plan in whole time equivalent (WTE's) as at the end of each month. Organisations are also asked to outline key workforce information in relation to BAME assessments and anticipated absences upon which the operating plan for Q3 and 4 would be based. This is based on existing workforce return to Welsh Government.

WORKFORCE PLANS - WTE		ACTUAL WTE		WORKFORCE PROFILE @ END OF MONTH					
		ACTUAL as @ 31/3/2020	ACTUAL as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar
METRIC		WTE							
ESTABLISHMENT & BANK ADDITIONAL HOURS									
Administrative, Clerical & Board Members		2,910.7	2,911.2	2,911.2	2,925.2	2,939.2	2,967.2	2,995.2	3,023.2
Medical & Dental		1,571.0	1,421.5	1,421.5	1,431.5	1,441.5	1,451.5	1,461.5	1,481.5
Nursing & Midwifery Registered		5,119.0	5,050.7	5,050.7	5,188.7	5,238.7	5,238.7	5,238.7	5,238.7
Prof Scientific & Technical		666.6	675.3	675.3	675.3	675.3	675.3	675.3	675.3
Additional Clinical Services		3,700.5	3,703.5	3,703.5	3,728.5	3,753.5	3,778.5	3,803.5	3,828.5
Allied Health Professionals		909.7	959.3	959.3	959.3	959.3	959.3	959.3	959.3
Healthcare Scientists		257.8	250.1	250.1	250.1	250.1	250.1	250.1	250.1
Estates & Ancillary		1,351.7	1,358.4	1,358.4	1,358.4	1,358.4	1,358.4	1,358.4	1,358.4
TOTAL ESTABLISHMENT & BANK ADDITIONAL HOURS		16,486.9	16,330.0	16,330.0	16,517.0	16,616.0	16,679.0	16,742.0	16,815.0
AGENCY									
Administrative, Clerical & Board Members		159.0	203.0	203.0	208.0	230.0	240.0	230.0	220.0
Medical & Dental		91.6	47.9	109.4	89.4	113.0	109.8	95.1	110.0
Nursing & Midwifery Registered		176.4	171.3	204.3	196.4	204.1	218.4	206.5	211.7
Prof Scientific & Technical		-	-	-	-	-	-	-	-
Additional Clinical Services		-	-	-	-	-	-	-	-
Allied Health Professionals		53.0	68.0	68.0	72.0	80.0	82.0	75.0	70.0
Healthcare Scientists		-	-	-	-	-	-	-	-
Estates & Ancillary		-	-	-	-	-	-	-	-
TOTAL AGENCY		480.0	490.2	584.7	565.7	627.0	650.2	606.6	611.6
RETURNERS									
Administrative, Clerical & Board Members		-	-	-	-	-	-	-	-
Medical & Dental		-	19.0	19.0	19.0	19.0	19.0	19.0	19.0
Nursing & Midwifery Registered		-	76.0	76.0	76.0	76.0	76.0	76.0	76.0
Prof Scientific & Technical		-	-	-	-	-	-	-	-
Additional Clinical Services		-	-	-	-	-	-	-	-
Allied Health Professionals		-	-	-	-	-	-	-	-
Healthcare Scientists		-	-	-	-	-	-	-	-
Estates & Ancillary		-	-	-	-	-	-	-	-
TOTAL RETURNERS		-	95.0	95.0	95.0	95.0	95.0	95.0	95.0
STUDENTS									
Administrative, Clerical & Board Members		-	-	-	-	-	-	-	-
Medical & Dental		-	-	-	-	-	-	-	-
Nursing & Midwifery Registered		17.9	224.1	224.1	20.0	20.0	20.0	20.0	20.0
Prof Scientific & Technical		-	-	-	-	-	-	-	-
Additional Clinical Services		-	-	-	-	-	-	-	-
Allied Health Professionals		-	-	-	-	-	-	-	-
Healthcare Scientists		-	-	-	-	-	-	-	-
Estates & Ancillary		-	-	-	-	-	-	-	-
TOTAL STUDENTS		17.9	224.1	224.1	20.0	20.0	20.0	20.0	20.0
OTHER TEMP STAFF									
Administrative, Clerical & Board Members		135.2	131.4	131.4	137.4	137.4	137.4	137.4	137.4
Medical & Dental		221.0	231.5	231.5	237.5	237.5	237.5	237.5	237.5
Nursing & Midwifery Registered		99.1	95.2	155.2	155.2	155.2	169.2	169.2	169.2
Prof Scientific & Technical		60.8	79.3	79.3	79.3	79.3	79.3	79.3	79.3
Additional Clinical Services		169.9	214.8	274.8	274.8	274.8	274.8	274.8	274.8
Allied Health Professionals		17.1	17.9	17.9	17.9	17.9	17.9	17.9	17.9
Healthcare Scientists		7.4	9.2	9.2	9.2	9.2	9.2	9.2	9.2
Estates & Ancillary		20.3	19.2	19.2	19.2	19.2	19.2	19.2	19.2
TOTAL OTHER TEMP STAFF		730.8	798.5	918.5	930.5	930.5	944.5	944.5	944.5
COVID-19 ANTICIPATED ABSENCE DATA (Profiled BY MONTH for remaining year)									
Anticipated sickness rate (%)		6%	5%	6%	7%	8%	8%	8%	9%
Anticipated COVID 19 sickness (headcount)		517.0	158.0	170.6	195.8	233.5	283.9	346.8	422.3
Anticipated Self Isolation (headcount)		1,383.0	832.0	920.7	1,098.1	1,364.1	1,718.8	2,162.3	2,694.4
Anticipated Shielding (headcount)		440.0	299.0	299.0	299.0	299.0	299.0	299.0	299.0
Anticipated all other sickness absence (headcount)		2,797.0	2,473.0	3,184.0	3,188.0	3,414.0	3,232.0	2,659.0	2,797.0
% of COVID 19 workforce risk assessments completed		0.0%	37.4%	47.0%	56.6%	66.2%	75.8%	85.4%	95.0%
% of BAME staff that have completed the COVID 19 risk assessment tool		0.0%	80.9%	81.6%	84.3%	87.0%	89.7%	92.4%	95.0%



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Please fill in the lightly yellow shaded cells													
This section captures a summarised position of Test, Trace and Protect (TTP) monitoring. The data is collected monthly through policy leads via the monthly monitoring return process.													

TEST, TRACE, PROTECT	MONTHLY PROFILE (ACTUAL / FORECAST)												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	

ANTIGEN													
DEMAND	POPULATION DEMAND (INSERT ACTUAL/FORECAST DEMAND) - No's												
Hospital Staff	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospital Patients	-	-	-	-	-	-	-	-	-	-	-	-	-
Care Homes - Staff and Patients	-	-	-	-	-	-	-	-	-	-	-	-	-
Symptomatic Population	-	-	-	-	-	-	-	-	-	-	-	-	-
Community - Closed settings (incl. outbreaks)	-	-	-	-	-	-	-	-	-	-	-	-	-
Other - please specify below:													
CTU total	2,782	11,567	26,226	18,356	22,179	6,261	7,000	9,000	12,000	11,000	11,000	11,000	
SUB TOTAL ANTIGEN DEMAND	2,782	11,567	26,226	18,356	22,179	6,261	7,000	9,000	12,000	11,000	11,000	11,000	
SAMPLING	SAMPLING SITES / UNITS (NUMBER OF EACH TYPE)												
Community Testing Units (CTU's)	5	5	5	4	4	4	4	4	4	4	4	4	4
Mobile Testing Units (MTU's)	-	-	2	1	1	1	3	3	3	3	3	3	3
Population Sampling Centres (PSCs)	-	1	2	2	2	2	2	2	2	2	2	2	2
SUB TOTAL ANTIGEN SAMPLING SITES	5	6	9	7	7	6	7	9	9	9	9	9	
SAMPLING	SAMPLING SUPPLY (INSERT ACTUAL/FORECAST CAPACITY)												
Community Testing Units (CTUs)	2782	11567	26226	18356	22179	6261	16,500	16,500	16,500	16,500	16,500	16,500	16,500
Mobile Testing Units (MTUs)	-	-	-	-	-	-	3,500	21,000	21,000	21,000	21,000	21,000	21,000
Population Sampling Centres (PSCs)	-	-	-	47,000	47,000	22,000	22,000	22,000	22,000	TBC	TBC	TBC	TBC
Home Testing	-	-	-	-	-	-	-	-	-	-	-	-	-
Other - please specify below:													
Local Testing Unit	-	-	-	-	-	-	TBC	TBC	TBC	TBC	TBC	TBC	TBC
SUB TOTAL ANTIGEN SAMPLING SUPPLY	2,782	11,567	26,226	65,356	69,179	28,261	42,000	59,500	59,500	37,500	37,500	37,500	
TESTING	TESTING CAPACITY (ACTUAL/FORECAST TESTING PROVISION)												
Laboratory Tests (Forecast Monthly Laboratory Tests)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Point of Care Tests (Forecast Monthly POCT)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SUB TOTAL ANTIGEN TESTING CAPACITY	-	-	-	-	-	-	-	-	-	-	-	-	-
R Rate (% positive tests)	-	-	-	-	-	-	-	-	-	-	-	-	-
Monthly Index Cases	n/a	n/a	1,300.00	477.00	324.00	936.00	3,000.00	11,200.00	48,000.00	49,500.00	19,000.00	9,100.00	

ANTIBODY													
DEMAND	POPULATION DEMAND (INSERT ACTUAL/FORECAST DEMAND)												
Education Staff	n/a	n/a	-	891	4,945	3,264	345	TBC	TBC	TBC	TBC	TBC	TBC
Health Care Workers	n/a	n/a	739	4,314	-	-	-	-	-	-	-	-	-
Other - please specify below:													
SUB TOTAL ANTIBODY DEMAND	-	-	739	5,205	4,945	3,264	345	-	-	-	-	-	-
SAMPLING	SAMPLING SUPPLY												
Serology Antibody Testing - Phlebotomy Service	n/a	n/a	-	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000
Antibody - Point of Care Testing	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Other - please specify below:													
SUB TOTAL ANTIBODY SAMPLING SUPPLY	-	-	-	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000
TESTING	TESTING CAPACITY (ACTUAL/FORECAST TESTING PROVISION)												
Laboratory Tests (Forecast Monthly Laboratory Tests)	n/a	n/a	-	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000
Point of Care Tests (Forecast Monthly POCT)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SUB TOTAL ANTIBODY SAMPLING CAPACITY	-	-	-	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000	14,000

TTP PROGRAMME COSTS													
OPERATIONAL EXPENDITURE - £'000													Forecast year-end position
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Testing (including Sampling) - Antigen	-	-	-	72	44	55	109	175	175	175	175	175	1,155
Contact Tracing - Health Board Costs	-	-	-	44	722	444	431	440	436	440	438	349	2,856
Contact Tracing - Local Authority Costs	-	-	-	-	139	248	491	491	1,749	1,778	1,828	1,829	8,553
Testing (including Sampling) - Antibody	-	-	6	104	39	145	276	278	299	279	278	301	2,005
Protect	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL TTP PROGRAMME COSTS	-	-	6	220	944	4	1,307	1,384	2,659	2,672	2,719	2,654	14,569

Betsi Cadwaladr ULHB									
Please fill in the lightly yellow shaded cells.									
This section collects information in respect of the core activity that organisations' aim to deliver over the coming six months including Primary & Community Care, Mental Health, Cancer, Acute Care, Diagnostics and Ambulance Services against key priorities areas.									
This is not intended to be an exhaustive list as organisations narrative plans will provide context and detail on wider organisational deliverables.									

DELIVERY OF ESSENTIAL SERVICES IN PRIMARY & COMMUNITY CARE			Forecast Profile							
	FY % 31/03/2020	YTD % 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total	
METRIC	%									
1. Essential prevention of adverse outcomes against tier 1 targets										
		Q1 71.9% Q2 71.8% Q3 70.3% Q4 66.5%	Q1 77.4%		75.5%			82.7%		
% of Babies six week check complete										
% of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months	Data not available	Data not available			Data not available			Data not available		
% of patients with any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months	Data not available	Data not available			Data not available			Data not available		
% of current smokers with any of the following conditions: CHD, PAD, stroke/TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who have an offer of support and treatment within the preceding 15 months	Data not available	Data not available			Data not available			Data not available		
METRIC	FY as @ 31/03/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total	
2. Responsive urgent care										
Dental: Number of Aerosol Generating Procedures	4,223	2,300	2,500	2,000	2,000	2,700	3,000	18,723		
Dental: Number of Aerosol non-Aerosol Generating Procedures	8	39,003	13,500	15,000	12,000	15,500	17,000	124,003		
Optometry: Acute eye care presentations (EHEW band 1)	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	
Optometry: Low vision service (Care home residents) - number of patients accessing the service - new patients (as per EHEW Band 1)	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	
Optometry: Low vision service (Care home residents) - number of patients accessing the service - follow up patients (as per EHEW Band 1)	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	
Optometry: number of patients seen	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	
Optometry: number of patients maintained in primary care	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	
GP: In hours GP demand vs capacity: No. of GP practices at escalation levels 3 and 4	2	2	2	2	10	10	10	2	38	
GP's demand vs capacity: No. of community pharmacy services at escalation levels 3 and 4	8	12	12	12	30	30	30	12	138	
GP: Ambulatory sensitive conditions referral numbers (interface with secondary care)	12,477	2,790	364	364	364	364	364	400	6,010	
GP: Urgent Cancer OPD referral numbers	26,016	9,790	1,700	1,900	1,900	2,000	2,400	2,690	21,390	
GP: Urgent non-Cancer OPD referral numbers	32,231	10,248	900	1,300	1,300	1,500	2,000	2,690	19,938	
GP: Total number of referrals for termination of pregnancy	2,161	970	187	187	187	187	187	187	2,092	
Community: Total number of tests relating to sexual health conditions (Syphilis and Chlamydia)	39,976	11,503	1,900	1,900	2,000	2,000	2,000	2,000	23,303	
METRIC	FY as @ 31/03/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total	
3. Essential management of chronic conditions										
Number of admissions where the primary diagnostic reason for admission is exacerbation of COPD or asthma	2,667	403	100	150	250	250	200	200	1,553	
Number of COPD/asthma patients managed by the community team/pulmonary rehab team	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	
Number of patients receiving anti coagulants (DOAC/Warfarin)	14,156	Data not available	14,160	14,160	14,160	14,160	14,160	14,160	84,960	
METRIC	FY as @ 31/03/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total	
4. Timely diagnosis of new problems										
Optometry: number of practices open at least 75% of normal pre Covid-19 hours	74	72	72	72	72	72	73	74	507	
METRIC	FY as @ 31/03/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total	
5. Proactive management of vulnerable groups										
DES for Care Homes – compliance rate (%)	98%	94%	94%	94%	94%	94%	94%	94%		
No. of advanced care plans in place for palliative care	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	Data not available	-	

MENTAL HEALTH	FY as @		Forecast Profile						
	31/03/2020 No's	30/09/2020 No's	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No's								
	Mental Health								
Number of Part 1a and 1b referrals	14,180	4,142	1,409	1,177	1,095	1,361	1,227	1,213	11,624
Number of Mental Health Crisis referrals (Crisis Resolution Home Treatment)	2,399	500	200	183	166	189	190	170	1,538
Number of Child and Adolescent Mental Health (CAMHS) Crisis referrals and assessments	829	336	65	65	50	65	65	65	711
Number of Memory assessment service (MAS) referrals and assessments	1,492	120	139	104	65	98	83	119	728
Part 2 duty - % of total case loads with a valid care and treatment plan (%)	90.3%	89.8%	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	

ACUTE CARE - UNSCHEDULED CARE			Forecast Profile						
	FY as @ 31/03/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No's								
	1. Unscheduled Care Activity								
A&E Attendances	170,873	69,830	14,614	13,610	13,967	14,049	12,989	14,332	153,391
Emergency admissions	82,924	30,951	6,791	7,020	7,050	7,418	6,710	7,199	73,139

ELECTIVE CARE	Ave. Volumes per Month 2019/20	Ave. Volumes per Month YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No's								
2. Elective Care Activity									
OPA First appointment - face to face	13,267	2,024	5,138	5,364	5,364	5,364	5,364	5,364	
OPA First appointment - virtual	566	1,415	2,021	2,021	2,021	2,021	2,021	2,021	
OPA Follow up - face to face	25,557	3,072	14,108	14,108	14,108	14,108	14,108	14,108	
OPA Follow up - virtual	3,748	5,847	9,458	9,667	9,667	9,667	9,667	9,667	
Compliance with eye care measure for new and follow up patients (%)	83%	84%	84%	84%	82%	82%	84%	84%	
Number of inpatient procedures	742	137	1,335	1,390	1,390	1,390	1,390	1,390	
Number of day case procedures	2,014	311	974	1,060	1,060	1,060	1,060	1,060	

OUTSOURCED ACTIVITY		Ave. Volumes per Month 2019/20	Ave. Volumes per Month YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC		No's								
		3. Outsourced Activity								
Number of inpatient procedures	225	138	138	138	138	138	138	138	138	
Number of day case procedures	733	272	272	272	272	272	272	272	272	

CANCER CARE	FY as @ 31/03/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No's								
	Cancer								
Anticipated new referrals	28,500	11,158	2,300	2,300	2,300	2,300	2,300	2,300	24,958
Number of cancer patients starting treatment	4,200	1,588	280	280	280	270	290	290	3,278
Single cancer pathway performance (62 day) (% compliance with)	80%	75%	75%	75%	75%	75%	75%	75%	

DIAGNOSTICS	Backlog @ 31/03/2020	Backlog @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No. px waiting > 8 weeks		Activity no's						
Diagnostics Anticipated Activity									
Cardiology:									
Blood Pressures Monitoring	1	83	91	91	91	91	91	91	546
Cardiac CT	6	144	60	60	60	60	60	60	360
Cardiac MR	8	36	46	46	46	46	46	46	276
Diagnostic Angiography	1	74	74	74	74	74	74	74	444
Diagnostic Electrophysiology	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
Dobutamine Stress Echocardiogram	8	25	45	45	45	45	45	45	270
Echo	451	1,028	605	605	605	605	605	605	3,630
Heart Rhythm Recording	32	546	313	313	488	513	531	531	2,689
Myocardial Perfusion Scanning	14	166	15	30	20	20	45	45	175
Stress Test	5	70	33	33	33	33	33	33	198
Trans Oesophageal Echocardiogram	-	13	16	16	16	16	16	16	96
Endoscopy:									
Bronchoscopy	-	-	12	12	12	12	12	12	72
Colonoscopy	76	750	240	447	410	494	489	515	2,595
Cystoscopy	87	360	-	-	-	-	-	-	-
Flexi sigmoidoscopy	108	448	80	149	137	165	163	172	866
Gastroscopy	169	851	213	397	365	439	461	484	2,359
Imaging:									
Fluoroscopy	6	173	405	405	405	405	405	405	2,430
Neurophysiology:									
Electromyography	158	359	96	96	96	216	216	296	1,016
Nerve Conduction Studies	14	410	76	211	211	211	81	76	866
Radiology:									
Barium Enema	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	-
Non-cardiac CT	273	1,767	4,985	5,169	5,169	5,629	5,629	5,744	32,325
Non-cardiac MR	193	2,067	1,175	1,175	1,495	1,815	1,815	1,895	9,370
NDUS	339	5,580	7,051	7,993	7,993	7,948	7,948	8,081	47,014
Nuclear Medicine	44	172	300	300	300	300	300	300	1,800
Physiological Measure:									
Urodynamic Tests	41	107	35	35	35	35	35	35	210
Vascular Technology	27	190	50	50	50	50	50	50	300

AMBULANCE	FY 31/03/2020	YTD 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No's								
Ambulance									
Goal 2 (signposting, information & assistance) Forecasting 111 online & symptom checker impacts or web hits									
Goal 2 (signposting, information & assistance) Predicted levels of 111 resolution without referral to ED (%)	86.7%	85.7%	85.0%	85.3%	86.3%	85.4%	86.0%	86.0%	
Goal 3 (preventing unnecessary attendance & admission) What are the predicted levels of hear & treat to prevent conveyance/attendance/admission	5.9%	7.2%	5.3%	5.8%	7.0%	6.3%	5.7%	4.0%	0
Incident volume									
Total incident volume	124,666	55,245	10,470	10,640	13,559	12,315	10,277	9,920	122,426
No. of which relates to fallers	16,175	7,282	1,379	1,401	1,604	1,342	1,161	1,149	15,318
No. of which relates to Breathing difficulties	13,634	3,561	681	751	958	692	593	792	8,028
No. of which originate from Care and Nursing homes	-	-	-	-	-	-	-	-	-
No. of which relates to Mental health (Psychiatric Call only)	7,172	3,155	602	586	579	541	600	513	6,576
% Incident Volume									
% of which relates to fallers	13.0%	13.2%	13.2%	13.2%	11.8%	10.9%	11.3%	11.6%	
% of which relates to Breathing difficulties	10.9%	6.4%	6.5%	7.1%	7.1%	5.6%	5.8%	8.0%	
% of which originate from Care and Nursing homes	-	-	-	-	-	-	-	-	
% of which relates to Mental health (Psychiatric Call only)	5.8%	5.7%	5.7%	5.5%	4.3%	4.4%	5.8%	5.2%	
% conveyance, by condition, of patients to Emergency Departments (verified incident demand)									
% of falls incidents resulting in conveyance to an Emergency Department	40.7%	41.4%	28.9%	28.9%	31.2%	39.4%	44.7%	42.4%	
% of Breathing difficulties incidents resulting in conveyance to an Emergency Department	62.7%	57.5%	40.3%	48.0%	45.5%	54.2%	59.6%	49.8%	
% of Care and Nursing Home residents conveyance to an Emergency Department	-	-	-	-	-	-	-	-	
% of Mental health (Psychiatric Call only) conveyance to an Emergency Department	35.6%	37.8%	24.6%	29.2%	21.6%	36.5%	39.8%	39.6%	

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Please fill in the lightly yellow shaded cells

This section is intended to cover anticipated % delivery of each metric, at the period end stated for areas identified as Essential Services.

SCREENING PROGRAMMES	%		PROFILE @ END OF MONTH					
	ACTUAL as @ 31/3/2020	YTD as @ 30/09/2020	Oct	Nov	Dec	Jan	Feb	Mar
METRIC	%							

SCREENING PROGRAMME								
% Uptake of bowel cancer screening programmes	56%	N/A						
% Uptake of AAA screening programmes	N/A	N/A						
% - Breast Test Results sent within 2 weeks of scan (Target 95%)	N/A	N/A						
% - Breast Test Assessment Invitations within 3 weeks of Screening Date (Target 70%)	N/A	N/A						
% - Diabetic Eye Screening Letters within 3 wks of screen date (target 50%)	33%	N/A						
% - Waiting Time within 4 Weeks for a Colposcopy Appointment (CSW direct ref with abnormal cytology) (Target 95%)	100%	94%						
% - Waiting Time within 4 Weeks from Sample to Cervical Screening Test Result (Target 98%)	N/A	N/A						
% - Babies who complete New-born Hearing Screening programme within 4 weeks (Target 98%)	N/A	N/A						
% - Babies who complete New-born Hearing Assessment Procedure by 3 months (Target 85%)	100%	78%						

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THIS SECTION SHOULD NOT BE COMPLETED AT THIS STAGE.

This section is under review whilst organisations vaccinations programmes are being developed, a further update will be shared over the coming weeks.

VACCINATION PROGRAMME	FORECAST PROFILE								
	Actual as @ 31/03/2020	YTD as @ 31/09/2020	Oct	Nov	Dec	Jan	Feb	Mar	Total
METRIC	No's & %								

Number of Vaccinations									
Total number of flu vaccinations									
Total number of COVID-19 vaccinations planned									
Flu vaccinations of at risk populations 2019-20 (%) Actual and End of Year Target (%)									
65 year old and over (%)	71%	34%							
Under 65 at risk (%)	47%	11%							
Pregnant women (%)	86%	N/A							
Children aged 2-3 (%)	52%	23%							
Children aged 4-8 (%)	69%	77%							
NHS staff with patient contact (%)									
Childhood vaccinations Actual and End of Year Target (%)									
Uptake of 5 in 1 vaccination at one year (%)	96%								
Uptake proportion of childhood vaccinations by age 4 (%)	90%								
Uptake proportion of two MMR vaccinations by age 5 (%)	94%								
Uptake proportion of two MMR vaccinations by age 16 (%)	93%								

Contact Information - Executive Lead for Vaccinations	
Name	
Email address	
Contact Information - Social Care Workforce Vaccination Lead for each local authority (Name)	
Name	
Email address	
Contact Information - Emergency Planning Support (Named Contact)	
Name	
Email address	
Contact Information - Vaccination Co-ordination (Named Contact)	
Name	
Email address	
Contact Information - Vaccine Storage and Distribution Lead (Named Contact)	
Name	
Email address	

Date of last review of the Mass Vaccination Plan	
Mass Vaccination Plan for each cluster? (Yes/No)	
Has the Mass Vaccination Plan been discussed at the Regional Partnership Board? (Yes/No)	
Date of the last Mass Vaccination Exercise	

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Please fill in the lightly yellow shaded cells

This should reflect the corresponding amounts included within the M6 MMR submission to WG

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Please fill in the lightly yellow shaded cells.  
Net IMTP/Annual Plan values should exclude any assumed savings that were not finalised at Month 1.

NET EXPENDITURE PROFILE ANALYSIS	£		FORECAST PROFILE							FORECAST YEAR-END POSITION
	ACTUAL 2019/20	2020/21 TOTAL M6 YTD	Oct	Nov	Dec	Jan	Feb	Mar		
METRIC	£'000									
MONTHLY SUMMARISED STATEMENT OF COMPREHENSIVE NET EXPENDITURE/INCOME										
Revenue Resource Limit	1,622,156	821,489	148,643	146,923	149,009	150,606	149,551	152,025		1,718,246
Miscellaneous Income - Capital Donation(Government Grant Income	1,591	357	143			250		277		1,027
Miscellaneous Income - Other (including non resource limited income)	81,321	4,627	824	824	824	824	824	827		9,574
Welsh NHS Local Health Boards & Trusts Income	10,464	21,982	3,703	3,703	3,703	3,703	3,703	3,703		44,200
WHSSC Income	41,442	625	37	37	37	37	37	37		847
Welsh Government Income	7,954	33,942	5,587	5,585	5,580	5,377	5,376	5,505		66,952
SUB TOTAL INCOME	1,764,928	883,022	158,397	157,072	159,153	160,797	159,491	162,374		1,840,846
Primary Care Contractor (excluding drugs; including non resource limited expenditure)	213,809	102,047	18,055	17,858	17,832	17,209	17,908	18,178		209,089
Primary Care - Drugs & Appliances	108,773	56,768	10,123	10,021	10,464	10,391	9,913	10,330		118,061
Provided Services - Pay	785,315	398,112	74,119	71,764	72,460	73,008	72,751	72,850		835,064
Provider Services - Non Pay (excluding drugs & depreciation)	170,629	99,109	16,073	16,877	18,419	18,372	18,331	19,940		207,121
Secondary Care - Drugs	72,312	33,365	6,597	6,505	6,669	6,660	6,635	6,971		73,401
Healthcare Services Provided by Other NHS Bodies	259,988	133,767	23,071	23,071	23,072	23,071	23,048	23,050		272,150
Non Healthcare Services Provided by Other NHS Bodies										
Continuing Care and Funded Nursing Care	97,042	53,151	9,645	9,408	9,488	9,463	9,167	9,436		109,758
Other Private & Voluntary Sector	11,010	4,857	856	1,126	1,205	1,602	1,543	1,604		12,893
Joint Financing and Other	2,796	4,013	678	678	678	678	678	678		8,081
DEL Depreciation/Accelerated Depreciation/Impairments	31,593	16,837	2,806	2,806	2,806	2,807	2,806	2,806		33,674
AME Donated Depreciation/Impairments	50,376	778	130	130	129	129	129	129		1,554
Non Allocated Contingency										-
Profit/Loss Disposal of Assets	19									-
SUB TOTAL EXPENDITURE	1,803,624	902,824	162,153	160,345	162,630	164,013	162,910	165,972		1,880,846
TOTAL DEFICIT/SURPLUS	38,696	19,802	3,215	3,273	3,476	3,216	3,419	3,598		40,000

EXPENDITURE CATEGORY	£		FORECAST PROFILE							FORECAST YEAR-END POSITION
	ACTUAL 2019/20	2020/21 TOTAL M6 YTD	Oct	Nov	Dec	Jan	Feb	Mar		
METRIC	£'000									
PROVIDER PAY EXPENDITURE ANALYSIS										
IMTP/Annual Plan Net pay (plan before COVID-19) @ M1		379,695	67,154	64,341	64,538	64,366	64,237	64,318	768,649	
SPEND INCREASES DUE TO COVID-19										
Additional Field Hospital Pay	-	168		13	236	427	427	425	1,694	
Additional Internal Capacity	-	15,801	2,296	2,100	2,175	2,151	2,070	2,042	28,725	
TTP	-	553	672	751	754	759	756	668	4,913	
Additional Flu Vaccination Programme (above baseline spend)	-		668	668	668	668	668	667	4,007	
COVID-19 Vaccination Programme	-		52	19	726	726	681	738	2,434	
Additional Other Pay (exc categories above)	-		1,104	1,104	1,104	1,104	1,104	1,103	6,624	
PAY EXPENDITURE IMPACT DUE TO COVID-19	-	16,612	4,792	4,655	5,155	5,835	5,706	5,643	48,397	
Spend Decreases due to COVID-19 (negative value)	-	1,280	-	-	-	-	-	-	1,280	
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-	
PAY SPEND SUB TOTAL AFTER IMPACT OF COVID-19	-	15,332	4,792	4,655	5,155	5,835	5,706	5,643	47,117	
In year cost pressures/funded spend not related to COVID-19	-	4,189	2,358	2,948	2,970	3,008	3,006	3,090	21,569	
In year mitigating actions/Addition in year savings (negative value)	-	1,104	185	180	202	200	199	200	2,272	
CURRENT NET PAY FORECAST	-	398,112	74,120	71,764	72,460	73,008	72,750	72,850	835,064	
NON PAY (excluding drugs & depreciation) EXPENDITURE ANALYSIS										
IMTP/Annual Plan Net Non Pay (exc drugs & depreciation) (plan before COVID-19) @ M1		65,722	12,857	12,920	13,389	13,652	13,457	13,358	145,355	
SPEND INCREASES DUE TO COVID-19										
Revenue Field Hospital (Set up, running costs, decommissioning and consequential not listed below)	-	26,102	538	1,196	941	932	931	2,608	33,248	
Additional PPE (above baseline spend)	-	1,995	771	768	779	771	771	771	6,623	
TTP	-	621	635	633	1,905	1,913	1,963	1,986	9,656	
Additional Flu Vaccination Programme (above baseline spend)	-									
COVID-19 Vaccination Programme	-			10	384	134	178	112	818	
Other Non Pay inc Additional Internal Capacity	-	12,012	921	901	493	463	400	465	15,655	
NON PAY EXPENDITURE IMPACT DUE TO COVID-19	-	40,730	2,865	3,508	4,502	4,212	4,242	5,941	66,000	
Spend Decreases due to COVID-19 (negative value)	-	9,302	759	762	711	709	687	691	13,620	
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-	
NON PAY SUB TOTAL AFTER IMPACT OF COVID-19	-	31,428	2,106	2,746	3,791	3,504	3,555	5,250	52,379	
In year cost pressures/funded spend not related to COVID-19	-	2,255	1,225	1,333	1,388	1,473	1,475	1,511	10,659	
In year mitigating actions/Addition in year savings (negative value)	-	296	114	122	149	256	156	178	1,272	
CURRENT NET NON PAY FORECAST	-	99,109	16,073	16,877	18,419	18,372	18,331	19,941	207,121	
PRIMARY CARE DRUGS EXPENDITURE ANALYSIS										



IMTP/Annual Plan Net Primary Care Drugs (plan before COVID-19) @ M1		58,502	9,769	9,649	10,121	10,004	9,526	9,942	117,513
SPEND INCREASES DUE TO COVID-19									
Primary Care Drugs			452	452	452	452	452	452	2,714
Additional Flu Vaccination Programme (above baseline spend)	-	-	-	-	-	-	-	-	-
COVID-19 Vaccination Programme	-	-	-	-	-	-	-	-	-
PRIMARY CARE DRUGS EXPENDITURE IMPACT DUE TO COVID-19	-	-	452	452	452	452	452	452	2,714
Spend Decreases due to COVID-19 (negative value)	-	-	-	-	-	-	-	-	-
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-
PRIMARY CARE DRUGS SUB TOTAL AFTER IMPACT OF COVID-19	-	-	452	452	452	452	452	452	2,714
In year cost pressures/funded spend not related to COVID-19	-	-	-	-	-	-	-	-	-
In year mitigating actions/Addition in year savings (negative value)	-	1,714	99	80	79	65	65	64	2,166
CURRENT PRIMARY CARE DRUGS FORECAST	-	56,788	10,122	10,021	10,494	10,391	9,913	10,330	118,061
SECONDARY CARE DRUGS EXPENDITURE ANALYSIS									
IMTP/Annual Plan Net Secondary Care Drugs (plan before COVID-19) @M1		31,745	6,054	5,936	5,943	5,924	5,907	6,240	67,749
SPEND INCREASES DUE TO COVID-19									
Secondary Care Drugs		343	43	65	218	220	212	216	1,318
Additional Flu Vaccination Programme (above baseline spend)	-	-	286	286	286	286	287	286	1,717
COVID-19 Vaccination Programme	-	-	-	-	-	-	-	-	-
SECONDARY CARE DRUGS EXPENDITURE IMPACT DUE TO COVID-19	-	343	329	351	504	506	499	502	3,035
Spend Decreases due to COVID-19 (negative value)	-	-	-	-	-	-	-	-	-
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-
SECONDARY CARE DRUGS SUB TOTAL AFTER IMPACT OF COVID-19	-	343	329	351	504	506	499	502	3,035
In year cost pressures/funded spend not related to COVID-19	-	1,787	307	315	315	323	323	323	3,693
In year mitigating actions/Addition in year savings (negative value)	-	510	94	97	93	93	94	95	1,076
CURRENT SECONDARY CARE DRUGS FORECAST	-	33,365	6,597	6,505	6,669	6,660	6,635	6,970	73,401
PRIMARY CARE CONTRACTOR (EXCL DRUGS, INCL NON RESOURCE LIMITED) EXPENDITURE ANALYSIS									
IMTP/Annual Plan Net Primary Care Contractor (plan before COVID-19) @M1		100,624	17,715	17,518	16,703	17,064	17,081	17,578	204,283
SPEND INCREASES DUE TO COVID-19									
Primary Care Contractor		3,316	534	534	701	701	760	534	7,080
Additional Flu Vaccination Programme (above baseline spend)	-	-	-	-	-	-	-	-	-
COVID-19 Vaccination Programme	-	-	-	-	-	-	-	-	-
PRIMARY CARE CONTRACTOR EXPENDITURE IMPACT DUE TO COVID-19	-	3,316	534	534	701	701	760	534	7,080
Spend Decreases due to COVID-19 (negative value)	-	2,292	261	261	262	-	-	-	3,076
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-
PRIMARY CARE CONTRACTOR SUB TOTAL AFTER IMPACT OF COVID-19	-	1,024	273	273	439	701	760	534	4,004
In year cost pressures/funded spend not related to COVID-19	-	399	67	67	67	67	67	65	799
In year mitigating actions/Addition in year savings (negative value)	-	-	-	-	-	-	-	-	-
CURRENT PRIMARY CARE CONTRACTOR FORECAST	-	102,047	18,055	17,858	17,209	17,832	17,908	18,177	209,086
CONTINUING HEALTHCARE / FUNDED NURSING CARE EXPENDITURE ANALYSIS									
IMTP/Annual Plan Net CHC/FNC (plan before COVID-19) @M1		50,337	8,733	8,718	8,798	8,772	8,440	8,722	102,519
Spend Increases due to COVID-19	-	4,561	1,200	995	995	995	995	998	10,739
Spend Decreases due to COVID-19 (negative value)	-	-	-	-	-	-	-	-	-
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-
CHC/FNC SUB TOTAL AFTER IMPACT OF COVID-19	-	4,561	1,200	995	995	995	995	998	10,739
In year cost pressures/funded spend not related to COVID-19	-	-	-	-	-	-	-	-	-
In year mitigating actions/Addition in year savings (negative value)	-	1,747	288	305	305	304	268	284	3,500
CURRENT CHC/FNC FORECAST	-	53,151	9,645	9,408	9,488	9,463	9,167	9,436	109,758
COMMISSIONED SERVICES (HEALTH CARE & NON HEALTH CARE) EXPENDITURE ANALYSIS									
IMTP/Annual Plan Net Commissioned Services (plan before COVID-19) @ M1		141,663	24,125	24,123	24,124	24,123	24,100	24,104	286,362
SPEND INCREASES DUE TO COVID-19									
Private Provider	-	-	76	76	76	141	141	141	195
Other Commissioned Services	-	-	-	-	-	-	-	-	-
COMMISSIONED SERVICES EXPENDITURE IMPACT DUE TO COVID-19	-	-	76	76	76	141	141	141	195
Spend Decreases due to COVID-19 (negative value)	-	3,039	122	122	122	122	122	122	3,771
Non Delivery of M1 Finalised Savings due to COVID-19	-	-	-	-	-	-	-	-	-
COMMISSIONED SERVICES SUB TOTAL AFTER IMPACT OF COVID-19	-	3,039	198	198	198	19	19	19	3,576
In year cost pressures/funded spend not related to COVID-19	-	-	372	351	351	531	472	531	2,257
In year mitigating actions/Addition in year savings (negative value)	-	-	-	-	-	-	-	-	-
CURRENT COMMISSIONED SERVICES FORECAST	-	138,624	23,927	24,297	24,277	24,673	24,591	24,654	285,043
INCOME ANALYSIS									
IMTP Annual total income including RRL (before COVID-19) @M1		812,713	141,298	138,033	138,196	138,615	137,389	138,690	1,644,934
WG Allocations / Income Received due to COVID-19	-	21,272	869	869	869	870	869	875	26,491
WG Allocations / Income Anticipated Due to COVID-19	-	46,486	11,694	12,016	13,878	14,749	14,727	16,135	129,686
Loss of Planned Income (excluding Dental Patient Charges as part of Primary Care net spend) due to COVID-19	-	4,077	314	314	314	270	270	270	5,827
Non Delivery of M1 Finalised Income Generation due to COVID-19	-	-	-	-	-	-	-	-	-
TOTAL INCOME SUB TOTAL AFTER IMPACT OF COVID-19	-	876,394	153,547	150,604	152,629	153,963	152,715	155,431	1,795,283
Additional In year Income Generation	-	41	7	7	7	7	7	5	81
Additional In year WG Allocations / Income Received NOT related to COVID-19	-	3,998	1,742	1,742	1,742	1,742	1,742	1,740	14,448
Additional WG Allocations / Income Anticipated NOT related to COVID-19	-	2,589	3,641	4,719	4,775	5,085	5,027	5,198	31,034
CURRENT INCOME FORECAST	-	883,022	158,937	157,072	159,153	160,797	159,491	162,374	1,840,846
OTHER ASSUMPTIONS									
Non delivery of planning assumptions not finalised at M1 due to COVID-19	-	18,109	2,637	2,638	2,637	2,635	2,636	2,638	33,932

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Please fill in the lightly yellow shaded cells

Please detail the organisations financial risk and opportunities for 2020/21.

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This section should capture the deliverable actual and forecast savings profile by expenditure category for 2020/21.

2020/21 SAVINGS FORECAST	FORECAST PROFILE												TOTAL	NON RECURRING	RECURRING	FYE OF RECURRING
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR				
METRIC	£'000												£'000			
£'000 (All Positive Entries)																
Pay	-	15	311	204	322	254	185	180	202	200	199	200	2,272	658	1,614	2,113
Non Pay	-	8	94	49	43	101	114	122	149	256	156	178	1,272	160	1,112	1,311
Primary Care Prescribing	-	-	794	413	244	263	99	80	79	65	65	64	2,166	846	1,321	1,345
Secondary Care Prescribing	-	8	83	128	207	84	94	97	93	93	94	95	1,076	748	327	414
Primary Care	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Continuing Care and Funded Nursing Care	-	63	324	331	536	491	288	305	305	304	268	284	3,500	600	2,900	2,900
Commissioned Services	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TOTAL SAVINGS FORECAST	-	94	1,606	1,126	1,352	1,193	781	784	827	919	782	822	10,286	3,012	7,274	8,084

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### PROPERTY & ASSET INVESTMENT

2020-21

METRIC

£m

EXPENDITURE		£m
Gross Capital Expenditure		28
less: Receipts		0
Disposals (ENTER BELOW):		
	Brymbo Health Centre	0
	Ala Road, Pwyheli	0
NET CAPITAL EXPENDITURE		28

FUNDING		£m
Welsh Government Funding		
Discretionary (Group 1 - CRL / CEL)		13
Approved Schemes (Group 2 - CRL / CEL)		15
WG Funding Required (approved)		
Funding for identified schemes not approved by Welsh Government (ENTER BELOW)		
	COVID – 19 Funding requirements for 2020-21. (Tranche 4)	4
NET CAPITAL FUNDING		32

KEY PERFORMANCE INDICATORS	2018-19 as per EFPMS	2020-21 Forecast
	£m	£m
High Risk Backlog Maintenance	24	24
	%	%
Physical Condition: % in Category B or above	63%	63%
Statutory, Safety & Compliance: % in Category B or above	78%	78%
Fire Safety Compliance : % in Category B or above	78%	78%
Functional Suitability: % in Category B or above	79%	79%
Space Utilisation: % in Category F or above	92%	92%
Energy Performance: % with Energy B or better	Above 90%	95%

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Please fill in the lightly yellow shaded cells
-

PROPERTY & ASSET INVESTMENT - APPROVED	2020-21
METRIC	£m

CAPITAL EXPENDITURE	
DISCRETIONARY	£m
IT	2
Equipment	2
Statutory Compliance	-
Estates	10
Other	
SUB TOTAL DISCRETIONARY	13
DISCRETIONARY NON CASH	£m
Discretionary Other Revenue Costs	
Discretionary Revenue Savings	
SUB TOTAL NON CASH	-

APPROVED SCHEMES	NON CASH - DEL	NON CASH - AME	OTHER REVENUE COSTS	REVENUE SAVINGS	NET REVENUE
PLEASE DELETE & INSERT SCHEME BELOW					
	£m				
PAS System	0				
Substance Misuse - Holyhead, Anglesey	-				
Substance Misuse - Shotton, Flintshire	-				
North Denbighshire Community Hospital	-				
Albiett SOC - OBC	-				
Orthopaedic Plan Fees	-				
Emergency Dept Systems	0				
Slippage from 19/20 (Replacement CT Scanner - YGC) into 20/21	0				
Ruthin	0				
Covid19	0				
ICF	-				
SCHEME TITLE 12					
SCHEME TITLE 13					
SCHEME TITLE 14					
SCHEME TITLE 15					
SCHEME TITLE 16					
SCHEME TITLE 17					
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SCHEME TITLE 38					
SCHEME TITLE 39					
SCHEME TITLE 40					
SUB TOTAL APPROVED SCHEMES	1	-	-	-	-

UNAPPROVED SCHEMES	NON CASH - DEL	NON CASH - AME	OTHER REVENUE COSTS	REVENUE SAVINGS	NET REVENUE
PLEASE DELETE & INSERT SCHEME BELOW					
	£m				
COVID – 19 Funding requirements for 2020-21. (Tranche 3)	0				
PRIORITY SCHEME TITLE 2					
PRIORITY SCHEME TITLE 3					
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SUB TOTAL UNAPPROVED SCHEMES	0	-	-	-	-

<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Quality and Performance Report					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Mr Mark Wilkinson, Executive Director of Planning & Performance					
<b>Awdur yr Adroddiad Report Author:</b>	Mr Ed Williams, Head of Performance Assurance					
<b>Craffu blaenorol: Prior Scrutiny:</b>	This paper has been scrutinised and approved by the Director of Performance.					
<b>Atodiadau Appendices:</b>	None					
<b>Argymhelliad / Recommendation:</b>						
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						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	<input checked="" type="checkbox"/>	<b>Er gwybodaeth For Information</b>
<b>Sefyllfa / Situation:</b>						
<p>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.</p> <p>This report includes available indicators from the National Delivery Framework, together with a section on Covid-19 and Essential Services Delivery.</p> <p>The Financial Report will be presented separately.</p>						
<b>Cefndir / Background:</b>						
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



# Quality & Performance Report



## Finance & Performance Committee

## September 2020

## 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 September 2020 is not compared as 'like-for-like' to previous months/ years performance. National reporting of performance has recommenced however Health Boards are not being actively performance managed on certain measures such as Referral to Treatment or Diagnostic Waits.**

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 was submitted to Welsh Government in July 2020. The progress against the actions contained within this plan are reported in the accompanying Q2 Operational Plan Monitoring Report.

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.

Where monthly data is provided this is submitted as of 31st September 2020 position, unless stated otherwise.



Performance has improved since last reported



Performance has got worse since last reported



Performance remains the same as last reported





## Key Messages

Second wave of Covid-19 pandemic has begun with Wales in a 3 week fire-break lockdown

Unscheduled Care attendances falling, however increase in admissions of Covid-19 positive patients impacting on Acute Sites and pressure at the ED front doors

Essential Services largely maintained, however activity significantly reduced and capacity challenges emerging

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Essential Services	7	Unscheduled Care
Quadruple Aim 1:	8	Quadruple Aim 2: Charts 25 & 26
Quadruple Aim 2: Key Messages	9	Planned Care
Quadruple Aim 2: Unscheduled Care	10 to 12	Quadruple Aim 3: Charts 27 & 28
Quadruple Aim 2: Planned Care	13 to 16	Further Information 29

The committee are asked to note the following:

## Covid-19 Update

At the time of writing, to date over a quarter of a million tests have been carried out, of which 7,612 were positive for Covid-19. The turnaround from Test to Result is now averaging at 98% completed within 24 Hours.

In light of the second wave of the pandemic, testing capacity has been increased with the opening of an additional testing centre on Anglesey.

The Health Board is putting into action its surge capacity plans to ensure that services can manage the increasing demand on acute services as admissions of patients tested positive for Covid-19 begin to rise.

## Essential Services

Whilst routine referrals remain low in comparison to pre-Covid-19 rates, urgent, suspected cancer referrals are slightly higher for the first time since the outbreak of the pandemic.

## Quadruple Aim 1: Screening Services

All the national screening programmes have now recommenced and it expected that referrals from the screening services will begin to rise in coming weeks.

## Quadruple Aim 2: Unscheduled Care

Through the summer the number of attendances to our emergency departments were increasing to almost pre-Covid-19 levels, however September has seen attendances plateau and start to fall again. ED 4 Hour performance remains stronger than for the same period in 2019, however the number of 12 hour waits and ambulance handover breaches have risen sharply. The services are working through plans to improve performance over coming months, details of which can be seen on page 11.

Performance against all four of the national measures for Stroke Care have improved in September.

## Quadruple Aim 2: Planned Care

In North Wales, like all the other Health Boards in Wales, Covid-19 continues to severely impact upon our capacity to

safely deliver planned care services at the pre-Covid-19 rates and as a result waiting times are increasing. However, the Health Board is continually monitoring the waiting and using technology to deliver services in a new way, such as offering virtual appointments where appropriate to do so.

Performance against the 31 Day cancer target remains strong at 100%, however the capacity issues leading to delays in radiology and endoscopy continue to impact upon performance against the 62 day measure.

## Quadruple Aim 3: Workforce

Staff sickness rates continued to fall for the third consecutive month in September. Whilst non-Covid-19 related sickness rates rose slightly, Covid-19 related sickness remained static at 0.3%. However, the second wave of the pandemic has now begun and it is likely that sickness rates will rise in coming weeks.

PADR Rates remain high and the Health Board is the second best performing

Health Board in Wales in terms this measure.

## Quadruple Aim 4: Critical Care DToC

The latest published figures for the percentage of critical care bed days lost due to delayed transfers of care (DToC) , quarter 1 20/21 show an marked improvement at 5.6% almost a 10% reduction compared with the previous quarter.

## Quadruple Aim 4: Agency /Locum Spend

Reducing the spend on agency and locum staff continues to be a priority for the Health Board and this month sees a continued reduction to 6% of our staffing budget being spent on Agency and locum staff. Reductions are being achieved by recruiting to substantive posts where possible, increasing available internal bank staff supplies and reducing sickness rates. However, challenges remain in particular the number of vacancies for Nursing & Midwifery Band 5's and Consultants.



# Covid-19

## Key Messages

Second wave of Covid-19 has begun.

Wales has entered into a full 'fire-break' lockdown to help delay/ prevent the spread of the virus

Covid-19 contingency and surge plans are being put into action

## Measures

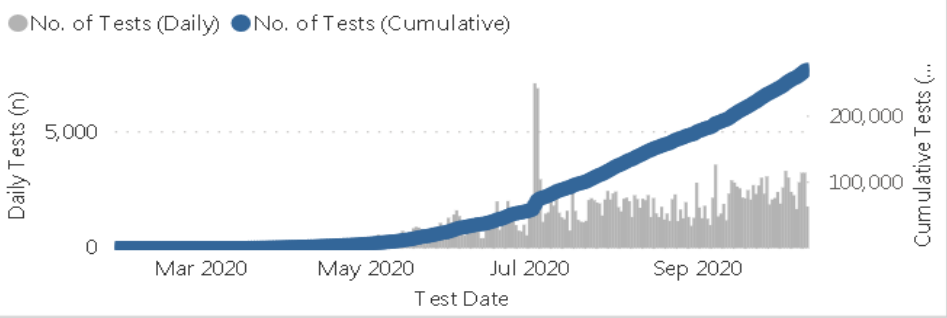
### Measure

at 15th October 2020

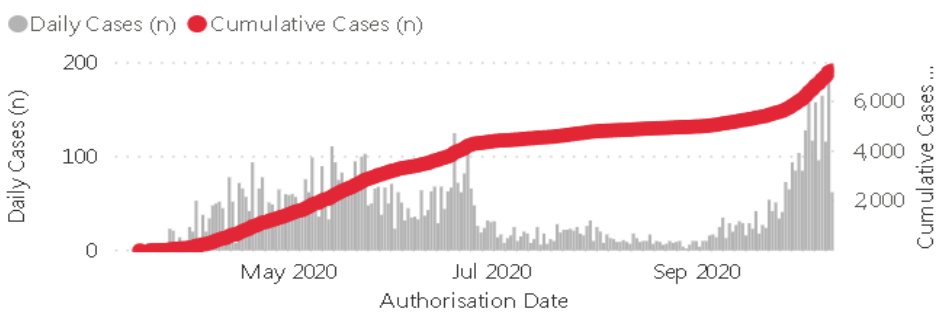
Total number of tests for Covid-19	276,111
% Tests turned around within 24 Hours (Last 7 days)	98%
Number of results: Positive	7,612
Number of results: Negative	268,499
% Prevalence of Positive Tests (cumulative since 30th January 2020)	6.0%
Number of Deaths - Confirmed Covid-19*	429

## Coronavirus (Covid-19) | Testing Summary

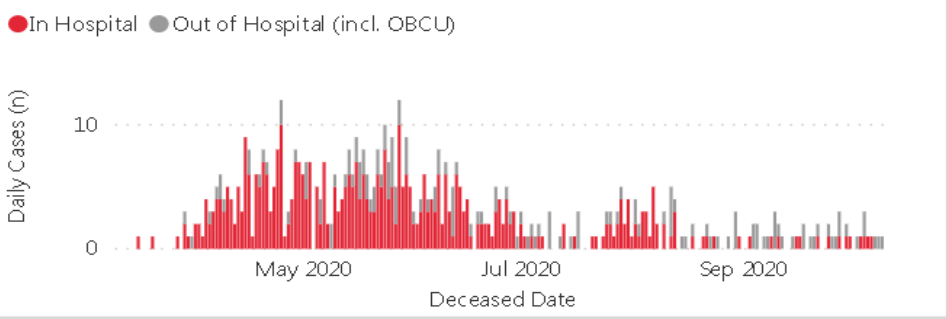
**Tests Completed | Total: 270,285**



**Confirmed Cases | Cumulative Total: 7,246**



**Deaths With Confirmed Test**



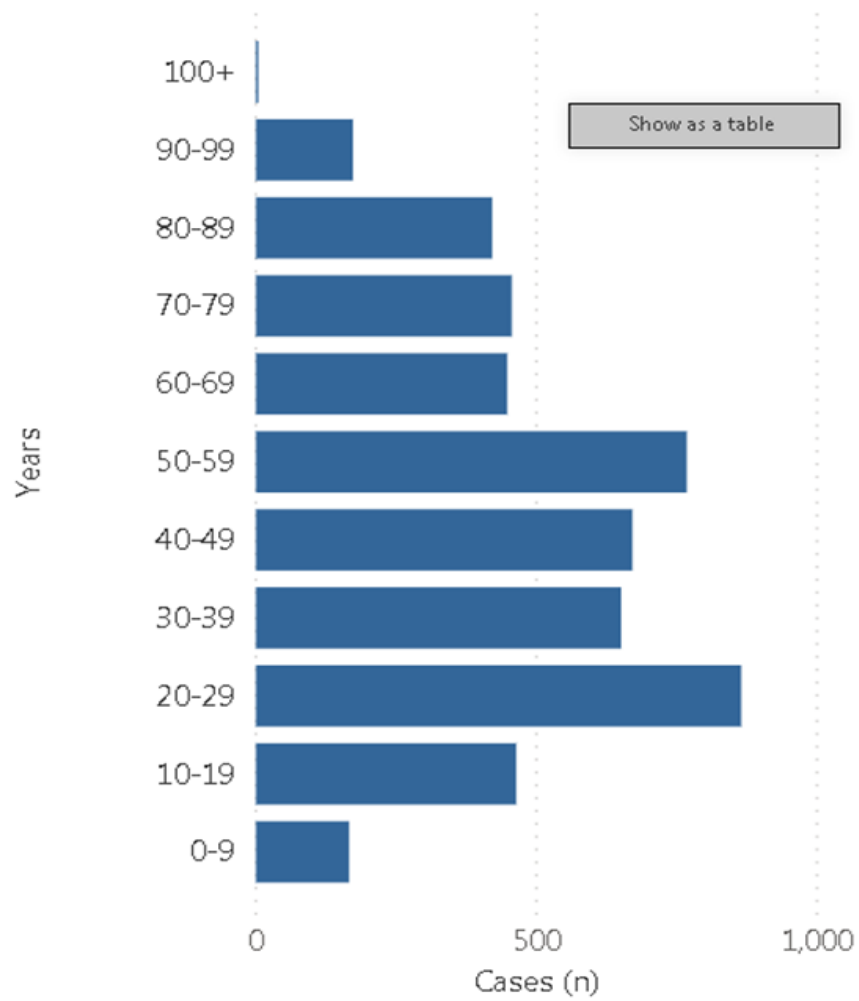
**Test Turnaround within 24 Hours (last 7 days)**

**98%**

Last week was 99%

Source: IRIS Covid-19 Dashboard – Early Warning Page – Accessed at 16:50 19th October 2020

## Patient Tests Confirmed by Age Group







# Essential Services

## Key Messages

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

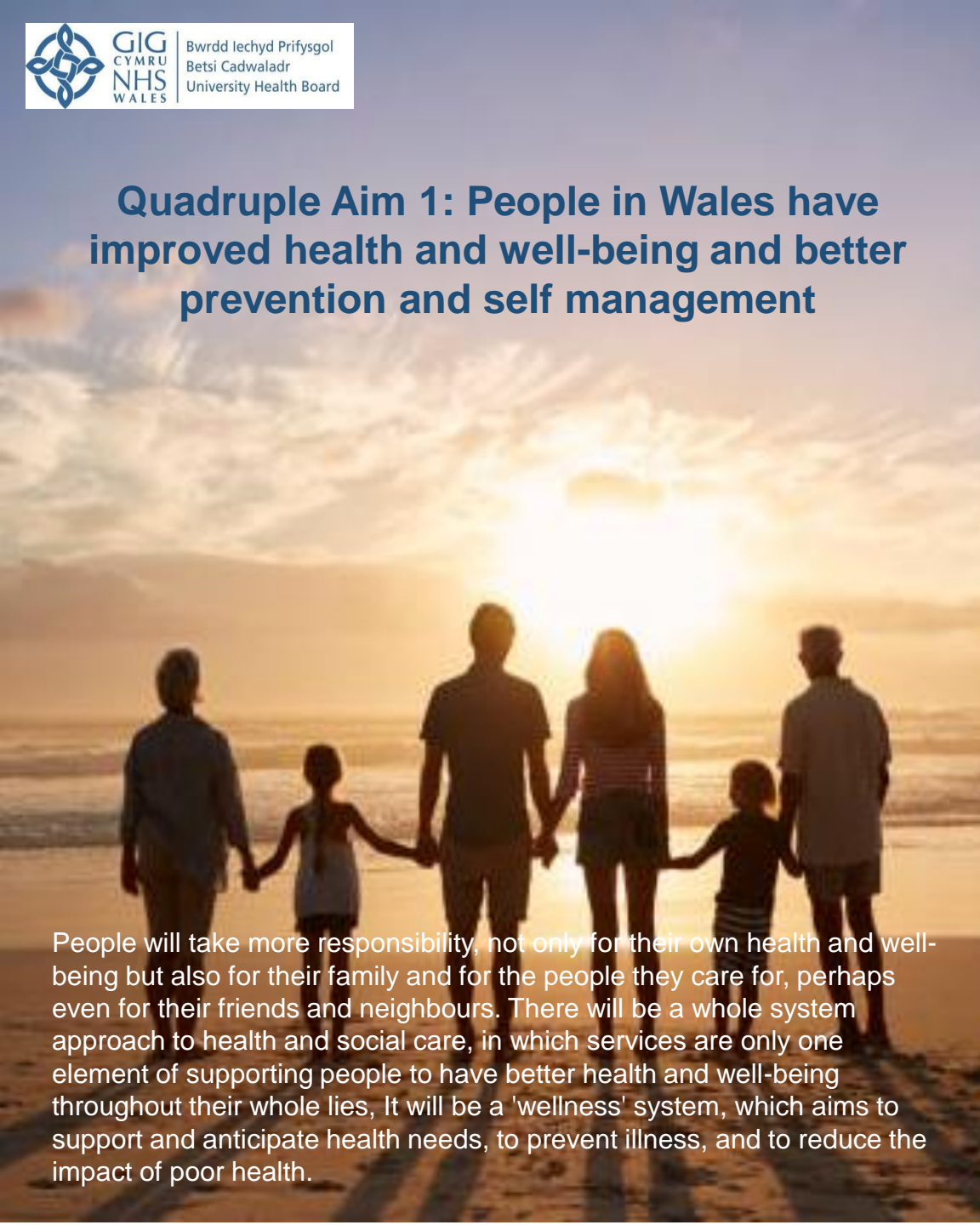
Essential services covers a wide range of Primary, Community, Secondary and Tertiary care Pathways

Re-start of planned care impacted by second wave of pandemic

## Measures

Average Number comparison:	Pre Covid-19	Post Covid-19
Referrals into Secondary Care (average per week) w/e 13th September	5,330	3,589
Referrals Urgent, suspected Cancer (average per week) w/e 15th October	539	559
New Outpatient Attendances (Year to Date includes Virtual) April to September	132,036	76,051
Follow Up Outpatient Attendances (Year to Date includes Virtual) April to September	271,933	169,128
Diagnostic 8 Weeks Breaches (Per Month) - September 2020	2,816	15,711
Patients over 62 Days open on Urgent, suspected cancer pathway (at 15th October 2020)	103	288
Elective Inpatient/ Daycase Procedures (Year to Date compared to same period 2019) to 30th September 2020	23,472	10,802

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



People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lives. 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

Bowel and Breast Screening services restarted in July/September 2020

Diabetic eye screening and Abdominal Aortic Aneurysm screening restarted in September 2020

Work being done to identify capacity for additional sessions are required to deliver the Bowel Screening recovery programme

## Measures

Following a cessation of Breast, Bowel and Aortic Aneurysm screening services in March, Breast and Bowel screening have recommenced. Diabetic retinopathy screening is recommencing in September on a smaller number of locations than previously. 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 breast 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. Nationally the programmes are working to assess how they can move to recovery and removal of backlogs by the end of March 2020. BCU are working with Public Health Wales to assess the impact of this backlog reduction on demand for secondary care services.

Additional capacity required for endoscopy is being planned with tenders progressing to support the additional service requirements.



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

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

## Key Messages

Planned Care delivery developed a new approach to clinical risk and service capacity

Bed Occupancy on acute sites is high and Covid-19 positive admissions increasing

Significant challenges becoming evident with ambulance handovers delays and 12 hour waits

## Top 5 Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Sep 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%	77.57%	↓
Sep 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	1,187	↓
Sep 20	Number of Ambulance Handovers over 1 Hour	0	811	↓
Sep 20	Number of patients waiting more than 36 weeks for treatment	0	39,736	↓
Sep 20	Number of patients waiting more than 52 weeks for treatment	0	17,303	↓

# Quadruple Aim 2: Unscheduled Care Measures

Period	Measure	Target	Actual	Trend	Period	Measure	Target	Actual	Trend
Sep 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	90%	99%	↑	Sep-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%	37.00%	↑
Sep 20	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	>= 65%	61.30%	↓	Sep-20	Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours of the patient's clock start time	>= 85%	81.40%	↑
Sep-20	Number of Ambulance Handovers over 1 Hour	0	811	↑	Sep-20	Percentage compliance against the therapy target of an average of 16.1 minutes of Speech and Language Therapist input per stroke patient	TBA	48.90%	↑
Sep-20	Percentage of patients who spend less than 4 hours in all major and minor	>95%	77.57%	↓	Q1 20/21	Percentage of stroke patients who receive a 6 month follow up assessment	TBA	49.90%	↑
Sep-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	1,187	↑	Sep-20	Number of health board patients non mental health delayed transfer of care	> 30	37	↑
July 20	Percentage of survival within 30 days of emergency admission for a hip fracture	>= 80%	84.20%	↓	Sep-20	Number of health board beddays non mental health delayed transfer of care		538	↓

*\*Stroke 6 month follow up Time is reported 6 months in arrears*



## Emergency Department (ED) Performance

The combined ED performance across BCUHB for September 2020 was 77.57%, which was comparable with August performance of 77.9%. This comprised of 86.5% West, 71.6% Centre and 75.5% East. The overall performance is reporting an improved combined position compared to the same period last year of 71.7%. ED only performance was maintained at 71.4% compared to August (71.8%). The number of both >12 and >24 hour delays increased during September with totals of 1,187 and 265 respectively. There was a reduction in the number of attendances at both YGC and YG sites but an increase at Wrexham resulting in an aggregated decrease in the number of attendances for BCUHB from 13,784 in August to 13,072 in September. Ambulance handover performance for >60 minute handover is showing a deteriorating position for the past 4 months reporting a total of 811 in September BCU wide.

The key drivers for performance include; lack of flow out to base wards, high ED occupancy and long doctor waits largely due to lack of available capacity to review and treat patients quickly (Wrexham); poor primary care input for face to face appointments (West) and increased number of WAST conveyances. Challenges are being presented on some sites where 'spontaneous' positive patients have been identified in 'green' patient areas which subsequently created 'contact' issues requiring cohorting patients. Wrexham has experienced high locum reliance across all shifts which will see some stabilisation at SHO level with a number of new starters coming off supernumerary status and await decisions about further investment.

Specific actions are identified across sites to improve KPIs, including dual-PIN handover; non-medical RAT and dealing with diverted vehicles for most days. This includes; a strong focus on addressing the ambulance diverts and an agreed Standing Operating Procedures (SOP) has been developed by clinical team, working with Welsh Ambulance Service NHS Trust (WAST), to improve the position. In Wrexham there is renewed focus on maintaining operational communications between the ED and WAST ODU. Other actions include; Continued development of SDEC models, development and support in creating Red and Green waiting rooms to support demand in the coming months. Internal Professional Standards are being piloted with surgery and consulted with medicine.

Unscheduled care *site escalation processes*, comprising four escalation levels are being embedded at each site and *whole system situation reports (SITREPs)* have been developed and implemented this month. The standardised processes aim to improve patient flow through the hospital, reducing delays in EDs and delays in discharges. This will also increase clinical safety and reduce level of risk through shared processes and improve unscheduled care performance.

Work has been completed in relation to Covid-19 predicted demand curve which demonstrates that the HB requires circa 196 beds above that which can be provided through the acute site and community hospital surge capacity. Given the pressures being experienced at 2 of our 3 acute sites, it is clear that, as a minimum, one of our three Ysbytai Enfys is required quickly. Work is already underway to mobilise Ysbyty Enfys Deeside in the first instance with delivered through a pan BCU Delivery Group accountable to an BCU Assurance Group.

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

## Stroke Care Performance

BCUHB	Thrombolysis rate	Direct admission to ASU <= 4hrs	CT <= 1hr	Cons <= 24hrs	Swallow Screen <=4hrs	Formal swallow <= 72 hrs
<u>Aug-20</u>	15%	29%	48%	71%	69%	100%
<u>Sep-20</u>	13%	37%	62%	81%	71%	86%

The key drivers for stroke performance include:

- Access to stroke co-ordinators, due to sickness in East and Centre
- Availability of stroke on-call consultants
- Timeliness of referrals for CT – not a capacity issue
- Availability of beds on ASU – needs more rigour on all sites

In order to address the issues, the following actions have been identified:

- Pathway work with ED to review audit of stroke proforma, pre-alerts and swallow screens
- Stroke team to clerk patients on arrival at ED & work on referral pathways when Stroke Co-ordinators not available
- Work with Site Management re adherence to retaining 2 beds on ASU
- Recruitment in SALT team in East
- The move of some therapists to focus on stroke
- The commencement of multi-professional rehab assistants

## Delayed Transfers of Care Performance (DToC)

As at 16th September census date there was an increase in the number of non-Mental Health DTOCs to 37 compared to 6 as at August Census date. The number of Mental Health DTOCs dropped from 22 at August census date to 15 for September.

The key drivers for DTOC across the acute sites and communities are due to; awaiting new placements, delays in placement accepting returning residents; care and support packages at home; increasing number of 'RED' homes unable to accept new or returning patients; increasing delay in nursing homes responding to nursing assessments resulting in patients being referred to several homes many out of area; Difficulties placing Elderly Mentally Infirm (EMI) Nursing patients who wander (due to concerns re isolating should they need to); Local Authorities not advocating the Choice policy and also incomplete paper work.

Actions being taken to address delays across sites include: Weekly review of all patients in acute and community with a Length of Stay (LoS) 7+ days; Daily review of all Medically Fit for Discharge (MFD) patients to review any alternative pathways with community Services/ Community Resource Teams (CRTs) in reach; scrutiny at weekly meetings with actions reviewed daily by the Home First Bureau; Increased focus on Discharge to Recover and Assess pathways with Local Authority (LA) colleagues; escalation to LA managers regarding Choice policy not being implemented; Tuag Adref (in the West) is being utilised for packages of care (especially in the Meirionnydd & Llyn area where care providers have pulled out of area).

## Quadruple Aim 2: Planned Care Measures

Period	Measure	Target	Actual	Trend	Period	Measure	Target	Actual	Trend
Aug-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%	➡	Sep-20	Percentage of patients waiting less than 26 weeks for treatment	>= 95%	57.33%	⬆
Aug-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%	79.50%	⬇	Sep-20	Number of patients waiting more than 36 weeks for treatment	0	39,736	⬇
Aug-20	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	TBA	79.80%	⬆	Sep-20	Number of patients waiting more than 52 weeks for treatment	0	17,303	⬇
Sep-20	Number of patients waiting more than 8 weeks for a specified diagnostic	0	15,711	⬇	Aug-20	Number of patients waiting for a follow-up outpatient appointment	Reduce	195,642	⬇
Sep-20	Number of patients waiting more than 14 weeks for a specified therapy	0	4,060	⬆	Aug-20	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	34,721*	65,780	⬇
Sep-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%	43.90%	⬆	Q2 20/21	Percentage children regularly accessing NHS Primary Dental Care	Improve	60.20%	⬆

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

## Referral to Treatment (RTT) Performance

Overall waiting list size stands at 110,924, compared to 109,567 last month.

Long waiters continues to rise with 39,736 over 36 week waiters, The over 52 week waiters has increased to 17,303, showing a continuing worsening position we should expect the length of wait for P4 patients to continue to increase due to the limited capacity available.

The Q3/Q4 plan is indicating approximately 63% of the pre-Covid-19 activity will be delivered.

Theatre activity on all sites has increased in September but the average case per session is approximately 1 case lower than in pre-Covid-19 and is currently 1.67 cases per list. Work is on-going to identify solutions to these issues.

The P risk stratification is continuing to be a risk for the organisation despite the upgrades of the PAS system and is being mitigated by manual counts and reconciliation. It is difficult to implement the Once for North Wales approach whilst this is on-going.

## Diagnostics Performance

Radiology: The number of patients waiting for radiology diagnostics increase from the end of August position- this is primarily driven by an increase in referrals in month (up by almost 2000 cases compared to August) with the biggest proportion in ultrasound. This is part of an ongoing trend following the initial phase of Covid-19. We are continuing to use a combination of additional hours, Spire Yale and insourcing to help address the capacity gap. We are working with the providers to bring in 4 days of additional ultrasound scanning per week and approx. 30 hours of additional MRI capacity through November. We are also bringing a proposal for additional mobile scanning capacity to the planned care group and EMG in the next few weeks.

Although future referral rates are uncertain, we anticipate the upward trend in waiting list size to continue through November but hope to see reductions commencing thereafter.

## Cancer Performance

The number of patients tracked reduced from 3,312 in early March to 1,959 at the beginning of May. Numbers have since increased reaching 3,036 at the end of September

The reduction was mainly due to the fall in GP USC referrals at the start of the pandemic although numbers are now increasing;

The volume and percentage of patients awaiting diagnostics increased from 734 patients (22% of patients on the PTL) at 11<sup>th</sup> March to 931 patients (45% of the PTL) at 3<sup>rd</sup> June due to cessation of some diagnostic services (see below); the number and percentage awaiting diagnostics has since decreased to 809 patients (27% of the PTL) at the end of September as diagnostic services have partially resumed

GP USC vetted referrals fell significantly at the start of the pandemic, falling to 37% of 2019 monthly average in April 2020, but have risen back to 98% of expected levels in July 2020 and 97% in September following a small dip in August (NB provisional September data will increase as upgrades are confirmed)

Lung remains the tumour site with the slowest recovery; this is a national concern and may relate to confusion with COVID symptoms. It may lead to an increase in later stage diagnoses in the coming months

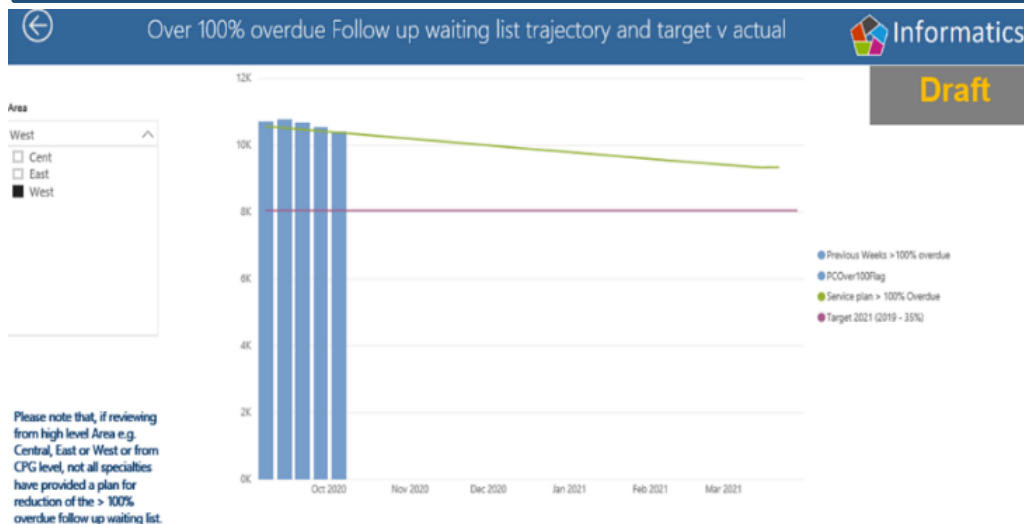
Provisional September figures indicate referrals to breast, gynaecology, upper GI and urology are beginning to rise above average figures. This is placing pressure on services due to reduced capacity due to social distancing measures. Services with historic capacity issues are under increased pressure, in particular: Breast – patients are being transferred to other sites in order to equalise waits which are now up to 6 weeks. Successful radiology recruitment and a review of clinic capacity mean 2 additional clinics in West and Central are due to start in October to reduce waiting times Urology – patients are being transferred to other sites to equalise waits whilst additional capacity is created

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

## Follow-up Backlog Performance

Following the August update trajectories to manage the backlog have been received and are now being monitored (delivery against the trajectories) weekly (in the BCU Performance meeting Access) with some to be validated for resilience and confidence in delivery being undertaken.

Initial outcomes of the approach taken has seen a positive reduction over the past few weeks, this while managing the tip into the breach category.



No	Risk	Mitigation	Progress to date
1	The availability of a video consultation platform to support video consultations	In preparation of the handover in November (informatics to Operational) a Rapid Deployment proposal has been developed and business case created	Business case for rapid deployment in final draft
2	<b>Covid-19</b>		
	Impact of an increase in cases	Deployment of Consultant Connect to support a reduction in first acute outpatient referrals releasing capacity for follow-up	Consultant Connect delayed. Focus now is on getting Primary care to use this product and for secondary care to support the provision of advise and guidance.
	The impact on flow through the estates reducing the face to face / consultant review capacity	Review of estates and mixed face to face and verbal appointment/clinic sessions	On-going assessment and review of estates capacity with an increase plan for Llandudno location being deployed
3	Validation resource to conduct desktop validation	A review of validators and assessment to determine if centralising this resources would secure them and add focus to specific areas inline with largest need	Identification of validation staff being draw to undertake the assessment of centralisation and have a BCU validation team



## Ophthalmology Performance

Eye Care measure performance continues to be impacted by Covid-19 with the reduction in routine elective capacity. The picture reported in BCU is in line with the national picture and presents a risk to eye care patients which will require innovative solutions to mitigate.

In BCU the Eye Care consultants have risk stratified the R1 glaucoma waiting list into red, amber and green in line with College recommendations. Primary Care appointed optometrists are available to undertake enhanced diagnostic tests to support decision making.

A new pathway for primary care appointed optometrists to support diagnostics for diabetic retinopathy continues to be implemented in October to reduce the risk arising from delay for these patients. The training of the 6 Primary Care ODTTC optometrists in glaucoma has been delayed nationally until March 2020, however we are aiming to commence clinical placements from October to build relationships with consultants and increase skills and knowledge of the appointed optometrists ahead of the formal commencement of the higher diploma training programme. IVT injections have continued throughout the covid-19 period and actions are being taken to reduce wait times for these patients through use of non-medical injectors who have returned to their substantive roles. Cataract surgery has restarted, with the waiting list being risk stratified and surgery being prioritised. These patients are R2 and so while waiting for longer are at lower risk of harm than the delays in the medical management of eye care.

Overall the present backlogs in both medical and surgical eye care provision present a high risk for patients, we are expecting demand to grow further as optometrists practices have re-opened and are currently in amber phase 2 . The capacity we have available is and will remain reduced and therefore clinical risk stratification and full use of the multi-professional workforce and clinical pathways will be required to mitigate some of this risk, together with investment in expanded service provision to address the backlog of patients and the sustainable service model. The Digital eye care plan is a key enabler to support this model of working and is most welcome but will take around 12months to roll out to BCU.

## 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.

## Key Messages

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

Staff have responded well to the demands placed upon them

Continued reduction in Agency/ locum spending in a challenging environment

## Measures

Period	Measure	Target	Actual	Trend
Sep-20	Personal Appraisal and Development Review (PADR)	>= 85%	68.63%	↑
Sep-20	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	>= 85%	83.02%	↓
Sep-20	Percentage of sickness absence rate of staff	< 5%	5.56%	↑

# Quadruple Aim 3: Narrative – Workforce

## PADR

PADR overall compliance is steadily increasing month by month, it has now improved by 3% since June 2020 and continues to recover towards pre-pandemic levels.

However some large divisions such as Estates & Facilities and North Wales Wide Hospital services have seen a decrease from previous months.

To support these divisions with the longer term sustainability, the OD team is meeting with Directors and senior managers to understand the barriers and issues faced and to support corrective action. This will be an opportunity to share best practice in terms of how other divisions are maintaining and improving compliance.

Of note are the numbers of areas with large numbers of “amber” staff. Consideration will need to be given to balancing the need for individual feedback and an opportunity to discuss development with the time taken to prepare and conduct a full PADR. This is particularly relevant moving into winter and potential impact of COVID.

## Sickness Absence

The BCU overall total sickness absence rate (12 month rolling) has fallen for the third consecutive month at 5.56%.

Non-Covid-19 related sickness absence has increased marginally this month, however the September 2020 figure of 4.6% is half a percent better than the same period last year (5.1% September 2019).

Covid-19 related sickness has fallen from a high of 2% in May to 0.3% in September. However, this is likely to increase as cases increase.

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

To mitigate winter impact staff Flu vaccinations are a priority. In the first 10 days of this Flu campaign over 6,000 staff have been vaccinated. Target is at least 75% of staff, BCU is on target with 34% vaccinated in 10 days.

Staff Wellbeing Support Service (SWSS) is in place to support mental wellbeing throughout the Covid-19 period

## Mandatory Training

Level 1 compliance rates have decreased and are now at 83%, marginally short of 85% target. Detailed non-compliance reports have been shared with the subject matter experts who are chasing improvements in all ten nationally reported level 1 subjects.

There has been a significant drop of 4% (BCU) within Mental Capacity Act compliance. YMW, Women's & Corporate have all dropped more than 5% month on month, NWMCS has dropped more than 10%. A detailed list of non-compliance related to Mental capacity training has been forwarded to areas decreasing. Support has been offered to all Mandatory training subject leads.

Further development of a blended approach to delivering training is being prioritised. Examples are; People and Load Handling is being amended to enable part of the classroom training to move into a virtual classroom environment along with the creation of video links to support their training curriculum, a local E-learning module for Health and Safety training is under development.



**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.

### Key Messages

Patients and families supported stay in touch via innovation and technology while in hospital

Consultant Connect initial feedback and utilisation received

Funding released for Digital Eye Care programme

### Measures

Period	Measure	Target	Actual	Trend
Sep-20	Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	TBA	28.50%	↓
Q1 20/21	Percentage of critical care bed days lost to delayed transfer of care (ICNARC definition)	Reduce	5.60%	↑
Sep-20	Agency spend as a percentage of total pay bill	Reduce	6.00%	↑

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

# Quadruple Aim 4: Narrative – Agency Spend

## Agency Spend as % of Total Spend

Key points are:

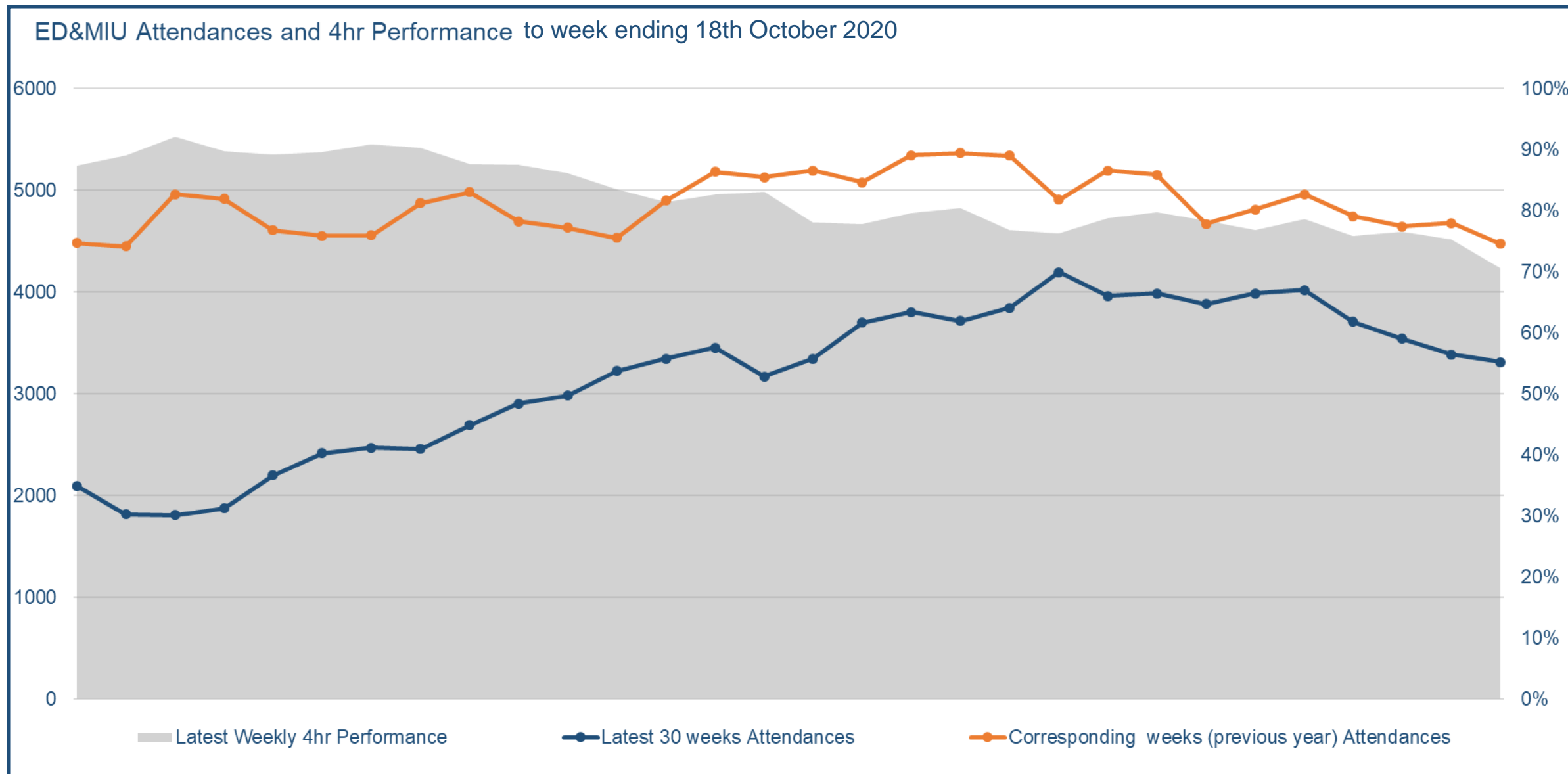
Non core spend has decreased in September compared to August (-£1,091,000) and is also lower than this period last year. In the last month M&D non core has increased by £103,000 , N&M non-core has decreased by £84,000.

- Agency spend as a percentage of total spend has decreased with Bank spend percentage increasing this month.
- Agency spend percentage is 1% lower than the comparable period last year.
- Agency M&D is up on last month but within the range for the previous 5 months. East Area, YG, YWM, NWMCS and Women's seeing increases with corresponding reductions in Additional clinical sessions/bank for East, YGC, YWM, NWMCS and MHLD
- An increase in N&M bank percentage spend month on month has seen a corresponding decrease in N&M Agency percentage spend.
- The most significant reductions in Agency spend have occurred in Agency Admin & Clerical, this is mainly in the new Test, Trace and Protect area where there has been substantive recruitment and also journal adjustments have been made to the ledger for this area.

Actions to address:

- Filling substantive vacancies – BCU overall vacancy rate is marginally over the 8% target at 8.2%, however there are still shortages in key staff groups. Most significantly BCU has 60fte consultant vacancies. An action plan has been developed to increase the speed and effectiveness of M&D recruitment. The TRAC recruitment system and Establishment Control process are being joined into a concurrent process of inputting Trac vacancies at the point of the EC being raised. Actions taken to speed M&D recruitment have seen time to hire reducing over the last five months. Support is being focussed on hard to fill vacancies including wide reaching social media campaigns. N&M vacancies are still of concern with 541fte Band 5 vacancies. A dedicated N&M Recruitment and Retention working group has developed a Nursing Recruitment and Retention work plan, sub-groups are enacting this with progress being reported monthly to the steering group.
- Reducing sickness absence – BCU sickness rate (12 month rolling) fallen for the third month. Non-Covid-19 sickness absence (Sept 2020) at 4.6% is half a percent better than the same period last year (5.1% September 2019). Covid-19 related sickness has fallen from a high of 2% in May to 0.3% in September. Workforce & OD teams including HR managers continue to focus on hotspot areas and on complex cases. Flu vaccinations are a priority, BCU is on target to achieve 75% or more vaccinated. Staff Wellbeing Support Service (SWSS) is in place to support mental wellbeing throughout the Covid-19 period
- 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 428 'bank only' N&M registered staff now registered to internal bank, up from 307 in March. M&D - Medical Staff Bank (MSB) - Recruitment to MSB has seen large increase in 'bank only' workers with 231 'bank only' Medical Staff Bank registered staff, up from 138 in March. In September 2020 17,353 hours of MSB registered bank work was delivered, the highest single month total since MSB was introduced around 12 months ago.

