Bundle Finance & Performance Committee 30 September 2020

Agenda
Meeting to be held via Webex

1 FP20/113 Apologies for absence
David Fearnley (Arpan Guha deputising)

2 FP20/114 Declaration of Interests

3 FP20/115 Draft minutes of the previous meeting held on 27.8.20 and summary action plan
FP20.115a Minutes FPC 27.8.20 v.03 public draft.docx
FP20.115b Summary Action Log.pdf

4 FP20/116 Planned Care - Diagnostic and Treatment Centre
Gill Harris
Andrew Kent / Gavin Macdonald in attendance
FP20.116 Planned Care_Diagnostic and treatment centreFinal.docx

5 FP20/117 Finance Report Month 5
Sue Hill
FP20.117 Finance Report M05.docx

6 FP20/118 Savings report
Sue Hill
FP20.118 Savings Plan Update - Month 5.docx

7 FP20/119 Issues of significance to inform the Chair's assurance report

8 FP20/120 Date of next meeting 29.10.20

Finance & Performance Committee
DRAFT Minutes of the meeting held in public on 27.8.20
via Webex

Present:

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

In Attendance:

Sally Baxter (SB)	Assistant Director Health Strategy
Neil Bradshaw (NB)	Assistant Director Capital Strategy *(part meeting)*
Andrew Doughton	Wales Audit representative – to observe
Mark Elias	Consultant Radiologist *(part meeting)*
David Fearnley (DF)	Executive Medical Director
David Fletcher	Directorate General Manager N W Managed Clinical Services *(part meeting)*
Sue Green	Executive Director Workforce and Organisational Development (OD)
Gill Harris	Deputy Chief Executive / Executive Director Nursing and Midwifery *(part meeting)*
Sue Hill (SH)	Acting Executive Director of Finance
Ian Howard	Assistant Director Strategic and Business Analysis *(part meeting)*
David Jones	Radiology Manager *(part meeting)*
Marian Wyn Jones	Board Advisor
Andrew Kent	Interim Head of Planned Care Improvement *(part meeting)*
Joel Tofton	Senior Analyst, Financial Delivery Unit (FDU) – *to observe*
Pat Youds	Professional Lead, Radiography / Radiology Manager *(part meeting)*
Diane Davies	Corporate Governance Manager (Committee Secretariat)

Agenda item	Action by
FP20/91 Chairman's opening remarks and apologies for absence **FP20/91.1** It was noted that BCUHB was presently unable to accommodate attendance by members of the public to Health Board committee meetings due to Covid-19 restrictions. **FP20/91.2** The Chairman explained that Simon Dean would not be in attendance as his secondment as Interim Chief Executive was ending on 31.8.20 and the Deputy Chief Executive was in attendance. **FP20/91.3** Apologies were received from Simon Dean, Helen Wilkinson, Jill Newman, Gavin Macdonald and Mark Wilkinson – for whom Sally Baxter deputised.	

FP20/92 Declarations of Interest None received	
FP20/93 Draft minutes of the previous meeting held on 16.7.20 and summary action log **FP20/93.1** The minutes were agreed as an accurate record and updates were provided to the summary action log. **FP20/93.2** In respect of FP20/77 the Committee was pleased to note that Covid19 Block contract updates would be provided to each Committee meeting going forward as the expenditure was significant. It was agreed that future reports would also provide further detail of the services provided and it was noted that WG were aware of BCU's current position and were about to start the next round of discussion with NHS England, although imminent guidance was not currently expected.	SH
FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR) **FP20/94.1** The Assistant Director Health Strategy presented this report which provided July 2020 monitoring data. She advised that in regard to AN3.1 Review of healthy weight services for children, a business case was being developed and delayed recruitment processes were now commencing. **FP20/94.2** The Committee raised a number of questions. The Executive Medical Director clarified the reasons for the pause in respect to engagement sessions being held with psychologists for action AN18.6 Implementation of recommendations from the Psychological Therapies review. In respect of action AN27.1 Develop preferred service model for acute urology services, the Committee raised concern on the reasons the preferred strategic model was not being progressed. The Chairman advised that significant correspondence was taking place in respect of this issue and that he had requested a report to be prepared by the Medical Director Secondary Care which he undertook to share with members on receipt. 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. **FP20/94.3** The Committee was concerned with the recent national issues affecting functionality of the Attend Anywhere software being utilised for areas of patient bookings. The Executive Medical Director clarified the position and emphasised the need for a more strategic investment in technology rather than many individual projects. The Committee stressed the need to ensure that contingency would be built into BCU's Q3 and Q4 planning. **FP20/94.4** The Chairman requested that member briefings be provided in respect of : *AN19.1* Revew current process for booking and allocation to ensure it is fit for purpose and consistently applied across North Wales *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	MP DF SB

It was resolved that the Committee noted the report and progress made	
FP20/95 Quality and Performance (QAP) report **FP20/95.1** The Assistant Director Health Strategy presented this item and highlighted a number of areas provided within the executive summary of the report. *The Deputy Chief Executive joined the meeting* **FP20/95.2** The Chairman acknowledged the significant work undertaken to produce the report, however he 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. **FP20/95.3** The Chairman reflected that the report provided positive news in addressing diagnostic and phlebotomy services and BCU was reporting the lowest staff sickness rate in Wales. However, he was greatly concerned with Planned and Unscheduled Care, especially in respect of winter protection planning which the Board needed to be sighted on. The Deputy Chief Executive acknowledged the complexity of the incoming winter period which would be extremely challenging and undertook to move this forward. The Chairman requested that the report also reflect improvements introduced through the response to Covid19 and how temporary hospitals would be used in respect of surge capacity. In discussion of learning, the Deputy Chief Executive assured that, following exploration of Acute and Area flow issues, trigger points would be shared across the economies to make improvements. **FP20/95.4** The Chairman questioned what consideration was being undertaken to evaluate prioritisation of investment within Emergency Departments should Welsh Government financial support become available in the future. The Executive Director Workforce and OD advised that arrangements were in hand to explore this area with Kendal Bluck; in addition the service plan reviews, which had been paused due to the Covid19 response, would be explored by the executive team. **FP20/95.5** The Chairman stated that the organisation needed to focus on quality and patient safety ensuring the involvement of clinical colleagues. **It was resolved that** the Committee noted the report	GH GH GH
FP20/96 Planned Care update including RTT and essential services *The Interim Head of Planned Care Improvement joined the meeting* **FP20/96.1** The Deputy Chief Executive introduced this item. She reported that much work was taking place on clinical prioritisation via clinical desktop reviews and she contextualised that in previous years there would be a scheduled reduction in planned activity during the upcoming period, however this would not be an option in the current climate. Additionally, the customary availability of contractual English providers to	

draw on would be significantly reduced due to the national Covid19 response. The Deputy Chief Executive advised that alternative ways of demonstrating improvements were also being explored with WG. **FP20/96.2** The Interim Head of Planned Care Improvement presented the report, advising that the organisation was in a process of re-stratification with waiting lists over 36 weeks on the incline. Potential cancer referrals were at pre-Covid19 levels, however recommencement had not been as quick as possible as this had been affected by a number of issues including patients not wishing to attend. He stated that at the current run rate there was a potential for patients exceeding 36 week waiting times to increase to 60,000 by March 2021. For meaningful comparison purposes, the Interim Head of Planned Care Improvement advised that appropriate benchmarking data was being sought. He drew attention to theatre capacity and also other workforce issues highlighted in the report which were affecting the restart process. **FP20/96.3** A discussion ensued on RTT and new measurements as advised within the report, in which the Interim Head of Planned Care Improvement stressed the risk and mitigation work being undertaken. In respect of essential services, it was noted that compliance with the Essential Service Framework was being reviewed on a monthly basis. The July position demonstrated the majority of essential services were being maintained and actions had been implemented to address shortfalls. Attention was drawn to actions to address delays in diagnostic pathways and phlebotomy service eg use of facilities at Spire Yale for diagnostics and essential surgery procedures. It was noted that referrals for urgent suspected cancer and the volume of confirmed strokes had increased, returning to their near pre-covid levels. The list of essential services (ie those services that needed to continue throughout Covid 19 to avoid the risk of harm arising from life threatening and life changing treatments) provided within the report was acknowledged. **FP20/96.4** The Committee raised their grave concern regarding the current position, likening it to a perfect storm due to the additional pressure of Covid19. The Committee stressed the need to address the situation with ambitious and radical change. A number of alternative ways of working to help to help allieviate the waiting list position such as operating over more days in the week, increasing staff levels and inhouse activities instead of expensive outsourcing short term solutions were put forward. The Committee acknowledged the Public's patience and support during the initial peak of Covid19 however, it was necessary to address the population's needs effectively at the earliest opportunity in restarting procedures. **FP20/96.5** The Committee also discussed the Orthopaedic position, being a high volume service which was not life threatening. Discussion ensued on alternative ways of providing surgical interventions, including the use of temporary hospital capacity. It was agreed that a report be presented to the next meeting along with greater detail on the development of a diagnostics and treament centre. 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, whilst also considering patient safety and the balance of financial prudence required in the use of available WG funding. The Deputy Chief Executive emphasised that whilst it was acknowledged that delays caused patient harm it was not the organisation's intent to do so. In response to the Chairman's question as to whether the timeline for presentation of a revised	GH MP

Orthopaedics business case to the Committee was soon enough, the Deputy Chief Executive agreed to address this within the October RTT report. In response to the Acting Executive Director of Finance, the Interim Head of Planned Care Improvement confirmed that plans were in hand to address costing with the Finance Director – Provider Services. **FP20/96.6** The Executive Director Workforce and OD referred to the complex resources required to address the issues discussed. She also stated that the current models being explored to ensure less infection and improve staff safety might not necessarily meet community expectation which would need to be addressed through effective BCU communications. The Chairman stressed the Board's committment to support patients within the North Wales population and looked to the Board's executive professional leads to put forward plans to address the situation, including discussion with other stakeholders. **FP20/96.7** Discussion ensued in respect of the patient target date approach and concerns regarding treatment priorities, the Deputy Chief Executive supported the approach to patient assessment being undertaken which had resulted in a greater clinician lead approach than previously and improved consistency. The Assistant Director Health Strategy pointed out that social impacts and health inequalities needed also to be addressed to ensure that some groups within the population were not adversely affected. The Interim Head of Planned Care Improvement assured that work was underway in conjunction with WG to develop a vulnerability index to address this. In further discussion of BCU's socio–economic duty, the Executive Director Workforce and OD advised that she would move forward, with executive colleagues, the improved submission of equality impact assessments. **FP20/96.8** The Chairman questioned why Ysbyty Glan Clwyd planned and essential service provision was out of kilter with other sites. He was advised that restart issues were being addressed and monitored and that transfers to community hospitals were also impacting. The recovery plan for imaging outlined in the report was noted, as well as Planned Care Group work to address the challenges involved. **FP20/96.9** The Committee noted the proportion of Outpatient Department (OPD) activity being delivered virtually and work being moved forward by the OPD improvement group with clinicians to increase this level. **FP20/96.10** The Board Advisor and Chairman emphasised that restarting planned care was a mandatory requirement of the Board. It **was resolved that** the Committee noted • the overall growth in the waiting times due to the Covid19 legacy and continuing reduction in available/functional capacity • that essential elective activity being undertaken was lower in number than pre-Covid19 • that the paper described the challenging senario for planned care and its mitigations in a pandemic • that the recovery and re-set would take a considerable amount of time which needed to be measured in quarters/years rather than in months.	GH