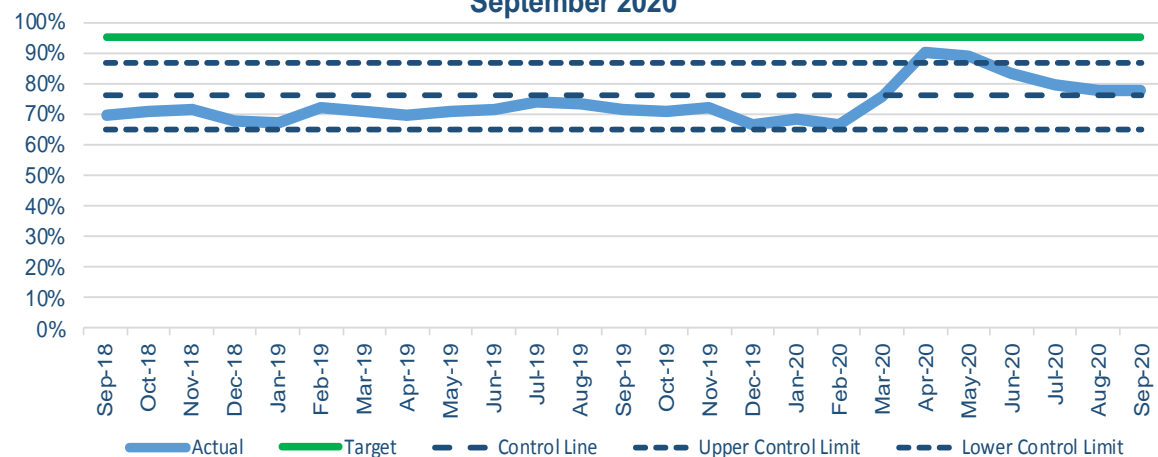
# Quadruple Aim 2: Unscheduled Care: Attendances



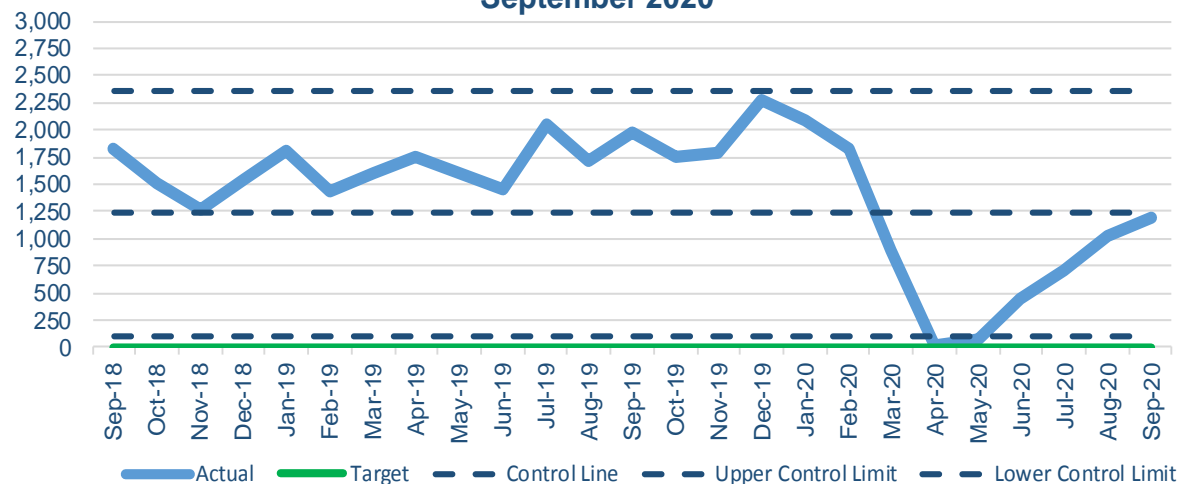


# Quadruple Aim 2: Charts Unscheduled Care Page 1

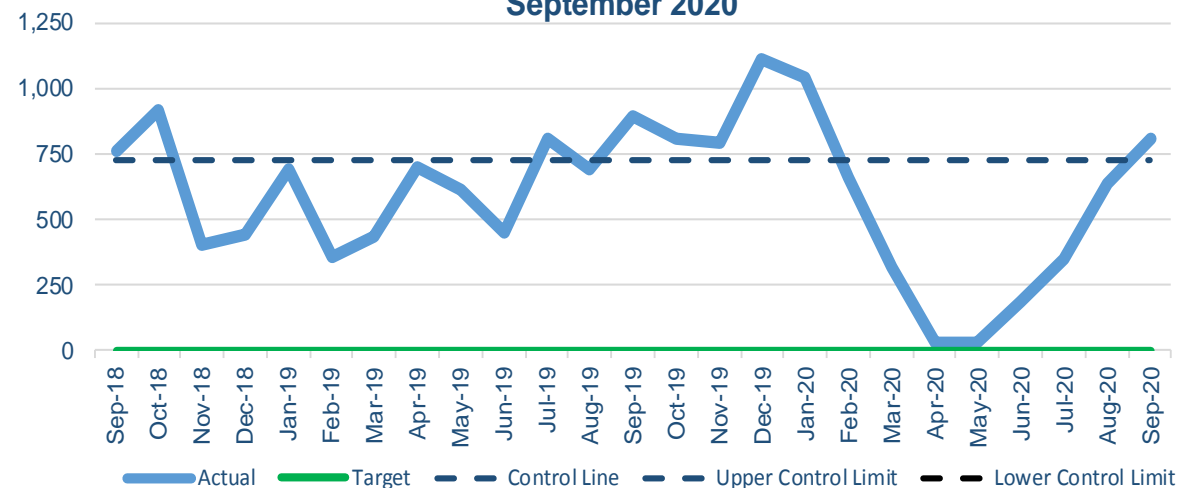
BCU Level - Emergency Department (inc MIU) 4 Hour Waits:  
September 2020



BCU Level - Emergency Department 12 Hour Waits:  
September 2020

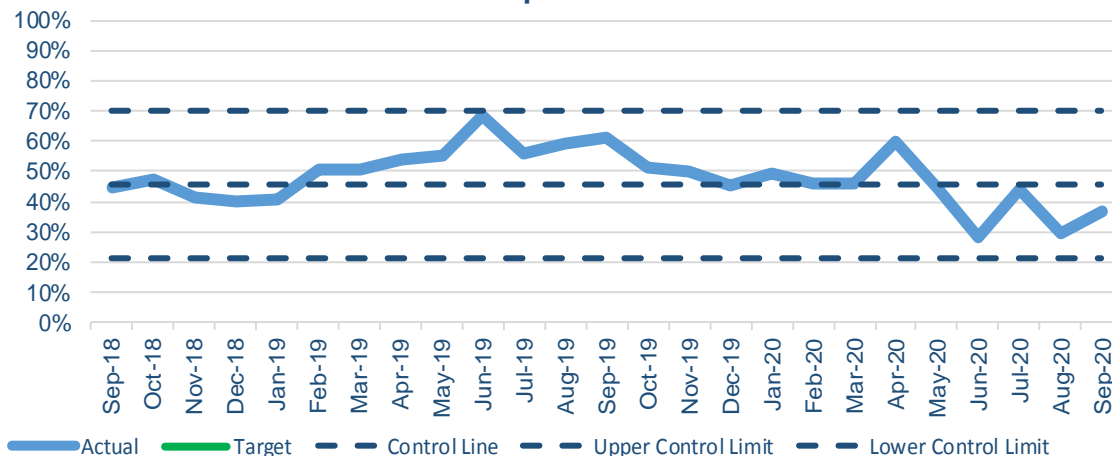


BCU Level - Ambulance Handovers over 1 Hour:  
September 2020

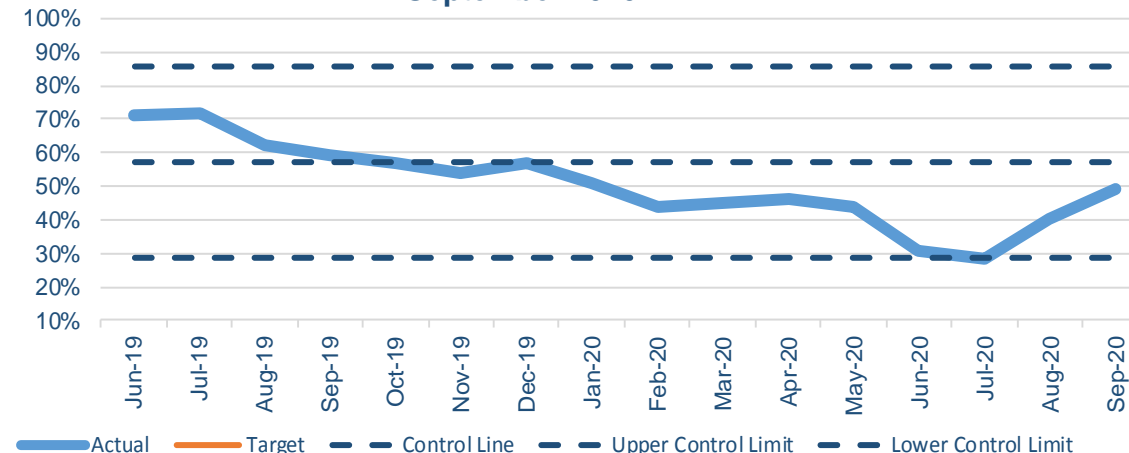


# Quadruple Aim 2: Charts Unscheduled Care Page 2

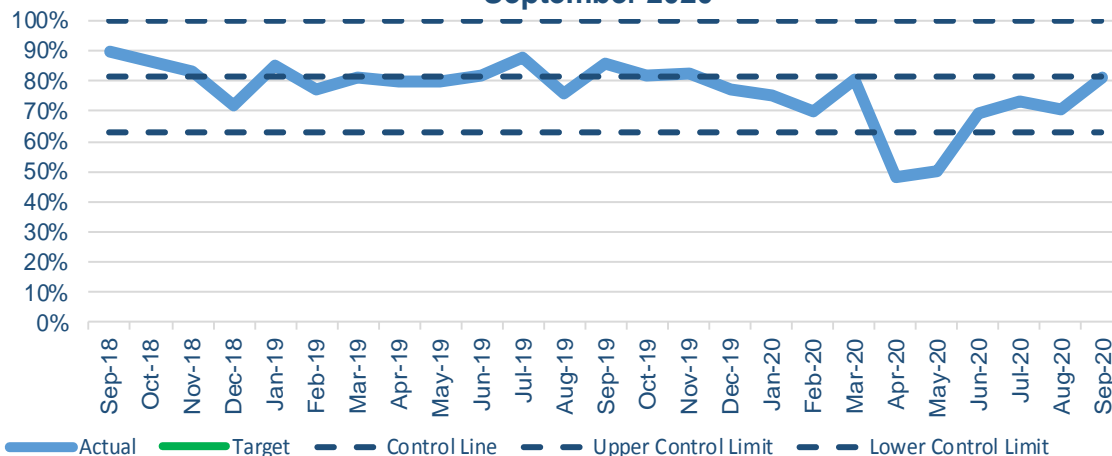
**BCU Level - Stroke Care - Admissions within 4 Hours:**  
**September 2020**



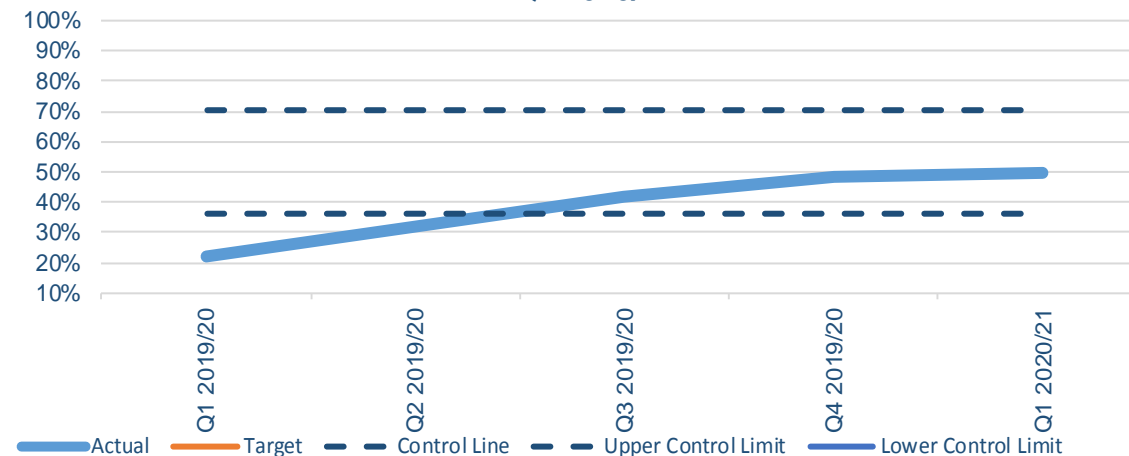
**BCU Level - Stroke Care - Appropriate SALT Time:**  
**September 2020**



**BCU Level - Stroke Care - Consultant Assessed within 24 Hours:**  
**September 2020**



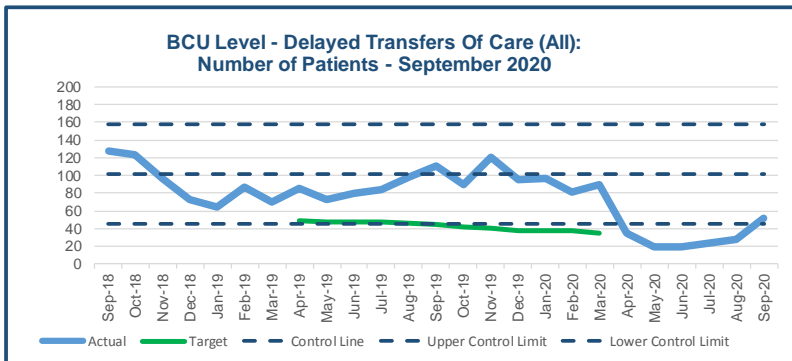
**BCU Level - Stroke Care - 6 Month Follow Up:**  
**Q1 2020/21**



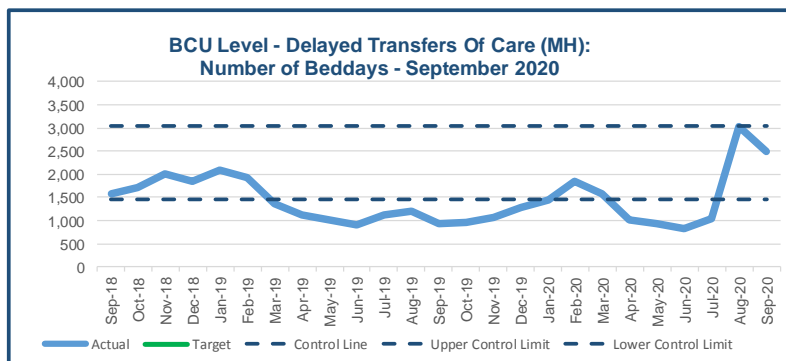
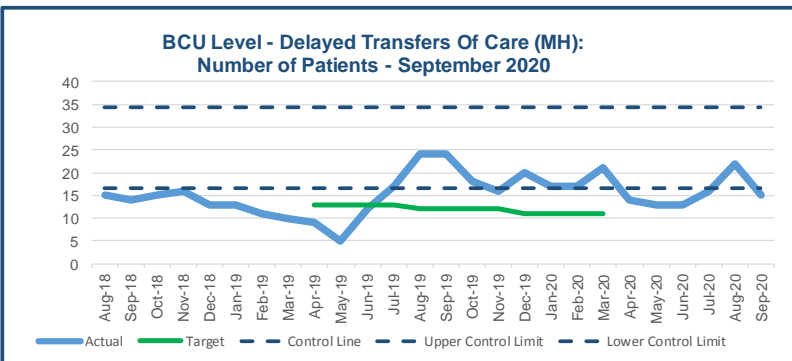
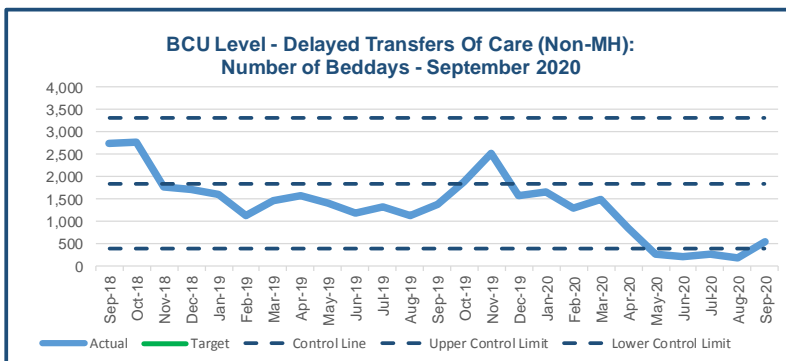
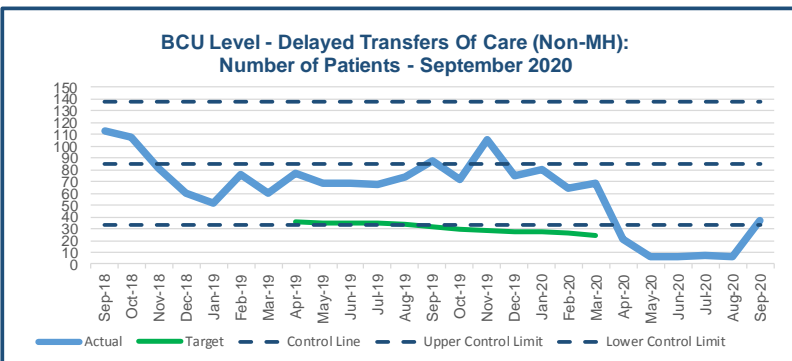
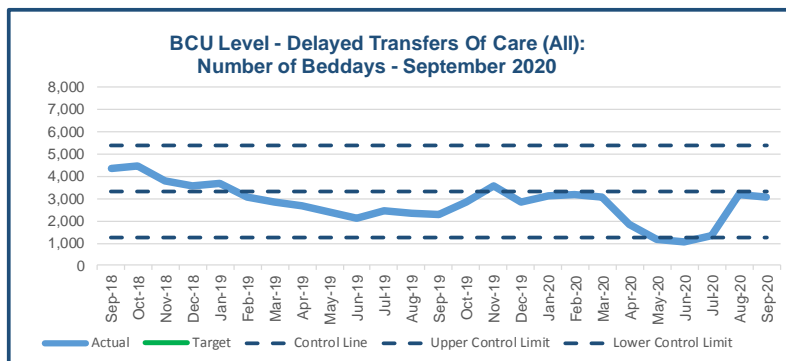


# Quadruple Aim 2: Charts Unscheduled Care page 3

**Delayed Transfers of Care (DToC) Number of Patients**

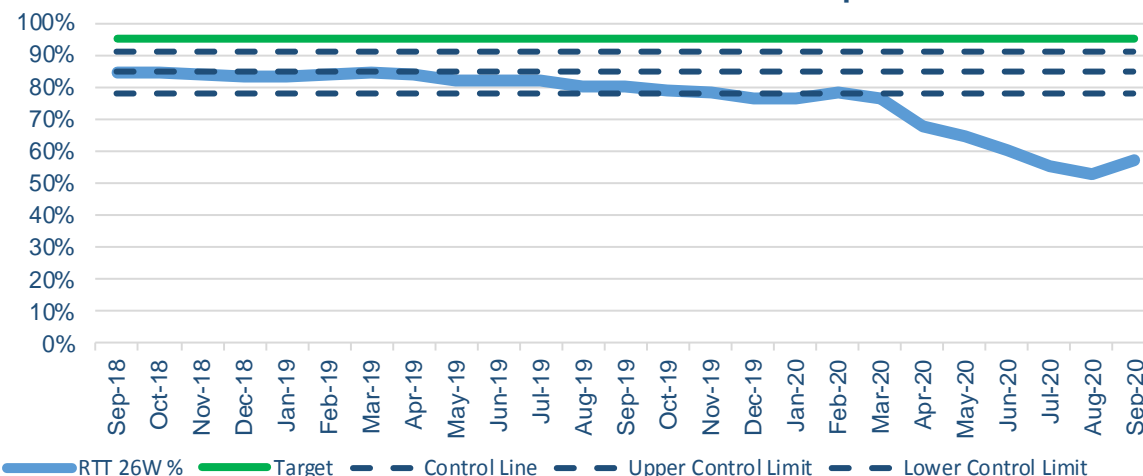


**Delayed Transfers of Care (DToC) Number of Beddays**

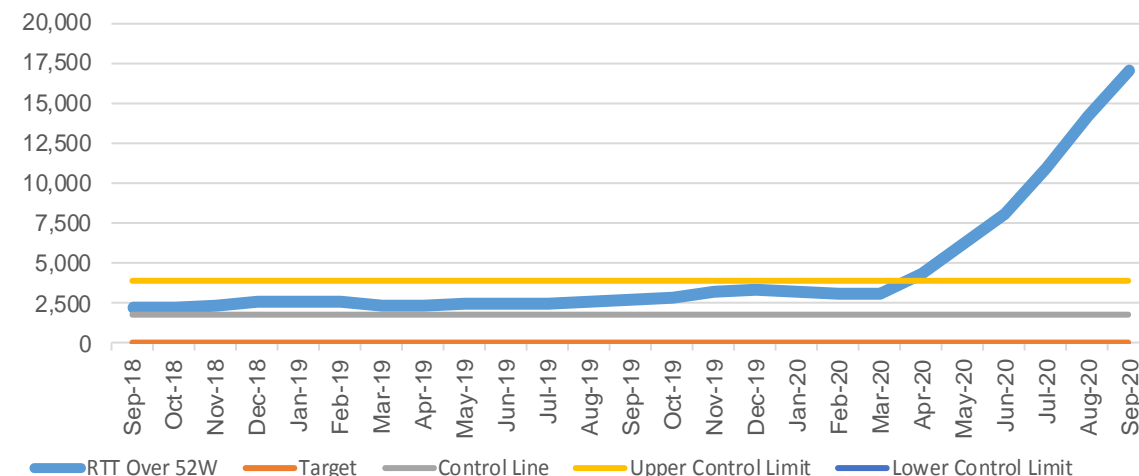


# Quadruple Aim 2: Charts Planned Care page 4

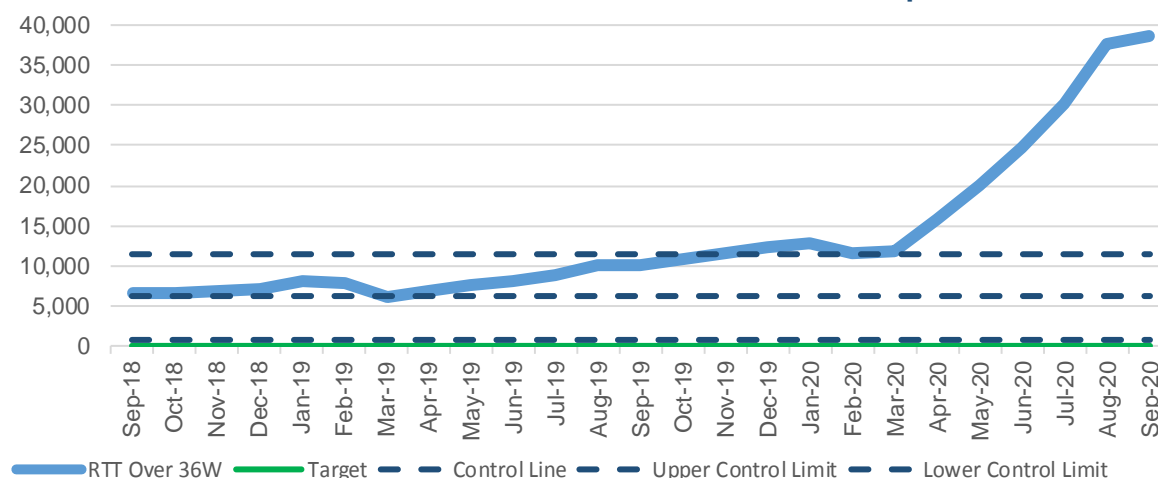
BCU Level - RTT Waits % <= 26 Weeks: September 2020



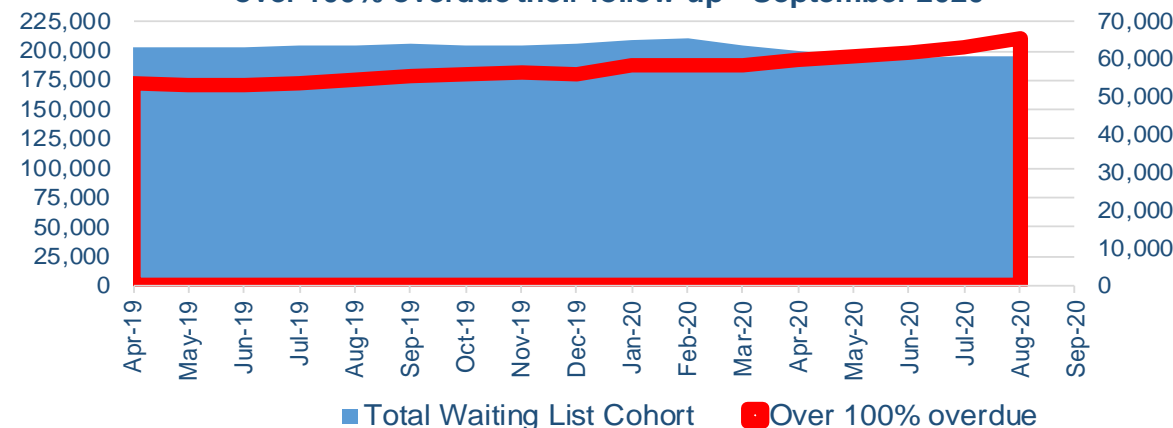
BCU Level - RTT Waits Number > 52 Weeks: September 2020



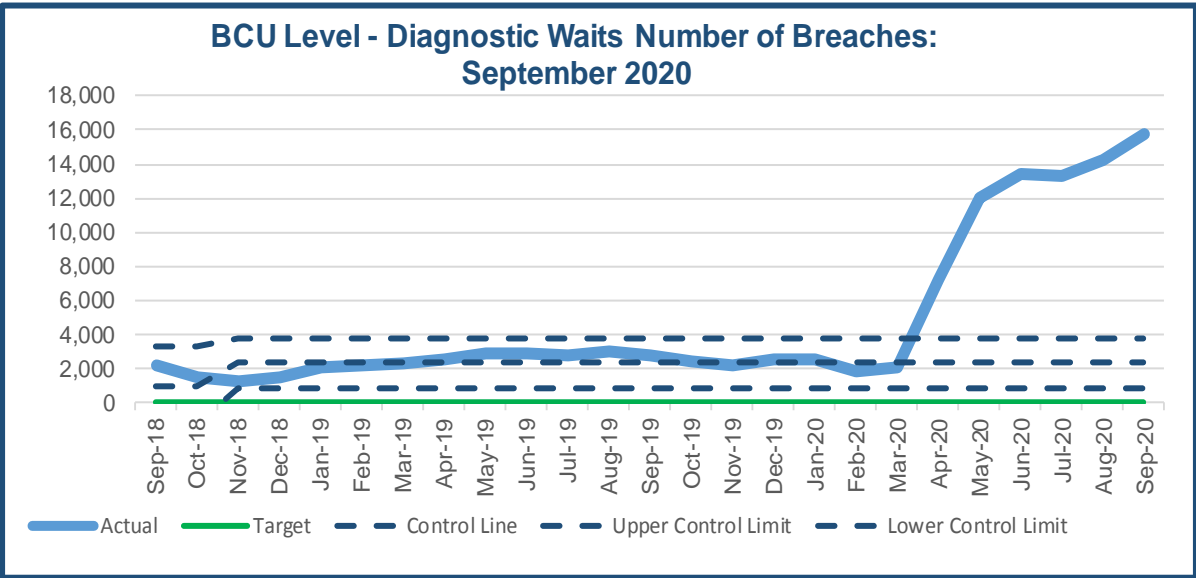
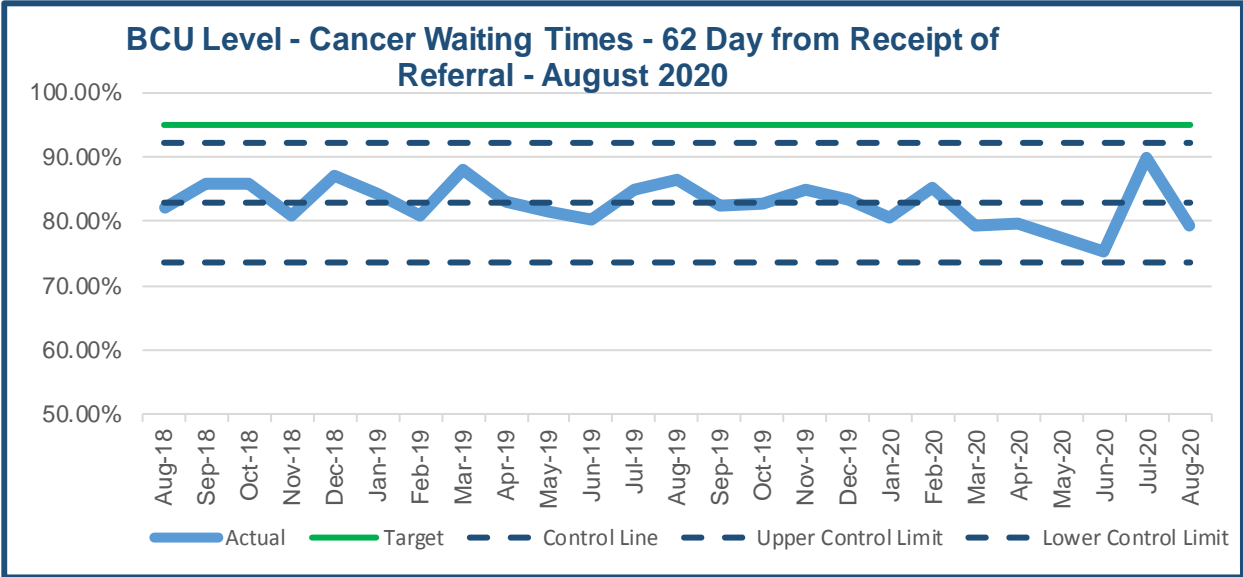
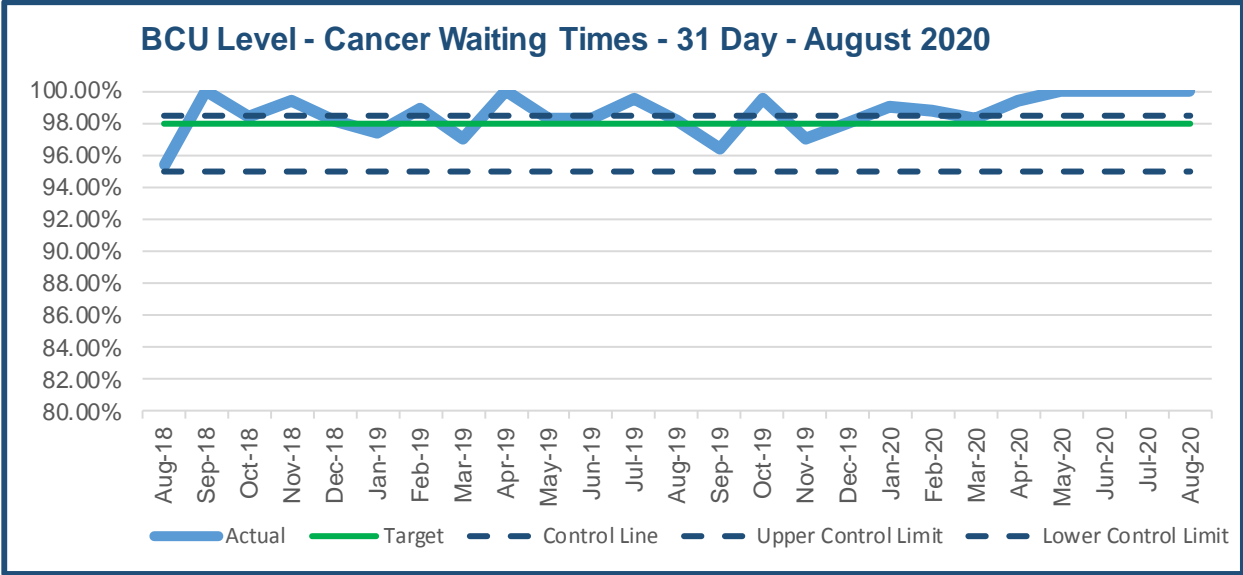
BCU Level - RTT Waits Number > 36 Weeks: September 2020



BCU Level - Total Waiting List cohort with Number of patients over 100% overdue their follow up - September 2020



# Quadruple Aim 2: Charts Planned Care page 6

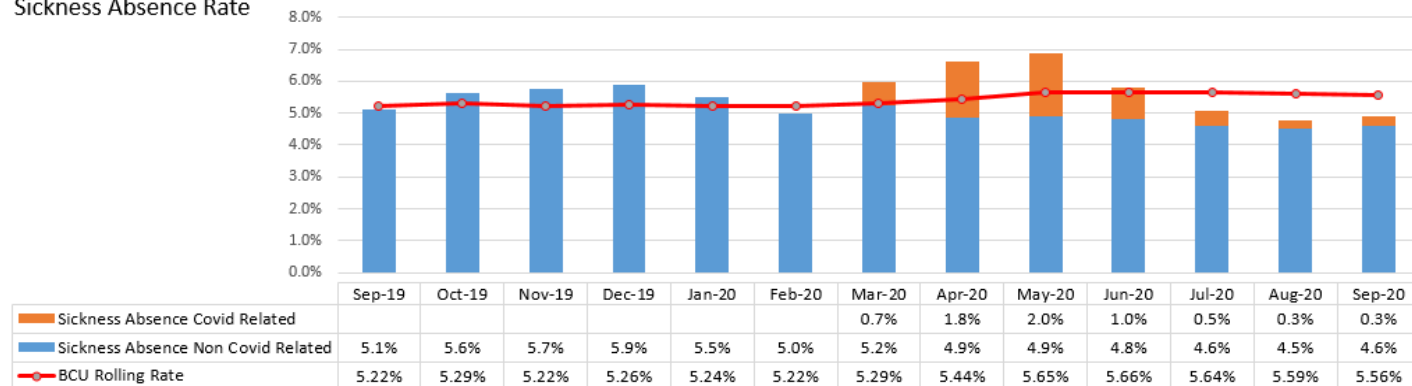






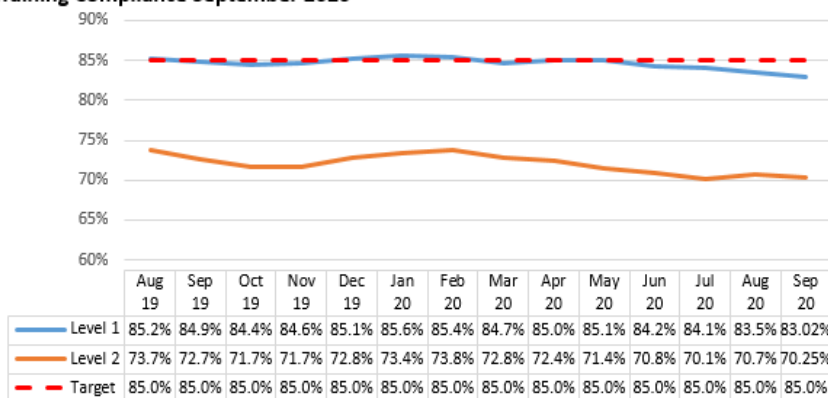
## Sickness absence Rates

Sickness Absence Rate

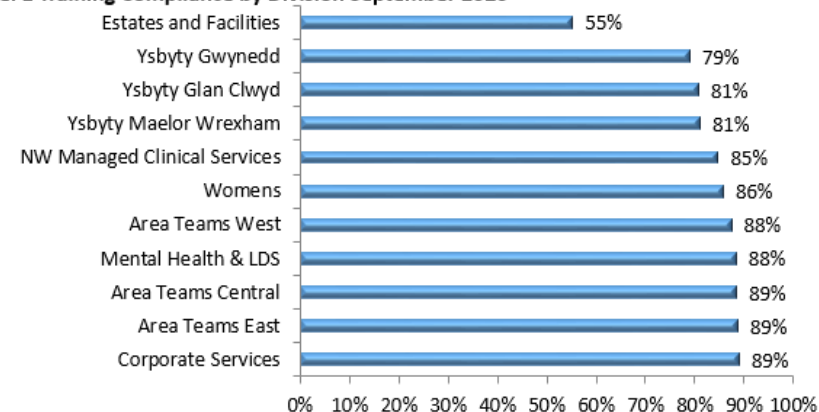


## Core Mandatory Training Rate

Training Compliance September 2020

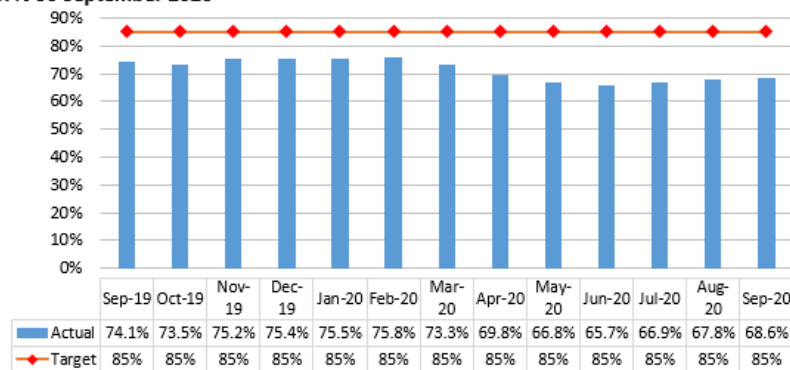


Level 1 Training Compliance by Division September 2020

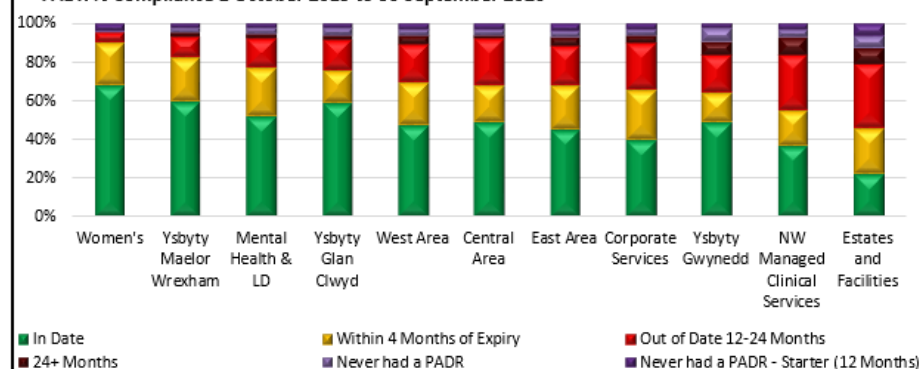


## PADR

PADR % 30 September 2020



PADR % Compliance 1 October 2019 to 30 September 2020

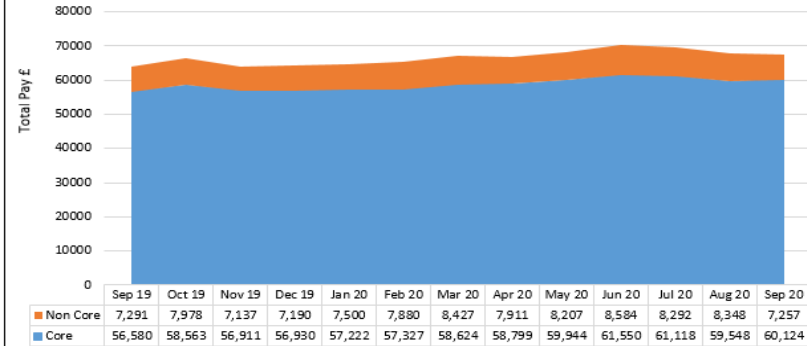


September 2020

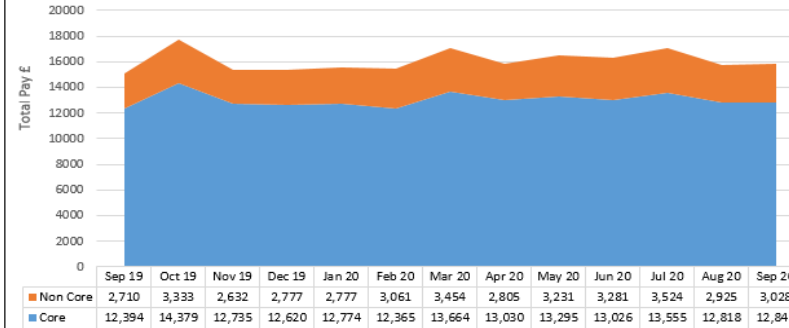
# Quadruple Aim 4: Narrative – Agency Spend

## Agency Spend as % of Total Spend

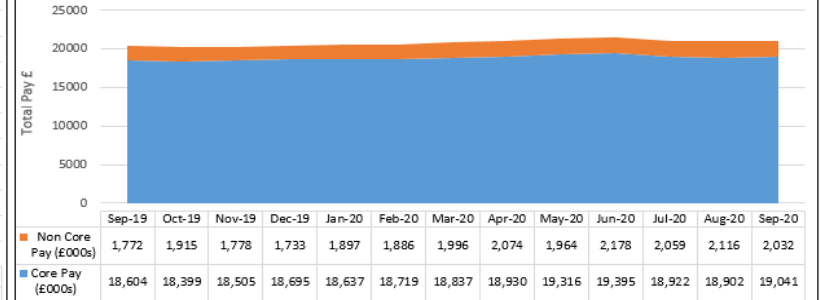
BCUHB Pay Core vs Non Core (£000s)



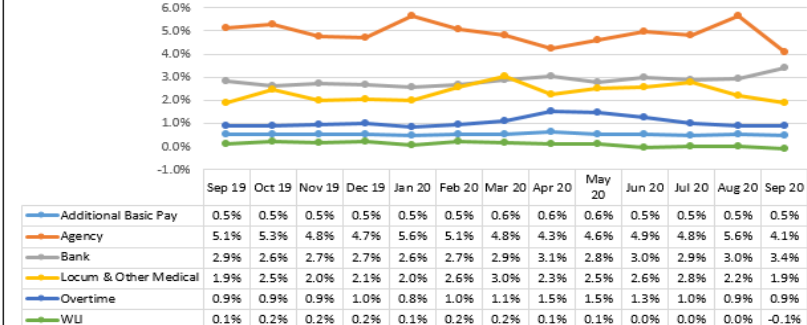
Medical & Dental Pay Core vs Non Core (£000s)



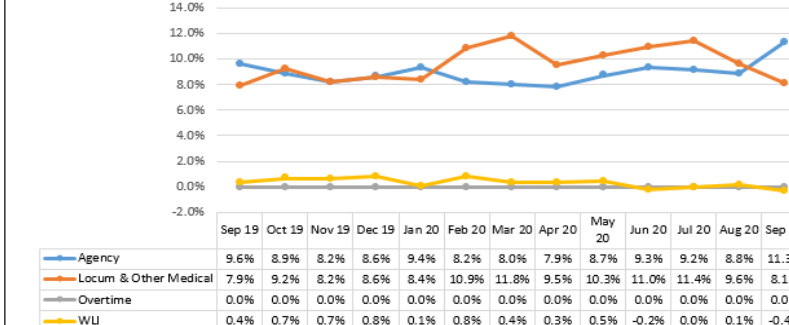
Nursing & Midwifery Pay Core vs Non Core (£000s)



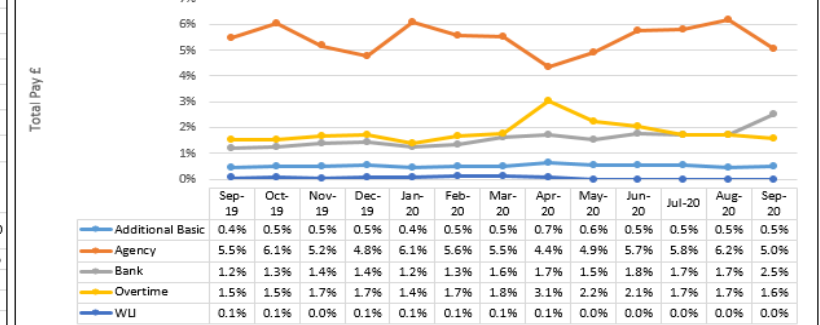
BCU Non Core Pay % of Total Spend



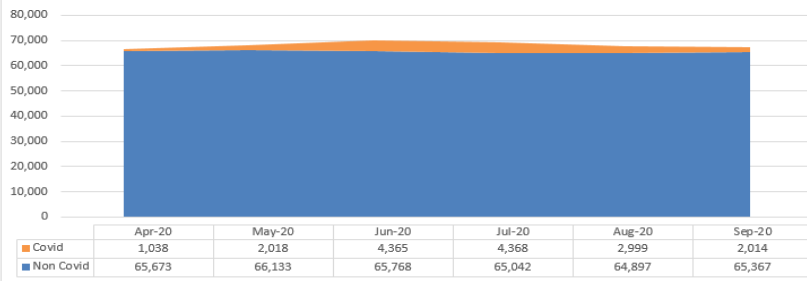
M&D Non Core Pay % of Total Spend



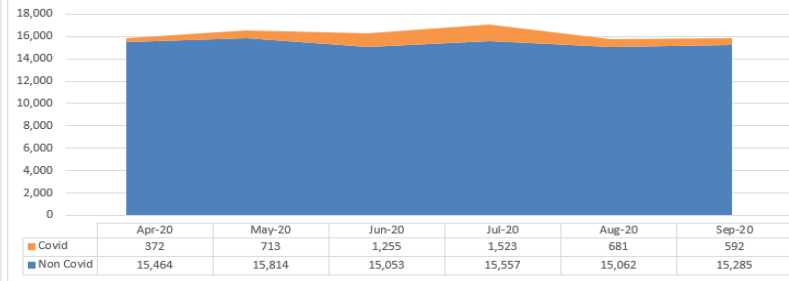
% Total Pay Spend for Nursing & Midwifery



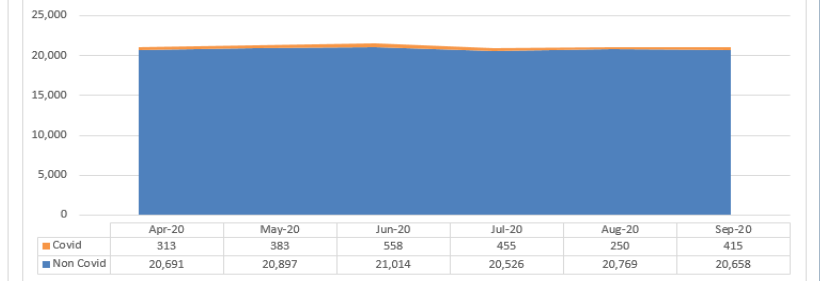
BCUHB Covid v Non Covid Spend (£000s)



Medical & Dental Covid v Non Covid Spend (£000s)



Nursing & Midwifery Covid v Non Covid Spend (£000s)



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

- performance reference tables
- tolerances for red, amber and green

Further information on our performance can be found online at:

- Our website [www.pbc.cymru.nhs.uk](http://www.pbc.cymru.nhs.uk)  
[www.bcu.wales.nhs.uk](http://www.bcu.wales.nhs.uk)
- Stats Wales [www.statswales.wales.gov.uk](http://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>

<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance &amp; Performance Committee 29.10.20</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Elective Orthopaedic Services briefing paper						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Mark Wilkinson Executive Director Planning and Performance / Senior Responsible Officer - Delivering Sustainable Elective Orthopaedic and Musculoskeletal (MSK) Services Programme Business Case						
<b>Awdur yr Adroddiad Report Author:</b>	Neil Windsor – Orthopaedic Network Delivery Manager						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Verbal update to Planned Care Transformation Group						
<b>Atodiadau Appendices:</b>	n/a						
<b>Argymhelliad / Recommendation:</b>							
<p>It is recommended that the Committee notes :</p> <ul style="list-style-type: none"> <li>the rationale for the potential revision of the current orthopaedic case, including the contextual drivers for change.</li> <li>the engagement strategy undertaken with the clinical teams and the subsequent option appraisal conducted.</li> <li>the alternative model clinically agreed and proposed following full consideration of the emerging Diagnostic &amp; Treatment Centre (DTC) model.</li> <li>the proposed timescale for the completion of a revised orthopaedic business case.</li> </ul>							
Please tick as appropriate							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>	√	<b>Er gwybodaeth For Information</b>	√
<b>Sefyllfa / Situation:</b>							
<p>The purpose of this briefing paper is to provide an update around the development of a long-term clinical model for Orthopaedic delivery across North Wales and the timescales for the subsequent translation of the proposed model into a formal Orthopaedic business case. The paper references the approach undertaken to ensure appropriate levels of clinical engagement, the options reviewed as part of the appraisal process and the subsequent emerging clinical preference.</p>							
<b>Cefndir / Background:</b>							
<p>Following a series of clinical workshops, culminating in a formal option appraisal in autumn 2017, the “Delivering Sustainable Orthopaedic &amp; Musculoskeletal (MSK) Services, a Pathway Approach” business case proposed the continuation of a three-site District General Hospital (DGH)-led long-term Orthopaedic model, which would repatriate activity from Abergele and Llandudno back onto the acute sites. The business case was costed at over £62m, and required the non-recurrent provision of</p>							

revenue funding for backlog clearance, recurrent revenue funding for additional core capacity and capital investment to support the repatriation ambition from Abergele and Llandudno.

The plan assumed significant ability to ring-fence elective Orthopaedic capacity, making it immune from Unscheduled Care bed demand.

Consequently, the Health Board has been in discussion with Welsh Government around long-term financial support for the plan and to date, £1.7m has been released, largely to support the recruitment of an additional six Orthopaedic Consultants, providing recurrent revenue support for additional core capacity.

However, in the intervening period, winter pressures have challenged our perceived ability to successfully ring-fence elective capacity, with Orthopaedic activity compromised by unscheduled care demand in Q3/4 2019/20. Also, the current Covid-19 pandemic has resulted in the significant loss of activity from a service perceived as benign. Recent clinical conversations have therefore challenged whether the original model remains fit for purpose and the framework for an alternative model which splits hot and cold activity has been proposed.

A series of clinical engagement meetings have subsequently taken place to test the clinical appetite for an alternative hot/cold split approach, in conjunction with the full consideration of the Health Board's emerging Diagnostic & Treatment Centre model. This has resulted in the clinical appraisal of a new set of options which potentially challenges the current business case.

### **Asesiad / Assessment & Analysis**

Over the past few weeks, face-to-face clinical engagement meetings have been initiated on each site, led by the North Wales Orthopaedic Network Delivery Manager, Head of Planned Care and Orthopaedic Clinical Lead. These discussions have been both positive and constructive with a formal critique of emerging options, including: -

Option 1 – Continuation of Pre-Existing Business Case

Option 2 – Regional Orthopaedic Centre excluding DTC option

Option 3 – Ambulatory Orthopaedic DTC model with Elective Orthopaedic Inpatient Hub

Option 4 – DTC model with short-stay bed capacity

As a result of the option appraisal, the model generating the most clinical support was Option 4, with a high-level of support from East and West clinicians, with Ysbyty Glan Clwyd (YGC) yet to declare a preference. The provision of a DTC-model with ring-fenced bed capacity would allow the majority of Orthopaedic cases to be provided outside of an acute hospital setting, with Trauma and complex joint replacements remaining on a DGH site. This delivers the hot and cold split model recommended by Getting It Right First time (GIRFT) and delivered by many sites in England over the last few years.

This is seen as a 3-5 year backlog reduction strategy, with a long-term solution developed by the Orthopaedic Network in the interim, which may include the recommendation of permanent DTC capacity, DTC capacity with a Regional Surgical Complex Inpatient Treatment Centre, or a stand-alone Elective Orthopaedic Treatment Centre (EOTC). The plans contained within the current business case could be a 'stepping stone' to any of these potential futures.

Confirmation of the clinical opinion in YGC will now be obtained and a revised Orthopaedic Business Case based on the new option appraisal will be developed (including post-Covid capacity & demand

remodelling) and submitted to F&P Committee for formal review, before end March 2021 (and dependent on progress being made with the DTC proposal).

**Strategy Implications**

The paper aligns to the referral to treatment national target, operational plan and financial balance.

**Financial Implications**

Changes in the long-term strategic vision will require a refresh of the Orthopaedic business case and re-engagement with Welsh Government in relation to long-term investment into a sustainable model for Orthopaedic service delivery.

**Risk Analysis**

Risks associated with the proposal will be covered as part of the wider risk assessment of the Orthopaedic Business Case.

**Legal and Compliance**

No legal implications.

**Impact Assessment**

n/a

Finance and Performance Committee  
Briefing Paper on Elective Orthopaedic Services

**Purpose**

The purpose of this paper is to provide a briefing to the Health Board on our progress in developing an alternative clinical model and subsequent business case, for long-term Orthopaedic service delivery across North Wales.

**Background**

Following extensive clinical engagement and a formal option appraisal, a model for the long-term delivery of Orthopaedic services in North Wales was proposed in autumn 2017, which formed the basis of the “Delivering Sustainable Orthopaedic & Musculoskeletal (MSK) Services, a Pathway Approach” business case. This business case advocated the maintenance of a traditional DGH-level, ‘hot and cold’ combined Orthopaedic delivery model, which supported the repatriation of elective activity from previous ring-fenced capacity in Abergele and Llandudno. The business case was costed at over £62m, split between non recurrent revenue for backlog reduction, recurrent revenue for additional core capacity and capital investment for additional theatre and bed capacity in both Ysbyty Glan Clwyd and Ysbyty Gwynedd, to support repatriation plans. The entire model was based on an assumption that the Health Board could adequately ring-fence elective Orthopaedic capacity, in order for it to be immune from the effects of unscheduled care demand. In response, only £1.7m has been invested by Welsh Government to date, to provide additional support with Clinical Musculoskeletal Assessment & Treatment Service (CMATs), early capital design works and the appointment of six additional Orthopaedic Consultants across North Wales.

**Drivers for Change**

In the intervening period since the proposal, questions have been raised in terms of whether it remains fit for purpose and following an Orthopaedic workshop in early August 2020, a framework for an alternative clinical model emerged, which advocated the formal separation of “hot and cold” Orthopaedic activity. From a clinical perspective, there were two key drivers for this change: -

1. The impact of winter pressures on Orthopaedic capacity, with a significant proportion of activity in Q3/4 continually compromised by unscheduled care demand.
2. The impact of Covid-19 and the subsequent loss of elective activity from a service perceived as ‘benign’.



Therefore, these issues (particularly the recurrent issues cited in driver 1) question a plan reliant on our ability to adequately protect elective Orthopaedic activity on our acute sites.

### **Strategic Context**

At a UK and National-level, there has been a marked shift in strategy towards approaches which support the segregation of hot and cold activity, since the development of the original plan. The “Getting It Right in Orthopaedics – Reflecting on Success & Reinforcing Improvement” Report (February, 2020), references several examples of transformative service redesign through the establishment of hot and cold sites, which have delivered reductions in length of stay, reductions in cancellations day of surgery and increased elective activity, despite winter pressures (Kings College Hospital NHS Foundation Trust; United Lincolnshire Hospital NHS Trust; Royal Cornwall Hospitals NHS Trust; Gloucestershire Hospitals NHS Foundation Trust; East Kent Hospitals University NHS Foundation Trust; Southport & Ormskirk Hospital NHS Trust; University Hospitals Plymouth NHS Trust; Maidstone & Tunbridge Wells NHS Trust; Royal Free London NHS Foundation Trust). Similarly, the Department of Health in Northern Ireland have recently launched their blueprint document “Rebuilding, Transition and Transformation of Elective Orthopaedic Care (July, 2020), which advocates a similar approach. In Wales, recent discussions within the National Orthopaedic Board suggest an appetite at Welsh Government-level, for the development of more regional Elective Orthopaedic centres.

Within BCU, the emergence of the Diagnostic & Treatment Centre model has further questioned the business case and could deliver an alternative pathway which (at a minimum) provides a mechanism to split hot and cold ambulatory care activity. Consequently, discussions around the viability of a DTC model within a new Orthopaedic framework have resulted in the formal consideration of the DTC model as part of a wider clinical review of our current strategic intent. This has formed the basis of an engagement strategy, around potential alternative options for our own internal transformative redesign of Orthopaedics.

### **Clinical Engagement & Option Appraisal**

Over the past few weeks, the North Wales Orthopaedic Network Delivery Manager, Head of Planned Care and Clinical Lead for Orthopaedics across North Wales have initiated a series of face-to-face clinical engagement meetings, to test the assumption that the pre-existent business case requires refinement and to introduce the concept of the DTC, as part of a small and discrete alternative option appraisal. These engagement events have been extremely well attended on all three acute sites and formed a highly constructive and positive clinical conversation. The options appraised during these meetings included: -

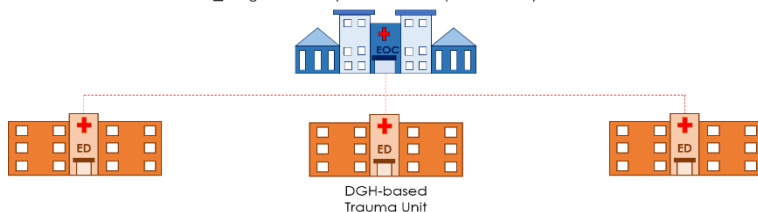
## Option 1 – Continuation of Pre-Existing Business Case

### 1 x3 Site DGH Model (with repatriated activity from Abergele & Llandudno)



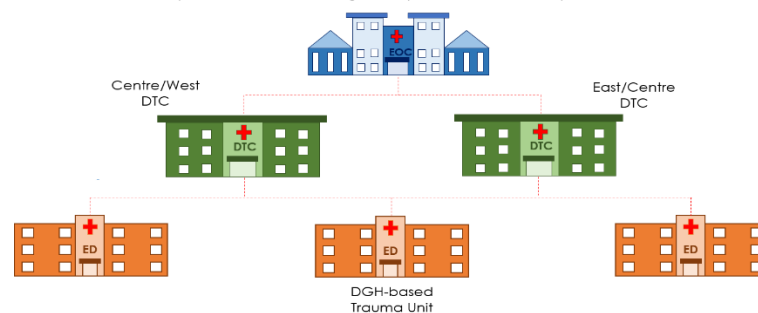
## Option 2 – Regional Orthopaedic Centre excluding DTC option

### 2 Regional Orthopaedic Centre (with no DTC)



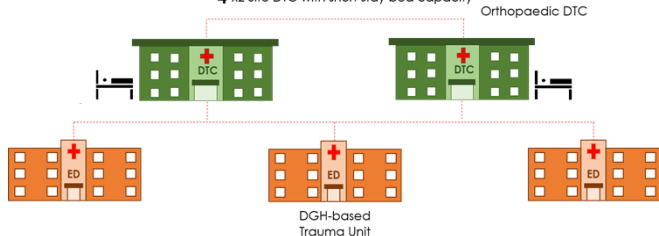
## Option 3 – Ambulatory Orthopaedic DTC model with Elective Orthopaedic Inpatient Hub

### 3 x2 site Ambulatory DTC with additional Regional Inpatient Elective Orthopaedic Treatment Centre



## Option 4 –DTC model with short-stay bed capacity (complex patients ASA 4s\* to remain on DGH site)

### 4 x2 Site DTC with short stay bed capacity



\*ASA 4 – American Society of Anaesthesiologists 4 (a scoring system to determine patient fitness prior to surgery)

### Emerging Immediate Clinical Model

Following the engagement events on all three sites, the model generating the most clinical support was Option 4. In particular, this was the dominant preference of Clinicians in East & West, with Central yet to formally declare a preference.

Whilst appreciating potential issues re: the provision of bed capacity within a DTC, it was felt other models exist (Orthopaedic DTC at Royal Bournemouth Hospital) which successfully segregate DTC and DGH capacity at all times. However, another popular alternative was to develop the units within a non-acute footprint.

In proposing this model, there is an expectation that a large proportion of elective activity could be undertaken within the DTC, with a far smaller footprint required on a DGH site for Trauma and complex ASA 4 patients. Fig 1 below shows the potential pathway: -

**Fig 1 – Orthopaedic Delivery by Option 4**

Ambulatory DTC	Short-Stay Bed Capacity	DGH Site
Anterior Cruciate Ligament (ACL) reconstruction	Fast Track Arthroplasty	ASA 4's (+ some 3's)
Therapeutic Arthroscopy of Shoulder	Uni Knees	Trauma
Achilles Tendon Repair	Complex Hindfoot	
Forefront & Midfoot procedures	Complex Handwork	
Hand Surgery		

### Long-Term Approach

There was a common opinion that the option proposed should form the basis of a first phase approach to long-term Orthopaedic delivery, supporting the need to deliver extensive backlog reduction over the next 3-5 years, within dedicated and ring-fenced capacity. Once backlog has stabilised, the regional network has matured, newly commissioned pan-BCU sub-specialty pathway redesign programmes have delivered and post-pandemic requirements are understood, the network will obtain a consensus for and propose a sustainable, long-term solution. This may include the permanent provision of DTC-type capacity or the shift to either a regional cold-site Orthopaedic Elective Treatment Centre or as part of a regional cold-site Surgical Elective Treatment Centre, dependant on the future vision of the organisation.

### Next Steps

A formal response from the clinical team in the Centre will be obtained and a revised Business Case will be prepared (with post-Covid demand and capacity remodelling), to be submitted to Finance & Performance Committee before end of March 2021.

### Timeline

Orthopaedic Business Case	Date	Diagnostic & Treatment Centre	Date
Business Case Briefing Paper to F&PC	Oct-20	Pre Strategic Outline Case to F&P	Oct-20
Business Case Briefing Paper to Execs	Oct-20	Pre Strategic Outline Case to Execs	Oct-20
Orthopaedic DTC Outline	Dec-20	Full Strategic Outline Case	Nov-20
Full Business Case	Mar-21	Outline/Full Business Case	Dec-20
		WG Decision	Dec 20 /Jan-21
		Contract Awarded	Jan/Feb-21
		Commission, Installation & Start-Up of DTC	Feb/Oct-21

### Recommendation

The Finance and Performance Committee is asked to receive this report.

<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Unscheduled Care and Building Better Care						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Gavin MacDonald Interim Chief Operating Officer (COO)						
<b>Awdur yr Adroddiad Report Author:</b>	Meinir Williams, Director of Unscheduled Care						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Reviewed by Interim COO						
<b>Atodiadau Appendices:</b>	None						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to note the Unscheduled Care performance for September 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)							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input checked="" type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
This report provides an update against the unscheduled care performance at the end of September 2020. Work has commenced to review and refresh the Improvement Programme for Unscheduled Care, 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. However, the HB ED teams have been working to mature the Reset and Recover plans as part of the work aligned to the National EDQDF programme. This has resulted in plans to implement streaming pathways as part of the Same Day Emergency Care (SDEC) approach to care. Bids have been submitted through the EDQDF programme for funding to support speedy delivery through winter.							
<b>Cefndir / Background:</b>							
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-19 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.

This work has continued as we see our EDs demand increase – though not quite to pre-Covid periods, social distancing and IPC controls means our department capacity is less than before. This is further compounded by ambulance conveyances almost on par with the same period last year. Ensuring continued separation of the red and green pathways through our EDs remains essential as we head towards second peak, and teams are challenged with managing waiting areas and timely flow out of ED into beds or community care.

The combined 4 hour performance has broadly maintained at 77.6% in September 2020 compared to 77.9% last month. This is an improved position on 71.7% reported in September 2019. ED only performance was 71.4% in September 2020 and is broadly maintaining the same position as last month at 71.8%.

The number of ED attendances shows a continued increase over the 4 months from 7,773 in April to 13,784 in August, with a slight dip to 13,072 in September 2020. However, this remains lower than the same period last year which reported 14,468 attendances in September 2019.

The number of patients who waited in EDs for more than 12 hours is showing a continued increase with 1,187 reported in September 2020, compared to 1,063 in August 2020 but is a better position compared to 1,977 in September 2019. The key drivers for performance delays is the lack of flow from ED. The number of patients waiting in ED for longer than 24 hours has also continued to rise with 265 reported in September 2020 compared to 147 in August 2020.

## **Ambulance performance**

### **Ambulance CAT A performance**

The 8 minute red performance target relates to ambulance response to red calls (very urgent) is reporting a slight improvement from 60.9% last month to 61.05% in September 2020 which remains below the 65% performance target.

### **Ambulance handovers over 60 minutes**

The ambulance handover performance shows a continued increase in the number of ambulance handover delays >60 minutes for the past 4 months and is reporting 811 for September 2020 compared to 636 in August. However this is an improved position compared to 895 in September 2019.

## **West Health Community**

### **4 hour performance**

The combined 4 hour performance for September 2020 in the West Area has maintained performance of 86.5% compared to August performance of 86.8%. ED only performance was 82.2% in September 2020.

### **12 & 24 hour delays performance**

There were 126 patients delayed >12 hours within YG ED for the month of September 2020 which is an increase on 100 delays reported in August 2020. There were 7 patients delayed over 24 hours in September compared to 1 last month.

**Ambulance 60 minute handover performance**

There were 134 ambulance handover delays >60 minutes for the month of September 2020 which is an increase in the number of delays from 70 reported in August.

**Under 18 years of age breaches**

There were 42 breaches for <18 year olds in September which is an improvement from August which reported 63 delays.

**Central Locality****4 hour performance**

The combined 4 hour performance for Central area in September 2020 was 71.6% which is a slight improvement from 69.8% in August 2020. ED only performance was 59.2% in September 2020.

**12 & 24 hour delays performance**

There were 642 patients delayed >12 hours within YGC ED for the month of September 2020 which is an increase in the number of delays from 589 in August 2020. There were 196 patients delayed over 24 hours in September compared to 84 last month.

**Ambulance 60 minute Handover performance**

There were 520 ambulance handover delays >60 minutes for the month of September 2020 which is a slight increase from 514 delays reported in August 2020. Pre covid-19 handover delays were of concern at this site. Further work to review and refresh the pre covid-19 action plan to address this is underway.

**Under 18 years of age breaches**

There were 68 breaches for under 18 year olds for the month of September 2020 which is an improvement from 97 in August 2020.

**East Locality****4 Hour performance**

The combined 4 hour performance for East area in September 2020 was 75.5%, which was a decrease from 78.4% in August 2020. ED only performance was 73.1% in September 2020.

**12 & 24 hour delays performance**

There were 419 patients delayed >12 hours within Wrexham ED for the month of September 2020 which is an increase in the number of delays from 374 in August 2020. There were 62 patients delayed over 24 hours in September which was maintained from the previous month.

**Ambulance 60 minute Handover performance**

There were 157 ambulance handover delays >60 minutes for the month of September 2020 which is a significant increase from 52 delays reported in August 2020.

**Under 18 years of age breaches**

There were 53 breaches for under 18 year olds for the month of September 2020 which is an increase from 24 in August 2020.



## **Asesiad / Assessment & Analysis**

### **Strategy Implications**

This report relates directly to the Health Boards strategic and business plans up until 13<sup>th</sup> 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.



GIG  
CYMRU  
NHS  
WALES

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Cydwethredol Cenedlaethol  
National Collaborative  
Commissioning Unit

# Unscheduled Care

Stephen Harrhy

29<sup>th</sup> October 2020



## Feedback

- You have the basis of a good plan but...
- You have already identified some opportunities within YGC
- Celebrate good practice as well as demanding better delivery
- Stability and support
- Understanding the “DGH plus” nature of YGC
- Demand management is as important as additional capacity and better flow
- Key principle and goal improving quality and patient safety and reduce harm
- Tactical approach
- Offer of support
- Will share report with officers first

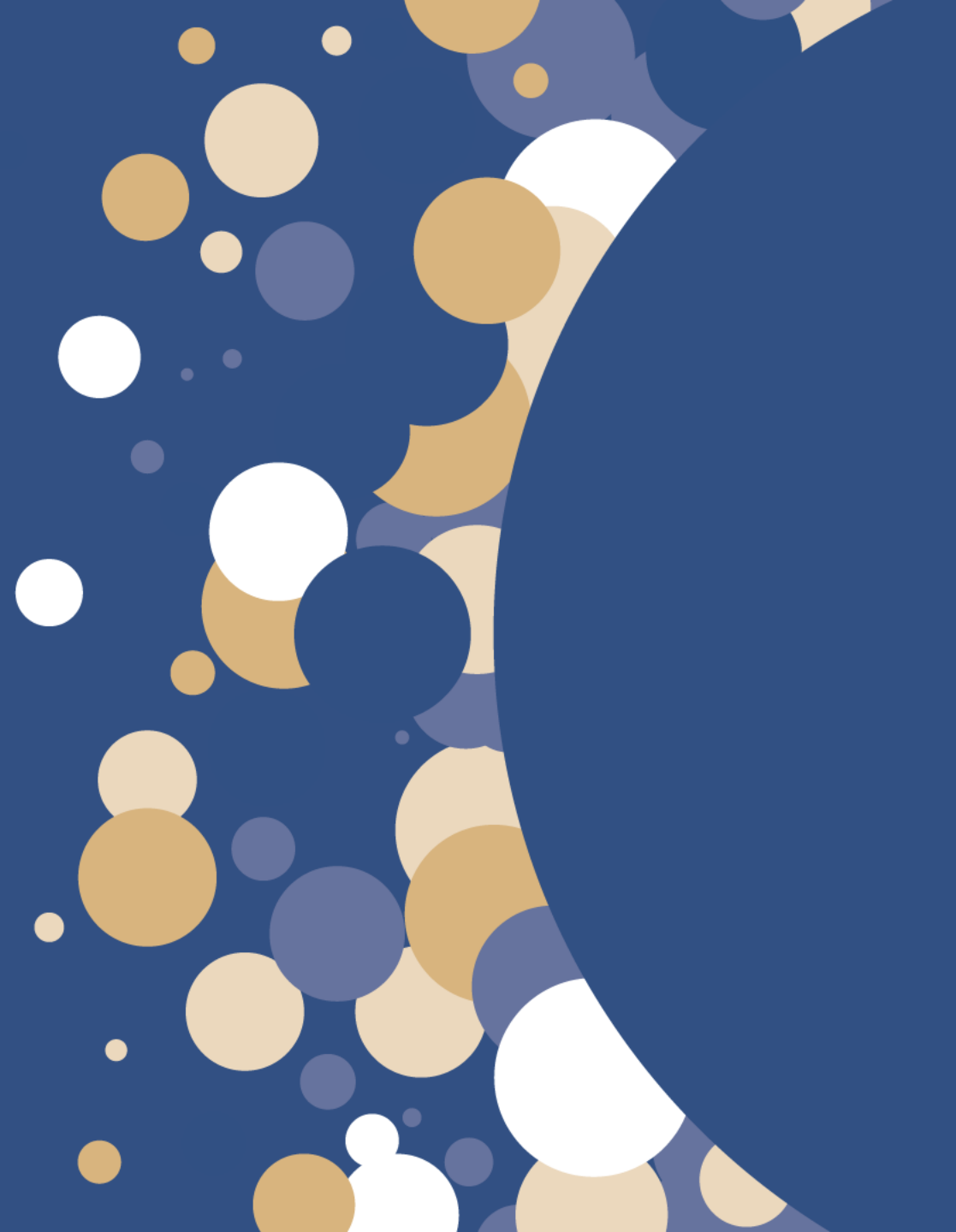
## Quick wins

- Support the work on “tempo of the day”, reduce bureaucracy to strengthen governance, move the day forward
- The EDQ plan will work, but prioritise and focus on a couple of key priorities
- Support the Site Management “Directorate”
- Push the introduction of the Acute Physician Model
- Work on reduced conveyance into YGC
- Agree with WAST their key actions
- The targets in your winter plan are the right ones what is your transition plan
- Recruitment plan
- Management and Leadership development plan



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NHS  
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Cydwethredol Cenedlaethol  
National Collaborative  
Commissioning Unit





<b>Cyfarfod a dyddiad: Meeting and date:</b>	Finance and Performance Committee 29.10.20						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Finance Report Month 6 2020/21						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Sue Hill, Acting Executive Director of Finance						
<b>Awdur yr Adroddiad Report Author:</b>	Eric Gardiner, Finance Director - Provider Services						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Acting Executive Director of Finance						
<b>Atodiadau Appendices:</b>	<u>Appendix 1</u> : Summary of Position by Division <u>Appendix 2</u> : COVID-19 Income and Expenditure <u>Appendix 3</u> : Field Hospitals: Consequential Losses <u>Appendix 4</u> : Income <u>Appendix 5</u> : Savings <u>Appendix 6</u> : Expenditure <u>Appendix 7</u> : Value Based Healthcare Update <u>Appendix 8</u> : Financial Risks and Opportunities						
<b>Argymhelliad / Recommendation:</b>							
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)							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input checked="" type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
The purpose of this report is to provide a briefing on the financial performance of the Health Board as at 30 <sup>th</sup> September 2020 and reflects the financial impact of the continuing response to the COVID-19 pandemic.							
<b>Cefndir / Background:</b>							
<p>The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m, based on achieving savings of £45m. The initial plan did not take into account the impact of COVID-19, and therefore it will change throughout the year. In the first half of the year, expenditure has been considerably higher than planned due to the pandemic response and savings delivery has continued to be significantly impacted as the Health Board prioritised the clinical and operational response to the pandemic.</p> <p>The Health Board's plan for Quarters 3 and 4 focuses on increasing activity and dealing with winter escalation plans, however, the recent substantial increase in COVID-19 infections is likely to affect the plan, potentially reducing activity and increasing costs.</p>							

The uncertainty about the potential resurgence of COVID-19 in the winter months and the essential infection prevention measures that have been implemented will continue to affect expenditure forecasts and savings delivery is likely to be significantly reduced for the remainder of the year.

## **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	£20.0m Deficit	Plan	£40.0m Deficit
Actual	£24.6m Surplus	Actual	£19.8m Deficit	Forecast	£40.0m Deficit
Variance	£27.9m Favourable	Variance	£0.2m Favourable	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:

- During September, Welsh Government notified the Health Board of additional funding for COVID-19. This included £83.1m to support the impact of COVID-19, plus specific funding to cover the costs of PPE, the extended flu vaccination programme, the COVID-19 vaccination programme, COVID-19 testing, Field Hospital decommissioning costs, consequential losses arising from the Field Hospitals and the cost of using the independent sector to support activity. In total, an additional £106.2m of COVID-19 funding has been included in the forecast position in Month 6. Of this additional income, £27.6m has been brought into the position in Month 6 to fund COVID-19 costs incurred in Months 1 to 5 and additionally Month 6 have been funded. This has resulted in a significant improvement in the financial position and the forecast this month.
- It is anticipated that the additional Welsh Government income will fully cover the costs of COVID-19 this year and so the Health Board forecast has been amended to a £40.0m deficit, in line with the financial plan.
- Savings schemes have delivered £1.2m this month, increasing total delivery to £5.5m for 2020/21. The overall forecast for savings, including those schemes in the pipeline, has increased by £0.1m to £15.0m. Undelivered savings are included in the costs of COVID-19, so the development and implementation of further schemes would provide an opportunity for 2020/21 and reduce the underlying deficit carried forward into 2021/22.



### 3.2 Revenue Position

	Actual						Cumulative			Forecast
	M01	M02	M03	M04	M05	M06	Budget	Actual	Variance	
	£m	£m	£m	£m	£m	£m	£m	£m	£m	
Revenue Resource Limit	(154.7)	(128.5)	(133.2)	(140.1)	(103.7)	(161.2)	(821.4)	(821.4)	0.0	(1,708.2)
Miscellaneous Income	(9.7)	(9.8)	(9.3)	(9.6)	(12.1)	(11.1)	(69.2)	(61.6)	(7.6)	(122.6)
Health Board Pay Expenditure	65.0	66.1	68.1	67.3	66.0	65.6	403.6	398.1	5.5	833.7
Non-Pay Expenditure	102.8	75.5	77.7	85.7	80.8	82.2	507.0	504.7	2.3	1,037.1
<b>Total</b>	<b>3.4</b>	<b>3.3</b>	<b>3.3</b>	<b>3.3</b>	<b>31.0</b>	<b>(24.5)</b>	<b>20.0</b>	<b>19.8</b>	<b>0.2</b>	<b>40.0</b>

- Overview (Appendix 1):** The in-month position is a £24.6m surplus, which is £27.9m under the plan for Month 6. This gives a cumulative year to date position of £19.8m deficit, which is £0.2m below the plan of a deficit of £20.0m. There has been a significant movement in the position this month due to additional Welsh Government COVID-19 funding that was notified to the Health Board in late September. In total, an additional £106.2m of COVID-19 funding has been included in the forecast position in Month 6. £27.6m of this income has been brought into the position in Month 6 to fund COVID-19 costs incurred in prior months, hence the movement in the Month 6 financial position.

<b>Movement in Financial Position</b>	<b>£m</b>
YTD Position at Month 5	27.7
Additional COVID-19 income related to M01-M05 expenditure	(27.6)
Reduction in other cost pressures	(0.3)
<b>YTD Position at Month 6</b>	<b>(0.2)</b>

- Impact of COVID-19 (Appendix 2):** The cost of COVID-19 in September is £7.3m, with a year to date cost of £67.8m. Specific funding sources totalling £2.6m have been redirected to COVID-19 to cover some of these costs. £65.2m of Welsh Government income has been received or notified to cover the remaining costs to date. Therefore, overall the costs of COVID-19 are not impacting on the year to date position.

	M01	M02	M03	M04	M05	M06	YTD	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	6.1	4.8	57.8	131.7
Lost income	1.2	1.4	1.2	1.6	1.6	0.4	7.4	12.3
Non delivery of savings	3.7	3.6	2.0	2.7	2.3	3.9	18.2	33.9
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(1.9)	(1.5)	(13.4)	(19.3)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(0.2)	(0.2)	(1.7)	(1.8)
Cluster funding	0.0	0.0	(0.3)	(0.1)	0.0	(0.1)	(0.5)	(0.6)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0	0.0	0.0	0.0
<b>Total COVID-19 costs</b>	<b>30.8</b>	<b>5.1</b>	<b>7.5</b>	<b>9.2</b>	<b>7.9</b>	<b>7.3</b>	<b>67.8</b>	<b>156.2</b>
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(0.1)	(0.1)	(1.8)	(2.5)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	0.0	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	0.0	0.0	(0.1)	(0.2)
Welsh Government	(30.8)	(5.1)	(7.5)	(6.8)	19.8	(34.8)	(65.2)	(152.8)
<b>Total COVID-19 income</b>	<b>(30.8)</b>	<b>(5.1)</b>	<b>(7.5)</b>	<b>(9.2)</b>	<b>19.7</b>	<b>(34.9)</b>	<b>(67.8)</b>	<b>(156.2)</b>
<b>Impact on position</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>27.6</b>	<b>(27.6)</b>	<b>0.0</b>	<b>0.0</b>

- Further details on the consequential losses arising from the Field Hospitals are included in Appendix 3.
- Forecast: In Month 5, the Health Board increased its forecast position to £122.2m, reflecting the change in income assumptions around anticipated income from Welsh Government towards the cost of COVID-19. The additional COVID-19 funding awarded in September is forecast to fully cover the additional cost to the Health Board this year. Therefore, the forecast financial position at Month 6 has been reduced to £40.0m, in line with the financial plan for 2020/21.

Forecast at M06	£m
Planned deficit	40.0
Forecast COVID-19 net costs	156.2
Redirected funding	(3.4)
WG COVID-19 specific funding	(152.8)
<b>Forecast outturn</b>	<b>40.0</b>

- 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 £1,557.5m, with further anticipated allocations in year of £150.7m, a total forecast Revenue Resource Limit (RRL) of £1,708.2m for the year. Miscellaneous income totals £61.6m to Month 6, £7.6m below budget, of which £7.4m is due to income lost as a result of COVID-19.
- Savings (Appendix 5): The identification of savings plans and the delivery of plans already identified has been severely impacted by COVID-19. Forecast savings delivery is currently £15.0m against the plan of £45.0m, a shortfall of £30.0m. Included in this forecast are schemes of £3.9m that are still in the pipeline and so where delivery is more at risk. The forecast shortfall plus the value of schemes still in the pipeline has been included as a cost of COVID-19 and so offset as part of the overall funding package.
- Expenditure (Appendix 6): Total expenditure to date is £902.8m, giving rise to an under spend of £7.8m. Expenditure in Month 6 was £148.8m. £4.8m of this month's expenditure is directly related to COVID-19, of which £1.8m is included in pay and £3.0m across non-pay expenditure categories.
- An update regarding Value Based Healthcare (VBHC) within the Health Board, in the context of the current pandemic response, is included in Appendix 7.

### 3.3 Balance Sheet

- Cash: The closing cash balance for September was £9.0m, which included £1.8m cash held for capital projects. The revenue cash balance of £7.2m was within the internal target set by the Health Board. The cash flow forecast is currently reporting a shortfall of £43.1m at the end of the year, relating to both the forecast overspend of £40.0m and adjustments to working capital balances and capital allocations. As in previous years, the Health Board will consider all possible actions to minimise the level of Strategic Cash Assistance required from Welsh Government to enable payments to continue. Current forecasts indicate that £5.0m of cash pressures can be managed internally and this will continue to be reviewed as further opportunities arise.
- Capital: The Capital Resource Limit (CRL) for 2020/21 is £27.6m. Actual expenditure to the end of September was £8.4m, against a plan of £11.1m. The year to date slippage of £2.7m will be recovered during the remainder of the year. Further details and analysis of Capital is included in the Capital Programme Report.

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

#### **4.0 Risk Analysis (Appendix 8)**

There are opportunities to improve the financial position by £3.9m, which relate to the savings schemes that are in the pipeline and are anticipated will move into green or amber in October. There are four risks to the financial position, but the value of these cannot be currently quantified.

#### **5.0 Legal And Compliance**

Not applicable.

#### **6.0 Impact Assessment**

Not applicable.