ageed • that moving forward a diagnostic and treatment centre for North Wales be explored at pace, with progress presented to the Committee at a date agreed by the Chairman *The Interim Head of Planned Care Improvement and FDU observer left the meeting*	
FP20/97 Unscheduled Care and Building Better Care update **FP20/97.1** The Deputy Chief Executive presented the report which outlined the July position. She stated that the newly appointed Interim Chief Operating Officer was leading with a refreshed approach that included moving forward the Unscheduled Care Improvement Group with partners. Attention was drawn to the marked increase of presentations at Emergency Departments (ED) and that EDs at both Ysbyty Gwynedd (YG) and Ysbyty Glan Clwyd (YGC) had reached level 4 (max capacity) at times. She reported that this had necessitated urgent conversations with Welsh Ambulance Service Trust in regard to conveyances to YGC particularly. The Deputy Chief Executive also outlined issues arising from the reduced numbers of beds at acute and community sites due to the Covid19 response, which would impact on surge plans going forward. She also advised that 'Winter' plans were being developed to present to the Committee and Health Board. Attention was also drawn to outbreak impacts on services. **FP20/97.2** In response to the Committee, the Deputy Chief Executive assured that a communications plan was being drawn together by the Workforce and OD team to provide greater understanding on the utilisation of BCU's temporary hospitals resource for the Public. This would include detail on potential alternative activities to support the response to Covid19 and other health services. **It was resolved that** the Committee • noted the Unscheduled Care performance in July across BCUHB and for each Health Community • agreed the next report would provide greater detail on the use of temporary hospitals and how the organisation would overcome restrictions which were creating barriers to theatre usage due to the Covid19 response.	
FP20/98 Capital Programme Month 3 **FP20/98.1** The Assistant Director Capital Strategy joined the meeting to present this item. He highlighted to the Committee that the pandemic had an adverse impact on the progress of a number of schemes planned to commence on site during the first quarter of 2020/21 (ie. extension/refurbishment of Ruthin Hospital, Substance Misuse units at Holyhead and Shotton and the Integrated Dementia unit at Bryn Beryl hospital) . However, the schemes had now commenced and mitigating measures had been implemented to maintain social distancing and minimise risks. There was an expectation that the measures would extend the programme and potentially increase the out turn cost.	

FP20/98.2 Due to the challenges of releasing staff to attend project boards and design user groups, alternative governance arrangements were put in place to allow the designs of the Royal Alexandra Hospital (formerly known as North Denbighshire Community hospital) and the redevelopment of the new build Ablett unit to progress. However, physical surveys could not progress during quarter 1 and the development of the business cases had therefore been delayed. Both the full business case for the Royal Alexandra hospital and the outline business case for the Ablett unit were expected to be submitted to the Committee in October. He advised that since the approval of the outline business case for the Royal Alexandra hospital WG had issued guidance re-basing the calculation of capital cost for all business cases this, combined with adapting the design to respond to WG's climate emergency, the necessity to appoint a new supply chain partner and the condition of the existing building, were all expected to increase the target cost for the project. **FP20/98.3** The Committee discussed the consultation undertaken around the redevelopment of the Ablett unit as a new build. It was noted that wide engagement had taken place but not formal consultation as there was no service change. The Assistant Director Health Strategy informed of the NW Community Health Council positive reflection on the engagement undertaken. The Chairman sought assurance that the Executive team were mindful of public opinion in respect of this development. **FP20/98.4** The Acting Executive Director of Finance queried how effectively the Supply Chain Provider was working with the Health Board on the Royal Alex development, given that the Health Board had not previously worked with the company, and sought further detail for discussion with the Executive team. **FP20/98.5** It was agreed that the Executive Director Workforce & OD would discuss with the Assistant Director Capital Strategy, outside the meeting, the proposals to address electric charging point commuting cost recovery for staff, given concerns raised by a member of the Committee. **FP20/98.6** In response to the Chairman, the Assistant Director Capital Strategy confirmed that Estates were involved in the development of the Orthopaedics business case. **It was resolved that** the Committee noted the report The Assistant Director Capital Strategy left the meeting	NB SG/NB
FP20/99 Finance Reports - Month 4 and 3 **FP20/99.1** The Acting Executive Director of Finance presented this report. It was noted that the £3.3m in-month deficit, £13.3m year to date deficit, was in line with the plan for Month 4. The position assumed that all Covid19 costs incurred by the Health Board were fully funded. The value of WG funding available for Covid19 had not yet been confirmed and this therefore a significant risk to the financial position. Following discussions with WG, the Health Board was reviewing its income assumptions around anticipated Covid19 funding, with a view to effecting any amendments in Month 5.	

FP20/99.2 The overall net cost of Covid19 on the year to date position was reported as £52.6m. Some specific funding sources had been redirected to Covid19 to provide funding of £2.4m. £17.5m of WG income had been received to cover year to date costs and a further £32.7m of WG funding was anticipated, giving a nil overall impact on the position. In Month 4, actual expenditure was £7.1m. Offsetting underspends were seen in Elective Care, where activity had significantly reduced as part of the pandemic response, with limited planned activity in July leading to cost reductions of £2.6m. In addition, there had been £0.5m slippage against some investments planned for 2020/21 and the use of £0.1m of Cluster funding. This provided a total cost of Covid19 for July of £8.2m. **FP20/99.3** In respect of the forecast, the Health Board was anticipating that it would achieve the £40.0m deficit, as per the financial plan at the end of the year, on the basis that all Covid19 costs were fully funded by WG. It was noted that any changes to income assumptions for anticipated WG Covid19 funding would impact on the forecast. **FP20/99.4** In respect of the identification of savings plans, and the delivery of plans already identified, it was noted that these had been severely impacted by Covid19 with savings currently forecast to under deliver by £30.8m against the £45.0m target. The Acting Executive Director of Finance advised that there would be critical focus on converting savings that were in the pipeline. She also drew the Committee's attention to the prescribing cost analysis provided within the report which indicated rising drug prices during the pandemic, in one case by 600% which was of concern. **FP20/99.5** In response to the Committee, the Acting Executive Director of Finance assured ongoing discussion with WG also included awareness of a potential risk to cash flow arising from additional Covid19 expenditure. She agreed to look into the largest budget variance of £2.5m and feedback to the Committee. **FP20/99.6** The Acting Executive Director of Finance agreed to share with the Chairman and Committee members the change of accountable officer letter to be provided to WG before the commencement of Mrs Gill Harris as Interim Chief Executive until Ms Jo Whitehead takes up the substantive role in January 2021. **It was resolved that** the Committee noted the report	SH SH
FP20/100 Interim report on Covid 19 financial governance **FP20/100.1** The Acting Executive Director of Finance explained the briefing paper was intended as a pre-cursor to the "Lessons Learned" report from the Finance Governance Self-Assessment Group, which was planned to report at a later meeting. This report provided a specific early summary of the self-assessment against each of the 10 key Principles of Financial Governance set out in the Welsh Government guidance of 30.3.20. It was reported that up to Month 4, the Health Board had reported Covid19 related costs of £56million, with a forecast of £122million, across a number of key Revenue, Capital and Charitable Funds elements. Information was also provided to compare the BCU approach to a sample of other NHS Wales organisations. It was noted that the Covid19 specific Finance Risk (ID 3152) – 'Covid19 expenditure may exceed funding available from WG' was logged in the Finance Directorate's risk log.	

FP20/100.2 The Acting Executive Director of Finance reported that formal "Lessons Learned" paper would be presented to the Committee in October, however in the main the Lessons Learned were in relation to; • Formalising the SORD for any future Emergency Control Centre(s), and sub-groups. • Formalising and clarifying what must be reported to the Board versus what can be managed within such an Emergency Control Centre. • Improved Communication Governance in relation to Policy changes (for example temporary pay related changes that were implemented during CV19). • Continue to working closely with NWSSP Procurement to further tighten up the controls over purchase orders between £5,000 and the £25,000 Tender limits. **FP20/100.3** The Chairman questioned why expenditure attributed to Covid19 was rising. Discussion ensued in which the Executive Director of Workforce and OD suggested that pay costs could be a factor and the Executive Medical Director advised that BCU had dealt with a different 'flattened' profile in response to Covid19 as opposed to the peaks of other Health Boards. **FP20/100.4** 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. **FP20/74.5** The Acting Director of Finance agreed to clarify the anomaly in respect of the Ysbyty Gwynedd expenditure (Appendix A) following the meeting. **It was resolved that** the Committee note • the early self-assessment against the key Welsh Government Principles. • the formal "Lessons Learned Report" from the Governance Cell will be issued for discussion at the October Committee meeting. agreed • future Finance reports would include the Covid19 expediture within their monthly position reporting, in line with other Health Boards in Wales.	SH SH SH
FP20/101 Estates / Capital business cases **FP20/101.1 Nuclear Medicine Consolidation Strategic Outline Business Case** **FP20/101.1.1** The Committee was supportive of the direction being undertaken as the 'right thing to do' and recognised the licensing issue detailed in the document. Clarification was sought on what level of engagement and consideration had been undertaken in respect of a single site choice of the consolidation of nuclear medicine services. The Consultant Radiologist advised that an options appraisal would be taken forward at a later stage to include the 3 main district general hospital sites. It was understood from the Assistant Director Health Strategy that the North Wales Community Health Council had commended the approach undertaken with other CHCs in Wales regarding this proposal in respect of consultation.	

FP20/101.2 In response to the Committee, the Consultant Radiologist explained the differences between nuclear medicine and imaging diagnostics, providing examples and explaining the additional benefits for patient diagnosis. **FP20/101.3** The Executive Director Therapies and Health Sciences joined the meeting and advised that the Executive team were supportinve of the OBC which would provide a more sustainable service and, in the long term, financial savings. **FP20/101.4** Following the suggestion of the Deputy Chief Executive, the Executive Director Therapies and Health Sciences agreed that the timeline outlined would allow for the work to develop the Diagnostic and Treatment Centre discussed earlier in the meeting to be dovetailed with the SOC so that additional potential financial savings opportunities could be explored. She was mindful however that that this condideration should not cause delays to the agreed SOC schedule. **FP20/101.5** The Chairman commended the colleagues (who had joined the meeting for this item only) in their preparation of a detailed and comprehensive OBC which had enabled the Committee to consider the proposal in detail. **It was resolved that** the Committee agreed submission of the OBC to the next Board meeting **FP20/101.2 Staff Lottery – from Charitable Funds** **FP20/101.2** In consideration of the proposal, the Committee questioned the level of oversight of BCU's Charitable Funds Committee and it was agreed that a comparative be undertaken with a staff lottery operating within a South Wales Health Board and reported back. In addition, the Committee questioned whether market testing had been undertaken with BCU staff. Whilst it was noted that the Local Partnership Forum had been supportive it was agreed that this should be explored further to ensure a successful launch and opportunity to improve the profile of Awyr Las with BCU staff. In discussion of governance concerns, as a previous Chair of the Charitable Funds Committee, the Board Advisor stated that it was impossible to convert restricted funds to non restricted and therefore the opportunity to increase general funds was welcomed. The Committee also questioned whether the governance process was sufficiently robust in respect of potential fraud. **It was resolved that** the Committee agreed to consider a revised paper at 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.	SH SH
FP20/102 Committee Annual report 2019/20 **FP20/102.1** The Acting Executive Director of Finance presented this item, advising that she had been prudent in respect of the draft assessments she had applied to each of the Committee objectives within the report. The Committee agreed these, with the exception of bullet 5 to be amended to amber status.	

FP20/102.2 The Chairman emphasised to the Executives present that he expected a review of the Health Board's Performance Management framework to be addressed as a priority in 2020/21, and this should be included in the Committee's focus for the year ahead section. **FP20/102.3** As a point of accuracy, the appendices required relabelling. **It was resolved that** the Committee • agreed the overall rating as 'amber' • agreed the individual Committee objectives' RAG status draft ratings, with the exception of point 5 to be amended to amber • approved the Committee Annual Report 2019/20, subject to the amendments agreed above, for submission to the Audit Committee to be held on 17.9.20.	GH DD SH
FP20/103 Monthly monitoring reports Months 4 and 3 **It was resolved that** the Committee noted the reports	
FP20/104 Summary of private business to be reported in public **It was resolved that** the Committee noted the report	
FP20/105 Issues of significance to inform the Chair's assurance report To be agreed outside the meeting	
FP20/106 Date of next meeting A meeting would be held on 29.10.20 however, the Chairman would advise should a meeting also be required during September to address urgent business.	
Exclusion of the Press and Public Resolution to exclude the Press and Public "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."	

BCUHB FINANCE & PERFORMANCE COMMITTEE **Summary Action Log – arising from meetings held in public**				
Officer	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
Actions from 24.10.19 meeting:				
Sue Hill	**FP19/236 Finance Academy** Forecasting Best Practice Guide A plan to implement the guidance would be provided In December	~~December meeting (11.12.19)~~ January meeting	Moved to January agenda due to short December meeting Deferred to February 2020 agenda due to timing of January meeting 10.2.19 Deferred to March 2020 agenda 27.2.20 The Chairman requested that the item be addressed at the next meeting 18.5.20 – Deferred to July 2020 23.6.20 Given the current planning guidance from Welsh government requiring the submission of quarterly operational plans, this item was deferred until 29.10.20 meeting	~~Jan 2020~~ February 2020 March 2020 22.4.20 25.6.20 19.10.20
Actions from 27.8.20 meeting:				
Sue Hill	**Matters arising** **FP20/93.2** 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	**FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR)** **Acute Urology Services**	11.9.20	23.9.20 Circulated to members	Action to be closed

	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	**FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR)** **Acute Urology Services** 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.	
Sally Baxter	**FP20/94 Operational plan 2020/21 Q2 monitoring report (OPMR)** **FP20/94.** Provide member briefings be provided in respect of : **AN19.1** Review current process for booking and allocation to ensure it is fit for purpose and consistently applied across North Wales **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	7.9.20	Member briefings re AN19.1 and AN25.2 circulated to members 23.9.20	Action to be closed

Gill Harris / Mark Wilkinson	**FP20/95 Quality and Performance (QAP) report** **FP20/95.2** 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		
Gill Harris	**FP20/95.3**. 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	**FP20/96 Planned Care update including RTT and essential services** **FP20/96.5**. 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	19.10.20

Mark Polin	**FP20/96 Planned Care update including RTT and essential services** **FP20/96.5**. 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	**FP20/96 Planned Care update including RTT and essential services** 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	10.12.20
Neil Bradshaw	**FP20/98 Capital Programme** **FP20/98.4** 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	**FP20/98 Capital Programme** **FP20/98.5** 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	**FP20/99.5 Finance report** **FP20/99.5** Clarify the largest budget variance of £2.5m	14.9.20	Member briefing circulated 22.9.20	Action to be closed
Sue Hill	**FP20/99 Finance report** **FP20/99.6** The Acting Executive Director of Finance agreed to share with the Chairman and Committee members the	31.8.20	Circulated on behalf of the Chairman 7.9.20	Action to be closed

	change of accountable officer letter to WG			
Sue Hill	**Covid19 Financial governance** **FP20/100.4** In respect of rising expenditure, **i**t was agreed that further detail would be provided in the next report to the Committee, including demonstrating a reconciliation of the additional pay costs. Agreed future Finance reports would include the Covid19 expenditure within their monthly position reporting, in line with other Health Boards in Wales.	19.10.20 19.10.20	This will be included in the next paper which is on the agenda in October This has now been actioned	Action to be closed Action to be closed
Sue Hill	**FP20/74.5** 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	A briefing note will be provided to Committee members ahead of eth October meeting	19.10.20
Sue Hill	**FP20/101 Staff Lottery** • Undertake a comparative with another staff lottery operating within a South Wales Health Board and report back. • Provide a revised paper at the 29.10.20 Committee meeting, addressing the	19.10.20		

	concerns raised and to include more detail of how the lottery would be implemented and operated, along with evidence of sufficient potential staff support.			
~~Gill Harris~~ Mark Wilkinson	**FP20/102 Committee Annual report 2019/20** Arrange for a review of the Health Board's Performance Management framework to be addressed as a priority in 2020/21			
Sue Hill / Diane Davies	**FP20/102 Committee Annual report 2019/20** Update the draft report and submit to the Audit Committee	9.9.20	Submitted 9.9.20	Action to be closed

23.9.20

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **30.9.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Planned Care ~ Diagnostic and Treatment Centre**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Acting Chief Executive Gavin McDonald, Interim Chief Operating Officer
Awdur yr Adroddiad **Report Author:**	Andrew Kent- Interim Head of Planned Care Transformation
Craffu blaenorol: **Prior Scrutiny:**	Acting Chief Executive and Interim Chief Operating Officer
Atodiadau **Appendices:**	Appendix 1 – Activity assumptions Appendix 2 SWOT analysis of the five options

Argymhelliad / Recommendation:

The Committee is asked to provide a strategic discussion and agreement in principle to allow further development of the business case and to test the market.

Please tick as appropriate

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

Sefyllfa / Situation:

The Covid 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. 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 undertakes an exploration of the current options available. It needs to be noted early that this paper discusses day case/ambulatory care only, the intended consequence is by undertaking one of these options is that extra in-patient capacity could be created in the DGH's.

Cefndir / Background:

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 beginning of September the "all over 36 week waiters" has increased to over 36,000 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 option 1. The organisation is at risk of reaching over 80,000 over 36 week waiters by the end of March 2021.

This paper looks at the options available to support a mid to long term strategy to treat Daycase patients in a new model, giving early access to diagnostics and treatments and a way to reduce long waiters caused by the covid pandemic and legacy of previous years.

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 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

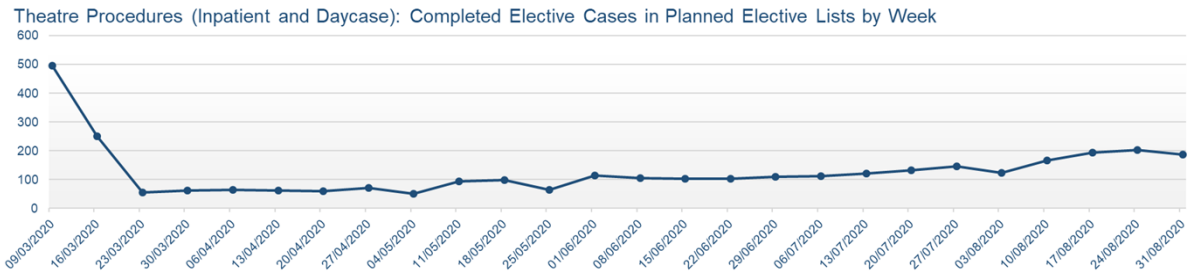
Diagnostic and Treatment Centre

Introduction

The Covid 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. 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 undertakes an exploration of the current options available. It needs to be noted early that this paper discusses day case/ambulatory care only, the intended consequence is by undertaking one of these options is that extra in-patient capacity could be created in the DGH's.

Context

As of the beginning of September the "all over 36 week waiters" has increased to over 36,000 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 option 1. The organisation is at risk of reaching over 80,000 over 36 week waiters by the end of March 2021. The run rate of operations, shown below, signals the "new normal" after covid with late August delivering 200 cases per week, compared to the March position of 500 a reduction of 60%.



The Q3/4 plans currently being finalised are demonstrating that P2 activity will continue but it is quite clear that the functional capacity for the last 2 quarters is falling far short of the backlog clearance required. These activity rates are currently supported by Spire at Wrexham and this will be reduced in the coming autumn.

On a positive note, more services are reporting start-ups but planned care activity does not have significant resilience and is subject to disruption being co-located with unscheduled care.

During the covid peak, planned care introduced the option 5 "Once for North Wales" for key specialties, which placed risk stratification at the heart of the waiting list and undertook measures to share capacity across North Wales based on need not postcode. Therefore, patients would be offered the most available date not necessarily at their nearest centre to ensure equitable access for key specialties. This has introduced the process of how we deliver timely care, but had not concluded the where. At the time, it was thought that activity would bounce back to pre-covid; this is now looking less likely.

During a number of engagement events building up to option 5, discussions were undertaken to transform either one or two DGH centres into covid light facilities. This was discounted due to the need to completely re-design unscheduled care and making a Covid heavy site. This paper has taken into account those options and builds on the next steps.

This paper describes four options that would reduce the backlogs in key specialties and provide a new clinical model that would deliver the foundations to improve patient access and safety, whilst offering additional capacity to the organisation. The fifth is carrying on with activity as we deliver today.

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. 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 four options proposed for discussion are:

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 Daycase pathways within the current DGH's

Workforce implications

Before exploring the options, it is important to describe that the significant constraint is the workforce, the risk in establishing the diagnostic and treatment centre and seven day working is how it could be resourced and what the workforce model would look like.

With clinician support, each pathway would need to be designed to fit the needs of the patients. In the diagnostic and treatment centre, the Outpatient model could be very different. Following similar models in the independent sector where there are less nursing staff and more administrative support to guide and sign post patients, leaving clinical staff to undertake clinical duties.

The medical workforce would be required to undertake their day surgery and outpatient activity in the diagnostic centre and their In-patient activity in the three acute sites. Further locum/midterm contracts would need to be explored with the possibility of a blended workforce to undertake the day case procedures.

By providing these centres as low covid burden areas, there is an opportunity to provide a safe environment for staff who may be shielding or can no longer be patient facing if working in a high/medium covid burden environment. There are a number of staff within the organisation, who could possibly be returned to work safely by using this approach.

The ability to move day surgery from three to two sites will have some economy of scales not yet fully understood at the time of writing. It is also thought by having ring-fenced facilities efficiencies would occur with throughput.

Early discussions with workforce and development staff suggest mitigating actions would need to be put in place and a deeper understanding of the workforce required could be undertaken, for example, a blended workforce. However all the options described would require recruitment and retention strategies to ensure it works effectively.

It is recognised that further staff are required in any of the options listed in this paper and a full workforce evaluation would be undertaken once the size of the clinical specification is fully understood. The committee are asked to note that all options in this paper would see the cost per case rise compared to the pre-covid era.

Options:

1. Business as usual post –covid

This option uses functional capacity. In Q1, planned care was only able to deliver essential services and in Q2, P2 capacity was commenced. As the plans for Q3/4 emerge, it is clear that at best the organisation will only be able to maintain this delivery. As more P3 patients move into P2, there will not be enough functional capacity to continue delivery. Leaving P4 patients with little opportunity for surgical treatment.

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.

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.

2. Three session days and 7 day working, all sites

During the Q3/4 planning the acute DGH's and areas have been asked to review how to increase activity including looking at 3 session days and weekend working, to increase activity. There are benefits to this approach and could deliver extra activity.

This will allow further P3 activity to be delivered complementing the P2 delivery. This model would require the same staff to work extra or work differently to maximise use of estates. It is subject to disruption due to winter pressures including or excluding any second peak in Covid.