## Appendix 1 – Summary of Position by Division

The overall divisional position at Month 6 and the forecast variance over plan for the full year are shown below:

	M01	M02	M03	M04	M05	M06	Cumulative			Forecast
	Actual	Actual	Actual	Actual	Actual	Actual	Budget	Actual	Variance to Plan	Variance to Plan
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>WG RESOURCE ALLOCATION</b>	(154,715)	(128,474)	(133,260)	(140,076)	(103,736)	(161,229)	(821,489)	(821,489)	0	0
<b>AREA TEAMS</b>										
<b>West Area</b>	13,969	13,417	13,666	14,796	13,328	13,342	81,887	81,742	145	(2,323)
<b>Central Area</b>	18,101	17,247	18,204	18,507	17,620	17,933	105,662	106,872	(1,210)	(4,768)
<b>East Area</b>	19,908	19,137	19,730	21,713	19,307	19,550	117,417	118,455	(1,038)	(5,150)
<b>Other North Wales</b>	360	2,701	3,017	3,022	3,112	3,910	17,028	18,483	(1,455)	(4,547)
<b>Field Hospitals</b>	25,037	(539)	1,001	573	778	(575)	26,272	26,272	(0)	(0)
<b>Track, Trace and Protect</b>	4	5	41	162	959	(102)	1,067	1,067	0	0
<b>Commissioner Contracts</b>	17,951	17,816	16,890	17,659	17,399	17,659	108,524	105,373	3,151	2,195
<b>Provider Income</b>	(1,170)	(1,252)	(1,195)	(1,211)	(2,000)	(2,046)	(11,487)	(8,873)	(2,613)	(2,916)
<b>Total Area Teams</b>	94,160	68,532	71,353	75,222	70,503	69,670	446,370	449,391	(3,021)	(17,509)
<b>SECONDARY CARE</b>										
<b>Ysbyty Gwynedd</b>	8,248	8,076	8,561	8,942	8,318	8,618	50,211	50,756	(545)	(2,561)
<b>Ysbyty Glan Clwyd</b>	10,151	10,259	10,480	10,557	10,231	10,549	62,622	62,225	398	(2,399)
<b>Ysbyty Maelor Wrexham</b>	9,054	8,930	9,199	9,185	8,702	8,907	52,995	53,822	(827)	(3,531)
<b>North Wales Hospital Services</b>	8,520	8,074	8,807	8,826	8,309	8,931	51,311	51,467	(155)	(2,321)
<b>Womens</b>	3,404	3,514	3,264	3,516	3,306	3,350	19,923	20,353	(430)	(1,205)
<b>Total Secondary Care</b>	39,377	38,853	40,310	41,026	38,866	40,354	237,063	238,623	(1,560)	(12,016)
<b>Total Mental Health &amp; LDS</b>	10,920	10,773	11,349	11,295	11,327	11,417	66,698	67,081	(382)	(1,900)
<b>Total Corporate</b>	11,765	11,585	12,211	11,555	11,419	11,829	68,704	70,576	(1,872)	(1,820)
<b>Total Other Budgets incl. Reserves</b>	1,897	2,059	1,352	4,316	2,585	3,411	22,653	15,620	7,033	33,245
<b>TOTAL</b>	<b>3,404</b>	<b>3,329</b>	<b>3,316</b>	<b>3,338</b>	<b>30,965</b>	<b>(24,547)</b>	<b>20,000</b>	<b>19,802</b>	<b>198</b>	<b>0</b>

## Appendix 1 – Summary of Position by Division

A significant proportion of costs this year relate to COVID-19. Removing this expenditure and any corresponding funding shows the underlying position by division:

	Core Position			COVID-19 Expenditure			Total Position		
	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
<b>WG RESOURCE ALLOCATION</b>	(763,669)	(763,669)	0	(57,820)	(57,820)	0	(821,489)	(821,489)	0
<b>AREA TEAMS</b>									
West Area	79,182	79,037	145	2,705	2,705	(0)	81,887	81,742	145
Central Area	102,503	103,713	(1,210)	3,159	3,159	(0)	105,662	106,872	(1,210)
East Area	114,737	115,776	(1,039)	2,680	2,679	1	117,417	118,455	(1,038)
Other North Wales	16,273	17,728	(1,455)	755	755	0	17,028	18,483	(1,455)
Field Hospitals	0	2	(2)	26,272	26,270	2	26,272	26,272	(0)
Track, Trace and Protect	(107)	(107)	(0)	1,174	1,174	0	1,067	1,067	0
Commissioner Contracts	108,270	104,512	3,758	254	861	(607)	108,524	105,373	3,151
Provider Income	(11,487)	(8,873)	(2,613)	0	0	0	(11,487)	(8,873)	(2,613)
<b>Total Area Teams</b>	<b>409,372</b>	<b>411,788</b>	<b>(2,416)</b>	<b>36,999</b>	<b>37,603</b>	<b>(604)</b>	<b>446,370</b>	<b>449,391</b>	<b>(3,021)</b>
<b>SECONDARY CARE</b>									
Ysbyty Gwynedd	45,965	46,509	(545)	4,246	4,247	(1)	50,211	50,756	(545)
Ysbyty Glan Clwyd	58,876	58,478	399	3,746	3,747	(1)	62,622	62,225	398
Ysbyty Maelor Wrexham	49,242	50,085	(843)	3,753	3,737	16	52,995	53,822	(827)
North Wales Hospital Services	50,314	50,468	(154)	998	999	(1)	51,311	51,467	(155)
Womens	18,975	19,406	(431)	948	947	1	19,923	20,353	(430)
<b>Total Secondary Care</b>	<b>223,372</b>	<b>224,946</b>	<b>(1,574)</b>	<b>13,691</b>	<b>13,677</b>	<b>14</b>	<b>237,063</b>	<b>238,623</b>	<b>(1,560)</b>
<b>Total Mental Health &amp; LDS</b>	<b>63,608</b>	<b>63,991</b>	<b>(383)</b>	<b>3,090</b>	<b>3,090</b>	<b>0</b>	<b>66,698</b>	<b>67,081</b>	<b>(382)</b>
<b>Total Corporate</b>	<b>65,221</b>	<b>67,090</b>	<b>(1,869)</b>	<b>3,483</b>	<b>3,486</b>	<b>(3)</b>	<b>68,704</b>	<b>70,576</b>	<b>(1,872)</b>
<b>Total Other Budgets incl. Reserves</b>	<b>22,096</b>	<b>15,656</b>	<b>6,440</b>	<b>557</b>	<b>(36)</b>	<b>593</b>	<b>22,653</b>	<b>15,620</b>	<b>7,033</b>
<b>TOTAL</b>	<b>20,000</b>	<b>19,802</b>	<b>198</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>20,000</b>	<b>19,802</b>	<b>198</b>

## Appendix 2 – COVID-19 Income and Expenditure

### COVID-19 Income

- Total Welsh Government COVID-19 income is now £156.2m for the year, of which £67.8m has been included in the year to date financial position. The remaining funding is forecast to be fully spent in the second half of the financial year.

	Total Funding £m	Actual Expenditure to M06 £m	Forecast Expenditure M07 to M12 £m
Additional COVID-19 support	83.1	31.5	51.6
Field Hospital commissioning costs	23.6	23.6	0.0
Trace element of TTP (including IT)	11.4	0.7	10.7
PPE	6.5	2.0	4.5
Extended flu vaccination programme	5.7	0.0	5.7
Quarter 1 Pay	5.4	5.4	0.0
Support for adult social care providers	5.0	0.8	4.2
COVID-19 vaccination programme	3.3	0.0	3.3
COVID-19 testing	3.1	0.5	2.6
Field Hospital decommissioning cost	2.2	0.0	2.2
Consequential losses	2.2	0.4	1.8
Independent sector	0.7	0.0	0.7
Additional cross border costs 0.8%	0.5	0.3	0.2
MH Helpline	0.1	0.0	0.1
<b>COVID-19 Specific Funding</b>	<b>152.8</b>	<b>65.2</b>	<b>87.6</b>
Optimise Flow & Outcomes (ICF)	2.5	1.8	0.7
Mental Health Improvement Fund	0.7	0.7	0.0
GMS (DES)	0.2	0.1	0.1
<b>Redirected Funding</b>	<b>3.4</b>	<b>2.6</b>	<b>0.8</b>
<b>Total Welsh Government Funding</b>	<b>156.2</b>	<b>67.8</b>	<b>88.4</b>

## Appendix 2 – COVID-19 Income and Expenditure

- This funding will be used to fund COVID-19 expenditure, as well as the net impact of COVID-19 on other areas, such as lost income and undelivered savings, offset by savings on elective care and delayed developments. The forecast funding requirements by division are shown below:

	<b>Total Funding £m</b>	<b>Actual Expenditure to M06 £m</b>	<b>Forecast Expenditure M07 to M12 £m</b>
Field Hospitals	34.9	26.3	8.6
Test Trace Protect (TTP)	14.6	1.2	13.4
Area Teams	33.6	16.2	17.4
Commissioner Contracts	5.7	2.4	3.3
Secondary Care	33.1	14.4	18.7
Mental Health	5.8	3.1	2.7
Corporate	9.2	5.3	3.9
Other Budgets	19.3	(1.1)	20.4
<b>Total</b>	<b>156.2</b>	<b>67.8</b>	<b>88.4</b>

- Income to fund the extension of the flu vaccination campaign (£5.7m), the COVID-19 vaccination programme (£3.3m) and additional costs to support planned care (£10.1m) have been included in Other Budgets.



## Appendix 2 – COVID-19 Income and Expenditure

### COVID-19 Expenditure

- Expenditure directly related to COVID-19 is £4.8m for September, of which £1.8m is included in pay and £3.0m across non-pay expenditure categories. During the month there was a reduction in the building contracts cost for Field Hospitals totalling £0.6m. There was also an adjustment to TTP costs to correct an over accrual in Month 5, meaning that the year to date spend has remained at £1.2m.
- Forecast COVID-19 expenditure for 2020/21 is £131.7m. Included in Field Hospital costs are consequential losses totalling £0.4m for the year to date, with a full year forecast of £2.2m. This value remains subject to revision as negotiations progress.
- Forecast costs for the extension of the flu vaccination campaign (£5.7m), the COVID-19 vaccination programme (£3.3m) and additional costs to support planned care (£10.1m) have been included in Other Budgets. These costs are based on initial estimates, as plans continue to be developed.

Type	M01 £000	M02 £000	M03 £000	M04 £000	M05 £000	M06 £000	Total £000	Forecast £000
Field Hospitals	25,037	(543)	996	565	792	(577)	26,270	34,942
Test Trace Protect (TTP)	4	4	47	170	945	4	1,174	14,569
Area Teams	607	947	1,852	2,228	1,427	2,236	9,298	20,038
Commissioner Contracts	0	0	0	100	567	194	861	2,970
Secondary Care	2,133	2,033	2,811	2,940	1,588	2,172	13,677	27,449
Mental Health	289	427	788	641	485	460	3,090	5,794
Corporate	728	868	759	441	336	354	3,486	5,108
Other Budgets	0	0	1	(21)	(14)	(2)	(36)	20,821
<b>Total</b>	<b>28,798</b>	<b>3,737</b>	<b>7,254</b>	<b>7,064</b>	<b>6,126</b>	<b>4,841</b>	<b>57,820</b>	<b>131,691</b>

- COVID-19 expenditure to date by category is shown below.

## Appendix 2 – COVID-19 Income and Expenditure

Type	M01 £000	M02 £000	M03 £000	M04 £000	M05 £000	M06 £000	Total £000
Other Income	(30)	30	0	0	(66)	0	(66)
<b>Total Income</b>	<b>(30)</b>	<b>30</b>	<b>0</b>	<b>0</b>	<b>(66)</b>	<b>0</b>	<b>(66)</b>
Additional Clinical Services	170	357	683	532	407	447	2,596
Administrative & Clerical	166	427	417	374	884	(40)	2,228
Allied Health Professionals	22	50	57	116	81	37	362
Estates & Ancillary	(15)	36	166	148	158	209	702
Healthcare Scientists	10	34	15	10	(1)	8	75
Medical and Dental	437	648	1,255	1,523	681	338	4,882
Nursing and Midwifery Registered	313	383	1,729	1,592	732	757	5,506
Professional Scientific & Technical	0	18	43	73	57	25	215
<b>Total Pay</b>	<b>1,103</b>	<b>1,953</b>	<b>4,365</b>	<b>4,368</b>	<b>2,999</b>	<b>1,779</b>	<b>16,567</b>
Primary Care	(10)	21	42	395	(15)	6	439
Primary Care Drugs	0	0	0	0	0	0	0
Secondary Care Drugs	129	61	38	89	(2)	36	352
Clinical Services & Supplies	1,129	580	387	120	396	610	3,221
General Services & Supplies	589	378	444	160	291	661	2,524
Healthcare Services Provided by Other NHS Bodies	0	10	5	5	498	99	616
Continuing Care and Funded Nursing Care	338	655	712	1,128	849	1,503	5,185
Establishment & Transport Expenses	66	92	52	25	51	72	358
Premises and Fixed Plan	25,352	(522)	1,420	585	961	(409)	27,387
Other Non-Pay	133	480	(212)	189	165	484	1,237
<b>Total Non-Pay</b>	<b>27,725</b>	<b>1,754</b>	<b>2,889</b>	<b>2,696</b>	<b>3,194</b>	<b>3,061</b>	<b>41,320</b>
<b>Total</b>	<b>28,798</b>	<b>3,737</b>	<b>7,254</b>	<b>7,064</b>	<b>6,126</b>	<b>4,841</b>	<b>57,820</b>

## Appendix 3 – Field Hospitals: Consequential Losses

The building of the three Field Hospitals in North Wales required minimal disruption to the existing sub-tenants because the country was in full lockdown. However, as the country moved out of full lockdown and efforts are being made to restart the economy the issue of consequential losses has become an issue across each of the three sites.

The issues are different across the three sites as some are a single landlord, whilst at least one of the sites has sub-tenants who could have started trading as we moved out of the full lockdown. The Health Board is negotiating consequential losses directly through the Local Authorities or Bangor University, rather than with the individual sub-tenant.

The approach will be to seek appropriate legal advice and liaise with Welsh Government colleagues and other Health Boards to ensure we have a consistent approach, and once we have an agreement in principal, we will discuss with Welsh Audit Office the level of evidence required to support any payment.

This will be reported through the Finance and Performance Committee and the Audit Committee, with any payment above £1m subject to Welsh Government approval.

Once we have agreement, Welsh Legal Services will draft the commercial agreement, one for each party (Flintshire County Council (FCC), Conwy County Council (CCC) and Bangor University (BU)) when we will agree the financial envelope. All three bodies have submitted claims in this regard.

The process we have followed with the involvement / guidance from Shared Service (Legal and Risk) and Specialist Estates Services (Property) is:

1. Licence to Occupy for all three sites – this covers the building liabilities, utilities, rates, water R&M, SLAs etc. (all three are now complete).
2. Consequential losses as a result of the Health Board occupation – Welsh Legal Services will draft these for all three occupations when we sign off the financial envelope of exposure. This will ultimately limit any further exposure and will be a payment to the FCC, CCC and BU by BCUHB and / or Welsh Government.

Welsh Legal Services have provided a draft document, which will require further work when we completed our consequential losses negotiations.

Key to our negotiations are the Health Board's position in regards to:

1. End dates for all three sites
2. Decommissioning arrangements and / or end of occupancy settlements

## **Appendix 3 – Field Hospitals: Consequential Losses**

Future updates will summarise the position across the sites and provide a detail narrative on a specific sub-tenant where discussions are more advanced.

## Appendix 4 – Income

The total forecast Revenue Resource Limit (RRL) of £1,708.2m for 2020/21 consists of the following allocations:

Description	£m
<b>Allocations Received</b>	
Opening allocation	1,516.6
COVID-19 costs	23.7
DDRB Pay Award 2020/21	2.9
Transformation Fund - Financial Support to Optimise Flow & Outcomes	2.4
Dementia Action Plan ICF Bid	2.2
GMS Contract : In Hours Access Funding 2020-21	2.0
Treatment Fund	1.8
Dental Contract Pay & Expenses Uplift	0.8
Mental Health Service Improvement Fund 2020-21	0.7
Single Cancer Pathway	0.6
Primary Care Improvement Grant	0.4
Vocational Training	0.4
Wales Community Care Information System (WCCIS) - ICF Funding	0.3
A Healthier Wales	0.3
ARRP	0.3
British Red Cross Funding	0.3
Carers' Funding 2020-21	0.2
GMS (DES) - Easter bank holiday	0.2
SpR Allocation	0.2
Other allocations	1.2
<b>Total Allocations Received</b>	<b>1,557.5</b>

Description	£m
<b>Allocations Anticipated</b>	
COVID-19 costs	129.7
Substance Misuse	5.5
IM&T Refresh Programme	1.9
NICE Drugs Treatment Fund	1.8
Prevention and Early Year Funding for 2019/20	1.3
MSK Orthopaedic Services	1.2
Invest to Save	0.6
Outpatients Transformational Fund Bid	0.6
Vocational Training	0.5
Consultant Clinical Excellence Awards	0.4
Mental Health Individual Placement Support (IPS)	0.4
WAST Emergency Services Mobile Communications Programme	0.3
SpR Allocation	0.2
CAMHS In-Reach	0.2
A Healthier Wales	0.2
Augmentative and Alternative Communication (AAC) Pathway	0.1
Capital Adjustment	5.8
<b>Total Allocations Anticipated</b>	<b>150.7</b>

	£m
<b>Total Allocations Received</b>	<b>1,557.5</b>
<b>Total Allocations Anticipated</b>	<b>150.7</b>
<b>Total Welsh Government Income</b>	<b>1,708.2</b>

## Appendix 5 – 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).

### Scheme Development and Risk

Progress in identifying schemes is summarised in the table below:

Programme Area	Original PMO Review - March 20		June 19th Review		M06 Position	
	No.	£000	No.	£000	No.	£000
Divisional Schemes	88	6,450	56	6,835	71	10,570
Improvement Groups	18	21,327	10	5,404	2	3,236
<b>Total</b>	<b>106</b>	<b>27,776</b>	<b>66</b>	<b>12,239</b>	<b>73</b>	<b>13,806</b>

All schemes within the savings programme are subject to risk assessment. The risk status at Month 6 is summarised below:

## Appendix 5 – Savings

Programme Area	Total £m	Green £m	Amber £m	Red £m
<u>Divisions</u>				
Area - Centre	2.70	1.59	1.05	0.06
Area - East	1.33	1.29	0.00	0.03
Area - West	1.64	1.57	0.07	0.00
Corporate	1.07	0.03	0.87	0.17
MHLD	1.00	1.00	0.00	0.00
Provider - NW	0.49	0.49	0.00	0.00
Provider - YG	0.92	0.39	0.48	0.06
Provider - YGC	0.54	0.15	0.11	0.28
Provider - YMW	0.74	0.63	0.04	0.07
Womens	0.15	0.15	0.00	0.00
<b>Divisional Total</b>	<b>10.57</b>	<b>7.29</b>	<b>2.62</b>	<b>0.66</b>
<u>Improvement Groups</u>				
Procurement	2.00	0.00	0.00	2.00
Workforce	1.24	0.00	0.00	1.24
<b>IG Total</b>	<b>3.24</b>	<b>0.00</b>	<b>0.00</b>	<b>3.24</b>
<b>Grand Total</b>	<b>13.81</b>	<b>7.29</b>	<b>2.62</b>	<b>3.90</b>
<b>% Distribution</b>	<b>1.00</b>	<b>0.53</b>	<b>0.19</b>	<b>0.28</b>
<u>Month 5 Position</u>				
Total	13.90	4.27	3.14	6.49
% Distribution	1.00	0.31	0.22	0.47

During Month 6 the overall value of the programme has reduced by £0.09m to £13.81m. The risk profile has improved significantly with 72% of programme value in the amber and green categories compared with 53% in Month 5.

### Scheme Delivery

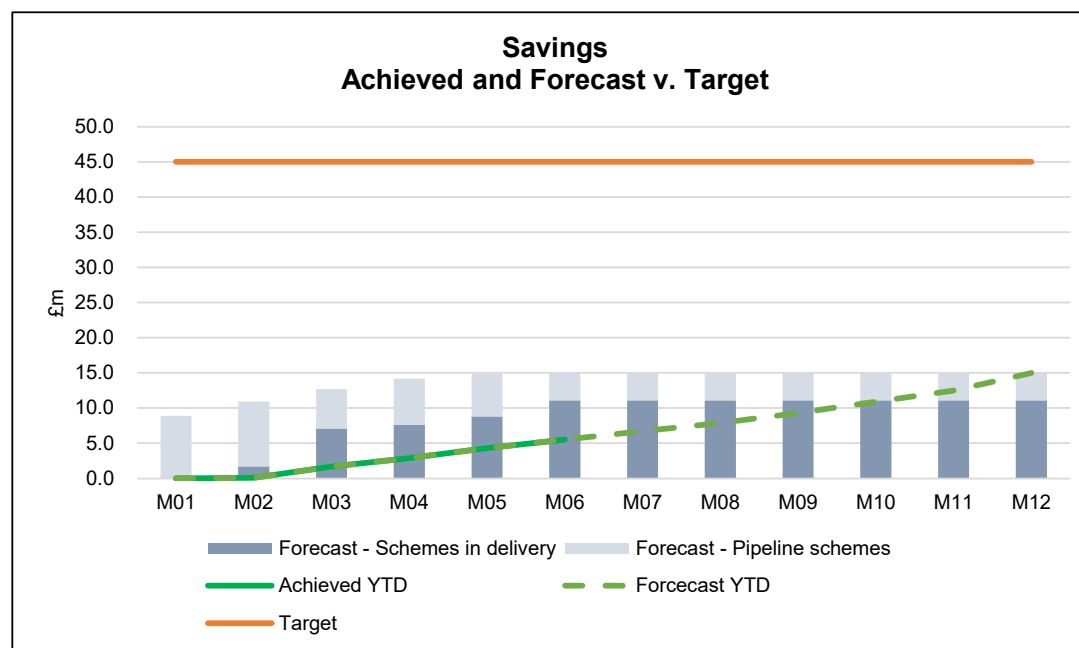
Savings of £1.2m are reported in Month 6, increasing the overall year to date delivery to £5.5m. The year to date delivery is a £16.5m shortfall against target.

## Appendix 5 – Savings

The total in-year forecast for savings which are in delivery amounts to £11.1m, of which £8.2m is recurrent. This is an increase of £2.3m over the Month 5 position reflecting the movement of schemes from pipeline. This leaves a shortfall of £33.9m against the £45.0m annual savings target.

Schemes remaining in pipeline have a value of £3.9m and work is ongoing to progress these to amber / green during Month 7. Following a review in Month 6, workforce optimisation schemes have been removed for 2020/21, reflecting the current pressures on the workforce team in supporting the pandemic response and the anticipated impact of the current rise in cases upon the deployment of staff for the remainder of the financial year. Additional savings, including CHC and travel are being progressed to replace the workforce programme. The full year effect of pipeline schemes is being reviewed as these schemes are developed. Delivery of the pipeline schemes will increase the forecast out-turn to £15.0m, leaving a shortfall of £30.0m against the original savings target.

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 5 – Savings

	Savings Target £000	SCHEMES IN DELIVERY								PIPELINE SCHEMES				TOTAL PROGRAMME	
		Year to Date			Forecast					Recurring Forecast £000	Non-Recurring Forecast £000	Total Forecast £000	Forecast FYE £000	Total Forecast £000	Variance £000
		Savings Target £000	Savings Delivered £000	Variance £000	Recurring Forecast £000	Non-Recurring Forecast £000	Total Forecast £000	Variance £000	Forecast FYE £000						
Ysbyty Gwynedd	4,167	2,083	558	(1,526)	511	337	848	(3,319)	789	120	0	120	151	968	(3,199)
Ysbyty Glan Clwyd	5,079	2,539	217	(2,322)	136	286	422	(4,656)	311	255	0	255	160	677	(4,401)
Ysbyty Wrexham Maelor	4,414	2,207	334	(1,873)	305	449	754	(3,660)	381	27	23	50	120	804	(3,610)
North Wales Managed Services	4,300	2,150	270	(1,880)	503	10	513	(3,787)	636	0	0	0	0	513	(3,787)
Womens Services	1,733	866	64	(803)	152	0	152	(1,581)	174	0	0	0	0	152	(1,581)
<b>Secondary Care</b>	<b>19,692</b>	<b>9,846</b>	<b>1,442</b>	<b>(8,404)</b>	<b>1,607</b>	<b>1,082</b>	<b>2,689</b>	<b>(17,004)</b>	<b>2,291</b>	<b>402</b>	<b>23</b>	<b>425</b>	<b>431</b>	<b>3,114</b>	<b>(16,578)</b>
Area - West	4,402	2,201	918	(1,283)	1,553	395	1,948	(2,455)	1,610	0	0	0	0	1,948	(2,455)
Area - Centre	6,408	3,204	1,184	(2,019)	2,896	0	2,896	(3,512)	2,955	60	0	60	60	2,956	(3,452)
Area - East	6,464	3,232	900	(2,332)	158	1,446	1,605	(4,859)	158	19	15	34	33	1,639	(4,825)
Area - Other	607	304	0	(304)	0	0	0	(607)	0	0	0	0	0	0	(607)
Contracts	1,000	500	0	(500)	0	0	0	(1,000)	0	0	0	0	0	0	(1,000)
<b>Area Teams</b>	<b>18,881</b>	<b>9,440</b>	<b>3,002</b>	<b>(6,438)</b>	<b>4,607</b>	<b>1,841</b>	<b>6,448</b>	<b>(12,433)</b>	<b>4,723</b>	<b>79</b>	<b>15</b>	<b>94</b>	<b>93</b>	<b>6,542</b>	<b>(12,339)</b>
MHLD	1,000	0	898	898	1,000	0	1,000	(0)	1,000	0	0	0	0	1,000	(0)
Corporate	5,426	2,713	149	(2,564)	131	800	931	(4,496)	141	169	0	169	571	1,100	(4,327)
<b>Divisional Total</b>	<b>45,000</b>	<b>22,000</b>	<b>5,491</b>	<b>(16,509)</b>	<b>7,345</b>	<b>3,723</b>	<b>11,068</b>	<b>(33,932)</b>	<b>8,155</b>	<b>650</b>	<b>38</b>	<b>688</b>	<b>1,095</b>	<b>11,756</b>	<b>(33,244)</b>
Procurement IG										2,000	0	2,000	2,000	2,000	2,000
Workforce IG										1,236	0	1,236	4,438	1,236	1,236
<b>Improvement Group Total</b>										<b>3,236</b>	<b>0</b>	<b>3,236</b>	<b>6,438</b>	<b>3,236</b>	<b>3,236</b>
<b>Total Programme</b>	<b>45,000</b>	<b>22,000</b>	<b>5,491</b>	<b>(16,509)</b>	<b>7,345</b>	<b>3,723</b>	<b>11,068</b>	<b>(33,932)</b>	<b>8,155</b>	<b>3,886</b>	<b>38</b>	<b>3,925</b>	<b>7,533</b>	<b>14,992</b>	<b>(30,008)</b>

### Identifying Further Savings

The current shortfall in savings delivery presents a significant challenge to the Board's financial plan. Short term opportunities to secure further savings in 2020/21 will continue to be progressed, noting the challenges presented by the current operating environment and COVID-19 pressures, however there is a need to move away from the transactional nature of savings which have dominated the 2020/21 programme.

It is critical that the focus of savings and efficiency is aligned to the priorities contained in the Board's plan. Opportunities to progress further savings building towards 2021/22 have been reviewed and aligned to the five priorities within the Q3 / Q4 Plan.

The opportunities identified align with the key objectives within the Plan as follows:

## Appendix 5 – Savings

- Planned Care – outpatients; theatres
- Unscheduled Care – ambulatory care; length of stay
- Mental Health – inpatient and rehabilitation services
- Safe, Secure and Healthy – staffing efficiency, agency / locum costs; staff absence; ward staffing
- Resource utilisation – medicines management; estate costs; delayed transfers of care; corporate services

The table below identifies the range of potential financial opportunity in each of the five priority areas, by reference to benchmark comparators:

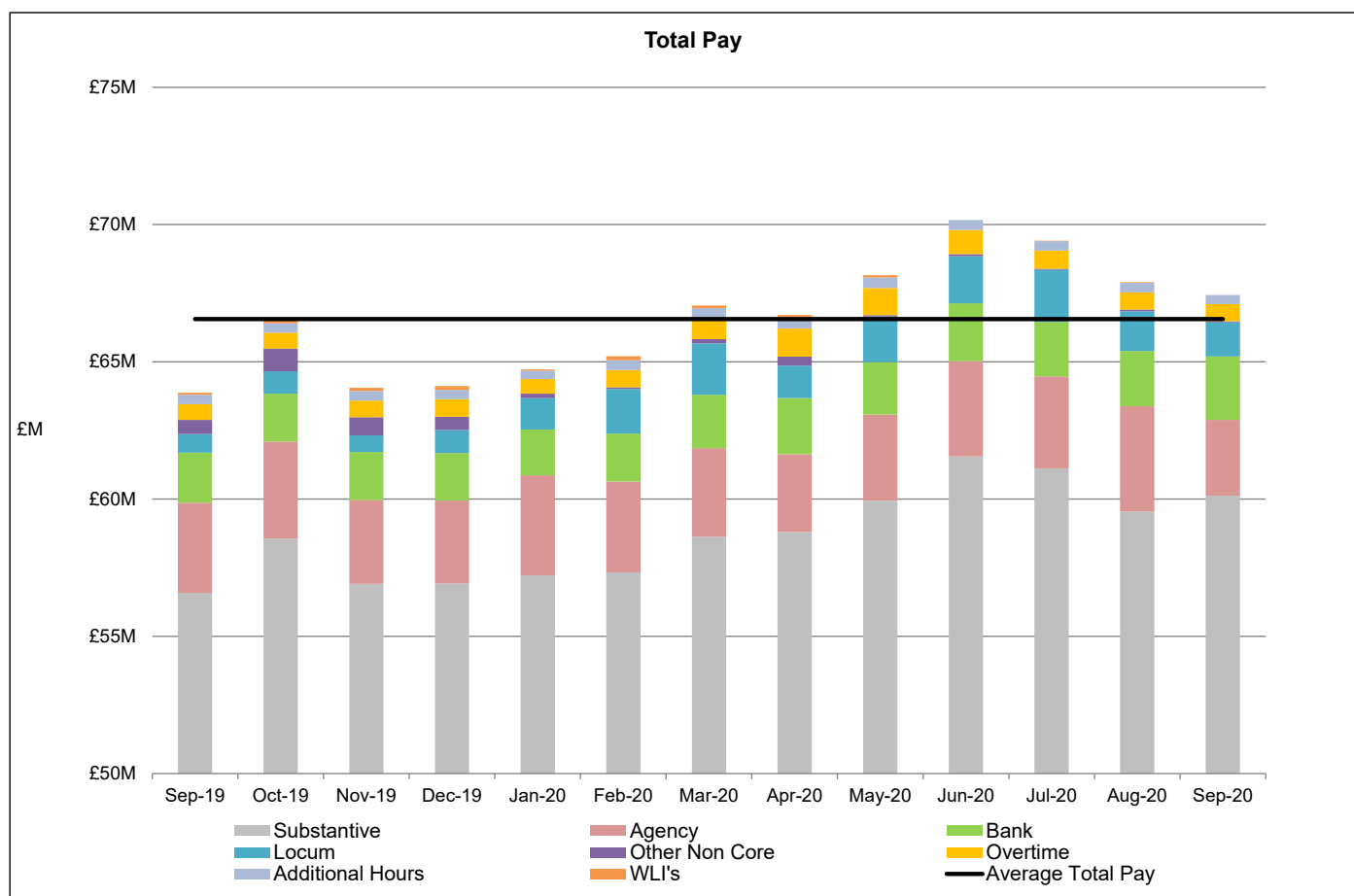
Priority Area	Low £m	High £m
Essential Services and Safe Stepping up of Planned Care	9.1	15.3
Safe Unscheduled Care	10.9	23.8
Safe Integration and Management of Mental Health Services	6.3	11.9
Safe, Secure and Healthy Environment for our People	11.0	25.7
Effective Use of our Resources	6.7	20.8
<b>Total</b>	<b>44.0</b>	<b>97.5</b>

The opportunities above could form the basis of a savings programme, which will cover a period of 1 to 3 years. Developing these opportunities into robust savings plans will be progressed during quarters 3 and 4 of this financial year.

## Appendix 6 – Expenditure

### Pay Expenditure

Health Board pay costs in August are £65.6m, a decrease of £0.4m from last month. Month 6 spend includes £1.8m of pay costs directly related to COVID-19, £1.2m lower than last month. Variable pay costs this month total £7.3m (10.8% of pay), £1.0m lower than in August. Overall, pay is £5.5m under spent against budget.



## Appendix 6 – Expenditure

	Actual						Forecast						Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	8.6	8.8	8.8	8.6	9.1	8.0	9.9	9.5	9.6	9.6	9.6	9.5	55.5	51.9	3.6	109.6
Medical & Dental	15.2	15.6	15.5	16.1	15.0	15.1	17.8	17.1	17.2	17.2	17.2	17.2	89.6	92.5	(2.9)	196.2
Nursing & Midwifery Registered	20.6	20.8	21.2	20.6	20.6	20.7	23.0	22.2	22.3	22.2	22.2	22.2	131.8	124.5	7.3	258.6
Additional Clinical Services	9.4	9.5	9.8	9.3	9.4	9.6	3.4	3.3	3.3	3.3	3.3	3.3	53.4	57.0	(3.6)	76.9
Add Prof Scientific & Technical	3.1	3.1	3.0	3.0	3.0	3.1	10.4	10.0	10.0	10.0	10.0	10.0	19.3	18.3	1.0	78.7
Allied Health Professionals	3.8	3.8	4.0	4.0	3.9	4.0	4.3	4.1	4.1	4.1	4.1	4.1	23.2	23.5	(0.3)	48.3
Healthcare Scientists	1.1	1.2	1.2	1.2	1.2	1.1	1.3	1.2	1.2	1.2	1.2	1.2	7.2	7.0	0.2	14.3
Estates & Ancillary	3.2	3.2	3.4	3.3	3.3	3.4	3.6	3.5	3.5	3.5	3.5	3.5	20.3	19.8	0.5	40.9
Students	0.0	0.1	1.2	1.2	0.5	0.6	0.7	0.7	0.7	0.7	0.7	0.7	3.3	3.6	(0.3)	7.8
<b>Health Board Total</b>	<b>65.0</b>	<b>66.1</b>	<b>68.1</b>	<b>67.3</b>	<b>66.0</b>	<b>65.6</b>	<b>74.4</b>	<b>71.6</b>	<b>71.9</b>	<b>71.8</b>	<b>71.8</b>	<b>71.7</b>	<b>403.6</b>	<b>398.1</b>	<b>5.5</b>	<b>831.3</b>
Primary care	1.7	2.1	2.0	2.1	1.9	1.8	1.9	1.9	1.9	2.0	2.0	2.0	9.7	11.6	(1.9)	23.3
<b>Total Pay</b>	<b>66.7</b>	<b>68.2</b>	<b>70.1</b>	<b>69.4</b>	<b>67.9</b>	<b>67.4</b>	<b>76.3</b>	<b>73.5</b>	<b>73.8</b>	<b>73.8</b>	<b>73.8</b>	<b>73.7</b>	<b>413.3</b>	<b>409.7</b>	<b>3.6</b>	<b>854.6</b>

Variable Pay	M01	M02	M03	M04	M05	M06	Total
	£m	£m	£m	£m	£m	£m	£m
Agency	2.8	3.1	3.5	3.3	3.8	2.8	19.3
Overtime	1.0	1.0	0.9	0.7	0.6	0.6	4.8
Locum	1.2	1.7	1.7	1.9	1.4	1.2	9.1
WLLs	0.1	0.1	0.0	0.0	0.0	0.0	0.2
Bank	2.1	1.9	2.1	2.0	2.0	2.3	12.4
Other Non Core	0.3	0.0	0.1	0.0	0.1	0.0	0.5
Additional Hours	0.4	0.4	0.3	0.4	0.4	0.4	2.3
<b>Total</b>	<b>7.9</b>	<b>8.2</b>	<b>8.6</b>	<b>8.3</b>	<b>8.3</b>	<b>7.3</b>	<b>48.6</b>

Areas of note are:

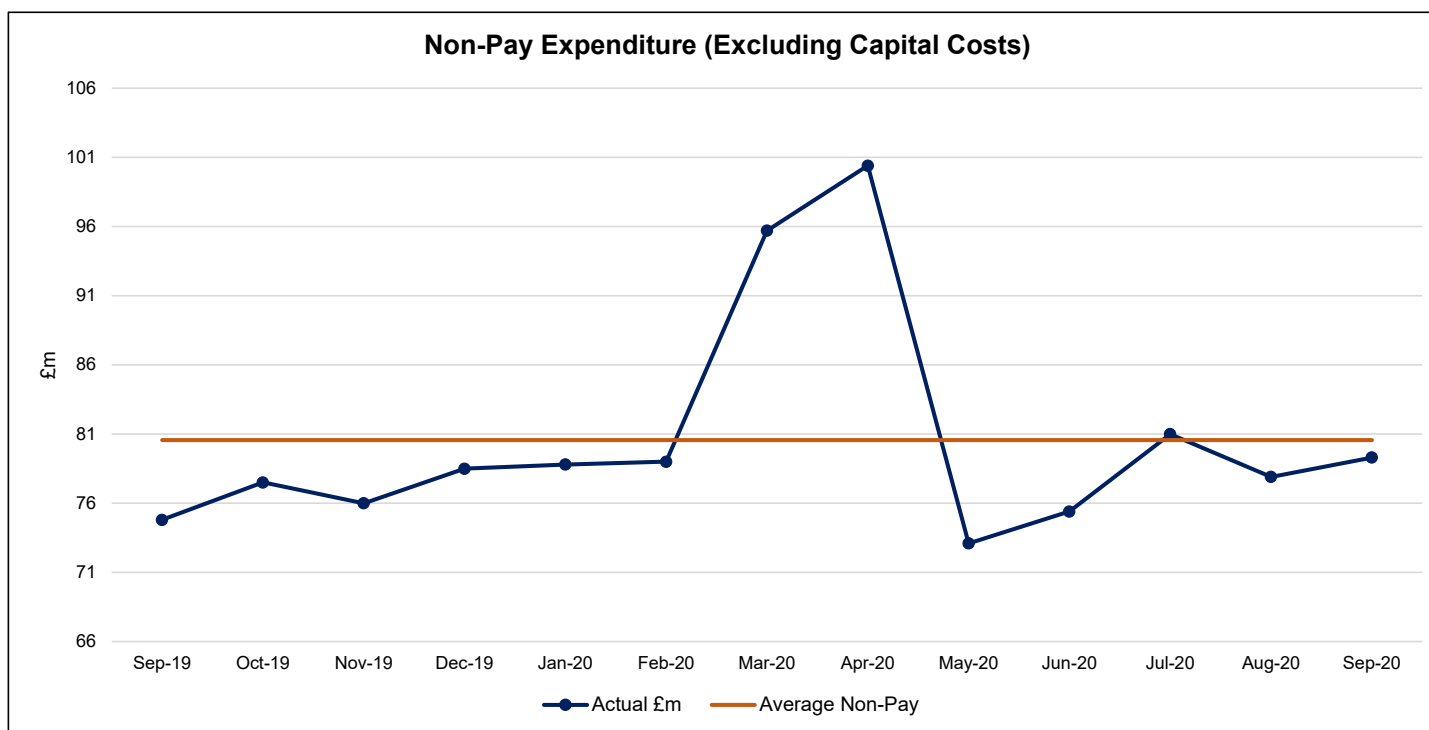
- Admin and Clerical pay has reduced by £1.1m. This relates to an adjustment to agency costs where £0.6m of Test Trace Protect (TTP) costs categorised as Admin and Clerical agency in Month 5 were reallocated to other pay codes in Month 6, as additional information became available.
- Agency costs for Month 6 are £2.8m, representing 4.1% of total pay, a decrease of £1.0m on last month. Agency spend related to COVID-19 in September was £0.3m, the same as last month. Medical agency costs have increased by £0.4m to an in-month spend of £1.8m. Nurse agency costs totalled £1.1m for the month, £0.2m less than last month. Reductions in agency usage have been seen across the acute hospitals and Mental Health as additional bank staff have been used. Other agency costs have seen the largest movement this month, with a decrease of £1.2m. This is primarily due to a reduction in Admin and Clerical agency spend as part of the TTP adjustment noted above.

## Appendix 6 – Expenditure

### Non-Pay Expenditure

Non-pay costs this month are £82.2m, which is £1.4m more than in Month 5; with a year to date under spend of £2.3m.

Month 6 non-pay costs include £3.0m directly related to COVID-19 (£41.3m year to date). The impact of COVID-19 on the savings programme has resulted in planned savings of £3.9m not being achieved this month and this shortfall is included within the 'Other' category of non-pay. Offsetting these costs is a reduction in planned care non-pay costs and slippage on planned investments totalling £1.7m.



## Appendix 6 – Expenditure

	Actual						Forecast						Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD	YTD	YTD	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	Budget £m	Actual £m	Variance £m	£m
Primary Care	17.2	17.5	15.9	17.6	17.2	16.8	18.0	17.8	17.1	17.7	17.8	18.1	105.4	102.2	3.2	208.7
Primary Care Drugs	8.9	8.6	10.5	11.0	8.7	9.0	9.7	9.6	10.0	9.9	9.5	9.9	52.9	56.7	(3.8)	115.3
Secondary Care Drugs	5.4	5.0	5.5	5.8	5.4	6.2	6.6	6.5	6.7	6.6	6.6	6.9	35.5	33.3	2.2	73.2
Clinical Supplies	4.8	3.6	4.2	4.6	4.3	5.4	4.3	4.4	4.7	4.8	4.8	5.2	32.9	26.9	6.0	55.1
General Supplies	2.7	2.6	2.1	4.7	3.0	3.5	2.9	3.1	3.3	3.3	3.3	3.6	19.4	18.6	0.8	38.1
Healthcare Services Provided by Other NHS Bodies	22.7	22.7	21.5	22.3	22.1	22.4	23.1	23.1	23.1	23.1	23.0	23.1	136.3	133.7	2.6	272.2
Continuing Care and Funded Nursing Care	8.4	8.2	9.1	9.0	9.0	9.6	9.6	9.4	9.5	9.5	9.2	9.4	54.8	53.3	1.5	109.9
Other	30.3	4.9	6.6	6.0	8.2	6.4	10.0	10.4	11.1	11.4	11.3	12.2	52.2	62.4	(10.2)	128.8
<b>Non-pay costs</b>	<b>100.4</b>	<b>73.1</b>	<b>75.4</b>	<b>81.0</b>	<b>77.9</b>	<b>79.3</b>	<b>84.2</b>	<b>84.3</b>	<b>85.5</b>	<b>86.3</b>	<b>85.5</b>	<b>88.4</b>	<b>489.4</b>	<b>487.1</b>	<b>2.3</b>	<b>1,001.3</b>
Cost of Capital	2.4	2.4	2.3	4.7	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	17.6	17.6	0.0	35.0
<b>Total non-pay including cost of capital</b>	<b>102.8</b>	<b>75.5</b>	<b>77.7</b>	<b>85.7</b>	<b>80.8</b>	<b>82.2</b>	<b>87.1</b>	<b>87.2</b>	<b>88.4</b>	<b>89.2</b>	<b>88.4</b>	<b>91.3</b>	<b>507.0</b>	<b>504.7</b>	<b>2.3</b>	<b>1,036.3</b>

The main areas of significance this month are:

- **Primary Care drugs:** GP prescribing and dispensing costs continue to be a significant risk in 2020/21, although there are signs that costs are starting to decrease. The year to date over spend at Month 6 is £3.8m, with a forecast overspend of £8.8m for the year. Spend has increased by £0.3m compared to last month, but is still under the run rate for the year. The data for July, which was received this month, showed a further decrease in the average cost per prescribing day, with decreases in both the average cost per item and also the number of items prescribed. On a rolling 12-month basis, the average cost per prescribing day has reduced by 7%. This is as a result of the cost per items being 1% lower and the number of items being reduced by 2.5%.
- **Secondary Care drugs:** Costs have increased by £0.8m to £6.2m, which is the highest level for the year so far. There has been an increase in costs across most specialties, but notably in Oncology (by £0.3m), Haematology (by £0.2m) and for staff flu vaccines (by £0.1m).
- **Clinical and General Supplies:** Costs are rising as activity levels across the Health Board increase. In addition, the rising cost of some elements of PPE, particularly gloves and masks, is resulting in increased non-pay costs. Usage of PPE has increased due to the pandemic, but the concern is around the unit cost, which has seen a significant increase over the last two months.
- **Continuing Healthcare (CHC):** Expenditure in September has increased by £0.6m compared to August, with this rise relating to COVID-19 costs, chiefly in Mental Health. Efforts to review placements and packages, particularly for those patients discharged due to COVID-19, are ongoing.
- **Other:** The significant over spend relates to under delivery on savings schemes (£18.2m), offset by COVID-19 income held in reserves relating to the non-expenditure impacts of COVID-19 (£7.8m).

## **Appendix 7 – Value Based Healthcare Update**

### **Purpose**

To provide the Committee with a brief update regarding Value Based Healthcare (VBHC) within the Health Board, in the context of the current pandemic response. A full update will be presented to the Committee in December.

### **Background**

In November 2019, the Committee received a paper proposing a way forward in developing Value Based Healthcare within the Health Board. A proposal for a pilot based upon Heart Failure services was agreed. Initial engagement with the clinical team commenced, led by the then Deputy Medical Director, Arpan Guha. However, this was shortly before the onset of the pandemic and activity was suspended in order to focus upon the pandemic response.

In addition to the heart failure proposal, there were examples of early work in adopting VBHC principles and the use of patient reported outcomes (PROMs) in other services, for example orthopaedics and audiology. National initiatives to establish PROMs continue to develop and these are supported by a national reporting system. Adoption of these PROMs and the deployment of the national reporting system is limited within BCU and is not supported by any organisational framework or resource.

### **Progress and Action Required**

The Acting Medical Director has been engaged in discussion with the national lead for VBHC, Dr Sally Lewis, who has indicated that support is available from the national team and colleagues elsewhere in Wales to assist the Health Board in developing its approach. Discussions have included the potential to secure some funding from Welsh Government to establish a core team to support the development and adoption of VBHC in the Health Board.

The following summarises the key issues and actions required to restart the VBHC work following the disruption caused by the pandemic response.

### **Leadership and Governance**

Visible Executive leadership of the VBHC agenda within the Health Board is critical. The Committee previously agreed that this should be provided by the Medical Director and the Finance Director. The Deputy Medical Director (currently Acting Medical Director) has been identified as the lead for driving forward this work. These arrangements remain appropriate going forward; however, given the impact of the pandemic upon the activity and profile of work aligned to VBHC, there is a need to communicate the purpose and approach to VBHC to clinicians and other staff across the organisation in a consistent manner.

## Appendix 7 – Value Based Healthcare Update

Governance arrangements for the VBHC programme were agreed to be delivered through the Clinical Effectiveness Group. The Terms of Reference for the Group have been refreshed to include this remit and make provision for a Steering Group to progress the VBHC programme. These arrangements remain appropriate and will be utilised to oversee the development of the programme and report its impact.

### Organisational Capacity

People – Organisational capacity to develop and mobilise a programme remains a challenge. There are no dedicated resources within the Health Board to undertake this task.

In discussions with Dr Sally Lewis, National Clinical Lead, this has been identified as a critical step in implementing an effective approach to VBHC. Reference has been made to the approach taken in Aneurin Bevan Health Board and also Swansea Bay. Discussions with colleagues in these organisations have identified a core range of skills that are required to facilitate the adoption of a VBHC approach and to ensure the necessary systems and information flows are in place to bring critical elements, such as PROMs, into daily clinical activity and decision making.

The following roles are considered critical to underpin a meaningful VBHC programme:

- Programme Manager
- Project Management / Improvement skills
- Information analyst
- Digital Infrastructure developer
- Administrative support

In addition to these core roles there are active contributions required from other functions, such as the wider improvement team and finance in order to support individual projects.

Establishing a central resource which can engage with clinical teams to help them deliver service transformation will enable a more rapid and systematic adoption of VBHC principles across the Health Board.

Systems – the ability to capture outcome data from various sources and report this in a meaningful way is critical to the success of VBHC. PROMs are one example where systems need to be deployed into clinical pathways to enable service improvement and change. Currently the Health Board does not have an agreed approach to this issue. A national platform is available, albeit with limited functionality at present. Other Health Boards have procured commercial solutions to enable the capture and reporting of PROMs. The Health Board will need to determine its approach to data capture and reporting.



## **Appendix 7 – Value Based Healthcare Update**

### Building a VBHC Programme

There are examples of a VBHC approach being adopted within the Health Board as previously referenced. The approach to clinical pathways work during COVID-19 has also incorporated essential elements of VBHC principles.

In addition, discussions with clinical teams, such as heart failure, have identified motivated clinicians who wish to adopt a VBHC approach. Increasingly, national programmes such as musculoskeletal, are adopting VBHC approaches. They are developing PROMs and working to incorporate these into the national PROMs platform with the expectation of local adoption across Health Boards. At present, this reflects a piecemeal approach, which will not optimise benefits for patients.

Recent experience within the Health Board in responding to the pandemic has seen clinicians come together to agree clinical pathways and drive rapid change in service delivery. Much of this work is reflective of the principles of VBHC and offers potential to develop as a core theme in the Board's VBHC programme. There are 32 such pathways currently available on the Health Board's intranet site. Furthermore, discussions within the Executive Team and Board have confirmed the need to adopt a clinical pathways approach to the development of a new Clinical Services Strategy and therefore embedding this into the VBHC programme is critical.

Determining priorities for VBHC and building a clear programme of work is a critical next step. In order to do this information needs to be collated which brings together:

- A register of current activities within the Health Board which align with the VBHC agenda.
- Intelligence regarding the approaches being adopted nationally and examples of successful work elsewhere.
- Health Board priorities for further work to embed VBHC within existing pathways and identification of new clinical areas where pathway development needs to progress.

### VBHC in Planning

In order to ensure that VBHC becomes a core element of the way in which the Health Board delivers current services and designs services for the future, its principles need to be embedded in the Health Board's planning systems and infrastructure. Adopting a clinical pathways approach to planning will be a key aspect of this.

Further action is required to ensure that the information that supports key decisions by the Health Board, in terms of service provision and resource allocation, includes clear evidence of the adoption of VBHC principles and approaches. Guidance in terms of planning approaches, business case development and investment decision making needs to be updated to include VBHC principles.

### **Next Steps**

The priorities and issues identified in this update will be progressed under the leadership of the Acting Medical Director and a further report and draft development programme will be included on the Committee's agenda for its December meeting.

## Appendix 8 – Financial Risks and Opportunities

	Issue	Description	£m	Key Decision Point & Summary Mitigation	Risk Owner
1	<b>Opportunity:</b> Red Pipeline Savings Schemes	– Red rated savings schemes that total £3.9m are currently held in pipeline and are due to start delivering over the next month.	3.9	– Work is progressing to move these schemes into amber / green. It is expected that all current schemes will be amber or green by the end of October.	Sue Hill, Acting Executive Director of Finance
2	<b>Risk:</b> Vaccination Programme for Flu and COVID-19	– An initial estimate for the cost of the extension of the flu vaccination programme and a potential COVID-19 vaccination programme have been included in the forecast this month. Welsh Government income to match these costs has also been included in the forecast. However, there is a risk that these costs will be higher than currently forecast.		– An initial plan has been submitted to Welsh Government for the flu and COVID-19 vaccination programme. The plan continues to be developed.	Sue Hill, Acting Executive Director of Finance
3	<b>Risk:</b> Savings Programme	– There is a risk that the amber schemes within the savings programme will not deliver to their forecast values.		– The Executive Team is currently considering options and capacity requirements for the savings delivery and PMO function to be re-established, which will provide dedicated capacity to drive forward the schemes currently identified.	Sue Hill, Acting Executive Director of Finance
4	<b>Risk:</b> 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	<b>Risk:</b> 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

<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance &amp; Performance Committee - 29 October 2020</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Financial Governance Cell – Update on Controlled Self-Assessment						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Sue Hill, Acting Executive Director of Finance						
<b>Awdur yr Adroddiad Report Author:</b>	Nigel McCann, Chief Finance Officer, Chair of Financial Governance Cell						
<b>Craffu blaenorol: Prior Scrutiny:</b>	Sue Hill, Acting Executive Director of Finance						
<b>Atodiadau Appendices:</b>	APPENDIX A – Completed Governance Self-Assessment Checklist APPENDIX B – Advisory Review Briefing Note, CV19 Discretionary Capital APPENDIX C – All Wales Directors of Finance views and findings APPENDIX D – Draft Work-plan						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to:							
<p>a) <i>Note the collaborative work undertaken through the Financial Governance Cell</i></p> <p>b) <i>Note the Areas of Good Practice and the Lessons Learned suggestions from the Governance Cell.</i></p> <p>c) <i>Consider the next steps (Draft Action Plan) and the future role of the Governance Cell.</i></p>							
Please tick as appropriate							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/Approval</b>	✓	<b>Ar gyfer Trafodaeth For Discussion</b>	✓	<b>Ar gyfer sicrwydd For Assurance</b>	✓	<b>Er gwybodaeth For Information</b>	
<b>Sefyllfa / Situation:</b>							
This paper summarises the work of the Financial Governance Cell working in partnership with Internal Audit and Audit Wales, also building on work undertaken across NHS Wales through the Directors of Finance, in the context of a fast emerging pandemic response.							
The Acting Executive Director of Finance presented an interim Briefing Paper to the August Committee in August 2020 highlighting performance against the Welsh Government COVID-19 Guidance.							
<b>Cefndir / Background:</b>							
The Welsh Government issued Guidance to Chief Executives on the 30 March 2020 specifically in relation to Financial Governance and Decision-Making during the COVID-19 (CV19) emergency period and response.							
On the 3 April 2020, the Acting Executive Director of Finance shared the Welsh Government Guidance with all Directors and Divisions, clearly setting out the Financial Governance arrangements and controls that were being put in place across the Health Board.							
The Acting Executive Director of Finance established the Financial Governance Cell, working in partnership with Internal Audit and Audit Wales, to review these arrangements.							
<b>Asesiad / Assessment &amp; Analysis</b>							

## 1. Strategy Implications

The August Committee was provided with a Self-Assessment against the key Principles of Financial Governance set out in the Welsh Government Guidance of the 30<sup>th</sup> March 2020.

This Report now draws out the main “Lessons Learned” identified through the Financial Governance Self-Assessment and the small number of response items highlighted in **blue-bold** in Appendix A.

## 2. Options considered

This is a Briefing Paper to provide the Committee with an update the work of the Financial Governance Cell.

## 3. Financial Governance Summary

The in-month and year to date costs of CV19, and the income and funding assumptions are detailed in the Month 6 Finance Report and in the Welsh Government Monitoring Return Tables.

This paper focusses on the main areas of good governance and the lessons learned processes and controls that could be undertaken differently in the future.

### 3a. What went well and is regarded as good financial governance

1	The Acting Executive Director of Finance issued formal and detailed Guidance to all Directors and Budget Managers on the 3 <sup>rd</sup> April ahead of the new financial year. This guidance covered revenue, capital and charitable funds income and expenditure.
2	The Acting Executive Director of Finance established the Finance Governance Cell in April.
3	Joint working with Internal Audit, Audit Wales, Procurement and Payroll, Workforce.
4	Senior finance staff in place across HECC, OCC and all CV19 financial decisions.
5	Financial controls were built around <u>existing</u> systems; Divisional Scheme of Reservation and Delegation (SORD); Oracle, ESR; e-Rostering; Establishment Control; TRAC.
6	A unique set of CV19 cost centres were created within each individual Division, to ensure local control and accountability over financial decisions, as well as to facilitate comprehensive CV19 Cost Reporting at the Divisional, Board and Welsh Government levels.
7	Expenditure charged against the cost of CV19 was scrutinised and reversed where not consistent with the Health Board process guidance.
8	While the annual accounts timetable was extended to the 22 <sup>nd</sup> May, the accounts and statements were produced in line within the original deadline of the 7 <sup>th</sup> May, with all teams working remotely. Audit Wales did not observe any significant issues in their audit.
9	The finance team adapted to remote working without impacting on reporting timescales or key Finance activities.
10	The Health Board continued to pay suppliers, contractors and public sector partners within agreed guidance, policy and timescale and we achieved the PSPP target.
11	Whilst working remotely, Counter Fraud remained operational throughout and formal fraud updates were provided in the weekly bulletins.
12	The Finance Department had an existing Business Systems Continuity Plan in place pre-CV19, which provided the starting point for the rapid transition to remote working.
13	The Finance Department developed the process for the daily PPE Stock Counts and reporting to HECC, and led the build of a PPE Modelling toolkit.

### **3b. What could be strengthened in any future emergency need;**

1	Specific reporting guidance agreed with and issued to NHS organisations in relation to both funding and expenditure in a timely manner to ensure consistency of approach.
2	Existing controls need to be reviewed to ensure they are robust enough to deal with the additional requirements identified through the recent, current experience of responding to a pandemic.
3	In establishing an Emergency Control Structure (HECC, OCC or equivalent), the Health Board should also formally establish a temporary / time-limited Scheme of Delegation (SORD), a comprehensive set of Terms of Reference (TOR) and a Decision-making Framework, which apply across all Committees, Groups and sub-groups within the Control Structure.

### **3c What could be strengthened as part of business as usual;**

1	Consolidate and improve links with NWSSP Procurement to agree further controls over; purchase orders between £5,000 and the £25,000 Tender limits; PPE; and Stock.
2	Review the existing Conformance Report to Audit Committee in relation to recommendations in this paper.
3	Standardise the ongoing review of SORDs and approval controls (system hierarchies) into the monthly reporting and budgetary control arrangements.
4	Embed the benefits of flexible and agile working into the way that corporate functions are structured and ensure that governance and risk arrangements reflect this new way of working.
5	Continually review and refresh the Business Continuity Plans and Desktop Procedures, especially as the organisation moves to a more flexible and agile working arrangement.
6	Continue the positive engagement and joint finance working with partners (e.g. Local Authorities through the Regional Partnership Board and its sub-structures)
7	The Health Board should maintain a register of non-standard pay terms and conditions and payments against such.
8	Review controls over critical stock to ensure that such stock is secured appropriately to reduce the risk of theft, and to ensure that the processes for ordering, recording and controlling such stock is as efficient as it can be (e.g. PPE).
9	Ensure that insurance and indemnity arrangements are adequate to cover any additional sites or services that may need to be established.

### **3d Additional points from the All-Wales Directors of Finance, not already identified;**

1	Further develop techniques and the use of dynamic capacity and capability modelling.
2	Earlier collaboration on consistent planning assumptions & modelling approaches.
3	Consider earlier joint working between Directors of Finance and Directors of Workforce.
4	Review, identify and share best practice in relation to managing risk.
5	Information Governance – ensure the security of information when remote working.
6	Review and improve capacity, skills and competencies re Modelling & Analytics.
7	Finance should ensure that Value Based Healthcare is embedded in recovery plans.
8	Maximise opportunities to deliver VFM through Regional and Partnership working.
9	Field Hospitals

#### **4. Risk Analysis**

The COVID-19 specific Finance Risk (ID 3152) is logged and continues to be monitored in light of the recent receipt of and additional £83million of Funding from Welsh Government:

#### **5. Legal and Compliance**

Not Applicable.

#### **6. Impact Assessment & Recommendations**

This briefing paper has summarised the key findings, elements of good practice and learning opportunities, identified through the Financial Governance Cell established by the Acting Executive Director of Finance in April 2020.

The Committee is asked to:

- a)** Note the positive actions and controls that were put in place in advance of the CV19 Response
- b)** Note the level of work undertaken to date through the Finance Governance Cell and the Controlled Self-Assessment
- c)** Note the joint working through the Finance Governance Cell, across Finance, Workforce, Information Governance, Shared Services (NWSSP), Internal Audit and Audit Wales
- d)** Consider the Lessons Learned and the Draft Action Plan as set out in Appendix D

## **APPENDIX D : DRAFT ACTION PLAN**

<b>ID</b>	<b>Theme</b>	<b>Action Narrative</b>	<b>Lead Exec</b>	<b>Supported By</b>	<b>Timescale</b>
1	Emergency Control Structures & Arrangements	Controls and Emergency Plans need to be reviewed to ensure they are robust enough to deal with the additional requirements identified through the recent, current experience of responding to a pandemic.	Director of Planning & Performance	Finance	30/11/20
2	Emergency Control Structures & Arrangements	Board to formally agree an Emergency SORD and any necessary changes to SO's and SFI's	Company Secretary	Finance	31/12/20
3	Emergency Control Structures & Arrangements	Consider and the need for centralised control over certain aspects, for example; PPE Stock, Asset Tracking, Ad-Hoc Pay Arrangements.	Director of Finance	WOD / Procurement	31/3/21
4	Business Continuity & Procedures	All Departments to review, refresh (or develop) BCP's and Desktop Procedures / SOP's, reflective of the increased move towards flexible, agile and home working.	Director of Finance	ICT	31/12/20
5	Retrospective Review	Review of significant investments / CV19 expenditure to identify the additional benefit / outcome that this investment delivered and future use (where relevant).	Director of Finance	Planning & Performance	31/3/21
6	Skills, Capacity & Capability	Critical review of skills, capacity and tools for dynamic modelling, planning and prioritising.	Director Primary & Community Care	ICT; Planning & Performance	31/12/20
7	Field Hospitals	Formally review the DoF Recommendations.	Director of Finance	Planning & Performance	31/12/20
8	Collaboration	Review how to maximise joint working, both internally across Departments and externally	Chief Executive		31/3/21

## **Betsi Cadwaladr University Health Board**

### **COVID-19 Financial Governance self-assessment**

**Internal Audit**

**BCU 2020/21**

**October 2020**

**NHS Wales Shared Services Partnership**



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## Introduction and Background

On the 30<sup>th</sup> March 2020 the Director General Health & Social Services/NHS Wales Chief Executive wrote to all NHS Wales Chief Executives concerning 'COVID-19 Decision Making and Financial Guidance'. The letter included specific guidance titled 'COVID-19 Financial Guidance to NHS Wales' Organisations' that had eleven key headings:

- Financial Governance.
- Core Financial Systems & Processes.
- Counter Fraud.
- Revenue & Capital Allocations and Cash.
- Ring-fenced Allocations (excluding DEL/AME Non Cash Depreciation).
- Cost Reimbursement – Revenue Costs.
- Financial Reporting & Monitoring.
- Capital.
- Purchase of enhanced discharge support services / Partnership arrangements.
- Cross-Border Flows.
- Primary Care Contractors.

On the 3<sup>rd</sup> April 2020, the Executive Director of Finance wrote out to Directors and senior officers outlining the key messages that needed to be adhered to during the COVID-19 pandemic, these included:

- Ensuring adherence to 'Managing Welsh Public Money'.
- Compliance with Standing Financial Instructions and Standing Orders for all investment and expenditure.
- Issue of additional financial guidance and policy where services develop further.

## Associated Risks

- Financial guidance issued by Welsh Government and Director of Finance is not adhered to.
- Poor decision making with non-compliance with Standing Orders and Standing Financial Instructions.
- Value for money is not achieved.

## Self-assessment Checklist

Following the request to prepare a self-assessment checklist this document was prepared, a number of key documents and sources were reviewed and a list of expected controls was collated. The resulting table is detailed below:

**Table 1 – Self assessment checklist**

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>1. Board meetings</b></p> <p>a) Have agendas been reviewed to ensure meetings are focused on key risks both in relation to the Covid crisis and those identified in the Corporate Risk register.</p> <p>b) To enable meetings to function as required and informed decisions to be made are papers as submitted being streamlined?</p> <p>c) Are meetings being held virtually where possible, is the technology in place to support this, with all Members able to contribute when desired?</p> <p>d) Have arrangements been made to exclude the public from Board meetings in compliance with The Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020?</p>	<p>In addition to the Command and Control structure, the Health Board implemented a range of temporary measures to facilitate new ways of working including:</p> <ul style="list-style-type: none"> <li>• Streamlining the Board and Committee structure including the suspension of Committees of the Board, excepting the Audit and Quality, Safety and Experience Committees;</li> <li>• Introduction of virtual meetings with the available telephone and video conferencing facilities and changes to the public's access to meetings and records; and</li> <li>• Created a Cabinet, where the Board considered and approved its Terms of Reference, which detailed its purpose "...to be responsible for oversight of key high-level strategic matters relating to the Health Board's response to the health emergency presented by the Covid-19 pandemic. This will involve consideration of the outputs of</li> </ul>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter to Board Secretaries from the Director of Mental Health, Vulnerable Groups and NHS Governance, 26<sup>th</sup> March 2020: <i>Advice/Proposals from NHS Board Secretaries/Directors of Corporate Governance on Covid-19</i></p> <p>Welsh Government Guidance Note: <i>Discharging Board Committee Responsibilities during COVID-19 response phase</i></p> <p>Standing Orders</p>

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>e) Have quoracy requirements been reviewed?</p> <p><b>2. Committee meetings (see Board meetings)</b></p> <p>a) Have Committees been reviewed and streamlined or delayed where appropriate?</p> <p>b) How is assurance and issues for escalation being addressed due to possible suspension in Committees' meeting/reduced focus on key issues?</p> <p>c) Have quoracy requirements been reviewed and mandatory attendance by relevant Executives determined and formally approved by the Board?</p>	<p>Gold Command and other levels within the Command Structure as necessary - providing scrutiny, challenge and seeking assurance - and also decision-making on those matters requiring escalation to the full Board."</p> <ul style="list-style-type: none"> <li>The Health Board moved quickly to ensure that Board and Committee meetings could continue to be held virtually in order to comply with social distancing and other Welsh Government guidance, with Executive Directors and Independent Members showing a great deal of flexibility. Members of the public were unable to observe Board meetings until the Board meeting of the 21st May 2020, intended for live streaming via Webex and Youtube, but despite two successful dry runs, the live stream failed due to technical issues. Subsequently the Board has successfully streamed live on Youtube on the 23rd July 2020.</li> <li>The Board, Audit Committee and Quality, Safety and Experience Committee (QSE) continued to operate, with all other</li> </ul>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Welsh Government Guidance Note: <i>Discharging Board Committee Responsibilities during COVID-19 response phase</i></p>

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
	Committees stood down. This was formalised through the Board meeting of the 15th April 2020 and detailed within the 'Maintaining Good Governance COVID-19' paper.		
<b>3. Executive roles and responsibilities – Scheme of Reservation and Delegation (SoRD)</b>  a) Has the SoRD been updated to reflect changes to enable delivery of COVID-19 whilst also maintaining business as usual services? Where were these changes approved? b) Is there a specific SoRD for the HECC and Field Hospitals (where relevant) that has been formally approved by the Board? c) Confirm that changes made to delegated limits, authorised signatories are subject to	a) The SORD was not updated however the Standing Orders were amended for administrative purposes.  <b>b) No there was no specific SORD or full Terms of Reference for the HECC or its Sub-Structures.</b>	<b>Governance Arrangements during the Covid-19 Pandemic</b>  Advisory Review Final Report 2020/21  Betsi Cadwaladr University Health Board  Audit and Assurance Services	Welsh Government Guidance Note: <i>Discharging Board Committee Responsibilities during COVID-19 response phase</i>  Letter from Director General Health and Social Services/NHS Wales Chief Executive 30 <sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales' organisations</i>  Standing Orders

Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
review, and where appropriate reversal, once COVID-19 arrangements are stood down and decommissioning is complete.	c) Whilst the change made to the SO's was only for administrative purposes, The Audit Committee meeting on the 28th July 2020 received a paper 'Resetting Governance' to formally reset the temporary governance arrangements and associated Standing Order amendments.		
<b>4. Emergency powers and decision making</b>  a) Does the SoRD capture any revised decision-making processes including emergency powers? b) Is there a documented reporting process in place that formally records decisions taken that are formally reported to the Board?	a) <b>There was no dedicated SORD or full Terms of Reference for the HECC.</b>  b) HECC and all its sub-structures were required to maintain formal Decision Logs.	<b>Governance Arrangements during the Covid-19 Pandemic</b>  Advisory Review Final Report 2020/21  Betsi Cadwaladr University Health Board  Audit and Assurance Services	Welsh Government Guidance Note: <i>Discharging Board Committee Responsibilities during COVID-19 response phase</i>  Standing Orders



Strategic Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>5. Changes to Governance arrangements</b></p> <p>a) Are arrangements in place to keep revised structures under review as the situation changes?</p> <p>b) What steps are being taken to ensure conflicts of interest in decision making are not encountered between Operational and HECC management structures?</p> <p>c) Have key controls been identified in the event of reduced staff numbers in key areas to reduce the risk of fraud e.g. segregation of duties.</p>	<p>a) Yes, further evidenced by the recent appointment of the “Associate Director COVID” reporting to the Executive Director of Primary Care &amp; Community.</p> <p>b) All Decisions were formally logged.</p> <p>c) Under the Workforce SRO Group, 3 Workforce Hubs were established and a Redeployment Process and central log was created and maintained.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Standing Orders</p> <p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales’ organisations</i></p>

Risk Management			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>6. Risk Management</b></p> <p>a) Are risk management arrangements appropriately factored in the COVID-19 management and operational structure?</p> <p>b) Do all decisions taken have a documented risk assessment?</p> <p>c) Is there a COVID-19 risk register and what scrutiny is in place to oversee the risks and ensure control measures are effective?</p> <p>d) Step up and step down arrangements/plans for potential second/third spikes in cases are identified and known?</p>	<p>a) Risk Management arrangements remained extant throughout, <b>although the Guidance on Decision Making for Command did not provide the full criteria for risk rating.</b></p> <p>b) Decision Logs recorded Risks.</p> <p>c) A specific CV19 Risk Register was established and reported to Cabinet and all Work streams reported Risks into HECC.</p> <p>d) Managed through the HECC, Executive Team and through the Executive Director of Primary Care and Community.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales’ organisations</i></p> <p>Risk Management Strategy and Policy</p>



Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>7. Standing Financial Instructions (SFIs)</b></p> <p>a) Have any changes been made to the SFI's?</p> <p>i. If yes, what were the changes and have they been formally approved by the Board?</p>	<p>a) No changes were made to the SFI's.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Standing Financial Instructions</p> <p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales' organisations</i></p> <p>HFMA Covid-19 Briefing March 2020 <i>"Covid-19 financial governance considerations"</i></p>
<p><b>8. Annual Accounts</b></p> <p>a) Has the accounts timetable been updated to reflect new deadlines issued by Welsh Government?</p> <p>b) Have the revised reporting requirements been received,</p>	<p>a) Yes the timetable was updated, however we successfully delivered the Accounts in line with the original timetable.</p> <p>b) Yes.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>communicated effectively and being worked to?</p> <p>c) Have any changes to year-end processes been made? If so, where have these been formally agreed?</p>	<p>c) Accounts were delivered within the normal timetable and complied with Welsh Government Guidance, with no significant issues raised by Audit Wales.</p>	<p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	
<p><b>9. Authorised Signatories/Approval Hierarchy in E-Financials/Delegated limits</b></p> <p>a) Are additional authorised signatories required to ensure 'contingency'/ cover arrangements for when staff are absent or operating remotely - Have any changes been made and subject to formal approval and recorded?</p> <p>b) Are electronic signatures (for bank account signatories) held securely and are processes in place to maintain an audit trail of usage?</p>	<p>a) <b>No changes were made to the SORD's</b></p> <p>b) Yes, Bank Account signatories and controls are all managed via Financial Services.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales' organisations</i></p> <p>Letter from Executive Director of Finance 3<sup>rd</sup> April 2020, <i>COVID-19; Financial Governance and Decision Making</i></p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>c) Where appropriate has the Divisional SoRD been updated and formally approved by the Board Secretary?</p> <p>d) Have any changes been made to the E-Financials Hierarchy? If so, what are they and have they been formally approved the lead Director/Director of Finance?</p> <p>e) Review of changes in financial controls e.g. delegated limits, signatories, to ensure appropriate mitigations/reporting of changes and documenting formal approval by the Board.</p>	<p>c) No formal Changes were made, although <b>one Division did make administrative changes to their SORD.</b></p> <p>d) The key changes were the addition of CV19 specific cost centres, which was led by Finance.</p> <p>e) No Changes were made.</p>		
<p><b>10. Systems and processes (Standing Financial Instructions)</b></p> <p>a) Are processes in place to update/develop procedures to support system changes/new systems?</p>	<p>a) Yes, Business Systems is managed as a single Team within the overall Finance Department.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 COVID-19 – Decision Making that included Financial Guidance and COVID-19 - Financial Guidance to</p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>b) Are procedure notes and operational procedures available for all staff in relation to key systems and processes.</p> <p>c) In addition are details around revised arrangements available to view in conjunction with the main procedures to which the changes pertain.</p> <p>d) A Financial Governance document has been issued in relation to the Field Hospitals and all related expenditure.</p> <p>e) Have significant investments, for example an extra 1,000 beds, been asset-tracked and will they be able to be re-deployed on de-commissioning, with clear financial benefits visible in both revenue and capital plans for 2021/22?</p> <p>f) Is there a Finance Directorate Business Continuity and Disaster Recovery Plan in place,</p>	<p>b) <b>NO – these are currently being developed</b></p> <p>c) <b>NO – these are currently being developed</b></p> <p>d) Yes, via the Temporary Hospital Capacity Silver Group</p> <p>e) <b>In part yes, but some assets (such as these beds) are not owned by the Health Board and as such do not sit on the HB Asset Register.</b> <b>The HB may wish to consider its wider strategy for Asset Tracking.</b></p> <p>f) Yes</p>	<p>Betsi Cadwaladr University Health Board Audit and Assurance Services</p> <p>KPMG Review of Field Hospitals</p>	<p><i>NHS Wales' organisations</i> Letter from Executive Director of Finance 3<sup>rd</sup> April 2020, <i>COVID-19; Financial Governance and Decision Making</i> Field Hospital financial governance framework Manual for Accounts 2019/20 HFMA Covid-19 Briefing March 2020 <i>"Covid-19 financial governance considerations"</i></p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>in accordance with Health Board Policy?</p> <p>i. Has it been communicated to all staff who are aware of its existence and where to obtain a copy?</p> <p>ii. When was it last updated, tested and lessons learnt?</p> <p>iii. The plan records both recovery and continuity arrangements for all core financial systems, financial systems, monitoring, reporting and continued service delivery across the broad services the Finance Directorate are accountable for.</p> <p>g) Do all proposed/actual service delivery solutions in response to COVID-19, e.g. field hospitals, testing centres, have appropriate NHS Indemnity arrangements and documented advice from Welsh Risk Pool?</p>	<p>Yes.</p> <p>Updated March 2020.</p> <p>Yes, and was updated to include NWSSP managed services such as Payroll and Procurement.</p> <p>g) NWSSP issued an updated Indemnity Paper.</p>	<p>NHS Wales Shared Service Partnership Document</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>h) Procedures, and rules for key systems are available and accessible to all appropriate staff (both hard copy and electronically) to support staff required to undertake roles outside of their normal duties.</p> <p>i) In light of pressures on key stock items e.g PPE/single use items to ensure all items are available at the right times to deliver patient care:</p> <p>i. What documented stock check procedures are in place for products in high demand?</p> <p>ii. Have additional, more frequent, stock checks been introduced?</p> <p>iii. Is distribution of stock effective to limit reduce the risk of no stock available for patients/staff?</p>	<p>h) <b>NO – these are currently being developed.</b></p> <p>i) A detailed PPE Stock Policy / SOP was put in place, initially through the Finance SRO and then later managed by the Executive Director of Nursing &amp; Midwifery through a Daily PPE Steering Group and PPE SRO Group.</p> <p>Stock counts were coordinated through Finance and taken daily, 7 days a week by all Divisions (including Mental Health).</p> <p>Where necessary, PPE Stock was moved between Divisions / Sites to ensure that adequate stocks were available.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>j) <b>NHS organisations/Primary Care/Care Home/Local Authorities</b> – If stock/items are moved, what records have been kept of where these items have/are /being sent to ensure that they are appropriately accounted for and are not lost or wasted?</p> <p>k) <b>Losses and Special Payments</b> – Have the requirements set out in the Manual for Accounts and Finance Procedure F06 been followed for any items/services that meet the criteria for recording as loss/special payment?</p>	<p>j) Stock counts were coordinated through Finance and taken daily, 7 days a week by all Divisions (including Mental Health). Where necessary, PPE Stock was moved between Divisions / Sites to ensure that adequate stocks were available.</p> <p>k) There have been no Health Board losses or write offs relating to CV19 recorded, however had there been a need then the Policy would have been followed.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	
<p><b>11. COVID-19 Expenditure</b></p> <p>a) Has the Health Board continued to ensure its core Financial Systems (Oracle and ESR) is used for all expenditure; pay,</p>	<p><b>General point regarding Value &amp; Impact.</b></p> <p>a) Yes, the Health Board continued to use all existing systems and controls to manage CV19 income and expenditure.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance</i></p>



[illegible]



Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>c) The Health Board has developed a process that clearly collects all COVID-19 financial information that includes all details supporting all decisions taken.</p> <p>d) The Health Board has developed a robust reporting process to record the reduction in planned care, resources freed up from this reduction and how it is being used to support COVID-19 expenditure.</p> <p>e) The Executive Director of Finance letter of the 3<sup>rd</sup> April 2020 details the control process template documentation required to be followed within the Health Board for recording <u>all</u> Capital investment-decisions and <u>all</u> Revenue investment-decisions.</p> <p>i. Are all capital and revenue specific COVID-19 expenditure supported by a capital/revenue fund</p>	<p>c) Yes, CV19 spend formally reviewed and reported to the Board and Welsh Government.</p> <p>d) "Savings" from the reduction in planned care form part of the formal monthly Monitoring Return report to Welsh Government.</p> <p>e) All revenue expenditure was managed through the Divisional SORD and Oracle approval hierarchies however Not ALL revenue items were supported by a "Request Form" as an operational de-minims level was put in place, however all spend was approved by an authorised manager.</p> <p><b>See previous comment (11-b) re the reporting of Capital Expenditure decisions to HECC Command and the Health Board</b></p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p> <p>Advisory Review Second Draft Briefing Note: COVID-19 Discretionary Capital Expenditure</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>request form? Have all sections been completed in full and all authorisation sections complete in accordance with the SoRD?</p> <p>ii. In raising the required Oracle requisition, has the funding request form been attached to the requisition?</p> <p>iii. For Pharmacy/Estates systems COVID-19 specific expenditure, all Capital and Revenue request forms are included with the requisition?</p> <p>f) If quotation/ tender arrangements need to be waived, are processes in place to document this?</p> <p>i. Have any Single Quotation/Tender Actions been completed for COVID-19 expenditure and formally approved and reported on in line with SFI's?</p>	<p>f) <b>Retrospectively a number of expenditure items should have been supported by a STW, and as such are reported in the Conformance Report.</b></p> <p><b>The Tender &amp; Quotes approach needs to be reviewed heading into 20/21.</b></p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>g) Have any changes/streamlining of process been made to adding a new supplier for procurement purposes?</p> <p>i. What due diligence and supplier checks have/are being made?</p> <p>h) Prepayments</p> <p>i. The Health Board has robust processes in place to ensure any prepayment is compliant with Standing Financial Instruction 14.4 - Prepayments?</p> <p>ii. Has the Health Board identified any goods/services, prior to COVID-19, were scheduled to be delivered but due to restrictions have not been carried out e.g. planned maintenance/servicing of equipment?</p>	<p>g) All new Suppliers are created using NWSSP Process and checks.</p> <p>h) No specific payments in advance were made.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>iii. What steps are being/will be taken to ensure the Health Board is not paying for services it has not received?</p> <p>i) Recruitment – Have all posts been subject to the Establishment Control process approval and supported by a completed Revenue Fund Request form?</p> <p>j) Recruitment – Have all pre-employment checks, references etc been sought prior to confirming a start date due to the pressures on service delivery?</p> <p>k) Recruitment – Have any non-Agenda for Change rates/Incentives been made to attract staff? Have these been formally approved by the Remuneration and Terms of Service Committee?</p>	<p>i) All recruitment activities are approved through the Establishment Control and TRAC process.</p> <p>j) Audit were not able to verify all pre-employment checks were undertaken by NWSSP</p> <p>k) <b>A Non-A4C change to Overtime payments for Band 8 and Band 9 staff was implemented, although it is not clear that this decision was escalated to HECC Command or the Health Board for ratification.</b></p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>12. Payments to Agency, Locum and Substantive staff</b></p> <p>a) What approval process is in place to ensure agency/locum payments, enhanced rates and use of non-contract agency(ies) is appropriately approved prior to engagement? Is this adequately recorded in the SoRD?</p> <p>b) What process is in place to formally approve any overtime and other enhancements for senior managers, other officers involved with COVID-19, ensuring value for money and service needs at all times?</p>	<p>a) Agency spend was approved through the normal route with any “above cap” rates requiring Director approval.</p> <p>Agency Spend is formally reported to the Health Board and Welsh Government every month.</p> <p>b) <b>See 11.k) – the Policy was not explicitly clear who it applied to and who should approve claims; the evidence sample identified varying levels of approval.</b>  <b>The Overtime Form lacked any narrative section for the individual to document exactly what CV19 related duties they were undertaking during these overtime hours as such the sample reviewed could only identify the number of hours and the value paid and the approver.</b></p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales’ organisations</i></p> <p>Letter from Executive Director of Finance 3<sup>rd</sup> April 2020, <i>COVID-19; Financial Governance and Decision Making</i></p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>13. Financial reporting</b></p> <p>The Health Board is complying with the revised reporting arrangements set by Welsh Government, including, amongst others the following:</p> <ul style="list-style-type: none"> <li>i. Baseline position pre COVID-19 (per previous financial plan).</li> <li>ii. Year to date and forecast outturn</li> <li>iii. Risks.</li> <li>iv. Allocation and Income assumptions.</li> <li>v. Cashflow and capital assumptions.</li> <li>vi. Additional COVID-19 expenditure incurred.</li> <li>vii. Planned expenditure or investments not incurred due to COVID-19.</li> </ul>	<p>Financial Reporting internally within the Divisions and to the Health Board and its Committees includes a full suite and range of CV19 related reports and analysis.</p> <p>Reporting to the Welsh Government is fully prepared in line with the Mentoring Return and the additional CV19 Tables.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations</i></p> <p>Letter from Executive Director of Finance 3<sup>rd</sup> April 2020, <i>COVID-19; Financial Governance and Decision Making</i></p> <p>HFMA Covid-19 Briefing March 2020 <i>"Covid-19 financial governance considerations"</i></p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<b>14. 2020/21 budget and month end processes</b>  a) Is a 2020/21 budget in place to support financial reporting? b) Do the financial reports clearly identify the implications of COVID-19 against the Board approved budget? Has this been reported on regularly? c) Are there any proposed changes to month end processes? d) Have cashflow forecasting and reporting processes been reviewed?	a) The 20/21 Budget was approved at the Board on the 1th April 2020.  b) Monthly reports clearly spate out all CV19 costs and income and risk assumptions.  c) During the Pandemic, Monthly reporting has remained at Day 4 with a Day 5 positon reported to Welsh Government.  d) Cash Flow is reviewed and reported monthly.	<b>Governance Arrangements during the Covid-19 Pandemic</b>  Advisory Review Final Report 2020/21  Betsi Cadwaladr University Health Board  Audit and Assurance Services	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30 <sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations</i>  Standing Orders  Standing Financial Instructions  HFMA Covid-19 Briefing March 2020 <i>"Covid-19 financial governance considerations"</i>
<b>15. Savings</b>  a) Are arrangements in place to report the 2019/20 position?	a) Savings Performance continues to be reported monthly to Divisions the Board and its Committees and to Welsh Government.	<b>Governance Arrangements during the Covid-19 Pandemic</b>	Letter from Director General Health and Social Services/NHS Wales Chief Executive 30 <sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance</i>



Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>b) What savings/service redesign programmes will/will not be maintained/ceased in 2020/21?</p> <p>c) What progress to date has been made in identifying savings already achieved and reported on, remaining conscious of the need to maintain financial prudence?</p> <p>d) What steps are in place to re-start the savings programmes once the normal position returns?</p> <p>e) The Health Board has a clear assessment of the forecast outturn on non-delivery of planned savings?</p>	<p>b) All schemes continue to be pursued, although it is recognise that Workforce Schemes may be delayed as staff are required to focus on supporting the CV19 response.</p> <p>c) Savings continue to be tracked through Finance and reported to the Board, Committee and Welsh Government</p> <p>d) Specific Savings “re-start” processes discussed at Executive Team and the Board and its Committees.</p> <p>e) Savings continue to be tracked through Finance and reported to the Board, Committee and Welsh Government</p>	<p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>and COVID-19 - Financial Guidance to NHS Wales’ organisations</p> <p>Standing Orders</p> <p>Standing Financial Instructions</p>



Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>16. Capital</b></p> <p>a) Is the Health Board cognisant of Welsh Government's requirements in respect of:</p> <p>i. Where additional capital funding is required above approved Capital Resource Limits (CRLs) and Capital Expenditure Limits (CELs).</p> <p>ii. Depreciation funding requirements above baseline.</p> <p>b) Is the Health Board/Committee being kept aware of all capital projects and progress during this time?</p> <p>c) Are systems and processes in place to capture specific IT expenditure relating to COVID-19?</p>	<p><b>See capital comment in Section 11b &amp; e</b></p> <p>a) Yes, capital is managed through CPMT and all allocations and expenditure are managed through the CRL.</p> <p>b) Capital reporting is included in the Board Finance Report and in the Welsh Government Monitoring Return.</p> <p>c) All IT spend is managed via the IT Department.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations</i></p> <p>Standing Orders</p> <p>Standing Financial Instructions</p> <p>HFMA Covid-19 Briefing March 2020 <i>"Covid-19 financial governance considerations"</i></p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>17. Partnership arrangements/Enhanced Discharge support services</b></p> <p>a) Where the Health Board has purchased additional capacity, has this been in accordance with the Standing Financial Instructions and revenue purchase guidelines? What additional capacity has been purchased locally?</p> <p>b) Use of the Integrated Care Fund has been revisited, re-aligned where necessary to focus on emerging pressures from COVID-19.</p>	<p>a) Additional capacity has been secured (eg Spire), through the agreed Contracts Team and process.</p> <p>b) ICF funds (Revenue and capital) have been re-allocated to support CV19, with the full approval of the NWRPB and Welsh Government ICF Team.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p> <p>North Wales Regional Partnership Board</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020</p> <p><i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 – Financial Guidance to NHS Wales’ organisations</i></p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>18. Cross-Border Flows and Long Term Agreements</b></p> <p>a) What block contracts have been agreed during this period and have the implications of these been assessed and reported on? Are they the right contracts?</p> <p>b) Have the Standing Financial Instructions/delegated limits been complied with in agreeing and signing the contracts?</p> <p>c) What are the financial consequences/risk to the Health Board in agreeing block contracts and has the Health Board been made aware of this?</p> <p>d) What arrangements are in place to monitor the contracts?</p> <p>e) Has the all-Wales approach endorsed by Welsh Government for long-term agreements been shared with the Health Board with any financial risk of the approach identified?</p>	<p>a) All existing contracts have been retained. and rolled over from 2019/20</p> <p>b) Yes.</p> <p>c) The ongoing cost of these contracts and the financial risk, is reported to the Board and its Committees.</p> <p>d) Contracts are monitored monthly through the Finance Contracting team.</p> <p>e) Yes, all payments and contracts re in line with the National Guidance and Policy, with the financial risk reported to the Board and its Committees.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations</i></p> <p>Standing Orders</p> <p>Standing Financial Instructions</p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>19. Primary Care Contractors</b></p> <p>a) How are additional costs for COVID-19 being captured, scrutinised by the Health Board and re-imbursement sought from Welsh Government?</p> <p>b) Has further guidance been received by the Health Board from Welsh Government Policy Leads that have a financial consequence/risk for the Health Board and is being complied with?</p>	<p>a) GMS Contractors are required to make formal claims for CV19 financial support on an agreed Claim Form, approved by the relevant Area Director in line with the SORD.</p> <p>All CV19 spend (including GMS and GDS) is reported to Welsh Government via the Monitoring return Tables, a specific CV19 Table has been established.</p> <p>b) Welsh Government Guidance received in relation to the use of Cluster Funds and in relation to the payment of GMS / GDS and Optometrists – all Guidance has been and is being followed.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations</i></p> <p>Standing Orders</p> <p>Standing Financial Instructions</p>

Financial Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>20. Decommissioning of Temporary sites/services</b></p> <p>a) The Health Board has a documented process detailing expected controls that when the time comes, it vacates all property/services used as part of COVID-19 in a structured manner, ensuring value for money.</p> <p>b) All items are tracked and traceable when re-distributed/ongoing services e.g. oxygen/heat/light/water are terminated etc.</p>	<p>a) Field Hospital contracts include Decommissioning arrangements.</p> <p><a href="#">See asset tracker comment above; 10e).</a></p>	<p>KPMG Review of Field Hospitals</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 <i>COVID-19 – Decision Making</i> that included <i>Financial Guidance and COVID-19 - Financial Guidance to NHS Wales' organisations</i></p> <p>Standing Orders</p> <p>Standing Financial Instructions</p>

Counter Fraud			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>21. Counter Fraud (LCFS)</b></p> <p>a) Have Counter Fraud been regularly contacted for advice and guidance? Are they adequately resourced?</p> <p>b) Are Counter Fraud contactable during this period of lockdown and have their contact details been widely circulated?</p> <p>c) Has there been a reduction in the number of fraud referrals and if so, is action required to re-enforce the fraud awareness message?</p> <p>d) How have Counter Fraud LCFS' discharged their responsibilities during the period of heightened risk?</p> <p>e) Is there a Fraud Risk Assessment that has been updated and reported on due to the impact of COVID-19?</p>	<p>a) Counter Fraud has been regularly contacted for advice and guidance during lockdown and are adequately resourced.</p> <p>b) LCFS has been contactable during lockdown and their contact details have been widely circulated.</p> <p>c) There has been a reduction in the number of referrals. Action has been taken to re-enforce the Counter Fraud message.</p> <p>d) LCFS has discharged its responsibilities during the period of heightened risk by working agilely using all of the tools and techniques which would be used in times of usual operation.</p> <p>e) Security alerts are circulated by the UK Cabinet Office, COVID 19 Fraud Response Team / NHS Counter Fraud Authority and NHS CFS Wales.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p> <p>LCFS Performance Statistics for Welsh Government.</p> <p>LCFS Newsletter and payslip message circulated to all staff.</p>	<p>Letter from Director General Health and Social Services/NHS Wales Chief Executive 30<sup>th</sup> March 2020 COVID-19 – <i>Decision Making</i> that included <i>Financial Guidance</i> and <i>COVID-19 - Financial Guidance to NHS Wales' organisations</i></p> <p>Letter from Executive Director of Finance 3<sup>rd</sup> April 2020, <i>COVID-19; Financial Governance and Decision Making</i></p>

Charitable Funds			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>22. Charitable Funds</b></p> <p>The Charitable Funds Committee has allocated financial support from funds to support the impact of COVID-19 on both staff and service users.</p> <p><i>COVID-19 Staff Support Fund, 8T53 £50,000</i></p> <p>a) What reporting arrangements and delegated authority is in place to ensure expenditure is appropriate and in line with the terms stipulated by the Committee – This allocation is overseen by Mental Health Services &amp; HECC.</p> <p><i>COVID-19 Response Charitable Funding needs under £100 (£2,000 each to Ysbyty Glan Clwyd; Gwynedd &amp; Wrexham Maelor)</i></p>	<p>a) Guidance “COVID-19 Voluntary Support Plas” was shared across the Organisation.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>Letter from Executive Director of Finance 3<sup>rd</sup> April 2020, <i>COVID-19; Financial Governance and Decision Making</i></p> <p>BCUHB'S COVID-19 Voluntary Support Plan</p>



Charitable Funds			
Areas for consideration	Findings	Evidence	Supporting guidance
<p>a) All items of expenditure from this allocation are supported by proof of purchase and a formal request that is approved by a Band 8a or above?</p> <p>b) Where a Band 8a is self-approving, and has ticked the 'Self-authorisation' box, all expenditure is subject to independent scrutiny?</p> <p><i>COVID-19 Response Charitable Funding needs over £101 - £4,999</i></p> <p>a) A Funding Request Form (for items £101 to £4,999) must be submitted by a Band 8a and approved by the HECC Gold Command?</p> <p><i>COVID-19 Response Charitable Funding needs over £5,000</i></p> <p>a) An Application Form (For items £5,000 and over) must be completed by a Band 8a and approved by the HECC Gold Command and then the Charitable Funds Committee.</p>	<p><b>b) Self-Authorisation of expenditure or petty cash claims is not recommended</b></p> <p>All Charitable Funds expenditure is recorded centrally within Finance and is reported to the Charitable Funds Committee formally.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	



Charitable Funds			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><i>Donations and receipt of income</i></p> <p>a) Are existing internal controls for the receipting of donations/income being complied with?</p> <p>b) What additional controls have been applied to recognise the increase public support during COVID-19?</p> <p>c) Has the Charity provided detailed guidance to all staff on who may be approached to accept donations?</p> <p><i>Registering Gifts and Hospitality</i></p> <p>a) Whilst being mindful that the public want to show their appreciation for all NHS Wales staff at this time, have all staff been reminded of their obligation to record any gifts/hospitality they receive?</p>	<p>a) All gifts and hospitality are formally recorded. The Awyr Las Team maintained a record of all donations and offers of support, working alongside the WorkForec staffing Hubs in relation to managing volunteers.</p>	<p><b>Governance Arrangements during the Covid-19 Pandemic</b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	

Information Governance			
Areas for consideration	Findings	Evidence	Supporting guidance
<p><b>23. Information Governance</b></p> <p>a) Have robust measures and controls been established by the Information Governance department to mitigate issues and risks arising from the Covid-19 crisis?</p> <p>b) Are operational systems and assurance processes being maintained for the management of cyber risks?</p>	<p>a) Robust measures remained in place throughout the CV19 crisis with outstanding areas of work now being worked back into BAU.</p> <p>Senior Information Risk Owner (SIRO) was also the HECC Silver Commander</p> <p>There is focus on CV19 information governance risks, with a specific document on the Health Board's website developed to provide guidance (COVID-19 NHS Wales Information Governance Joint Statement).</p> <p>b) Operational processes for cyber security have not changed during the pandemic. Encryption and other security measures maintained with the increased numbers of laptops (etc) issued. Existing security arrangements have continued, eg ,monitoring mail for viruses / malware etc.</p>	<p><b><i>Governance Arrangements during the Covid-19 Pandemic</i></b></p> <p>Advisory Review Final Report 2020/21</p> <p>Betsi Cadwaladr University Health Board</p> <p>Audit and Assurance Services</p>	<p>National Information Governance Managers' Group (IGMAG)</p> <p>NHS Wales Operational Security Service Management Board (OSSMB)</p>

**To:** Acting Executive Director of Finance  
Chief Finance Officer – Central  
Assistant Director of Planning & Performance – Capital  
Financial Accountant – Tax & Capital

**For Information** Acting Board Secretary

**From:** Audit Manager - Capital  
Head of Internal Audit

**Date:** 20<sup>th</sup> July 2020; 7<sup>th</sup> August 2020

**Executive approval:**

**Re:** Advisory Review Final Briefing Note: COVID-19 Discretionary  
Capital Expenditure

## Introduction & Background

1. This assignment was commissioned by the Acting Executive Director of Finance in order to evaluate the processes and procedures within the Health Board that support the management and control of discretionary capital expenditure that is being utilised as part COVID-19 measures.
2. This assignment has been undertaken as part of the Financial Governance Controlled Self-Assessment, instigated and led by the Acting Director of Finance.
3. Whilst there are no formal recommendations within this assignment, the Lessons Learned will be reported as part of the overall Financial Governance Self-Assessment Report, to be issued in Quarter 2.
4. The basis for the review will be the discretionary capital expenditure identified as part of the COVID-19 response during the period March – June 2020.
5. Information available for this review as at the 2<sup>nd</sup> June 2020 records discretionary capital expenditure for 2019/20 for COVID-19 totalled £858,819 and in 2020/21 currently stands at £4,554,417.
6. This advisory paper should be seen in the context of management dealing with a pandemic and needing to react quickly to changing risks and demands.

## Objective and Scope

7. The objective of the assignment was to review discretionary capital expenditure relating to COVID-19.
8. Accordingly, the scope and remit focused on:
  - Reviewing the process for all five (5) COVID-19 schemes funded from 2019/20 discretionary capital ensuring that the approval and expenditure was in line with Health Board's processes.
  - For those COVID-19 schemes identified as being funded from 2020/21

discretionary capital we will review the five (5) with the highest individual spend and review the processes followed against Health Board's capital procedures.

Appendix 1 details the schemes we reviewed.

## Associated Risks

9. The risks considered at the outset of this review were:

- Financial guidance issued by Welsh Government and Director of Finance is not adhered to.
- Decision making with non-compliance with Standing Orders and Standing Financial Instructions.
- Value for money is not achieved.

## Summary of Findings

10. The findings within this advisory paper should be seen in the context of management dealing with a pandemic and needing to react quickly to changing risks and demands.
11. It should be noted that we did find it challenging to obtain and corroborate approval of our sample, whilst recognising the pressure and time constraints placed upon the service in dealing with issues that required an immediate decision.
12. This briefing paper is based upon the information provided to us at the start and during the review. We have relied solely on the documents, information and explanations provided, except where otherwise stated. We have not sought to or undertaken work to verify the accuracy of the information provided.
13. We were advised at the outset that the Scheme of Reservation and Delegation (SoRD) had not been amended. Whilst noting the Health Board did approve administrative changes to its Standing Orders, the Standing Financial Instructions were not changed and all requirements for the capital procurement in respect of COVID-19 expenditure remained extant.
14. Similarly we have worked on the premise that the *Procedure Manual for Managing Capital Projects (Oct 2018 v10)* remained in operation as we received no evidence to the contrary indicating that it had been suspended.
15. We were advised that the Executive Team stood down a number of groups to focus on the pandemic response which included the Capital Planning Management Team (CPMT) whose remit is to review and consider the receipt of all capital requests from the Divisions, for formal submission to the Executive Team for consideration within the approved Discretionary Capital programme.
16. Welsh Government issued several guidance papers to NHS Wales concerning financial governance. We focused this element of the review on the letter and supporting correspondence issued on the 30<sup>th</sup> March 2020 by the Director General Health and Social Services/NHS Wales Chief Executive titled *COVID-19 – Decision Making & Financial Guidance* which stated the following:
  - *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.*

- *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 defensible to the patients and public we serve, and this should provide a clear and consistent test to our actions.*
17. With the letter, guidance was included titled COVID-19 - *Financial Guidance to NHS Wales' organisations* which noted the following (extracts from the guidance):

### **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.*

### **Capital**

*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.*

18. On the 3<sup>rd</sup> April 2020, the Executive Director of Finance wrote out to the Health Board notifying all officers that the requirement within the Standing Financial Instructions remained in situ for all COVID-19 expenditure. In addition there was a requirement for all capital funding requirements to be submitted on a dedicated COVID-19 Capital Funds Request form.
19. Cabinet meeting of the 16<sup>th</sup> April 2020 received several governing COVID-19 documents including 'COVID-19 Command, Control and Co-ordination Framework (Version 1.3 14/4/20)'. The framework noted the roles for Workstream Senior Responsible Officers (SRO) and Workstreams:

*Work streams – Are led by an Executive Senior Responsible Officer (SRO) and have been established on a pan-BCU basis to proactively look ahead and*



*prepare. Providing subject expert direction, advice and support. Work stream Senior SROs are responsible for ensuring mobilisation within the scope of the Work stream. The output from those groups, once signed off by the Executive Command Group must be considered as mandatory. This does not prevent variance on the basis of appropriate clinical exceptionality, in line with good practice.*

### 3.4 Work stream SRO

- *Accountable for the planning and delivery of the designated workgroup within the defined scope.*
- *Will ensure the plan is clearly defined and will manage delivery against the plan.*
- *Addresses issue resolution and manages risk within the workgroup.*
- *Identifies issues, risks, decisions for escalation.*

### *Estates and Facilities Workstream*

*This work stream will ensure that our estates and facilities infrastructure is able to respond to a Covid-19 escalation. This includes the distribution infrastructure require to distribute new and re-purposed equipment, and consumables in a timely and robust way.*

20. We have been unable to identify Terms of Reference for the relevant Workstreams that delegates authority to the SRO and Workstream and what decisions it is authorised to complete. We did find a scope for the Estates & Facilities Workstream, as reported at the COVID Command Group meeting 19th May 2020:
  - *Increase infrastructure to support surge*
  - *Additional staff accommodation*
  - *Public and patient transport*
  - *Medical gases - source*
  - *Oxygen pressure*
  - *Catering*
  - *Cleaning*
  - *Storage*
  - *Security*
21. At the outset, we were advised that the Health Board did not seek any approval from Welsh Government for any additional discretionary capital expenditure over and above its allocation; we were also told that scheme costs for 19/20 had been reimbursed in full but we have not corroborated this assertion.
22. For 20/21 we have noted that as funding was not guaranteed from Welsh Government, a 'COVID-19 Contingency' of £3.802m was included in the interim discretionary programme for 2020/21 as considered by the Executive Team at its meeting of the 17<sup>th</sup> June 2020.
23. We have been advised that Welsh Government has refunded £1.266m of capital expenditure for the current financial year that we have confirmed through Welsh Government award of funding letters.

24. Noting guidance as issued, all capital funding over and above the initial allocation, we believe, should have been notified to Welsh Government for approval; that being said we note that Welsh Government has not enforced this.
25. Whilst not related, the Health Board has continued to submit 'Covid 19 - 20-21 - Funding Requirements - both approved and anticipated' and the return required by the 17<sup>th</sup> July 2020 records a funding requirement of £2.281m for twenty-eight schemes.

#### Issues identified for learning lessons

26. We reviewed the Decision Making Logs for the ten schemes in our sample and found one recorded decision for the Estates and Facilities Workstream concerning the Ysbyty Glan Clwyd Voids and the second for the Operations – Acute Workstream concerning the Radiology Home reporting workstations, details are included at Appendix 2. From the minutes of the Covid Command Group Meeting of the 19<sup>th</sup> May 2020 we note that under the workstream SITREPS, decision logs and risk logs both operational and acute (CCG20.075) and Estates and Facilities (CCG20.077) merely records noted for both these decisions, we were unable to confirm that these specific items were formally reported and considered by Gold Command or Health Board.

*To ensure all decisions taken are recorded in Decision Logs and escalated in accordance with the Scheme of Reservation and Delegation.*

27. There has been inconsistent use of the specific funding request forms introduced by the Director of Finance and where available to view were not consistently completed correctly or retrospectively. Additionally we found this was the case also for completion of Single Tender Waivers.

*To ensure Health Board and Welsh Government guidance is followed.*

28. There was no change to the Scheme of Reservation and Delegation or Standing Financial Instructions, however COVID-19 documentation suggested and implied delegation to Gold Command through the command structure.

*To ensure a clear accountability and decision making powers are detailed and escalated through to the Board where the decision is reserved to the Board.*

## **Appendix 1 – Sample of schemes reviewed**

Strategic Group	Scheme	2019/20 (£)	Forecast 2020/21 (£)	Out-turn (£)
Medical Devices	6 Mobile Xray Units-Glan Clwyd, Wrexham Maelor & Ysbyty Gwynedd	-	690,324.00	
Medical Devices	80 Monitors		650,328.00	
Medical Devices	46 Glidescopes		533,508.00	
Estates	Reconfigure Ward 10-Glan Clwyd	210,000.00	434,525.00	
Estates	Reconfigure Ward 6-Glan Clwyd	339,600.00	304,925.00	
Estates	various schemes		220,000.00	
Estates	Increase bed capacity-Ysbyty Gwynedd		202,000.00	
IM&T	18 Home Reporting Stations-Radiology	83,996.78	84,000.00	
Medical Devices	6 Portable Ultrasounds-Glan Clwyd, Wrexham Maelor & Ysbyty Gwynedd	118,692.43		
IM&T	Remote Access Software	106,530.00		
	<b>Total</b>	<b>858,819.21</b>	<b>3,119,610.00</b>	

Source: Scheme details and financial information provided by the Finance Directorate.



## **Appendix 2 – Extract from Decision Logs relating to the sample**

Decision id	Decision date	Description of decision	Decision made by - individual or group	Decision to be communicated elsewhere? If so, where	Action complete? Y/N	Notes	Rationale	Other options considered	Escalate to Gold?	Notify Board?
7	3/26/2020	Agreed that on two voids in YGC can be utilised to facilitate increase of 70+ beds	Group	Secondary Care Planning - Deborah Carter leading	Yes	Scheduled for completion 20 April.	Cost effective transformation to provide additional bed spaces on one of our main acute sites. These newly converted wards may give us an ongoing post COVID 19 benefit.	A range of other choices have been evaluated and a number progressed as part of our surge planning.	N	N

Source: Agenda Item CCG20.077b Covid Command Group meeting 19<sup>th</sup> May 2020

016	4/13/2020	8 medical grade home stations for radiology reporting agreed and funded. (total, £69,997)	Clinical Reference group	Agreement cascaded to Dave Fletcher, Phil Collins and the clinical pathways group and consultants involved.	Yes	A further number of units have been requested.	N	Supports remote working whilst maintaining service	See rationale	No	No
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Source: Agenda Item CCG20.075b Covid Command Group meeting 19<sup>th</sup> May 2020

# Covid-19 Governance and Financial Reviews

Combined Views and Findings

# INTRODUCTION

## Background

This pack combines the views and findings of the following reviews:

- 12 Internal Audit Reviews of Covid-19 Governance Arrangements
- Finance Academy Reflections on Governance and Decision Making
- FDU Peer Review of Financial Plans
- Five KMPG due diligence reviews of field hospitals commissioned by Welsh Government

92 separate views and findings were identified, which were a mixture of recommended actions, suggested activity, observations and questions for organisations to consider.

## Summary

The views and findings have been grouped according to common themes in order to arrive at the following:

- 8 shared actions that would benefit from an all-Wales basis approach, 6 are primarily for Finance Directors to take forward, 2 are primarily for Board Secretaries to take forward, with input from Finance Directors
- 18 actions for organisations to take forward which could benefit from a collaborative approach

# SHARED ACTIONS

## **Finance Business Planning**

1. Develop finance team business continuity plans, appropriate for organisation but reflecting peer best practice, and to include drawing support from each other as needed

## **Modelling & Analytics**

2. Further develop techniques, and promote use of, dynamic modelling - both capacity & capability

## **Integrated Planning**

3. Earlier collaboration on consistent planning assumptions and modelling approaches to influence organisations, more benchmarking on assumptions across organisations
4. Prescribe template to support concise plans, with clearer priorities, based on agile approach
5. Integrated planning / Workforce planning & modelling identified as weakness - consider opportunity to work with DoP and WoDs to improve at an early stage

## **Field Hospitals**

6. Develop procedures, contracting and legal frameworks for future need

## **Governance and Decision Making (primarily for Board Secretaries)**

7. Review & identify best practice in decision making, including command structure or framework, group membership, clarity of reporting lines and opportunities of safe decision making at pace
8. Organisations need to refresh business continuity plans to reflect changes required and lessons learnt from the pandemic

# COLLABORATIVE ACTIONS

## Governance

### Decision Making

1. Ensure finance input to decisions at early stage

### Risk

2. Review & identify best practice in managing risks

### Scrutiny & Audit Trail

3. Develop common narrative / explanations for additional funding required for Covid related expenditure
4. Develop documentation standards / template for logging decisions and supporting justification & information - to aid decision making and provide clear audit trail

### Information Governance

5. Ensure security of information when remote working

## Modelling & Analytics

### Planning Assumptions

6. Review, and improve as needed, capacity/skills/competence for Demand & Capacity

## Service Sustainability

### Value, innovation and efficiency

7. Organisations need to refocus efforts onto savings and efficiencies plans and make the most of sharing examples where innovation and efficiencies have been identified as a result of the pandemic

8. Finance should ensure that VBHC principles are adopted as part of the recovery plans.

### Legal

9. Liaise with the Welsh Risk Pool team to establish what the indemnity/insurance requirements are for operating additional sites

### Regional Opportunities

10. Organisations should maximise opportunities to deliver VFM through regional planning and other sector partnership opportunities

# COLLABORATIVE ACTIONS

## Field Hospitals

### Legal

11. Ensure legal scrutiny of Letters of Intent and contract agreements

### Audit & Review

12. Undertake post contracts audit of costs

### Pricing Challenge

13. Undertake best practice review and apply learning on innovative or reactive contract or pricing during pandemic

14. Strengthen capacity to scrutinise, validate and challenge cost and VFM

## Reinstatement/ Consequential Losses

15. Consider and manage approach to consequential losses / reinstatement costs, including recognising impact of other local authority COVID funding

## Wider Public Sector & Partnerships

16. Organisations should reflect on use of contractors / Local Authorities in field hospitals and how the partnerships have worked

## VFM

17. Develop reporting to Audit Committees on contract awards and value for money/appropriate use of public money assessments made during the Covid-19 period

18. Consult and agree on advance pay rates

A more detailed summary has also been produced which includes the 92 views and findings in full, analysed by theme and referenced to the source review should further information be required.

<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance &amp; Performance Committee 29.10.20</b>					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Quarter 3-4 Plan – Affordability Assumptions					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Sue Hill, Acting Executive Director of Finance					
<b>Awdur yr Adroddiad Report Author:</b>	Rob Nolan, Finance Director					
<b>Craffu blaenorol: Prior Scrutiny:</b>	N/A					
<b>Atodiadau Appendices:</b>	N/A					
<b>Argymhelliad / Recommendation:</b>						
The Committee is asked to note the financial impact of the agreed revisions to the operational plan submitted to WG on the 19 <sup>th</sup> October and the affordability of the plan and the funding risk.						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>		<b>Er gwybodaeth For Information</b> /
<b>Sefyllfa / Situation:</b>						
The purpose of this paper is to update the Committee on the financial impact of the agreed revisions to the operational plan submitted to WG on the 19 <sup>th</sup> October and to provide clarity on the affordability of the plan and any funding risk.						
<b>Cefndir / Background:</b>						
The BCUHB Plan and Routemap for Quarters 3 and 4 was presented at the Board Workshop on the 15 <sup>th</sup> October 2020.						
The summary financial plan for Quarters 3 and 4 is below.						
<u>Table 1 – Summary Financial Plan</u>						
20/21 Full Year Position	Plan	Forecast	COVID-19	Mths 1-6	Mths 7-12	
	£m	£m	£m	Actual	Forecast	
Resource Allocation	1562.0	1718.2	156.2	821.5	896.7	
Expenditure	1602.0	1758.2	156.2	841.3	916.9	
Deficit	-40.0	-40.0	0.0	-19.8	-20.2	

The table below summarises the assumed funding source for each of the commitments included within the Quarter 3 and 4 Plan and quantifies the financial risk of £16.8m, which relates to bids for funding which have not been confirmed.

With regards to the Diagnostics and Orthopaedic business cases, indicative costs are being presented to F & P, and at this point there are no quantifiable costs in 20/21 as both Business Cases are subject to Board and Welsh Government approval.

**Table 2 – Summary of Financial Commitments and Anticipated Funding Source – Quarter 3 and 4 Plan**

	£m
Confirmed Funding	
COVID-19 Surge Funding	132.6
Q3-4 Funding Bids	23.5
	156.2
Funding not anticipated, bids to be submitted	16.5
Bids to be submitted for funding, not yet confirmed	0.3
	173.0

The table below provides additional details and highlights the financial risk areas.

**Table 3 – Detail of Financial Commitments and Risk areas – Quarter 3 and 4 Plan**

	COVID-19 Surge Funding		Q3-4 Funding Bids		Additional WG Resource Allocation		RPB Money		New Service Developments	
	Funding £m	Spend £m	Funding £m	Spend £m	Funding £m	Spend £m	Funding £m	Spend £m	Funding £m	Spend £m
Surge Capacity	83.10	83.10								
Unscheduled Care					5.08	5.08	1.11	1.11		
Field Hospital Set Up	28.03	28.03								
Additional Pay	5.38	5.38								
Mental Health	1.03	1.03								
Discharges to Care Homes	2.44	2.44								
Care Home Funding	5.01	5.01								
TTP			14.57	14.57						
COVID Vaccination			3.25	3.25						
Primary Care Schemes										
Cross border & Indep't Providers	1.16	1.16								
PPE	6.48	6.48								
Planned Care Schemes					10.31	10.31				
Planned Care Ambition										
Diag. & Treatment Centres									TBA	TBA
Orthop. Business Case									TBA	TBA
Robotics Business Case									0.28	0.28
Flu Vaccination			5.72	5.72						
<b>Total</b>	<b>132.6</b>	<b>132.6</b>	<b>23.5</b>	<b>23.5</b>	<b>15.4</b>	<b>15.4</b>	<b>1.1</b>	<b>1.1</b>	<b>0.3</b>	<b>0.3</b>
<b>Variance</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

**Key**

	Bids to be submitted for funding, not yet confirmed
	Funding not anticipated, bids to be submitted
	Funding confirmed, final costs to be quantified



### COVID-19 Surge Funding

The COVID-19 Surge Funding is the total funding received to date from Welsh Government to cover the cost of COVID in 2020/21.

It includes the Surge funding of £83m allocated as part of the Quarter 3 and 4 Planning Guidance; funding for the set-up, decommissioning and consequential losses of Field Hospitals and other cost pressures such as PPE, Care Home Funding and cross border activity.

In addition, Surge funding includes £3.79m of Winter Resilience Surge Schemes.

### Quarter 3 and 4 Funding Bids

Additional funding bids of £23.5m remain subject to final agreement with Welsh Government. The Health Board has been notified of the funding for Test, Trace and Protect (TTP) of £14.57m. This funding is to be drawn down from Welsh Government based on our actual costs, and therefore the £14.57m should be seen as the maximum sum available. The Health Board is working closely with the Local Authorities in North Wales, in particular with Flintshire County Council to validate cost incurred to date and forecast the cost of TTP over the rest of the year.

Forecasting the cost of the Extended Flu vaccination campaign and the COVID vaccination programme is extremely complicated because of speed at which we have to operate. As such, the costs in table 1 are estimates based on the best information available at the time and will be subject to revision as we work with Welsh Government and other Health Boards to agree a consistent approach to estimating the costs.

As with the TTP programme, once we agree the costs of these programmes for the year it is anticipated that the funding will be allocated to the Health Board.

### Additional WG Resource Allocation

It is anticipated that the Health Board will access additional funding held nationally to cover the cost of Unscheduled Schemes agreed in the Winter Plan (£5.05m) and the cost of Planned Care Recovery (£10.31m).

### RPB Money

This commitment represents the contribution from the £2.238m recently allocated to the North Wales Regional Partnership Board to support the delivery of Discharge to Recovery and Assess (D2RA) pathways in North Wales. The funding is for the Home First Project identified in the Winter Resilience Surge Plan. The Home First project is funded in part from RPB money, with the balance coming from the Surge Funding.

### New Service Developments

New Service Developments covering Diagnostic & Treatment Centres, Orthopaedics Business Case and Robotics Business Case have been identified in the Plan. To date no costs are available. Once the costs are agreed, they will be subject to individual bids to Welsh Government for funding.

### Conclusion

The Health Board will need to continue to work with Welsh Government and other Health Board colleagues to continue to refine its estimates of costs for a number of its programmes, and as cost estimates become more certain the financial planning assumptions will be updated.

## **Asesiad / Assessment & Analysis**

### **Strategy Implications**

The paper highlights the financial impact of the agreed revisions to the operational plan submitted to WG on the 19th October and to provide clarity on the affordability of the plan and any funding risk.

### **Options considered**

The paper highlights the sources of funding being accessed to support the new developments in the plan.

### **Financial Implications**

The paper identifies the financial risk of £16.8m, which relates to bids for funding which have not been confirmed. It also identifies the underpinning assumptions behind the additional spend identified on COVID-19. .

### **Risk Analysis**

The paper summarises the assumed funding source for each of the commitments included within the Quarter 3 and 4 Plan and quantifies the financial risk of £16.8m, which relates to bids for funding which have not been confirmed. It includes that with regards to the Diagnostics and Orthopaedic business cases, at this point there are no quantifiable costs in 20/21 as both Business Cases are subject to Board and Welsh Government approval.

### **Legal and Compliance**

In line with the organisation's standing financial instructions and the Welsh Government's administrative target within the 3 year planning cycle, BCUHB is required to set a budget and financial plan.

### **Impact Assessment**

This paper highlights the key issues that need to be considered in relation to budget setting for 2021/22, as opposed to Corporate or Information Governance.



<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance &amp; Performance Committee 29.10.20</b>					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Budget Setting Framework and Timetable for 2021/22					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Sue Hill, Acting Executive Director of Finance					
<b>Awdur yr Adroddiad Report Author:</b>	Rob Nolan, Finance Director					
<b>Craffu blaenorol: Prior Scrutiny:</b>	Sue Hill, Acting Executive Director of Finance					
<b>Atodiadau Appendices:</b>	Annex 1: Consultation Questions					
<b>Argymhelliad / Recommendation:</b>						
The Committee is asked to note the approach to budget setting for 2021/22						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>		<b>Er gwybodaeth For Information</b>
<b>Sefyllfa / Situation:</b>						
<p>This paper summarises the approach to budget setting for 2021/22 and will need to be aligned to the all Wales planning guidance with the anticipated requirement to submit a plan to Welsh Government by the end of January 2021 covering the period 2021/22.</p> <p>This assumption will be dictated by the continued impact of COVID with Health Boards expected to focus on annual operational plans. Once we have further clarity, we will amend our planning assumptions accordingly.</p> <p>The paper includes a reference to the annual consultation exercise undertaken by the Committees of the Welsh Parliament who are seeking information to inform their scrutiny of the Welsh Government's 2021-22 Draft Budget proposals.</p>						
<b>Cefndir / Background:</b>						
<p>The purpose of the document is :</p> <ul style="list-style-type: none"> <li>To provide a baseline Annual Budget based on the Health Board Funding Allocation for 2021/22, for consideration and approval by the Health Board at its March meeting.</li> <li>To provide the methodology for setting the proposed budget baseline.</li> <li>To provide the savings target and how this will be allocated to Divisions / Health Economies and Improvement Groups.</li> </ul>						

- To provide an opening baseline budget resource allocation broken by division/department along with any centrally held provisions and reserves.
- To link the strategy to the governance framework and completion of the budget accountability agreements.
- To highlight our 3 year assumptions on developments, cost pressures, uplifts and savings that demonstrates a commitment to achieve break even in 3 years' time, and show how we will prioritise any new developments if they are in line with the Health Board strategy.

In line with the organisation's standing financial instructions and the Welsh Government's administrative target within the 3 year planning cycle, our expectation is that BCUHB will be required to set an annual budget and financial plan in advance of the new financial year.

The budget setting framework will be aligned to the all Wales planning guidance with the anticipated requirement to submit a plan to Welsh Government by the end of January 2021 covering the period 2021/22, in line with previous years.

This assumption is based upon the continued impact of the COVID response with Health Boards expected to focus on annual operational plans. Once we have further clarity, we will amend our planning assumptions accordingly.

The Health Board is committed to agree delegated budgets that reflect the need to reduce our deficit and manage cost pressures within resources that is consistent with a Deficit Reduction Plan that achieves break even in 3 years.

The key purpose of the Budget Setting Framework is:

- To provide a baseline Annual Budget based on the Health Board Funding Allocation for 2021/22, for consideration and approval by the Health Board at its March meeting.
- To describe the methodology for setting the proposed budget baseline.
- To clarify the savings opportunity and to agree an indicative target of 3% (subject to alignment with WG planning guidance) and how this will be allocated to Divisions / Health Economies and Improvement Groups.
- To provide an opening baseline budget resource allocation broken by division/department along with any centrally held provisions and reserves.
- To link the strategy to the governance framework and completion of the budget accountability agreements.
- To highlight our medium term assumptions on developments, cost pressures, uplifts and savings that demonstrates a commitment to achieve break even over a 3 year period
- To explain how we will prioritise any new developments if they are in line with the Health Board strategy.

### **Consultation: Welsh Government's draft Budget proposals 2021-22**

The Welsh Government's draft budget is usually published in October. However, this year it will be delayed as the Welsh Government does not have an indication of the total funding available until the UK Government publish UK Departmental Spending plans.

The Minister for Finance and Trefnydd has announced that the Welsh Government is planning to publish the outline and detailed draft Budgets together on 8 December 2020, and the final Budget on 2 March 2021.

The Committees of the Welsh Parliament are seeking information to inform their scrutiny of the Welsh Government's 2021-22 Draft Budget proposals. They are interested in exploring expectations of the 2021-22 Budget, including financial readiness for the 2021-22 year and the impact of the 2020-21 Budget, including how the 2021-22 Draft Budget will be impacted by the focus of recovery from the Covid-19 pandemic.

The questions the Committees of the Welsh Parliament are seeking information responses from Health Boards are shown in Annex 1.

Responses from interested parties are invited to submit written evidence to arrive by Friday 27 November 2020.

### **Funding Assumptions: Welsh Government Draft Budget, Allocation Letter and Funding Uplift**

Based on this latest information available on budget setting for 2021/22 the following assumptions are being made within the draft budget setting framework:

- A 2% allocation uplift
- Within the 2% uplift, 1% is for pay. Any cost pressure from the pay award above the 1% will be funded by Welsh Government separately
- Funding will be made by Welsh Government for the inflation uplifts in the primary care ring-fence allocations
- Assume any development funding for enhanced services in primary care ring-fence allocations will need to include an agreement on whether it represents a transfer from secondary care, therefore requiring a corresponding transfer of funding.
- The drug treatment fund will cover new drugs for 2021/22, and therefore the full year effect of this year's (2020/21) drugs will be cost growth
- Do not assume any additional funding for Recovery, new Service Developments or impact of COVID

As the picture for 2021/22 becomes clearer the Health Board will refine its planning assumptions in line with national policy.

### **The Budget Setting Methodology**

In previous years, the Health Board's budget setting methodology has been based on a 4-step approach:

1. Baseline Budget - pay set using the funded establishment and Non pay budgets will reflect the recurrent budgets.
2. Cost Pressure Assessment - all unfunded and underlying cost pressures including utilisation of non-recurrent slippage to cover recurrent spend and full year effect of cost pressures and savings.
3. Inflation and Growth assumptions - including pay awards, prescribing, packages of care, external providers, NICE & high cost drugs etc.
4. Service Change Decisions – Investment and Disinvestment - proposed financial impact of service changes developed and supported by approved business cases.

Welsh Government have consistently challenged the Health Board in its approach to the Cost Pressure Assessment in particular in relation to its underlying deficit.

In response, the Health Board is now updating its underlying position monthly within the Monitoring Return, which negates the need to include this step as part of budget setting.

It is important we continue to focus on our Underlying Position during the year as we will see a significant impact on our position as a direct result of the Pandemic and its effect on our spending and savings plans.

It is therefore proposed for 2020/21 the Health Board will adopt the following 3 Steps to Budget Setting:

1. Baseline Budget - pay set using the funded establishment and Non Pay budgets will reflect the recurrent budgets. Additional cost pressures in excess of the baseline budget will be highlighted and subject to approval by the board.
2. Inflation and Growth assumptions - including pay awards, prescribing, packages of care, external providers, NICE & high cost drugs etc.
3. Service Change Decisions – Investment and Disinvestment - proposed financial impact of service changes developed and supported by approved business cases including outcomes, activity impacts and benefits realisation.

### **Baseline Budget**

The baseline budget for pay will be set using the funded establishment, with month 8 as the starting point. This will be undertaken within the Prophix system. This will need to be reconciled to the recurrent pay budgets, with any variances identified.

Non-pay budgets will reflect the recurrent budgets within the ledger. Any negative baseline budgets carried forward from previous years will need to be cleared for 2021/22.

All Baseline budgets are set on the assumption that they will fund the staffing and infrastructure required to deliver the agreed Core activity as a Health Board.

Additional cost pressures in excess of the baseline budget will be highlighted and subject to approval by the Board.

Prior to the sign off of the individual divisional baseline budget, a comprehensive review will be undertaken by the senior finance team, which will validate the assumptions built into budgets for both pay and non-pay.

### **Inflation and Growth assumptions**

An assessment of the Inflation cost pressures and growth assumptions will be undertaken. In addition the Health Board is taking part in the all Wales National Cost Assessment exercise which allow us to compare our assumptions with other Health Boards.

The individual **Inflationary pressures** are as follows:

1. Pay Awards – including assumptions on the actual uplift across the different pay groups; the increase in the Living Wage; and other pay items
2. Non Pay – will need to review RPI and CPI assumptions
3. Primary Care Prescribing – including GP and Pharmacy prescribing and is purely focused on price changes
4. Secondary Care Prescribing – including Rheumatology, Dermatology etc.

5. Packages of Care – CHC and Packages of Care and significantly influenced by the uplifts applied by our Local Authorities. In addition the Health Board is reviewing its CHC pricing methodology which is expected to require additional investment
6. External Providers – including WHSSC, EASC, WAST, English Contracts and Wales LTAs all of which are subject to national discussions and agreed the Chief Executives group

The areas identified as subject to **Growth pressures** are:

1. GP Prescribing – growth in the number of drugs issued
2. NICE &HCDs (Drug Treatment Fund FYE) - The drug treatment fund covers new drugs for 2021/20, the Health Board therefore has to make a provision for the full year effect of this year's (2020/21) new drugs
3. Packages of Care – the growth in the number of new packages
4. Demographic Growth Provision – any assumptions on the increase in secondary and community activity
5. Full Year Effect of developments implemented mid-way through the 2019/20 Financial Year

### **Service Change Decisions – Investment and Disinvestment**

Any proposed financial impact of service changes will need to reflect the agreed priorities within the annual plan and have clear and measurable outcomes, activity assumptions and benefits realisation.

All proposed investment plans will need to be developed and supported by approved business cases, with a clear narrative on how the cost of any new investment will be recurrently funded; whether it is from new recurrent funding, funding from WG, linked disinvestment, or an additional savings target.

### **Savings Assumptions**

The Health Board has had significant challenges in respect of managing the impact of significant cost pressures; vacancy rates and the consequential premium rate pay expenditure, quality and scale of estate, reconciling core operational capacity to clinical demand and the resulting financial deficit.

The pandemic has placed additional significant strain upon all the Health Board resources, particularly in terms of our people and estate. These demands are expected to continue and focussed action is required to ensure that we make the best use of resources in the short, medium and long term. Our approach to this challenge is set out below and aligns with our effective use of resources:

- Prioritised plan for the use of sustainability funding
- Workforce optimisation programme
- Systematic review of estates and assets
- Value based efficiency programme

### **Identifying Further Savings**

The shortfall in savings delivery in 2020/21 represents a significant challenge to the Board's financial plan as we move into 2021/22. Opportunities to progress further savings building towards 2021/22 have been reviewed, and aligned to the five priorities within the Q3 / Q4 Plan.

Short term opportunities to secure further savings in 2020/21 will continue to be progressed, noting the challenges presented by the current operating environment and COVID pressures. These discussions will also inform savings for 2021/22.

The opportunities identified align with the key of the Plan as follows –

- **Planned Care** – outpatients; theatres
- **Unscheduled Care** – ambulatory care; length of stay
- **Mental Health** – inpatient and rehabilitation services
- **Safe, Secure and Healthy environment** – agile working; corporate services
- **Use of Resources** – medicines management; estate costs; delayed transfers of care; staffing efficiency, agency / locum costs; absence; ward staffing

The table below identifies the range of potential financial opportunity by reference to updated benchmark comparators –

Table 1 – Potential Financial Opportunities

Priority Area	Low £m	High £m
Essential Services and Safe Stepping up of Planned Care	9.1	15.3
Safe Unscheduled Care	10.9	23.8
Safe Integration and Management of Mental Health Services	6.3	11.9
Safe, Secure and Healthy Environment for our People	11.0	25.7
Effective Use of our Resources	6.7	20.8
<b>Total</b>	<b>44.0</b>	<b>97.5</b>

The opportunities above can form the basis of a savings programme which will cover a period of 1 to 3 years. Developing these opportunities into robust savings plans will be progressed during quarters 3 and 4.

### Draft Timetable

The draft timescales outline the key dates in setting and approving the 2020/21 Budget Strategy is included below.

Table 2 – Draft timetable

Oct-20	F&P Approve Budget Setting Framework
13-Nov-20	Submission Deadline for Baseline Budget, and Inflation and Growth Assumptions
Nov-20	F&P Update
Dec-20	Savings Plan submitted to Execs for approval
Dec-20	Finance to Finance meetings to agree final Divisional proposals
Dec-20	F&P Update on Financial Plan
Jan-21	Draft Financial Plan submission to WG
Feb-21	F&P Approves Financial Plan
Mar-21	Final submission of Financial Plan



## **Asesiad / Assessment & Analysis**

### **Strategy Implications**

In line with the organisation's standing financial instructions and the Welsh Government's administrative target within the 3 year planning cycle, BCUHB is required to set an annual budget and financial plan in advance of the coming financial year.

### **Options considered**

This paper highlights the change of approach adopted when calculating the HB Baseline Budget.

### **Financial Governance Summary**

This paper provides a narrative on the approach to budget setting for 2021/22. It includes the need to recognise our assumptions will be dictated by the continued impact of COVID, and once we have further clarity on the national planning framework we will amend our planning assumptions accordingly.

### **Risk Analysis**

The continued uncertainty of the impact of COVID-19 will need to be continually reassessed in terms of the recurrent cost pressures and the impact the pandemic will have on the level of public funding available in 2021/22.

### **Legal and Compliance**

In line with the organisation's standing financial instructions and the Welsh Government's administrative target within the 3 year planning cycle, BCUHB is required to set an annual budget and financial plan in advance of the coming financial year.

### **Impact Assessment**

### **Impact Assessment**

This paper highlights the key issues that need to be considered in relation to budget setting for 2021/22, as opposed to Corporate or Information Governance.

**Consultation Questions**

1. What, in your opinion, has been the impact of the Welsh Government's 2020-21 budget including recent funding related to COVID-19?
2. How do you think Welsh Government priorities for 2021-22 should change to respond to COVID-19?
3. How financially prepared is your organisation for the 2021-22 financial year, and how can the budget give you more certainty in planning and managing budgets given the ongoing volatility and uncertainty?
4. Given the ongoing uncertainty and rapidly changing funding environment do you think there should be changes to the budget and scrutiny processes to ensure sufficient transparency and Ministerial accountability?.
5. Does the Fiscal Framework adequately reflect the impact of the public health emergency in Wales compared to other UK countries and do you support increasing the annual and/or overall limits to current Welsh Government borrowing within this Framework?
6. The Committee would like to focus on a number of specific areas in the scrutiny of the budget, do you have any specific comments on any of the areas identified below, particularly in light of the COVID-19 situation and how these should be reflected in the 2021-22 budget?
  - How resources should be targeted to support economic recovery and what sectors in particular need to be prioritised.
  - To what extent alleviating climate change should be prioritised in supporting economic recovery.
  - Welsh Government policies to reduce poverty and gender inequality.
  - Approach to preventative spending and how is this represented in resource allocations (Preventative spending = spending which focuses on preventing problems and eases future demand on services by intervening early)
  - Sustainability of public services, innovation and service transformation
  - How evidence is driving Welsh Government priority setting and budget allocations
  - How the Welsh Government should use taxation powers and borrowing.
  - Support for businesses' economic growth and agriculture after EU transition ends.
  - What are the key opportunities for Government investment to support 'building back better' (i.e. supporting an economy and public services that better deliver against the well-being goals in the Well-being of Future Generations Act?)



<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	<b>Finance and Performance Committee</b> <b>29.10.20</b>																			
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public																			
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	Capital Programme Report to 30 <sup>th</sup> September 2020																			
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Mark Wilkinson, Executive Director of Planning and Performance																			
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Neil Bradshaw – Assistant Director – Capital Denise Roberts – Financial Accountant Tax & Capital																			
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	This paper will be subject to scrutiny by the Capital Programme Management Team and shared with the Capital Investment Group.																			
<b>Atodiadau</b> <b>Appendices:</b>	1 Capital Governance Structure (August 2020)																			
<b>Argymhelliad / Recommendation:</b>																				
The Committee is asked to receive this report and note the reported exceptions.																				
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval *</b>		<b>Ar gyfer Trafodaeth</b> <b>For Discussion*</b>		<b>Ar gyfer sicrwydd</b> <b>For Assurance*</b>	✓	<b>Er gwybodaeth</b> <b>For Information*</b>														
<b>Sefyllfa / Situation:</b>																				
<p>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.</p> <p>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).</p>																				
<b>Cefndir / Background:</b>																				
The agreed capital funding from all sources may be summarised as follows:																				
<table border="1"> <thead> <tr> <th>Capital Programme</th> <th>£ '000</th> </tr> </thead> <tbody> <tr> <td>All Wales Capital Programme</td> <td>14,632</td> </tr> <tr> <td>Discretionary Capital</td> <td>12,921</td> </tr> <tr> <td><b>Total Welsh Government CRL</b></td> <td><b>27,553</b></td> </tr> <tr> <td>Capital Receipts</td> <td>150</td> </tr> <tr> <td>Donated Funding</td> <td>1,027</td> </tr> <tr> <td><b>TOTAL</b></td> <td><b>28,730</b></td> </tr> </tbody> </table>						Capital Programme	£ '000	All Wales Capital Programme	14,632	Discretionary Capital	12,921	<b>Total Welsh Government CRL</b>	<b>27,553</b>	Capital Receipts	150	Donated Funding	1,027	<b>TOTAL</b>	<b>28,730</b>	
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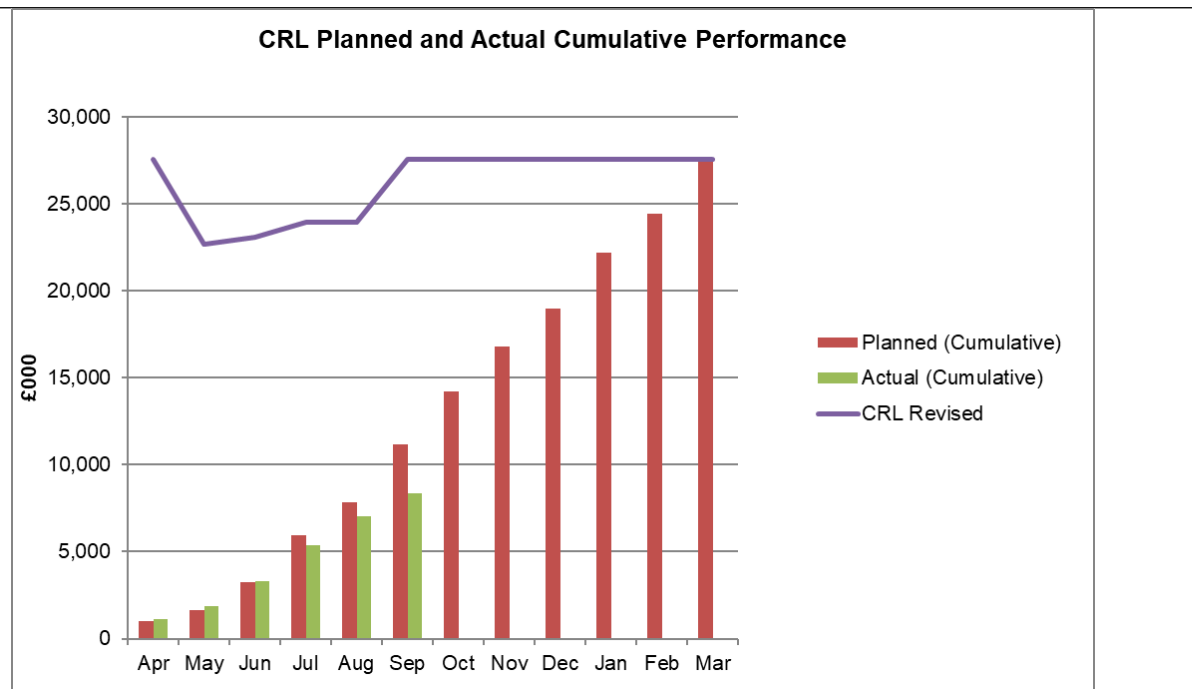
The Welsh Government (WG) have undertaken a review of the capital programme to seek to identify additional funds to support the on-going cost of the pandemic. All Health Boards and Trusts were requested to review their expected expenditure of major capital schemes to 31<sup>st</sup> March 2021. As previously reported, progress on Ruthin Hospital, the Substance Misuse units at Holyhead & Shotton and the Integrated Dementia unit at Bryn Beryl hospital have been delayed as a consequence of the pandemic. We assessed the impact of this delay to be a reduction in the total planned expenditure of £2.058m. As a consequence WG have reduced the CRL for each of these schemes but has also provided an additional allocation of funding for COVID-19 of £2.590m. This has resulted in a net increase of £532k overall as illustrated below.

<b>2020/21 Capital Resource Limit (CRL) - 22nd September 2020</b>	<b>22-Sep-20</b>	<b>07-Oct-20</b>	<b>Variance</b>
	<b>£m</b>	<b>£m</b>	<b>£m</b>
<b>1) DISCRETIONARY CAPITAL FUNDING</b>	<b>12.921</b>	<b>12.921</b>	<b>0.000</b>
<b>2) CAPITAL PROJECTS WITH APPROVED FUNDING</b>	<b>14.100</b>	<b>14.632</b>	<b>0.532</b>
PAS System	0.592	0.592	0.000
Substance Misuse - Holyhead, Anglesey	0.873	0.748	-0.125
Substance Misuse - Shotton, Flintshire	2.089	1.635	-0.454
North Denbighshire Community Hospital	2.004	1.823	-0.181
Albion SOC - OBC	0.435	0.435	0.000
Orthopaedic Plan Fees	0.068	0.000	-0.068
Emergency Dept Systems	0.701	0.701	0.000
Slippage from 19/20 (Replacement CT Scanner - YGC) into 20/21	0.530	0.340	-0.190
Ruthin	2.471	1.431	-1.040
COVID – 19 Funding requirements for 2020-21. (Tranche 1 – June 2020)	0.423	0.423	0.000
COVID – 19 Funding requirements for 2020-21. (Tranche 2 – July 2020)	0.823	0.823	0.000
COVID - 19 Digital Devices	0.842	0.842	0.000
ICF	2.249	2.249	0.000
COVID – 19 Funding requirements for 2020-21. (Tranche 3)	0.000	2.590	2.590
<b>TOTAL CRL - Approved Funding</b>	<b>27.021</b>	<b>27.553</b>	<b>0.532</b>

### 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	14,632	7,351	50%
Discretionary	12,921	1,028	8%
<b>Subtotal CRL</b>	<b>27,553</b>	<b>8,379</b>	<b>30%</b>
Capital Receipts	150	0	0%
Donated Capital	1,027	357	35%
Grant Capital	0	0	0%
<b>Total</b>	<b>28,730</b>	<b>8,736</b>	<b>30%</b>

## **All Wales Capital Programme**

### North Denbighshire Community Hospital, Rhyl

The Full Business Case for the new community hospital and refurbishment and extension of the Royal Alexandra Hospital is the subject of a separate report to this Committee.

### Ablett Redevelopment, Ysbyty Glan Clwyd (YGC)

Since the approval of the Strategic Outline Case (SOC) the Project Board has progressed the development of the Outline Business Case (OBC), although this has yet to be received and approved by the Capital Investment Group and Executive Team

A series of engagement events were undertaken to discuss, develop and review the service model and consider the potential options. The outcome of the engagement concluded that the needs of patients, carers and staff would be better met in a new build rather than redeveloping the existing Ablett Unit. This is consistent with the options set out in the SOC, the purpose of which is to indicate a preferred high level option which is then developed in more detail through OBC development.

The Project Board has reviewed the locations of a new build at YGC and noted that the “best” option appears to be to develop the existing car park adjacent to the Pathology department which would necessitate the re-provision of approximately 350 existing parking spaces. The design has been developed further in support of the OBC and includes the re-provision of 400 car parking spaces within a three storey structure located on the existing “north end” front car park adjacent to Sarn Lane. The estimated total capital cost is £63.234m (as at August 2020).

Concerns have been expressed with respect to the communication of the change in the Project Board’s preferred option and the proposal to develop a new facility on the YGC site, together with the associated multi-storey car park. A separate report is to be submitted to the Audit committee on the governance and communication aspects of this project.

## **Discretionary Capital Programme**

Following approval of the discretionary capital programme progress has been made in implementing the approved schemes. The increasing incidence in COVID infections and the Health Board’s response has led to a request to delay the works to Ward 14 and the Aseptic Unit at YGC due to their potential impact upon capacity. At the same time a number of requests have been submitted for additional works in support of a number of identified risks including:

- Works to improve segregation at Wrexham Maelor hospital
- Works to minimise ligature risks at Ablett, Heddfan and NWAS units following changes in the assessment of the risk.
- Minor works to Wrexham Children’s Centre, the Shooting Star Unit, Mold hospital, Wrexham Maelor hospital (additional COVID works) and Eryri hospital.

The cost and programme of these requests are currently being finalised by the Capital Investment Group and a further detailed report will be brought to the Committee.

## **Capital Governance**

A review of the capital governance structure highlighted a number of opportunities to build on the previous arrangements in particular:

- Greater consistency regarding engagement across the organisation.
- Greater clarity as to how strategic programmes eg. Endoscopy, Stroke, Orthopaedics etc, are accommodated/included.
- Responding to the disbanding of the Safe Clean Care programme with a new focus on environment.
- Balancing of financial recovery with a clear focus on all capital investment.
- Transparency of decision making processes and structure.

The Executive Team have proposed that the strategic capital programmes should be aligned to the divisions and given responsibility for:

1. Determining estate priorities in the short, medium and long term aligned to short term operational risks and the Division's service plan
2. Develop divisions estates development plan (i.e. Division's programme business case)
3. Support annual capital programme by confirming priorities
4. Ensure integration of primary, community, mental health and acute care.

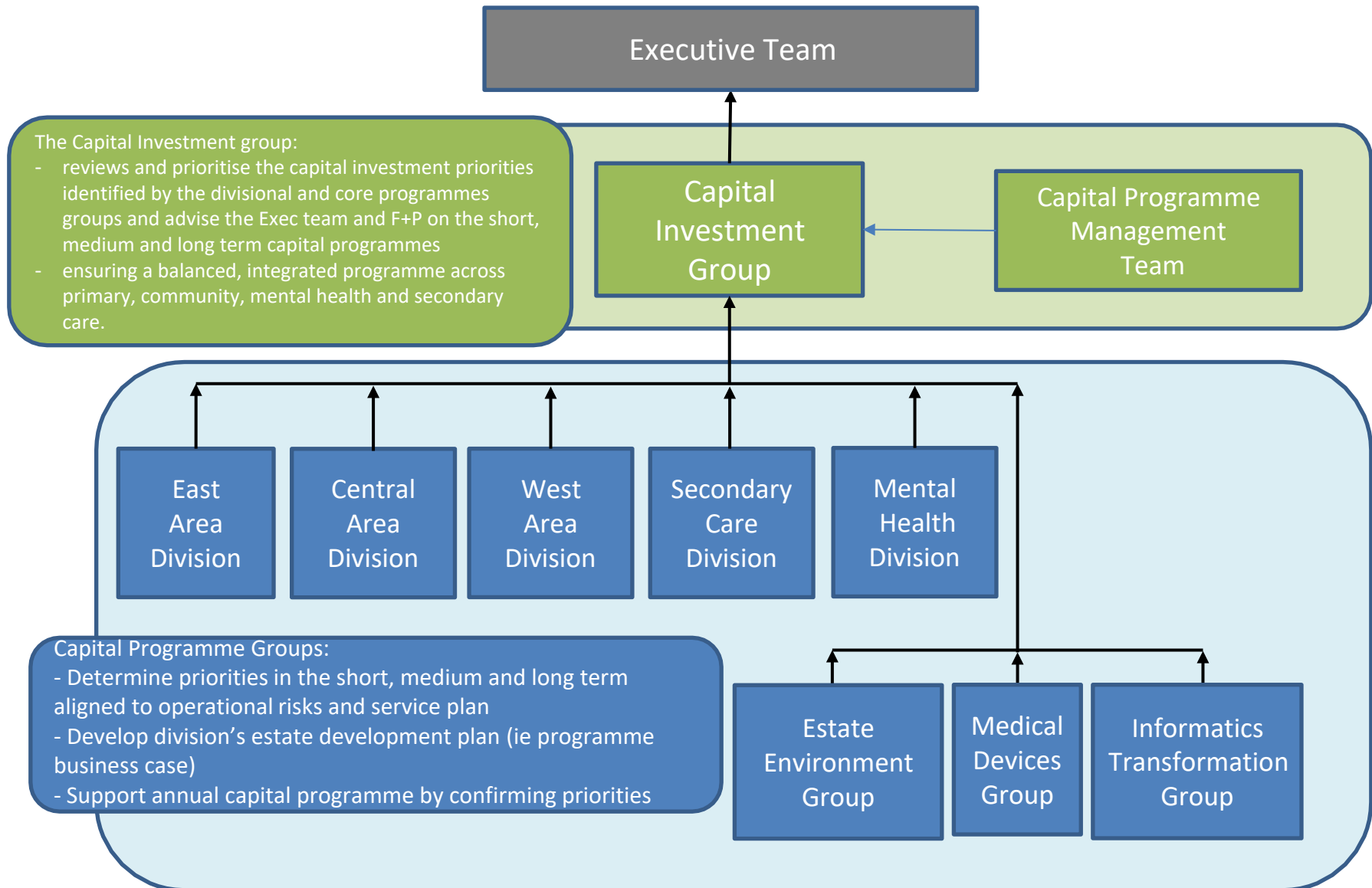
The new arrangements would retain the existing core compliance groups for Medical Devices and Informatics but their plans should include longer term strategic development (medical devices will now include the likes of radiology, radio-therapy and pharmacy programmes).

The structure introduces the establishment of an Estate Environment Group (EEG), chaired by the Director of Estates including senior nursing and health and safety colleagues. The remit of this group is the immediate environmental risks, linked to the strategic health and safety and infection prevention groups, and including backlog maintenance

It has been agreed that the former EIG becomes the Capital Investment Group (CIG) whose remit is expanded to review and prioritise the capital investment priorities identified by the divisional and core programmes groups and advise the Executive Team and Finance and Performance Committee on the short, medium and long term capital programmes. The group would be chaired by the Executive Director of Planning & Performance and include divisional directors and chairs of the core programme groups together with planning, capital, clinical, health and safety and finance colleagues. The group has a key role in ensuring a balanced, integrated programme across primary, community, mental health and secondary care.

A diagrammatic representation of the new governance arrangements is included as Appendix 1

# CAPITAL GOVERNANCE STRUCTURE - AUGUST 2020







**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	<b>Finance and Performance Committee</b> <b>29.10.20</b>						
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public						
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	BCU Symphony / National WEDS (Welsh Emergency Department System) Revenue Business Case						
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Chris Stockport, Executive Director Primary and Community Services						
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Fiona Mash, Informatics Project Manager						
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	BCU Symphony / National WEDS Project Board, Informatics Chief Information Officer, Medical Information Officer & Senior Management Team Executive Medical Director Executive Director of Finance Secondary Care Medical Director Health Board Review Team Executive Team						
<b>Atodiadau</b> <b>Appendices:</b>	BCU Symphony / National WEDS Revenue Business Case						
<b>Argymhelliad / Recommendation:</b>							
<p>The Committee is asked to approve the BCU Symphony / National WEDS Revenue Business Case to allow a phased implementation of the BCU Symphony in West and East Emergency Departments and all Minor Injury Units (MIU) in BCU, in readiness for the fully integrated WEDS solution (which includes Central Emergency Department).</p> <p>Without the support from this Business Case the Emergency Departments and Minor Injury Units across BCU would not be able to implement BCU Symphony or the integrated WEDS solution.</p>							
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)							
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer Trafodaeth</b> <b>For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd</b> <b>For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth</b> <b>For Information</b>	<input type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
The purpose of the BCU Symphony / National WEDS Revenue Business Case is to seek revenue funding to support ongoing system support, hardware and staffing costs to allow the phased implementation of BCU Symphony:							

**Phase 1 2020/2021** - Implement Symphony v2.38 in the West hosted locally including 6 MIUs (including Llandudno) associated with the West area.

**Phase 2 2021/2022** – Move East Area onto the BCU Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including 1 MIU associated with the East.

**Phase 3 2021/2022** – Implement Symphony v2.38 into 2 MIUs in Central Area.

A further Phase will be required to move all areas, including Central ED on to the full WEDS integrated solution (date to be confirmed).

#### **Cefndir / Background:**

The current systems do not allow for an effective process within Emergency Departments for the documentation of the patients journey, resulting in a lack of real time patient progression.

The ability to have a single system with real time information sharing would ensure a clear journey from point of admission, through investigation, treatment and outcome phases of a patient attendance. This would provide digitally signed transaction events and assurance of accurate completion of records to provide effective data sharing within the health board and partner services.

The current systems in use are inadequate to meet both current and future needs. This all Wales approach will enable the service to develop to meet the challenges ahead and deliver significant benefits with particular regard to information sharing across NHS Wales.

Without the support from this Business Case the Emergency Departments or Minor Injury Units across BCU would not be able to implement BCU Symphony or the integrated WEDS solution.

#### **Asesiad / Assessment & Analysis**

## Strategy Implications

The Strategic Case successfully demonstrates how the proposed investment fits within the existing business strategies of the Health Board, and establishes a compelling case for change to the existing methods for supporting the delivery of excellent patient care.

The original (National) Full Business Case, developed by NWIS (NHS Wales Informatics Service), states *“Together for Health”* as one of the main strategic driver for this proposed investment. It placed emphasis on service reconfiguration via clinical networks, performance management as key enablers for improving health and social care across Wales and the need to better promote NHS Wales as a center for excellence and recruitment for Emergency Departments.

In terms of ICT specifically, the main health strategy will aim to deliver against the national architecture recommendations from the Informed Health and Care Strategy (2015).

The BCU local strategy aims to ensure implementations, such as WEDS (Welsh Emergency Department Systems), benefit from the more open and interoperable approach in Wales allowing connection to multiple Patient Administration Systems (PAS) systems. The publication of the ICT Strategy for the Public Sector in Wales in 2011 provided a standardised, flexible and efficient infrastructure, which enables delivery of individual sector and departmental business. Consequently, the strategy identified the need for common standards.

These strategies and policies outline the transformation needed in health and social care provision in Wales leading to the declaration of a “Once For Wales” approach recognised by the Commission on Public Service Governance and Delivery (2014), and the Minister for Health and Social Care. This Revenue Business Case underpins the full National Business Case supporting the delivery of critical components within BCUs local Integrated Five Year Plan (IMTP).

## Options considered

The options considered in this Revenue Business Case are to discuss the delivery of BCU Symphony / National WEDS in BCU a National product procured by NHS Wales Informatics Service (NWIS).

## Financial Implications

In summary, the table below describes the Revenue consequences required for both ongoing system support, hardware renewal and staffing costs.

	Supplier Support Costs (including Hardware Renewal)			Staffing Revenue Costs	Total Cost	Additional Cost in year
	West	East	Central	BCU		
2020/21	£65.5k	£54k <i>(already paid by the ED area in East)</i>	N/A*	£40k	£159.5k	£105.5k
2021/22		£117.5k	N/A*	£185k	£302.5k	£248.5k
2022/23		£90.5k		£190k	£280.5k	£226.5k

<b>2023/24</b>	£232.5k	£221k	£453.5k	£399.5k
<b>2024/25</b>	£137.5k	£221k	£358.5k	£304.5k
<b>2025/26</b>	£137.5k	£221k	£358.5k	£304.5k
<b>2026/27</b>	£137.5k	£221k	£358.5k	£304.5k

Capital costs are being provided by Welsh Government monies during 2020/2021. Any slippage to the timescales will be monitored by the Project Board and the Capital Finance Representative and ongoing discussions with WG.

## Risk Analysis

The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression, which is a patient safety risk for the health board. Inaccurate national reporting on performance on a daily basis being submitted to national governing bodies in relation to performance. There are multiple logins required to review a patient's care, along with difficulties in relation to GP discharge letters being incomplete, therefore, numerous daily requests for reports. The ability to have a single system with real time information sharing would ensure a clear journey from point of admission, through investigation, treatment and outcome phases of a patient attendance. This would provide digitally signed transaction events and assurance of accurate completion of records to provide effective data sharing within the health board and partner services.

If the Revenue Business Case is not supported:

- East Emergency Department will remain on an unsupported version of Symphony with an increased annual cost
- West Emergency Department and Minor Injury Units will have to move onto WPAS in November 2021 (TBC), which is an administration system not an ED clinical System
- Central Emergency Department will remain on WPAS
- Minor Injuries Units in East and Central will remain on paper
- BCU Emergency Departments will not be able to move on to the fully integrated Welsh Emergency Department System which may incur penalty charges (see Legal and Compliance below)
- Inability to continue as an early adopter with EDQDF (Emergency Department, Quality Delivery Framework) due to the requirement for accurate and effective data capture to support nationally agreed performance standards, in particular, time to clinical assessment. The East and the Centre are able to achieve this via Symphony and WPAS. Therefore, West being unable to report on this will substantially reduce the BCU overall figures.

## Legal and Compliance

In 2015, NWIS managed a procurement on behalf of NHS Wales Health Boards to establish an appropriate contractual arrangement to enable the phased implementation of a WEDS. The Evaluation Team recommended Ascribe Ltd be awarded the Master Services Agreement (MSA) for a period of seven years with an option to extend for a further four years (in increments of one year). A Deployment Order (DO) to provide the system was executed between Ascribe, trading as EMIS, and BCU in May 2015.

Due to the National Datacentre Hardware renewal implications, the decision around hosting has moved from National Hosting to Local Hosting, this is described in detail in section 2.1 (Introduction). Contractual discussion are ongoing on how to best “pause” BCU contractual arrangement described in the MSA and progress to extending the existing local Symphony contract currently in place for BCU East.

### **Impact Assessment**

An EQIA was completed by NWIS (NHS Wales Informatics Service) (Appendix 4). The assessment highlighted 2 recommendations, which the Supplier have addressed making the system compliant.

A DPIA has been completed and reviewed by Information Governance. Recommendations will be shared and agreed with the Project Board.

<b>Division / Area / Department</b>	<b>Emergency Care Directorate</b>
<b>Development or Scheme Title</b>	<b>BCU Symphony / National WEDS (Welsh Emergency Department System) Project</b>
<b>Author/s</b>	<b>Fiona Mash</b>
<b>Executive Sponsor</b>	<b>Dr Kate Clark – Secondary Care Medical Director</b>
<b>Version</b>	<b>Final 5.2</b>
<b>Date</b>	<b>October 2020</b>

## 1. Executive Summary

This document represents the Full Business Case (FBC) to enable a phased implementation of the BCU Symphony/National WEDS Project across the Health Board (HB) and seeks to secure revenue funding for supplier system support, hardware renewal and staffing costs.

This investment is fully supported by Welsh Government (WG), in particular the First Minister, the National Informatics Management Board (NIMB), and the Welsh Clinical Informatics Council (WCIC).

A number of systems are mentioned in the following discussion, they are described as they are introduced, but for clarity, a glossary is provided at the end of this summary.

In summary, the outdated v2.29 of Symphony currently in use in East is on an unsupported platform and needs to be upgraded to v2.38 as soon as possible. This will give East Emergency Department (ED) staff access to Manchester Triage 3 (MT3), which staff in the Centre and West already have access to via other systems. Manchester Triage 3 is a publication and set of tools used to enable clinicians to prioritise care to the most accurate, in an efficient and timely manner to ensure patients get the most appropriate care for their needs. West ED staff currently have limited ED functionality using the current PiMS, but this system is to be replaced in November 2021 (TBC) with WPAS (Welsh Patient Administration System), which is not a clinical system. Central are already using the ED module in WPAS since the implementation in November 2016.

The current systems (including the WPAS ED module) do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression. There are multiple logins required to review a patient's care, along with difficulties in relation to GP discharge letters being incomplete, therefore, numerous daily requests for reports. The ability to have a single system with real time information sharing would ensure a clear journey from point of admission, through investigation, treatment and outcome phases of a patient attendance. This would provide digitally signed transaction events and assurance of accurate completion of records to provide effective data sharing within the health board and partner services.

It is safe to say the current systems in use are inadequate to meet both current and future needs. This all Wales approach will enable the service to develop to meet

the challenges ahead and deliver significant benefits with particular regard to information sharing across NHS Wales.

This Business Case will reflect the option agreed by the BCU Symphony / National WEDS Project Board to:

**Phase 1 2020/2021** - Implement Symphony v2.38 in the West hosted locally including 6 MIUs (including Llandudno) associated with the West area.

**Phase 2 2021/2022** – Move East Area onto the BCU Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including 1 MIU associated with the East.

**Phase 3 2021/2022** – Implement Symphony v2.38 into 2 MIU's in Central Area.

A further Phase will be required to move all areas, including Central ED on to the full WEDS\* integrated solution (date to be confirmed).

*\*Full WEDS is contingent on a single WPAS*

## Revenue Costs

In summary, the table below describes the Revenue consequences required for both supplier support costs, hardware renewal and ongoing staffing. Further detail is available in section 4 (Financial Case).

	Supplier Support Costs (including Hardware Renewal)			Staffing Revenue Costs	Total Cost	Additional Cost in year
	West	East	Central	BCU		
2020/21	£65.5k	£54k <i>(already paid by the ED area in East)</i>	N/A*	£40k	£159.5k	£105.5k
2021/22	£117.5k		N/A*	£185k	£302.5k	£248.5k
2022/23	£90.5k			£190k	£280.5k	£226.5k
2023/24	£232.5k			£221k	£453.5k	£399.5k
2024/25	£137.5k			£221k	£358.5k	£304.5k
2025/26	£137.5k			£221k	£358.5k	£304.5k
2026/27	£137.5k			£221k	£358.5k	£304.5k

*\*WPAS ED module currently used in Central is covered as part of the WPAS SLA already in place.*

As part of this implementation, it has been agreed the following additional staff will be required on a permanent basis. These staffing levels are based on the current models we use to support other major systems such as WPAS and WCP; also, our experience of running Symphony in East has shown this level of additional staffing is appropriate.

	Yr 1 (2020/ 2021)	Yr 2 (2021/ 2022)	Yr 3 (2022/ 2023)	Yr 4 (2023/ 2024)	Yr 5 (2024/ 2025)	Yr 6 (2025/ 2026)	Yr 7 (2026/ 2027)
1 x B6 System Owner (ED)	£12k	£47k	£48k	£48k	£48k	£48k	£48k
1 x B4 System Admin West (ED)	£8k	£30k	£31k	£31k	£31k	£31k	£31k
1 x B4 System Admin East (ED)		£30k	£31k	£31k	£31k	£31k	£31k
1 x B4 System Admin Central (ED)				£31k	£31k	£31k	£31k
1 x B5 System Manager (Informatics)	£10k	£39k	£40k	£40k	£40k	£40k	£40k
1 x B5 Information Analyst (Informatics)	£10k	£39k	£40k	£40k	£40k	£40k	£40k
<b>TOTAL</b>	£40k	£185k	£190k	£221k	£221k	£221k	£221k

Without the support from this Business Case the ED services across BCU will not be able to implement BCU Symphony or the integrated WEDS solution.

## Glossary

### PAS

Patient Administration System (generic term): A non-clinical system used to register patient attendances, bookings, etc.

### PIMS

Patient Information Management System. The System used as a PAS currently in West. It is outdated and is to be replaced with WPAS.

### Symphony

This is an ED management system with both patient administration and clinical record functionality. The older version (2.29) currently in use in East does not have clinician-usable functionality.

### WEDS

Welsh Emergency Department System. It is a national procurement of (and is identical to) Symphony 2.38 but with interfaces to other national systems.

### WPAS

Welsh Patient Administration System.

### WPAS ED Module

A module within WPAS, which allows it to register patient attendance within an ED setting. It provides only limited PAS functionality and does not provide any clinical functionality.



2.	<b>The Strategic Case</b>
2.1	<p><b>Introduction</b></p> <p>In 2015, NWIS managed a procurement on behalf of NHS Wales Health Boards to establish an appropriate contractual arrangement to enable the phased implementation of a WEDS, formerly known as EDCIMS (Emergency Department Clinical Information Management System). Delivering a common solution to enable Health Boards to procure and implement a new suite of applications, hardware and services to support the ongoing delivery of Emergency Services.</p> <p>The FBC, led by NWIS, justified the proposed investment for four Health Boards over an eleven-year period. The Evaluation Team recommended Ascribe Ltd be awarded the Master Services Agreement (MSA) for a period of seven years with an option to extend for a further four years (in increments of one year). The Ascribe product, Symphony, was already in use in BCU East, albeit an earlier version (v2.29). A Deployment Order (DO) to provide the system was executed between Ascribe, trading as EMIS, and BCU in May 2015.</p> <p>BCU participated in the National procurement and following the award the Health Board was actively involved with Swansea Bay Health Board (SBHB) in the configuration and testing to support the working practices of the future for BCU.</p> <p>Early 2017, SBHB raised concerns about the progress being made with their implementation, particularly around the ability to interface to other National systems. As a result, commercial and contractual discussions began with the supplier to find a way forward. These have been resolved and EMIS and NWIS are re-engaging with the Health Boards. Aneurin Bevan Health Board (ABHB) upgraded to v2.38, the latest version of Symphony, in November 2018 (locally hosted).</p> <p>The National plan was for Cwm Taf Morgannwg University Health Board (CTMHB) to implement full WEDS in May 2020, however, there have been delays due to COVID-19 pressures.</p> <p>The BCU project had previously spent £548k of the £1.2m original Capital allocation. All WG Capital monies for 2019/20 were returned following confirmation WG would broker the £701k remaining Capital allocation in 2020/21. Discussions are taking place to extend to 2021/22. The Capital spend to date was to upgrade hardware and infrastructure in the 3 ED areas and for Informatics and operational staff to project manage the implementation and undertake testing.</p> <p>The project was due to be implemented in the Centre of BCU before the WPAS Go Live in November 2016. However, due to issues described in the “Options to Manage Business Continuity during transition to the WEDS” paper dated September 2016 this was not possible. The paper recommended the preferred option to achieve business continuity was to</p>

	<p>take the ED Module within WPAS whilst the WEDS solution was proved, tested, configured and finally deployed. The Central Area remain on the WPAS ED module.</p> <p>Following a pause in the Project, a BCU Symphony / National WEDS Project Board was reconvened and met for the first time in September 2019. The Board agreed:</p> <ul style="list-style-type: none"> <li>• West to implement Symphony as soon as possible and before WPAS implementation</li> <li>• East required an upgrade from v2.29 to v2.38. This upgrade has been a priority for many years but has been deferred due to the promise of the WEDS solution</li> <li>• Central area would remain as is until the availability of National WEDS*</li> <li>• Further agreement was required around hosting environment, sequencing and patient demographic data migration.</li> </ul> <p><i>*Full WEDS is contingent on a single WPAS</i></p> <p>The BCU Symphony / National WEDS Project Board were made aware at their July 2020 meeting of a requirement to replace the national data centre hardware before any Symphony/WEDS implementation. This was due to the data centre hardware coming out of warranty and being end-of-life. This left NWIS and all health boards wishing to implement Symphony/WEDS with three options.</p> <p><b>Option 1:</b> to expand the Infrastructure provision in Primary Care Data Centre to include WEDS</p> <p><b>Option 2:</b> replace existing hardware on like for like basis</p> <p><b>Option 3:</b> purchase an extended one year warranty for existing hardware, followed by Option 1 or 2</p> <p>The BCU Symphony / National WEDS Project Board expressed a preference for Option 3 as this provided the least risk to project timescales. However, at a meeting between NWIS and Health Board's on the 14<sup>th</sup> of August 2020, the preferred option was to proceed with Option 1 (expansion of VSan Infrastructure provisioned for Primary Care to also host WEDS); subject to timescale and costs. It was confirmed in September 2020 this move to Primary Care Data Centre would take 16-20 weeks to delivery from project start up. Therefore, to de-risk the possibility of the ED Service having to move onto the non-clinical WPAS system and achieve implementation onto the BCU Symphony system, BCU Informatics are to implement onto a Locally Hosted Solution by expanding the existing BCU East Local Agreement with EMIS.</p> <p>BCU remain committed to the National Solution and decisions regarding the National Architecture. BCU will review the architecture both nationally and locally when we are in a position to implement the full integrated WEDS Solution. If it were agreed to move to National hosting some</p>
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	hardware renewal costs and NWIS support costs would be required. These are currently forecasted to be at a cost of £95k (Hardware renewal costs) and £46k (NWIS support/hosting costs) and are included in this Business Case as 2023/2024 costs. If following the review BCU remain on local hosting then these costs would not be required.																																													
2.2	<b>Strategic Context</b>																																													
2.2.1	<b>Organisational Overview</b> <p>Previously, BCU had 3 different PAS in use, but with the passage of time, this has changed and there are currently 2. BCU West are scheduled to implement WPAS in November 2021 (TBC). Leaving BCU in a position, whereby, all 3 areas will be using the same WPAS, albeit, 3 separate instances. The plan is to merge these PAS systems to one single instance across BCU creating one PMI (Patient Master Index), currently forecasted to be available 2023/2024.</p> <p>The EDs form part of BCU’s Secondary Care. The number of EDs (3) and MIUs (9) are listed below along with the areas they serve and the average number of attendances they see per annum. It is worth noting none of the current systems in use are paperless.</p> <table><tr><th>Hospital Site</th><th>BCU Area</th><th>Type of Service</th><th>Current System in use</th><th>Average Attendances per Annum</th></tr><tr><td>Wrexham Maelor Hospital</td><td>East</td><td>ED</td><td>Symphony v2.29</td><td>65000</td></tr><tr><td>Glan Clwyd Hospital</td><td>Central</td><td>ED</td><td>WPAS ED Module</td><td>57500</td></tr><tr><td>Ysbyty Gwynedd</td><td>West</td><td>ED</td><td>PiMS (until November 2021 TBC)</td><td>52000</td></tr><tr><td>Bryn Beryl Hospital</td><td>West</td><td>MIU</td><td>PiMS (until November 2021 TBC)</td><td>4000</td></tr><tr><td>Dolgellau &amp; Barmouth District Hospital</td><td>West</td><td>MIU</td><td>PiMS (until November 2021 TBC)</td><td>2500</td></tr><tr><td>Tywyn Memorial Hospital</td><td>West</td><td>MIU</td><td>PiMS (until November 2021 TBC)</td><td>2000</td></tr><tr><td>Ysbyty Penrhos Stanley</td><td>West</td><td>MIU</td><td>PiMS (until November 2021 TBC)</td><td>6500</td></tr><tr><td>Ysbyty Alltwen</td><td>West</td><td>MIU</td><td>PiMS (until November 2021 TBC)</td><td>4500</td></tr></table>	Hospital Site	BCU Area	Type of Service	Current System in use	Average Attendances per Annum	Wrexham Maelor Hospital	East	ED	Symphony v2.29	65000	Glan Clwyd Hospital	Central	ED	WPAS ED Module	57500	Ysbyty Gwynedd	West	ED	PiMS (until November 2021 TBC)	52000	Bryn Beryl Hospital	West	MIU	PiMS (until November 2021 TBC)	4000	Dolgellau & Barmouth District Hospital	West	MIU	PiMS (until November 2021 TBC)	2500	Tywyn Memorial Hospital	West	MIU	PiMS (until November 2021 TBC)	2000	Ysbyty Penrhos Stanley	West	MIU	PiMS (until November 2021 TBC)	6500	Ysbyty Alltwen	West	MIU	PiMS (until November 2021 TBC)	4500
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	Llandudno General Hospital	West	MIU	PIMS (until November 2021 TBC)	19500
	Denbigh Community Hospital	Central	MIU	Paper	4000
	Holywell Community Hospital	Central	MIU	Paper	11500
	Mold Community Hospital	East	MIU	Paper	6500
	<p>This investment is fully supported by WG, in particular the First Minister, the National Informatics Management Board (NIMB), and the Welsh Clinical Informatics Council (WCIC).</p>				
2.2.2	<b>Relevant National and Local Strategies</b>				
	<p>The original FBC states <i>“Together for Health”</i> as one of the main strategic driver for this proposed investment. It placed emphasis on service reconfiguration via clinical networks and performance management as key enablers for improving health and social care across Wales, and the need to better promote NHS Wales as a center for excellence and recruitment for EDs.</p> <p>New legislative powers have led to the Well-being of Future Generations (Wales) Act, the Social Services and Well-being (Wales) Act, the Regulation and Inspection of Social care (Wales) Act.</p> <p>In terms of ICT specifically, the main health strategy will aim to deliver against the national architecture recommendations from the Informed Health and Care Strategy (2015).</p> <p>The reviews from the Welsh Audit Office (WAO) report and Public Accounts committee highlighted the changing approach to technology supporting data and the open standards moving away from pre architecture reviews based on legacy single system ideologies. The BCU local strategy aims to ensure that implementations, such as WEDS, benefit from the more open and interoperable approach in Wales allowing connection to multiple PAS systems.</p> <p>These strategies and policies outline the transformation needed in health and social care provision in Wales so that citizens are treated closer to home, avoiding unscheduled admissions where possible, and therefore, receive care from an integrated team working across disciplines in health and social care.</p> <p>Information Technology has a significant part to play in enabling this transformation through improving efficiency, reducing duplication and</p>				

	<p>making available information that is shareable and accessible at the point of care. The publication of the ICT Strategy for the Public Sector in Wales in 2011 provides a standardised, flexible and efficient infrastructure, which enables delivery of individual sector and departmental business. Consequently, the strategy identified the need for common standards. Such strategies have led to the declaration of a “Once For Wales” approach. This was echoed by the report produced by the Commission on Public Service Governance and Delivery (2014), and further in the statement by the Minister for Health and Social Care regarding e-Health and Care, where the “Once For Wales” approach was considered as being an enabler to delivery efficiency and value. The FBC also aims to support the delivery of the critical components within BCUs local Integrated Five Year Plan (IMTP).</p> <p>The <i>One Wales</i> Strategy document outlined the delivery of the NHS in Wales, and stated there was a need to redesign to improve health outcomes and ensure the NHS delivers care effectively with its partners. In essence, more emphasis was placed on the requirement to provide and share patient information across NHS Wales’ systems and associated partners.</p> <p>This procurement demonstrated the potential to deliver the Once for Wales approach and be an enabler that can improve services in line with national and local strategic objectives.</p> <p>In line with EDQDF (Emergency Department, Quality Delivery Framework) standards (Time to 1<sup>st</sup> Assessment, Time to Triage and reporting), a real time electronic ED system would support all Key Performance Indicators (KPI’s) and ensure an improved performance around patient care. It would ensure the ability to track and trigger the patient journey giving a clear visual display.</p>																						
2.3	<b>The Case for Change</b>																						
2.3.1	<p><b>Existing Arrangements</b></p> <table border="1"> <thead> <tr> <th>Hospital</th><th>ED Solution</th></tr> </thead> <tbody> <tr> <td>Wrexham Maelor Hospital</td><td>Symphony V2.29</td></tr> <tr> <td>Glan Clwyd Hospital</td><td>WPAS ED Module</td></tr> <tr> <td>Ysbyty Gwynedd</td><td>PiMS (until November 2021 TBC)</td></tr> <tr> <td>Bryn Beryl Hospital</td><td>PiMS (until November 2021TBC)</td></tr> <tr> <td>Dolgellau &amp; Barmouth District Hospital</td><td>PiMS (until November 2021TBC)</td></tr> <tr> <td>Tywyn Memorial Hospital</td><td>PiMS (until November 2021TBC)</td></tr> <tr> <td>Ysbyty Penrhos Stanley</td><td>PiMS (until November 2021TBC)</td></tr> <tr> <td>Ysbyty Alltwen</td><td>PiMS (until November 2021TBC)</td></tr> <tr> <td>Llandudno General Hospital</td><td>PiMS (until November 2021TBC)</td></tr> <tr> <td>Denbigh Community Hospital</td><td>Paper based</td></tr> </tbody> </table>	Hospital	ED Solution	Wrexham Maelor Hospital	Symphony V2.29	Glan Clwyd Hospital	WPAS ED Module	Ysbyty Gwynedd	PiMS (until November 2021 TBC)	Bryn Beryl Hospital	PiMS (until November 2021TBC)	Dolgellau & Barmouth District Hospital	PiMS (until November 2021TBC)	Tywyn Memorial Hospital	PiMS (until November 2021TBC)	Ysbyty Penrhos Stanley	PiMS (until November 2021TBC)	Ysbyty Alltwen	PiMS (until November 2021TBC)	Llandudno General Hospital	PiMS (until November 2021TBC)	Denbigh Community Hospital	Paper based
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	Holywell Community Hospital	Paper based
	Mold Community Hospital	Paper based
	<p>All 5 Minor Injury Units (MIU's) in the West plus Llandudno MIU are currently using PiMS until November 2021 (TBC). The other 3 MIUs are paper based. All have an increased need of a dedicated clinical system.</p> <p>In summary, the outdated v2.29 of Symphony currently in use in East is on an unsupported platform and needs to be upgraded to v2.38 as soon as possible. This upgrade has been a priority for many years but has been deferred due to the promise of the WEDS solution. This will give East ED staff access to Manchester Triage 3 (MT3), which staff in the Centre and West already have access to via other systems. Manchester Triage 3 is a publication and set of tools used to enable clinicians to prioritise care to the most accurate, in an efficient and timely manner to ensure patients get the most appropriate care for their needs. West ED staff currently have limited ED functionality using the current PiMS, but this system is to be replaced (November 2021 TBC) with WPAS, which is not a clinical system. Central are already using the ED module in WPAS since the implementation in November 2016.</p> <p>It is safe to say the current systems in use are inadequate to meet both current and future needs and this all Wales approach will enable the service to develop to meet the challenges ahead and deliver significant benefits with particular regard to information sharing across NHS Wales.</p>	
2.3.2	<p><b>Issues and Risks with the Existing Arrangements – What is Wrong with the Status Quo</b></p> <p>The current systems do not allow for an effective process within ED for the documentation of the patients journey, resulting in a lack of real time patient progression. There are multiple logins required to review a patient's care, along with difficulties in relation to GP discharge letters being incomplete, therefore, numerous daily requests for reports. The ability to have a single system with real time information sharing would ensure a clear journey from point of admission, through investigation, treatment and outcome phases of a patient attendance. This would provide digitally signed transaction events and assurance of accurate completion of records to provide effective data sharing within the health board and partner services.</p> <p>Lesley Griffiths AM (2011), former Minister for Health and Social Services stated in "Together for Health - A 5-year vision for the NHS in Wales" <i>....status quo is not an option. We all now face a choice. We could continue as we are, trying to deal with every issue as it comes along, achieving at best slow, incremental change in the face of increasing pressure. However, that would be risky and ultimately unrewarding. The alternative is to seize the initiative and drive hard for a better future. That is the road that opportunity and our ambition point us towards. That is the option this vision (Together for Health) proposes. It means we must</i></p>	



*promote and protect positive health, see the NHS become more engaged in the wider Government agenda and act quickly to create sustainable, reliable services within an NHS easy to access whatever the problem and quick to offer a personalised and effective response.*

Whilst WEDS pre dates the Welsh Government's adoption of the National Architecture Review recommendations the solution will support and enable BCU to move forward and standardize data collection in ED. Implementing BCU Symphony / National WEDS in BCU will enable the Health Board to operate its three District General Hospitals (DGH) and 9 Minor Injuries (MIUs) as "one hospital" – currently unachievable.