It would rely on the good will of staff working extra shifts or changing working patterns to work out of hours for a considerable period. As described earlier this recovery could take 2-3 years to achieve reduction in backlog.

To support this option extra staff would be required and discussions with clinicians around changing their job plans to weekend working or employing 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 or not this would be consolidated on one, two or all three sites.

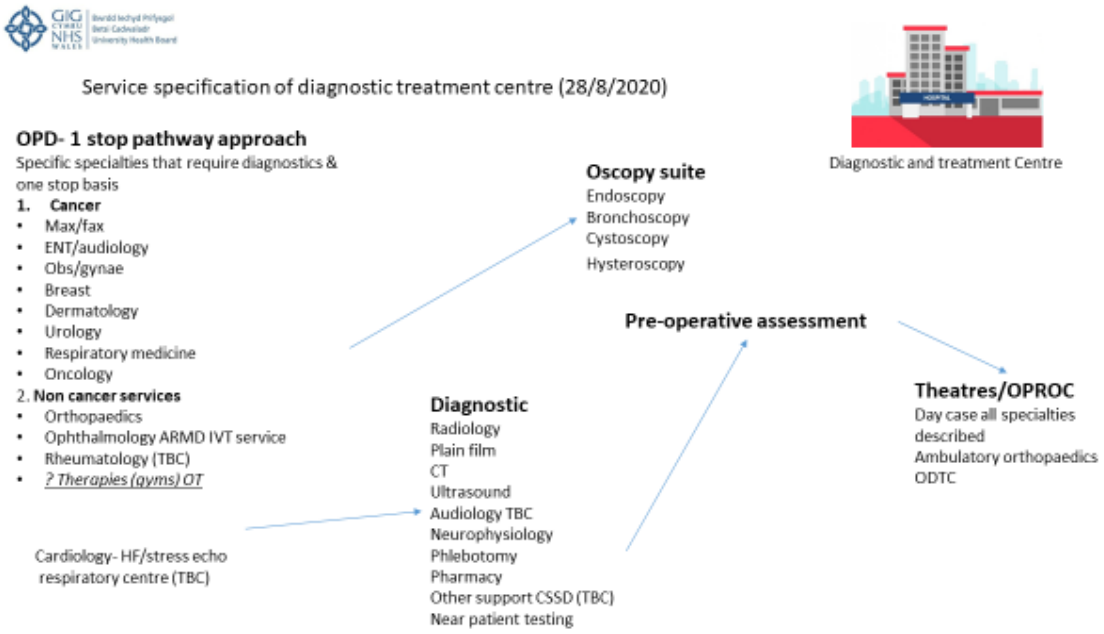
All three sites have unscheduled activity, disruption due to these pressures is likely to occur, and sustained planned care activity would be unlikely.

3. Diagnostic and treatment centre –including theatres

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 and two are described in this paper. A task and finish group has been commenced to look at the clinical specification and significant clinical engagement has been undertaken to receive reaction to the concept.

The diagram below outlines the clinical specification of the centre to date.



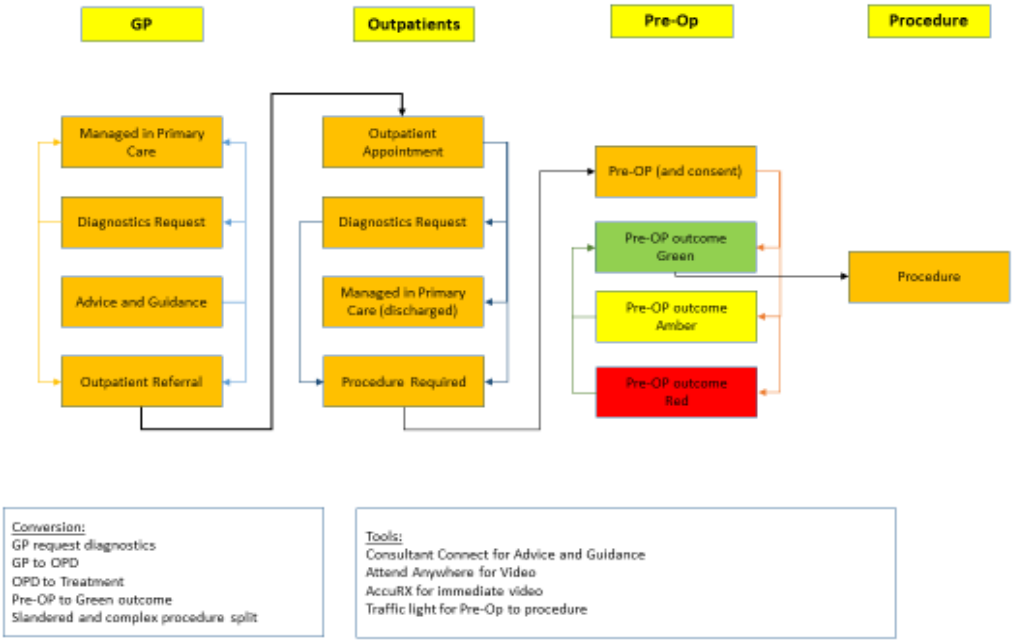
So far ten services, have been identified which could be using such a facility, they are listed in the diagram above. ***need to include upper GI pathway – one stop to link with endoscopy.

Outpatients

Early conversations with primary care and cancer services is suggesting they would be a one stop approach to service delivery with the patient entering the diagnostic centre straight to test, using consultant connect and or attend anywhere platforms to assist with the pathway. The first time a patient, in some cases, could be meeting a secondary care clinician face to face. Would be at the post diagnostic phase when the patient has been investigated.

Therefore, we perceive that the outpatient pathway would be promoting primary care face to face with non-face to face support from secondary care, to reduce footfall and keeping patients closer to their home.

Proposed Pathway model



Diagnostics

Current assessment is suggesting that seven services would be located within the D&T

- Radiology
- Plain film
- CT
- Ultrasound
- Audiology (TBC)
- Neurophysiology
- Phlebotomy

There are current business cases in circulation to bring in “CT in a box”, these could be moved to the diagnostic and treatment centres to provide support. It is thought that the other services could be carved out to support the diagnostic centre promoting a one-stop approach. The one service yet to be decided is Audiology where other strategies are being pursued. Near patient testing and pathology would also need to be explored to establish if specimens would need to be transported.

Oscopy Centre

The diagnostic and treatment centre would also include an “Oscopy” centre providing the following procedures:

- Endoscopy
- Bronchoscopy
- Cystoscopy
- Hysteroscopy

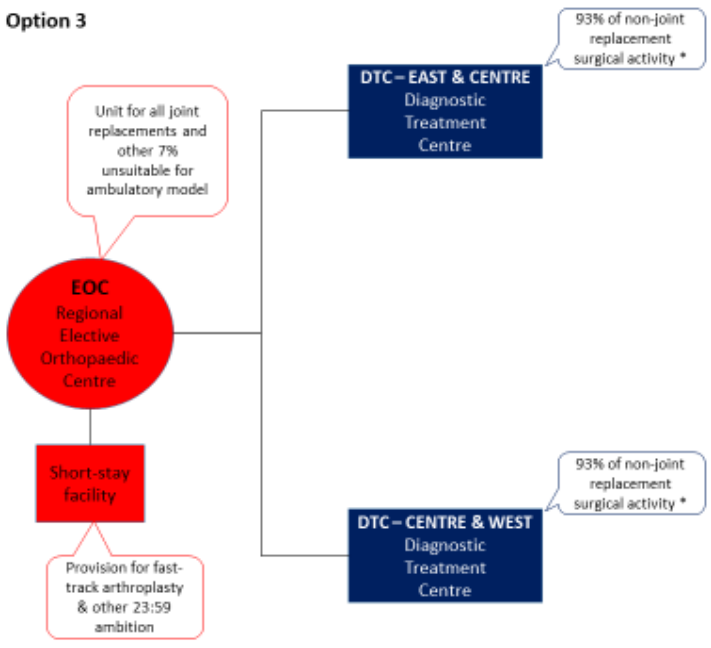
This would consolidate into a new service where oscopies could be delivered, improving throughput and providing a ring-fenced activity, within the diagnostic centre. This could potentially free up theatres, requiring a smaller theatre footprint. Further work is on going to understand this capacity.

Operating Theatres

The theatre capacity would be day surgery use only. This would reduce the need for full "hospital support." The current modelling is suggesting a minimum of 14 theatres would be required based on 10-session working (Monday-Friday); this would be most suitable to seven theatres across two sites (see location section). However, this number of theatres could be reduced if the organisation moved towards 3 session and six or seven day working, to ensure optimisation of the theatres and provide more access and flexibility for the population. (More analysis that is detailed is found later). As described earlier the Oscopy suite could also reduce the need for theatre capacity.

Orthopaedics

The current business case for Orthopaedics is under review, following conversations with the orthopaedic lead it is thought a blended model could be adopted with Ambulatory orthopaedics being delivered through this approach and a single orthopaedic hub treating the complex patients. A draft model is below:



Type of Procedures Within DTC
ACL Reconstruction
Therapuetic Arthroscopy of Shoulder - SAD - Cuff Repair
- Achilles Tendon Repair
- Forefoot & Midfoot Procedures Surgery
Hand Surgery - Carpal Tunnel - Tendon Realignment - Trigger Finger - Dupytrens

Type of Procedures Within EOC	
Inpatient	**Short Stay**
Complex joint replacement	Uni Knees (100%)
	THR (Approx 25%)
	TKR (Approx 25%))
	Complex Hindfoot
	Complex Hand Work

This model if accepted could mean a smaller orthopaedic centre and a hub and spoke model. This is being explored through the orthopaedic business case and further discussions with clinicians. Close working is ongoing to ensure where shared capacity could improve patient access and value for money.

Support Services

Discussions are underway on the support services required to support the Centre. However, it is recognised that the services below would be required as a minimum

- CSSD
- Pharmacy
- Estates
- Laboratory facilities

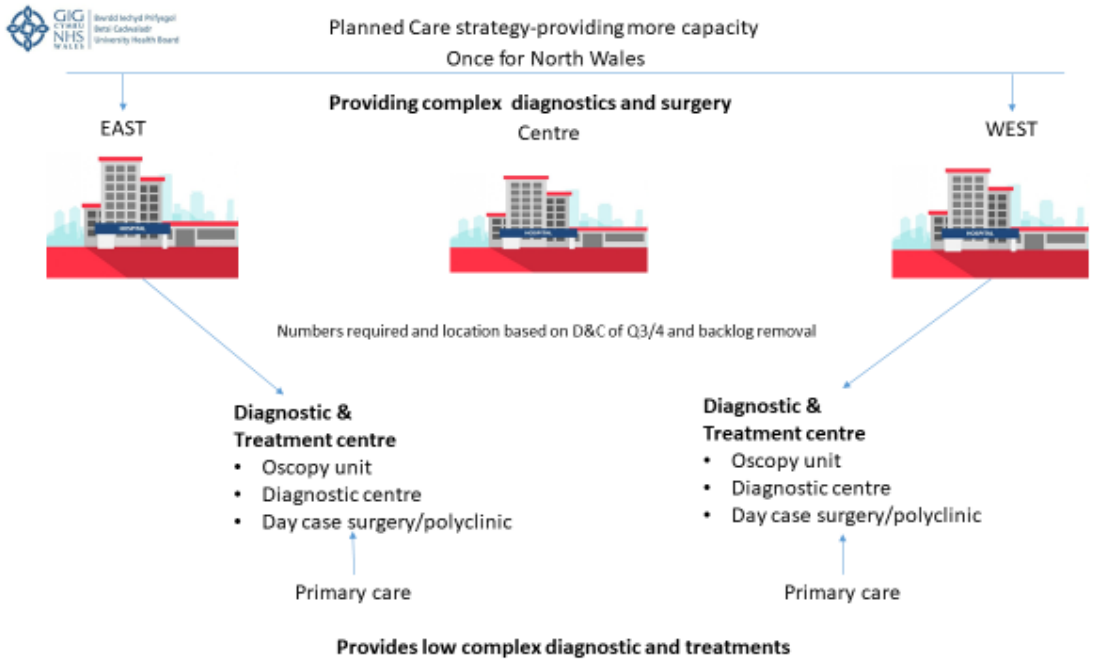
Non-surgical specialties
At this moment, Cardiology services have expressed an interest in utilising a diagnostic and treatment centre approach for the delivery of one stop and Cardiac diagnostics.