The All Wales approach will provide the following:

- Support of policy initiatives
- Provision of a single view of the patient record for ED
- Easier sharing of information generally and particularly concerning children and vulnerable adults/ repeat attendees across EDs and MIUs in Wales – although in future this will be supported more effectively via a new architecture rather than a single system
- A consistent information strategy for the ED environment
- ED staff trained on a single solution, therefore, allowing for easier transition when working at different ED sites
- Stronger approach to application development and influence within the supplier user groups –although this does mean no variation and lack of flexibility or control of the system
- Scalable to all for common use across Wales
- The opportunity for future deployment to Admission areas and G.P. Out-of-Hours (OOHs) integration
- With the implementation of Emergency Medical Retrieval and Transfer Service (EMRTS) and development of the national trauma networks, there is a requirement to have the facility to share patient information as part of their hospital journey. This would support the ability for rapid and effective discharge communication and repatriation communication

BCU via NWIS agreed to the Master Services Agreement (MSA) in 2015 and a Deployment Order (DO) was executed between Ascribe, trading as EMIS, and BCU in May 2015. This was to detail and agree the implementation plan and a Go Live in the Centre before their WPAS implementation in November 2016. This was not achieved and the Health Board had to put a last minute plan in place to use the ED module within WPAS. In early 2017, SBHB raised concerns about the progress being made with their implementation, particularly around the ability to interface to other National systems, and as a result, commercial and contractual discussions began with the supplier to find a way forward. The solution is now in a position ready to be deployed and West ED need a system in place before WPAS is implemented (November 2021 TBC).

	These delays have meant EDs and MIUs in BCU have not been able to move forward and are still using unsupported systems or systems not suitable for their clinical needs.	
2.4	<b>Scope of the Case</b>	
2.4.1	<b>Objectives and Benefits</b>  The main outcomes and benefits are outlined in the following table and the Draft Benefits Plan is available in Appendix 6.	
	Key Outcomes	Related Benefits
	Improved patient safety	<ul style="list-style-type: none"> <li>• Ability to view the patient record across multiple BCU ED and MIU sites using the same system. Over time this will particularly support the identification and management of vulnerable patients and enable clinicians to speedily note relevant clinical history</li> <li>• Live patient tracking, triage monitoring and triage management supporting clinical decision making improved clinical information flows</li> <li>• The use of consistent clinical protocols across all sites in BCU, electronically supported, to reduce serious incidents and complaints</li> <li>• The ability to review the patient journey and management plan to support Police enquires/Coroners enquiries</li> <li>• The electronic adoption of the Royal College of Emergency Medicine (RCEM) clinical measures to prompt standardized approaches to the delivery of clinical treatment and ensure compliance with RCEM Audits</li> <li>• It would give the ability to have a real time departmental escalation display to support managing predictive workloads.</li> <li>• Accurate recording of COVID-19 patients, which will assist in the preparation should a second wave take place</li> </ul>
	Improved administrative efficiency	<ul style="list-style-type: none"> <li>• A step towards implementing paperless processes reducing the need for paper-based administration intervention. This will enable resource efficiencies by releasing staff currently tied into manual administrative processes into front line delivery of healthcare services and over time will release the cost of external storage</li> <li>• A step towards eradicating the requirement for hybrid paper/electronic data capture e.g. avoid the</li> </ul>



		<p>need to scan paper records into electronic systems, allowing the reallocation of resources</p> <ul style="list-style-type: none"> <li>• Ability to ensure timely discharge letters back to primary care</li> <li>• Improved clinical governance around patient attendance</li> <li>• In the past, EDs have employed 'Progress Chasers' to ensure that the patient journey (and therefore the calculated time points on which targets are based) are up to date, and there has been discussion about recommencing these roles. An integrated system would remove the need for such personnel as timestamps can be taken directly from clinician interaction with the system.</li> </ul>
	Patient experience	<ul style="list-style-type: none"> <li>• Live patient status and treatment pathway tracking grid enables improved communication with patients and relatives</li> <li>• Improved communication based on robust live information will support a reduction in complaints relating to the service. Out of 160 complaints relating to EDs and MIUs during 2019/2020, 16 related to Communication with the patient (other than consent issues)</li> <li>• Improved patient journey with real time tracking to ensure no unnecessary delays. Out of 160 complaints relating to EDs and MIUs during 2019/2020, 21 were related to unacceptable waiting times or waiting times too long in reception to see Consultant, Doctor, Nurse.</li> </ul>
	Patient flow	<ul style="list-style-type: none"> <li>• Patient location tracking supports the improvement in patient flow across the department</li> <li>• Improved monitoring and management of waiting times in ED to support waiting time performance</li> <li>• Effective audit for triage and patient pathway management. Robust evidence to facilitate service improvements</li> </ul>
	Enhanced clinical presence	<ul style="list-style-type: none"> <li>• Live electronic departmental overview and patient "status at a glance" to enhance clinical management and control of patient flow</li> <li>• Reduced clinical time required on administrative tasks enabling improved clinical presence at departmental and patient level. Although this is difficult to quantify it is strongly felt by clinicians that the ability to spend more time on patient interaction improves quality of care. This was a major finding of the Topol Review (HEE: <a href="https://topol.hee.nhs.uk/">https://topol.hee.nhs.uk/</a>)</li> </ul>

2.4.2	<p><b>Constraints</b></p> <p>The project is subject to the following constraints:</p> <ul style="list-style-type: none"> <li>• Availability of adequate funding (Capital and Revenue)</li> <li>• Availability of key personnel to undertake the enabling activities required for readiness (EMIS, NWIS, BCU Programmes, Information and ED resource)</li> <li>• If the West readiness activities do not remain on schedule, the West will be moving onto WPAS ED Module (November 2021 TBC) and this will need to be factored into WPAS readiness activities</li> <li>• There will be patient demographic data migration only and NO activity data migration. This means at the point of Go Live historic re-attendances will not be highlighted to clinical staff via Symphony in the first instance, however, a workaround has been identified and accepted by the service</li> <li>• COVID-19 will remain a concern with regards to staff resource</li> </ul>
2.4.3	<p><b>Dependencies</b></p> <p>The project is subject to the following dependencies that will be carefully monitored and managed throughout the lifetime of the investment:</p> <ul style="list-style-type: none"> <li>• Approval of this Revenue Business Case. Approval by the Health Board Review Team and the Finance &amp; Performance Committee is required to ensure the revenue costs for ongoing system support/hardware and staffing costs have been accepted by the Service/Health Board</li> <li>• Availability of Supplier EMIS, NWIS and Health Board resource</li> <li>• IT infrastructure at national and health board levels to support the implementation of the new system.</li> <li>• ED admin resource required double register patients in Symphony (as per current process in East)</li> </ul>
3.	<p><b>Options</b></p>
3.1	<p><b>Criteria for Option Appraisal</b></p> <p>As described in 2.1 (Introduction), the National FBC, led by NWIS, agreed the option to invest in a Master Service Agreement (MSA) for a period of seven years with an option to extend for a further four years with Ascribe. The Ascribe product, Symphony, was already in use in BCU East, albeit an earlier version (v2.29). A Deployment Order to provide the system was executed between Ascribe, trading as EMIS, and BCUHB in May 2015.</p> <p>Due to the National Data Centre Hardware renewal implications, the decision around hosting has moved from National Hosting to Local Hosting, this is described in detail in section 2.1 (Introduction). Contractual discussion are ongoing on how to best “pause” BCU contractual</p>

	<p>arrangement described in the MSA and progress to extending the existing local Symphony contract currently in place for BCU East.</p> <p>This Business Case will reflect the option agreed by the BCU Symphony / National WEDS Project Board to:</p> <p><b>Phase 1 2020/2021</b> - Implement Symphony v2.38 in the West hosted locally including 6 MIUs (including Llandudno) associated with the West area.</p> <p><b>Phase 2 2021/2022</b> – Move East Area onto the BCU Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including the 1 MIU associated with the East.</p> <p><b>Phase 3 2021/2022</b> – Implement Symphony v2.38 into 2 MIU's in Central Area.</p> <p>A further Phase will be required following Phase 3 to move all including Central ED on to the full WEDS* integrated solution (date to be confirmed). The new National Architecture recommendations, which includes open interoperability with other systems, may change the approach to the integrated solution.</p> <p><i>*Full WEDS is contingent on a single WPAS.</i></p>												
3.2	<p><b>Longlist of Options</b></p> <p>Following the national pause in Summer 2017, a newly formed BCU wide Symphony / National WEDS Project Board met at the end of September 2019 and an interim option was tabled in order to progress. This option was to upgrade the current v2.29 in use in the East to Symphony v2.38 remaining locally hosted until WEDS was available as Phase 1.</p> <p>The interim options paper described a Phase 2 with 3 Options. For full details, Appendix 1.</p> <table><tr><th></th><th>Option A</th><th>Option B</th><th>Option C</th></tr><tr><td><b>Central</b></td><td>Do nothing - Remain on WPAS ED Module</td><td>Do nothing - Remain on WPAS ED Module</td><td>Do nothing - Remain on WPAS ED Module</td></tr><tr><td><b>West</b></td><td>Remain on PiMS</td><td>Move to WPAS ED Module</td><td>Move to Symphony v2.38</td></tr></table> <p>The Board asked for further consideration to the sequencing and asked for an appraisal to take place to consider moving West onto Symphony before upgrading East which is detailed in section 3.3.</p>		Option A	Option B	Option C	<b>Central</b>	Do nothing - Remain on WPAS ED Module	Do nothing - Remain on WPAS ED Module	Do nothing - Remain on WPAS ED Module	<b>West</b>	Remain on PiMS	Move to WPAS ED Module	Move to Symphony v2.38
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<b>West</b>	Remain on PiMS	Move to WPAS ED Module	Move to Symphony v2.38										

3.3	<p><b>Appraisal of Longlist and Creation of Shortlist of Options</b></p> <p>Following a review of the longlist options, a change of sequence was discussed with West implemented before East. This was due to the implementation of WPAS in West in November 2020, which has subsequently been delayed.</p> <p>This second options paper was discussed at the November Project Board.</p> <table border="1" data-bbox="339 517 1372 1158"> <thead> <tr> <th data-bbox="339 517 531 562">Option</th><th data-bbox="531 517 1372 562">Description /Steps</th></tr> </thead> <tbody> <tr> <td data-bbox="339 562 531 857">Option 1 – Separate Instances</td><td data-bbox="531 562 1372 857"> <p><u>West</u> Create West Symphony v2.38 as a separate instance.</p> <p><u>East</u> East remain on v2.29, until plans are put in place to upgrade to v2.38, remaining locally hosted until BCU move on to National WEDS.</p> </td></tr> <tr> <td data-bbox="339 857 531 1158">Option 2 – Single BCU environment</td><td data-bbox="531 857 1372 1158"> <p><u>East</u> Upgrade East to v2.38.</p> <p><u>West</u> Add additional West department. Plan to undertake testing for the West department alongside the East implementation.</p> </td></tr> </tbody> </table> <p>The Board then asked if a hybrid option of the above could be captured as “Option 1b” an addendum to Option 1 above. Whereby, a single instance of Symphony, hosted Nationally with the West ED and MIUs (including Llandudno) implemented first followed by East ED and MIU and the Central MIUs.</p> <p>At the time, this was to ensure West ED and MIUs had a system they could use when WPAS was implemented in West in November 2020. Although the WPAS implementation date has changed to November 2021 (TBC), it is clear the West implementation needs to take precedence, and as soon as possible, as the same Information Department resource is used for both projects.</p> <p>It has also become apparent, as BCU is an early adopter site for EDQDF (Emergency Department, Quality Delivery Framework) the West of BCU is unable to report on time to clinical assessment of the EDQDF KPIs. The East and the Centre are able to achieve this via Symphony and WPAS. Therefore, West being unable to report on this will substantially reduce the BCU overall figures.</p>	Option	Description /Steps	Option 1 – Separate Instances	<p><u>West</u> Create West Symphony v2.38 as a separate instance.</p> <p><u>East</u> East remain on v2.29, until plans are put in place to upgrade to v2.38, remaining locally hosted until BCU move on to National WEDS.</p>	Option 2 – Single BCU environment	<p><u>East</u> Upgrade East to v2.38.</p> <p><u>West</u> Add additional West department. Plan to undertake testing for the West department alongside the East implementation.</p>
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3.4	<p><b>Appraisal of Shortlisted Options</b></p>						

	<p>Following the November Board, option 1b was drafted and sent to the Board for review. Board members accepted the option but were concerned over the original timeline due to close proximity to the WPAS implementation (which was then November 2020). EMIS redrafted the plan with a July 2020 Go Live and this was accepted at the February Board. This was to implement BCU Symphony into the West hosted Nationally. This ambitious plan relied heavily on the Revenue Business Case being approved and the service releasing staff to test the system and deliver training. This will be re-planned once the Revenue Business Case is approved but it is likely to commence in the West in November 2020 for a period of 12 weeks. The Project Team will then move on to East.</p> <p><b>Phase 1 2020/2021</b> - Implement Symphony v2.38 in the West hosted Nationally including 6 MIUs (including Llandudno) associated with the West area.</p> <p><b>Phase 2 2021/2022</b> – Move East Area onto the BCU Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including the 1 MIU associated with the East.</p> <p><b>Phase 3 2021/2022</b> – Implement Symphony v2.38 into 2 MIU's in Central Area.</p>																																								
3.4.1	<p><b>Appraisal against Non-Financial Criteria</b></p> <p>Appendix 2 - BCU Symphony/National WEDS November 2019 Option Paper. Pages 9/10 details the Benefits and Risk associated with each option.</p>																																								
3.4.2	<p><b>Comparative Costs</b></p> <p><b>Recurring revenue costs:</b></p> <p><b><u>Supplier support costs</u></b></p> <p>The table below details the Systems Support and Hardware costs on a yearly basis.</p> <table><tr><th></th><th>Yr1 (2020/ 2021)</th><th>Yr 2 (2021/ 2022)</th><th>Yr 3 (2022/ 2023)</th><th>Yr 4 (2023/ 2024)</th><th>Yr 5 (2024/ 2025)</th><th>Yr 6 (2025/ 2026)</th><th>Yr 7 (2026/ 2027)</th></tr><tr><td>NWIS Support</td><td></td><td></td><td></td><td>£47k</td><td>£47k</td><td>£47k</td><td>£47k</td></tr><tr><td>NWIS Hardware</td><td></td><td></td><td></td><td>£95k</td><td></td><td></td><td></td></tr><tr><td>EMIS</td><td>£65.5k</td><td>£117.5k</td><td>£90.5k</td><td>£90.5k</td><td>£90.5k</td><td>£90.5k</td><td>£90.5k</td></tr><tr><td>TOTAL</td><td>£65.5k</td><td>£117.5k</td><td>£90.5k</td><td>£232.5k</td><td>£137.5k</td><td>£137.5k</td><td>£137.5k</td></tr></table>		Yr1 (2020/ 2021)	Yr 2 (2021/ 2022)	Yr 3 (2022/ 2023)	Yr 4 (2023/ 2024)	Yr 5 (2024/ 2025)	Yr 6 (2025/ 2026)	Yr 7 (2026/ 2027)	NWIS Support				£47k	£47k	£47k	£47k	NWIS Hardware				£95k				EMIS	£65.5k	£117.5k	£90.5k	£90.5k	£90.5k	£90.5k	£90.5k	TOTAL	£65.5k	£117.5k	£90.5k	£232.5k	£137.5k	£137.5k	£137.5k
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The BCU Symphony/National WEDS service is a fully managed service delivered by EMIS. The element of the Service to be provided by NWIS is the support and service management of hosting, national service desk and interfaces to other national services when the Health Board move onto fully integrated WEDS.

Support payments towards the local Symphony instance in East will continue to be paid by the East ED service - £54k pa from 1st April 2020 and pro rata for 2021/2022, until the East move onto the version 2.38 of Symphony.

If East do not migrate to version 2.38 2021/2022, the revenue cost will be £54k pa and will continue until they migrate. The East revenue costs is currently paid for by the service.

### **Potential Hardware Costs**

As described in 2.1 above, the BCU Symphony / National WEDS Project Board were made aware of a requirement to replace the national data centre hardware before any Symphony/WEDS implementation. This was due to the data centre hardware coming out of warranty and being end-of-life.

It was confirmed in September 2020 this move to Primary Care Data Centre would take 16-20 weeks to delivery from project start up. Therefore, to de-risk the possibility of the ED Service having to move onto the non-clinical WPAS system and achieve implementation onto the BCU Symphony system, BCU Informatics are to implement onto a Locally Hosted Solution by expanding the existing BCU East Local Agreement with EMIS.

BCU remain committed to the National Solution and decisions regarding the National Architecture. BCU will review the architecture both nationally and locally when we are in a position to implement the full integrated WEDS Solution. If it were agreed to move to National hosting some hardware renewal costs and NWIS support costs would be required. These are currently forecasted to be at a cost of £95k (Hardware renewal costs) and £46k (NWIS support/hosting costs) and are included in this Business Case as 2023/2024 costs. If following the review BCU remain on local hosting then these costs would not be required.

### **Ongoing Staffing support costs**

Informatics do not have sufficient resources to support new software that services procure. Each service is now required to identify a System Owner for new and existing systems. A System Owner is defined as “an organisational official responsible for the procurement, development, integration, modification, operation, maintenance, and disposal of an information system” (Johnson 2015). It is also accepted that generally System Owners will oversee their systems on a day-to-day basis to provide support and escalate issues to their Head of Department, as necessary.

The ED posts, described below, will provide training where required and work closely with the supplier to roll out necessary upgrades and future developments.

Informatics are not responsible for the current East Symphony and there is no system owner. The creation of such a role would provide essential support to clinical and clerical staff, but would also improve the quality of data provided by the system. The Informatics posts will assist with maintaining data quality and will be the conduit between the Health Board, Supplier and NWIS when technical issues are raised.

As part of this implementation, it has been agreed the following additional staff will be required on a permanent basis. All staffing costs included are based on the top increment and an assumed rate of inflation of 2% will apply year on year. Experience from North Middlesex and Mid Essex highlights admin support was crucial to the ongoing success of the system.

	Yr 1 (2020/ 2021)	Yr 2 (2021/ 2022)	Yr 3 (2022/ 2023)	Yr 4 (2023/ 2024)	Yr 5 (2024/ 2025)	Yr 6 (2025/ 2026)	Yr 7 (2026/ 2027)
1 x B6 System Owner (ED)	£12k	£47k	£48k	£48k	£48k	£48k	£48k
1 x B4 System Admin West (ED)	£8k	£30k	£31k	£31k	£31k	£31k	£31k
1 x B4 System Admin East (ED)		£30k	£31k	£31k	£31k	£31k	£31k
1 x B4 System Admin Central (ED)				£31k	£31k	£31k	£31k
1 x B5 System Manager (Informatics)	£10k	£39k	£40k	£40k	£40k	£40k	£40k
1 x B5 Information Analyst (Informatics)	£10k	£39k	£40k	£40k	£40k	£40k	£40k
<b>TOTAL</b>	£40k	£185k	£190k	£221k	£221k	£221k	£221k

In summary, the table below describes the Revenue consequences required for both supplier support, hardware costs and ongoing staffing costs.

	Supplier Support Costs (including Hardware Renewal)			Staffing Revenue Costs	Total Cost	Additional Cost in year
	West	East	Central	BCU		
<b>2020/21</b>	£65.5k	£54k <i>(already paid by the ED area in East)</i>	N/A*	£40k	£159.5k	£105.5k
<b>2021/22</b>	£117.5k		N/A*	£185k	£302.5k	£248.5k
<b>2022/23</b>	£90.5k			£190k	£280.5k	£226.5k



	<b>2023/24</b>	£232.5k	£221k	£453.5k	£399.5k																								
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<p><i>*WPAS ED module currently used in Central is covered as part of the WPAS SLA already in place.</i></p> <p><b>Capital costs 2020/2021:</b></p> <p>The Capital costs for implementing the 3 phases described will total £313k. These Capital costs are being paid for by WG monies during 2020/2021. Any slippage to the timescales will be monitored by the Project Board and the Capital Finance Representative and ongoing discussions with WG. The Capital spend to date was to upgrade hardware and infrastructure in the 3 ED areas and for Informatics and operational staff to project manage the implementation and undertake testing.</p>																													
3.4.3	<p><b>Risk Appraisal</b></p> <p>Appendix 2 - BCU Symphony/National WEDS November 2019 Option Paper. Pages 9/10 details the Risks associated with each option.</p>																												
3.4.4	<p><b>Conclusion – Preferred Option</b></p> <p>Following the decision at the September Board, a phased approach was agreed to implement BCU Symphony as shown below.</p> <p><b>Phase 1 2020/2021</b> - Implement Symphony v2.38 in the West hosted locally including 6 MIUs (including Llandudno) associated with the West area.</p> <p><b>Phase 2 2021/2022</b> – Move East Area onto the BCU Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including the 1 MIU associated with the East.</p> <p><b>Phase 3 2021/2022</b> – Implement Symphony v2.38 into 2 MIU's in Central Area.</p> <p>As part of this implementation, the following additional staff will be required on a permanent basis.</p> <table><tr><td></td><td>Yr 1 (2020/ 2021)</td><td>Yr 2 (2021/ 2022)</td><td>Yr 3 (2022/ 2023)</td><td>Yr 4 (2023/ 2024)</td><td>Yr 5 (2024/ 2025)</td><td>Yr 6 (2025/ 2026)</td><td>Yr 7 (2026/ 2027)</td></tr><tr><td>1 x B6 System Owner (ED)</td><td>£12k</td><td>£47k</td><td>£48k</td><td>£48k</td><td>£48k</td><td>£48k</td><td>£48k</td></tr><tr><td>1 x B4 System Admin West (ED)</td><td>£8k</td><td>£30k</td><td>£31k</td><td>£31k</td><td>£31k</td><td>£31k</td><td>£31k</td></tr></table>						Yr 1 (2020/ 2021)	Yr 2 (2021/ 2022)	Yr 3 (2022/ 2023)	Yr 4 (2023/ 2024)	Yr 5 (2024/ 2025)	Yr 6 (2025/ 2026)	Yr 7 (2026/ 2027)	1 x B6 System Owner (ED)	£12k	£47k	£48k	£48k	£48k	£48k	£48k	1 x B4 System Admin West (ED)	£8k	£30k	£31k	£31k	£31k	£31k	£31k
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<b>TOTAL</b>	£40k	£185k	£190k	£221k	£221k	£221k	£221k

The table below reflects the Revenue costs required for both supplier support, hardware and ongoing staffing.

	Supplier Support Costs (including Hardware Renewal)			Staffing Revenue Costs	Total Cost	Additional Cost in year
	West	East	Central	BCU		
<b>2020/21</b>	£65.5k	£54k <i>(already paid by the ED area in East)</i>	N/A*	£40k	£159.5k	£105.5k
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<b>2024/25</b>	£137.5k			£221k	£358.5k	£304.5k
<b>2025/26</b>	£137.5k			£221k	£358.5k	£304.5k
<b>2026/27</b>	£137.5k			£221k	£358.5k	£304.5k

### 3.5 Preferred Option Detailed Analysis

#### 3.5.1 Full Description of the Proposed Change

Following the agreement to host locally a Single Instance of Symphony hosted on Local Infrastructure. This will be done in the following phases:

**Phase 1 2020/2021** - Implement Symphony v2.38 in the West hosted Locally including 6 MIUs (including Llandudno) associated with the West area.

**Phase 2 2021/2022** – Move East Area onto the BCU Symphony, alongside the West, which entails an upgrade from v2.29 to v2.38 including the 1 MIU associated with the East.

**Phase 3 2021/2022** – Implement Symphony v2.38 into 2 MIU's in Central Area.

	<p>BCU remain committed to the National Solution and decisions regarding the National Architecture. BCU will review the architecture both nationally and locally when we are in a position to implement the full integrated WEDS Solution. If it were agreed to move to National hosting some hardware renewal costs and NWIS support costs would be required. These are currently forecasted to be at a cost of £95k (Hardware renewal costs) and £46k (NWIS support/hosting costs) and are included in this Business Case as 2023/2024 costs. If following the review BCU remain on local hosting then these costs would not be required.</p>
3.5.2	<p><b>Impact on Activity and Performance</b></p> <p>There historically is a drop in performance of 5% for any Health Board until a system is embedded. It is envisaged once it is fully embedded there will be a minimum of 10% improvement in 4hr performance within the first 6 months. This is based on experience of implementation in other Trusts in England.</p> <p>Time to triage will improve against the 15 minute trajectory, and time to first assessment will remain within 60 minutes.</p>
3.5.3	<p><b>Other Areas affected by the Proposal / Interdependencies / Assumptions</b></p> <p>Although this is deemed an ED service proposal, there will be an impact on a variety of BCU Informatics Services including Information department and Service Desk. These will be addressed by appointing an Information Analyst and System Manager, as previously detailed.</p>
3.5.4	<p><b>EqlA of the Preferred Option</b></p> <p>The National EqlA is attached in appendix – see appendix 4</p> <p>The EqlA was completed by NWIS. The assessment highlighted 2 recommendations, which have now been addressed by the Supplier.</p>
4.	<p><b>The Financial Case</b></p>
4.1	<p><b>Revenue Cost</b></p> <p>The Revenue cost for the Business Case as summarized in 3.4.4 and is to be met by the service.</p> <p><b>Recurring revenue costs:</b></p> <p><b><u>Supplier support costs</u></b></p>

	Yr1 (2020/ 2021)	Yr 2 (2021/ 2022)	Yr 3 (2022/ 2023)	Yr 4 (2023/ 2024)	Yr 5 (2024/ 2025)	Yr 6 (2025/ 2026)	Yr 7 (2026/ 2027)
<b>NWIS Support</b>				£47k	£47k	£47k	£47k
<b>NWIS Hardware</b>				£95k			
<b>EMIS</b>	£65.5k	£117.5k	£90.5k	£90.5k	£90.5k	£90.5k	£90.5k
<b>TOTAL</b>	£65.5k	£117.5k	£90.5k	£232.5k	£137.5k	£137.5k	£137.5k

Support payments towards the local Symphony instance in East will continue to be paid by the East ED service - £54k pa from 1st April 2020 and pro rata for 2021/2022, until the East move onto the version 2.38 of Symphony.

If East do not migrate to version 2.38 2021/2022, the revenue cost will be £54k pa and will continue until they migrate. The East revenue costs is currently paid for by the service.

#### **Ongoing Staffing support costs**

	Yr 1 (2020/ 2021)	Yr 2 (2021/ 2022)	Yr 3 (2022/ 2023)	Yr 4 (2023/ 2024)	Yr 5 (2024/ 2025)	Yr 6 (2025/ 2026)	Yr 7 (2026/ 2027)
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1 x B4 System Admin Central (ED)				£31k	£31k	£31k	£31k
1 x B5 System Manager (Informatics)	£10k	£39k	£40k	£40k	£40k	£40k	£40k
1 x B5 Information Analyst (Informatics)	£10k	£39k	£40k	£40k	£40k	£40k	£40k
<b>TOTAL</b>	£40k	£185k	£190k	£221k	£221k	£221k	£221k

The table below reflects the Revenue costs required for both Supplier support, hardware renewal and ongoing staffing.

	Supplier Support Costs (including Hardware Renewal)			Staffing Revenue Costs	Total Cost	Additional Cost in year
	West	East	Central	BCU		

	<table><tr><td>2020/21</td><td>£65.5k</td><td>£54k (already paid by the ED area in East)</td><td>N/A*</td><td>£40k</td><td>£159.5k</td><td>£105.5k</td></tr><tr><td>2021/22</td><td colspan="3">£117.5k</td><td>N/A*</td><td>£185k</td><td>£302.5k</td></tr><tr><td>2022/23</td><td colspan="3">£90.5k</td><td>£190k</td><td>£280.5k</td><td>£226.5k</td></tr><tr><td>2023/24</td><td colspan="3">£232.5k</td><td>£221k</td><td>£453.5k</td><td>£399.5k</td></tr><tr><td>2024/25</td><td colspan="3">£137.5k</td><td>£221k</td><td>£358.5k</td><td>£304.5k</td></tr><tr><td>2025/26</td><td colspan="3">£137.5k</td><td>£221k</td><td>£358.5k</td><td>£304.5k</td></tr><tr><td>2026/27</td><td colspan="3">£137.5k</td><td>£221k</td><td>£358.5k</td><td>£304.5k</td></tr></table>	2020/21	£65.5k	£54k (already paid by the ED area in East)	N/A*	£40k	£159.5k	£105.5k	2021/22	£117.5k			N/A*	£185k	£302.5k	2022/23	£90.5k			£190k	£280.5k	£226.5k	2023/24	£232.5k			£221k	£453.5k	£399.5k	2024/25	£137.5k			£221k	£358.5k	£304.5k	2025/26	£137.5k			£221k	£358.5k	£304.5k	2026/27	£137.5k			£221k	£358.5k	£304.5k
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2026/27	£137.5k			£221k	£358.5k	£304.5k																																												
4.2	<p><b>Capital Cost (If Any)</b></p> <p><b>Capital costs 2020/2021:</b></p> <p>The Capital costs for implementing the 3 phases described will total £313k. These Capital costs are being paid for by WG monies during 2020/2021. Any slippage to the timescales will be monitored by the Project Board and the Capital Finance Representative and ongoing discussions with WG. The Capital spend to date was to upgrade hardware and infrastructure in the 3 ED areas and for Informatics and operational staff to project manage the implementation and undertake testing.</p> <p>Further WG monies will be required to support roll out on to the full WEDS solution.</p>																																																	
4.3	<p><b>Affordability and Source of Funding</b></p> <p>Without the support from this Business Case the ED services across BCU would not be able to implement BCU Symphony or the integrated national WEDS solution.</p>																																																	
5.	<b>Governance and Project Management</b>																																																	
5.1	<p><b>Approval Route</b></p> <p>This Business Case was approved by the BCU Symphony / National WEDS Project Board on 27<sup>th</sup> May 2020. This confirmed commitment from all parties including the ED service to support the full implementation and ongoing revenue consequences, subject to approval detailed above.</p> <p>The Business Case went to the Health Board Review meeting on 12<sup>th</sup> October 2020 and following minor amendments was tabled at the Executive meeting on 14<sup>th</sup> October 2020. The Business Case is to be tabled at the Finance and Performance Committee on 29<sup>th</sup> October 2020.</p> <p>This will include revenue for system support, hardware renewal and ongoing staffing costs.</p>																																																	

5.2	<p><b>Project Management</b></p> <p>This section details the proposed project management and governance arrangements that will be put in place to ensure successful delivery of the preferred option (Option 1b). The BCU Symphony / National WEDS project will form part of a wider portfolio of projects within the Informatics team, working alongside the ED Service, which will deliver the necessary changes to ensure the strategic ambitions of the Informatics Operational Plan are met.</p> <p>The project will be managed in accordance with Managing Successful Projects (MSP) and Prince 2 methodology.</p> <p>The Senior Responsible Officer (SRO) for the project is Dr Jason Walker, Consultant Anaesthetist / BCU West Medical Information Officer (MIO).</p> <p>A management structure comprising of a Project Board and Project Team with multi-disciplinary membership has been identified with clear Terms of Reference and stated project roles and responsibilities. A description of the Project Board roles and responsibilities is provided in Appendix 5.</p> <p>There is also a National Project Board whose Terms of Reference seeks to ensure the benefits of acting on an All Wales NHS level is maintained throughout the duration of the contract.</p> <p>Lessons learned at each implementation will be shared with other Health Boards.</p>
5.3	<p><b>Project Plan – Implementation Timeline</b></p> <p>Project Startup commenced – 01/06/2019. The agreed high-level plan for Phase 1, 2, 3 needs to reviewed following approval of this Revenue Business Case.</p>
5.4	<p><b>Post Implementation Review</b></p> <p>The Benefits Realisation plan outlines the expected benefits and outputs, detailing how these will be measured and who will be responsible for doing so. This live document has been drafted and is awaiting approval from the Project Board.</p> <p>An evaluation will be undertaken following Phase 1 of the project to determine if the project has delivered the expected outputs. The evaluation will provide a structured review of the process of delivering the project as well as a review of operational, functional and strategic performance following implementation once business as usual is achieved. Following completion of Phase 1, an evaluation report will be presented to the Project Board, detailing lessons learned from the implementation to date. This report will be taken into consideration during further phases of the project.</p>

	<p>Further evaluations will be conducted following phases 2 and 3.</p> <p>A Project Closure report will be produced once all phases of the project have been delivered. This will contain reference to the Post Project Evaluation and Benefits Realisation Plan. The Project Manager will be responsible for ensuring this is planned for, however, the Project Board and SRO will be responsible for ensuring post-project benefit reviews are undertaken. Post Project Evaluation will also be undertaken within a contingency plan in the event the project is not implemented to its full extent as outlined within this business case.</p> <p>The Post Project Evaluation will encompass the following questions;</p> <ul style="list-style-type: none"> <li>- <i>Is the system functioning as expected / is it fit for purpose against agreed quality metrics?</i></li> <li>- <i>Have all objectives been achieved?</i></li> <li>- <i>Are benefits being realised?</i></li> <li>- <i>Are users adequately trained and supported?</i></li> <li>- <i>Are the necessary controls and processes in place?</i></li> <li>- <i>How does the deliverable compare with the original project plan, in terms of quality, schedule and budget?</i></li> <li>- <i>Identify lessons learnt from post implementation stage</i></li> <li>- <i>Identify ongoing benefit realisation and ongoing risks and issues</i></li> </ul> <p>Key project documentation will be reviewed to deliver an appropriate report and to present any recommendations back to the Board and / or organisation following completion of the evaluation. There is a risk that following project closure the benefits will not be measured, as the benefit realisation would be handed over to the business. It will be the responsibility of the SRO to ensure this is undertaken in a timely way.</p>
6.	<p><b>Conclusions and Recommendations</b></p> <p>It is recommended the Revenue Business Case is approved to allow a phased implementation of the BCU Symphony in West and East EDs and all MIUs in BCU, in readiness for the fully integrated WEDS solution (including Central Emergency Department).</p> <p>Without the support from this Business Case the ED services across BCU would not be able to implement BCU Symphony or the integrated WEDS solution.</p>
7.	<p><b>Declarations</b></p> <p><input type="checkbox"/> 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</p> <p><input type="checkbox"/> 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</p>

- ☐ 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 Managers have signed below to confirm

The appropriate signatures must be obtained before a case can be submitted for scrutiny. This must include the signatures of any other Area/Division/Department materially affected by the proposal.

**Signed by:**

.....  
**Area/Corporate/Secondary  
Care Director**

.....  
**Area/Secondary Care  
Nurse Director**

.....  
**Area/Secondary Care  
Medical Director**

.....  
**Chief Finance Officer**

.....  
**Director / Asst. Director  
(Other Area/Corporate  
if required)**

.....  
**Director / Asst. Director  
(Other Area/Corporate  
if required)**

**Appendix 1 - BCU Symphony / National WEDS September 2019 Options Paper**

Document Available on Request

**Appendix 2 - BCU Symphony/National WEDS November 2019 Option Paper**

Document Available on Request

**Appendix 3 - BCU Symphony / National WEDS Addendum to Option 1b – December 2019**

Document Available on Request

**Appendix 4 - NWIS EqIA**

Document Available on Request

**Appendix 5 - Project Board Roles**

Document Available on Request

**Appendix 6 – Draft Benefits Plan**

Document Available on Request





<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Full Business case for North Denbighshire Community Hospital					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Chris Stockport Executive Director Primary and Community services, Mark Wilkinson Executive Director Planning and Performance					
<b>Awdur yr Adroddiad Report Author:</b>	Ian Howard, Steph O'Donnell					
<b>Craffu blaenorol: Prior Scrutiny:</b>	In line with the organisation's Procedure for Managing Capital Projects the business case has been endorsed by: North Denbighshire Project Board - 7 <sup>th</sup> September 2020 Capital Investment Group – 18 <sup>th</sup> September, 2020 Executive Team – 21 <sup>st</sup> October, 2020					
<b>Atodiadau Appendices:</b>	The Business Case and its 9 appendices are attached.					
<b>Argymhelliad / Recommendation:</b>						
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						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input checked="" type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input checked="" type="checkbox"/>	<b>Er gwybodaeth For Information</b>
<b>Sefyllfa / Situation:</b>						
<p>This Full Business Case (FBC) proposes the investment of £63.98 million in the development of a North Denbighshire Community Hospital (NDCH) in Rhyl, creating a healthcare and well-being campus on and around the site of the Royal Alexandra Hospital (RAH).</p> <p>The FBC is the third and final stage in the development of a business case. The Strategic Outline Case (SOC) established the strategic context, made a robust case for change and provided a suggested way forward. The Outline Business Case (OBC) was approved by Welsh Government in 2019. It: identified the preferred option; set out how the scheme would be procured; and identified the necessary funding and management arrangements for the successful delivery of the scheme.</p> <p>This FBC builds on the OBC. Its focus is on: the negotiated commercial and contractual arrangements for the deal, based on the detailed design work undertaken since the OBC was approved; affordability; and the detailed management arrangements for the successful delivery of the scheme. The case for change and the preferred option outlined in the OBC have not fundamentally changed. These sections of the FBC therefore contain brief summaries of the main points, and focus on the elements of the scheme where thinking has evolved since the OBC.</p>						

Approval of the FBC by the Health Board and subsequently Welsh Government secures the funding to deliver the scheme.

### **Cefndir / Background:**

As outlined above, the project is seeking strategic capital investment of £63.98million (at *PubSec 250*) in the development of a new health and well-being centre and refurbishment of the existing Royal Alexandra Hospital (RAH) building and wider campus. The RAH refurbishment will deliver a support centre and provide clinical accommodation for CAMHs and paediatric services. The project will deliver a range of expanded and redesigned services, supporting regeneration plans for the local area.

The key milestones are:

<b>Milestones</b>	<b>Target Date</b>
Welsh Government approval of FBC	February 2021
Commence works	March 2021
Complete enabling works	July 2021
Complete new build	February 2023
Demolitions and complete car park and externals	July 2023
Complete refurbishment of existing	September 2023
Project closure	September 2024

### **Asesiad / Assessment & Analysis**

## Strategy Implications

The scheme is informed by various national and local drivers, notably “A Healthier Wales: Our Plan for Health and Social Care”, and the Health Board’s overarching 10-year clinical strategy, “Living Healthier, Staying Well” (LHSW). It supports the shift of resources to community settings, the movement of care closer to home, the development of seamless multi-agency services and the emphasis on a well-being system. It also fulfils the commitments made by the Health Board in 2013 following public consultation as part of “Healthcare in North Wales is Changing” (HCiNWiC). Specifically, it was agreed as part of that consultation that an inpatient facility would be provided following the closure of Prestatyn Community Hospital in 2013 and the closure of inpatient wards at the RAH in 2010.

## Options considered

The business case contains a full options appraisal. A brief summary of the shortlisted options, and the evaluation, are as follows:

1. **The Status Quo – or business as usual:** this does not address any of the objectives of the project, but is included as a baseline against which the other shortlisted options are compared.
2. **Refurbish the RAH and provide a new build on the site for clinical accommodation. Provide the full scope of services outlined in the strategic case:** this design means that clinical services will be delivered in new fit for purpose accommodation, with office accommodation provided in upgraded facilities in the RAH. The condition of the RAH building will be improved, and the solution supports the regeneration plans for the area. It delivers the full scope of the project, and is the preferred option.
3. **Refurbish and extend the RAH to provide clinical and office accommodation. Provide the full scope of services outlined in the strategic section of the case:** this design was the preferred way forward in the SOC. However a more in-depth analysis indicates that issues with the existing building would significantly constrain the design and prove costly.
4. **Refurbish the RAH and provide a new build on the site for clinical accommodation. Provide a greater scope of services than is outlined in the strategic case:** the range and scale of services included in the scope of the project has been determined through a rigorous process of analysis, and an increase cannot be justified as value for money.

## Financial Implications

The capital cost of the scheme is £63.98 million. As regards revenue, the gross increase in cost in 2023 is £3.025 million. £1.5 million of cash releasing savings have been identified to offset this increase. In terms of the balancing figure of £1,547k, this will be addressed in the 21/22 budget setting and requires c£0.5m to be identified each year over the next three years. This will be funded through application of the WG resource allocation formula (which allocates new growth monies based on population need) and / or through service improvement and consolidation efficiencies.

## **Risk Analysis**

The latest version of the project's Risk Register is attached at Appendix G. This document outlines the organisation's plan for the ongoing mitigation and management of risk. The risk register details how the risks have been apportioned between the BCUHB and the SCP. The risk register was generated by following the NWSSP-SES Standard Risk Register Template, adding scheme specific risks and the apportionment of the risks between the BCUHB and SCP has been agreed, and is subject to regular review, at periodic risk workshops.

## **Legal and Compliance**

Subject to approval of the case by the Board and Welsh Government, the project will be managed in line with the Health Board's Procedure for Managing Capital Projects.

## **Impact Assessment**

The Health Impact Assessment is enclosed as Appendix A. It concludes that the scheme will result in a wide range of positive impacts on: determinants of health and wellbeing, including lifestyle factors; local access to services; social and community influences on health; living and environmental and economic contributions; staff facilities and wellbeing; integration of care and access; and service sustainability. The Equality Impact Assessment (Appendix B) concludes that there are several positive impacts (in terms of age, disability, gender reassignment, maternity and pregnancy, and religion or belief) and no negatives.

## **Full Business Case**

### **Royal Alexandra Hospital**

#### **Finance and Performance Committee October 2020**

# Contents

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# **1. Executive Summary**

## **1.1 Introduction**

This Full Business Case (FBC) proposes the investment of £63.98 million in the creation of a healthcare and well-being campus on and around the site of the Royal Alexandra Hospital (RAH) in Rhyl.

The project will deliver a range of expanded and redesigned services within new and existing facilities on the RAH site, supporting regeneration plans for the local area. The scheme is informed by various national and local drivers, notably “A Healthier Wales: Our Plan for Health and Social Care”, and the Health Board’s overarching 10-year clinical strategy, “Living Healthier, Staying Well” (LHSW). It supports the shift of resources to community settings, the movement of care closer to home, the development of seamless multi-agency services and the emphasis on a well-being system. It also fulfils the commitments made by the Health Board in 2013 following public consultation as part of “Healthcare in North Wales is Changing” (HCiNWic). Specifically, it was agreed as part of that consultation that an inpatient facility would be provided following the closure of Prestatyn Community Hospital in 2013 and the closure of inpatient wards at the RAH in 2010.

Subject to the approval of this case, construction will begin in March 2021, and the new facilities will be fully open in September 2023.

## **1.2 The Nature of the FBC and how the case has evolved since the OBC**

The FBC is the third and final stage in the development of a business case. The Strategic Outline Case (SOC) established the strategic context, made a robust case for change and provided a suggested way forward. The Outline Business Case (OBC) was approved by Welsh Government in 2019. It: identified the preferred option; set out how the scheme would be procured; and identified the necessary funding and management arrangements for the successful delivery of the scheme.

This FBC builds on the OBC. Its focus is on: the negotiated commercial and contractual arrangements for the deal, based on the detailed design work undertaken since the OBC was approved; affordability; and the detailed management arrangements for the successful delivery of the scheme. The case for change and the preferred option outlined in the OBC have not fundamentally changed. These sections of the FBC therefore contain brief summaries of the main points, and focus on the elements of the scheme where thinking has evolved since the OBC. It should be noted that the SOC and the OBC referred to this case as the North Denbighshire Community Hospital project. In June 2020 it was agreed that the site should retain the name “Royal Alexandra Hospital.” Permission to use the “Royal Alexandra” name has been sought and granted by the Cabinet Office, in line with the Royal Sites protocol.

## **1.3 The Strategic Case**

The case of need is driven by the gap between the intended service model of providing integrated care closer to home, as articulated in both “A Healthier Wales” and the Health Board’s Strategy Living Healthier Staying Well (LHSW), and the current service provision in

North Denbighshire. It also takes account of the poor physical condition of the Royal Alexandra Hospital.

The project has the following objectives, which are linked to specific, measurable benefits:

1. To provide safe and sustainable services in response to the current and future health and well-being needs of the local population;
2. To further develop multi-agency, integrated, responsive primary and community care services in the area;
3. To increase the range of local services, thereby reducing the reliance on the District General Hospital;
4. To deliver services in an environment which is fit for purpose and enhances health and well-being for service users and staff;
5. To move care closer to people's homes, including inpatient bed-based care;
6. To improve economic, social, environmental and cultural well-being, as outlined in The Future Generations Act.

This has resulted in the following scope for the project:

- Re-provision of community beds in Rhyl, including repatriation of beds which transferred to Holywell and Denbigh when Prestatyn Community Hospital and the RAH wards closed
- Provision of a Same Day service to reduce admissions and support the reduction of A&E attendances at YGC
- Provision of a Treatment Zone to support BCUHB's changing model of care for community nurses to undertake more complex activity in a community hospital setting
- Provision of a Level 1, 2 and 3 sexual health service
- Provision of an enhanced outpatient therapy service
- Provision of a Day Therapy Assessment Unit (IV Suite) to provide care closer to home for those living in the Rhyl and Prestatyn area
- Re-provision and extension of the Community Dental Service
- Re-provision and extension of Radiology services
- Re-provision of services currently undertaken on the RAH site:
  - Outpatients
  - Older People's Mental Health Services
  - Adult Psychology Services
  - Child and Adolescent Mental Health and Paediatric Occupational Therapy services
- Provision of Advice and Information through a third sector presence onsite and close working with the Community Resource Team, co-located on the campus
- Delivery of preventative programmes such as smoking cessation to support self-management.
- Creation of multi-disciplinary accommodation to enable integrated working between primary, community, local authority and third sector care
- Car parking enhancements



- Improvement to the physical environment for patients and staff, including achieving a greater level of statutory compliance.

The final design solution takes account of changes in the strategic context since the production of the OBC – notably the declaration by Welsh Government of a climate emergency, and the impact of COVID-19. A decision has also been made to change the orientation of the new clinical building in relation to the existing building. The revised design brings the units closer together on the campus, improving staff access to buildings, facilitating the transfer and management of medical records sited in the old RAH building and positioning the new build away from residential units adjacent to the campus. The case also reflects the evolution of thinking about the specific services to be provided – notably an increase in therapy services to the wards, enhanced Audiology services and a decision not to include an Ambulatory Care Unit in the first instance.

#### 1.4 The Economic Case

The Economic Case focuses on the main options available for delivering the objectives of the scheme, in order to identify the option which gives the best Value for Money. Nothing material has changed since the OBC evaluation of the shortlisted options. A brief summary of those options, and the evaluation, are as follows:

1. **The Status Quo – or business as usual:** this does not address any of the objectives of the project, but is included as a baseline against which the other shortlisted options are compared.
2. **Refurbish the RAH and provide a new build on the site for clinical accommodation. Provide the full scope of services outlined in the strategic case:** this design means that clinical services will be delivered in new fit for purpose accommodation, with office accommodation provided in upgraded facilities in the RAH. The condition of the RAH building will be improved, and the solution supports the regeneration plans for the area. It delivers the full scope of the project, and is the preferred option.
3. **Refurbish and extend the RAH to provide clinical and office accommodation. Provide the full scope of services outlined in the strategic section of the case:** this design was the preferred way forward in the SOC. However a more in-depth analysis indicates that issues with the existing building would significantly constrain the design and prove costly.
4. **Refurbish the RAH and provide a new build on the site for clinical accommodation. Provide a greater scope of services than is outlined in the strategic case:** the range and scale of services included in the scope of the project has been determined through a rigorous process of analysis, and an increase cannot be justified as value for money.

#### 1.5 The Commercial Case

The commercial case outlines the contract strategy. The approach is the one mandated in the Welsh Government NHS Infrastructure Investment Guidance and the contract will be the national Engineering Contract 3 with target cost.

The Supply Chain partner has changed since the OBC, and is now Kier Construction Limited. Gleeds management Services Limited has been appointed to provide the roles of both Project Manager and Cost Advisor.

## 1.6 The Financial Case

The financial case sets out the financial implications of the preferred option. In terms of capital, the total cost is £63.98 million, and the reconciliation to the OBC cost is as follows:

	£m
<b>Outline business case</b>	<b>40.241</b>
Re-base to PUBSEC 250	11.354
“Climate emergency”	1.357
Enhance fire protection	0.974
Increase scope of refurbishment	3.083
Structural repairs to existing	3.681
Increase in programme	2.552
Impact COVID-19 and Brexit	0.738
<b>Full business case</b>	<b>63.98</b>

As regards revenue, the gross increase in cost in 2023 is £3.025 million. £1.5 million of cash releasing savings have been identified to offset this increase. In terms of the balancing figure of £1,547k, this will be addressed in the 21/22 budget setting and requires c£0.5m to be identified each year over the next three years. This will be funded through application of the WG resource allocation formula (which allocates new growth monies based on population need) and / or through service improvement and consolidation efficiencies.

## 1.7 Management Case

The project will be managed in line with the Health Board’s Procedure Manual for Managing Capital Projects. The key project milestones are as follows:

<b>Milestones</b>	<b>Target Date</b>
BCUHB approval Full Business Case	November 2020
Approval Full Business Case by Welsh Government	February 2021
Commence construction	March 2021
Complete enabling works	July 2021
Complete new build	February 2023
Demolitions and complete car park and externals	July 2023
Complete refurbishment of existing RAH	September 2023
Project closure	September 2024

## 2. Purpose and Structure of the Full Business Case

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

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

There are three key stages in the development of a project business case, which correspond to key stages in the spending approvals process. These are the Strategic Outline Case (SOC), the Outline Business Case (OBC) and the Full Business Case (FBC). The SOC established the strategic context, made a robust case for change and provided a suggested way forward. The Outline Business Case (OBC) was agreed by the BCU Board in November 2018 and approved by Welsh Government in 2019. It: identified the preferred option; set out how the scheme would be procured; and identified the necessary funding and management arrangements for the successful delivery of the scheme.

The FBC builds on the OBC. Its focus is on: the negotiated commercial and contractual arrangements for the deal, based on the detailed design work undertaken since the OBC was approved (the Commercial Case); affordability (the Financial Case); and the detailed management arrangements for the successful delivery of the scheme (the Management Case). The case for change (the Strategic Case) and the preferred option (the Economic Case) outlined in the OBC have not fundamentally changed since the case was approved by Welsh Government in 2019. These sections of the FBC therefore contain brief summaries of the main points, and focus on the elements of the scheme where thinking has evolved since the OBC. The measurable benefits of the scheme are also articulated more fully in the Economic Case – in particular a lot of work has been done on establishing the baselines from which the improvements as a result of the scheme will be measured.

### 3. The Strategic Case

As outlined in section 2, the fundamental strategic case for this development remains unchanged from the OBC.

#### 3.1 Summary of the Strategic Case

The project will deliver a range of expanded and redesigned services, supporting regeneration plans for the local area. The service model for the scheme is informed by various national and local drivers, notably “A Healthier Wales: Our Plan for Health and Social Care”, “The Well-being of Future generations Act” (Wales) 2015, and the Health Board’s overarching 10-year strategy, “Living Healthier, Staying Well” (LHSW). The design of development has been influenced by our *2019/22 Estates Strategy*. Estates targets include: reducing the property portfolio, reducing the estates revenue costs, delivering a minimum 90% compliance to relevant statutory requirements, delivering a 90% reduction in risk backlog maintenance and the same percentage of the estate to be sound, operationally safe and exhibiting only minor deterioration.

The case is predicated on the following strategic drivers for change:

- Rhyl is an area of significant socio-economic deprivation and has a large population of over 65s. Access to services is a particular issue for the community.
- This level of social deprivation is associated with health and well-being inequalities and a disproportionate demand and need for services.
- There is commitment from the Health Board to offer care closer to home, set out in its 2018 strategic engagement.
- In 2013 BCUHB launched a major consultation, “Healthcare in North Wales is Changing”, which resulted in a Board commitment to re-provide community beds following the closure of Prestatyn and the inpatient ward in RAH.
- BCUHB has made a commitment to refurbish and maintain the existing RAH grade II listed building which is of historic and architectural significance.
- The re-development of Glan Clwyd Hospital and the need to free space and resources at the acute hospital prompted a review of the services to be provided on the new campus.
- Services to local people must be provided in modern, fit for purpose facilities.
- The project is also aligned to the strategies of other organisations - in particular the local authority’s plans for the regeneration of Rhyl and the need to provide a solution to the sustainability of the Royal Alexandra Hospital building.

The case of need is driven by the gap between the future service model, as articulated in both “A Healthier Wales” and LHSW, and the current service provision in North Denbighshire. It also takes account of the poor physical condition of the Royal Alexandra Hospital. This has resulted in the following scope for the project:

- Re-provision of community beds in Rhyl, including repatriation of beds which transferred to Holywell and Denbigh when Prestatyn Community Hospital and the RAH wards closed.
- Provision of a Same Day service to reduce admissions and support the reduction of A&E attendances at YGC.

- Provision of a Treatment Zone to support BCUHB's changing model of care for community nurses to undertake more complex activity in a community hospital setting.
- Provision of a Level 1, 2 and 3 sexual health service.
- Provision of an enhanced outpatient therapy service.
- Provision of a Day Therapy Assessment Unit (IV Suite) to provide care closer to home for those living in the Rhyl and Prestatyn area.
- Re-provision and extension of the Community Dental Service.
- Re-provision and extension of Radiology services.
- Re-provision of services currently undertaken on the RAH site:
  - Outpatients
  - Older People's Mental Health Services
  - Adult Psychology Services
  - CAMHs and Paediatric OT services
- Provision of Advice and Information through third sector presence onsite and close working with the Community Resource Team, co-located on the campus.
- Delivery of preventative programmes such as smoking cessation to support self-management.
- Creation of multi-disciplinary accommodation to enable integrated working between primary, community, local authority and third sector care.
- Car parking enhancements.
- Improvement to the physical environment for patients and staff, including achieving a greater level of statutory compliance.

### 3.2 Changes to Strategic Context since OBC

The strategic context has not shifted fundamentally since OBC approval in 2019. However there have been some important developments which have shaped the development of the project, as follows:

- Welsh Government declared a "climate emergency" in 2019<sup>1</sup> and has subsequently introduced legislative changes which have informed decisions on sustainable building design.
- The move towards an agile working culture engendered by the Covid-19 pandemic has influenced the allocation and design of office space on the campus.
- The Health Board and its partners in social care and the third sector are engaged in a broad Transformation Programme to enable the aims of "A Healthier Wales". In particular, one of the Transformation "Pacesetter" schemes entails working with *Skills For Health* to deliver a series of interventions which enable the integration of the Health and Social Care workforce. One area for development is collaboration through co-located teams under joint Health and Social care leadership, which is supported through the new RAH development.
- The planned co-location and collaborative work spaces support the themes set out in the Cluster IMTP from October 2019, putting the emphasis on shared working between GP Practices and community health and social care professionals in the locality. This was

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<sup>1</sup> <https://gov.wales/welsh-government-makes-climate-emergency-declaration>

further strengthened through recent experience during the initial response to Covid-19 in the community, which saw excellent cross-functional working and decision-making.

The Cluster plans place emphasis on prevention and early intervention. The same day service and treatment zone afford opportunity for Primary care input and the preventative agenda will be strengthened through Third Sector integration on the site.

- There has been a review of the details of the original design and development, reflecting changes in circumstances and individuals in post since 2018.

### **3.3 Investment Objectives and Measurable Benefits**

The investment objectives are unchanged from the OBC, and are as follows:

1. To provide safe and sustainable services in response to the current and future health and well-being needs of the local population;
2. To further develop multi-agency, integrated, responsive primary and community care services in the area;
3. To increase the range of local services, thereby reducing the reliance on the DGH;
4. To deliver services in an environment which is fit for purpose and enhances health and well-being for service users and staff;
5. To move care closer to people's homes, including inpatient bed based care;
6. To improve economic, social, environmental and cultural well-being, as outlined in The Future Generations Act.

The specific measurable benefits related to these objectives are outlined in full in the Benefits Realisation Plan (Appendix C). The forecast benefits are as set out at OBC and the project team has updated baselines where relevant. The Financial tables in the Appendices (Appendix D) detail the cash releasing savings and the non-cashable monetised benefits. The table below summarises some of the key benefits which will be achieved.

Description of Benefit	Measurement and baseline	Beneficiary
Improved access to a range of health and well-being services closer to home for people from Rhyl and Prestatyn. New services provided over increased hours - including education, information and preventative services offered in partnership with social services and the third sector.	<ul style="list-style-type: none"> <li>• Increased hours of service: <ul style="list-style-type: none"> <li>• Sexual Health 10% increase – 3 hours per week</li> <li>• IV Suite – Monday to Friday 09:00 – 17:00 hours = 40 hours</li> <li>• Ward: 24x7</li> <li>• Same day service: 84 hours per week</li> </ul> </li> <li>• New services – number of people accessing: <ul style="list-style-type: none"> <li>• Sexual Health 10% increase – 180 attendances</li> <li>• Continence clinics – c. 520 attendances pa</li> <li>• District nurse new clinics – c. 1820 Healthy Legs Year 1</li> <li>• IV Suite – 260 attendances per month by mid-year</li> </ul> </li> </ul>	Service user Community
Reduced demand on local acute, community & primary care services, improving flow of patients at the DGH in inpatient care and the Emergency Department	<ul style="list-style-type: none"> <li>• Access to same Day Service and corresponding access to the Emergency Department at YGC – 9,00 attendances</li> <li>• Bed occupancy accommodate up to 400 patients pa at varying average length of stay – assumes 21 days average length of stay</li> </ul>	Service Users, Health Board
Working climate for innovation and Research and Development – added value through knowledge transfer as a result of collaboration and co-location of staff.	<ul style="list-style-type: none"> <li>• To baseline in year 1- number training attendances and staff survey</li> </ul>	Staff, service users
The provision of a local IV service will result in both avoiding multiple hospital admissions & early discharge from the DGH for patients in Rhyl and Prestatyn localities.	<ul style="list-style-type: none"> <li>• Forecast c 1,300 attendances in Year 1.</li> <li>• 10% will be reduced attendance from YGC</li> </ul>	Service User Health Board
Patients will benefit from an improved physical environment in terms of: functional suitability;	<ul style="list-style-type: none"> <li>• Estates Key Performance Indicators achieved as detailed in Appendix C</li> </ul>	Service Users

Description of Benefit	Measurement and baseline	Beneficiary
safety and compliance; accessibility; ease of use for those suffering from Dementia.		
Contribute to the regeneration of Rhyl by providing local employment opportunities, revitalising a building of local cultural and historic significance on the Rhyl coastline, in line with the Rhyl Going Forward plans	<ul style="list-style-type: none"> <li>• 66 new staff employed in clinical, administrative and Facilities Management roles</li> <li>• Feedback from local Heritage groups and general public in Year 1</li> </ul>	Health Board, Wider Community



### **3.4 Changes in Scope and Design from the OBC**

As a result of the changes to the strategic environment outlined above, and the views new senior user groups involved, the following changes have been made to the project since the approval of the OBC:

- The service model for the inpatient ward has been considered and a stronger Therapies Services input will be provided to enable rehabilitation of patients and help them home as safely and quickly as possible
- Enhanced Audiology services are planned, in a more accessible setting, to meet the needs of the growing population of hearing impaired people
- The OBC stated that an Ambulatory Care Unit may be included, depending on the outcome of the pilot in Llandudno. Following consideration of that pilot, and the introduction of a range of improvements to patient flow through the acute hospital setting to Community Hospitals and people's own homes, it has been decided not to include an Ambulatory Care Unit.
- The orientation of the new clinical building has moved in relation to the existing building. The design now brings the units closer together on the campus, improving staff access to buildings, facilitating the transfer and management of medical records sited in the old RAH building and positioning the new build away from residential units adjacent to the campus
- Open, light and clear wayfinding through the main atrium entrance with increased permeability to the external space at the back of the site
- Centralised stair increases wayfinding and reduces internal circulation
- A full specification, design and loaded drawings have been developed for clinical and patient-facing services remaining within the existing RAH building, notably:
  - Children and Adolescent Mental Health clinics
  - Paediatric OT services
  - Single Point of Access (SPOA) multi-agency team which will relocate from Local Authority offices in Russell Road
- Broader consideration has been given to enabling agile working for staff and provision of hot desk areas, in line with most recent Welsh Government guidance on home working during and beyond the Covid-19 pandemic
- Ongoing consideration is taken of the requirements for social distancing

## 4. The Economic Case

As with the strategic case the essence of the economic case is unchanged since the OBC, and is not re-stated in full in this document.

The Economic Case focuses on the main options available for delivering the objectives of the scheme, in order to identify the option which gives the best Value for Money. A long-list of potential options was evaluated at OBC, looking at: scope; service solution; service delivery; implementation; and funding. The analysis concluded that all shortlisted options should be for a single stage implementation funded by public capital, with the clinical services provided by the Health Board. It was also clear, following discussion with the Local Authority, that any planning application made in regard to this project would need to include the future of the RAH, and that an unoccupied building on the sea front would not support the regeneration plans for the area. All shortlisted options therefore locate the development on the RAH site. Four options were shortlisted, and the following is a brief summary of the evaluation carried out at OBC.

1. **The Status Quo – or business as usual:** this does not address any of the objectives of the project, but is included as a baseline against which the other shortlisted options are compared.
2. **Refurbish the RAH and provide a new build on the site for clinical accommodation. Provide the full scope of services outlined in the strategic case:** this design means that clinical services will be delivered in new fit for purpose accommodation, with office accommodation provided in upgraded facilities in the RAH. The condition of the RAH building will be improved, and the solution supports the regeneration plans for the area. It delivers the full scope of the project, and is the preferred option.
3. **Refurbish and extend the RAH to provide clinical and office accommodation. Provide the full scope of services outlined in the strategic section of the case:** this design was the preferred way forward in the SOC. However, a more in-depth analysis, undertaken as part of the development of the OBC, indicates that issues with the existing building would significantly constrain the design and prove costly.
4. **Refurbish the RAH and provide a new build on the site for clinical accommodation. Provide a greater scope of services than is outlined in the strategic case:** the range and scale of services included in the scope of the project has been determined through a rigorous process of analysis, and an increase cannot be justified as value for money.

The costs and benefits of the four options were analysed in the OBC in terms of:

- A qualitative benefits analysis
- A risk analysis
- Analysis of lifecycle costs for the development.

In terms of qualitative benefits: Option 2, the preferred way forward, scored substantially better than the other options in terms of clinical quality and safety and sustainability of services. The scoring was closer between all options, bar the Status Quo option, for Integration and Corporate Responsibility. The status Quo option scored higher on Deliverability; however, it would not be possible to deliver the benefits and sustainable service model through this option.

In summary, the benefits appraisal demonstrates that all three options for change are superior to the Status Quo, and option 2 scores higher overall. Nothing has changed since the production of the OBC to alter this conclusion.

For monetised benefits, the Status Quo is clearly superior, as the other options are focused upon additional investment to improve clinical services and the standard of accommodation.

The risk analysis reaches the same conclusion as the assessment of qualitative benefits, and its conclusions remain valid at FBC stage. While there has been some reduction of risk around Workforce, Model of Care and Service Capacity, as outlined in Appendix G, there have not been any changes that would materially change the ranking of the options.

The Economic Appraisal has been re-run based on the final capital and revenue costs, and is enclosed in Appendix E. The ranking is unchanged from the OBC.

<b>Summary of NPC and EAC Appraisal</b>				
	<b>Option 1</b>	<b>Option 2</b>	<b>Option 3</b>	<b>Option 4</b>
	<b>(£000's)</b>	<b>(£000's)</b>	<b>(£000's)</b>	<b>(£000's)</b>
<b>NPV (Net Present Value)</b>	89,955	173,238	173,702	211,513
<b>EAC (Equivalent Annual Cost)</b>	4,639	6,568	6,586	8,019
<b>Ranking</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

The rankings, in summary, therefore remain as follows:

<b>Appraisal</b>	<b>Option 1</b>	<b>Option 2</b>	<b>Option 3</b>	<b>Option 4</b>
Qualitative	4	1	2	3
Financial	1	2	3	4
Risk	4	1	2	3
<b>Overall Ranking</b>	<b>3</b>	<b>1</b>	<b>2</b>	<b>4</b>

## **5. The Commercial Case**

### **5.1 Introduction**

This section of the FBC outlines the proposed contract strategy in relation to the preferred option. The aim of the *Commercial Case* is to secure the optimal deal for the preferred option. In accordance with national guidance the contract will be the National Engineering Contract 3 with target cost.

### **5.2 Required Services**

As mandated in the Welsh Government NHS Infrastructure Investment Guidance the required services have been procured via the *Building for Wales Frameworks*.

BCUHB have been supported by NWSSP Specialist Estates Services in procuring the following services: Supply Chain Partner; Project Manager; and Cost Advisor.

The national Frameworks comprise companies with proven experience and resources to deliver complex health capital projects. All companies are subject to regular performance review by a Framework Board that comprises members from NWSSP, Welsh Health Boards, Welsh Government and industry bodies. Selection from the Framework therefore provides the Health Board and Welsh Government with assurance of the selected organisation's ability to successfully deliver the project.

#### Supply Chain Partner (SCP)

The SCP is required to provide design services through each stage of the process up to Guaranteed Maximum Price (GMP). Once the GMP is agreed, the SCP will undertake the works as designed.

Upon approval of the OBC the Health Board were unable to secure an acceptable commercial agreement with the original SCP to progress the full business case. Following legal advice the Health Board took the decision to seek a new SCP. Kier Construction Ltd were appointed through a competitive tender process utilising the mandated Building for Wales framework. Tender submissions for the required services were evaluated on the basis of cost and quality, and each company was invited to attend an interview in support of their tender. The interviews, together with the company's written submissions, assessed their proposed team, their experience of similar commissions and their approach to the project.

Tenders were evaluated by a small team comprising the Area Division Programme Manager, Head of Capital and Project Manager together with support from NWSSP – SES.

#### Project Manager (PM)

The OBC confirmed that Gleeds Management Services Ltd have been appointed for the services of Project Manager.

### Cost Advisor (CA)

The OBC confirmed that Gleeds Cost Management Services Ltd have been appointed for the services of Cost Advisor.

### **5.3 Potential for Risk Transfer**

The general principle is that risks should be passed to the party best able to manage them, subject to Value for Money (VfM).

The risk register details how the risks have been apportioned between the BCUHB and the SCP. The risk register was generated by following the NWSSP-SES Standard Risk Register Template, adding scheme specific risks. The apportionment of the risks between the BCUHB and SCP has been agreed, and is subject to regular review, at periodic risk workshops.

Risk Category	Potential Allocation		
	BCUHB	SCP	Shared
Design Risk			X
Construction Risk		X	
Transition & Implementation Risk	X		
Availability & Performance Risk	X		
Operating Risk	X		
Revenue Risks	X		
Termination Risks			X
Technological Risks			X
Control Risks			X
Residual Value Risks	X		
Financial Risks			X
Legislative Risks	X		
Other Project Risks			X

### **5.4 Proposed Charging Mechanisms**

The charging mechanisms in respect of this project will be in accordance with the framework agreement described above. The framework requires a Guaranteed Maximum Price (GMP) and stipulates the requirement for a staged payment mechanism, which would normally be monthly via valuation. Once approved by open book the BCUHB will issue an interim certificate for payment.

The SCP is required to “market test” all elements of the works to ensure that the GMP reflects best value. The Building for Wales process requires the design to progress to achieve a minimum of 80% cost certainty at the FBC stage. The current level of cost certainty for the project is 97%. Although the remaining 3% may present a risk, this risk will be mitigated by the following:

1. 97% of the works packages have been market tested.
2. The areas that are not market tested have been benchmarked using robust data to support the figures.
3. Provision for the potential risk has been made within the overall budget.

The risk is therefore not considered material and the Cost Advisor has confirmed that the remaining elements to be agreed will not increase the GMP.

## 5.5 Total Capital Cost

The total capital cost of the scheme is £63.98million. This is a Guaranteed Maximum Price, following detailed design and the market testing of 97% of the works.

This is an increase of £23.74m above the outline business case (OBC) estimated cost of £40.241m. Of this increase some £11.354m is due to the Welsh Government issuing revised guidance to re-base all capital business cases from PUBSEC index of 195 to 250.

The remaining increase, approx. £12.385m, is due to a number of factors as follows:

- Review of the design to meet the Welsh Government's declaration of a "climate emergency." This has included amendments to reduce reliance on fossil fuels and carbon emissions, make provision for renewable energy generation, maximise natural lighting and (where appropriate) ventilation, minimise solar gain and increase thermal efficiency.
- Incorporation of guidance to enhance fire protection including the adoption of sprinkler systems.
- With respect to the existing Royal Alexandra Hospital:
  - The project team reviewed the extent of the replacement/refurbishment. The OBC assumed a comparatively "light touch". However, following confirmation of the requirements of the Conservation Officer and CADW, further investigation confirmed that to attempt to retain elements of the existing external fabric and internal engineering installations, internal doors, ceilings and floor finishes would be uneconomic.
  - The condition of the existing structural elements including the basement slab, upper floors and roof, were found to be poorer than assumed at OBC.
  - Increase in programme with associated costs
- Delay due to the pandemic and general market increase due to COVID-19 and impending Brexit.

A summary of the reconciliation between the OBC and the FBC is as follows:

	£m
<b>Outline business case</b>	<b>40.241</b>
Re-base to PUBSEC 250	11.354
"Climate emergency"	1.357
Enhance fire protection	0.974
Increase scope of refurbishment	3.083
Structural repairs to existing	3.681

Increase in programme	2.552
Impact COVID-19 and Brexit	0.738
<b>Full business case</b>	<b>63.98</b>

It is acknowledged that the change in SCP is likely to have had an impact on the capital cost. As an example, the programme was delayed by some six months and as a result was adversely affected by the impact of the global pandemic. However, it is not possible to accurately quantify the impact of this change.

## 5.6 Proposed Contract Lengths

The proposed contract length for the project is 30 months from approval of the Full Business Case to handover.

The partnership between the SCP and the BCUHB will continue for twelve months after project completion and handover, ensuring that any defects have been made good.

## 5.7 Proposed Key Contractual Clauses

The form of contract will be the *NEC 3 Option C* with Target Cost that is utilised within the *Building for Wales Framework*.

## 5.8 Contractual Arrangements

The contractual relationships between the various parties are subject to the rules and regulations of the framework.

## 5.9 Contract Type

The NEC contract has been chosen as the contract type to be utilised under the framework. The NEC contract will be applicable to the appointment of both the Supply Chain Partners and the Support Consultants. The Support Consultants will enter into the NEC Professional Services Contracts (PSC) with the BCUHB.

## 5.10 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.

## 5.11 Implementation Timescales

It is anticipated that the key implementation milestones will be as follows (A full project timetable is enclosed in the Estates Annex).

<b>Milestones</b>	<b>Target Date</b>
Welsh Government approval of FBC	February 2021
Commence works	March 2021
Complete enabling works	July 2021
Complete new build	February 2023

Demolitions and complete car park and externals	July 2023
Complete refurbishment of existing	September 2023
Project closure	September 2024



## 6. The Financial Case

### 6.1 Introduction

The purpose of this section is to set out the financial implications of the preferred option. The capital cost is £63.98 million, as outlined in the Commercial Case. This section of the case focuses primarily on the revenue implications.

Detailed financial tables are provided in Appendix D to support the summary information set out in the financial case and the economic case.

### 6.2 Developments since the OBC

At OBC a gap was presented between the current costs of service delivery at RAH and the proposed future provision following this development. Options to close the affordability gap have been reviewed at FBC. A number of new services will be delivered, affording benefits to the community and to the acute sector, as flow will be improved. A number of cash-releasing benefits have been identified, which can be achieved through delivering the strategic benefits of the case. The remainder of the gap will be addressed in the 21/22 budget setting and requires c£0.5m to be identified each year over the next three years. This will be funded through application of the WG resource allocation formula (which allocates new growth monies based on population need) and / or through service improvement and consolidation efficiencies.

### 6.3 Summary of Capital and Revenue Cashflow

The capital and revenue cash flow is summarised in the table below:

	Capital to date	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	Total
Additional Costs & Funding Streams	Year -3 £000's	Year -2 £000's	Year -1 £000's	Year 1 £000's	Year 2 £000's	Year 3 £000's	Year 4 £000's	Year 5 £000's	Year 5 £000's	Capital £000's
<b>Projected Costs</b>										
Capital Costs	1,851	2,686	14,006	35,854	9,577					63,974
Depreciation		479	479	479	958	1,316	1,316	1,316	1,316	
Operational Revenue Costs		3,347	3,347	3,347	5,518	6,242	6,242	6,300	6,372	
<b>TOTAL</b>	<b>1,851</b>	<b>6,512</b>	<b>17,832</b>	<b>39,680</b>	<b>16,053</b>	<b>7,559</b>	<b>7,559</b>	<b>7,616</b>	<b>7,688</b>	<b>63,974</b>
<b>Funding Streams</b>										
WG Capital CRL	1,851	2,686	14,006	35,854	9,577					63,974
WG Depreciation Funding		479	479	479	958	1,316	1,316	1,316	1,316	
Existing Cost of Services		3,347	3,347	3,347	3,347	3,347	3,347	3,347	3,347	
Internal Savings & Funding					2,172	2,896	2,896	2,953	3,025	
<b>TOTAL</b>	<b>1,851</b>	<b>6,512</b>	<b>17,832</b>	<b>39,680</b>	<b>16,053</b>	<b>7,559</b>	<b>7,559</b>	<b>7,616</b>	<b>7,688</b>	<b>63,974</b>
<b>IN YEAR SURPLUS / DEFICIT</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

### 6.4 Revenue Costs and Affordability

The Financial case from the original OBC has been uplifted for 2020, resulting in a net increased annual revenue cost of £3.025 million at current forecast, before any savings or mitigation are identified. The total comparative operational revenue costs are shown below:

Operational Revenue Cost Element	Cost of Existing Services £000's	Cost of New Service Model £000's	Increase in Costs £000's
Inpatient Facilities	0	1,711	1,711
Same Day Service	0	284	284
Outpatients & Treatment Zone	1,137	1,137	0
Mental Health	235	235	0
Assessment Unit / IV Suite	0	176	176
Dental	817	817	0
Sexual Health	519	519	0
Clinical Support Services	204	419	215
Non-Clinical Support Services	205	499	294
Estates, Maintenance & Utilities	231	576	345
<b>Total Operational Revenue Costs</b>	<b>3,347</b>	<b>6,372</b>	<b>3,025</b>

Specific cash releasing savings of £1.478 million have been identified and validated, which leaves a funding gap of £1.547 million as illustrated in the following table:

OBC Funding & Savings Options:	£000s
Reduction in the requirement for Escalation Beds in YGC	(287)
Dental Clinic transfer	(16)
Impact on CHC Activity	(212)
Impact on inpatient beds across the wider community hospitals	(608)
Primary Care Treatment Zone Funded from Primary Care Monies	(138)
Review of Medical support arrangements	(78)
Remove Contingency	(15)
Additional Maintenance (e.g. new build so maintenance should be minimal in first 5 years)	(114)
Additional Laundry & Linen funded by transferring services from YGC / Community Hospitals	(10)
Funding gap to be addressed in 21/22 budget setting process	(1,547)
<b>Total Savings/Alternative Funding</b>	<b>(3,025)</b>
<b>Revenue Shortfall Assessment</b>	<b>(0)</b>

In terms of the funding gap, this will be addressed in the 21/22 budget setting and requires c£0.5m to be identified each year over the next three years. This will be funded through application of the WG resource allocation formula (which allocates new growth monies based on population need) and / or through service improvement and consolidation efficiencies.

## 7. The Management Case

### 7.1 Introduction

This part of the Business Case addresses the achievability of the scheme. It sets out the actions that will be undertaken to ensure the successful delivery of the project.

The first section covers the formal mechanisms for managing the project to a successful conclusion, and describes: the project governance framework; the project plan; the arrangements for benefits realisation; the approach to the management of risk; and post-project evaluation.

The second section focuses on key challenges and risks to the delivery of the scheme, as reflected in the risk register. It outlines the actions that have been taken since the production of the OBC to address risks and issues, current status, and the plans to ensure the successful delivery of the scheme.

### 7.2 Formal mechanisms for managing the project

The project continues to follow the overall project management arrangements for capital projects as outlined in the Procedure Manual for Managing Capital Projects. The project continues to be managed in accordance with PRINCE 2 project management methodology to enable a well-planned and smooth transition to the new service models.

#### 7.2.1 The Project Governance Framework

The framework for managing the project is outlined in the Governance Framework (enclosed as Appendix H). It outlines the project structure, reporting lines and roles and responsibilities, together with named individuals.

Since OBC named individuals have changed as follows:

**Senior Responsible Officer (SRO).** The SRO for this project is now Bethan Jones, Area Director, Central.

**Senior User (Clinical Lead).** The Senior User for this project is now Nicola Eatherington, Assistant Area Director, Intermediate Care & Specialist Medicine, Central Area, BCUHB

**Senior Supplier.** The Senior Supplier for this project is Liam Erwin, BCUHB Project Manager, Gleeds

**Finance Lead.** The Financial Planning Manager for this project is now Nigel McCann, Chief Finance Officer, BCUHB

#### 7.2.2 The Project Plan

It is anticipated that the key implementation milestones will be as follows:

Milestones	Target Date
BCUHB approval Full Business Case	November 2020
Approval Full Business Case by Welsh Government	February 2021
Commence Construction	March 2021
Complete enabling works	July 2021
Complete new build	February 2023
Demolitions and complete car park and externals	July 2023
Complete refurbishment of existing RAH	September 2023
Project closure	September 2024

The latest version of the full project plan is attached at Appendix F.

The project will be delivered in a phased approach as follows:

- Phase 1 – site preparation and demolitions
- Phase 2 – new building construction
- Phase 3 – demolition
- Phase 4 – refurbishment

The phased delivery facilitates the preparation of site, construction of the new building, demolition of non-viable buildings and refurbishment of the original RAH building in a planned and managed approach. This aims to minimise disruption and adverse impact on services to patients, staff and local residents.

Staff and services relocating from the original building to the new building will transfer across upon completion of construction and commissioning of the new building. Areas vacated by such services within the old building will facilitate further decant to alternative areas and enable further progression of the refurbishment programme. Outpatient and dental services will transfer to the new building enabling the final phase of demolition from the Glan Traeth and Edith Vizard buildings. Demolition of these buildings enables development of further on site facilities including car parking spaces and the designated service yard.

### **7.3 Arrangements for Benefits Realisation**

The benefits realisation strategy and framework are enclosed as Appendix C. As outlined in the Strategic Case this has evolved since the OBC, in particular with the inclusion of baseline measurements. The benefits register will be reviewed regularly at the Project Board. Benefits will be tracked to the end of the first full Financial Year of service delivery.

### **7.4 Arrangements for Risk Management**

The latest version of the project's Risk Register is attached at Appendix G. This document outlines the organisation's plan for the ongoing mitigation and management of risk.

## **7.5 Arrangements for Post Project Evaluation**

Post-project evaluation will be carried out as outlined in the Procedure Manual for Managing Capital Projects. The post project review covers: the achievement of benefits (both expected and unexpected); problems; user reaction; contractor review; consultant review; issues/areas for improvement; and overall project performance. It is anticipated that a Gateway Review (Benefits Realisation) will also be undertaken in accordance with the OGC Gateway Process. As with all major capital projects, a post-project evaluation of the scheme, including the realisation of benefits, will be presented to the Finance and Performance Committee.