Understanding the capacity required
We have used the end of August position of 36,000 over 36 week waiters and 13,000 diagnostic waiters as the baseline. The lead-time is estimated to be a 20-26 weeks after the award of a contract, therefore adjustments are being made on the backlog size to ensure the correct capacity is identified and the length of time a diagnostic and treatment centre would need to be in place.

Another assumption is that the Q3/4 plan will be able to deliver the P2 activity; therefore, the diagnostic centre would deliver P3/4 activity with ambulatory P2 as well. F&P are asked to note that these figures will be subject to significant change over the next two quarters depending on the activity delivered.

From this modelling, it is suggested that two centres are required. One being East/Centre the other being Centre/West, as illustrated in diagram below. To date we have not discussed the sites, 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.

The task and finish group prefer the modular building approach, similar to the theatres placed at Wrexham over the last few years. These could be purchased or leased and allows the ability to have them removed after the 2-3 year duration. The modular units can be provided for outpatients, diagnostics, oscopies and theatres.



This approach allows subsequent strategic discussions by giving capacity to the DGH's for complex surgery, surge and Covid acute capacity. It also allows the headroom to discuss the next phase of the development of the DGH's, which is not covered in this paper.

4. Diagnostic centre – OPD and diagnostics only

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 patients vulnerable at the stage 4. Nor does this option provide backlog clearance as discussed earlier. However this option does provide a smaller footprint and less cost, as illustrated in the outlying financials.

5. Diagnostic and treatment Centre that has limited theatre capacity to clear backlogs and service transformation is undertaken to instigate covid light Daycase centres.

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.

Outline capacity required for options 3 and 5

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 24 outpatient rooms would be required if a two centre approach, or 48 if a one-centre approach.

Oscopy is estimated to be 10 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 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
3 sessions per week x 5 days	**8.1**	**5.1**	**2.5**	**1.7**	**13.2**	**10.7**	**9.8**
3 sessions per week over 6 days	6.7	4.2	2.1	1.4	10.9	8.8	8.1

Given The above data, three sub options are available within option 3.

1. Undertake all recurring activity within the diagnostic theatres.

To undertake just the recurring activity using 3 session days over 5 days, eight theatres would be required; backlog clearance could be undertaken in the redundant capacity in the DGH's. Then long term the diagnostic and treatment centre would undertake ambulatory procedures. This option is a significant strategic shift compared to just achieving backlog clearance.

2. Undertake both recurring and backlog in the Diagnostic and treatment centre

To optimise operational capacity the unit would undertake 3 sessions per week over five days, as the most operationally desirable, leaving the weekends for further "buffer capacity." To achieve this the organisation would require 10 theatres over a three-year period, reducing to eight theatres once backlogs are cleared.

3. Undertake all theatre backlog activity only in the diagnostic and treatment centre

The most economical model would be to undertake Outpatients, oscopies and diagnostics as a low covid burden site **but** only undertake backlog activity; this would require three theatres over a 3-year period. However, it is recommended you may want to keep the facility as a Buffer capacity as backlogs in any system will continue when interruptions will occur, such as winter etc.

High-level financial analysis

Options three, four and five have capital cost implications based on the need for theatres, Oscopy and Outpatient facilities. The outline costs of Option three and five are listed below. The differences are considerable, based on the preferred sessional rate of 3 session working over 5 days for 3 years means that a fully diagnostic and treatment centre undertaking recurring and backlog would be £60 million in capital. The table below illustrates the range of three of the options.

Undertaking option five, a diagnostic centre with only backlog clearance would be £6.9m, with other options being between these ranges.

Option	Session	Theatres	Cost £m
Option 3– backlog + recurring + Out-patient + endoscopy	3 sessions x 5 days x 3 years	10	60m
Option 5 -Diagnostic and treatment Centre that has limited theatre capacity to clear backlogs and service transformation is undertaken to instigate covid light Daycase pathways within the current DGH's	3 sessions x 5 days x 3 years	2	6.9m

Notes

All costs are current as at Sept 2020 (PUBSEC 250)

Costs allow for 2 or 3 storey modular construction

Enabling includes allowance for substructures, structural frame, plant room and engineering supply

Costs exclude land costs and legal fees

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 below 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.

Summary of Estimated Direct Treatment Costs

Daycase 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
Grand Total	**13,612**	[redacted]	**15,385,396**

Notes
Cost includes consultant surgeon (with Pre-op), Anaesthetist, theatre staff & consumables, HSDU, POAC and Daycase 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 would like to note to F&P that these are the **minimum** likely costs.

Summary

The covid pandemic and the legacy of long waiters at the end of 19/20 has left the organisation with a significant clinical risk, although not unique to this organisation, the size of activity required to be undertaken and the previous backlog has left ourselves in a challenging situation.

To solve the problem mid to long term this paper describes a diagnostic and treatment centre strategic approach that would “carve out” Outpatients, Day case, Oscopies and other key ambulatory services. E.g. Cardiac services which would provide long term resilience to

the organisation by being able to treat highly vulnerable patients without interruption from unscheduled care surges and further Covid surges, it would also keep activity in wales supporting the welsh economy and we would have low reliance on other external providers both NHS and Independent.

The two centres would provide a low covid 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.

The discussion is whether all day surgery would be moved to the diagnostic and treatment centre or they would be used for backlog clearance only, providing “buffer capacity” during and after the clearance, as we do not understand the implications of this winter on diagnostic and theatre backlogs. Therefore, where we are currently predicting 3 years to clear the backlog, it may take four years after this winter.
There is a significant cost to the preferred option that would require subsequent financial analysis; all of the calculations are based on what is known at the time of writing, in the time available.
This paper could also stimulate the debate about an urgent reconfiguration of one of the sites, but this option is not discussed in this paper, but may reduce the significant cost outlined.

Next steps
This paper has considered a number of options to improve the planned care recovery for the mid and long term. The preferred options are option 3 or 5. The next steps, following discussions at F&P, is to move to an overarching business case that would pull together all the costs and site options for the diagnostic and treatment centre approach. The task and finish group would then continue this work over the next 4-6 weeks.

Conclusion
The significant aftermath of the covid pandemic was the delay to planned care, theatre capacity within planned care is currently an average of 35-40% of pre-covid operational activity, with a slower than expected increase in activity. Finance and performance committee requested a conceptual paper of which five options are being asked to be considered, two of the options have clinical support and give the organisation a medium to longer-term strategy. The paper highlights the significant problem for planned care and cover a solution for Daycase only. A further paper will need to review in-patient activity dependent on the outcome of this paper to align all the work.

However, the preferred options of either 3 or 5 gives potential opportunity to provide resilience, a new model of working and further capacity in the hospitals, supporting the unscheduled care capacity.

Recommendations
F&P are asked to provide a strategic discussion and agreement in principle to allow further development of the business case and to test the market.

Appendix 1- activity used for financial analysis

Spec	Day Case Numbers	backlog numbers as of 31/8/2020	Average time in theatre plus 15min turnaround time per patient	Pts per session	Routine Sessions Req'd (Col B/Col E)	Backlog Sessions Req'd (Col C/Col E)	Sessions required
Maxillo-Facial Surgery	1323	557	77	2.7	490	206	487
ENT	2546	1368	75	2.8	909	489	908
Breast Surgery	820	93	101	2.1	390	44	396
Gynaecology	1201	322	68	3.1	387	104	390
Obstetrics	143	0	76	2.8	51	-	52
Trauma & Orthopaedics	3450	4582	89	2.4	1,438	1,909	1,457
Urology	2792	930	64	3.3	846	282	844
Ophthalmology	10056	5760	36	5.8	1,724	987	1,724
Grand Total	**22331**	**13612**	**73.25**	**3.1**	**6,236**	**4,021**	**4,537**
Grand Total excl Ophthal	**12275**	**7852**	**79**	**2.7**	**4,512**	**3,034**	
Opthalmology (ex AMD)	7315	4190	48	4.4	1672	958	
Totals excl AMD	**19590**	**12,042**	**127**	**7**	**6,184**	**3,992**	

Appendix 2- SWOT analysis of each option

SWOT analysis for Option 1- Business as usual post-covid

Strengths	Weakness	Opportunities	Threats
Essential and P2 activity will be continued	Long waiting patients will continue to wait longer	Treat patients in a non-surgical pathway who are waiting for a long time	Patients may have untreated conditions whilst waiting
	Activity will be subject to surge pressures	Low cost option, expected surplus in planned care	Public confidence will be lost
	No ability to improve the clinical model for planned care		Treating patients in a non-surgical pathway may only delay their treatments
	Many clinical staff may not operate in the future causing skill decay		We may never treat some patients
	P3/4 patients will not be seen		This option cannot cope with increase in referrals

SWOT analysis for Option 2-Three session days and 7 day working -all sites

Strengths	Weakness	Opportunities	Threats
Provides short term limited increase in capacity	Theatre capacity still reduced, therefore limited scope	Six/seven day working would give most	Requires significant time 2-3 years of clearance
No further requirement for additional buildings	Susceptible to surge or covid outbreaks	Might be affordable, planned care is underspent	Potential burnout of staff
Normal way the NHS deals with backlogs	Relies on good will of staff- unsustainable model	Introduction of seven day working into consultant body	May never clear backlogs
Will require extra staff, therefore supporting services	Early evidence is clearance times will be a long time due to capacity only available at weekends and evenings		Staff engagement
	Still mixes day and in-patient cases		Introduction of seven day working into consultant body
	Covid restrictions causing capacity in OPD, diagnostics		Employing mid-term staff may not give value for

	and theatres would continue		money if activity is disrupted
	Still have A&E departments.		On/off will length time to reduce backlogs
	Still presents with same workforce issues as option 3		
	Will rely on an “on/off approach”		
	Cost per case will increase		

SWOT analysis for Option 3 -Diagnostic and treatment centre – including theatres

Strengths	Weakness	Opportunities	Threats
Protected extra capacity to remove backlog	Has lead time of minimum of 20 weeks	Has potential to return staff to work who may be high risk and/or shielding	Demand and capacity modelling could be wrong and therefore too many or not enough capacity
Modular approach…. can be dismantled after reduction of backlogs.	Possibility of diluting staff across numerous sites	Allows further strategic planning as backlogs are removed as what to do with space. Reconfiguration of services etc.	Clinical staff unwilling to change practice
Allows re-design of pathways for an ambulatory surgical model	Increasing expense in delivery of planned care	Other strategies can be aligned such as endoscopy and diagnostics once the centres are open and running	Location not fully understood
Introduces “one stop” approach to key specialties for patients	Not operational for this winter	Delivers care closer to the community	Puts current DGH’s at risk
	Will require more staff	Facilitates more day case surgery against British association of day case surgery	If working six days 3 session days may require less theatres
Consolidates virtual and non-face to face platforms	Cost per case will increase	Facilitates delivery of moving day case to out-patient procedure rooms	Digital transformation would need to support the delivery to be as paperless as possible
Fits into a number of national programmes, Endoscopy, Cardiology, national		Patient confidence in delivering carved out elective capacity	WG, funding support for this work

planned care programme			
Reduces backlog of patients over defined period of contract		Introduce 3 session , 6 day working infrastructure	How extra staff can be brought in: Short term contracts Locum/agency costs
Provides further space within DGH's for other uses such as covid escalation, surge etc.		Re-addresses non-expansion of planned care	IT/ patient record implications, how would it fit into digital strategy
Covid light centre			
Introduces right first time approach for patients.			