## **8 Conclusion and Recommendation**

This FBC builds on the case outlined in the OBC. The fundamental strategic case for change remains valid, as does the preferred option. The analysis outlined in this case gives robust capital and revenue costs, and demonstrates affordability. The management case provides assurance that the project is achievable, and that the known risks and issues are being robustly managed. This business case is recommended for approval.

## **List of Appendices**

- A      Health Impact Assessment**
- B      Equality Impact Assessment**
- C      Benefits Realisation Strategy and Framework**
- D      Financial Appraisal**
- E      Economic Appraisal**
- F      Project Control Plan**
- G      Risk Register**
- H      Project Governance Framework**
- I      Estates Annex**

# **North Denbighshire Community Hospital**

**Betsi Cadwaladr University Health Board**

## **Health Impact Assessment Report**

### **Rapid Desktop Appraisal for Full Business Case**

**March 2020**



## 1. Introduction

The Welsh Government supports the use of Health Impact Assessments (HIA) as part of the evidence to justify infrastructure investment proposals, improve health and reduce inequalities. The use of this tool is not currently Statutory.

Health Impact Assessment (HIA) is a process which supports organisations to assess the potential consequences of their decisions on people's health and well-being, and can be used to predict improved health outcomes and potential health benefits.

There are three main types of Health Impact Assessments (HIA):

**Prospective** – at the start of the development of the project

**Concurrent** – runs alongside the implementation of the project

**Retrospective** – assesses the effect of an existing project

Within any of the above, HIA can be undertaken in three different ways:

**Desktop** – a small number of participants around a table using existing knowledge and evidence to assess a project.

**Rapid** – Usually a small steering group is established and uses the approach of a participatory stakeholder workshop. It typically involves a brief investigation of health impacts, including a short literature review of quantities and qualitative evidence and the gathering of knowledge and evidence from a number of stakeholders.

**Comprehensive** – are more detailed and can take a number of months to complete and are used for complex proposals.

The proposed investment of **£39,983,340** will result in the development of a new North Denbighshire Community Hospital (NDCH) in Rhyl, enabling the creation of a healthcare campus in and around the site of the Royal Alexandra Hospital (RAH) and consolidating other health service facilities in the area. The project will facilitate the development of a range of services to meet local needs, centred on the principles of “Living Healthier, Staying Well” and, in particular, the Care Closer to Home programme which places the person at the centre, with all available primary and community services inputting care and support when appropriate to meet identified needs.

The HIA rapid desktop appraisal undertaken to support the Full Business Case submission for the new North Denbighshire Community Hospital (NDCH) is based upon local and national policy drivers described below.

### Local Drivers

- Commitments made by the Health Board in 2013 following public consultation as part of “Healthcare in North Wales is Changing” (HCiNWIC)

- Integrated Primary and Community Services Strategic Framework
- The Ysbyty Glan Clwyd (YGC) Redevelopment Project
- Local Authority - Integrated multi-agency working, Planning and Regeneration

### **National Policy Drivers**

- The Well-being of Future Generations (Wales) Act, 2015. This is about improving the social, economic, environmental and cultural well-being of Wales. To make sure that we are all working towards the same vision, the Act puts in place seven well-being goals
- The Social Services and Well-being (Wales) Act 2014
- The Public Health (Wales) Bill November 2016
- Our Plan for a Primary Care Service for Wales up to 2018 (2015)
- Taking Wales Forward (2016-2017)
- The Welsh Government's Tackling Poverty Plan
- The Welsh Language (Wales) Measure 2011

## **2. Proposed Vision and Service Delivery Model**

Taking into account the local and national policy drivers, BCUHB's purpose, vision and strategic goals set out the long term aims of the Board. The vision is to:

- improve the health of the population, with a particular focus upon the most vulnerable in our society, including:
  - age-related groups: children, young and older people
  - income-related groups: people on a low income, unemployed, people unable to work due to ill health
  - groups who suffer discrimination or other social disadvantages: people with physical or learning disabilities/difficulties, single parent families
  - geographical groups - people living in isolated areas, people unable to access services and facilities
- develop an integrated health service, which provides excellent care delivered in partnership with the public and other statutory and third sector organisations
- develop our workforce so that it has the right skills and operates in a research-rich, learning culture.

This project provides BCUHB with an opportunity to reshape the way that community healthcare services are delivered. The service model has therefore been developed to focus on:

- Integration of physical and mental wellbeing of older people through:
  - A broader range of teams working together to provide a more holistic service
  - Increased accessibility and dementia friendly design
- The provision of Community Hospital beds
- Urgent/same day care provision through:
  - A minor injuries unit
  - Increased sexual health services
- A range of Ambulatory/outpatient care, with an emphasis on care closer to home
- Integration of a range of partners across health, local authority, third sector and community
- A community hub to improve access to health, wellbeing, prevention, and health promotion services
- An integrated campus approach

### **3. Case for Change**

The building is a significant landmark with a prominent position on the seafront. The building is Grade II listed and has historical and cultural significance to the local community. In addition, part of BCUHB's well-being goals (from the Well-being of Future Generations (Wales) Act 2015) is to encourage a society that promotes and protects culture.

There are also a number of key issues which compromise the sustainability of care currently being delivered from the RAH site. These include the following services:

- Outpatients
- Diagnostics
- Physiotherapy
- Children's Services
- Community Dental
- Older Peoples Mental Health Day Services
- Office Accommodation

If BCUHB does not respond to these challenges, the local health system faces one or more of the following risks:

- Ad hoc cuts and closures
- Increased likelihood of adverse clinical incidents

- Increasing recruitment and staffing problems leading to workforce shortages
- Unfairness in access to services
- Failure to meet performance targets
- Healthcare services that are not in keeping with local and national strategic policy
- The best outcomes for patients will not be achieved

### 3. Demography and Health Needs

There are a number of significant issues affecting the North Denbighshire locality which impact on the shape of future service provision for this community. A particular feature of the population is the significant proportion of older people aged 65 years of age and over and the high levels of multiple-deprivation.

#### 3.1 Population

The population of Denbighshire is approximately 95,000 (2020), of which 24% are over the age of 65<sup>1</sup>. The age of the population is an important determinant of the level of need for health care. Older persons are disproportionately affected by chronic conditions. The Welsh Health Survey reported that 82% of respondents aged 65 years and over suffered from a chronic condition, of whom 54% suffered from two or more<sup>2</sup>.

StatsWales has projected that the number of over 65s living in Denbighshire will rise by 17% over the next 20 years from 23,550 to 27,638 people, while the population aged 18 to 64 years is projected to decrease from 54,542 to 48,580 during the same period, a fall of 11%<sup>3</sup>. These population changes, which are mirrored across North Wales, were a key part of the strategy set out in HiNWIC and underpin the agreed clinical model to move healthcare delivery out of hospital settings and into local communities where it is appropriate to do so.

The type and range of community service delivery currently available in North Denbighshire does not necessarily match the demographic profile of the locality. The NDCH development presents an opportunity to provide future health services that are responsive to the demographic demands of the locality by providing local facilities and community services that enable residents to receive the best possible care and support.

#### 3.2 Deprivation

Conwy and Denbighshire have some of the most deprived communities in Wales, particularly along the coastal belt. For example, the Welsh Index of Multiple Deprivation, which divides the country into a large number of 'lower super output areas' and ranks them by deprivation indicators, reports 'Rhyl West 2' and 'Rhyl West 1' as the first and second most deprived areas in Wales respectively<sup>4</sup>. However, it is worth noting that the proposed location for NDCH is in 'Rhyl East 2' which despite being adjacent to some of the most

<sup>1</sup>StatsWales (2020). Available online - <https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2018-based/populationprojections-by-localauthority-variant-year>

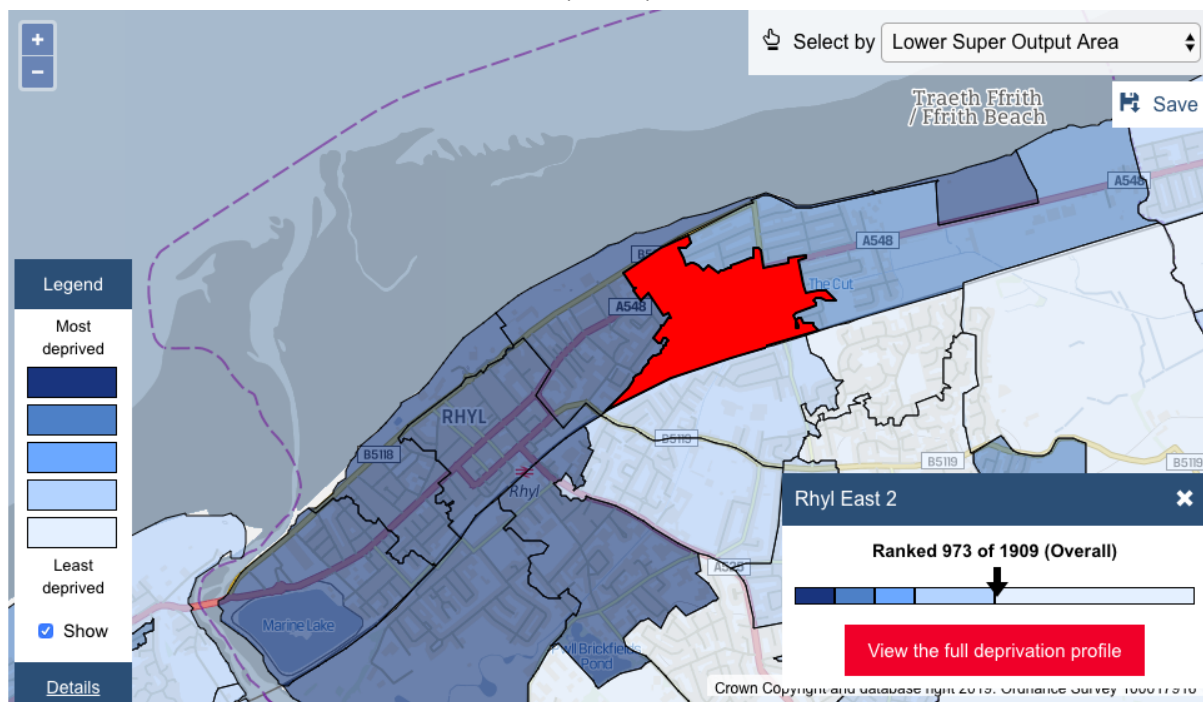
<sup>2</sup>Welsh Health Survey (2014) Available online - <http://www.wales.nhs.uk/thewelshhealthsurvey>

<sup>3</sup>StatsWales (2020). Available online- <https://statswales.gov.wales/Catalogue/Population-and-Migration/Population/Projections/Local-Authority/2018-based/populationprojections-by-localauthority-variant-year>

<sup>4</sup> Welsh Index of Multiple Deprivation (2019). Available online - <https://wimd.gov.wales/>

deprived areas of Wales is actually ranked as amongst the 'least deprived' by the metric (see image below). Therefore it is of key importance that barriers to accessing the hospital, such as transport are addressed.

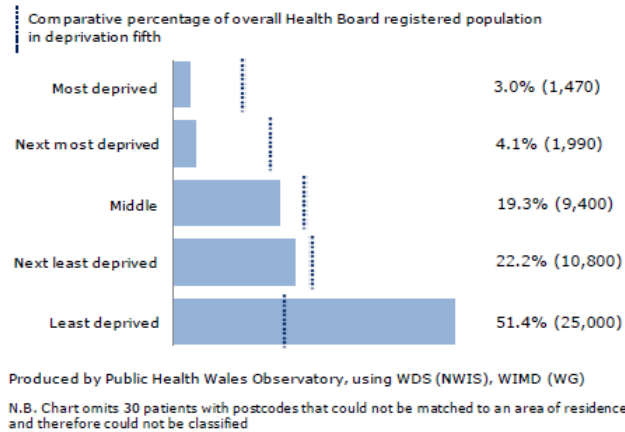
Fig 1. Map of Rhyl, taken from <https://wimd.gov.wales/>, displaying the relative lack of deprivation near the proposed NDCH site (in red).



The coastal towns of Rhyl and Prestatyn are home to communities which are amongst the most deprived in Wales with high levels of health, housing and income deprivation, and high levels of multiple deprivation exist particularly in the areas of West/South West/East Rhyl, Abergele and Kinnel Bay<sup>5</sup>. The graph below shows percentages of patients by deprivation across the health board as a whole<sup>6</sup>.

<sup>5</sup> Welsh Index of Multiple Deprivation (2019). Available online - <https://wimd.gov.wales/>

<sup>6</sup> Public Health Wales Observatory (2019). Available online - <http://www.publichealthwalesobservatory.wales.nhs.uk/bculhb-demography-profile#Population>



### 3.3 Tourism

The towns of Rhyl and Prestatyn in North Denbighshire are tourist resorts and consequently, the number of people accommodated in the towns varies across the year, rising substantially in the summer months. Development of a Same Day Service to be delivered from the proposed NDCH will divert activity from the Ysbyty Glan Clwyd Accident and Emergency department.

## 4. Impact of new Community Hospital on Determinants of Health & Wellbeing

1. Lifestyle factors and determinants of health and wellbeing	
Improvements	Anticipated Impact on health and wellbeing
<ul style="list-style-type: none"> <li>Increased physical activity and active travel to new community hospital, with good pedestrian/public transport links.</li> <li>Increased provision of health promotion services, illness prevention and third sector opportunities.</li> <li>Training and education facilities will provide accommodation for the delivery of training and education of staff, improving their skills and knowledge.</li> </ul>	<ul style="list-style-type: none"> <li>Positive impact upon healthy behaviours leading to reduced burden of disease over time – particularly long term conditions;</li> <li>Increased uptake of health promotion and third sector interventions offered in the main entrance area.</li> <li>Increased signposting to other local services.</li> <li>Stronger and more integrated partnerships between different agencies.</li> <li>Supporting residents to take more responsibility for their own health and wellbeing.</li> </ul>

	<ul style="list-style-type: none"> <li>• More resilient and engaged local population.</li> </ul>
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<b>2. Access to Local Services</b>	
<b>Improvements</b>	<b>Anticipated Impact on health and wellbeing</b>
<ul style="list-style-type: none"> <li>• Development of a single point of access locally to a range of primary and community health services</li> <li>• Priority car parking and easy access spaces will be provided.</li> </ul>	<ul style="list-style-type: none"> <li>• Supports greater self-care and maintenance of patients within community settings.</li> <li>• Supports transfer of care out of acute settings.</li> <li>• Improved access and mental wellbeing with the provision of Older Peoples Mental Health services.</li> <li>• The provision of a modern Dental Suite</li> </ul>

<b>3. Social and Community Influences on Health</b>	
<b>Improvements</b>	<b>Anticipated Impact on health and wellbeing</b>
<p>The new community hospital will remain in the local community, dealing with demand from the local population, and the influx of visitors to the area during holiday periods.</p> <p>The provision of a medical assessment unit within the new hospital will provide appropriate services for older people and an environment that caters for carers also.</p>	<ul style="list-style-type: none"> <li>• Strengthened community interaction with health &amp; wellbeing services.</li> <li>• Positive impact upon health behaviours and self-responsibility</li> </ul>

<b>4. Living and Environmental and Economic Contributions</b>	
<b>Improvements</b>	<b>Anticipated Impact on health and wellbeing</b>
The proposed hospital is to be	<ul style="list-style-type: none"> <li>• Contribution to the overall</li> </ul>

<p>developed on a site adjacent to the existing Royal Alexandra Hospital (RAH), and the existing RAH being refurbished to provide an attractive, modern, well designed, fit for purpose facility which supports a new model of service delivery and will have a positive impact on all those using the facilities – patients and staff. (This should also have a positive impact on recruitment, which will improve the range of services available to vulnerable groups affected.)</p> <p>The hospital is designed to address the needs of people with a range of disabilities, and with wheelchair accessible facilities.</p> <p>Signage will be designed to take account of visual impairment, along with hearing loops and accessible toilet facilities, baby change, a ‘Changing Places’ facility and Décor colours that take account of the needs of those with dementia.</p>	regeneration of the area
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<b>5. Staff Facilities and Wellbeing</b>	
<b>Improvements</b>	<b>Anticipated Impact on health and wellbeing</b>
Provision of purpose-built modern working premises.	Improved job satisfaction, mental wellbeing and physical health of staff within primary and community services.

<b>6. Integration of Care and Access</b>	
<b>Improvements</b>	<b>Anticipated Impact on health and wellbeing</b>
<ul style="list-style-type: none"> <li>• Better co-ordination of care.</li> <li>• Less duplication in care and service delivery.</li> <li>• Improved team- and inter-agency working</li> </ul>	<ul style="list-style-type: none"> <li>• Reduction in current burden of ill-health over time, particularly long-term conditions due to improved co-ordination of care.</li> <li>• Fewer unplanned hospital admissions, and a greater proportion of care delivered locally or transferred out of acute settings;</li> <li>• Improvement in outcomes associated with long-term</li> </ul>



	conditions
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<b>7. Service Sustainability</b>	
<b>Improvements</b>	<b>Anticipated Impact on health and wellbeing</b>
<p>Increased accommodation to enable services to grow to meet future projections in demography and demand.</p> <p>Ability to train and recruit new clinical staff will strengthen service sustainability.</p> <p>The flexible use of clinical rooms, areas and technology (including telemedicine) will all contribute to service(s) sustainability</p>	<ul style="list-style-type: none"> <li>• A more sustainable service able to meet current and future health needs and demand.</li> <li>• A reduced risk of unmet demand leading to longer term ill health.</li> </ul>

## **5.0 Securing the positive impacts upon Health and Wellbeing**

As with other elements of the planning and design of the new community hospital, this qualitative Health Impact Assessment will be kept under regular review by the local project board and any successor body once the development is complete. It will form a formal part of the benefits realisation plan for the new Community Hospital.



Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

## EQUALITY IMPACT ASSESSMENT FORMS

### PARTS A and B: SCREENING AND OUTCOME REPORT

#### **Introduction:**

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

**This is not optional:** Equality Impact Assessment is a specific legal requirement on public sector organisations under equalities legislation and failure to comply could result in a legal challenge to a decision or strategy. More importantly, equality impact assessment helps to inform better decision-making and policy development leading to improved services for patients. **This form should not be completed by an individual alone, but should form part of a working group approach.**

#### **The Forms:**

You must complete:

- **Part A** – this is the Initial Screening that is always undertaken and consists of Forms 1 to 3; these forms are designed to enable you to make an initial assessment of the potential impact of what you are doing, and decide whether or not you will need to proceed to a Full Impact Assessment (Part C);

AND

- **Part B** – this is the Outcome Report and Action Plan (Form 4) you will need to complete whether or not you proceed to a Full Impact Assessment;

Together, these forms will help to provide evidence of your Impact Assessment and how you have shown “due regard” to the duties.

You may also need to complete Part C (see separate Form) – if parts A and B indicate you need to undertake a Full Impact Assessment. This enables you to fully consider all the evidence that is available (including engagement with the people affected by your document or proposals) to tell you whether your document or proposal will affect people differently. It also gives you the opportunity to consider what changes you may need to make to eliminate or mitigate any adverse or negative impact you have identified.

Remember that these forms may be subject to external scrutiny e.g. under a Freedom of Information request.

Once completed, the EqIA Forms should accompany your document or proposal when it is submitted to the appropriate body for approval.

## Part A

### Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Full Business Case for North Denbighshire Community Hospital (NDCH)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	<p>The Full Business Case proposes the investment of £40.3 million in the development of a North Denbighshire Community Hospital (NDCH) in Rhyl, creating a healthcare and well-being campus in and around the site of the Royal Alexandra Hospital (RAH).</p> <p>The project will deliver a range of expanded and redesigned services within new and existing facilities on the RAH site, supporting regeneration plans for the local area. It supports the shift of resources to community settings, the movement of care closer to home, the development of seamless multi-agency services and the emphasis on a well-being system. It also fulfils the commitments made by the Health Board in 2013 following public consultation as part of “Healthcare in North Wales is Changing” (HCiNWic). Specifically, it was agreed as part of that consultation that an inpatient facility would be provided following the closure of Prestatyn Community Hospital in 2013 and closure of inpatient wards at the RAH in 2009.</p> <p>The Full Business Case will be submitted in March 2020. The new build elements of the proposal are planned to open in April 2022, and the refurbishment of the existing hospital will be completed in December 2022.</p> <p>The new hospital will accommodate some services currently delivered in the RAH, repatriate some services from other sites and will offer new innovations, such as: a same day/urgent care centre for minor ailments and injuries; a Ward comprising individual en-suite rooms and an IV therapy suite. The project has the following investment objectives:</p> <ol style="list-style-type: none"> <li>1. To provide safe and sustainable services in response to the current and future health and well-being needs of the local population</li> <li>2. To further develop multi-agency, integrated, responsive primary and community care services in the area</li> </ol>

		<ol style="list-style-type: none"> <li>3. To increase the range of local services, thereby reducing the reliance on Glan Clwyd Hospital</li> <li>4. To deliver services in an environment which is fit for purpose and enhances health and well-being for service users, carers and staff</li> <li>5. To move care closer to people's homes, including inpatient bed-based care</li> <li>6. To uphold our statutory duty to support the Future Generations Act and the sustainable goals</li> </ol>
3.	Who is responsible for the document/work you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	<p>Project SRO: Sally Baxter, Acting Director of Strategy, BCUHB</p> <p>Project Director: Gareth Evans, Director Clinical Services, Therapies, BCUHB</p>
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	<p>The NDCH project supports BCUHB's strategic direction of travel as set out in the Health Board's system-wide strategy for health, well-being and healthcare, "Living Healthier, Staying Well", in particular "Care Closer to Home". This strategy sets out the strategic vision for delivery of services in Primary and Community care to support good healthcare for the medium to longer term.</p> <p>The development of the strategy is shaped by a number of national and local policies and drivers:</p> <ul style="list-style-type: none"> <li>• "A Healthier Wales: Our Plan for Health and Social Care" (2018 WG)</li> <li>• The Well-being of Future Generations (Wales) Act 2015 (WFG Act)</li> <li>• The Social Services and Well-being (Wales) Act 2014 (SSWB Act)</li> <li>• The Welsh Government document 'Our Plan for a Primary Care Service for Wales up to 2018' (2015 WG)</li> </ul> <p>In keeping with the principles of "Living Healthier, Staying Well" (LHSW), Primary and Community services will be age inclusive, recognising the need to adopt a life-course approach. This is a joined-up approach, with an emphasis on education and early intervention, aiming to address early any implications for long term health gain.</p>

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals?	<p>Stakeholder mapping has been an important step in understanding who our key stakeholders are, where they come from, and what they are looking for in relationship to our organisation. Mapping out our stakeholders helped us to engage the right people in the right way and was based upon assessing and prioritising their influence and interest.</p> <p>We mapped our stakeholders into groups based on their levels of influence and interest.</p> <p>In summary, the stakeholder groups are:</p> <ul style="list-style-type: none"> <li>• Citizens who live in the locality and are most likely to use the services – primarily residents of Rhyl, Prestatyn, Meliden, Kinmel Bay, Elwy and St Asaph</li> <li>• Tourists in the local area who may need to access services during holidays</li> <li>• Citizens with protected characteristics and local groups representing citizens with protected characteristics</li> <li>• Special interest groups in the area</li> <li>• Welsh government</li> <li>• Local politicians</li> <li>• Partner organisations, particularly: <ul style="list-style-type: none"> <li>○ Denbighshire County Council</li> <li>○ Conwy County Borough Council</li> <li>○ 3<sup>rd</sup> Sector organisations, accessed through Denbighshire Voluntary Services Council (DVSC)</li> </ul> </li> <li>• Community Health Council for Denbighshire and for Conwy</li> <li>• BCU staff, particularly the Central Area team</li> <li>• Primary Care Providers including GPs, Dentists, Optometrists, Pharmacists</li> </ul>
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc?	<p>The communication activities are set out at a high level in the Stakeholder Analysis. Significant communication and engagement were carried out with stakeholder groups in 2014 when the project was developing the service model. This engagement work informed the analysis and engagement undertaken in 2016/17 for the revised case.</p> <p>The service model has been updated to reflect strategic drivers and demographic changes described in the Outline Business Case and referenced against Question 2 above. A rolling programme of engagement with local groups was carried out in 2019/20. This has focused primarily on the service model, culture change, and aspects of building design which will meet</p>

the needs of protected groups locally. This commenced with engagement with a LGBT group in Rhyl, which was not part of the previous EQIA, and Denbighshire Voluntary Services Council (DVSC) led engagement events for the project in 2017 with a wide group of third sector organisations and representatives of local groups of citizens.

The project has a risk and issues log which lists all of the main factors which may impact upon this proposal. The control document includes actions identified to treat risks and manage issues, providing the Project Board with the necessary assurance to undertake this project.

**Factors will hinder the outcome of the project:**

- Availability of resources to support the implementation of the development
- Local sensitivities associated with the previous closure of Prestatyn Community Hospital
- Responsiveness of partner organisations who have capacity and staffing issues
- Workforce constraints
- Financial constraints
- Existing estates constraints
- Current transport infrastructure which will require development
- Challenging time scales

**Factors which might help the development of the project:**

- Robust communication strategy and action plan
- Robust Recruitment and Attraction Strategy and action plan
- Transparency
- Political support
- Compatible and reliable transport service for parents, families, staff, visitors
- Trade Union support
- Support from secondary and Primary Care
- Support from the CHC

## Form 2: Considering the potential impact of your document, proposals etc in relation to equality and human rights

Characteristic or other factor to be considered	Potential Impact by Group. Is it:		Please detail here, for each characteristic listed on the left: (1) any Reports, Statistics, Websites, links etc. that are relevant to your document/proposal and have been used to inform your assessment; and/or (2) any information gained during engagement with service users or staff; and/or any other information that has informed your assessment of Potential Impact.
	Positive (+), Negative (-), Neutral (N) or No Impact/Not applicable (N/A)	High, Medium or Low	
Age	+	High	<p><b>Older People</b></p> <p>The Full Business Case is built on research related to the needs of older people to access care and support services closer to home. It is recognised that 22.8% of service users are likely to be aged 65 or over<sup>1</sup>. The local area has a relatively high proportion of people in this age group<sup>2</sup> and this is set to rise within the next decade<sup>3</sup>. People aged 65 and over living in Denbighshire and Conwy - where the majority of service users reside - make up a significant proportion of the population (20% in Denbighshire and 24% in Conwy<sup>4</sup>).</p> <p>The service model being proposed needs to understand and respond to changes in future demography. The aim is to promote preventative and self-managed care, which will ultimately reduce the need for acute hospital intervention, long hospital stays and re-admission to community settings including day services attendance (for all age groups).</p> <p><b>Children</b></p> <p>The number of children in North Wales is expected to decline over the next decade<sup>5</sup>. At present there are around 36,000 children in Conwy and Denbighshire, this is predicted to fall to 32,000 by 2030 and just 31,000 by 2040.</p>

<sup>1</sup> Health Maps Wales (2017) Broad Age Group Population Estimates. Available online - <https://www.healthmapswales.wales.nhs.uk/>

<sup>2</sup> Health Maps Wales (2017) Broad Age Group Population Estimates. Available online - <https://www.healthmapswales.wales.nhs.uk/>

<sup>3</sup> Welsh Government (2018) Subnational population projections (local authority): 2018-based. Available online - <https://gov.wales/subnational-population-projections-2018-based-html>

<sup>4</sup> North Wales population assessment Draft 0.1 24 November 2016

<sup>5</sup> Health Maps Wales (2017) Broad Age Group Population Estimates. Available online - <https://www.healthmapswales.wales.nhs.uk/>

			<p>In order to promote good outcomes throughout life, support in the early years is crucial as experiences during childhood can have a significant impact on health and well-being in later life<sup>6</sup>. Child poverty, Adverse Childhood Experiences, childhood obesity, disability, emotional and mental health and well-being, resilience, education attainment and many other factors can contribute. The first 1000 days from conception are acknowledged as the most significant in a child's development<sup>7</sup>.</p> <p><b>All Ages</b></p> <p>In developing the Health Board's Mental Health Strategy which covers all ages, there are specific priorities for a number of improvements to support children, young people and families including Child and Adolescent Mental Health (mental health, eating disorders and preventing suicide and self-harm).</p> <p>Reducing loneliness and isolation is one of the main challenges in improving well-being for all ages; however, for older people, the risk factors for loneliness and isolation tend to increase and converge. Participation and good community support networks are important.</p> <p>Further information can be found in the supporting document of LHSW where extensive engagement was undertaken in relation to Care Closer to Home, Aging Well and Children &amp; Young People.</p>
Disability	+	Medium	<p>The Equality Act (2010) states that you are disabled if 'you have a physical or mental impairment, and that impairment has a substantial and long-term adverse effect on your ability to carry out normal day-to-day activities'<sup>8</sup>.</p> <p>It is difficult to estimate accurately the number of disabled people in North Denbighshire. However, the Office of National Statistics (ONS) reports that 'the proportion of people with a disability in Wales (22.7%) was notably higher than in England (17.6%)'<sup>9</sup>. In addition to this, the Joseph Roundtree Foundation (JRF) report that 39% of disabled people in Wales live in poverty compared to 22% of non-disabled people<sup>10</sup> - this is particularly relevant as the Health Foundation</p>

<sup>6</sup> Hughes et al (2017) 'The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis', *The Lancet*, 2(8):356-366

<sup>7</sup> Welsh Government (2018a) *A Healthier Wales: our plan for Health and Social Care*. Available online - <https://gov.wales/sites/default/files/publications/2019-04/in-brief-a-healthier-wales-our-plan-for-health-and-social-care.pdf>

<sup>8</sup> The Equality Act (2010) Available online - <http://www.legislation.gov.uk/ukpga/2010/15/section/6>

<sup>9</sup> ONS (2015) *Nearly one in five people had some form of disability in England and Wales*. Available online - <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/nearlyoneinfivepeoplehadsomeformofdisabilityinenglandandwales/2015-07-13>

<sup>10</sup> JRF (2018) *Poverty in Wales 2018*. Available online - <https://www.jrf.org.uk/report/poverty-wales-2018>



		<p>find that factors such as disability and poverty can have a compounding, negative effect on a person's ability to access healthcare<sup>11</sup>.</p> <p>Imperial College London<sup>12</sup> use the following broad categories of disabilities, and consideration has been given to each category when analysing the Full Business Case:</p> <ul style="list-style-type: none"> <li>• Social/Communication impairment such as Autistic Spectrum Disorder</li> </ul> <p>The National Autistic Society estimate that around 1 in 100 people in the UK are on the autistic spectrum and that as a result of this, 'if you include their families, autism is a part of daily life for 2.8 million people'<sup>13</sup>. Chiri and Warfield (2012) found that people with autism often found accessing core healthcare services more challenging than cognitively-typical people and were more likely to have unmet therapy needs<sup>14</sup>.</p> <ul style="list-style-type: none"> <li>• Sight impairment which cannot be corrected with glasses</li> </ul> <p>In the UK, there are almost 2 million people living with sight loss. Of these, around 360,000 are registered as blind or partially sighted<sup>15</sup>. We know that sight impairment is correlated with old age, so can expect this figure to grow as Wales and North Denbighshire's population continues to grow older.</p> <ul style="list-style-type: none"> <li>• Serious hearing impairment</li> </ul> <p>Around 19% of the population in the UK have hearing loss or are deaf. Many people within the deaf community will use BSL as their first or preferred language, and many others will know and use sign language<sup>16</sup>.</p>
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<sup>11</sup> The Health Foundation (2018) *Poverty and Health*. Available online - <https://www.health.org.uk/infographic/poverty-and-health>

<sup>12</sup> <https://www.imperial.ac.uk/disability-advisory-service/thinking-about-disability/disability-categories/>

<sup>13</sup> National Autistic Society (2018) *Autism Facts*. Available online - <https://www.autism.org.uk/about/what-is/myths-facts-stats.aspx>

<sup>14</sup> Chiri, G. & Warfield, M. (2012) 'Unmet Need and Problems Accessing Core Health Care Services for Children with Autism Spectrum Disorder', *Maternal and Child Health Journal*, 16:1081-1091

<sup>15</sup> NHS (2018) *Blindness and Vision Loss*. Available online <https://www.nhs.uk/conditions/vision-loss/>

<sup>16</sup> HM Government Digital Service (2020) *Deaf User Research and Analysis*. Available online - <https://www.gov.uk/government/publications/understanding-disabilities-and-impairments-user-profiles/saleem-profoundly-deaf-user>

			<p>Healing Impairments are associated with mental health problems. People with hearing loss are more likely to have poor mental health - up to 50%, compared to 25% for the general population.</p> <p>Additionally, it is estimated that the number of people who are deafblind - having vision and hearing impairments that significantly impact on day to day lives - will increase to around 1% of the population by 2030.</p> <ul style="list-style-type: none"> <li>• Long-term illness or health condition, such as diabetes</li> </ul> <p>Welsh Government research suggests that 46% of the Welsh adult population has some sort of - long-standing illness' and 34% report a limiting longstanding illness. Longstanding illnesses increase with age, are more likely to affect women, and are also strongly correlated with deprivation<sup>17</sup>.</p> <ul style="list-style-type: none"> <li>• Mental health conditions</li> </ul> <p>Around 13% of respondents in the Welsh Health Survey reported receiving treatment for mental health needs in the last year. The number of adults with a common mental health need is expected to increase, this may be due to risk factors such as unemployment, lower income, debt and stressful life events<sup>18</sup>.</p> <ul style="list-style-type: none"> <li>• Specific Learning Disabilities, such as dyslexia</li> </ul> <p>Current projects estimate that the total number of people with a learning disability needing support will increase 2% each year until 2020 and then will stabilise. People with a learning disability are living longer, but it is important that the needs of older people with a learning disability, which may be more complex are addressed. They are also at greater risk of dementia, experience poorer health, and experience barriers to care and support because of communication difficulties<sup>19</sup>.</p> <ul style="list-style-type: none"> <li>• Physical Impairment or Mobility Issues</li> </ul>
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<sup>17</sup> Welsh Government (2019) *National Survey for Wales 2017-18: Adult general health and illness*. Available online - <https://gov.wales/sites/default/files/statistics-and-research/2019-03/national-survey-for-wales-2017-18-adult-general-health-and-illness-658.pdf>

<sup>18</sup> StatsWales (2020) *Mental Health and Wellbeing*. Available online <https://statswales.gov.wales/Catalogue/National-Survey-for-Wales/Population-Health/Mental-Health-and-Wellbeing>

<sup>19</sup> Welsh Government (2018b) *Learning Disabilities Improving Lives Programme*. Available online - <http://allwalespeople1st.co.uk/wp-content/uploads/2018/06/Improving-Lives-Programme-Report-June-18.pdf>

			<p>A significant proportion of the population has some degree of mobility issue. 1.2 million people in the UK use a wheelchair, with 2/3 of that figure using their wheelchair on a regular basis.<sup>20</sup></p> <p>Accessibility and the importance of removing barriers for disabled people will be addressed throughout this development. The design of the proposed solution has reviewed requirements for accessibility of services, for example using guidance from the Changing Places campaign in relation to toilets and public spaces<sup>21</sup>. All toilet areas have access to a fully accessible toilet.</p> <p>There will be a facility on the ground floor for adult changing. The building itself is designed to comply with regulatory guidelines for public buildings and will be fully accessible and dementia-friendly throughout. The floors will be colour coded with simple, dementia friendly signage and the central courtyard will assist way finding in the building.</p> <p>The Ward consists of 22 individual rooms with en-suite, plus 6 beds spread across 2 bays. There will be pull-down beds for carers in some of the individual rooms. The role of the carer in the life of the person cared-for will be actively encouraged to continue on the Inpatient Ward. This supports research undertaken by John's Campaign<sup>22</sup> and aligns with the feedback from local Carers' groups<sup>23</sup>.</p>
Gender Reassignment	+	Low	<p>Data on gender reassignment are not routinely collected. The Gender Identity Research and Education Society estimates the transgender community in the UK range from 65,000 to 300,000. This includes people who have transitioned to a new gender role via medical intervention, and the broader transgender community<sup>24</sup>.</p> <p>The absence of official estimates makes it difficult to ascertain the level of discrimination, inequality or social exclusion faced by the trans community. Is Wales Fairer? Identifies there is still the need to eliminate violence, abuse and harassment against LGBT people<sup>25</sup>.</p> <p>The new Primary Care led Gender Identify Care Pathway in Wales is a positive step forward, with the new service being operational from April 2019, although there are still significant issues to work through.</p>

<sup>20</sup> NHS England (2020) *Improving Wheelchair Services*. Available online <https://www.england.nhs.uk/wheelchair-services/>

<sup>21</sup> <http://www.changing-places.org/>

<sup>22</sup> <http://johnscampaign.org.uk/#/about>. Also: <https://www.theguardian.com/society/series/johns-campaign>.

<sup>23</sup> Denbighshire Carers' Strategy Forum attended twice this year

<sup>24</sup> <https://www.gires.org.uk/>

<sup>25</sup> Equality and Human Rights Commission (2018) *Is Wales Fairer?* Available online - <https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-2018-is-wales-fairer.pdf>

			<p>Overall data suggests that Lesbian, Gay, Bisexual and Transgender people are more likely to experience health inequalities and report lack of access to services.</p> <p>The new accommodation provided will have a positive impact in relation to privacy, dignity and respect, but work will need to increase / continue on staff training – 51% of transgender people in Wales said that healthcare staff lacked understanding of specific trans health needs when accessing general health care last year . The health improvement, health inequalities programme of the Health Board is seeking to promote staff health and well-being for all, with a focus on mental well-being, and will work to ensure consistent fair and equitable treatment. There is a positive commitment to continue to improve and each of the strategy programmes will need to ensure that the needs and rights of transgender community are identified, respected and addressed.</p>
Pregnancy & Maternity	+	Low	The new service will offer improved outpatient facilities for antenatal, postnatal care and breastfeeding. Additionally more suitable working environments for staff members wanting to express milk following return to work will be provided.
Race & Ethnicity	N	-	<p>No specific impact on this group has been identified.</p> <p>Through the engagement as part of LHSW, people from different groups described barriers to access that they had experienced. For example, some people reported that they had returned to their country of origin for certain treatment.</p> <p>There has been good work to engage with BME groups through the Equality Team and through community forums. There are no specific impacts identified for BME groups within this proposal; however, the emphasis on addressing inequalities and the causes of inequalities may have the potential produce a low positive impact, but this will require further consideration.</p>
Religion or Belief	+	Low	A multi-faith room will be offered from the new hospital in addition to the Chapel which will be maintained in the refurbished Royal Alexandra Hospital building. This offers the chance for prayer or quiet contemplation to people with a wide range of religious beliefs.
Sex	N	-	There remain differences in outcomes experienced by men and women in specific circumstances, and differences in the way that they access health advice, information and support.

			<p>Overall, men have lower life expectancy (78 years, compared to 82 years for women)<sup>26</sup>; there are more premature deaths from cancer, more deaths from cardiac disease and a three times higher risk of death from suicide.</p> <p>Women may experience different barriers to access in healthcare and health services. Feedback through engagement identified experiences of lack of support with certain issues, such as fertility, gynaecological conditions, and mental health. More women are unpaid carers<sup>27</sup>.</p> <p>Is Wales Fairer? identifies the need to eliminate violence, abuse and harassment, including against women. The partnership working needed to address violence against women and domestic abuse is identified within the SSWB population assessment and action plan.</p>
Sexual Orientation	N	-	<p>No specific impact on this group has been identified.</p> <p>The ONS report that 2% of the population of the UK report as lesbian, gay, or bisexual, which rises to about 4% amongst 16-24 year olds. However Wales has a lower percentage of self-reporting LGB people than the UK overall<sup>28</sup>.</p> <p>National reports highlight the barriers experienced by Lesbian, Gay and Bisexual (LGB) people accessing and using services<sup>29</sup>.</p> <p>The Health Board has been taking positive steps to promote LGBT equality for both staff and patients, with strong leadership and reverse mentoring initiatives taking place. This positive promotion, together with other initiatives in place and supported by the Celtic Pride network, is making a difference to the culture and behaviour within the organisation.</p> <p>The strategy's human rights approach and recognition of the need to tackle inequalities will continue the work to promote equality.</p>

<sup>26</sup> Health Maps Wales (2017) Broad Age Group Population Estimates. Available online - <https://www.healthmapswales.wales.nhs.uk/>

<sup>27</sup> Papworth Trust (2018) *Facts and Figures 2018, Disability in the UK*. Available online - <https://www.papworthtrust.org.uk/about-us/publications/papworth-trust-disability-facts-and-figures-2018.pdf>

<sup>28</sup> ONS (2017) *Sexual Orientation 2017*. Available online - <https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2017>

<sup>29</sup> Stonewall (2014) *Where are we now?* Available online - [https://www.stonewallcymru.org.uk/system/files/where\\_we\\_are\\_now\\_4.pdf](https://www.stonewallcymru.org.uk/system/files/where_we_are_now_4.pdf)

Welsh Language	N	-	<p>No specific impact on this group has been identified. However, it is notable that the hospital will be constructed in a disproportionately English speaking area of Denbighshire. With that in mind it is important that the promotion of the Welsh language is considered during the recruitment phase of the project and continuously through staff training.</p> <p>Figure 1 – Percentage of Welsh speakers in Denbighshire by electoral Ward (Source: Denbighshire.gov.uk)</p> <table><tr><th>Electoral District</th><th>% Welsh Speakers 2011</th></tr><tr><td>Llandrillo</td><td>59.2</td></tr><tr><td>Efenechtyd</td><td>53.7</td></tr><tr><td>Llanrhaeadr yng Nghynmeirch</td><td>50.0</td></tr><tr><td>Llanfair Dyffryn Clwyd/Gwyddelwern</td><td>48.3</td></tr><tr><td>Corwen</td><td>47.9</td></tr><tr><td>Ruthin</td><td>41.7</td></tr><tr><td>Denbigh Lower</td><td>40.2</td></tr><tr><td></td><td></td></tr><tr><td>Rhyl South West</td><td>13.7</td></tr><tr><td>Prestatyn South West</td><td>13.7</td></tr><tr><td>Rhyl East</td><td>13.0</td></tr><tr><td>Rhyl West</td><td>12.7</td></tr><tr><td>Prestatyn North</td><td>12.6</td></tr></table> <p>The Health Board is committed to promote the Welsh Language in line with the Measure and the Well-being of Future Generations. The LHSW strategy states that ‘<i>we will actively provide Welsh Language services to address the needs of our Welsh speaking population, in line with the Welsh Language (Wales) Measure 2011</i>’. The implementation of the new Standards will result in a greater consistency in relation to the standard of services that are provided through the medium of Welsh. One of the key principles in care provision is the Active Officer - providing a service in Welsh without someone having to ask for it.</p> <p>Research has identified the link between language and care and refers to examples which suggest the quality of care to vulnerable service users may be compromised by failure to communicate in their first or preferred language.</p>	Electoral District	% Welsh Speakers 2011	Llandrillo	59.2	Efenechtyd	53.7	Llanrhaeadr yng Nghynmeirch	50.0	Llanfair Dyffryn Clwyd/Gwyddelwern	48.3	Corwen	47.9	Ruthin	41.7	Denbigh Lower	40.2			Rhyl South West	13.7	Prestatyn South West	13.7	Rhyl East	13.0	Rhyl West	12.7	Prestatyn North	12.6
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Rhyl South West	13.7																														
Prestatyn South West	13.7																														
Rhyl East	13.0																														
Rhyl West	12.7																														
Prestatyn North	12.6																														

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Summary of Impact

	Positives	Negatives	Neutral
Number	6	0	4

<b>Demographic Tends</b>	<p><b>North Wales Demography</b></p> <p>The population of Denbighshire is 94,800. 20% of residents are over the age of 65. The age and sex composition of people is an important determinant of the level of need for health care. Older persons are disproportionately affected by chronic conditions. The Welsh Health Survey in 2015 reported that 82% of respondents aged 65 years and over have a chronic condition and 54% of whom suffered from two or more co-morbidities. If current trends continue the number of people living with chronic conditions will continue to increase in the future, with people living longer and developing more than one chronic condition<sup>30</sup>.</p> <p><i>StatsWales</i><sup>31</sup> projections show that the number of over 65s living in Wales will rise by 27% over the next 20 years. It is anticipated that Denbighshire's overall population is projected to increase by 2.7% (around 2,500 people) by 2039. The population aged 75 years and over is projected to increase by 7,500, while the population aged 18 to 74 years is projected to decrease by 4,800.<sup>32</sup> These population changes, which are mirrored across North Wales, inform the agreed clinical model to move healthcare delivery out of hospital settings and into local communities. The type and range of community services currently available in North Denbighshire does not necessarily match the demographic profile of the locality. The NDCH development presents an opportunity to provide future health services that are responsive to the demographic demands of the locality by providing local facilities and community services that enable residents to receive the best possible care and support.</p> <p>These population changes, which are mirrored across North Wales, were a key part of the strategic case set out in "Care Closer to Home" and underpin the agreed clinical model to move healthcare delivery out of hospital settings and into local communities where it is appropriate to do so. This model<sup>33</sup> is more scalable and capable of adapting to the demographic projections than one that is overly dependent upon bed-based services.</p>
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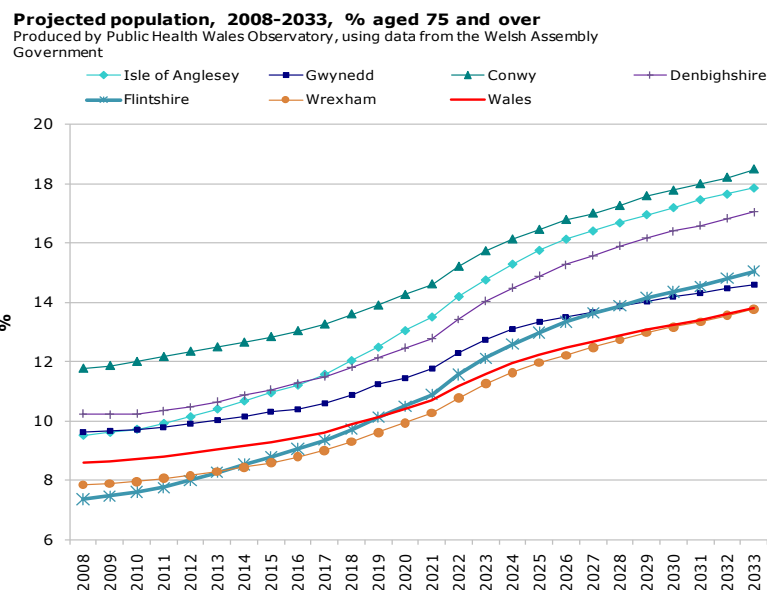
<sup>30</sup> Public Health Wales Observatory (2013) GP Cluster Profiles: Betsi Cadwaladr University Health Board

<sup>31</sup> <https://gov.wales/docs/statistics/2016/160929-local-authority-population-projections-2014-based-en.pdf>

<sup>32</sup> North Wales population assessment Draft 0.1 24 November 2016

<sup>33</sup> [www.wales.nhs.uk/sitesplus/888/opaendoc/212068](http://www.wales.nhs.uk/sitesplus/888/opaendoc/212068)





## POPULATION HEALTH NEED

- People in North Wales are living longer, but not necessarily healthier, lives. Frail elderly people are major users of health and social care services.
- Across the BCU area, around 20.6%, of all registered patients are aged 65 and over. The localities of Conwy East and West, Dwyfor and Meirionnydd have the highest percentage of elderly patients with between 24% and 26.2% recorded as being aged 65 and over. Anglesey and Conwy West have the highest number of elderly patients, with over 15,000 over 65s registered in each locality. For many older people, advancing age is associated with frailty, which is not itself a diagnosis, but is a useful term that describes the state of 'limited functional reserve' or 'failure to integrate responses in the face of stress.' Common co-morbidities such as dementia also contribute to frailty.
- An estimated 20-25% of older people have depression; this excludes those with psychological distress associated with isolation, loneliness or loss.
- Dementia presents a significant public health concern. It is a debilitating condition which describes a collection of symptoms, including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities.

- |  |   |
|--|---|
|  | <ul style="list-style-type: none"><li>• Dementia is more prevalent in people aged over 65, and prevalence roughly doubles every five years from this age onwards.</li></ul> |
|--|---|

The projected increase in dementia prevalence over the next 20-30 years means that dementia prevention and early intervention are key to securing improved health and wellbeing outcomes for people with the condition and their carers.<sup>34</sup>

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<sup>34</sup> . <http://www.wales.nhs.uk/sitesplus/documents/861/20131230%20Summary%20of%20Health%20Needs%20for%20BCUHB%20v1.pdf>

Guidance on completing Form 2: For each of the characteristics listed, and considering the aims and objectives you detailed in Q2 on Form 1, you need to consider whether your document or proposal likely to affect people differently, and if so, will this be in a positive or negative way? For example, you need to decide:

- will it affect men and women differently?
- will it affect disabled and non-disabled people differently?
- will it affect people in different age groups differently? - and so on covering all the protected characteristics.

Use your judgement to indicate the scale of any impact identified. The factors used to determine an overall assessment for each characteristic should include consideration of scale and proportionality as well as potential impact.

### Form 3: Assessing Impact Against the General Equality Duty

As a public sector organisation, we are bound by the three elements of the “General Duty”. This means that we need to consider whether (if relevant) the policy or proposal will affect our ability to:-

- Eliminate unlawful discrimination, harassment and victimisation;
- Advance equality of opportunity; and
- Foster good relations between different groups

1. Describe here (if relevant) how you are ensuring your policy or proposal does not unlawfully discriminate, harass or victimise

All policies which underpin the OBC are in line with BCU standards and policies, where these are available.  
The current configuration of the Royal Alexandra does not meet all of the needs of the population of North Denbighshire  
As highlighted within the document ‘An Equality and Human Rights Strategic Plan, For Betsi Cadwaladr University Health Board 2016 – 2020, the proposed development will enhance the ability to adapt to the changing health needs of our communities.  
**Human Rights:** This development will enable better health outcomes for everyone to be achieved, having regard for a persons protected characteristics; as highlighted under the Equality Act 2010

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnic origin • Religion or belief
- Sex

	<ul style="list-style-type: none"> <li>• Sexual orientation.</li> </ul> <p>The needs of individuals will be recognised and addressed whatever their identity and background, and their human rights will be upheld.</p> <p><b>Equality:</b> It is our understanding and belief that our proposal does not discriminate against those with the protected characteristic as identified in the Equality Act 2010.<sup>35</sup></p>
2. Describe here how your policy or proposal could better advance equality of opportunity (if relevant)	The continuation of engagement with key stakeholders from the Health Board, third party and public is pivotal in promoting equality of opportunities and raise awareness of cultural needs
3. Describe here how your policy or proposal might be used to foster good relations between different groups (if relevant)	Opportunities for on-going stakeholder engagement will continue as our proposal has a direct impact and vested interest for the population at large in Denbighshire.

<sup>35</sup> <http://www.wales.nhs.uk/sitesplus/documents/861/BCU%20HB%20SEP%20March%202016%20Executive%20Summary%20final%20draft.pdf>

**Part B:****Form 4 (i): Outcome Report**

Organisation:	BETSI CADWALADR UNIVERSITY HEALTH BOARD
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1. What is being assessed? (Copy from Form 1)	Outline Business Case (OBC) for North Denbighshire Community Hospital (NDCH)
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2. Brief Aims and Objectives: (Copy from Form 1)	<p>The project has the following investment objectives:</p> <ol style="list-style-type: none"><li>1. To provide safe and sustainable services in response to the current and future health and well-being needs of the local population</li><li>2. To further develop multi-agency, integrated, responsive primary and community care services in the area</li><li>3. To increase the range of local services, thereby reducing the reliance on the DGH</li><li>4. To deliver services in an environment which is fit for purpose and enhances health and well-being for service users and staff</li><li>5. To move care closer to people's homes, including inpatient bed based care</li><li>6. To uphold our statutory duty to support the future generations act</li></ol>
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3a. Could the impact of your decision/policy be discriminatory under equality legislation?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could any of the protected groups be negatively affected?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3c. Is your decision or policy of high significance?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

4. Did the decision	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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scoring on Form 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	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?  There are several positive impacts and no negatives; therefore a full EQIA is not required. As the project progressed any unintended negative impact on any of the protected characteristic groups will be considered and mitigating actions taken if appropriate	
5. If you answered 'no' above, are there any issues to be addressed e.g. mitigating any identified minor negative impact?	Yes <input type="checkbox"/>	<input checked="" type="checkbox"/> No
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your document or proposal?	Record Details:	
	Yes <input checked="" type="checkbox"/>	<input type="checkbox"/> No
	How is it being monitored?	Benefits Realisation Plan drafted as part of the OBC submission.  A Communication and engagement plan is in progress for the current stage, including local residents' drop-in sessions and the output from these sessions will be fed into the next stage of the Design.
	Who is responsible?	Overall Project Director (supported by Project Manager and Engagement Officer)
	What information is being used?	E.g. will you be using existing reports/data or do you need to gather your own information?  Summary reports of issues raised from each engagement event  Email account set up and monitored daily.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	The Project Board will review as part of developing the FBC.

7. Where will your decision or policy be forwarded for approval?	Main Board of 01/11/2018 then to Welsh Government for approval of funding the scheme.
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8. Describe here what engagement you have undertaken with stakeholders including staff and service users to help inform the assessment	<p>1. Full review of engagement undertaken in 2014</p> <p>2. Attendance at local elected representatives' meetings and review of the key issues raised with project board in 2016 - 2018</p> <p>3. Engagement activities from December 2016 through public drop-in sessions in Rhyl, Kinmel Bay, Prestatyn and Rhuddlan and in 2017 across Denbighshire and at DVSC events</p> <p>4. Staff engagement sessions in Royal Alexandra Hospital in 2016/17.</p> <p>5. Rolling programme of engagement during 2016 – 18, including some “hard to reach groups”</p>
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9. Names of all parties involved in undertaking this Equality Impact Assessment:	Name	Title/Role
	Steph O'Donnell	Project Manager, Central Area
	Megan Vickery	Engagement Officer, BCU
	Lisa Williams	DVSC
	Jane Trowman	Head of Health Planning and Strategy
	<p>As part of developing the business case a number of public and staff engagement events have been held. In addition an extensive programme of events were held as part of Living Healthier, Staying Well Engagement which were specific to North Denbighshire, these included Care Closer to Home, Acute Hospital care, Children &amp; Young People and Aging Well – Full information on events and attendees are available on request. Contributions from these events have been fed into this Equality Impact Assessment Screening.</p>	

**Please Note: The Action Plan below forms an integral part of this Outcome Report**



**Form 4 (ii): Action Plan**

This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	The assessment does not indicate significant potential negative impact; such that the proposals could not proceed.	N/A	N/A
2. What changes are you proposing to make to your document or proposal as a result of the EqIA?	In developing the business case the need to consider the potential impact on travel, to services has been recognised.	Project Board	
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to mitigate these impacts? Are these already in place?	Overall this proposal will have no negative impacts on protected characteristic groups, but it has been recognised that the Health Board and wider community have many opportunities to improve the current offer.	N/A	N/A
3b. Where negative impacts on certain groups have been identified, and you are proceeding without mitigating them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Refer to Action PlanProject Team		



## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
<b>1. To provide safe and sustainable services in response to the current and future health and well-being needs of the local population</b>								
1.1	Improved access to a range of health and well-being services - including education, information and preventative services offered in partnership with social services and the third sector.	Quantifiable (QB)	<ul style="list-style-type: none"> <li>• 10% increase in attendance at Sexual Health clinic.</li> <li>•</li> <li>• 5%-10% increase in people attending Continence management clinics.</li> <li>• 5%-10% increase in people attending Healthy legs clinic.</li> <li>• Number of people attending diabetic clinic (new)</li> <li>• Number of people receiving Intravenous (IV) sessions (new)</li> <li>• No of people receiving information, advice</li> </ul>	<ul style="list-style-type: none"> <li>• Sexual Health Clinic baseline 34 hours: Mon. 11:00-19:00; Tues 9:00-17:00, Weds 9:30-15:30; Thurs 9:00-17:00; Fri 09:00-13:00.</li> <li>• 1804 attendees 2019 /20</li> <li>• 526 patients a year 2019/ 20</li> <li>• 1820 clinic visits for 2019 / 20</li> <li>• New clinic baseline in year 1</li> <li>• Proxy baseline of 3138 sessions delivered in 201/19 and 3175 sessions were delivered in 2019/20 at LLGH ATU</li> <li>• New service baseline in year 1 circa 40 sessions</li> </ul>	<ul style="list-style-type: none"> <li>• Performance management data</li> <li>• Performance management data</li> <li>• Performance management data</li> <li>• Performance management data</li> </ul>	Annually	Service user Community	Clinic lead  District nurse service lead  Social care service lead.  3 <sup>rd</sup> sector partner organisations

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
			and support on health & social care issues. This will result in an increase in self-management in the local population	per week  • Baseline in 2021_22 with SPOA. When hospital open add contacts in Well-being hub.				
1.2	Reduce demand on local acute, community & primary care services by providing same day service	Quantifiable (QB)	<ul style="list-style-type: none"> <li>• 11,000 people attending same day service</li> <li>• Inpatient Ward to accommodate up to 400 patients at varying average length of stay – assumes 21 days average length of stay at 85% bed occupancy</li> </ul>	<ul style="list-style-type: none"> <li>• Baseline to build on 11,000 patients who would otherwise go to YGC ED &amp; G.P practices.</li> <li>• Baseline builds on number of Inpatients relocated from Holywell and Denbigh community hospitals – 16 beds. Assumes all patients from the local area can be accommodated here, based on 2019/20 Community Hospital admissions data</li> </ul>	<ul style="list-style-type: none"> <li>• Performance management data for the Same Day service</li> <li>• Ward admissions and length of stay data over first full year opening</li> </ul>	12 months after opening and then annually	Service Users.  Carers  Health Board	Central Area Leadership Team; YGC ED
1.3	Reduction in Central Area levels of hospital acquired infections	Quantifiable (QB)	<ul style="list-style-type: none"> <li>• Reduction in MRSA cases</li> <li>• Reduction in C Difficile cases</li> <li>• Reduction in E coli cases</li> <li>• Reduction in number of</li> </ul>	Baseline for 2019/20 across Central Community hospitals is 21 infections over 191,379 bed days = a rate of 1.10 infections per 10,000 bed days.	Management information quarterly review	12 months from opening	Service User.  Staff	Clinical leads

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
			Staphylococcus Aurious.					
1.4	Working climate for innovation, Advanced Practice and Research and Development created. The opportunity is created to add value through knowledge transfer through collaboration and co-location of staff.	Qualitative (Non QB)	The scale of Research and Development undertaken (specific measure to be determined) Number of training sessions held and attendees	Baseline end of year 1 and monitor over 5 years	Service review	12 months after opening and ongoing	Staff	Central Area Leadership Team
1.5	Improved Staff recruitment, retention and well-being	Quantifiable (QB)	<ul style="list-style-type: none"> <li>No of staff reporting improved well-being in Year 1</li> <li>No of staff retained</li> </ul>	<p>Focused survey before and 1 year after opening, plus a review of retention levels for same period.</p> <p>2018/19 staff survey <b>Q22 During the last 12 months have you been injured or felt unwell as a result of work related stress?</b> Central Area, 35% said yes, +1% on National</p> <p>2018/19 staff survey <b>25c There are enough staff at this organisation for me</b></p>	<p>HR staff survey data.</p> <p>HR staff recruitment data</p> <p>Staff questionnaire</p>	12 months after opening	Health Board	HR

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
				<b>to do my job properly.</b> Central Area 55% strongly disagree /disagree, -5% on National				
1.6	Improved patient experience.	Quantifiable (QB)	% of patients reporting a positive experience.  • Reduction in number of people making complaints about the general repair of the building	Currently not collecting this data. Baseline in 2021 and measure 1 year from opening.  9 complaints made about the general state of the premises in 2019 /20.	User experience survey.  Ward accreditation. No of complaints received	Service survey information  Annually from opening	Service Users. Carers	Central Area Leadership Team
<b>2. To further develop multi-agency, integrated, responsive primary and community care services in the area</b>								
2.1	Improved access to services by increasing operating hours.	Quantifiable (QB)	<ul style="list-style-type: none"> <li>No of additional hours provided outside usual operating hours.</li> <li>IV Suite – Monday to Friday 09:00 – 17:00 hours = 40 hours</li> <li>Ward: 24x7</li> <li>Same day service: 84 hours per week</li> <li>Sexual Health Clinic baseline in 2020 is 34 hours:</li> </ul>	<ul style="list-style-type: none"> <li>Additional hours provided baselined in Year 1</li> </ul>	To be monitored through management performance information.	Management information quarterly review Monitor over 5 years.	Service user Community Carers	Central Area Leadership team

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
			<p>Monday 11:00-19:00; Tues 9:00-17:00, Wed 9:30-15:30; Thurs 9:00-17:00; Fri 09:00-13:00.</p> <ul style="list-style-type: none"> <li>• Additional Dental Clinics: 37.5 hours per week currently offsite.</li> <li>• Additional Audiology clinics to baseline 2121/22.</li> </ul>					
2.2	Improved health service integration through co-location of physical and mental health services for older people.	Qualitative (Non QB)	Increased co-location of health services	<ul style="list-style-type: none"> <li>• Take staff survey Community Mental Health in 2021 to baseline. Re-survey 1 year after opening.</li> </ul>	Service review	Review year after build	Staff in co-located community teams	<p>Baseline: Project Team</p> <p>Follow-on: Central Area Leadership Team</p>
2.4	Improved integration of services through the co-location of health services, social services and the voluntary sector	Qualitative (Non QB)	Increased co-location of services	Baseline before construction. Take staff survey for CRT in 2021 to baseline. Re-survey 1 year after opening	Service review	Review year after build	Staff in co-located community teams	<p>Baseline: Project Team</p> <p>Follow-on: Central Area Leadership Team</p>

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
<b>3. To increase the range of local services, thereby reducing the reliance on the DGH</b>								
3.1	Reduced pressure on Ysbyty Glan Clwyd (YGC) by delivering Same Day service	Non cash-releasing	<p>No. Same day attendances by patients from North Denbighshire (LL18 and LL19 post code areas diverted from YGC.</p> <p>No. Same day attendances by patients from outside North Denbighshire (LL18 and LL19 post code areas diverted from YGC.</p> <p>No. Same day attendances by people outside of the BCUHB area during peak tourist season.</p>	<p>c. 9000 visits pa based on average annual footfall of local residents presenting at ED in YGC. Steep increase during Summer months.</p> <p>Potential for c. 2000 patients outside the locality to be treated.</p> <p>Baseline to be refined 6 months prior to opening. 2022</p>	<p>MIU attendances across the region by hospital.</p> <p>Specifically review attendances at YGC ED for post code areas specified.</p>	Quarterly review	<p>DGH (Ysbyty Glan Clwyd) – ED service</p> <p>Service users</p> <p>Carers</p>	<p>Baseline: Project Team.</p> <p>Review - Central Area Leadership team</p>
3.2	Reduction in ambulance journeys as a result of patients attending the local same day service	Non cash-releasing	50% reduction in ambulance conveyances for people attending the	<ul style="list-style-type: none"> <li>990 conveyances for local people attending the ED at YGC.</li> </ul>	Quarterly review WAST data for MIU attendances for Rhyl/Prestatyn service users.	12 months from opening	WAST. Health Board. Service Users	WAST



## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
	instead of YGC Emergency Department.		ED from LL18/LL19 with minor injuries.					
3.3	The provision of a local IV service will result in both avoiding multiple hospital admissions & early discharge from the DGH for patients in LL18 and LL19 postcodes.	Non cash-releasing	Admission avoidance for IV treatment at Ysbyty Glan Clwyd. Assumes reduction based upon current activity in LLGH Assessment Unit	Baseline 16 patients from LL18/19 in 2018/19 27 patients from LL18/19 in 2019/20	Attendance data from YGC. Attendance data from NDCH	12 months of opening	Service User Health Board	Central Area Leadership team
<b>4. To deliver services in an environment which is fit for purpose and enhances health and well-being for service users and staff</b>								
4.1	Patients will benefit from improved physical environment in terms of: Functional suitability; Fire safety compliance; Accessibility; Ease of use for those suffering from Dementia; Reduced risk of infections.	Quantifiable (QB)	Patients will receive a high quality of care that meets national quality guidelines	<ul style="list-style-type: none"> <li>Building meets Fire Strategy requirements – measure on opening in 2022</li> <li>Accessibility review with representatives from local groups – 2022 for new build and 2023 for refurbishment</li> </ul>	The service and physical environment meets the National Institutes of Clinical excellence QS 173 standard	12 months from opening	Service Users	Estates and Facilities; Audit; Central Area Leadership Team

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
4.2	The building will meet key HTM and HBN requirements.	Quantifiable (QB)	Estates Review	Building meets key HTM and HBN requirements. To baseline in 2022 for new build and again in 2023 upon completion of RAH.	Audit	On Opening	Health Board	Estates and Facilities
4.3	National Estate KPIs achieved	Quantifiable (QB)	National Estates KPIs	<ul style="list-style-type: none"> <li>Physical Condition – category D - A building that is not in an acceptable condition for its existing use and requires capital expenditure to bring it to condition B of between 50% and 100% of replacement cost.</li> <li>Functional Suitability – category DX - The building is very unacceptable for its current use, and this results in poor-quality and inefficient services being provided. The building is below an acceptable standard in terms of functional suitability. (When X added to C or D total replacement only real alternative)</li> </ul>	Audit	On Opening	Health Board	Estates and Facilities

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
				<ul style="list-style-type: none"> <li>Space utilization – category 2/3 - Underused/Adequate</li> <li>Statutory compliance – category C - Serious non-compliance rendering the building, part of building or engineering system unacceptable for its current use. Major capital expenditure required.</li> </ul> <p>Energy performance – exceeds 410 Wh/m2</p>				
<b>5. To move care closer to people's homes, including inpatient bed based care.</b>								
5.1	Patients will benefit from improved access to healthcare services closer to home.	Quantifiable (QB)	<p>New services which will be delivered closer to home:</p> <ul style="list-style-type: none"> <li>No. of patients attending Same Day Centre (minor injuries and ailments) from LL18 and LL19 post codes up to 11,000 cases p.a.</li> <li>11% of those attendance result in avoidance of</li> </ul>	<ul style="list-style-type: none"> <li>15% transfer of attendances from YGC ED to MIU: 11,000 p.a., notional value £684k</li> <li>Same Day Service estimate 4,000 case p.a. diverted from Primary care</li> <li>990 avoided journeys or 3,000 avoided hours @ Cost per hour lost of £150, assuming 40% can be avoided, £180k notional value</li> </ul>	Management Information and performance data	1 year from opening and annually	Service User	Central Area Leadership team

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
			transport conveyance • 28 Inpatient beds – up to 400 patients p.a. with AvLos of 21 days (at 85% bed occupancy) • IV therapy suite – up to 4500 sessions p.a. IV Therapy Assessment (NCRB): Multiple Hospital Admission Avoidance & allows early discharge from the DGH	• Inpatient beds currently c. 1500 total LOS days p.a. for Rhyl/Prestatyn patients in community hospitals across Denbighshire, Conwy and Flintshire. • IV Therapy Assessment (NCRB): Assuming 10% variation using average cost per non elective short stay of £833x marginal rate: £169,536 notional value				
<b>6. To improve economic, social, environmental and cultural well-being, as outlined in The Future Generations Act</b>								
6.1	Contribute to the regeneration of Rhyl by: providing local employment opportunities; revitalising a facility along the Rhyl coastline, in line with the Rhyl Going Forward plans	Qualitative (Non QB)	New jobs created locally: 33 Clinical roles 12.5 wte non-clinical support roles	Whole Time Equivalents 12 months before opening – 2022 and 1 year post opening.	HR data: new jobs created	12 months after opening	Health Board	HR

## North Denbighshire Community Hospital: Outline Business Case: Benefits Realisation Plan

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No	Description of Benefit	Type of Benefit	Specific Measurable	Baseline	Method to Review	Timetable	Beneficiary	Lead Responsibility
6.2	The preservation of a local building of local significant historical and cultural importance	Qualitative (Non QB)	Seek feedback from Heritage organisations after build.	N/A	N/A	On award	Local community	Central Area Team
6.3	Carbon emissions		50% reduction in ambulance journeys for same day service patients who would normally travel to YGC					

## APPENDIX D : 1 - Revenue & Capital Cash Flow Summary

[illegible]

## APPENDIX D : 2 - Additional Operational Revenue costs and funding sources

	FBC
<b>Affordability Assessment</b>	<b>£000s</b>
Made Up Of:	
Inpatient Beds	1,711
Same Day Service	284
Day Therapy Assessment Unit (IV Suite)	176
Additional Radiology staff and support	78
Estimated impact on Pathology	59
Estimated impact on Pharmacy	78
Additional Catering staff and provisions	130
Additional Domestic staff and consumables	99
Additional Portering staff	55
Estimated impact on Laundry & Linen services	10
Estimated impact on Rates, Energy & Utilities	215
Estimated impact on Building Maintenance	114
Contingency (already reduced in the OBC)	15
<b>Net Additional Operational Revenue Cost</b>	<b>3,025</b>
<b>OBC Funding &amp; Savings Options:</b>	<b>£000s</b>
Reduction in the requirement for Escalation Beds in YGC	(287)
Dental Clinic transfer	(16)
Impact on CHC Activity	(212)
Impact on inpatient beds across the wider community hospitals	(608)
Primary Care Treatment Zone Funded from Primary Care Monies	(138)
Review of Medical support arrangements	(78)
Remove Contingency	(15)
Additional Maintenance (e.g. new build so maintenance should be minimal in first 5 years)	(114)
Additional Laundry & Linen funded by transferring services from YGC / Community Hospitals	(10)
Funding gap to be addressed in 21/22 budget setting process	(1,547)
<b>Total Savings/Alternative Funding</b>	<b>(3,025)</b>
<b>Revenue Shortfall Assessment</b>	<b>(0)</b>

## **APPENDIX D : 3 Cash Releasing & Non Cash Releasing Savings**

### **Non Cash Releasing Benefits (NCRB)**

<b>1. Same Day Care (NCRB):</b> Support delivered to service users in SDC which provides care closer to home and reduces pressure on YGC and primary care.		£
15% transfer of attendances from YGC ED	9,000 attendance @ Cost per attendance of £190 x marginal rate	684,000
11% of those attendance result in avoidance of transport conveyance	990 avoided journeys or 3,000 avoided hours @ Cost per hour lost of £150 assuming 40% can be avoided	180,000
<b>Sub Total</b>		<b>864,000</b>
<b>2. IV Therapy Assessment (NCRB):</b> Multiple Hospital Admission Avoidance & allows early discharge from the DGH		
Assumes 10% variation based upon current activity in LLGH Assessment Unit	Assuming 10% variation using average cost per non elective short stay of £883 x marginal rate	<b>169,536</b>
<b>Total (NCRB)</b>		<b>1,033,536</b>

### **Cash Releasing Benefits/Savings and Transfers**

<b>3. Ward efficiencies (CRB):</b>		£
<b>Escalation Bed Savings within the Acute Sector (bank &amp; agency/seasonal plan savings)</b>		287,000
<b>Sub Total</b>		<b>287,000</b>
<b>4. Efficiencies in Estate and Facilities (CRB):</b>		
Savings from transfer of community dental clinics to new build		16,843
Savings from existing RAH site (@20%) - <i>netted against additional costs of new build</i>		71,992
<b>Sub Total</b>		<b>88,835</b>
<b>5. Impact of NDCH on CHC activity</b>		<b>212,000</b>
<b>6. Impact on inpatient beds across the wider community hospitals</b>		<b>608,100</b>
<b>7. Primary Care Treatment Zone</b>		<b>137,800</b>
<b>8. Other Savings</b>		<b>217,499</b>
<b>Total (CRB)</b>		<b>1,479,242</b>



## **APPENDIX D : 4 Ward Costs**

<b>Band</b>	<b>28 beds</b>	
	<b>WTE</b>	<b>Cost</b>
Band 7	1.00	54,916
Band 6	1.00	46,578
Band 5	17.50	720,066
Band 3 Housekeeper	1.00	25,464
Band 2 HCA	12.96	360,635
		-
	<b>33.46</b>	<b>1,207,659</b>
Clinical Leadership Payment (1 session)		12,826
GP Bedfund (estimated @ £3,500 per bed)		103,880
OPMH Liaison (1 session)		12,826
Drugs		63,000
M&SE		32,000
Cleaning materials		8,000
Other		7,000
		-
	<b>33.46</b>	<b>1,447,191</b>

**APPENDIX D : 5 Same Day Service**

Band	WTE	Cost
Band 7	2.84	176,080
Band 3	2.84	84,051
	5.68	260,131
General Non Pay		24,000
		-
	5.68	284,131

## **APPENDIX D : 6 Therapy Support to IP beds**

Integrated Service Model (Ward specific)

	Band	WTE	Cost
Weekdays	Band 6	1.24	57,757
	Band 4	1.24	36,277
Evenings:-	Band 6	0.62	28,878
	Band 3	0.62	15,788
Weekends:-	Band 6	0.25	11,551
	Band 4	0.25	7,255
Additional Support	Band 6	1.00	46,832
	Band 4	1.00	32,052
	Band 3	0.50	13,722
Non pay provision @ 10%			14,085
<b>Total</b>		<b>6.72</b>	<b>264,198</b>

## **APPENDIX D : 7 Assessment Unit**

<b>Band</b>	<b>WTE</b>	<b>Cost</b>
Band 7	1.32	63,488
Band 5	1.32	41,003
Band 3	1.32	29,099
Band 2	1.32	26,982
		-
	<b>5.29</b>	<b>160,572</b>
Non Pay		15,000
	<b>5.29</b>	<b>175,572</b>

## **APPENDIX D : 8 Clinical Support**

<b>Band / Post</b>	<b>WTE</b>	<b>Cost</b>
Radiographer	1.00	40,034
Radiographer Assistant	0.30	12,010
	0.30	7,038
Radiographer Assistant	0.20	11,610
	0.20	7,273
		-
	<b>2.00</b>	<b>77,965</b>
Pathology		59,487
Pharmacy		77,725
	<b>0.00</b>	<b>137,212</b>

## **APPENDIX D : 9 Non-Clinical Support**

<b>Band</b>	<b>WTE</b>	<b>Cost</b>
Porters pay and non pay	2.00	54,558
Catering pay and non pay	3.50	130,480
Domestics pay and non pay	4.00	99,300
Estate maintenance		114,499
Energy		129,446
Water & Waste		27,559
Laundry		9,809
Rates		58,388
<b>TOTAL ADDITIONAL COSTS</b>	<b>9.50</b>	<b>624,040</b>
<b>Potential savings from :</b>		
Abergele		14,730
Prestatyn		2,114
		<b>16,843</b>

## **APPENDIX D : 10 Capital, Impairment & Depreciation**

*Details as provided by Gleeds via e-mail on the 29th Sept*

<b>Capital Costs:-</b>			
	<b>RAH Refurb</b>	<b>New Build</b>	<b>Total</b>
	<b>£</b>	<b>£</b>	<b>£</b>
Build	11,263,813	25,103,352	36,367,165
Equipment		4,015,000	4,015,000
<b>Total</b>	<b>11,263,813</b>	<b>29,118,352</b>	<b>40,382,165</b>
<b>Impairment Calculation:-</b>			
At 30%	3,379,144	7,531,006	10,910,150
Less revaluation reserve	300,000		300,000
<b>Total Impairment</b>	<b>3,079,144</b>	<b>7,531,006</b>	<b>10,610,150</b>
<b>Depreciation Charge Calculation:-</b>			
<b>Asset Life</b>			
Build	30	60	
Equipment		10	
	<b>RAH Refurb</b>	<b>New Build</b>	<b>Total</b>
	<b>£</b>	<b>£</b>	<b>£</b>
<b>Calculation</b>			
Build	262,822	292,872	555,695
Equipment		401,500	401,500
<b>Total</b>	<b>262,822</b>	<b>694,372</b>	<b>957,195</b>
<b>New Charge</b>			
Current Charge			419,000
Less:			
Glantraeth & EMI Day Unit			60,000
Add:			
New development			957,195
<b>Total New</b>			<b>1,316,195</b>

North Denbighshire Hospital OBC (October 2020): Cost Benefit Analysis

Cost Assumptions

Capital Costs and Lifecycle costs were provided by and confirmed by Gleeds on the 8th October 2020

Property & Opportunity cost represents the Net Book Value of the existing Royal Alexander Hospital building as of 31/03/20

A cost benefit analysis has been completed based upon HM Treasury Guidance and completed using the DOH generic economic model.

The assumptions included within the model are:-

- Prices are maintained at a constant rate and are not inflated/indexed each year with 2020 as the baseline year.
- Capital and lifecycle costs are exclusive of VAT.
- Revenue costs exclude the depreciation charge.
- The cash flow has been discounted over a 30 year period for the do minimum option and 60 years for the development options.
- The cash flow factor applied is 3.5% up to 30 years and 3% thereafter.