SWOT- Option 4 - Diagnostic centre – OPD and diagnostics only

Strengths	Weakness	Opportunities	Threats
Protected extra capacity to remove backlog	Does not cover stage 4 backlogs	Has potential to return staff to work who may be high risk and/or shielding	Demand and capacity modelling could be wrong and therefore too many or not enough capacity
Modular approach…. can be dismantled after reduction of backlogs.	Possibility of diluting staff across numerous sites	Allows further strategic planning as backlogs are removed as what to do with space. Reconfiguration of services etc.	Clinical staff unwilling to change practice
Allows re-design of pathways for an ambulatory OPD and diagnostic model	Increasing expense in delivery of planned care	Other strategies can be aligned such as endoscopy and diagnostics once the centres are open and running by moving more services out of an acute hospital	Location not fully understood
Introduces "one stop" approach to key specialties for patients	Not operational for this winter	Delivers care closer to the community	Puts current DGH's at risk
Cost less than option 3	Will require more staff	Facilitates more day case surgery against British association of day case surgery	If working six days 3 session days may require less theatres
Consolidates virtual and non-face to face platforms	Cost per case will increase	Facilitates delivery of moving day case	Digital transformation would need to

		to out-patient procedure rooms	support the delivery to be as paperless as possible
Fits into a number of national programmes, Endoscopy, cardiology, nation planned care programme	Has lead time of minimum of 20 weeks	Patient confidence in delivering carved out elective capacity	Funding support for this work
Provides further space within DGH's for other uses such as covid escalation, surge etc.	Fragmented patient journey, Diagnostic treatment centre and then DGH.	Introduce 3 session , 6 day working infrastructure	How extra staff can be brought in: Short term contracts Locum/agency costs
Covid light centre		Re-addresses non-expansion of planned care	Only covers partial pathway, not total pathway
Introduces right first time approach for patients at first stages of treatment			Size of the unit-possibly too big for any footprint
			IT/ patient record implications, how would it fit into digital strategy

SWOT - 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.

Strengths	**Weakness**	**Opportunities**	**Threats**
Protected extra capacity to remove backlog	Has lead time of minimum of 20 weeks	Has potential to return staff to work who may be high risk and/or shielding	Demand and capacity modelling could be wrong and therefore too many or not enough capacity
Modular approach…. can be dismantled after reduction of backlogs.	Possibility of diluting staff across numerous sites	Allows further strategic planning as backlogs are removed as what to do with space. Reconfiguration of services etc.	Clinical staff unwilling to change practice
Allows re-design of pathways for an ambulatory surgical model	Increasing expense in delivery of planned care	Other strategies can be aligned such as endoscopy and diagnostics once the centres are open and running	Location not fully understood
Introduces "one	Not operational for	Delivers care closer	Puts current DGH's

stop" approach to key specialties for patients	this winter	to the community	at risk
Ensures recurring day case activity can be continued through a transformational approach	Will require more staff	Facilitates more day case surgery against British association of day case surgery	If working six days 3 session days may require less theatres
Consolidates virtual and non-face to face platforms	Cost per case will increase	Facilitates delivery of moving day case to out-patient procedure rooms	Digital transformation would need to support the delivery to be as paperless as possible
Fits into a number of national programmes, Endoscopy, Cardiology, national planned care programme	DGH's would need to commit to carving out day case capacity and protect its facilities	Patient confidence in delivering carved out elective capacity	WG, funding support for this work
Reduces backlog of patients over defined period of contract	Provides limited capacity for In-patient long waiters	Introduce 3 session , 6 day working infrastructure	How extra staff can be brought in: Short term contracts Locum/agency costs
Provides further space within DGH's for other uses such as covid escalation, surge etc.		Re-addresses non-expansion of planned care	IT/ patient record implications, how would it fit into digital strategy
Covid light centre			
Introduces right first time approach for patients.			
Reduces capital cost of more theatres			

Cyfarfod a dyddiad: **Meeting and date:**	**Finance and Performance Committee** **30.9.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Finance Report Month 5 2020/21**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Eric Gardiner, Finance Director - Provider Services
Craffu blaenorol: **Prior Scrutiny:**	Acting Executive Director of Finance
Atodiadau **Appendices:**	Appendix 1: Summary of Position by Division Appendix 2: COVID-19 Expenditure Appendix 3: Income Appendix 4: Savings Appendix 5: Expenditure Appendix 6: Continuing Healthcare (CHC) & Funded Nursing Care Appendix 7: Financial Risks and Opportunities

Argymhelliad / Recommendation:

It is asked that the report is noted.

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

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

Sefyllfa / Situation:

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

Cefndir / Background:

The financial plan for 2020/21, approved by the Board, is to deliver a deficit of £40m, based on achieving savings of £45m. The plan did not take into account the impact of COVID-19, and therefore it will change throughout the year. The Health Board has also submitted plans for both Quarter 1 and Quarter 2 to Welsh Government, which incorporate the impact of COVID-19 and a consolidated plan for the second half of the financial year is currently being developed.

In the first five months of the year, expenditure has been considerably higher than planned due to the pandemic response with savings delivery 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 forecast expenditure is much higher than planned and savings delivery will 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	£16.7m Deficit	Plan	£40.0m Deficit
Actual	£31.0m Deficit	Actual	£44.4m Deficit	Forecast	£122.2m Deficit
Variance	£27.7m Adverse	Variance	£27.7m Adverse	Variance	£82.2m Adverse

Achievement Against Key Targets

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

- Key points for the month:

  - The Health Board's reported position has deteriorated by £27.7m in Month 5 as the report only includes COVID-19 funding confirmed by Welsh Government, whereas last month funding for the total cost of COVID-19 was anticipated in the position. Consequently, both the year to date position and the year-end forecast deficit have increased significantly, but are broadly in line with the income risk reported at the last Committee meeting.
  - Confirmation of the Health Board's allocation of additional COVID-19 sustainability funding is due to be announced as part of the Welsh Government planning guidance for Q3/4 during September. It is expected that this allocation will be broadly in line with the previous forecast position reported at the Finance & Performance Committee.
  - Progress on savings schemes has been limited and it is currently forecast that there will be a shortfall of £30.1m against the target. The Health Board needs to focus on developing and moving forward schemes, so that delivery in 2020/21 can be maximised.
  - There is a significant risk about the cost of PPE due to increasing supply chain issues in the current market, growth in demand and use.
  - Prescribing costs, whilst still a concern; have reduced in Month 5 due to a lower average cost per prescribing day.

3.2 Revenue Position

	Actual					Cumulative		
	M01	M02	M03	M04	M05	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m
Revenue Resource Limit	(154.7)	(128.5)	(133.2)	(140.1)	(103.7)	(660.2)	(660.2)	0.0
Miscellaneous Income	(9.7)	(9.8)	(9.3)	(9.6)	(12.1)	(57.4)	(50.5)	(6.9)
Health Board Pay Expenditure	65.0	66.1	68.1	67.3	66.0	327.8	332.5	(4.7)
Non-Pay Expenditure	102.8	75.5	77.7	85.7	80.8	406.5	422.6	(16.1)
Total	**3.4**	**3.3**	**3.3**	**3.3**	**31.0**	**16.7**	**44.4**	**(27.7)**

- Overview (Appendix 1): The in-month position is a £31.0m deficit, which is £27.7m above the plan for Month 5. This gives a cumulative over spend 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. As a consequence of this change in reporting basis, the deficit position has significantly increased in Month 5 due to the reduced income assumption; forecast expenditure remains consistent with previous months.

  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	M02	M03	M04	M05	YTD
	£m	£m	£m	£m	£m	£m
Previously Reported Deficit	**(3.4)**	**(3.3)**	**(3.3)**	**(3.3)**		
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		
Position under M05 income assumptions	**(10.6)**	**(8.4)**	**(10.7)**	**(4.7)**	**(10.0)**	**(44.4)**
Planned deficit						**16.7**
Variance over plan						**(27.7)**

- Impact of COVID-19 (Appendix 2): 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 of £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	Forecast
	£m	£m	£m	£m	£m	£m	£m
COVID-19 spend (incl. Field Hospitals)	28.8	3.7	7.3	7.1	6.1	53.0	102.6
Lost income	1.2	1.4	1.2	1.6	1.6	7.0	14.0
Non delivery of savings	3.7	3.6	2.0	2.7	2.3	14.3	36.2
Elective underspend	(2.4)	(2.8)	(2.2)	(2.6)	(1.9)	(11.9)	(18.6)
Slippage on planned investments	(0.2)	(0.1)	(0.5)	(0.5)	(0.2)	(1.5)	(1.7)
Cluster funding	0.0	0.0	(0.3)	(0.1)	0.0	(0.4)	(0.6)
ICF Funding	(0.3)	(0.7)	0.0	1.0	0.0	0.0	0.0
Total COVID-19 costs	**30.8**	**5.1**	**7.5**	**9.2**	**7.9**	**60.5**	**131.9**
Funding:							
Optimise Flow & Outcomes (ICF)	0.0	0.0	0.0	(1.6)	(0.1)	(1.7)	(2.5)
Mental Health Improvement Fund	0.0	0.0	0.0	(0.7)	0.0	(0.7)	(0.7)
GMS (DES)	0.0	0.0	0.0	(0.1)	0.0	(0.1)	(0.2)
Welsh Government	(30.8)	(5.1)	(7.5)	(6.8)	19.8	(30.4)	(46.6)
Impact on position	**0.0**	**0.0**	**0.0**	**0.0**	**27.6**	**27.6**	**81.9**

- Forecast: 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 reporting basis and the reduced income assumption 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
Forecast outturn	**122.2**

The Health Board will receive an allocation of Welsh Government's recently announced £800m COVID-19 funding, which is likely to be confirmed at the time of the publication of Q3/4 planning guidance. This will significantly reduce the year-end forecast and should broadly be in line with the previous income assumption.

- Income (Appendix 3): Welsh Government funding, including funding for COVID-19, totals £660.2m for the year to date. Miscellaneous income totals £50.5m to Month 5.

- Savings (Appendix 4): The identification of savings plans and the delivery of plans already identified has been severely impacted by COVID-19. Forecast savings delivery is currently £14.9m against the plan of £45m, a shortfall of £30.1m.

- Expenditure (Appendix 5): Total expenditure to date is £755.1m, giving rise to an over spend of £20.8m. A focus on Continuing Healthcare (CHC) & Funded Nursing Care expenditure is included in Appendix 6.

3.3 Balance Sheet

- Cash: The closing cash balance for August was £10.5m, which included £1.5m cash held for capital projects. The revenue cash balance of £9.0m was within the internal target set by the

Health Board. The cash flow forecast is currently reporting a significant shortfall of £120.9m at the end of the year, relating to both the original forecast overspend of £40.0m and the impact of COVID-19 related expenditure. 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. Current forecasts indicate that £6.0m 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 £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.

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

4.0 Risk Analysis (Appendix 7)
There are currently four identified risks to the financial position and two opportunities.

5.0 Legal And Compliance
Not applicable.

6.0 Impact Assessment
Not applicable.

Appendix 1 – Summary of Position by Division

	M01 Actual £000	M02 Actual £000	M03 Actual £000	M04 Actual £000	M05 Actual £000	Cumulative Budget £000	Cumulative Actual £000	Cumulative Variance £000
WG RESOURCE ALLOCATION	(154,715)	(128,474)	(133,260)	(140,076)	(103,736)	(660,260)	(660,260)	0
AREA TEAMS								
West Area	13,969	13,417	13,666	14,796	13,328	67,219	68,401	(1,182)
Central Area	18,101	17,247	18,204	18,507	17,620	86,462	88,939	(2,477)
East Area	19,908	19,137	19,730	21,713	19,307	96,445	98,905	(2,460)
Other North Wales	364	2,706	3,017	3,022	3,112	13,253	14,573	(1,320)
Field Hospitals	25,037	(539)	1,043	735	1,737	24,549	28,017	(3,468)
Commissioner Contracts	17,951	17,816	16,890	17,659	17,399	90,327	87,714	2,613
Provider Income	(1,170)	(1,252)	(1,195)	(1,211)	(2,000)	(9,362)	(6,827)	(2,535)
Total Area Teams	94,160	68,532	71,354	75,222	70,503	368,892	379,721	(10,828)
SECONDARY CARE								
Ysbyty Gwynedd	8,248	8,076	8,561	8,942	8,318	39,149	42,138	(2,990)
Ysbyty Glan Clwyd	10,151	10,259	10,480	10,557	10,231	49,858	51,676	(1,818)
Ysbyty Maelor Wrexham	9,054	8,930	9,199	9,185	8,702	41,809	44,916	(3,106)
North Wales Hospital Services	8,520	8,074	8,807	8,826	8,309	41,661	42,535	(875)
Womens	3,404	3,514	3,264	3,516	3,306	15,938	17,003	(1,065)
Total Secondary Care	39,377	38,853	40,310	41,026	38,866	188,415	198,268	(9,853)
Total Mental Health & LDS	10,920	10,773	11,349	11,295	11,327	53,899	55,664	(1,764)
CORPORATE								
Chief Executive	213	209	225	257	224	859	1,128	(269)
Chief Operating Officer	0	0	233	164	153	961	1,026	(65)
Estates & Facilities	4,729	4,564	4,631	4,610	4,437	20,909	22,971	(2,062)
Utilities & Rates	1,508	1,409	1,482	1,414	1,369	6,875	7,181	(306)
Executive Director of Finance	739	761	750	734	631	3,375	3,615	(240)
Executive Director of Nursing & Midwifery	1,074	1,041	973	952	1,042	4,695	4,879	(184)
Executive Medical Director	1,760	1,839	1,725	1,748	1,746	8,446	8,843	(397)
Executive Director of Workforce & OD	1,068	1,157	1,619	1,218	1,269	5,034	6,333	(1,299)
Director of Planning & Performance	159	229	200	203	183	1,014	987	27
Executive Director of Public Health	135	88	67	93	70	486	453	33
Director of Corporate Services	0	0	0	0	0	0	0	0
Office to the Board	162	98	93	61	97	470	437	32
Director of Therapies	54	28	30	19	28	155	133	23
Executive Director of Primary Care & Comm Services	66	64	74	74	84	424	362	63
Director of Turnaround	98	98	110	8	85	651	399	252
Total Corporate	11,765	11,585	12,211	11,555	11,419	54,354	58,747	(4,393)
Total Other Budgets incl. Reserves	1,897	2,059	1,352	4,316	2,585	11,366	12,209	(842)

Appendix 2 – COVID-19 Expenditure

The total cost of COVID-19 is £7.9m for August. £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).

Type	M01 £000	M02 £000	M03 £000	M04 £000	M05 £000	Total £000
Field Hospitals	25,037	(543)	996	565	792	26,847
Test Trace Protect (TTP)	4	4	47	170	945	1,170
Area Teams	607	947	1,852	2,228	1,427	7,062
Commissioner Contracts	0	0	0	100	567	667
Secondary Care	2,133	2,033	2,811	2,940	1,588	11,505
Mental Health	289	427	788	641	485	2,630
Corporate	728	868	759	441	336	3,132
Other Budgets	0	0	1	(21)	(14)	(34)
Total	**28,798**	**3,737**	**7,254**	**7,064**	**6,126**	**52,979**

Appendix 2 – COVID-19 Expenditure

Type	M01 £000	M02 £000	M03 £000	M04 £000	M05 £000	Total £000
Other Income	(30)	30	0	0	(66)	(66)
Total Income	**(30)**	**30**	**0**	**0**	**(66)**	**(66)**
Additional Clinical Services	170	357	683	532	407	2,149
Administrative & Clerical	166	427	417	374	884	2,268
Allied Health Professionals	22	50	57	116	81	326
Estates & Ancillary	(15)	36	166	148	158	493
Healthcare Scientists	10	34	15	10	(1)	68
Medical and Dental	437	648	1,255	1,523	681	4,543
Nursing and Midwifery Registered	313	383	1,729	1,592	732	4,750
Professional Scientific & Technical	0	18	43	73	57	190
Total Pay	**1,103**	**1,953**	**4,365**	**4,368**	**2,999**	**14,787**
Primary Care	(10)	21	42	395	(15)	433
Primary Care Drugs	0	0	0	0	0	0
Secondary Care Drugs	129	61	38	89	(2)	316
Clinical Services & Supplies	1,129	580	387	120	396	2,612
General Services & Supplies	589	378	444	160	291	1,863
Healthcare Services Provided by Other NHS Bodies	0	10	5	5	498	518
Continuing Care and Funded Nursing Care	338	655	712	1,128	849	3,682
Establishment & Transport Expenses	66	92	52	25	51	285
Premises and Fixed Plan	25,352	(522)	1,420	585	961	27,796
Other Non-Pay	133	480	(212)	189	165	753
Total Non-Pay	**27,725**	**1,754**	**2,889**	**2,696**	**3,194**	**38,258**
Total	**28,798**	**3,737**	**7,254**	**7,064**	**6,126**	**52,979**

Appendix 3 – Income

Most of the Health Board's funding is from the Welsh Government allocation through the Revenue Resource Limit (RRL). Confirmed allocations to date are £1,552.7m, with further anticipated allocations in year of £44.3m, a total forecast Revenue Resource Limit (RRL) of £1,597.0m for the year.

Description	£m
Allocations Received	
Opening allocation	1,516.6
Covid-19 costs	23.7
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
Mental Health Service Improvement Fund 2020-21	0.7
Single Cancer Pathway	0.6
Primary Care Improvement Grant	0.4
Wales Community Care Information System (WCCIS) - ICF Funding	0.3
A Healthier Wales - Children & Young People's Mental Health	0.2
Carers' Funding 2020-21	0.2
GMS (DES) - Easter bank holiday	0.2
SpR Allocation	0.2
Other allocations	1.2
Total Allocations Received	**1,552.7**

Description	£m
Allocations Anticipated	
Covid-19 costs	22.9
Substance Misuse	5.5
IM&T Refresh Programme	1.9
Community Cardiology Scheme	1.8
Prevention and Early Year Funding for 2019-20	1.3
MSK Orthopaedic Services	1.1
Vocational Training	1.0
Outpatients Transformational Fund Bid	0.8
SpR Allocation	0.5
Consultant Clinical Excellence Awards	0.4
Mental Health Individual Placement Support (IPS)	0.4
CAMHS In-Reach	0.2
A Healthier Wales	0.2
Community Cardiology Scheme	0.2
Delivery Plan Palliative Care	0.2
Suicide Prevention	0.1
Capital Adjustment	5.8
Total Allocations Anticipated	**44.3**

	£m
Total Allocations Received	**1,552.7**
Total Allocations Anticipated	**44.3**
Total Welsh Government Income	**1,597.0**

Appendix 3 – Income

The change in reporting basis and the reduced income assumption for Welsh Government COVID-19 funding has reduced the income included in the forecast position, as shown below.

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
Total	**131.2**	**46.6**	**30.4**
Of which:			
Income Received	21.0	23.7	18.0
Income Notified or Anticipated	110.2	22.9	12.4

The Month 5 forecast position includes £46.6m of Welsh Government COVID-19 income, of which £30.4m has been included in the year to date position. This is significantly lower than the £131.2m of Welsh Government COVID-19 income included in the forecast position at Month 4.

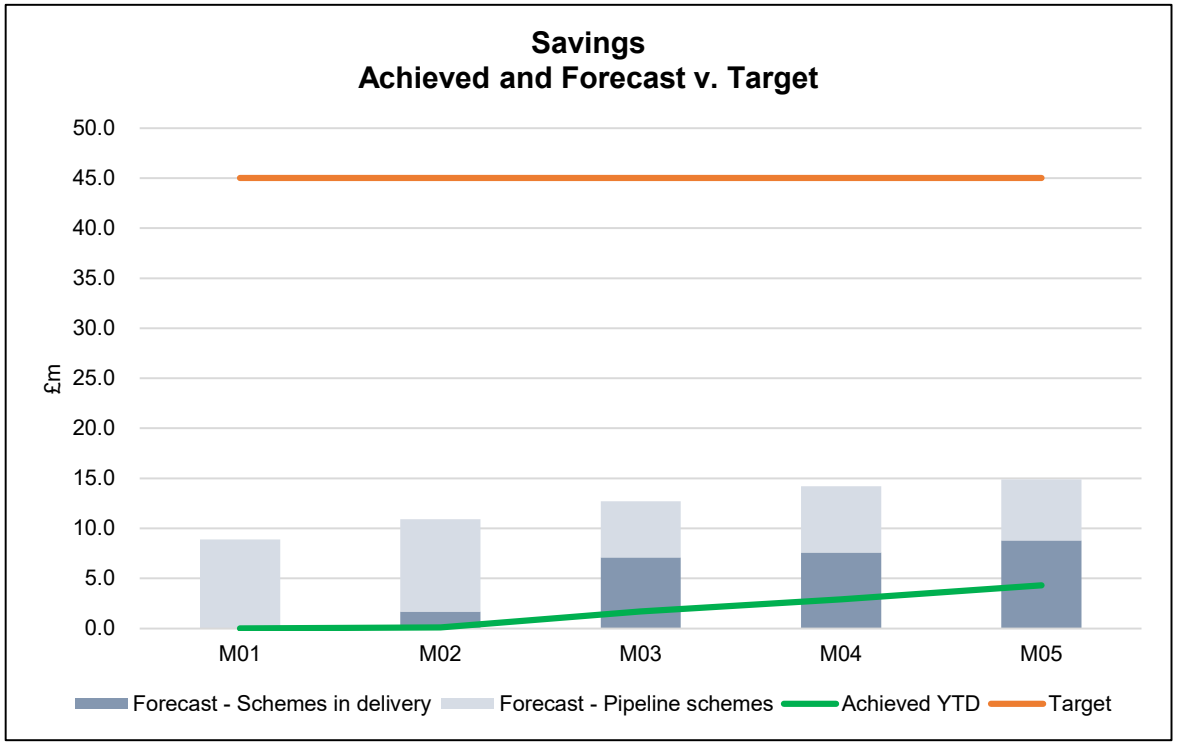
Miscellaneous income is showing a year to date shortfall, which is due to the impact of the pandemic on some of the Health Board's income streams (total lost income of £7.0m). This has been included as a cost of COVID-19 and arises from the following areas:

Loss of Income to Month 5	Total £m
Dental Patient Charge Revenue	2.9
Non-contracted activity (NCAs)	2.5
Other	1.6
Total Income	**7.0**

Appendix 4 – Savings

The financial plan for 2020/21 is based on delivering savings of £45.0m, equating to 3.6% of recurrent base budget (excluding ring-fenced budgets). Savings of £1.4m are reported in Month 5, increasing the overall year to date delivery to £4.3m. The Month 4 figure position some retrospective savings for schemes not identified in Month 4.