NPC and EAC Tables

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 1: Do minimum option		
Capital Costs (net VAT)	15,205	
Lifecycle Costs	8,020	
Risk Calculator (included under capital)	0	
Capital Cost Sub-total	23,225	
Property & Opportunity Costs	5,927	
Total NPC		89,955
EAC		4,639

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 2: New Build and Light Refurb		
Capital Costs (net VAT)	54,399	
Lifecycle Costs	16,106	
Risk Calculator (included under capital)	0	
Capital Cost Sub-total	70,505	
Property & Opportunity Costs	5,927	
Total NPC		173,238
EAC		6,568

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 3: Refurb and Extend		
Capital Costs (net VAT)	54,794	
Lifecycle Costs	16,339	
Risk Calculator (included under capital)	0	
Capital Cost Sub-total	71,133	
Property & Opportunity Costs	5,927	
Total NPC		173,702
EAC		6,586

	Undiscounted (£000s)	Net Present Cost (Value) (£000s)
Option 4: Max New Build and Light Refurb		
Capital Costs (net VAT)	64,007	
Lifecycle Costs	17,456	
Risk Calculator (included under capital)	0	
Capital Cost Sub-total	81,463	
Property & Opportunity Costs	5,927	
Total NPC		211,513
EAC		8,019

The results are summarised and shown in the following table:

Option	NPC (£000s)	Ranking
1. Do minimum	89,955	1
2. New build and light refurb	173,238	2
3. Refurb and extend	173,702	3
4. Max new build and light refurb	211,513	4

Option	EAC (£000s)	Ranking
1. Do minimum	4,639	1
2. New build and light refurb	6,568	2
3. Refurb and extend	6,586	3
4. Max new build and light refurb	8,019	4

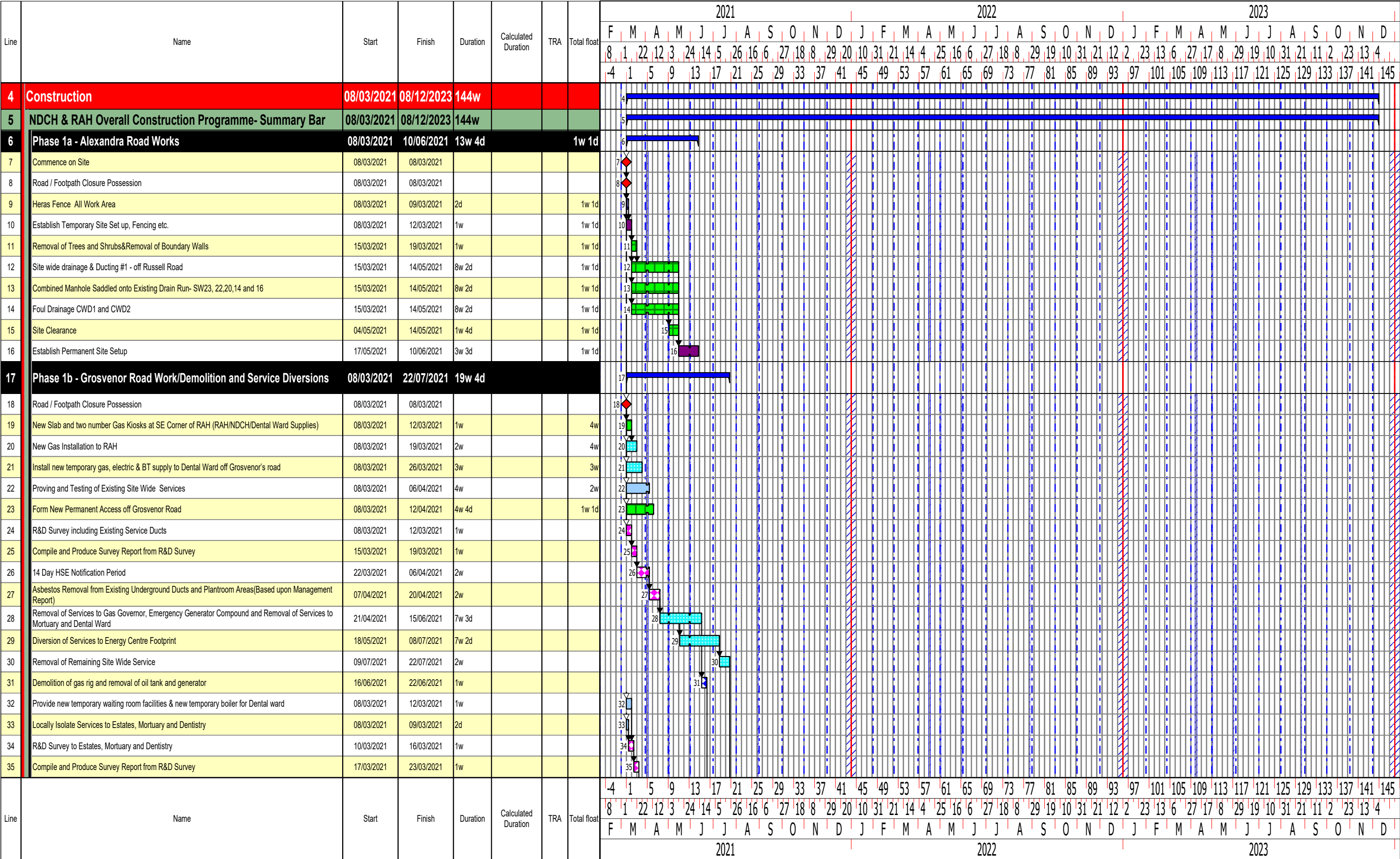
OBC COMPARISON		
	NPC (£000s)	Ranking
1. Do minimum	79,675	1
2. New build and light refurb	116,305	2
3. Refurb and extend	116,735	3
4. Max new build and light refurb	150,372	4

	EAC (£000s)	Ranking
1. Do minimum	4,109	1
2. New build and light refurb	4,410	2
3. Refurb and extend	4,426	3
4. Max new build and light refurb	5,701	4





NDCH & RAH - 2nd Stage Tender Programme: Rev C Option 2AA  
Current



Milestone Appearances  
◇ Start Milestone   ◇ Diamond   ◇ Finish Milestone




Programme No. :-  
Revision :- Rev C

Issue Date :- 24/09/2020  
Revision Date :- 24/09/2020




Notes:

Contract No. :-  
Drawn By :- MW/MT/MW/JD






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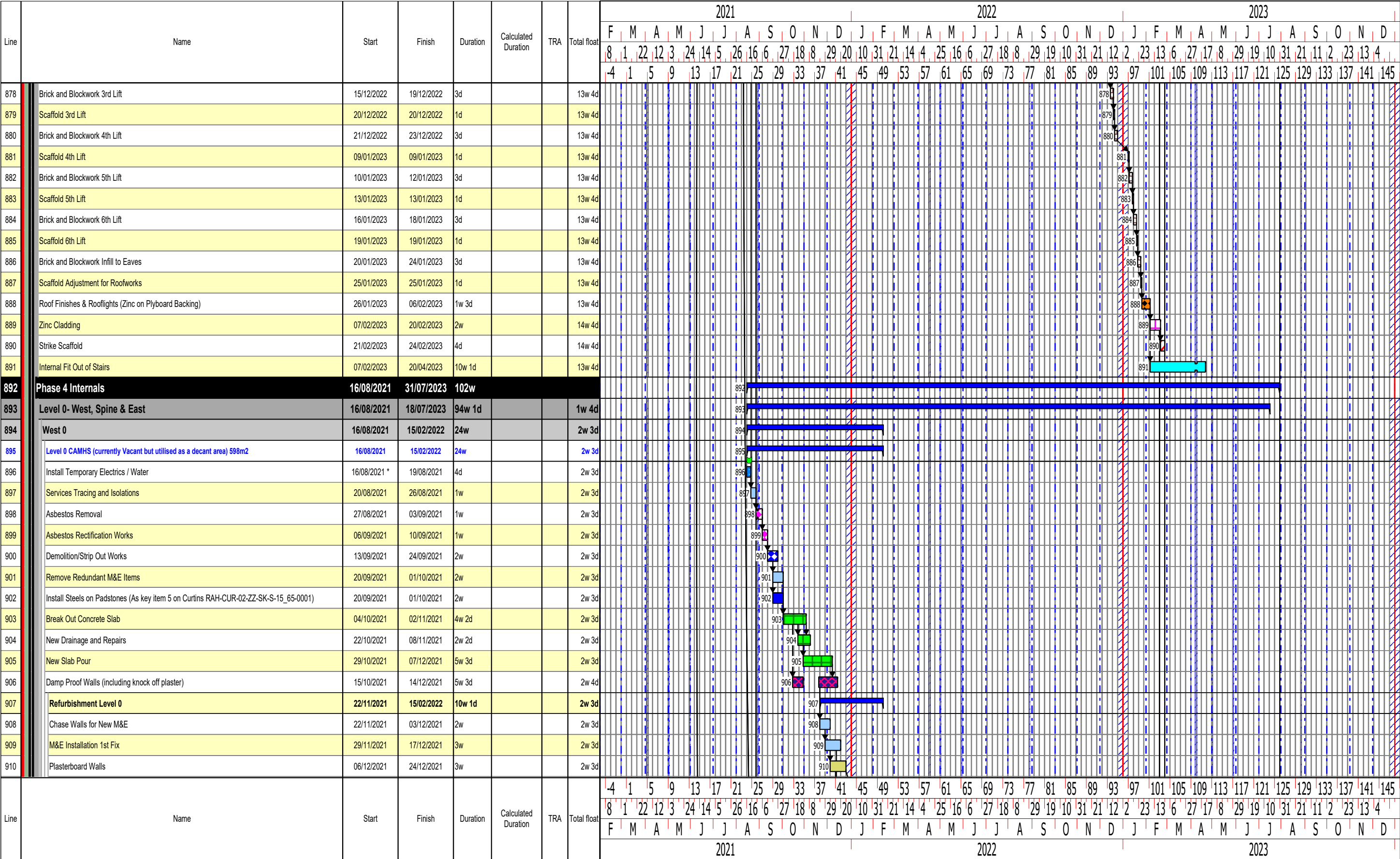


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NDCH & RAH - 2nd Stage Tender Programme: Rev C Option 2AA  
Current



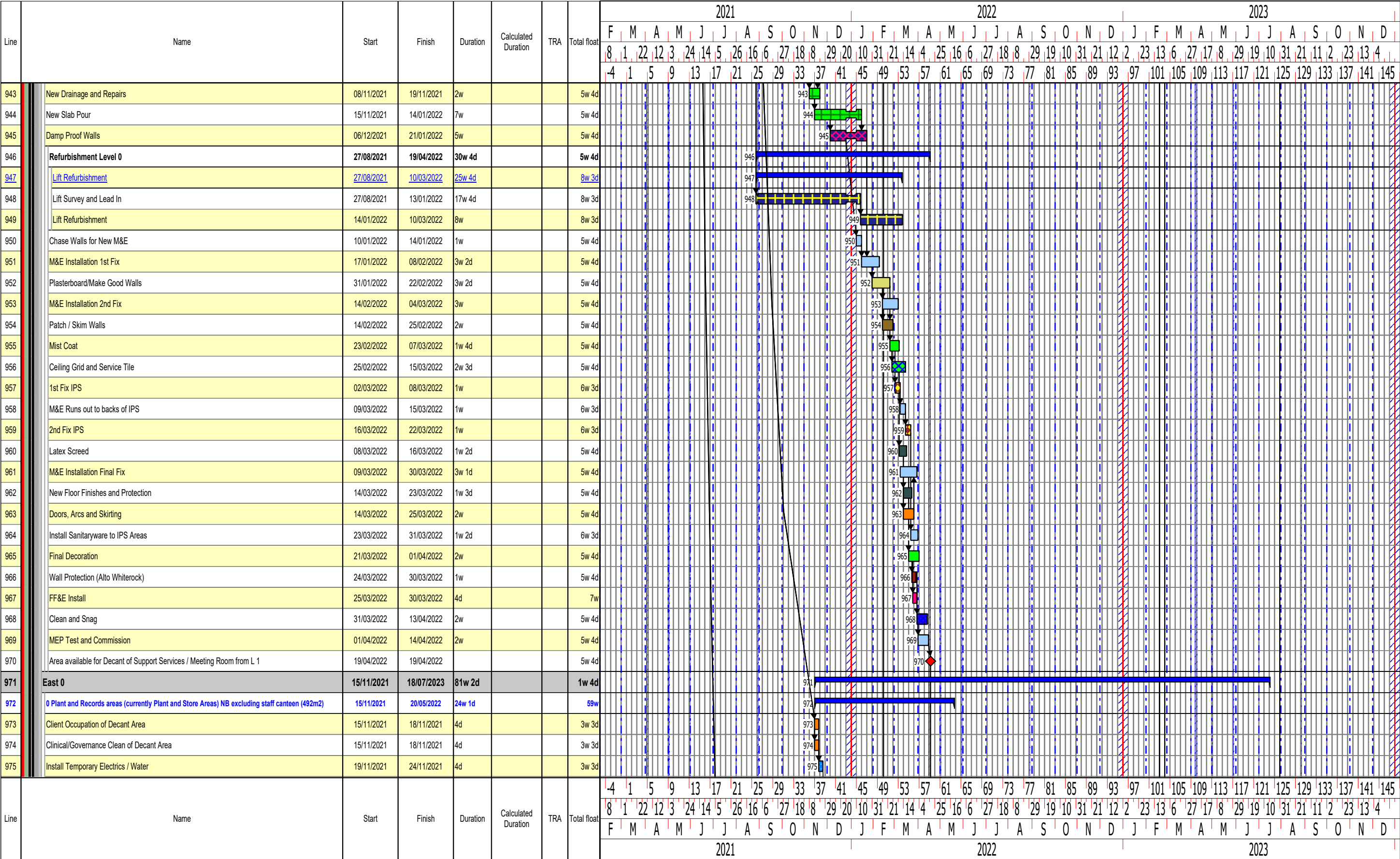
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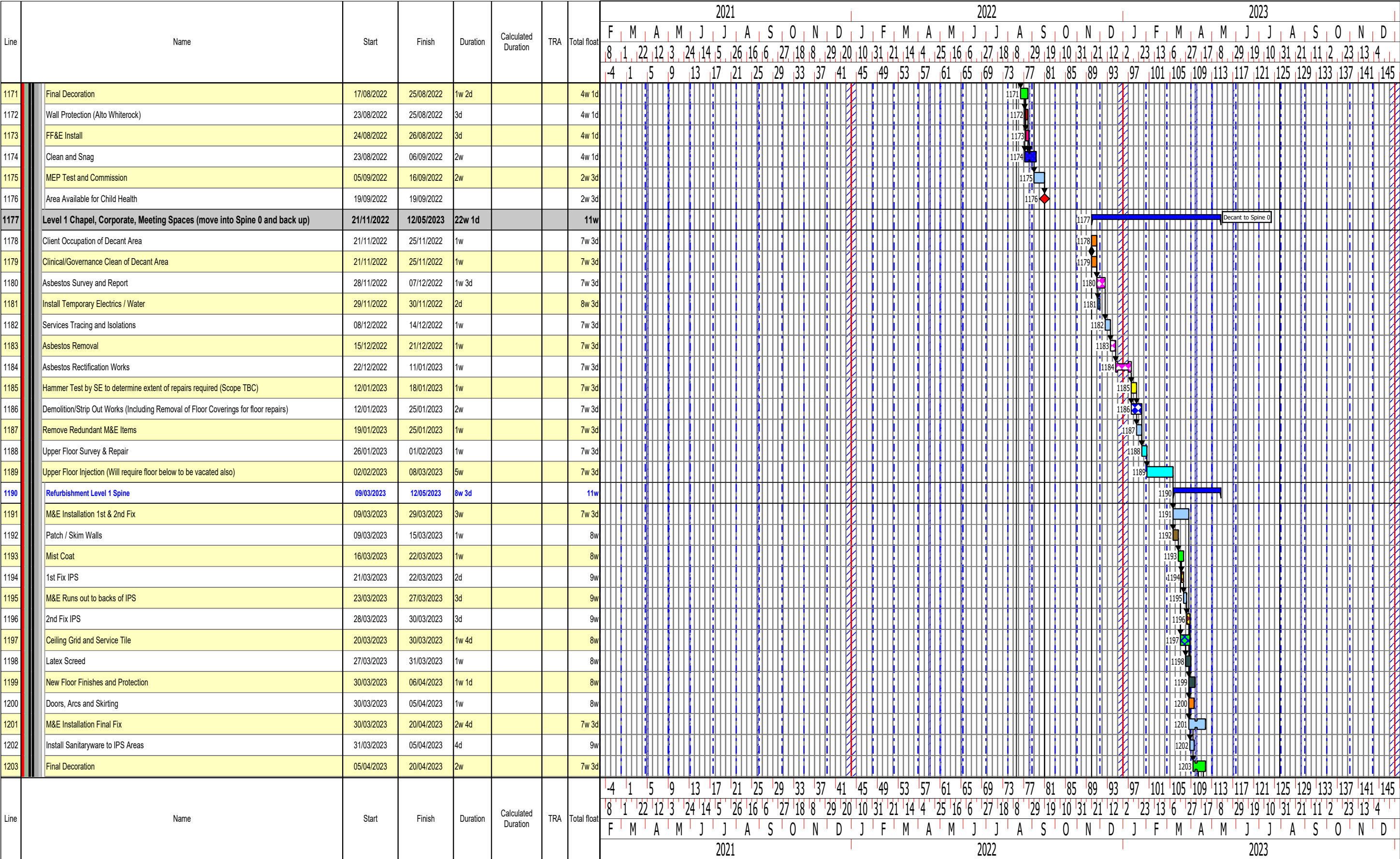




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# Risk Register : Legend

Likelihood	
Rare	1
Unlikely	2
Possible	3
Likely	4
Almost Certain	5

Impact	
Insignificant	1
Minor	2
Moderate	3
Major	4
Catastrophic	5

Score	
Low Risk	1-5
Medium Risk	6-14
High Risk	15-25

Risk Owner
Welsh Government
Health Board
Supply Chain Partner
Department
CPG

Risk Implications
Time
Cost
Quality
Operational

Risk Type
PDCR (Planning, Design & Construction Risk)
OR (Operational Risk)
ER (External Risks)

Ref	Risk Description	Current Score	Score at last meeting	Headline / Narrative
F1	Poor Quality or lack of existing as built information.	20	15	Impact increased - With the delays to Phase 1 impacting the start date of phase 2, the phase 2 duration has become increasingly compressed where any delay will likely be difficult to mitigate in order to achieve the April completion date.
F8	Phasing interface difficulties	16	16	Although the works to Paeds have commenced, the risk around phasing still remains. No reduction envisaged until further transfer of phases occurs and the phasing plans enacted.
F9	Hazardous activities (processes which cannot be avoided) in operational areas	15	15	Stayed the Same. Items such as the erection of hoarding in live areas.
F10	Client requested stoppages - Stop Notices.	16	12	Planning for phase 2 has revealed a number of penetrations through SCBU floor that are likely to face difficulties in continuous working given the level of noise associated. In addition, a number of penetrations are required for the phase 2 works.
F68	Construction programme over run	16	12	With the programme so close to completion for Phase 1, any issues during Commissioning would likely have a big impact on the completion of Phase 1 and following phases.
W6	Inability to recruit experienced nurses QIS	16	16	Risk remains Red as there are limitations to the tasks agency staff can perform. Also agency are not always able to requests. Interviews for outstanding posts scheduled for SuRNICC recruitment event 15th Dec.
PD13	Reduced capacity for surgical patients impacting on Surgical RTT	16	16	Risk remains Red due to issues with Surgical RTT, which Ops Management have escalated to surgery colleagues. JT has also emailed for latest position. 22nd Nov - JT progressing response from Surgery colleagues.
PD17	Poor control of high temperatures impacting patients, families and staff.	16	16	Fire Officer has agreed that doors can remain open for clinical access and observation when room is in use. Pharmacy have approved this, provided door is closed down when empty. Risk will be lowered once system agreed for holding door open. Heat recovery system won't be activated until November.

**BETSI CADWALADR UNIVERSITY HEALTH BOARD**  
**PROJECT: North Denbighshire Community Hospital**  
**Project Risk Register- Top Risks**

**For review at monthly Project Team and Project Board meetings.**

**Date: 05/08/2020**

[illegible]

Project Risk Register  
BETSI CADWALADR UNIVERSITY HEALTH BOARD  
PROJECT: North Denbighshire Community Hospital  
Project Risk Register- Design and Construction

Date reviewed: 01/09/2020  
Reviewed and Updated by: Gleeds PM  
Attendees at Risk Review : Clare Canty, Steve Teare,  
Liam Erwin and Hayley Dowrick

Low risk	1-5
Medium risk	6-14
High risk	15-25

£ 3,373,500

		Classification																			
Group Risk Number	Risk Description	Likelihood of Occurrence	Movement	Potential Impact	Risk Exposure Score	Score at last meeting	Owner	Risk Type	Risk Implications				Risk cost	Funding Implication	Risk Cost	Funding Implication	Risk Countermeasures	Action By	Risk Status	Comments 01/09/2020	
									Time	Cost	Quality	Operational									
2.001	There is a risk that client led design changes made after the planning application submission may require amendments to the application via material or non-material submissions.	2	MAINTAIN	3	6	6	BCUHB		√	√		√	£65,000				Ensure collaborative sign off of planning application prior to submission.				
2.002	Challenging programme - Health Board failure to sign off design	0	CLOSED	0	0	16	BCUHB		√	√		√					Structured engagement. BCUHB to ensure representation is appropriate and consistent. Escalation through contractual procedures if not			Risk reduced following feedback received from Ph 2 SI.	
2.003	<del>There is a risk that unexpected ground bearing conditions require an increase in the extent of foundations.</del>	0	CLOSED	0	0	0	SCP		√	√		√					SCP surveys to understand ground condition			Risk closed following submission of Work Stage 4 design.	
2.004	<del>Existing Building There is a risk that ventilation issues within the existing building impact operations and increase costs during construction.</del>	0	CLOSED	0	0	0	BCUHB		√			√								Wording amended.	
2.005	There is a risk that the thermal model for the New Build identifies that peak temperatures of the naturally ventilated rooms may be higher than desired for certain periods of the year within final design impacting time and cost	2	MAINTAIN	3	6	6	BCUHB			√	√	√	£9,600				Ensure thorough overheating report. If rooms fail then the design will consider assisted ventilation.				
2.006	<del>Existing Building - Defects in new fabric/elements contained in refurbished building after completion</del>	0	CLOSED	0	0	6	SCP		√	√	√	√									
2.007	There is a risk that the proposed design does not achieve sign off by the target price submission resulting in delays to the project programme whilst alternative options are developed.	1	MAINTAIN	3	3	3	BCUHB		√	√	√	√	incl								
2.008	Requirement for mock-ups/samples/scale models/3D imagery within project may increase costs not included in Kier FBC allowance.	2	MAINTAIN	2	4	4	BCUHB			√	√	√	£2,100				Scope to be developed within Works Information ahead of target price development				
2.009	There is a risk that BCUHB have rject the proposed materials resulting in delays to the project programme whilst alternatives are developed.	2	MAINTAIN	2	4	4	BCUHB		√	√	√	√	incl				Material sign off and quality inspection plans implemented.				
2.01	Lack of input from Principal Designer through initial design	0	CLOSED	0	0	4	SCP		√	√	√	√									
2.011	The existing drainage levels may not be adequate to accept the proposed drainage scheme.	0	CLOSED	0	0	12	BCUHB		√	√		√									
2.012	Existing Building- There is a risk that SCP fails to maintain services supplies during the refurbishment works which impacts on the business continuity.	3	MAINTAIN	3	9	9	SCP			√	√	√									
2.013	There is a risk that insufficient credits are achieved to obtain BREEAM excellent rating for the new build.	4	MAINTAIN	3	12	12	BCUHB			√	√	√	£97,500				Pre-Construction BREEAM tracker and early liaison with Assessor.				
2.014	Existing Building - No specific BREEAM rating identified by BCUHB for the refurbishment	0	CLOSED	0	0	12	BCUHB			√	√	√									
2.015	Existing Building - Can't reach WHTM guidelines due to constraints of existing structure / budget	0	CLOSED	0	0	12	BCUHB				√	√									
2.016	There is a risk that the recommendations outlined within the Environmental Impact Assessment increase the project cost and programme timescales.	2	MAINTAIN	3	6	6	BCUHB		√	√			£4,200				Early discussions with planners.				
2.017	There is a risk that Project Board decisions result in design changes that impact the project cost and programme.	3	MAINTAIN	3	9	9	BCUHB		√	√		√	£65,000								
2.018	There is a risk that the full planning permission is not granted resulting in delays to the project programme and increased costs.	2	MAINTAIN	3	6	6	SCP		√	√		√					Early discussions with planners.				
2.019	There is a risk that Building Control approval is not achieved resulting in delays to the project programme and increased costs.	2	MAINTAIN	2	4	4	SCP		√	√		√					Early discussions with BCO				
2.02	There is a risk that CDM regulations are breached by the employer resulting in delays to the project programme and potential health and safety issues.	2	MAINTAIN	2	4	4	BCUHB		√	√	√	√	£19,500				client adhere to duties under CDM.				
2.021	There is a risk that CDM regulations are breached by the contractor resulting in delays to the project programme and potential health and safety issues.	2	MAINTAIN	2	4	4	SCP		√	√	√	√					Principal designer to ensure team are clear of their duties under CDM.				
2.021	Failure of innovative design / construction systems	0	CLOSED	0	0	12	SCP		√	√	√	√									
2.022	There is a risk that if the decant phasing strategy is not agreed ahead of submission of Target Price, there may be additional costs not allowed for.	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	£32,500				Decant strategy in process of being developed				
2.023	There is a risk that works required by planners and consultees prejudice the affordability of the scheme.	3	MAINTAIN	3	9	9	BCUHB		√	√			£65,000				Communications with planners				
2.024	Building Control require works to project that prejudice affordability of the scheme	0	CLOSED	0	0	12	SCP		√	√											
2.025	Failure to achieve letter of comfort for OBC planned submission date	0	CLOSED	0	0	12	BCUHB		√	√											
2.026	Existing Building - There is a risk that Asbestos throughout building restricts the survey work, resulting in incomplete surveys, which could later lead to design changes and increased costs.	2	MAINTAIN	3	6	6	BCUHB		√	√			£14,550								
2.027	Existing Building - There is a risk that surveys undertaken miss problems or defects within the structure due to restricted access, which could lead to design changes and increased costs.	3	DECREASED	3	9	12	BCUHB		√	√			£720,000							Risk decreased as all key surveys have been undertaken, no notable areas denied access.	
2.028	Service specifications not being clearly defined impacting on progress of design	0	CLOSED	0	0	12	BCUHB		√	√											
2.029	Decanting impacts on service delivery	0	CLOSED	0	0	16	BCUHB		√	√											
2.03	There is a risk that service providers cannot provide adequate utility supplies/ capacities to the site which could impact on design solutions.	2	MAINTAIN	4	8	8	BCUHB		√	√			£42,000				Stats and early liaison with utility providers				
2.031	Existing building- There is a risk that conservation officer requirements and the subsequent impact to listed building application affects proposed development and impacts the project programme and cost.	3	MAINTAIN	3	9	9	BCUHB		√	√	√		£140,000								

2.032	There is a risk that residents adjacent to the RAH lodge objections against the proposed development due to concerns regarding disruption which may lead to programme delays.	3	MAINTAIN	3	9	9	BCUHB		√	√			£14,000				Regular engagement with stakeholders			
2.033	There is a risk that the project fails to fulfill the planning requirements within the FBC programme resulting in delays.	2	MAINTAIN	2	4	4	BCUHB		√	√			incl							
2.034	There is a risk that the scheme fails to provide adequate car parking spaces within the new design proposal impacting the operation of the site.	2	MAINTAIN	3	6	6	BCUHB		√	√		√	incl				SPG 21 DCC guidance to be used to advise the design			
2.035	There is a risk that the FBC programme is extended due to stakeholders being unable to accept design compromises.	2	MAINTAIN	3	6	6	BCUHB		√	√		√	incl							
2.036	Existing Building - There is a risk that incorporating elements of accessible design will not fall within the constraints of the existing building and budget.	4	MAINTAIN	3	12	12	BCUHB	2	√	√			£45,000				Inclusive design workshops being programmed and access strategy to be developed.			
2.037	<del>Wayleave disruption re-routing not acceptable</del>	0	CLOSED	0	0	12	BCUHB		√	√	√	√								
2.038	<del>not having a fully fire engineered solution at FBC could result in additional costs to achieve compliance</del>	0	CLOSED	0	0	8	SCP		√	√	√	√					Fire Engineer appointed			
2.039	Existing Building - additional costs of providing non standard sized doors to existing structural door openings	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.04	Existing Building - retained existing door openings not HTM compliant to non clinical areas	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.041	Existing Building - refurbishment ability internally is restricted by listed status	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.042	Existing Building - There is a risk that the phasing proposal impacts on existing fire evacuation policies resulting in costs incurred for the provision of additional temporary measures.	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	£30,000				Existing fire management plan to be reviewed againsts phasing			
2.043	Existing Building - refurbishment works will not change the ongoing maintenance responsibilities or resolve latent defects associated with the existing structure	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.044	Existing Building - Integrity of existing concrete floor structure	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.045	Existing Building - There is a risk that the existing building is unable to achieve framework sustainability guidance – 13.4 (EPC), 13.5 (baseline for carbon emissions), 13.6 (20% energy from renewables)	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	incl							
2.046	There is a risk that the SI notes contamination which required additional remedial works that impact the project programme and cost.	2	MAINTAIN	3	6	6	BCUHB		√	√	√	√	£9,750				Phase 2 GI to be undertaken and risk to be determined.			
2.047	Lack of clarity over medical gas requirements	0	CLOSED	0	0	3	BCUHB		√	√	√	√					Early user engagement			
2.048	Acoustic enclosures potentially required for generator	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.049	Existing Building - There is a risk that additional mechanical ventilation is required within existing building resulting in design changes and higher costs.	4	MAINTAIN	3	9	9	BCUHB		√	√	√	√	£181,800							
2.05	There is a risk that a lack of Estates engagement in M&E services strategy results in late design changes impacting programme and cost.	2	MAINTAIN	3	6	6	BCUHB		√	√	√	√	incl				Early liaison with OE and WSS			
2.051	There is a risk that late comments received on the fire strategy by BCUHB/WSS Fire Officer delay the design programme.	2	MAINTAIN	3	6	6	BCUHB		√	√	√	√	£18,000				LE confirmed that comments have been received and are in the process of being reviewed by Kier, any contradictions to be highlighted and responded to.			
2.052	Flue emission location – height of emissions	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.053	Existing Building - There is a risk that the condition of lead and lead support to existing lift shaft require additional works that impact project cost.	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	£75,000				Condition survey to be undertaken			
2.054	HB changes (A Pitcher) to fire assessment	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.055	Decant areas not available to suit phasing plan	0	CLOSED	0	0	9	BCUHB		√	√	√	√								
2.056	Stone/brick repairs not identified in Survey	0	CLOSED	0	0	8	BCUHB		√	√										
2.057	There is a risk that as the design does not fit within affordability amount and a value engineering exercise needs to be undertaken which results in late design changes impacting programme and cost.	5	MAINTAIN	4	20	20	BCUHB		√	√		√	incl				Monitor design in line with ongoing cost checks. VE exercises being progressed and will be presented by Kier.			
2.058	<del>New Building location changes</del>	0	CLOSED	0	0	12														
2.059	Scope creep completing instructed activities after OBC has been issued internally to BCUHB	0	CLOSED	0	0	4														
2.06	There is a risk that the Health Board fail to meet approval dates resulting in a delay to the project start date.	2	MAINTAIN	4	8	8	BCUHB	PD	√	√			incl							
2.061	There is a risk that on site works are delayed due to the construction noise, vibration and dust being beyond the limits stated within the Works Information.	3	MAINTAIN	3	9	9	SCP	SCP	√	√		√					Construction Phase/Management Plan to be developed and acceptable limits			
2.062	<del>Existing Building—There is a risk that a lack of communication results in bad publicity and press.</del>	0	CLOSED	0	0	0	BCUHB	PD/PM	√	√		√					Comms strategy			
2.063	There is a risk that business continuity is disrupted during construction works which impacts the operations of the current health services.	2	MAINTAIN	2	4	4	BCUHB	PM	√	√	√	√	incl							
2.064	There is a risk that the construction works are delayed due to 'stop / go' notices from clinicians which impacts programme duration.	3	MAINTAIN	2	6	6	BCUHB	PM	√	√		√	£30,000				Project Manager to manage communications between contractor and health board.			
2.065	There is a risk that the programme is delayed due to BCUHB causing site access issues for SCP.	3	MAINTAIN	3	9	9	BCUHB	PM/SCP	√	√		√	£30,000							
2.0651	There is a risk that the current medical services are disrupted due to SCP restricting access to site for users/patients.	3	MAINTAIN	3	9	9	SCP		√	√										
2.066	There is a risk that archaeological issues discovered delay the project programme and increase costs.	2	MAINTAIN	4	8	8	BCUHB	PM	√	√			£9,000							
2.067	Poor SCP co-ordination	0	CLOSED	0	0	6	SCP	SCP	√	√	√	√								
2.068	Poor SCP site supervision	0	CLOSED	0	0	10	SCP	SCP	√	√	√	√								
2.069	Fire caused by SCP prior to completion	0	CLOSED	0	0	9	SCP	SCP	√	√	√	√								
2.07	Existing Building - There is a risk that the engineering commissioning requirements are not fully communicated resulting in operational issues.	3	MAINTAIN	3	9	9	SCP	SCP	√	√		√					Soft Landings will be used on the project			
2.071	Phasing interface difficulties	0	CLOSED	0	0	12	SCP	SCP	√	√		√								
2.072	There is a risk that the SCP fails to deliver in line with Accepted FBC Programme resulting in time implications to the project.	3	MAINTAIN	4	12	12	SCP	SCP	√	√		√								
2.073	Safety related items - general (in relation to congestion, labour etc)	0	CLOSED	0	0	4	SCP/BCUHB	SCP/PM	√	√	√	√								
2.074	Adverse weather conditions that results in CE for time and cost	0	CLOSED	0	0	4	BCUHB	PM	√	√										Risk closed as pre-application consultation period has ended. It was noted that no
2.075	Adverse weather conditions that does not result in CE for time and cost	0	CLOSED	0	0	12	SCP	SCP	√	√										
2.076	Existing Building - Existing screed requires replacement	0	CLOSED	0	0	12	BCUHB	PM	√	√										
2.077	There is a risk that seagulls create environmental hazard during operational site.	4	MAINTAIN	2	8	8	SCP	SCP	√	√							Reduced as elements have been incorporated within the design to mitigate risk			
2.078	There is a risk that the preferred subcontractor go into insolvency resulting in delays to the project programme and cost.	3	MAINTAIN	4	12	12	SCP	SCP	√	√							Kier to carry out COVID-19 related risk assessments on all prospective sub-contractors.			

2.079	Existing building- There is a risk that M&E services are encountered that were not identified in the Works Information, resulting in disruption to existing hospital services and additional time and cost.	2	MAINTAIN	3	6	6	BCUHB	PM	√	√			£27,000				M&E survey undertaken			
2.08	<del>Security and protection of the SCP Site</del>	0	CLOSED	0	0	0	SCP	SCP	√	√							Security to be included in target price			
2.081	There is a risk that the availability of parking and traffic management issues during the works impacts the operations of the existing medical services.	4	MAINTAIN	3	12	12	BCUHB	PM	√	√			incl				Alterantive parking areas currently being discussed with third parties			
2.082	There is a risk that materials / consultant and contractor resources are not readily available which results in delays to the project programme.	4	MAINTAIN	3	12	12	SCP	SCP	√		√									
2.083	<del>Damage to building (within site) by persons unknown prior to handover</del>	0	CLOSED	0	0	9	SCP	SCP	√	√	√	√								
2.084	Exisiting Building - There is a risk that anthrax in existing lath and plaster impacts the project programme and cost.	3	MAINTAIN	3	9	9	SCP	SCP	√	√	√	√								
2.085	<del>Existing Building - screed breaking up as existing floor finishes beeing removed / repaired / replaced</del>	0	CLOSED	0	0	9	SCP/BCUHB	SCP/PM	√	√	√	√								
2.086	There is a risk that the repair / refurbishment "creeps" as a result of designed works carried out impacting on aesthetics of existing finishes relating to heritage items which leads to an increase in cost.	2	MAINTAIN	3	6	6	BCUHB	PM	√	√	√	√	£42,000				Scope for refurbishment to be signed off by BCUHB.			
2.087	<del>There is a risk that on-site traffic management issues impact the existing medical services and construction works.</del>	0	CLOSED	0	0	0	SCP	SCP	√	√		√					Traffic management plan to be developed and implemented			
2.088	<del>Existing Building - Condition of existing structure unknown at this point, work involved in connecting to existing structure could cause issues</del>	0	CLOSED	0	0	9	SCP	SCP	√	√	√	√								

2.089	There is a risk that adjacent residents are impacted by the demolition works which impacts public relations and attracts negative publicity.	4	MAINTAIN	2	8	8	BCUHB						£48,750				Phasing and methodology to be agreed in advance of demolition			
2.09	FBC delivery date missed	0	CLOSED	0	0	12	BCUHB	Strategic	√	√		√								
2.091	There is a risk that changes to health board policy have an external impact on the scheme resulting in design changes which increase project programme and cost.	2	MAINTAIN	3	6	6	BCUHB	Strategic	√	√		√	£27,000				Project Team awareness of changes and feed in to scheme where appropriate			
2.092	There is a risk that delays with WG decisions/approvals impact the project programme.	4	MAINTAIN	3	12	12	BCUHB	Strategic	√	√		√	£97,500				Continuing liaison with WG			
2.093	There is a risk that the Health Board change service requirements which increases the projects cost and duration.	2	MAINTAIN	3	6	6	BCUHB	Strategic	√	√	√	√	£19,500				BCUHB to define brief			
2.094	There is a risk that a lack of financial quantification of risk makes the scheme unaffordable.	2	DECREASED	4	8	12	BCUHB	CA/PM	√	√	√	√	incl				Risk Management process to include cost reviews.			Risk decreased as costed risk register has been developed.
2.095	There is a risk that problems with supply of specialist materials/ equipment delay the project programme.	3	MAINTAIN	3	9	9	SCP		√	√	√	√					Part of design philosophy			
2.096	Availability of key health board personnel during the user group process leads to a delay in making key decisions	0	CLOSED	0	0	9	BCUHB		√	√	√	√					appoint consistent Clinical and Management lead			
2.097	There is a risk that the equipment costs exceed equipment budget impacting on the project affordability.	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	incl				Equipment procurement/management process to be put in place			
2.098	Failure of end users to consistently attend design user group meetings to meet timescale of required Sign Off milestones	0	CLOSED	0	0	12	BCUHB		√	√	√	√								
2.099	There is a risk that damage to identified buried services due to construction traffic results in remedial works which impact the project programme.	2	MAINTAIN	4	8	8	SCP		√	√	√	√					Surveys executed			
2.1	There is a risk of damage to the junction with existing buildings and interface due to close proximity of demolition works which impacts the current operations of the site and increases costs due to remedial works.	3	MAINTAIN	3	9	9	SCP		√	√	√	√					Design process to mitigate, development of site plan and access strategy.			
2.101	Affordability constraints against developing design cause delay	0	CLOSED	0	0	12	BCUHB		√	√	√	√								
2.102	There is a risk that unidentified existing services may need diverting or relocating impacting the project programme and cost.	3	MAINTAIN	4	12	12	BCUHB		√	√	√	√	£120,000				Surveys and investigations to be carried out.			
2.103	There is a risk that changes in Legislation, Regulations and Standards prior to completion of the works result in abortive works impacting the project programme and cost.	2	MAINTAIN	3	6	6	BCUHB		√	√	√	√	£18,000							
2.104	Room data sheets have not been fully reviewed / signed off	0	CLOSED	0	0	12	BCUHB		√	√	√	√								
2.105	Restrictions of working in the existing hospital which are not currently defined	0	CLOSED	0	0	6	BCUHB		√	√	√	√								
2.106	There is a risk that the construction works result in an operational security risk to patients and contractor staff / workforce on site.	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	£19,500							
2.107	There is a risk that the construction works result in health and safety risks to patients and contractor staff / workforce on site.	3	MAINTAIN	2	6	6	BCUHB/SCP		√	√	√	√	£30,000							
2.108	There is a risk that surveys/construction works cause or exacerbate the risk of Aspergillus	3	MAINTAIN	3	9	9	SCP		√	√	√	√								
2.109	<del>Existing Building - There is a risk that a lack of as built information impacts on the design proposal and results in late design changes which impact project programme and cost.</del>	0	CLOSED	0	0	0	BCUHB		√	√	√	√					Internal surveys to be undertaken to develop information.			Closed as measured building survey undertaken and information gathered to mitigate.
2.11	<b>Existing Building</b> - Condition of existing services having an impact of performance of new equipment/installations	0	CLOSED	0	0	N/A	BCUHB													
2.111	There is a risk that underground obstructions, soft spots or structures not identified within the existing site information are discovered which impact the project programme and cost.	3	MAINTAIN	3	9	9	BCUHB						£65,000				SI to further inform risk.			
2.112	There is a risk that latent defects related to the existing building structures and services impact the project design, programme and cost.	4	MAINTAIN	4	16	16	BCUHB						£731,250				Structural and MEP condition surveys to be undertaken to inform.			
2.113	There is a risk that the proposed derogation items are not accepted by BCUHB resulting in delays to the project programme.	3	MAINTAIN	3	9	9	BCUHB						incl							
2.114	Presence of and dealing with existing ground contamination	0	CLOSED	0	0	N/A											Risk repeated			
2.115	There is a risk that the presence of/dealing with ACM's not identified within the existing site information cause delays to the project programme and increases	2	MAINTAIN	3	6	6							incl							
2.116	Existing Building - There is a risk that the poor condition of existing building elements has an impact on the scope of works which leads to unexpected design work resulting in extended programme and additional costs.	4	MAINTAIN	4	16	16	BCUHB		√	√	√	√	incl							
2.117	There is a risk that the availability of Health Board resources impact on the timescales for design sign off which results in delays to the programme.	3	MAINTAIN	4	12	12	BCUHB		√	√	√		incl							
2.118	There is a risk that the impact COVID19 jeopardises the timescales for achieving Key Dates in the FBC programme.	3	MAINTAIN	3	9	9	BCUHB		√	√		√	incl				The WS3 design will proceed on a generic basis and a number of assumptions will be identified prior to submission for sign off.	SCP / PM / Employer		
2.119	There is a risk that the availability of Health Board resources is limited due to restrictions caused by Covid-19, impacting the detail of the design.	3	MAINTAIN	3	9	9	BCUHB		√	√	√	√	incl				Kier will provide a list of assumptions in the design information that is submitted, this will be reviewed and communicated to BCUHB via Gleeds and the impacts discussed prior to acceptance of design information.			
2.12	<del>There is a risk that a complaint is received that invalidates the pre-application consultation resulting in programme delays.</del>	0	CLOSED	0	0	0	SCP		√	√		√					Welsh Gov guidance is being followed and information being issued to directly adjacent neighbours.			
2.121	<del>Existing Building - Surveys undertaken miss problems or defects within the structure due to lack of reasonable skill and care.</del>	0	CLOSED	0	0	6	SCP		√	√										
2.122	There is a risk that SCP enters insolvency which impacts on the project programme.	2	MAINTAIN	4	8	8	SCP		√	√										
2.123	There is a risk that SCP turnover of key staff impacts the continuity of the FBC submission.	2	MAINTAIN	3	6	6	SCP		√	√	√									
2.124	There is a risk that the existing services design impacts the phasing of the refurbishment.	3	DECREASED	3	9	12	SCP		√	√		√					Kier phasing proposal to consider existing services based on survey information gathered.			Risk decreased as agreed that this will be primarily driven by decant.
2.125	There is a risk that the Impact of COVID-19 effects the programme cost and supply chain during construction.	3	MAINTAIN	3	9	9			√	√	√	√	£0							COVID 19 additional costs would be recovered from the Welsh Government in accordance with SESN and the Procedure
2.126	There is a risk that the Value Engineering options presented by the Design Team are not accepted by BCUHB/ Shared Services and as such project remains unaffordable.		MAINTAIN		0	0			√	√	√	√	incl							

[illegible]

Project Risk Register

BETSI CADWALADR UNIVERSITY HEALTH BOARD

PROJECT: North Denbighshire Community Hospital

Project Risk Register- SCP Risks

Date reviewed:

Reviewed and Updated by:

Attendees at Risk Review :

Date reviewed:

Reviewed and Updated by:

Attendees at Risk Review :

Low risk	1-5
Medium risk	6-14
High risk	15-25

£2,124,447.38

Group Risk Number	Risk Description	Classification				Score at last meeting	Owner	Risk Type	Risk Implications				Risk cost	Funding Implication	Risk Countermeasures	Action By	Risk Status	Comments
		Likelihood of Occurrence	Movement	Potential Impact	Risk Exposure Score				Time	Cost	Quality	Operational						
7.001	Financial stability of supply chain may be compromised due to impact of Covid 19, and will not be apparent via D&B checks. Failure of supply chain will impact on programme.	3		3	9		Mark Welsh	Delivery					£74,796.17		Whilst project is still in tender stage ensure that communications are maintained with supply chain to gain understanding of the impact Covid 19 has had on business. Request quotation for performance bond and include cost in main tender for each works package			Include risk allowance
7.002	Main contract could to be in two - three sections. Therefore, any delay on the new build could impact on the refurb.	4		2	8		James Waddington	Delivery					Included		Qualify that bid offer is based on no sectional completions being included. To avoid delay being carried across, break link with supply chain by placing separate orders with supply chain who will work on both sections - one for new build and one for refurb. Additional surveyor in resources for procurement			Include on Assumptions, Exclusions and Derogations list
7.003	Due to exposed location of site the project could suffer form inclement weather which, whilst normal for the area, is abnormal for a standard project	3		3	9		Martin Walsh	Delivery					See item 41		Choose materials for envelope which are less prone to impact of weather; avoid reliance on cranes; build in float for weather in programme specific for North Wales coast.			Include risk allowance
7.004	The procurement strategy is based on single source MEP with Dodd Group. There is a risk that Dodd's will become aware of issues due to design development, and will need to adjust price or programme after Kier have submitted offer	3		3	9		James Waddington	Delivery					£216,340.30		Ensure Dodd's are kept up to date and informed of all latest developments on design to capture as much in price as possible			Include risk allowance
7.005	Failure to achieve the required level of community benefit will result in damages being deducted	2		2	4		James Waddington	Delivery					Included		Include requirement within supply chain tenders and also include damages to enable recovery. Step down in subcontract			Include risk allowance
7.006	Failure to get clause 26.3 approval for use of subcontractor due to subcontract conditions	2		2	4		James Waddington	Delivery					Included		Ensure that the form of subcontract is reflective of main contract. Kier Legal to develop subcontract.			Include risk allowance
7.007	New clause 61.8 attempts to remove the standard period in the contract for advising that a PMI will / has give rise to a compensation event. There is a requirement to advise PM before commencing works under PMI. Risk of debate over payment	3		1	3		James Waddington	Delivery					Included		Ensure we advise PM if we consider any PMI gives rise to a compensation event if the PM has not done so already, prior to commencing works. Ensure that this is stepped down in subcontract.			Include risk allowance
7.008	Kier will not be granted access to the existing building in one go - access will be phased with the remaining building still being occupied with patients using the facility. H&S risk, impact on hospital functions etc. if things go wrong	4		3	12		Kevin Hoare	Delivery					Included		Agree phasing with client. Include cost of temporary works and services required to maintain functional building for client, safe access, fire escapes / alarms etc.			Include risk allowance
7.009	During asbestos removal, asbestos may escape into occupied areas of the building	2		4	8		Kevin Hoare	Delivery					Included		Ensure methodology fully approved, and that all areas are sealed off as required			Include risk allowance
7.01	RAH - Phasing works within the building need to be agreed to confirm the release of design in a phase manner	4		2	8		Clare Canty						Included		Agree with client and include within Works Information in Date Part 2			Include risk allowance
7.011	RAH -Conservation Officer and level of influence - to be carefully managed with the HB	3		2	6		Clare Canty						£82,297.97		Engage in early dialogue and maintain through contract. Agree required scope in offer. Kept client informed on cost			Include risk allowance
7.012	The pipework from the sprinkler tanks to the riser in the building passes under the GF slab. If not procured early this will require breaking out for installation. Ditto with lightning protection tapes	4		2	8		James Waddington	Delivery					Included		Ensure there is an early order in place with Dodd's or divert pipe in design and / or allow for diversion of cost in cost plan			Include risk allowance
7.013	There is a risk of subcontractors renegeing on quotations due to the time period between quotation and works on site.	3		2	6		Mark Welsh	Tender					£79,741.35		Allow a risk provision for potential additional costs of alternative subcontractors			Include risk allowance
7.014	Increased market volatility beyond the norm due to C19 and Brexit.	3		2	6		Kevin Hoare	Tender					£49,168.25		Allow a risk provision for alternative subcontractors, or revised prices			Include risk allowance
7.015	There is a risk that further enhancements may be required to specifications in relation to the marine environment which have not yet been identified	3		2	6		Mark Welsh	Tender					£24,584.13		Team to review quotations prior to bid submission; review quotations prior to procurement to ensure what is included in bid is, in theory, correct			Include risk allowance
7.016	Potential damage to fire protection should we proceed with fire protection applied off site. Impact upon cost and possible programme.	3		2	6		Mark Welsh	Delivery					Included		Include risk allowance.			Include risk allowance
7.017	Downturn in subcontractor credit rating between tender period and start on site.	2		2	4		Neil Carson	Delivery					Included		Undertake credit review at tender stage and offer caution to any poor performing or declining subcontractors. Don't necessarily always use the cheapest subcontractor.			Include risk allowance



7.018	There is a risk that subcontract works will not be picked up within pricing documents due to level of design information and therefore there will be no allowance in price	4		2	8		Kevin Hoare	Delivery						£74,796.17		Do standard checks to mitigate risk; price residual risk			Include risk allowance
7.019	There is a risk that there will be damage caused to completed finishes during the completion stage of the contract including door, dry lining, suspended ceilings and decorations	4		2	8		Kevin Hoare	Delivery						£149,592.34		Include the standard protection measures to mitigate risk; price residual risk			Include risk allowance
7.02	There is a risk that due to unforeseen reasons, the planned completion date will not be met and additional prelim costs will be incurred.	2		4	8		Kevin Hoare	Delivery						£554,737.84		Include allowance in risk provisions for delay costs which would arise which are without means of recovery			Include risk allowance
7.021	There is a risk that one or more main subcontractors will go into administration, and whilst bonds will be procured, these will not cover all the additional cost due to likely additional works costs	2		4	8		Kevin Hoare	Delivery						£74,796.17		Ensure performance bonds are taken for all key			Include risk allowance
7.022	There is a risk that the quantities in the BofQ's may be low	2		2	4		Kevin Hoare	Delivery						£59,836.94		Undertake required BofQ checks; price residual risk			Include risk allowance
7.023	There is a risk that the inflation increase driven by PUBSEC will not cover cost incurred by Kier	3		2	6		Kevin Hoare	Delivery						£93,133.63		If possible procure subcontract packages on the same basis as main contract			Include risk allowance
7.024	Secondary steelwork for employers type 2 equipment not detailed	3		1	3		Kevin Hoare	Delivery						£9,833.65		If possible try to identify requirements			Include risk allowance
7.025	Goal post type arrangement required to heavy doors and screens in partitions	3		1	3		Kevin Hoare	Delivery						£9,833.65		If possible try to identify requirements			Include risk allowance
7.026	Temporary fire doors required to new building during construction	4		2	8		Kevin Hoare	Delivery						£5,900.19		Develop temporary fire strategy			Include risk allowance
7.027	Unforeseen scaffold adaptions and additional hire	4		2	8		Kevin Hoare	Delivery						£24,584.13		Ensure scaffold schedule as complete as possible			Include risk allowance
7.028	Treatment of surface of slab may be required prior to screed to remove laitance	3		3	9		Kevin Hoare	Delivery						£31,467.68		Try to procure risk in works package			Include risk allowance
7.029	Weekend working required to complete works to corridors and staircases in new build	4		1	4		Kevin Hoare	Delivery						£15,104.49		Try to procure risk in works package			Include risk allowance
7.03	Valve and zoning strategy issues on existing building to maintain services during replacement	4		2	8		Kevin Hoare	Delivery						£17,700.57		Procure from Dodd's			Include risk allowance
7.031	Cost of clashes in design	4		1	4		Kevin Hoare	Delivery						£4,916.83		Identify from clash detection on model			Include risk allowance
7.032	Unforeseen bulkheads required	3		1	3		Kevin Hoare	Delivery						£12,292.06		Identify at Stage 5 and procure			Include risk allowance
7.033	Unforeseen pipe boxings required	3		1	3		Kevin Hoare	Delivery						£8,850.29		Identify at Stage 5 and procure			Include risk allowance
7.034	Rebar kg / m3 may be light	2		1	2		Kevin Hoare	Delivery						£9,833.65		Procure based on schedules			Include risk allowance
7.035	Foundation and drainage co-ordination issues	3		1	3		Kevin Hoare	Delivery						£9,833.65		Identify at Stage 5 and procure			Include risk allowance
7.036	Plant bases, upstands, plinths and bunds not detailed; allowance may be low	4		2	8		Kevin Hoare	Delivery						£9,833.65		Dodd's to identify on Stage 5 design			Include risk allowance
7.037	Cast in items not detailed	2		2	4		Kevin Hoare	Delivery						£4,916.83		Subcontractors to identify on package design drawings at Stage 5			Include risk allowance
7.038	Tolerance interface issues during construction	3		1	3		Kevin Hoare	Delivery						£9,833.65					Include risk allowance
7.039	Dog kennel' roofing details may be required to services penetrating roof not currently detailed.	3		1	3		Kevin Hoare	Delivery						£4,916.83		Procure in roofing package when Dodd's have completed Stage 5			Include risk allowance
7.04	Roofing / waterproofing details around plant upstands, handrails and such like not detailed	4		1	4		Kevin Hoare	Delivery						£4,916.83		Procure in roofing package when Dodd's have completed Stage 5			Include risk allowance
7.041	Steelwork to roller shutters not detailed	4		1	4		Kevin Hoare	Delivery						£2,950.10		Procure with roller shutter door package			Include risk allowance
7.042	Cutting floor finishes around services / floor boxes etc.	3		1	3		Kevin Hoare	Delivery						£1,966.73		Procure in flooring package once Dodd's have completed Stage 5 design			Include risk allowance
7.043	Repair damage to lift caused during beneficial use	4		1	4		Kevin Hoare	Delivery						£9,833.65		Use protection to minimise damage			Include risk allowance
7.044	Additional hire on edge protection provided by steelwork subcontractor	3		1	3		Kevin Hoare	Delivery						£4,916.83		Identify periods in order; co=ordinate with other trades			Include risk allowance
7.045	Additional consultant fees expended due to additional services being required which are unforeseen	3		1	3		Kevin Hoare	Delivery						£98,903.71		Ensure appointments are complete to minimise risk			Include risk allowance
7.046	Samples will be required of materials and fixtures to assist employer with selection	3		1	3		Kevin Hoare	Delivery						£4,916.83		Agree list with Employer			Include risk allowance
7.047	Additional works required to obtain statutory approvals from fire officer, building regs etc. not envisaged at Stage 3 & 4	3		2	6		Kevin Hoare	Delivery						£159,482.71		Submit for review early to establish if any works are required.			Include risk allowance
7.048	Interface issues between partition, ceilings and MEP works resulting in additional costs / weekend working	3		2	6		Kevin Hoare	Delivery						£73,752.38		Ensure works packages are procured back to back. Clarify interfaces with each trade			Include risk allowance
7.049	Temporary propping / shoring may be required at the junction between Glan Traeth and Hafod buildings	2		1	2		Kevin Hoare	Delivery						£19,667.30		Opening up required to establish if needed in advance of demolition			Include risk allowance
7.05	In order to mitigate programme risk it may be necessary to upgrade plasterboards to moisture resistant grade in corridors to p	3		1	3		Kevin Hoare	Delivery						£14,750.48		Procure in dry lining package			Include risk allowance
7.051	Additional pattressing will be required over and above that included in price	3		1	3		Kevin Hoare	Delivery						£4,916.83		Complete Stage 5 and procure in dry lining package			Include risk allowance

Project Risk Register  
BETSI CADWALADR UNIVERSITY HEALTH BOARD  
PROJECT: North Denbighshire Community Hospital  
Project Risk Register- Service Model and Affordability

Date reviewed: 03/09/2020  
Reviewed and Updated by: Steph O'Donnell, Gareth  
Attendees at Risk Review : by email

Date reviewed: 03/09/2020

Reviewed and Updated by: Steph O'Donnell, Gareth

Attendees at Risk Review : by email

Low risk	1-5
Medium risk	6-14
High risk	15-25

Group Risk Number	Risk Description	Classification				Score at last meeting	Owner	Risk Type	Risk Implications				Risk Cost	Funding Implication	Risk Countermeasures	Action By	Risk Status	Comments
		Likelihood of Occurrence	Movement	Potential Impact	Risk Exposure Score				Time	Cost	Quality	Operational						

3																		
3.001	There is a risk that external impact on scheme from inflation will affect financial modelling	4	Maintain	2	8	8	BCUHB	ER	√	√		√			Nigel McCann has re-defined the cost model with salary uplift. Residual risk remains until case approved.	Nigel McCann	open	Countermeasure in place. Ongoing monitor. Total Capital Cost will impact on some elements
3.002	There is a risk of external impact on scheme due to changes in BCUHB and/or NHS policies & guidance	3	Maintain	3	9	9	BCUHB	OR	√	√		√			Project Team awareness of changes and feed in to scheme where appropriate	Senior Users	open	
3.003	There is a risk that case may not be accepted if benefits unclear and/or not viable.	2	Maintain	4	8	8	BCUHB	ER	√	√	√	√			Continuous review of key success criteria to ensure benefits are monitored and met	Gareth Evans	open	
3.004	There is a risk that Health Board changing service requirements may jeopardise strategic and financial case and the achievement of the integrated services model	1	decrease	3	3	6	BCUHB	OR	√	√	√	√			Service specifications to be approved and handed over to SCP 17/02/2020. Change Control Process in place within BCU user team. Ongoing monitor/RFCs and formal governance process	Steph O'Donnell	open	Design stage now closed Workforce model and plan confirmed and agreed
3.005	There is a risk that changes to catchment population may affect service model/capacity/demand	1	Maintain	3	3	3	BCUHB	ER	√	√	√	√			Ongoing monitoring interrogation of service user data, population & demographic trend analysis. services scaled to meet forecast demand which can be forecast over the next 20 years, based on ONS statistics.	Steph O'Donnell	open	Impact of COVID-19 on demographics to be considered
3.006	There is a risk that changes to agreed model of care post business case approval may jeopardise financial case	2	Maintain	4	8	8	BCUHB	OR	√	√	√	√			Each change has to be supported by RFC setting out business case	Steph O'Donnell	open	
3.007	There is a risk of changes in service demand over the lifetime of the project - affecting affordability	3	Maintain	3	9	9	BCUHB	ER	√	√	√	√			Ongoing monitoring	Senior Users	open	Similar to 3.005 - change in population leads to change in demand for services however forecasting data has been utilised to predict demand
3.008	There is a risk that changing capital cost of scheme will have an impact on affordability of the case	4	Maintain	3	12	12	BCUHB	PDCR	√	√	√	√			Financial case will need to be fine tuned when capital total costs confirmed. There will be small window to consider this impact. Will need to have key people on hand to review.	Nigel McCann/ Gareth Evans	open	SO'D has flagged timing issues to key Board members.
3.009	There is a risk of failure to achieve anticipated VAT recovery	3	Maintain	3	9	9	BCUHB	ER	√	√	√	√			VAT reclaim process in place	Nigel McCann	open	
3.01	There is a risk that cash releasing benefits are of lower value than operational revenue cost for scheme, so case not affordable - the funding/budget available to meet the projected costs gives a shortfall.	4	decrease	4	16	20	BCUHB	OR							With no defined savings plans to meet the shortfall, the scheme would fail the affordability test. 2nd. Revision of affordability options issued to this group early Feb. Meeting scheduled 28/2 to review	Gareth Evans/ Nigel McCann	open	Papers and meeting with execs to determine how to manage the £1.2 m revenue affordability gap held on 21st August 2020
3.011	There is a risk that depreciation and impairment costs may not be funded	3	Maintain	3	9	9	BCUHB	ER							In addition to the above we'd be looking to WG to fund depreciation and impairment costs. If they don't there is a risk.	Nigel McCann	open	
3.012	General inflation underestimated - IS THIS THE SAME AS 3.001	1		3	3	6	BCUHB/ SCP	PDCR	√	√	√	√			Continue monitoring	Nigel McCann	Closed	
3.013	There is a risk that costs exceed affordability due to increase in scope	2	Maintain	5	10	10	BCUHB	PDCR	√	√	√	√			Scope management and RFC process	Gareth Evans	open	Reduced Likelihood as cap on scope through DUG process
3.014	There is a risk that assessment of maintenance costs is inadequate	2	Maintain	3	6	6	BCUHB	PDCR	√	√	√	√			Continue monitoring	Nigel McCann	open	Under affordability review consideration given to Years 1 -5 maintenance of new build
3.015	Benchmarking exercise is now 2 years old and potentially out of date.	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	Undertake an updated benchmarking exercise.	TBC	Closed	closed following review of costs for inflationary uplift
3.016	There is a risk against Cash Releasing Benefits as CRES may claim these monies before build complete	4	Maintain	4	16	16	BCUHB	OR	√	√	√	√			When Options for CRB approved will continue monitoring against CRES	Nigel McCann	open	Factored some CRES (e.g.. Bed closures offsite) into latest iteration of Affordability case. However, there may be more challenge to come.
3.017	There is a risk that unknown cost linked to potential decanting, transitional costs, car parking charges and the impact of patient transport costs will affect affordability	3	Maintain	3	9	9	BCUHB	PDCR	√	√	√	√			To be determined through FBC design and impact assessed	Nigel McCann	open	

Project Risk Register  
BETSI CADWALADR UNIVERSITY HEALTH BOARD  
PROJECT: North Denbighshire Community Hospital  
Project Risk Register- Decant and Operational Commissioning

Date reviewed: 04/09/2020  
Reviewed and Updated by: Janet Michell  
Attendees at Risk Review : Janet Michell

		Classification																
Group Risk Number	Risk Description	Likelihood of Occuranc e	Movement	Potential Impact	Risk Exposure Score	Score at last meeting	Owner	Risk Type	Risk Implications				Risk Cost	Funding Implication	Risk Countermeasures	Action By	Risk Status	Comments
									Time	Cost	Quality	Operational						
4																		
4.001	There is a risk that the decant strategy / plan is not developed in enough time to implement the process.	3	Maintain	3	9	9	BCUHB	PDCR	√		√	√		decant costs not identified in sufficient time to inform the FBC and therefore be funded	Ongoing works lead by programme manager to formalise plan and strategy.	APM/Gleeds	open	01 Sept it was confirmed that the floor by floor decant strategy was not feasible due to issues that have been identified with the floor slabs which will require access from above and below hence floor by floor decant is not feasible
4.002	There is a risk that the operational policies are not developed.	3	Maintain	3	9	9	BCUHB	OR	√		√	√			Identify lead person to produce and formalise the operational procedures.	APM	open	operational policies required need to be clearly identified
4.003	There is a risk that there is a lack of coordination with the departments that are moving and the process that they will follow when being moved into temporary/permanent accommodation.	2	Maintain	3	6	6	BCUHB	OR			√	√			Formalise a plan and a handover procedure. Have decant workstream sign-off and oversight through regular reporting and meetings.	APM	open	
4.004	There is a risk that the operational commissioning team is not set up and we have not agreed a process for operational commissioning, resulting in a lack of handover understanding.	2	Maintain	3	6	6	BCUHB	OR			√	√			Central Area Team to put lead forward and support this piece of work.	SO'D	open	decreased as engagement with HMT and Teams is established and advance planning will mitigate risk
4.006	There is a risk that there will be a lack of clinical cleans prior to decanting departments into other areas as temporary accommodation.	2	Maintain	3	6	6	BCUHB	OR			√	√			create and share decant plan with facilities and schedule cleans in advance in a formal plan so resource can be secured	APM	open	decreased as engagement with facilities is established and advance planning will mitigate risk
4.007	There is a risk that there is no strategy/list of equipment and the placement of such equipment	2	Maintain	2	4	4	BCUHB	PDCR	√		√	√		new equipment for new departments in project scope may not be funded	Equipment procurement/management process being developed to offset this risk. Interim PM to continue this workstream and pick up equipment requirements.	APM	open	decreased as lists have been compiled however clarification is required on what equipment is in scope of the project and subsequent management of expectations and clear instruction to departments
4.008	There is a risk that there is no list of kit for all departments.	2	Maintain	3	6	6	BCUHB	PDCR		√	√	√		new kit for new departments in project scope may not be funded	Equipment procurement/management process being developed to offset this risk. Interim PM to continue this workstream and pick up equipment requirements.	APM	open	decreased as lists have been compiled however clarification is required on what kit is in scope of the project and subsequent management of expectations and clear instruction to departments
4.009	There is a risk that there is no resources for undertaking equipment management/lists	1	Maintain	3	3	3	BCUHB	OR	√		√	√			Equipment procurement/management process being developed to offset this risk. Interim PM to continue this workstream and pick up equipment requirements.	APM	open	lists have been compiled however clarification is required on what equipment is in scope of the project and subsequent management of expectations and clear instruction to departments
4.01	There is a risk that the purchase of new equipment is not undertaken to achieve project deadlines	2	decrease	3	6	9	BCUHB	PDCR	√		√	√			Equipment procurement/management process being developed to offset this risk. Interim PM to continue this workstream and pick up equipment requirements.	APM	open	decreased as procurement have been engaged for costing equipment lists and are alerted for a workstream to plan in and manage procurement to project deadlines
4.011	There is a risk that IT requirements are not fully identified by BCUHB - final scheme higher cost than TC allowance	2	decrease	3	6	9	BCUHB	PDCR	√	√	√	√		new equipment for new departments in project scope may not be funded	Equipment procurement/management process being developed to offset this risk. Interim PM to continue this workstream and pick up equipment requirements.	APM	open	decreased as engagement and requirements for IT have been discussed and costed by IT for both IT kit and data and comms links and costings submitted for FBC
4.012	There is a risk that there is insufficient BCUHB staff resource recruited for additional services and for handover and operational commissioning period	3	decrease	3	9	12	BCUHB	OR	√	√	√	√		additional workforce for new departments in project scope may not be funded	Workforce identified and costed for within FBC. Workforce workstream led by HR/Workforce to recruit, induct and train additional staff. Operational Commissioning team resource can be secured from current staff for transferring departments with enough time and planning, with support from Gareth and Neil.	APM	open	decreased as workforce model for additional services has now been agreed for FBC
4.013	There is a risk that there will be no input from a Fire Officer	2	Maintain	3	6	6	BCUHB	PDCR	√		√	√			BCUHB to keep pressure on Kier and Gleeds regarding engagement with Fire Officer.	PM	closed	closed as Phil Wilding is engaged and participating in meetings
4.014	There is a risk that the Corona Virus outbreak leaves BCUHB staff who are required to input the service model incapacitated and the updates are delayed.	1	Maintain	4	4	4	BCUHB	OR	√	√	√	√			Maintain contact with the team and ensure self isolation is utilised to reduce staff off with illness and allow people to work from home.	APM	open	decrease as countermeasure effective and likelihood has reduced

**Project Risk Register**  
BETSI CADWALADR UNIVERSITY HEALTH BOARD  
PROJECT: North Denbighshire Community Hospital  
Project Risk Register - Communications & Engagement

Date reviewed: 03/09/2020

Reviewed and Updated by: Area PM (JM)

Attendees at Risk Review : Megan Vickery & Janet Michell

Low risk	1-5
Medium risk	6-14
High risk	15-25

Group Risk Number	Risk Description	Classification					Owner	Risk Type	Risk Implications				Risk Cost	Funding Implication	Indicator	Risk Countermeasures	Action By	Risk Status	Comments
		Likelihood of Occurance	Movement	Potential Impact	Risk Exposure Score	Score at last meeting			Time	Cost	Quality	Operational							
5																			
5.01	There is a risk that Staff involvement/engagement is not delivered in a timely and effective manner and staff are then unaware of the scheme, feel excluded and do not provide their support.	2	Maintain	2	4	4	BCUHB	OR	√		√	√			Staff reporting that they are not briefed.	Engage with Listening Leads Meetings and follow up with staff feedback forms. Internal email to be circulated with links to draft planning information, fly through, elevation visuals and feedback survey.	Engagement Workstream	Open	August 2020 HMT meeting reported positive response from staff following issue of newsletter and update at July 2020 HMT by S'O'D.
5.02	There is a risk that planned Engagement activity will not be adequately supported by HMT and the Health Board	2	Maintain	2	4	4	BCUHB	OR			√	√			Documents/Stationary applicable to support the consultations. Time Commitment lacking from senior staff who need to be present.	1. Development Messages should be copied to Staff Newsletters. 2. Planned Engagement to allow Execs time to support.	Engagement Workstream	Open	
5.03	There is a risk of insufficient enagement and subsequent lack of feedback from public and external stakeholders, leading to uncertainty on the detail of the new project.	2	Maintain	3	6	6	Engagement Team	ER			√	√			Public complaints relating to information availaibility etc.	Engagement Plan and Milestone based Delivery Schedule approved.	Engagement Workstream	Open	
5.04	There is a risk that the community will not be informed and would feel excluded and not support the project as Community Dental Services from Abergele and Prestatyn are being relocated to the RAH and no consultation has been undertaken within Abergele and Prestatyn to make the community aware.	2	Maintain	2	4	4	Engagement Team	ER			√	√			public complaints relating to information availaibility etc.	Liaison with CHC to confirm requirements and process to follow	Engagement Workstream	Open	Confirmed by CHC in July 2020 that no consultation required for Prestatyn as this was covered by Healthcare is changing in Wales in 2012. CHC currently reviewing requirement for consultation on Abergele - initial feedback on August 2020 is that this would not be required. Final confirmation due imminently (Sept 2020)
5.05	There is a risk that there has been no engagement with the services that are leaving the RAH and these departments need to be aware of where they are moving to.	2	Maintain	3	6	6	BCUHB	OR			√	√			Staff reporting that they are not briefed, no workforce plan that shows where they are moving to.	HR & departmental management to engage and give notice of change	HR	Open	
5.06	There is a risk that there has been no engagement with the services that are moving into the RAH and these departments are unaware of the new facility, their relocation etc	2	Maintain	2	4	4	BCUHB	OR	√		√	√			Staff reporting that they are not briefed, no workforce plan that shows where they are moving to.	HR & departmental management to engage and give notice of change	HR	Open	
5.07	There is a risk that the lack of engagement with the Historic Society will result in their objections to the refurbishment of the existing RAH and they will want input into the redesign.	2	Maintain	3	6	6	Engagement Team	ER			√	√			Historic Society reporting that there has been a lack of engagement and no information available	invite to relevant DUG update as a stakeholder on specific items	Engagement Workstream	Open	Conservation Officer and CADWR currently involved and providing oversight and sign off relevant repair methods and materials proposed to be used
5.08	There is a risk that there has been a lack of Enagement with the Third Sector and they are unaware there will be new facilities for them to use.	2	Maintain	2	4	4	Engagement Team	ER			√	√			Third Sector reporting that there has been a lack of engagement and no information available	invite to relevant DUG update as a stakeholder on specific items	Engagement Workstream & Kier	Open	RNIB; Alzheimers Society etc to be invited to contribute to DUGs Café concession to be advertised at appropriate time following FBC sign off
5.09	There is a risk that the proposed pre-planning application leaflet drop area does not capture all local stakeholders causing residents to feel uninformed and unsupportive of the scheme.	3	Maintain	3	6	6	KIER	PDCR				√			Residents reporting that they are unaware of project developments.	issue survey and prompt for resident feedback	Engagement Workstream	CLOSED	
5.10	Risk that the online mechanisms of the pre-planning consultation exclude or discourage input from local residents who are unable to access the internet resulting in inadequate levels of feedback during the 28-day period.	3	Maintain	4	12	12	KIER	PDCR				√			Low levels of feedback seen within the 28-day public consultation period.	issue survey and prompt for feedback monitor returns and issue reminders if required	Engagement Workstream	CLOSED	
5.11	There is a risk that not all interest groups are captured within the pre application consultee distribution list resulting in lack of community support for the scheme.	2	Maintain	3	6	6	BCUHB	PDCR				√			Interest groups reporting low levels of engagement.	monitor and quantify feedback and identify who feedback is provided by	Engagement Workstream	CLOSED	
5.12	There is a risk that the FBC may now be delayed whilst waiting for planning to be determined as Kier issued incorrect wording on Consult Notice resulting in a delay to the consultation period. This has now deferred the consultation completion date.	2	Maintain	4	8	12	KIER/BCUHB	PDCR			√	√			Programme to be updated		Engagement Workstream	Open	
5.13	There is a risk that public confidence and BCUHB reputation is compromised due to slippage from the original timeline issued in early 2020.	3	new	4	12		BCUHB	ER				√			negative publicity lack of support or interest in the project from staff	issue newsletter and update detailing current stage of funding request; timelines and proposals include Q&A on date slippage	engagement workstream	Open	added as there new timelines and slippage are now confirmed
5.14	There is a risk that staff and the public have not clearly understood the project requirement for Welsh Government funding approval to progress the build and refurbishment proposals	3	new	4	12		BCUHB	OR			√	√			if funding is not approved public and staff may feel mislead negative publicity for BCUHB	issue newsletter and update detailing current stage of funding request; timelines and proposals confirming the submission of the FBC to WG	engagement worksteam	Open	added as there is indication from some internal and external people that the development is going to happen with no knowledge of the requirement for a funding request requirement

**Date reviewed: 03/09/2020**  
**Reviewed and Updated by: Janet Michell**  
**Attendees at Risk Review : for comment**

Low risk	1-5
Medium risk	6-14
High risk	15-25

[illegible]

## Appendix G

### Project Framework

The project delivery organisation structure is detailed below:

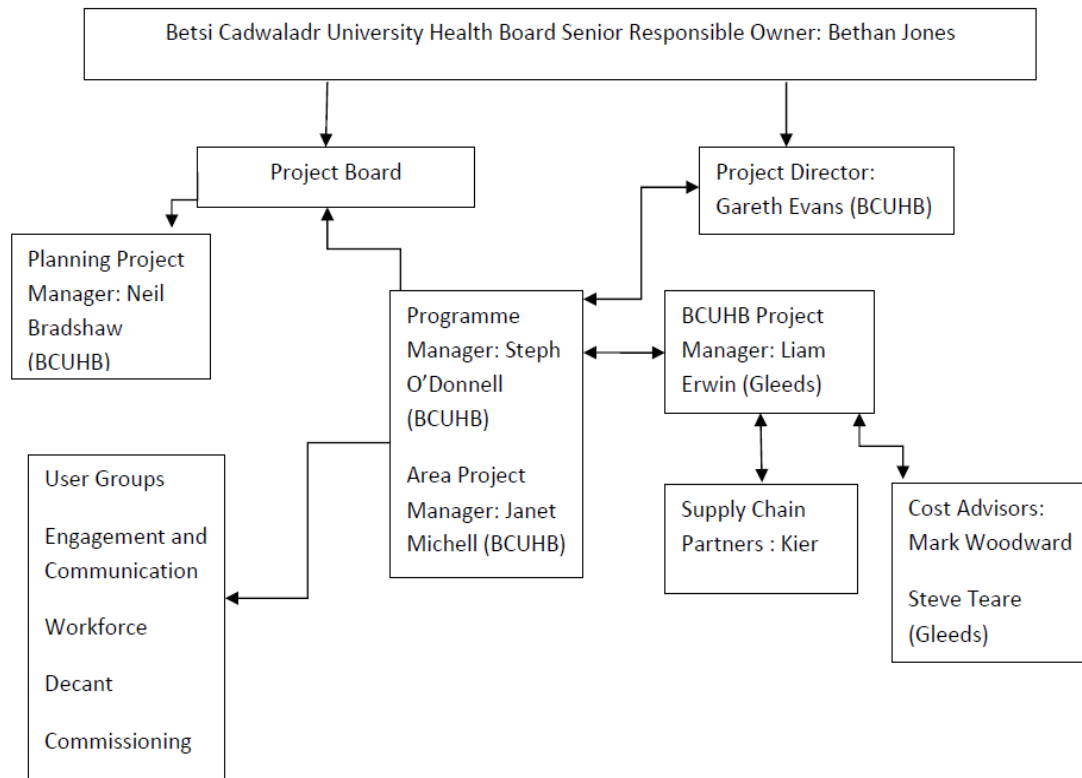
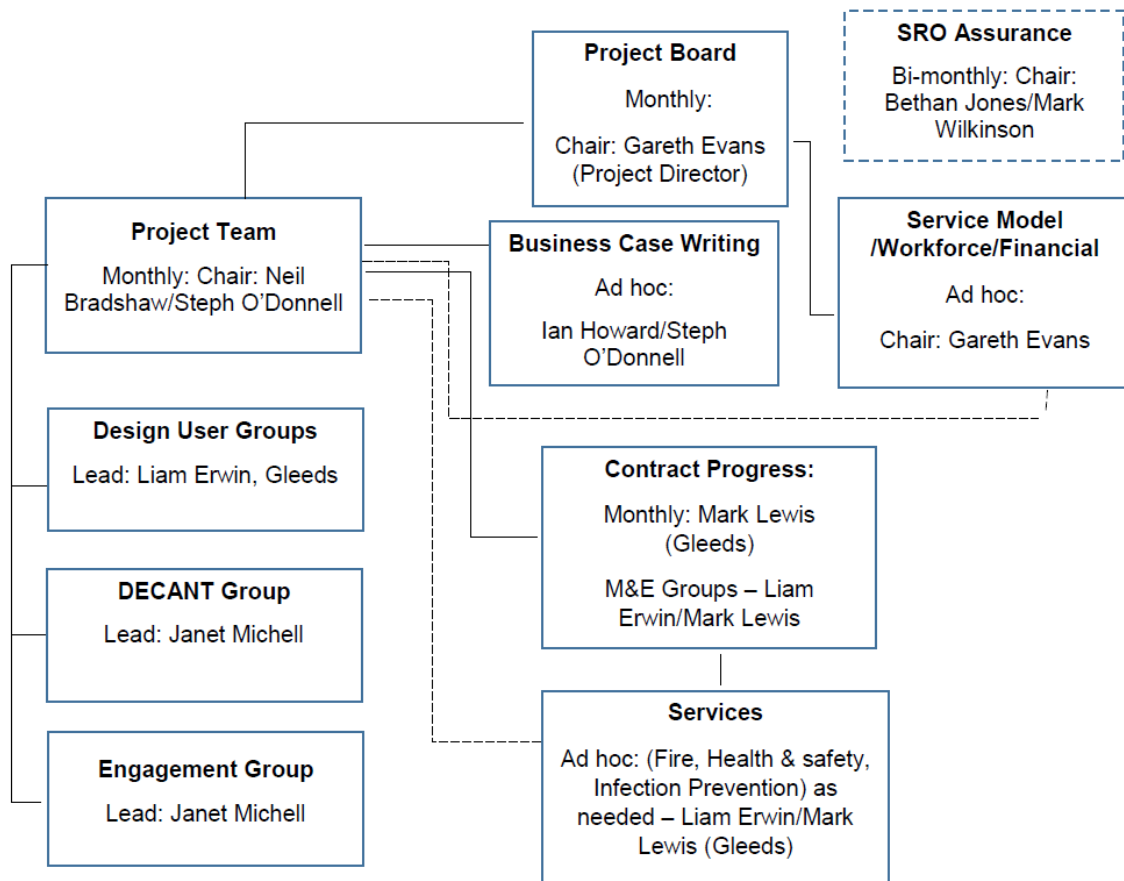


Figure 1: Project Structure

## Project Meetings and Governance

Project delivery is governed and managed through the Project Board; Project Team and other specific task groups which report into the Project Board. Meetings frequencies are detailed below in accordance with the Procedure Manual for Managing Capital Products:





<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Shared Services Partnership Committee quarterly assurance report (Period 1 <sup>st</sup> July 2020 – 30 <sup>th</sup> September 2020)						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Sue Hill, Acting Executive Director of Finance						
<b>Awdur yr Adroddiad Report Author:</b>	Andrew Butler, Director of Finance and Corporate Services, Corporate Services (NWSSP)						
<b>Craffu blaenorol: Prior Scrutiny:</b>	N/A						
<b>Atodiadau Appendices:</b>	Appendix 1: Organisation specific KPIs December 2019 – September 2020 Appendix 2: All Wales KPIs December 2019 – September 2020						
<b>Argymhelliad / Recommendation:</b>							
The Committee is asked to note the report.							
Please tick as appropriate							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
The purpose of this report is to provide summary performance data in respect of the services provided by NHS Wales Shared Services Partnership (NWSSP) for the quarter ending 30th September 2020.							
The report provides end of quarter detail for the Health Board for the rolling twelve-month period to 30th September 2020 (Appendix 1/2).							
<b>Cefndir / Background:</b>							
In common with other health bodies, the past six months have proved to be particularly challenging and have required many staff to work long hours to maintain business continuity and to meet the additional demands placed on NWSSP by the Service. Notwithstanding this, all core services have been delivered and quality has been maintained throughout. Staff have adapted well to the new ways of working which in, a number of cases, have led to improvements in productivity.							
Reported performance for September 2020 was good. However, NWSSP will continue to work with BCU to continue to improve performance against recruitment times, invoice turnaround within 4 days, delivering procurement savings plans and Audit turnaround times.							



## 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 assurance only.

### Financial Implications

### Performance Summary

Within NWSSP work has been undertaken to align the Key Performance Indicators to Key Focus Areas (KFA) to enable us to have a balanced view of the performance information we report.

#### *Financial Information*

NWSSP plans to return £0.75m direct savings to NHS Wales in 2020/21. For BCU a distribution of £90k is planned for 20/21.

In addition, professional influence benefits generated for Wales totals £99m for the year to September. This was made up of £10m Procurement Savings, £10m of savings relating to Specialist Estates Services and £79m of Legal and Risk savings. This includes £12m that can be attributed to BCU.

#### *Employment Services – Payroll*

The performance accuracy data produced for payroll services provides detail regarding the performance after accounting for the supplementary payroll. This reflects amendments and payments made in the period which would otherwise have been missed and represents benefits for organisations and employees. For BCU the reported payroll accuracy prior to the supplementary payroll was reported as 99.27%, this increased to 99.64% following the supplementary payroll. This was in line with the position reported in the previous quarter and represents continuing strong performance against the target of 99.6%.

#### *Employment Services – Recruitment*

For September, KPI performance driven by BCU showed the organisation missed the time to shortlist with 8.6 days reported against the target of 3 days. Time to approve vacancies achieved the target with 4.8 days reported against the 10 day target. Notification of outcome KPI achieved the target with 3 days reported against a target of 3 days.

For KPI performance driven by NWSSP recruitment team all of the 3 performance targets were met. For time to place adverts 1.8 days was reported and achieved the target of 2 days. For time to send applications to manager achieved the target with 1 day was reported against a target of 2 days and for time to send conditional offer letter achieved the target with 3.8 days was reported against a target of 4 days. The Calls Answered percentage KPI was 88.3%, which failed to achieve the 95% target for the quarter.

In the current year we are also reporting the recruitment KPIs as a percentage of the records that **achieved** the target timescales which are highlighted in the table below;

<u>Organisation KPIs Recruitment</u>		Target	Jun-20	Sept-20
Time to Approve Vacancies	10 days	70%	94%	93%
Time to Shortlist by Managers	3 days	70%	47%	46%
Time to notify Recruitment of Interview Outcome	3 days	90%	69%	72%
<u>NWSSP KPIs Recruitment</u>				
Time to Place Adverts	2 days	98%	95%	100%
Time to Send Applications to Manager	2 days	99%	99%	100%
Time to send Conditional Offer Letter	4 days	98%	97%	97%

### *Procurement Services*

For the year to September 2020 procurement savings for Wales were reported as £10m, against a target of £12m. This included savings of £1.195m for BCU, compared to a target of £4.014m.

### *Accounts payable - August*

The volume of invoice lines on hold greater than 30 days decreased from 3,242 in June 2020 to 2,072 in September 2020. Within this, the invoice lines on hold greater than 30 days marked as disputed was reported as 51%. The level of automated invoicing represents a key area for the efficiency of the Accounts Payable system, here performance for September for all Wales was reported as 97.1%.

The Public Sector payment target of 95% was achieved for the Health Board with reported compliance of 96.2% for the year to date. Invoice Turnaround within 4 days is now split by whether it is under NWSSP control or Health org control. Invoice Turnaround under NWSSP control was reported as 94.2% against a 90% target. Invoice Turnaround under Health Org control was reported as 66.1% against a 90% target.

### *Internal Audit*

To the end of September 19% of audits were reported against the target of 26%, with 16% of further audits in progress. The Health Board indicator of 80% for management responses to draft report to be received within 15 days missed the target with 60% reported. Report turnaround to draft response within 10 days is 100%.

### *Primary Care Services*

The published KPIs for contractor services relate to services provided to contractors. For the quarter ending September 2020 the indicators provided for BCU demonstrated full achievement against all indicators.

The All Wales key performance indicator for Prescribing Services for keying accuracy rates has been consistently met with 99.61% reported for September, against the target of 99%. For the year to July 2020 a total of 27.31m prescriptions were processed. This represents a slight increase on the prescriptions processed in the same time frame in the previous year.

### *Legal and Risk Services/Welsh Risk Pool*

The KPIs reported for Welsh Risk Pool relate to the management of claims processed through bimonthly committee meetings. For the 2nd quarter 100% performance has been achieved for acknowledgement, processing and paid. The Legal & Risk KPIs for acknowledgement within 1 day and response to advice within 3 days are consistently reported as achieving the 90% target. Achievement of the KPI related to time to raise invoices for the 2nd quarter was reported at 80% failing to achieve the 90% target.

**Risk Analysis**

N/A

**Legal and Compliance**

N/A

**Impact Assessment**

N/A

## Appendix 1

**Organisation specific KPIs December 2019 – September 2020**

BCU High Level - KPIs Sept 2020	KFA	Target	Health Org Position	Health Org Position	Health Org Position	Health Org Position
			31/12/2019	31/03/2020	30/06/2020	30/09/2020
<b>Financial Information</b>						
Direct Savings Notified - YTD	Value for Money	£90k	£240k	£240k	£90k	£90k
Professional Influence Savings - YTD	Value for Money		£29m	£37.5m	£8.04m	£11.70m
<b>Employment Services</b>						
Payroll services						
Payroll accuracy rate prior to Supp	Excellence	99.6%	99.40%	99.63%	99.34%	99.27%
Payroll accuracy rate post Supp	Excellence	99.6%	99.70%	99.81%	99.67%	99.64%
<b><u>Organisation KPIs Recruitment</u></b>						
Resignation to Vacancy Approval date (Nursing)	Excellence	5 days	62.5 days	74.9 days	54.5 days	70.4 days
Time to Approve Vacancies	Excellence	10 days	7.5 days	4.9 days	3.1 days	4.8 days
Time to Shortlist by Managers	Excellence	3 days	7.4 days	7.5 days	8.5 days	8.6 days
Time to notify Recruitment of Interview Outcome	Excellence	3 days	2.1 days	2.8 days	3.6 days	3.0 days
<b><u>NWSSP KPIs Recruitment</u></b>						
Time to Place Adverts	Excellence	2 days	1.7 days	1.7 days	2.2 days	1.8 days
Time to Send Applications to Manager	Excellence	2 days	2.1 days	1.1 days	1.0 days	1.0 days
Time to send Conditional Offer Letter	Excellence	4 days	3.9 days	4.0 days	3.9 days	3.8 days
Calls Answered % Quarterly Average	Customers	95%	98.90%	96.60%	89.90%	88.30%
<b>Procurement Services</b>						

Procurement savings - YTD	Value for Money	£4.014m	£5.936m	£7.012m	£0.205m	£1.195m
<b>Accounts Payable - August</b>						
Invoices on Hold > 30 days	Customers		4,022	3,237	2,242	2,072
% Invoices as being in dispute >30 days	Customers		36%	43%	54%	51%
E Enablement invoices	Excellence	83%	95.1%	95.3%	96.9%	97.1%
Invoice Turnaround within 4 Days (NWSSP Control) Basware, GHX, Manual & OCR	Excellence	90%	85.7%	92.7%	98.1%	94.2%
Invoice Turnaround within 4 Days (Health Org Control) Generic Feeds & Pharmacy	Customers	90%	64%	53.5%	68.4%	66.1%
PSPP Compliance non NHS – YTD (September)	Excellence	95%	95.3%	95.3%	95.3%	96.2%
<b>Primary Care Services</b>						
Primary Care payments made accurately and to timescale	Excellence	100%	99.99%	99.5%	100%	100%
Patient assignments actioned within 24 hours	Customers	100%	100%	100%	100%	100%
Medical record transfers to/from GPs and other primary care agencies within 6 weeks	Customers	95%	97%	98%	91%	99%
Urgent medical record transfers to/from GPs and other primary care agencies within 2 working days	Customers	100%	100%	100%	100%	100%
Cascade Alerts issued within timescale	Customers	100%	100%	100%	100%	100%
<b>Internal audit</b>						

Audits reported % of planned audits - YTD	Excellence	26%	48%	93%	6%	19%
Report turnaround management response to Draft report - YTD	Excellence	80%	71%	76%	n/a	60%
Report turnaround draft response-final-YTD	Excellence	80%	100%	100%	n/a	100%

**All Wales KPIs December 2019 – September 2020**

<b>ALL WALES KPIs</b>	<b>KFA</b>		<b>31/12/2019</b>	<b>31/03/2020</b>	<b>30/06/2020</b>	<b>30/09/2020</b>
<b>Primary Care Services</b>						
Prescription – Payment Month keying Accuracy rates	Excellence	99%	99.77%	99.51%	99.85%	99.61%
Prescriptions processed (Apr-Mar)	Excellence	25.81m	46.79m	67.63m	81.63m	27.31m
<b>Welsh Risk Pool</b>						
Acknowledgement of receipt of claim	Excellence	100%	100%	100%	100%	100%
Valid claims processed in time for next WRP committee	Excellence	100%	100%	100%	100%	100%
Claims agreed paid within 10 day	Excellence	100%	100%	100%	100%	100%
<b>Legal and risk</b>						
Advice acknowledgement- 24 hrs - YTD	Excellence	90%	99%	99%	99%	100%
Advice response – within 3 days - YTD	Excellence	90%	100%	99%	99%	100%
Invoices requested within 21 day - YTD	Excellence	90%	93%	95%	74%	80%





<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>					
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public					
<b>Teitl yr Adroddiad Report Title:</b>	Cross Border Block Contracts Update					
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Sue Hill, Acting Executive Director of Finance					
<b>Awdur yr Adroddiad Report Author:</b>	Adrian Tomkins – Associate Director of Healthcare Contracting					
<b>Craffu blaenorol: Prior Scrutiny:</b>	Finance and Performance Committee has requested regular updates regarding the cross border block contracts. This paper has been approved for circulation by the Acting Executive Director of Finance					
<b>Atodiadau Appendices:</b>	1					
<b>Argymhelliad / Recommendation:</b>						
<p>The Committee is asked to:</p> <ul style="list-style-type: none"> <li>Note the level of delivery within the Health Board managed Cross Border Block Contract arrangements up to Month 5</li> <li>Note the year on year activity reductions within the Health Board managed Cross Border Block Contract arrangements up to Month 5</li> <li>Note the level of delivery within the material WHSSC managed Cross Border Block Contract arrangements up to Month 5</li> <li>Note the latest position regarding Block contract arrangements for the period months 7 to 12</li> </ul>						
Please tick as appropriate						
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth For Discussion</b>		<b>Ar gyfer sicrwydd For Assurance</b>		<b>Er gwybodaeth For Information</b> ✓
<b>Sefyllfa / Situation:</b>						
<p>The purpose of this report is to provide an update on the position regarding Cross Border Block Contract arrangements using the latest information available (month 5) and to highlight the levels of activity reductions year to date and the subsequent financial subsidy being provided within the current agreements and builds on the note previously provided to the Committee. The report also gives an update regarding the ongoing discussions for the continuation of these agreements over the rest of 2020/21.</p>						

## Cefndir / Background:

- The Health Board (HB) directly manage external annual contracts with Cross Border providers totalling £65m and on behalf of the HB's, Welsh Specialised Commissioners (WHSSC) manage annual contracts totalling £119m of which a significant proportion is attributable to the HB.
- As a result of the COVID-19 pandemic response to ensure wider system sustainability and that systems have the resources to deal with the impacts of the pandemic for 2020/21 HB's have been directed by Welsh Government in line with NHS England guidance that these contracts have been managed on a 'Block' basis.
- The plan originally was for these Block contracts to be in place for the first 3- 4 months of the year but as the pandemic continues to impact on the wider NHS they have subsequently been extended until the end of September.
- In line with the guidance the Block values have been calculated based on 2019/20 actual performance uplifted by inflation
- The national guidance also suspended all formal contract management arrangements and the publication of the final Payment by Results (PbR) tariff in England.
- The Health Board has continued to receive activity and performance reports from Providers and have been tracking the actual activity delivered versus the anticipated levels of the 'Block' agreements.
- The latest information received from Providers (month 5) highlights that despite activity levels increasing as Providers implement recovery plans the HB has only received 60% of the levels anticipated in the 'Block' agreements some £10.7m under delivered year to date for directly contracted arrangements and 71% for WHSSC managed agreements £11.7m under delivery.
- Discussions remain ongoing regarding the potential extension of the current arrangements for the rest of 2020/21 between HB's, Welsh Government and NHS England, with HB's keen that there is recognition and redress of the balance within any future arrangements

## Asesiad / Assessment & Analysis

## **Strategy Implications**

The Health Board contracts with NHS Trusts across the border in England to provide capacity and services to HB patients in line with access and delivery plans.

## **Options considered**

None

## **Financial Implications**

The financial position for all external healthcare contracts is reported within the month 6 Finance report. Cross Border Block Contract agreements are accommodated within the existing budget and no year to date of forecast variance to budget is currently being reported.

## **Risk Analysis**

The current Block Contract arrangements do lead to 2 main risks for the Health Board

There is a Risk that as Cross Border Providers ramp up their recovery plans and have to adhere to NHS England guidance HB patients would not receive equitable access to commissioned services through dialogue with Welsh Government and NHS England regarding future proposals assurance has been sought to reduce this risk and through ongoing contract meetings with Providers this matter is also raised to gain further assurance.

As part of the dialogue regarding the future Block arrangements the HB have also raised awareness of the requirements for a clear exit strategy and a transition agreement once Block Arrangements end in order to reduce the Risk that has been raised regarding the potential for duplicate payment of patient care.

There is no Financial Risk posed by the current Block Arrangements as the current costs fall within the allocated budget however there has been a subsidy paid to ensure the stability of the wider NHS System during the pandemic which the HB is now in dialogue to reduce.

## **Legal and Compliance**

None

## **Impact Assessment**

None

## **1. Purpose of the Report / Background**

As previously reported to the Committee, in April 2020 as a response to the COVID-19 crisis, the Welsh Health Boards were directed by Welsh Government (In agreement with NHS England and the Welsh Directors of Finance) in order to give the wider Health system financial stability during the pandemic response to put Block contracts in place with other NHS organisations where they had an existing contractual relationship for the provision of Healthcare.

The plan was originally for these Block contracts to be in place for 3-4 months but these arrangements have subsequently been currently extended until the end of September 2020.

In line with the guidance the Block values have been calculated based on 2019/20 actual performance uplifted by inflation. The inflation uplift for Wales in 2020/21 is 2% however it has been agreed that the inflation uplift applied to English contracts will be uplifted by a further 0.8% to be consistent with NHS England guidance. This additional inflation uplift has been fully funded by Welsh Government.

To ensure sustainability and system stability to enable Organisations to respond to the pandemic the agreement for all the Block contracts is that there will not be subsequent adjustments to reflect actual performance, however actual activity data should continue to be provided to the commissioners.

The national guidance also suspended all formal contract management arrangements and the publication of the final Payment by Results (PbR) tariff in England.

The operational response to the crisis in both countries was to cease all non-urgent elective activity so it should be noted that whilst the Block contracts are affordable in terms of the 2020/21 available budgets, they do not reflect the actual value of the activity being delivered.

The Block contract arrangements in line with the guidance have been adopted by the Health Board for all Cross Border and Welsh agreements, also by WHSSC for all arrangements they manage on behalf of BCU.

## **2. Latest Position**

Table 1 below highlights the summary position using the latest month 5 data available from Trusts.

Table 1

<b>Summary Position at Month 5</b>			
	Payments to Month 5 £	Activity to Month 5 £	Variance £
BCU Held English Agreements	27,072,302	16,354,743	- 10,717,559
WHSSC Held English Agreements over £2.5m pa	40,225,774	28,548,625	- 11,677,149

As above the Health Board has received information from the majority of Trusts up to month 5. Table 2 below shows the difference between the payments made to external NHS bodies directly by BCU and the value of the activity provided at month 5. In most cases the value of work done is significantly less than the payments made, the one exception to this is the Liverpool Women's Hospital where there has been considerably more monthly neonatal activity in 2020/21 than in 2019/20.

Table 2 highlights for the period to 31<sup>st</sup> August the HB paid £27.1m for all block contract agreements and actual activity levels equated to £16.4m, under delivery of £10.7m, with overall delivery of 60% up to month 5 an increase from the previously reported position of 56% at month 3. Despite the activity levels being greatly reduced, the year on year analysis by Point of Delivery is demonstrated in Table 3, the Block contract agreements are in line with the budgeted positions, as a result no variations are being reported in the HB financial monitoring. The year on year analysis of activity levels is not fully reflective of the drop off in activity since April as the 2019/20 figures are artificially low due to the dispute during the early part of that year with the Countess of Chester hospital that saw them greatly reduce activity for the HB's patients.

Table 2 also highlights that activity levels have started to increase with delivery rising in both months 4 and 5 and that is expected to continue further as Providers start to increase their recovery processes. As part of the wider NHS planning regime the HB has been heavily involved with colleagues from WHSSC collating Provider quarter 3 and 4 recovery plans and assessing the impacts these have for HB activity in the latter months of the current year to date these responses have been limited to Trust plans in line with those submitted to NHS England, work continues to understand the impact these will have on the levels of activity currently being delivered. Through contract discussions with Providers the HB is also ensuring that our patients are receiving equal access and that it receives proportionate levels of capacity as the recovery phase ramps up.

Table 2

20/21 Contract Block V Actual																
	Annual Block	Monthly		%		%		%		%		%				
	Value £	payment £	Actual M1 £	v Block	Actual M2 £	v Block	Actual M3 £	v Block	Actual M4 £	v Block	Actual M5 £	v Block	YTD Payments	YTD Actual £	YTD Variance	YTD Delivery %
													£	£	£	v Block
Countess of Chester	24,955,804	2,079,650	1,255,703	60%	1,430,081	69%	1,662,119	80%	1,618,106	78%	1,688,280	81%	10,398,251.65	7,654,289.00	2,743,962.65	74%
Robert Jones & AH	14,523,281	1,210,273	263,362	22%	219,816	18%	359,375	30%	502,481	42%	460,868	38%	6,051,367.10	1,805,902.00	4,245,465.10	30%
Royal Liverpool	5,703,681	475,307	135,586	29%	202,904	43%	165,493	35%	247,988	52%	203,614	43%	2,376,533.75	955,585.00	1,420,948.75	40%
Uni Hospital North Midlands	5,647,244	470,604	287,851	61%	428,535	91%	193,817	41%	286,608	61%	499,287	106%	2,353,018.35	1,696,098.00	656,920.35	72%
Clatterbridge	3,572,569	297,714	236,720	80%	173,125	58%	283,125	95%	325,718	109%	323,269	109%	1,488,570.40	1,341,957.00	146,613.40	90%
Aintree Hospitals	3,567,353	297,279	158,663	53%	172,579	58%	200,346	67%	169,115	57%	178,098	60%	1,486,397.10	878,801.00	607,596.10	59%
Wirral Hospitals	2,288,954	190,746	185,941	97%	154,265	81%	83,705	44%	150,320	79%	222,881	117%	953,730.85	797,112.00	156,618.85	84%
Shrewsbury & Telford	1,719,168	143,264	44,605	31%	56,920	40%	73,961	52%	89,998	63%	89,853	63%	716,320.00	355,337.00	360,983.00	50%
Manchester University Hopsital	1,369,662	114,139	31,777	28%	34,712	30%	50,898	45%	78,642	69%	65,966	58%	570,692.50	261,995.00	308,697.50	46%
Liverpool Womens	830,074	69,173	122,729	177%	124,152	179%	73,703	107%	100,809	146%	62,523	90%	345,864.15	483,916.00	- 138,051.85	140%
Wrightington, Wigan & Leigh	231,000	19,250	924.00	5%	3,253.00	17%	1,999	10%	1,510	8%	6,143	32%	96,250.00	13,829.00	82,421.00	14%
Shropshire Community Health Trust	219,806	18,317	3,447	19%	8,425	46%	8,434	46%	12,601	69%	12,880	70%	91,585.85	45,786.72	45,799.13	50%
Sub Total	64,628,596	5,385,716	2,727,308	51%	3,008,767	56%	3,156,975	59%	3,583,896	67%	3,813,662	71%	26,928,582	16,290,608	10,637,974	60%
Midlands Partnership	191,004	15,917.00	not received		not received		not received		not received		not received		79,585.00	not received	-	
Cheshire & Wirral pre existing Block contract	102,800	8,567	8,567	100%	8,567	100%	8,567	100%	8,567	100%	8,567	100%	42,833.35	42,833.35	-	100%
Brigewater pre existing Block Contract	51,125	4,260	4,260	100%	4,260	100%	4,260	100%	4,260	100%	4,260	100%	21,302.10	21,302.10	-	100%
Total Contract Values	64,973,525	5,414,460	2,740,135	51%	3,021,594	56%	3,169,802	59%	3,596,723	66%	3,826,489	71%	27,072,302	16,354,743	10,637,974	60%

Table 3

Year on year Activity Analysis - All Cross Border Providers				
Point of Delivery	Activity 1 - 5 19/20	Activity 1 - 5 20/21	Reduction in activity ytd	% delivery of 19/20 activity levels
daycase	3,371	1,316	- 2,055	39%
Elective IP	1,001	689	- 312	69%
Non elective	2,424	1,879	- 545	78%
Non Elective Non Emergency (maternity / transfers)	654	263	- 391	40%
Outpatient First attendance	7,784	3,609	- 4,175	46%
Outpatient Follow Up	21,857	12,805	- 9,052	59%
Outpatient procedures	4,692	1,535	- 3,157	33%
Total	41,783	22,096	- 19,687	53%

The HB also has significant exposure to English providers through agreements managed on its behalf by WHSSC, these are also currently operating in line with guidance on a Block basis and information supplied by the WHSSC team to the HB

for the material contracts over £2.5m per annum again demonstrates significant levels of under delivery are being seen, at month 5 Block payments for all contracts were £40.2m against the value of actual activity delivered of £28.5m, some £11.7m under as highlighted in Table 4 below. It is important to note that the information supplied by WHSSC is on a total contract basis for all Welsh patients and BCU pick up a % proportion of each based on historic usage levels. These range from 99% down to 49% with the average overall approx. 96%, which would give a BCU proportion of the under delivery of approx. £11m to month 5 for WHSSC contracted activity.

Table 4

WHSSC NHS ENGLAND Contracts					
Provider	2020/21 COVID Block Apr-Sep Baseline	Monthly Payment Block 20/21 to M5	Actual Performance to August '20 (M5)	Variance	Performance - Percentage (%) +/-
Walton Centre NHS Foundation Trust	18,846,291	7,852,621	4,858,601	2,994,020	62%
Alder Hey Children's NHS Foundation Trust (Royal Liverpool)	18,507,374	7,711,406	5,719,245	1,992,161	74%
Liverpool Heart & Chest Hospital NHS Foundation Trust	17,329,901	7,220,792	5,852,676	1,368,116	81%
University Hospitals Bristol NHS Foundation Trust	11,378,610	4,741,088	4,021,767	719,320	85%
University Hospitals Birmingham NHS Foundation Trust	9,308,415	3,878,506	2,623,635	1,254,871	68%
Imperial College Healthcare NHS Trust	3,813,207	1,588,836	991,515	597,321	62%
Christie NHS Foundation Trust	3,768,207	1,570,086	1,512,561	57,525	96%
Manchester University Foundation Trust (previously Central & South)	3,691,756	1,538,232	646,601	891,631	42%
St Helens and Knowsley Teaching Hospitals NHS Trust	3,663,224	1,526,343	624,291	902,052	41%
Royal Brompton & Harefield NHS Foundation Trust	3,500,000	1,458,333	832,797	625,536	57%
University Hospitals of North Midlands NHS Trust	2,734,873	1,139,530	864,935	274,595	76%
<b>Sub Total NHSE Contract value &gt; £2.5m</b>	<b>96,541,858</b>	<b>40,225,774</b>	<b>28,548,625</b>	<b>11,677,149</b>	<b>71%</b>
<b>Total NHSE SLAs</b>	<b>119,077,697</b>				

### 3. Future Contracting / Payment Landscape for 2020/21

As previously reported on the 31/7 NHS England wrote to Providers in England laying out their clear expectations around the next stages of the recovery process and within that the Block contract arrangement would continue but with a closer link to delivery of activity levels seen in 2019/20 being expected going forward. That letter has been followed up with more detailed guidance and calculated baselines to Providers and wider systems in England but the key highlights of that letter remain and are:

- September at least 80% of their last year's activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August) should be delivered
- 100% of their last year's activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August) should be delivered.

- Elective waiting lists and performance should be managed at system as well as trust level to ensure equal patient access and effective use of facilities.
- Clinically urgent patients should continue to be treated first, with next priority given to the longest waiting patients, specifically those breaching or at risk of breaching 52 weeks by the end of March 2021.
- The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and the restoration of elective services. The intention is that systems will be issued with funding envelopes comprising funding for NHS providers equivalent in nature to the current block.
- Funding envelopes will be calculated on the basis of full external income recovery. For relationships between commissioners and NHS providers we will continue to operate nationally calculated block contract arrangements.
- Block payments will be adjusted depending on delivery against the activity restart goals.
- Written contracts with NHS providers for the remainder of 2020/21 will not be required.

In light of the high levels of subsidy being given by Welsh HB's towards Cross Border Providers high level discussions have been taking place between Welsh Government (WG), Health Board representatives and NHS England regards the continuation of the Block Contract arrangements for the rest of 2020/21.

To date these discussions have not led to an agreed position but a proposal has been put forward by WG to NHS England for consideration that would see Block contracts continue but with a revision to the values paid where year to date delivery has been below certain thresholds. NHS England have reviewed the proposals and circulated a subsequent draft that is currently being reviewed by HB's in the expectation of reaching an agreement as soon as possible.

If accepted the HB would expect to reduce the levels of payments made in the coming months and therefore reduce the levels of subsidy made alongside the expected activity levels also continuing to rise in line with recovery plans. The revised proposals would continue to share the risk of any underperformance between Welsh commissioners and English providers although being rebalanced, whilst also continuing to demonstrate a commitment to the financial stability of the providers who will be required to support HB's in their ongoing recovery and also recognising the higher costs and inefficiencies of delivering services during the pandemic. They are also similar in principle to the Elective Incentive Scheme being applied in England which will provide further assurance to the Welsh commissioners that their patients will share the benefits of the incentives that the combined arrangements create.



Even if revised arrangements are agreed for the remainder of 2020/21 as and when the time comes to switch off the current Block contract arrangements there needs to be careful consideration given regarding how they end, this need to include the levels of waiting lists that will have built up during the prolonged levels of reduced activity, also if PbR is switched back on and the mechanism to pay for a patients spell on discharge recommences in the first few months there is a significant risk of double paying for activity where a patients spell length straddles the transition date i.e. paying for a spell at Tariff on the patients discharge date where part of the spell may already have been covered under Block payments. These issues have already been highlighted in the current round of discussions that have taken place and the HB will ensure these matters continue to be the agenda for future resolution.



<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Monthly Monitoring Report – Month 6						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Mrs Sue Hill, Acting Executive Director of Finance						
<b>Awdur yr Adroddiad Report Author:</b>	Eric Gardiner, Finance Director, Provider Services						
<b>Craffu blaenorol: Prior Scrutiny:</b>	The submission made to Welsh Government required Chief Executive and Director of Finance sign off.						
<b>Atodiadau Appendices:</b>							
<b>Argymhelliad / Recommendation:</b>							
Note the contents of the report that has been made to the Welsh Government about the Health Board's financial position for Month 6 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)							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input checked="" type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
To report to the Committee the completion of monthly reporting to the Welsh Government for Month 6 of 2020/21.							
<b>Cefndir / Background:</b>							
<p>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 initial plan did not take into account the impact of COVID-19, and therefore it will change throughout the year. In the first half of the year, expenditure has been considerably higher than planned due to the pandemic response and savings delivery has continued to be significantly impacted as the Health Board prioritised the clinical and operational response to the pandemic.</p> <p>The Health Board is going to submit a consolidated plan for the second half of the financial year. The Month 6 return has been aligned as far as possible to the plan, but due to the fact that the Q3/4 Board workshop is happening after the MR submission means that there will be some minor differences in the Quarter 3 and 4 plan that is submitted.</p>							
<b>Asesiad / Assessment &amp; Analysis</b>							

## 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 Financial position

- The in-month position is a £24.6m surplus, which is £27.9m under the plan for Month 6. This gives a cumulative year to date position of £19.8m deficit, which is £0.2m below the plan of £20.0m.
- There has been a significant movement in the position this month, which is due to additional Welsh Government COVID-19 funding that was notified to the Health Board in September. In total, an additional £106.2m of COVID-19 funding has been included in the forecast position in Month 6. £27.6m of this income has been brought into the position in Month 6 to fund COVID-19 costs incurred in Months 1 to 5, hence the movement in the Month 6 financial position.

<b>Movement in Financial Position</b>	<b>£m</b>
YTD Position at Month 5	27.7
Additional COVID-19 income related to M01-M05 expenditure	(27.6)
Reduction in other cost pressures	(0.3)
<b>YTD Position at Month 6</b>	<b>(0.2)</b>

- The additional COVID-19 funding notified this month included £83.1m to support the impact of COVID-19, plus specific funding to cover the costs of PPE, the extended flu vaccination programme, the COVID-19 vaccination programme, COVID-19 testing, Field Hospital decommissioning costs, consequential losses arising from the Field Hospitals and the cost of using the independent sector to support activity.
- Total Welsh Government COVID-19 income is now £156.2m for the year, of which £67.8m has been included in the year to date financial position. The remaining funding is forecast to be spent in the second half of the financial year.
- The cost of COVID-19 in September is £7.3m, with a year to date cost of £67.8m. Specific funding sources totalling £2.6m have been redirected to COVID-19 to cover some of these costs. £65.2m of Welsh Government income has been received or notified to cover the remaining costs to date. Therefore, overall the costs of COVID-19 are not impacting on the year to date position.

	M01	M02	M03	M04	M05	M06	YTD	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	6.1	4.8	57.8	131.7
Lost income	1.2	1.4	1.2	1.6	1.6	0.4	7.4	12.3
Non delivery of savings	3.7	3.6	2.0	2.7	2.3	3.9	18.2	33.9
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(1.9)	(1.5)	(13.4)	(19.3)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(0.2)	(0.2)	(1.7)	(1.8)
Cluster funding	0.0	0.0	(0.3)	(0.1)	0.0	(0.1)	(0.5)	(0.6)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0	0.0	0.0	0.0
<b>Total COVID-19 costs</b>	<b>30.8</b>	<b>5.1</b>	<b>7.5</b>	<b>9.2</b>	<b>7.9</b>	<b>7.3</b>	<b>67.8</b>	<b>156.2</b>
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(0.1)	(0.1)	(1.8)	(2.5)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	0.0	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	0.0	0.0	(0.1)	(0.2)
Welsh Government	(30.8)	(5.1)	(7.5)	(6.8)	19.8	(34.8)	(65.2)	(152.8)
<b>Total COVID-19 income</b>	<b>(30.8)</b>	<b>(5.1)</b>	<b>(7.5)</b>	<b>(9.2)</b>	<b>19.7</b>	<b>(34.9)</b>	<b>(67.8)</b>	<b>(156.2)</b>
<b>Impact on position</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>27.6</b>	<b>(27.6)</b>	<b>0.0</b>	<b>0.0</b>

## 1.2 Forecast

- The uncertainty about the potential resurgence of COVID-19 in the winter months and the essential infection prevention measures that have been implemented will continue to affect expenditure forecasts and savings delivery is likely to be significantly reduced for the remainder of the year.
- In Month 5, the Health Board increased its forecast position to £122.2m, reflecting the change in income assumptions around anticipated income from Welsh Government towards the cost of COVID-19. The additional COVID-19 funding awarded in September is forecast to fully cover the cost of COVID-19 to the Health Board this year. Therefore, the forecast financial position at Month 6 has been reduced to £40.0m, in line with the financial plan for 2020/21.

Forecast at M06	£m
Planned deficit	40.0
Forecast COVID-19 net costs	156.2
Redirected funding	(3.4)
WG COVID-19 specific funding	(152.8)
<b>Forecast outturn</b>	<b>40.0</b>

### Risk Analysis:

- There is one opportunity to reduce the financial position, totalling £3.9m and four risks where the financial impact is not yet known. These are detailed in Section 3 of the attached report.

### Legal and Compliance:

Not applicable.

### Impact Assessment:

Not applicable.

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GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# MONITORING RETURN

MONTH 6 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 initial plan did not take into account the impact of COVID-19, and therefore it will change throughout the year. In the first half of the year, expenditure has been considerably higher than planned due to the pandemic response and savings delivery has continued to be significantly impacted as the Health Board prioritised the clinical and operational response to the pandemic.
- The Health Board is going to submit a consolidated plan for the second half of the financial year. The Month 6 return has been aligned as far as possible to the plan, but due to the fact that the Q3/4 Board workshop is happening after the MR submission, there will be some minor differences in the Quarter 3 and 4 plan that is submitted.
- The Quarter 3 and 4 plan focuses on increasing activity and dealing with winter escalation plans, however, the recent substantial increase in COVID-19 infections is likely to affect the plan, potentially reducing activity and increasing costs.
- The uncertainty about the potential resurgence of COVID-19 in the winter months and the essential infection prevention measures that have been implemented will continue to affect expenditure forecasts and savings delivery is likely to be significantly reduced for the remainder of the year.

## 1.2 Financial Position

- The in-month position is a £24.6m surplus, which is £27.9m under the plan for Month 6. This gives a cumulative year to date position of £19.8m deficit, which is £0.2m below the plan of £20.0m.
- There has been a significant movement in the position this month, which is due to additional Welsh Government COVID-19 funding that was notified to the Health Board in September. In total, an additional £106.2m of COVID-19 funding has been included in the forecast position in Month 6. £27.6m of this income has been brought into the position in Month 6 to fund COVID-19 costs incurred in Months 1 to 5, hence the movement in the Month 6 financial position.

<b>Movement in Financial Position</b>	<b>£m</b>
YTD Position at Month 5	27.7
Additional COVID-19 income related to M01-M05 expenditure	(27.6)
Reduction in other cost pressures	(0.3)
<b>YTD Position at Month 6</b>	<b>(0.2)</b>

## 1. FINANCIAL POSITION & FORECAST

- Total Welsh Government COVID-19 income is now £156.2m for the year, of which £67.8m has been included in the year to date financial position. The remaining funding is forecast to be spent in the second half of the financial year.

	Total Funding £m	Actual Expenditure to M06 £m
Additional COVID-19 support	83.1	31.5
Field Hospital commissioning costs	23.6	23.6
Trace element of TTP (including IT)	11.4	0.7
PPE	6.5	2.0
Extended flu vaccination programme	5.7	0.0
Quarter 1 Pay	5.4	5.4
Support for adult social care providers	5.0	0.8
COVID-19 vaccination programme	3.3	0.0
COVID-19 testing	3.1	0.5
Field Hospital decommissioning cost	2.2	0.0
Consequential losses	2.2	0.4
Independent sector	0.7	0.0
Additional cross border costs 0.8%	0.5	0.3
MH Helpline	0.1	0.0
<b>COVID-19 Specific Funding</b>	<b>152.8</b>	<b>65.2</b>
Optimise Flow & Outcomes (ICF)	2.5	1.8
Mental Health Improvement Fund	0.7	0.7
GMS (DES)	0.2	0.1
<b>Redirected Funding</b>	<b>3.4</b>	<b>2.6</b>
<b>Total Welsh Government Funding</b>	<b>156.2</b>	<b>67.8</b>

- The cost of COVID-19 in September is £7.3m, with a year to date cost of £67.8m. Specific funding sources totalling £2.6m have been redirected to COVID-19 to cover some of these costs. £65.2m of Welsh Government income has been received or notified to cover the remaining costs to date. Therefore, overall the costs of COVID-19 are not impacting on the year to date position.



# 1. FINANCIAL POSITION & FORECAST

	M01	M02	M03	M04	M05	M06	YTD	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	6.1	4.8	57.8	131.7
Lost income	1.2	1.4	1.2	1.6	1.6	0.4	7.4	12.3
Non delivery of savings	3.7	3.6	2.0	2.7	2.3	3.9	18.2	33.9
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(1.9)	(1.5)	(13.4)	(19.3)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(0.2)	(0.2)	(1.7)	(1.8)
Cluster funding	0.0	0.0	(0.3)	(0.1)	0.0	(0.1)	(0.5)	(0.6)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0	0.0	0.0	0.0
<b>Total COVID-19 costs</b>	<b>30.8</b>	<b>5.1</b>	<b>7.5</b>	<b>9.2</b>	<b>7.9</b>	<b>7.3</b>	<b>67.8</b>	<b>156.2</b>
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(0.1)	(0.1)	(1.8)	(2.5)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	0.0	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	0.0	0.0	(0.1)	(0.2)
Welsh Government	(30.8)	(5.1)	(7.5)	(6.8)	19.8	(34.8)	(65.2)	(152.8)
<b>Total COVID-19 income</b>	<b>(30.8)</b>	<b>(5.1)</b>	<b>(7.5)</b>	<b>(9.2)</b>	<b>19.7</b>	<b>(34.9)</b>	<b>(67.8)</b>	<b>(156.2)</b>
<b>Impact on position</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>27.6</b>	<b>(27.6)</b>	<b>0.0</b>	<b>0.0</b>

## 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.
- In Month 5, the Health Board increased its forecast position to £122.2m, reflecting the change in income assumptions around anticipated income from Welsh Government towards the cost of COVID-19. The additional COVID-19 funding awarded in September is forecast to fully cover the cost of COVID-19 to the Health Board this year. Therefore, the forecast financial position at Month 6 has been reduced to £40.0m, in line with the financial plan for 2020/21.

Forecast at M06	£m
Planned deficit	40.0
Forecast COVID-19 net costs	156.2
Redirected funding	(3.4)
WG COVID-19 specific funding	(152.8)
<b>Forecast outturn</b>	<b>40.0</b>

## 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
<b>Opportunities</b>			
Red Pipeline Savings Schemes	3.9		Red rated savings schemes that total £3.9m are currently held in pipeline and are due to start delivering over the next month.
<b>Risks</b>			
Vaccination Programme for Flu and COVID-19			An initial plan has been submitted to Welsh Government for the flu and COVID-19 vaccination programme. The plan continues to be developed and an initial estimate for the cost of these two programmes has been included in the forecast this month.
Savings Programme			There is a risk that the amber schemes within the savings programme will not deliver to their forecast values.
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 £172.2m for September.
- Confirmed allocations to date are £1,557.5m, with further anticipated allocations in year of £150.7m, a total forecast Revenue Resource Limit (RRL) of £1,708.2m for the year. £161.2m has been profiled into September, which is £57.5m higher than in August. This is primarily due to movements in COVID-19 funding. In August, anticipated but not notified income for COVID-19 was taken out of the position, in line with the change in income assumptions. In September, £27.6m of the additional COVID-19 funding relating to Months 1 to 5, which has now been notified to the Health Board, has been brought back into the position.
- A reconciliation between the RRL phased into the position and an equal phasing is shown in the table below.

	M06 £m
RRL (Table E)	1,708.2
Less COVID-19 funding (Table A, line 22)	(156.2)
Less funding for specific purposes, e.g. drug treatment fund / medical pay etc.	(44.6)
Adjusted RRL	1,507.4
Equal 12ths phasing	753.7
Add YTD COVID-19 costs	67.8
Phased YTD RRL	821.5
Actual YTD RRL (Table B)	821.5
<b>Variance</b>	<b>0.0</b>

- The impact of COVID-19 has resulted in lost income of £0.4m during September, which mainly relates to General Dental Services (GDS) patient income. Income from English Non-Contracted Activity (NCA) has increased significantly this month, with activity being around 80% of normal for the time of year.

### 4.2 Expenditure (Table B)

- Expenditure totals £147.87 for Month 6, £0.9m more than in Month 5.
- £4.8m of this month's expenditure is directly related to COVID-19, of which £3.0m is included in pay and £1.8m across non-pay expenditure categories.
- The impact of COVID-19 on the savings programme has resulted in planned savings of £3.9m not being achieved this month and this shortfall is included within non-pay. There

## 4. INCOME & EXPENDITURE

has been further increase in elective care activity during September and so the reduction in planned care non-pay spend has reduced to £1.5m. In addition, there is slippage on a number of planned investments of £0.2m and cluster funding of £0.1m.

<b>Primary Care</b>	<ul style="list-style-type: none"> <li>Expenditure has reduced by £0.5m in September. The main elements relate to General Dental Services (GDS) and General Medical Services (GMS). Further details on these are provided in section 14 of the report.</li> </ul>														
<b>Primary Care Drugs</b>	<ul style="list-style-type: none"> <li>GP prescribing and dispensing costs continue to be a significant risk in 2020/21. Spend has increased by £0.3m compared to last month, but is still under the run rate for the year. The year to date over spend at Month 6 is £3.8m, with a forecast overspend of £8.8m for the year.</li> <li>The data for July, which was received this month, showed a further decrease in the average cost per prescribing day, with decreases in both the average cost per item and also the number of items prescribed. On a rolling 12-month basis, the average cost per prescribing day is down by 7%. This is as a result of the the cost per items is being down by 1% and the number of items being reduced by 2.5%.</li> <li>The prescribing accrual is based on the rolling average cost per prescribing day. Actual costs for July were lower than had been accrued and the August and September accrual has been based on the reduced rolling average.</li> </ul>														
<b>Provided Services - Pay</b>	<ul style="list-style-type: none"> <li>Details are provided in Section 5.</li> </ul>														
<b>Provider Services Non-Pay</b>	<ul style="list-style-type: none"> <li>There has been a decrease of £1.2m in expenditure compared to Month 5.</li> <li>COVID-19 expenditure of £1.4m, which is £0.5m less than last month, is included within Provider Services Non-Pay in September, broken down as follows:</li> </ul> <table data-bbox="678 1507 1286 1785"> <tr> <th></th><th>£m</th></tr> <tr> <td>Clinical Services &amp; Supplies</td><td>0.6</td></tr> <tr> <td>Establishment &amp; Transport Expenses</td><td>0.0</td></tr> <tr> <td>General Services &amp; Supplies</td><td>0.7</td></tr> <tr> <td>Other services</td><td>0.5</td></tr> <tr> <td>Premises and Fixed Plan</td><td>(0.4)</td></tr> <tr> <td></td><td><b>1.4</b></td></tr> </table>		£m	Clinical Services & Supplies	0.6	Establishment & Transport Expenses	0.0	General Services & Supplies	0.7	Other services	0.5	Premises and Fixed Plan	(0.4)		<b>1.4</b>
	£m														
Clinical Services & Supplies	0.6														
Establishment & Transport Expenses	0.0														
General Services & Supplies	0.7														
Other services	0.5														
Premises and Fixed Plan	(0.4)														
	<b>1.4</b>														

## 4. INCOME & EXPENDITURE

	<ul style="list-style-type: none"> <li>– The negative Premises and Fixed Plan cost relates to a reduction in the building contracts cost for Field Hospitals. This reduction totalled £0.6m.</li> <li>– The rising cost of some elements of PPE, particularly gloves and masks, is also resulting in increased non-pay costs. Usage of PPE has increased due to the pandemic, but the concern is around the unit cost, which has seen a significant increase over the last two months.</li> </ul>
<b>Secondary Care Drugs</b>	<ul style="list-style-type: none"> <li>– Costs have increased by £0.8m to £6.2m, which is the highest level for the year so far.</li> <li>– There has been an increase in costs across most specialties, but notably in Oncology (by £0.3m), Haematology (by £0.2m) and for staff flu vaccines (by £0.1m).</li> </ul>
<b>Healthcare Services provided by other NHS Bodies</b>	<ul style="list-style-type: none"> <li>– 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.</li> <li>– There has been a small (2%) increase in spend compared to Month 5 of £0.4m. In September, WHSCC have reported a further under spend of £0.4m, primarily due to bringing in reserves.</li> </ul>
<b>Continuing Health Care (CHC) and Funded Nursing Care (FNC)</b>	<ul style="list-style-type: none"> <li>– Expenditure in September has increased by £0.5m compared to August, with this rise relating to COVID-19 costs.</li> <li>– Mental Health continues to have 19 placements arising from moving patients out to increase acute capacity for COVID-19. In addition, some beds are closed due to COVID-19 ward reconfigurations. Efforts to review placements and packages, particularly for those patients discharged due to COVID-19, are ongoing.</li> </ul>
<b>Other Private and Voluntary Sector</b>	<ul style="list-style-type: none"> <li>– There has been no material change in spend. Expenditure relates to a variety of providers, including hospices and Mental Health organisations.</li> </ul>
<b>Joint Financing</b>	<ul style="list-style-type: none"> <li>– Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget.</li> </ul>
<b>Losses, Special Payments and Irrecoverable Debts</b>	<ul style="list-style-type: none"> <li>– Includes Redress, Clinical Negligence, Personal Injury and loss of property.</li> <li>– Increase in spend of £1.1m in September relates to the quarterly adjustment for the Welsh Risk Pool clinical negligence provision,</li> </ul>

## 4. INCOME & EXPENDITURE

	because of an increase in the quantum.
<b>Capital</b>	– Includes depreciation and impairment costs, which are fully funded.

### 4.3 Forecast (Table B)

- Pay costs are forecast to increase in October, which reflects the payment of the Doctors' and Dentists' Review Body (DDRB) pay award.
  - Non-pay costs are forecast to increase from October, when it is forecast that there will be a step up in activity and costs relating to Test Trace Protect (TTP). There is a further rise in March due to the decommissioning costs of two of the Field Hospitals. 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 September are £67.4m, with Provided Services pay costs being £65.6m, which is £0.4m lower than in August. Primary Care pay costs at £1.8m are £0.1m lower than last month. A total of £1.8m of pay costs were directly related to COVID-19.
- Admin and Clerical pay has reduced by £1.1m. This relates to an adjustment to agency costs where £0.6m of TTP costs categorised as Admin & Clerical agency in Month 5 were reallocated to other pay codes in Month 6, as additional information became available.
- Additional Clinical Services pay has increased in Month 6 by £0.2m due to an increase in Health Care Support Worker costs as activity starts to increase.

### 5.2 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 6 are £2.8m, representing 4.1% of total pay, a decrease of £1.0m on last month. Agency spend related to COVID-19 in September was £0.3m, the same as last month.
  - Medical agency costs have increased by £0.4m to an in-month spend of £1.8m. Of this, £0.3m related to COVID-19 work, £0.1m higher than August. There has also been an opposing increase in locum costs of £0.2m.
  - Nurse agency costs totalled £1.1m for the month, £0.2m less than last month. These costs include £0.04m relating to COVID-19. Reductions in agency usage have been seen across the acute hospitals and Mental Health as additional bank staff have been used.
  - Other agency costs have seen the largest movement this month, with a decrease of £1.2m. This is primarily due to a reduction in Admin and Clerical agency spend as part of the TTP adjustment noted above.
-



## 6. COVID-19 ANALYSIS

### 6.1 COVID-19 Actual Costs (Table B3)

- The total cost of COVID-19, including the Field Hospitals and TTP is £7.3m for September. A total of £0.1m of specific funding has been redirected and used to offset the cost of COVID-19, leaving a net cost of £7.2m for the month.
- During the month there was a reduction in the building contracts cost for Field Hospitals totalling £0.6m.
- TTP costs have been included in accordance with Welsh Government guidance. There was an adjustment in Month 6 to correct an over accrual in Month 5, meaning that the year to date spend has remained at £1.2m.
- Included in Field Hospital costs are consequential losses totalling £0.4m for the year to date. The building of the three Field Hospitals in North Wales required minimal disruption to the existing sub-tenants because the country was in full lockdown. However, as the country moved out of full lockdown and efforts are being made to restart the economy the issue of consequential losses has become an issue across each of the three sites.
- The issues are different across the three sites as some are a single landlord, whilst at least one of the sites has sub-tenants who could have started trading as we moved out of the full lockdown. The Health Board is negotiating consequential losses directly through the Local Authority or Bangor University, rather than with the individual sub-tenant.
- The approach will be to seek appropriate legal advice and liaise with Welsh Government colleagues and other Health Boards to ensure we have a consistent approach, and once we have an agreement in principal, we will discuss with Welsh Audit Office the level of evidence required to support any payment.
- The current assessment of consequential losses is estimated at £2.2m, but clearly this value remains subject to revision as negotiations progress and if any if the rules on social contact change.

### 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. The current total cost of COVID-19 is forecast to be £152.9m.
  - The forecast for the Field Hospitals is based on the latest assumptions, but they are constantly under review. The work supporting the Quarter 3 and 4 Plan will help inform the assumptions over the winter months.
-

## 6. COVID-19 ANALYSIS

- This month, forecasts for the cost of utilising the independent sector, the extension of the flu vaccination campaign and the COVID-19 vaccination programme have been included in Table B3, along with the funding to support them.
  - Other specific assumptions made are:
    - Savings delivery for the year will be reduced against the plan of £45.0m and indicative estimates are that this will be £11.1m, although there are £3.9m of red rated schemes in the pipeline, which it is anticipated will increase savings delivery this year to £15.0m. Work is ongoing to increase the level of savings delivery during the year.
    - Costs for decommissioning the field hospitals are currently estimated at £2.2m, with £0.6m incurred in November for the closure of one hospital and the remaining two hospitals closed in March at a cost of £1.6m.
    - Elective under spends will continue for the rest of the year. There was an increase in the elective work undertaken in September. It is expected that activity will increase further 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 forecast elective under spend for the year is £19.3m.
-

## 7. SAVINGS

### 7.1 Savings (Tables C – C3)

- Development of the savings programme and delivery of savings continues to improve. Savings of £1.2m are reported in Month 6, increasing the year to date delivery to £5.5m. Schemes currently in delivery have a forecast in-year value in Table A of £11.1m. This includes delivery of £0.3m, 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, a further £0.3m, has been included in the pipeline value. Scheme trajectories have been reviewed to ensure that they are robust following feedback from the Month 5 return.
- The total in-year forecast for savings (including income generation and accountancy gains) including pipeline, has increased to £15.0m from the £14.9m reported in Month 5. Schemes that remain in the 2020/21 pipeline amount to £3.9m and work is progressing to move these into amber / green during Month 7. The review of workforce schemes in the pipeline are now not expected to deliver, however alternative schemes have been identified to cover this value.

Amber/Green Date	Forecast Annual Savings £000	Forecast FYE Savings £000
Oct-20	3,925	7,533
<b>Total</b>	<b>3,925</b>	<b>7,533</b>

- 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)

- Income for COVID-19 costs has only been anticipated from Welsh Government where it has been notified to the Health Board. This totals £129.7m for 2020/21, identified as follows:

WG Anticipated COVID-19 Income	£m
Additional COVID-19 support	83.1
Field Hospital commissioning costs	11.5
Test Trace Protect (TTP)	11.4
PPE	6.5
Extended flu vaccination programme	5.7
COVID-19 vaccination programme	3.3
COVID-19 testing	3.1
Field Hospital decommissioning costs	2.2
Consequential losses	2.2
Independent sector	0.7
<b>Total</b>	<b>129.7</b>

## 10. STATEMENT OF FINANCIAL POSITION

### 10.1 Statement of Financial Position (Table F)

- Key movements in the SoFP in the first half of 2021/21 are:
    - Fixed assets decrease of £8.9m due to newly capitalised assets in year less non-cash adjustments.
    - Trade and other receivables decrease of £17.9m primarily due to movements in the Revenue Resource Limit debtor of £7.0m and ICF debtor of £6.6m.
    - Cash increase of £5.8m due to revenue cash balance, which will be reduced in November drawdown.
    - Trade and other payables decrease of £10.4m due to reductions of £4.7m in losses payables and £7.5m in year-end ICF payments.
    - Provisions decrease of £3.1m mainly due to reductions in clinical negligence provisions of £2.4m.
    - General Fund reduction of £6.8m due to £19.8m year to date deficit less £13.0m CRL drawn down.
-

## 11. CASH

### 11.1 Cash Flow Forecast (Table G)

- The closing cash balance as at 30<sup>th</sup> September was £9.0m, which included £7.2m cash held for revenue expenditure and £1.8m cash held for capital projects.
- Table G – Monthly cash flow forecast currently forecasts a shortfall of £41.7m as at 31<sup>st</sup> March. In order to maintain the opening revenue balance of £1.5m the total cash requirement for the year would increase to £43.1m. This assumes a nil capital cash balance at the end of the year.
- The total forecast cash requirement of £43.1m consists of £40.0m to support the forecast deficit position reported on Table B, £6.0m 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 £5.0m 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 current forecast revenue and capital cash movements during 2020/21 is provided below:

Revenue cash requirements 2020/21	£000
Forecast revenue deficit	(40,000)
Forecast revenue deficit to be managed internally	5,000
Working capital balances	(6,000)
<b>Forecast revenue cash shortfall</b>	<b>(41,000)</b>

Capital cash requirements 2020/21	£000
<b>Forecast cash funding</b>	
Opening capital balance	1,698
Approved Capital Resource limit	27,553
Donated asset income	1,027
Disposal proceeds	150
<b>Total forecast cash funding</b>	<b>30,428</b>

## 11. CASH

<b>Forecast cash spend</b>	
Opening capital balance	(1,698)
Approved Capital Resource limit	(27,553)
Donated asset income	(1,027)
Disposal proceeds	(150)
Reduction in capital creditors (CRL not requested during 2019/20)	(2,109)
<b>Total forecast cash spend</b>	<b>(32,537)</b>
<b>Forecast capital cash shortfall</b>	<b>(2,109)</b>

<b>Forecast total revenue and capital cash shortfall</b>	<b>(43,109)</b>
--	-----------------

- Cash requirements currently exclude any pressures from in-year movements in CHC provisions, which will be updated following the provision commission exercise in November 2020.
- The forecast working capital movements detailed above are reflected in the current trade and other payables line of Table F – Statement of Financial Position for Monthly Period as below:

<b>Trade and other payables</b>	<b>£000</b>
<b>Opening balance 1<sup>st</sup> April 2020</b>	<b>(143,633)</b>
<b>Forecast movement in revenue payables</b>	
Increases to manage 2020/21 forecast cash deficit	(5,000)
Reduction including 2019/20 resource only allocations	6,000
<b>Forecast movement in capital payables</b>	
Reduction using opening cash balance	1,698
Reduction where CRL was not requested in 2019/20	2,109
<b>Forecast closing balance 31<sup>st</sup> March 2021</b>	<b>(138,826)</b>



## 12. PUBLIC SECTOR PAYMENT COMPLIANCE

### 12.1 PSPP (Table H)

- The Health Board has achieved the PSPP target to pay 95% of valid invoices within 30 days of receipt in three of the four measures of compliance both during Quarter 2 and cumulatively for 2020/21. NHS invoices by number remained below target during Quarter 2 at 86.0% (89.4% year to date).
  - A recently completed analysis of PSPP performance has identified a small number of areas where the NHS measure is not being achieved. Discussions are ongoing with budget holders and NWSSP Accounts Payable to consider measures to reduce authorisation delays in these specific areas.
  - Following discussions at the September Technical Accounting Group meeting, it was also agreed to establish a Task & Finish Group to consider common problems being experienced with NHS PSPP performance across Wales.
-

## 13. CAPITAL

### 13.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2020/21 is £27.6m. Actual expenditure to the end of September was £8.4m, against a plan of £11.1m. The year to date slippage of £2.7m will be recovered during the remainder of the year.

### 13.2 Capital Programme (Table J)

- The Capital Programme update is reported in Table J.
-

## 14. WELSH NHS DEBTORS

### 14.1 Welsh NHS Debtors (Table M)

- The Health Board held two NHS Wales invoices that were over eleven weeks old at the end of Month 6 that had been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales.
  - Public Health Wales NHS Trust has confirmed that these invoices have now been approved and will be paid shortly.
-

## 15. GMS & GDS

### 15.1 GMS (Table N)

- At the end September, the Health Board reported a £0.5m over spend position against the ring fence GMS budget. The reason for the over spend at the end of Quarter 2 is mainly due to increasing costs of drugs reported through GMS Dispensing and cost pressures within 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 30<sup>th</sup> September the Health Board is managing 15 practices and we are not aware of any further resignations at this stage in the financial year.
- Based on the Quarter 2 data, the current year-end forecast for GMS is £0.8m over spent, however we are still expecting further contractual changes during the year which may require the forecast to be amended.

### 15.2 GDS (Table O)

- At the end September, the Health Board reported a £0.8m over spend position against the ring fence GDS budget. The reason for the over spend at the end of Quarter 2 is still due to loss of the Patient Charge Revenue (PCR) exceeding the 20% contract reduction in Quarter 1 and 10% contract reduction Quarter 2, which was 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 31st December) the forecast has now been amended to reflect this. The current forecast is £2.9m over spent for the year (now including the 2.3% DDRB uplift and reflecting the 20% reduction on backdated payments for Quarter 1 and 10% reduction for Quarter 2), which is again the difference between the anticipated PCR income reduction and the reduced contractual payments. This should therefore should be viewed as the cost of COVID-19 within the GDS ring fence.
-

## 16. SUMMARY

### 16.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.
- The Month 6 Monitoring Return will be received by the Health Board's Finance and Performance Committee members at the October meeting.

**Gill Harris**  
**Interim Chief Executive**

**Sue Hill**  
**Acting Executive Director of Finance**

## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

### Month 5 Monitoring Return Responses

#### Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 5.1

As referenced above, for the first time this year you are reporting additional Operational Pressures (not due to COVID-19) of £0.245m, that are not forecast to be mitigated and therefore you will exceed the agreed £40.0m deficit. It is not clear if this was reported in error, given there is little reference to this in your narrative; please review and if an error, please remove the value in September. If however this is correct, then adequately describe what these pressures relate to and ensure you identify sufficient actions to mitigate by Month 6. The Health Board is expected to not exceed the £40.0m operational deficit. I note you have the benefit from the lower WRP commitment of £0.059m available and you should consider assigning your additional in-year Accountancy Gains to mitigate in-year operational pressures, before taking any benefit to the Covid Table.

#### Response

The additional COVID-19 income notified to the Health Board in September has changed the financial position and the forecast significantly this month. We are also no longer forecasting any additional pressures. The forecast has therefore reduced back down to a £40m deficit.

#### Monthly Profiles (Tables B) - Action Point 5.2

I note you are now reporting an YTD deficit of £44.349m based on your YTD planned deficit of £16.915m plus £27.437m due to unfunded Covid-19 costs. On review of the phasing of your RRL and your explanations for deviation from equal twelfths, it appears that your YTD RRL is under-phased. The below table shows the position at M5 and at M4:

Month 5	M5 - £m	M4 - £m
<b>Annual Resource Limit (as per Table E)</b>	<b>1,597</b>	<b>1,682</b>
Less COVID-19 (line 22, Table A)	<b>-50</b>	<b>-131</b>
	<b>0</b>	<b>0</b>
Less Funding for specific purposes not phased in (ICF/Dementia/medical pay etc)	<b>-12</b>	<b>-39</b>
<b>Adjusted Resource Limit</b>	<b>1,535</b>	<b>1,512</b>
<b>Equal 12ths</b>	<b>639</b>	<b>504</b>
Add COVID-19 YTD	<b>33</b>	<b>53</b>
<b>Phased YTD Resource Limit</b>	<b>673</b>	<b>556</b>
<b>Actual Phased YTD Resource Limit (Table B)</b>	<b>660</b>	<b>557</b>
<b>- Underphased / + Over phased</b>	<b>-12</b>	<b>0</b>

Please review this for Month 6 and ensure that any difference is sufficiently explained in your next return.

#### Response

The RRL phasing has been reviewed for Month 6 and the table to explain it amended to make it clearer how the phasing has been done.

## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

### Monthly Profiles (Tables B) - Action Point 5.3

I note that the balance of the Diagnostic Reserve increased at Month 5, suggesting a delay in the actions attracting the expenditure. Please can you provide an update at Month 6, if spend is delayed a further month, to assist us to understand the potential flexibility within this reserve.

#### Response

The original delay was created due to the implementation of solutions such as CT in a Box that was expected in July, but arrived September. The forecast profile has been reviewed in line with the delayed start date and the alternative insourcing and agency solutions for lost capacity have been factored into future months. Radiology anticipate the current solutions to be maintained until March 2021.

### Pay (Table B2) - Action Point 5.4

I note that your Agency spend materially increased this month and although your narrative references the increases there is little detail to explain the reasons for those quantified as 'not due to covid'. Please ensure your narrative provides sufficient detail to explain movements going forward.

#### Response

We will ensure the narrative provides sufficient detail regarding movements in agency going forward.

### Covid-19 (Table B3) - Action Point 5.5

I note you are including the £0.616m allocation for the 0.8% top up that is being passed on to WHSSC to pay English providers, as previously instructed. To ensure there is no double count with WHSSC, when we consolidate the returns, we now need to request that you do not include this particular income on the WG Covid line on Table A and remove the costs from Table B3 for future submissions. We apologise for any inconvenience caused; however the consolidation of WHSSC into the all Wales position is a one-off change due to Covid and therefore has required us to change the normal advice.

#### Response

Noted. Spend in Table B3 and COVID-19 income line on Table A has been adjusted to remove the £0.616m in Month 6.

### Covid-19 (Table B3) - Action Point 5.6

I note the amount reported on line 94 of £1.351m has increased by £0.989m in Month 5 with "Social distancing materials" being added to the free text line. Please consider if these more appropriately fall under "Equipment - other" (set text line).

## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

### Response

Noted. Social distancing materials now included within Equipment – Other. Adjustment made in Month 6.

### Covid-19 (Table B3) – Action Point 5.7

All organisations are being requested this month, to please use free text Line 107 (within the Major Projects section) to report all projected costs associated with a new Mass Covid-19 Vaccination programme. This in addition to using Line 108 for costs of extending the Flu Vaccination programme. Please also confirm in your narrative, which lines in section A you have recorded the associated spend.

### Response

Costs for the extended flu programme have been included in the forecast from this month on line 108 of Table B3. In section A of Table B3, these costs are analysed across drugs (£1.7m) and Prof Scientific & Technical pay (£4.0m).

Costs for the mass vaccination programme for COVID-19 have been included in the forecast from this month on line 107 of Table B3. In section A of Table B3, these costs are analysed across pay codes (£2.4m) and non-pay (£0.8m).

### Savings (Table C,C1, C2, C3) – Action Point 5.8

It is pleasing to note that savings delivery was £1.3m within August (a material improvement on last month's forecast). The future month forecast however, is currently due to reduce to c £600k per month. Please ensure that your forecast monthly savings reflect an accurate assessment of delivery.

### Response

All forecasts have been updated to reflect expected delivery in Months 7 to 12 and will be reviewed on a monthly basis to ensure they remain accurate.

As per the narrative, some schemes are delivering but future delivery remains in the pipeline value as PIDs remain under development, as per guidance issued after Month 3. This does have the impact of making future months delivery of actual savings lower than in month delivery value.

### Inter Organisational Income & Expenditure (Table D) – Action Point 5.9

I refer to Inter Organisation Income and Expenditure Reconciliation email of 15th September, which noted differences in your assumptions with Velindre of £0.130m. Please review and liaise with relevant colleagues to ensure this difference is eliminated in your next submission.

### Response

The Health Board has agreed the expenditure figure with Velindre for Month 6; therefore, all differences have been eliminated.



## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

### **Anticipated Allocations (Table E) – Action Point 5.10**

To aid our consolidation and ensure we are raising the correct amount with the applicable Policy Lead, please separate your anticipated income reported in Table E for Covid-19, between TTP and Field Hospital.

### **Response**

Anticipated income has now been split between TTP And Field Hospitals.



<b>Cyfarfod a dyddiad: Meeting and date:</b>	<b>Finance and Performance Committee 29.10.20</b>						
<b>Cyhoeddus neu Breifat: Public or Private:</b>	Public						
<b>Teitl yr Adroddiad Report Title:</b>	Monthly Monitoring Report – Month 5						
<b>Cyfarwyddwr Cyfrifol: Responsible Director:</b>	Mrs Sue Hill, Acting Executive Director of Finance						
<b>Awdur yr Adroddiad Report Author:</b>	Eric Gardiner, Finance Director, Provider Services						
<b>Craffu blaenorol: Prior Scrutiny:</b>	The submission made to Welsh Government required Chief Executive and Director of Finance sign off.						
<b>Atodiadau Appendices:</b>							
<b>Argymhelliad / Recommendation:</b>							
Note the contents of the report that has been made to the Welsh Government about the Health Board's financial position for Month 5 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)							
<b>Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval</b>	<input type="checkbox"/>	<b>Ar gyfer Trafodaeth For Discussion</b>	<input type="checkbox"/>	<b>Ar gyfer sicrwydd For Assurance</b>	<input type="checkbox"/>	<b>Er gwybodaeth For Information</b>	<input checked="" type="checkbox"/>
<b>Sefyllfa / Situation:</b>							
To report to the Committee the completion of monthly reporting to the Welsh Government for Month 5 of 2020/21.							
<b>Cefndir / Background:</b>							
<p>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; 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.</p> <p>In the first five 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.</p>							
<b>Asesiad / Assessment &amp; Analysis</b>							

## 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 Financial position

- The in-month position is a £31.0m deficit, which is £27.7m above the plan for Month 5. This gives a cumulative year to date position of £44.4m, which is £27.7m above the plan of £16.7m.
- Up to Month 4, the Health Board position assumed a level of additional income from Welsh Government that would offset the financial impact of the COVID-19 response. Following agreement at the August Finance & Performance Committee and in discussion with Welsh Government, for Month 5 the Health Board has changed this income assumption.
- From Month 5 onwards, only received or notified Welsh Government COVID-19 income has been included in the position. Therefore, income anticipated in Months 1 to 4 that did not meet this criteria has been removed. As a result of this change in reporting basis, the reported deficit position has significantly increased in Month 5, but this does not reflect an increase in forecast expenditure. This change in the assumptions in relation to income will ensure that the Health Board's reporting is in line with the other Health Boards across Wales.
- The table below shows how the position would have been reported for Months 1 to 4, if the revised income assumptions had been in place from the start of the year.

	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	YTD £m
<b>Previously Reported Deficit</b>	<b>3.4</b>	<b>3.3</b>	<b>3.3</b>	<b>3.3</b>		
Total cost of COVID-19	30.8	5.1	7.5	9.2		
Specific funding received & redirected	0.0	0.0	0.0	(2.4)		
WG COVID-19 income received or notified	(23.6)	0.0	(0.1)	(5.4)		
<b>Position under M05 income assumption</b>	<b>10.6</b>	<b>8.4</b>	<b>10.7</b>	<b>4.7</b>	<b>10.0</b>	<b>44.4</b>
<b>Planned deficit</b>						<b>16.7</b>
<b>Variance over plan</b>						<b>27.7</b>

- The cost of COVID-19 in August is £7.9m. The overall impact of COVID-19 on the year to date position is £60.5m. Specific funding sources totalling £2.5m have been redirected to COVID-19 to cover some of these costs. £30.4m of Welsh Government income has been received or notified to cover costs to date. This leaves the net impact of COVID-19 at £27.6m, which equates to almost the total reported year to date over spend.

	M01	M02	M03	M04	M05	YTD
	£m	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	6.1	53.0
Lost income	1.2	1.4	1.2	1.6	1.6	7.0
Non delivery of savings	3.7	3.6	2.0	2.7	2.3	14.3
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(1.9)	(11.9)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(0.2)	(1.5)
Cluster funding	0.0	0.0	(0.3)	(0.1)	0.0	(0.4)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0	0.0
<b>Total COVID-19 costs</b>	<b>30.8</b>	<b>5.1</b>	<b>7.5</b>	<b>9.2</b>	<b>7.9</b>	<b>60.5</b>
<b>Funding:</b>						
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(0.1)	(1.7)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	0.0	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	0.0	(0.1)
Welsh Government	(30.8)	(5.1)	(7.5)	(6.8)	19.8	(30.4)
<b>Impact on position</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>27.6</b>	<b>27.6</b>

## 1.2 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.
- Up to Month 4, the Health Board had anticipated that it would achieve the planned deficit of £40.0m at the end of the year, as per the financial plan. However, this was on the basis that all COVID-19 costs were fully funded by Welsh Government. Following the change in income assumptions noted above, the forecast outturn at Month 5 has increased to £122.2m. The deterioration is a reflection of the reduction in the anticipated income from Welsh Government towards the cost of COVID-19.

Forecast at M05	£m
Planned deficit	40.0
Forecast COVID-19 net costs	131.9
Redirected funding	(3.4)
WG COVID-19 specific funding	(46.6)
Other cost pressures	0.3
<b>Forecast outturn</b>	<b>122.2</b>

### Risk Analysis:

- There are two opportunities to reduce the financial position, totalling £6.2m and four risks where the financial impact is not yet known. These are detailed in Section 3 of the attached report.

### Legal and Compliance:

Not applicable.

### Impact Assessment:

Not applicable.



GIG  
CYMRU  
NHS  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

# MONITORING RETURN

MONTH 5 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; 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 five 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 Financial Position

- The in-month position is a £31.0m deficit, which is £27.7m above the plan for Month 5. This gives a cumulative year to date position of £44.4m, which is £27.7m above the plan of £16.7m.
  - Up to Month 4, the Health Board position assumed a level of additional income from Welsh Government which would offset the financial impact of the COVID-19 response. Following agreement at the August Finance & Performance Committee and in discussion with Welsh Government, for Month 5 the Health Board has changed this income assumption.
  - From Month 5 onwards, only received or notified Welsh Government COVID-19 income has been included in the position. Therefore, income anticipated in Months 1 to 4 that did not meet this criteria has been removed. As a result of this change in reporting basis, the reported deficit position has significantly increased in Month 5, but this does not reflect an increase in forecast expenditure. This change in the assumptions in relation to income will ensure that the Health Board's reporting is in line with the other Health Boards across Wales.
  - The Welsh Government COVID-19 income that has been included in the year to date position and forecast is as follows:
-

## 1. FINANCIAL POSITION & FORECAST

	YTD £m	Full Year £m
Quarter 1 Pay	5.4	5.4
MH Helpline	0.0	0.1
Field Hospital commissioning costs	23.6	23.6
Trace element of TTP	0.9	11.2
Trace element of TTP - IT costs	0.0	0.2
Additional cross border costs 0.8%	0.0	0.5
Additional cross border costs 0.8% - WHSCC	0.5	0.6
Support for adult social care providers	0.0	5.0
<b>COVID-19 Specific Funding</b>	<b>30.4</b>	<b>46.6</b>
Optimise Flow & Outcomes (ICF)	1.7	2.5
Mental Health Improvement Fund	0.7	0.7
GMS (DES)	0.1	0.2
<b>Redirected Funding</b>	<b>2.5</b>	<b>3.4</b>
<b>Total Welsh Government Funding</b>	<b>32.9</b>	<b>50.0</b>

- The table below shows how the position would have been reported for Months 1 to 4, if the revised income assumptions had been in place from the start of the year.

	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	YTD £m
<b>Previously Reported Deficit</b>	<b>3.4</b>	<b>3.3</b>	<b>3.3</b>	<b>3.3</b>		
Total cost of COVID-19	30.8	5.1	7.5	9.2		
Specific funding received & redirected	0.0	0.0	0.0	(2.4)		
WG COVID-19 income received or notified	(23.6)	0.0	(0.1)	(5.4)		
<b>Position under M05 income assumption</b>	<b>10.6</b>	<b>8.4</b>	<b>10.7</b>	<b>4.7</b>	<b>10.0</b>	<b>44.4</b>
<b>Planned deficit</b>						<b>16.7</b>
<b>Variance over plan</b>						<b>27.7</b>

- The cost of COVID-19 in August is £7.9m. The overall impact of COVID-19 on the year to date position is £60.5m. Specific funding sources totalling £2.5m have been redirected to COVID-19 to cover some of these costs. £30.4m of Welsh Government income has been received or notified to cover costs to date. This leaves the net impact of COVID-19 at £27.6m, which equates to almost the total reported year to date over spend.



# 1. FINANCIAL POSITION & FORECAST

	M01	M02	M03	M04	M05	YTD
	£m	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	6.1	53.0
Lost income	1.2	1.4	1.2	1.6	1.6	7.0
Non delivery of savings	3.7	3.6	2.0	2.7	2.3	14.3
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(1.9)	(11.9)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(0.2)	(1.5)
Cluster funding	0.0	0.0	(0.3)	(0.1)	0.0	(0.4)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0	0.0
<b>Total COVID-19 costs</b>	<b>30.8</b>	<b>5.1</b>	<b>7.5</b>	<b>9.2</b>	<b>7.9</b>	<b>60.5</b>
<b>Funding:</b>						
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(0.1)	(1.7)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	0.0	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	0.0	(0.1)
Welsh Government	(30.8)	(5.1)	(7.5)	(6.8)	19.8	(30.4)
<b>Impact on position</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>27.6</b>	<b>27.6</b>

## 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.
- Up to Month 4, the Health Board had anticipated that it would achieve the planned deficit of £40.0m at the end of the year, as per the financial plan. However, this was on the basis that all COVID-19 costs were fully funded by Welsh Government. Following the change in income assumptions noted above, the forecast outturn at Month 5 has increased to £122.2m. The deterioration is a reflection of the reduction in the anticipated income from Welsh Government towards the cost of COVID-19.

<b>Forecast at M05</b>	<b>£m</b>
Planned deficit	40.0
Forecast COVID-19 net costs	131.9
Redirected funding	(3.4)
WG COVID-19 specific funding	(46.6)
Other cost pressures	0.3
<b>Forecast outturn</b>	<b>122.2</b>

## 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
<b>Opportunities</b>			
Red Pipeline Savings Schemes	6.1		Red rated savings schemes that total £6.1m are currently held in pipeline and are due to start delivering over the next two months.
Welsh Risk Pool	0.1		There is potential that there will be a reduction in the Welsh Risk Pool cost share outturn from original IMPT value of £2.4m and this may lead to a benefit for the Health Board.
<b>Risks</b>			
Vaccination Programme for Flu and COVID-19			An initial plan has been submitted to Welsh Government for the flu and COVID-19 vaccination programme. The plan continues to be developed and the cost implications have not yet been determined.
Savings Programme			There is a risk that the amber schemes within the savings programme will not deliver to their forecast values.
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 £115.8m for August.
- Confirmed allocations to date are £1,552.7m, with further anticipated allocations in year of £44.3m, a total forecast Revenue Resource Limit (RRL) of £1,597.0m for the year. £103.7m has been profiled into August, which is £36.3m lower than in July. This is primarily due to the removal of anticipated income for COVID-19 that had been included in the position up to Month 4 and was taken out in Month 5, in line with the change in income assumptions. In addition, costs for Primary Care drugs, pay and Capital are lower in Month 5.
- A reconciliation between the RRL phased into the position and an equal phasing is shown in the table below.

	Annual £m	Phased at M05 £m	5/12ths £m
RRL	(1,597.0)	(660.3)	(665.4)
Less funded Covid-19 costs	46.6	30.4	30.4
<b>Non covid-19 budgets</b>	<b>(1,550.4)</b>	<b>(629.9)</b>	<b>(635.0)</b>
Funding for specific purposes, e.g. drug treatment fund / medical	12.2	0.0	5.1
	<b>(1,538.2)</b>	<b>(629.9)</b>	<b>(629.9)</b>

- The impact of COVID-19 has resulted in lost income of £1.6m during August, which includes £0.5m 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 £146.8m for Month 5, £6.1m less than in Month 4.
- £6.1m of expenditure is directly related to COVID-19, of which £3.0m is included in pay and £3.1m across non-pay expenditure categories. £0.8m of this relates to the three Field Hospitals and £0.9m to Test Trace Protect (TTP).
- The impact of COVID-19 on the savings programme has resulted in planned savings of £2.3m not being achieved this month and this shortfall is included within non-pay. There has been a small increase in elective care activity during July, but it is still at a much

## 4. INCOME & EXPENDITURE

reduced level. As a consequence there is a reduction in planned care non-pay spend of £1.9m. In addition, there is slippage on a number of planned investments of £0.2m.

<b>Primary Care</b>	<ul style="list-style-type: none"> <li>Expenditure is predominantly in line with last month, with a small 2% (£0.3m) reduction.</li> </ul>														
<b>Primary Care Drugs</b>	<ul style="list-style-type: none"> <li>GP prescribing and dispensing costs continue to be a significant risk in 2020/21, however there has been a reduction in costs this month.</li> <li>Spend has reduced by £2.3m compared to last month. This is a combination of a lower cost for June compared to the initial estimate and a reduction in the forecast for August, based on a lower average cost per prescribing day.</li> <li>The latest available data shows that the cost per prescribing day has reduced by 7%. This is due to the number of items issued reducing (down 7%), although cost of items has increased (up 2%).</li> </ul>														
<b>Provided Services - Pay</b>	<ul style="list-style-type: none"> <li>Details are provided in Section 5.</li> </ul>														
<b>Provider Services Non-Pay</b>	<ul style="list-style-type: none"> <li>There has been a small increase of £0.2m in expenditure compared to Month 4.</li> <li>COVID-19 expenditure of £1.8m is included within Provider Services Non-Pay in August, broken down as follows: <table border="1" data-bbox="695 1136 1271 1417"> <thead> <tr> <th></th><th>£m</th></tr> </thead> <tbody> <tr> <td>Clinical Services &amp; Supplies</td><td>0.4</td></tr> <tr> <td>Establishment &amp; Transport Expenses</td><td>0.0</td></tr> <tr> <td>General Services &amp; Supplies</td><td>0.3</td></tr> <tr> <td>Other services</td><td>0.1</td></tr> <tr> <td>Premises and Fixed Plan</td><td>1.0</td></tr> <tr> <td><b>Total</b></td><td><b>1.8</b></td></tr> </tbody> </table> </li> <li>An issue to note is the increasing cost of some elements of PPE, particularly gloves. Usage of gloves has increased significantly due to the pandemic, but the concern is around the unit cost. Prior to COVID-19, the cost of gloves was 3p per unit. Currently, the Health Board is paying 32p per unit. In Month 5, this is creating a pressure of £0.3m. NWSSP have confirmed that, given the increase in demand and the scarce raw materials, it is unlikely that pricing will be able to return to pre-pandemic levels. They have secured some additional stock at a cost of 10p per unit that will be distributed to Health Boards later this year, but this is still more than 3 times the</li> </ul>		£m	Clinical Services & Supplies	0.4	Establishment & Transport Expenses	0.0	General Services & Supplies	0.3	Other services	0.1	Premises and Fixed Plan	1.0	<b>Total</b>	<b>1.8</b>
	£m														
Clinical Services & Supplies	0.4														
Establishment & Transport Expenses	0.0														
General Services & Supplies	0.3														
Other services	0.1														
Premises and Fixed Plan	1.0														
<b>Total</b>	<b>1.8</b>														

## 4. INCOME & EXPENDITURE

	pre-pandemic cost and will result in a pressure across the organisation.
<b>Secondary Care Drugs</b>	<ul style="list-style-type: none"> <li>Costs have reduced by £0.4m this month and are back in line with the average for the year.</li> <li>Expenditure is notably reduced in Oncology (by £0.3m), Haematology (by £0.1m) and related to COVID-19 (by £0.1m).</li> </ul>
<b>Healthcare Services provided by other NHS Bodies</b>	<ul style="list-style-type: none"> <li>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.</li> <li>There has been a small (1%) decrease in spend compared to Month 4 of £0.3m. In August, WHSCC have reported a further under spend of £0.4m, primarily due to delayed developments.</li> </ul>
<b>Continuing Health Care (CHC) and Funded Nursing Care (FNC)</b>	<ul style="list-style-type: none"> <li>Expenditure in August has increased by £0.1m compared to July.</li> <li>COVID-19 related costs of £0.9m were incurred in Month 5, to give a year to date spend of £3.7m.</li> <li>There continues to be an increase in costs related to a number of new, high cost Mental Health and LDS placements. Efforts to review placements and packages, particularly for those patients discharged due to COVID-19, are ongoing.</li> </ul>
<b>Other Private and Voluntary Sector</b>	<ul style="list-style-type: none"> <li>There has been no material change in spend. Expenditure relates to a variety of providers, including hospices and Mental Health organisations.</li> </ul>
<b>Joint Financing</b>	<ul style="list-style-type: none"> <li>Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget.</li> </ul>
<b>Losses, Special Payments and Irrecoverable Debts</b>	<ul style="list-style-type: none"> <li>Includes Redress, Clinical Negligence, Personal Injury and loss of property.</li> </ul>
<b>Capital</b>	<ul style="list-style-type: none"> <li>Includes depreciation and impairment costs, which are fully funded.</li> </ul>

### 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.

## 4. INCOME & EXPENDITURE

- Non-pay costs are forecast to increase from December, when it is forecast that there will be a step up in activity and costs relating to Test Trace Protect (TTP). There is also a rise in March due to the decommissioning costs of two of the Field Hospitals. The third Field Hospital is due to be decommissioned in November, reflected by a small increase in non-pay costs that month.
  - Continuing Health Care (CHC) costs are forecast to increase in November, when we expect to pay the costs to date of the support to Adult Social Care providers.
-

## 5. PAY EXPENDITURE

### 5.1 Pay (Table B2)

- Total pay costs in July are £67.9m, with Provided Services pay costs being £66.0m.
- Provided Services pay costs are £1.3m lower than in July. A total of £3.0m of pay costs were directly related to COVID-19, £1.4m less than last month and the reason for the overall drop in pay. Primary Care pay costs at £1.9m have not changed significantly.
- Medical and Dental pay has decreased by £1.3m from last month, with £0.8m of the decrease relating to COVID-19. The premium rates that were being paid to some doctors because of the pandemic have now ceased, which has helped to reduce expenditure. However, we anticipate that there may be some further payments to be made going forward. In addition locum costs have fallen by £0.4m.
- Student pay costs have reduced in Month 5, as both Months 3 and 4 included back dated payments arising from the employment of student nurses as part of the COVID-19 response.

### 5.2 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 5 are £3.8m, representing 5.6% of total pay, an increase of £0.5m on last month. Agency spend related to COVID-19 in August was £0.3m, which is £0.5m less than last month.
  - Medical agency costs have decreased by £0.2m to an in-month spend of £1.4m. Of this, £0.2m related to COVID-19 work.
  - Nurse agency costs totalled £1.3m for the month, £0.1m higher than last month. These costs include £0.05m relating to COVID-19.
  - Other agency costs have seen the largest movement this month, with an increase of £0.6m. This is primarily down to an increase in Admin and Clerical agency spend.
-



## 6. COVID-19 ANALYSIS

### 6.1 COVID-19 Actual Costs (Table B3)

- The total cost of COVID-19, including the Field Hospitals and TTP is £7.9m for August.
- A total of £0.1m of specific funding has been redirected and used to offset the cost of COVID-19, leaving a net cost of £7.8m for the month.
- TTP costs have been included in accordance with Welsh Government guidance. Total cost in Month 5 was £0.9m, giving a year to date spend of £1.2m.

### 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.
  - The forecast for the Field Hospitals is based on the latest assumptions, but they are constantly under review. The work supporting the Quarter 3 and 4 Plan will help inform the assumptions over the winter months.
  - Other specific assumptions made are:
    - Savings delivery for the year will be reduced against the plan of £45.0m and indicative estimates are that this will be £8.8m, although there are £6.1m of red rated schemes in the pipeline, which it is anticipated will increase savings delivery this year to £14.9m. Work is ongoing to increase the level of savings delivery during the year.
    - Costs for decommissioning the field hospitals are currently estimated at £2.2m, with £0.6m incurred in November for the closure of one hospital and the remaining two hospitals closed in March at a cost of £1.6m.
    - Elective under spends will continue for the rest of the year. There was an increase in the elective work undertaken in August. It is expected that activity will increase further 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)

- Development of the savings programme and delivery of savings continues to improve. Savings of £1.4m are reported in Month 5, increasing the year to date delivery to £4.3m. The Month 5 figure includes some retrospective savings reported for schemes that were not reported in Month 4. Schemes currently in delivery have a forecast in-year value in Table A of £8.8m. This includes delivery of £0.5m, 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 £1.9m.
- The total in-year forecast for savings (including income generation and accountancy gains) including pipeline, has increased to £14.9m from the £14.2m reported in Month 4. Schemes that remain in the 2020/21 pipeline amount to £6.1m and work is progressing to move these into amber / green in the coming months. The expected movement is shown in the table below. The schemes with an expected date in October relate to workforce, where the ongoing impact of COVID-19 is challenging the original assumptions. These schemes will be subject to a detailed review in Month 6.

Amber/ Green Date	Forecast Annual Savings £000	Forecast FYE Savings £000
Sep-20	4,827	3,687
Oct-20	1,236	4,438
<b>Total</b>	<b>6,063</b>	<b>8,125</b>

- 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)

- In Month 4, the Health Board anticipated that it would receive £110.2m of funding from Welsh Government for COVID-19 costs. In addition, further funding of £1.1m was anticipated for the additional 0.8% nationally agreed inflation to fund the Block contracts with NHSE. This gave total Welsh Government funding of £131.2m.
- In Month 5, income for COVID-19 costs has only been anticipated from Welsh Government where it has been notified to the Health Board. This totals £22.9m for 2020/21, £87.3m less than in Month 4, and is identified as follows:

WG Anticipated COVID-19 Income	£m
Field Hospital commissioning costs	11.5
Trace element of TTP	11.2
Trace element of TTP - IT costs	0.2
<b>Total</b>	<b>22.9</b>

- Total Welsh Government COVID-19 income, excluding redirected funding, is therefore £46.6m.

WG COVID-19 Income	M04 Total Income in Forecast £m	M05 Total Income in Forecast £m	M05 YTD Income in Position £m
Pay costs	23.1	5.4	5.4
Non-pay costs	40.3	6.2	0.5
Field Hospital commissioning costs	23.6	23.6	23.6
Test Trace Protect (TTP) costs	14.5	11.4	0.9
Lost income	13.9	0	0
Non-delivery of savings plans	15.8	0	0
<b>Total</b>	<b>131.2</b>	<b>46.6</b>	<b>30.4</b>

- If the income assumptions had not been changed, anticipated income for COVID-19 in Month 5 would have totalled £104.8m, which would have given a forecast outturn of £40.3m. The change in income assumptions has therefore reduced anticipated income by £81.9m.

## 10. CASH

### 10.1 Cash Flow Forecast (Table G)

- The closing cash balance for August was £10.5m, which included £9.0m cash held for revenue expenditure and £1.5m cash held for capital projects.
- In accordance with the latest Monitoring Return submission guidance, an initial Table G – Monthly Cash flow Forecast will be included within the Month 6 submission.
- The Health Board is currently forecasting a significant cash shortfall for 2020/21 relating to both the original forecast overspend of £40.0m and the impact of COVID-19 related expenditure. This shortfall will in part be mitigated by additional resource allocations that are not currently included within anticipated income on Table E - Resource Limits.
- 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 31<sup>st</sup> March 2021. Current forecasts are that £6.0m of cash pressures resulting from the 2020/21 deficit position can be managed internally and this will continue to be reviewed as further opportunities arise.
- A full analysis of current 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	(122,156)
Forecast revenue deficit to be managed internally	6,000
Working capital balances	(2,622)
<b>Forecast revenue cash shortfall</b>	<b>(118,778)</b>

Capital cash requirements 2020/21	£'000
<b>Forecast cash funding</b>	
Opening capital balance	1,698
Approved Capital Resource limit	23,930
Donated asset income	1,027
Disposal proceeds	150
<b>Total forecast cash funding</b>	<b>26,805</b>

## 10. CASH

<b>Forecast cash spend</b>	
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)
<b>Total forecast cash spend</b>	<b>(28,914)</b>
<b>Forecast capital cash shortfall</b>	<b>(2,109)</b>
<b>Forecast total revenue and capital cash shortfall</b>	<b>(120,887)</b>

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## 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 August was £7.0m, against a plan of £9.1m. The year to date slippage of £2.1m will be recovered during the remainder of the year.

### 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 August, the Health Board had one NHS Wales invoice over eleven weeks old requiring escalation in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales. The invoice relates to Powys LHB and the amount outstanding is £0.004m.
-

## 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 5 Monitoring Return will be received by the Health Board's Finance and Performance Committee members at the October meeting.

**Gill Harris**  
**Interim Chief Executive**

**Sue Hill**  
**Acting Executive Director of Finance**

## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

### Month 4 Monitoring Return Responses

#### Risks (Table A2) – Action Point 4.1

I note you are now including a risk that the WRP risk sharing agreement will increase by a further £2.502m. I understand that NWSSP have since issued a further update to all organisations confirming that whilst the modelling indicates a further risk, they have decided not to include this for the time being. Therefore, you may wish to remove this from your Risks.

#### Response

The risk has been removed in Month 5 and the potential for a small opportunity recognised.

#### Covid-19 (Table B3) - Action Point 4.2

All organisations are being requested this month, to please use free text Line 108 (within the Major Projects section) to report all projected costs associated with extending the Flu Vaccination programme. Please also confirm, which lines (58-95) you have recorded the associated non pay spend.

#### Response

Projected costs relating to extension of the flu vaccination programme are still under review and are not yet included in the Month 5 return.

#### Covid-19 (Table B3) - Action Point 4.3

Please complete Line 109 (within the Major Projects section) with total TTP costs that agree to the TTP template.

#### Response

The total cost of TTP agrees between the TTP template and line 109.

#### Covid-19 (Table B3) - Action Point 4.4

On comparison to your last submission, it seems that the free text descriptions in Section C & D are misaligned with the relevant amounts.

#### Response

These have been reviewed and corrected for Month 5.

#### Covid-19 (Table B3) - Action Point 4.5

Please confirm if you have included the costs associated with the additional 0.8% uplift to English Providers, in your Covid Table B3. If you have, and the income received from WG is also included in Table A line 22; then please review the value of £110.227m that you have included in Table E as the outstanding Covid funding balance, as this appears to be overstated by this value.

## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

### Response

The costs associated with the 0.8% uplift were not included in Table B3, so the income assumptions are not overstated. For Month 5 we have included the costs in the B3 return, and included the income in Table A, line 22.

### Covid-19 (Table B3) - Action Point 4.6

I have been informed by colleagues that the allocation issued in July for the Primary Care Improvement Grant (£0.432m), may be re-purposed to offset other Covid related costs if the full amount is not going to be fully incurred on the original intended purpose. If applicable, this re-purposed value should be shown in section D of Table B3 and supporting details provided in your narrative. Please review and confirm your position regarding this allocation, at Month 5.

### Response

The Primary Care Improvement Grant is under review to establish if any funding can be re-purposed and any identified values will be shown in future returns.

### Savings (Table C) – Action Point 4.7

Thank you for the completion of the Tracker this month. On review, I note there are a significant proportion of schemes (95% of value) that are still classed as Amber. Please ensure you expedite actions to enable these to be classified as Green and provide details in your narrative to describe the activities and milestones that need to be completed to achieve this. I acknowledge that you also have a further £6.6m of schemes currently assessed as Red and that your plans are to progress these in order that they met the criteria for inclusion in the Tracker for Month 6. I look forward to receiving a progress update in your next narrative submission.

### Response

The point is noted. An update on progress is included within the Month 5 narrative submission.

### Monthly Profiles (Table B) – Action Point 4.8

On review of section C in comparison with the latest Non Cash Return, it appears you are including strategic depreciation costs & anticipated funding for, as yet, unapproved schemes. Please remove these from your future submissions until Capital Funding approval is received.

### Response

The strategic depreciation costs and anticipated funding for the unapproved COVID-19 schemes have been revised to only reflect the CRL we have received to date.

### TTP Template – Action Point 4.9

The FDU will be reviewing, and raising any material queries directly, the data submitted within the TTP template. This will include the data relating to the Demand and Supply, which I note is

## APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

showing some unusual surplus/shortfall values. However, I note the following completion issues:

- There were numerous 'REFS' errors on the Trace Tab (section C), which should be corrected for month 5.
- Within section A (HB) of the Trace tab, please include which A4C category (i.e. Admin & Clerical) within the description, if you use a free text line.
- Within section B (LA), please review the entry described as a 'contingency' of £4.779m on line 18.
- Within the Testing Antigen tab, please complete the line narrative on free text line 20 (antigen sampling section).

### Response

The above have been reviewed and are now correct.

- The 'REFS' errors have been corrected with the new template.
- The A4C Categories have been included in Section A of the Trace tab.
- The submission for the cost of Tracing across North Wales includes the expectation that the current capacity will need to be increased significantly over the winter months. The 'contingency' represents the cost of increasing the Tracing capacity, and has been phased over the period December to March. We will continue to liaise with the Tracing Programme firm up these assumptions as the plans for winter are agreed.
- The narrative on the free text line has been added.

### FH Template – Action Point 4.10

Please also review the following in the FH Template:

- Stationary Total on the summary tab – the formula appears to have been omitted and therefore your totals do not agree to the sum of individual cell values.
- Annual Estimate values on the Pay and Non Pay - on all tabs, these appear to be grossly incorrect.

### Response

The annual estimate values are no longer required in the new template, and the stationary total has been reviewed and corrected.



**GIG**  
CYMRU  
**NHS**  
WALES

Bwrdd Iechyd Prifysgol  
Betsi Cadwaladr  
University Health Board

<b>Cyfarfod a dyddiad:</b> <b>Meeting and date:</b>	<b>Finance and Performance Committee</b> <b>29.10.20</b>					
<b>Cyhoeddus neu Breifat:</b> <b>Public or Private:</b>	Public					
<b>Teitl yr Adroddiad</b> <b>Report Title:</b>	<b>Summary of business considered in private session to be reported in public</b>					
<b>Cyfarwyddwr Cyfrifol:</b> <b>Responsible Director:</b>	Sue Hill, Acting Executive Director Finance					
<b>Awdur yr Adroddiad</b> <b>Report Author:</b>	Diane Davies, Corporate Governance Manager					
<b>Craffu blaenorol:</b> <b>Prior Scrutiny:</b>	None					
<b>Atodiadau</b> <b>Appendices:</b>	None					
<b>Argymhelliad / Recommendation:</b>						
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)						
<b>Ar gyfer penderfyniad /cymeradwyaeth</b> <b>For Decision/ Approval</b>		<b>Ar gyfer Trafodaeth</b> <b>For Discussion</b>		<b>Ar gyfer sicrwydd</b> <b>For Assurance</b>		<b>Er gwybodaeth</b> <b>For Information</b>
						✓
<b>Sefyllfa / Situation:</b>						
To report in public session on matters previously considered in private session						
<b>Cefndir / Background:</b>						
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.						
<b>Asesiad / Assessment</b>						
<p>The Finance and Performance Committee considered the following matters in private session on 27.8.20</p> <ul style="list-style-type: none"> <li>• 2019/20 monthly monitoring report</li> <li>• approved a business case for the development of a new primary care centre for GP and community services through a third party development route.</li> <li>• Digital Dictation update</li> <li>• Programme Management Office capacity report</li> <li>• Medical and Dental Agency Locum monthly report</li> </ul>						