The total in-year forecast for savings, including pipeline, has increased by £0.7m from last month to £14.9m, of which £11.2m is recurrent. This leaves a shortfall of £30.1m against the full year savings target.



Schemes that remain in the pipeline amount to £6.1m. Work is progressing to fully develop these schemes and move them into amber and green over the next two months. 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. The forecast movement of the pipeline schemes to green / amber is shown in the table below.

Appendix 4 – Savings

Amber/ Green Date	Forceast Annual Savings	Forecast FYE Savings
	£000	£000
Sep-20	4,827	3,687
Oct-20	1,236	4,438
Total	**6,063**	**8,125**

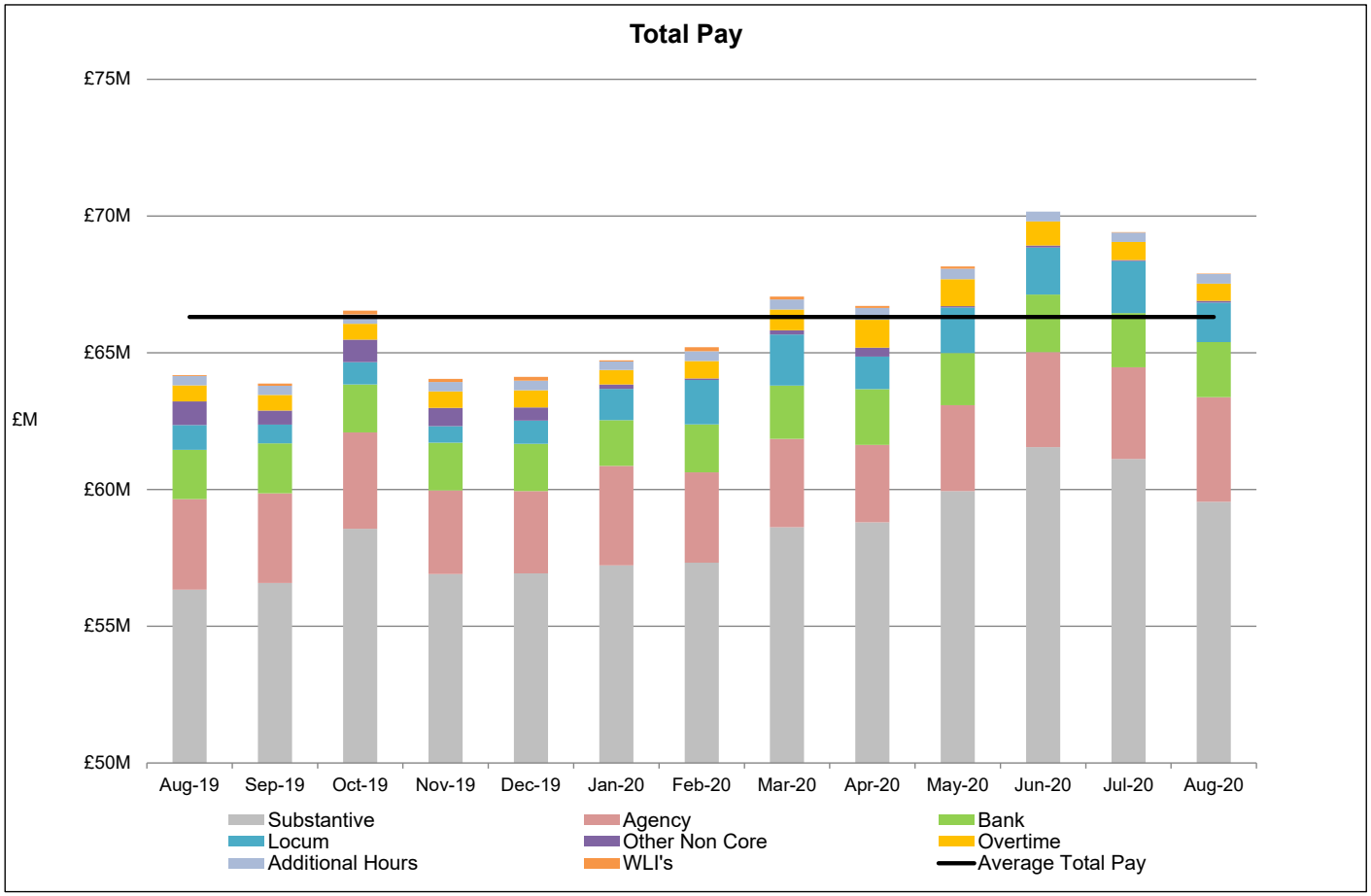
The full year effect of pipeline schemes, totalling £8.1m, is an estimate at this stage and requires further validation. The Executive Team is currently considering options and capacity requirements for the savings delivery and PMO function to be re-established. This will ensure that there is dedicated 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.

		SCHEMES IN DELIVERY								PIPELINE SCHEMES				TOTAL PROGRAMME	
		Year to Date			Forecast										
	Savings Target	Savings Target	Savings Delivered	Variance	Recurring Forecast	Non-Recurring Forecast	Total Forecast	Variance	Forecast FYE	Recurring Forecast	Non-Recurring Forecast	Total Forecast	Forecast FYE	Total Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Ysbyty Gwynedd	4,167	1,736	460	(1,277)	385	398	784	(3,383)	705	218	0	218	151	1,001	(3,165)
Ysbyty Glan Clwyd	5,079	2,116	180	(1,936)	47	329	376	(4,703)	440	344	0	344	360	720	(4,359)
Ysbyty Wrexham Maelor	4,414	1,839	269	(1,570)	273	375	648	(3,767)	333	92	27	119	168	767	(3,648)
North Wales Managed Services	4,300	1,792	209	(1,583)	478	10	488	(3,812)	636	59	0	59	118	547	(3,753)
Womens Services	1,733	722	51	(671)	152	0	152	(1,581)	174	0	0	0	0	152	(1,581)
Secondary Care	**19,692**	**8,205**	**1,169**	**(7,036)**	**1,335**	**1,112**	**2,447**	**(17,246)**	**2,288**	**713**	**27**	**740**	**797**	**3,186**	**(16,506)**
Area - West	4,402	1,834	710	(1,125)	1,453	395	1,848	(2,554)	1,516	63	0	63	50	1,911	(2,491)
Area - Centre	6,408	2,670	931	(1,739)	1,855	0	1,855	(4,553)	2,800	1,080	0	1,080	215	2,935	(3,473)
Area - East	6,464	2,693	758	(1,936)	158	1,340	1,498	(4,965)	158	19	15	34	33	1,532	(4,931)
Area - Other	607	253	0	(253)	0	0	0	(607)	0	0	0	0	0	0	(607)
Contracts	1,000	417	0	(417)	0	0	0	(1,000)	0	0	0	0	0	0	(1,000)
Area Teams	**18,881**	**7,867**	**2,398**	**(5,469)**	**3,467**	**1,735**	**5,202**	**(13,679)**	**4,475**	**1,162**	**15**	**1,177**	**298**	**6,379**	**(12,502)**
MHLD	1000	0	582	582	1,000	0	1,000	0	1,000	0	0	0	0	1,000	0
Corporate	5,426	2,261	142	(2,119)	110	79	189	(5,238)	111	189	721	910	592	1,099	(4,328)
Divisional Total	**45,000**	**18,333**	**4,292**	**(14,041)**	**5,911**	**2,926**	**8,837**	**(36,162)**	**7,873**	**2,064**	**763**	**2,827**	**1,687**	**11,664**	**(33,336)**
Medicines Management IG										0	0	0	0	0	0
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
Improvement Group Total										**3,236**	**0**	**3,236**	**6,438**	**3,236**	**3,236**
Total Programme	**45,000**	**18,333**	**4,292**	**(14,041)**	**5,911**	**2,926**	**8,837**	**(36,162)**	**7,873**	**5,300**	**763**	**6,063**	**8,125**	**14,900**	**(30,099)**

Appendix 5 – Expenditure

Pay Expenditure

Health Board pay costs in August are £66.0m, a decrease of £1.3m from last month. Month 5 spend includes £3.0m of pay costs directly related to COVID-19, £1.4m lower than last month, with variable pay costs of £8.3m (12.3% of pay), the same as in July. Overall, pay is £4.7m over spent against budget; however, this includes £8.4m of unfunded COVID-19 pay costs.



Appendix 5 – Expenditure

	Actual					Cumulative		
	M01	M02	M03	M04	M05	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Clerical	8.6	8.8	8.8	8.6	9.1	46.2	43.9	2.3
Medical & Dental	15.2	15.6	15.5	16.1	15.0	71.9	77.4	(5.5)
Nursing & Midwifery Registered	20.6	20.8	21.2	20.6	20.6	108.1	103.8	4.3
Additional Clinical Services	9.4	9.5	9.8	9.3	9.4	43.3	47.4	(4.1)
Add Prof Scientific & Technical	3.1	3.1	3.0	3.0	3.0	15.8	15.2	0.6
Allied Health Professionals	3.8	3.8	4.0	4.0	3.9	18.6	19.5	(0.9)
Healthcare Scientists	1.1	1.2	1.2	1.2	1.2	6.0	5.9	0.1
Estates & Ancillary	3.2	3.2	3.4	3.3	3.3	16.5	16.4	0.1
Students	0.0	0.1	1.2	1.2	0.5	1.4	3.0	(1.6)
Health Board Total	**65.0**	**66.1**	**68.1**	**67.3**	**66.0**	**327.8**	**332.5**	**(4.7)**
Primary care	1.7	2.1	2.0	2.1	1.9	8.0	9.7	(1.7)
Total Pay	**66.7**	**68.2**	**70.1**	**69.4**	**67.9**	**335.8**	**342.2**	**(6.4)**

Variable Pay	M01	M02	M03	M04	M05	Total
	£m	£m	£m	£m	£m	£m
Agency	2.8	3.1	3.5	3.3	3.8	16.5
Overtime	1.0	1.0	0.9	0.7	0.6	4.2
Locum	1.2	1.7	1.7	1.9	1.4	7.9
WLIs	0.1	0.1	0.0	0.0	0.0	0.2
Bank	2.1	1.9	2.1	2.0	2.0	10.1
Other Non Core	0.3	0.0	0.1	0.0	0.1	0.5
Additional Hours	0.4	0.4	0.3	0.4	0.4	1.9
Total	**7.9**	**8.2**	**8.6**	**8.3**	**8.3**	**41.3**

Areas of note are:

- 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, it is anticipated that there may be some further payments to be made going forward. In addition, locum costs have fallen by £0.5m.
- Student pay costs have reduced in Month 5, as both Months 3 and 4 included backdated payments arising from the employment of student nurses as part of the COVID-19 response.
- Agency costs for Month 5 are £3.8m, representing 5.6% of total pay. 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 which includes £0.05m relating to COVID-19.

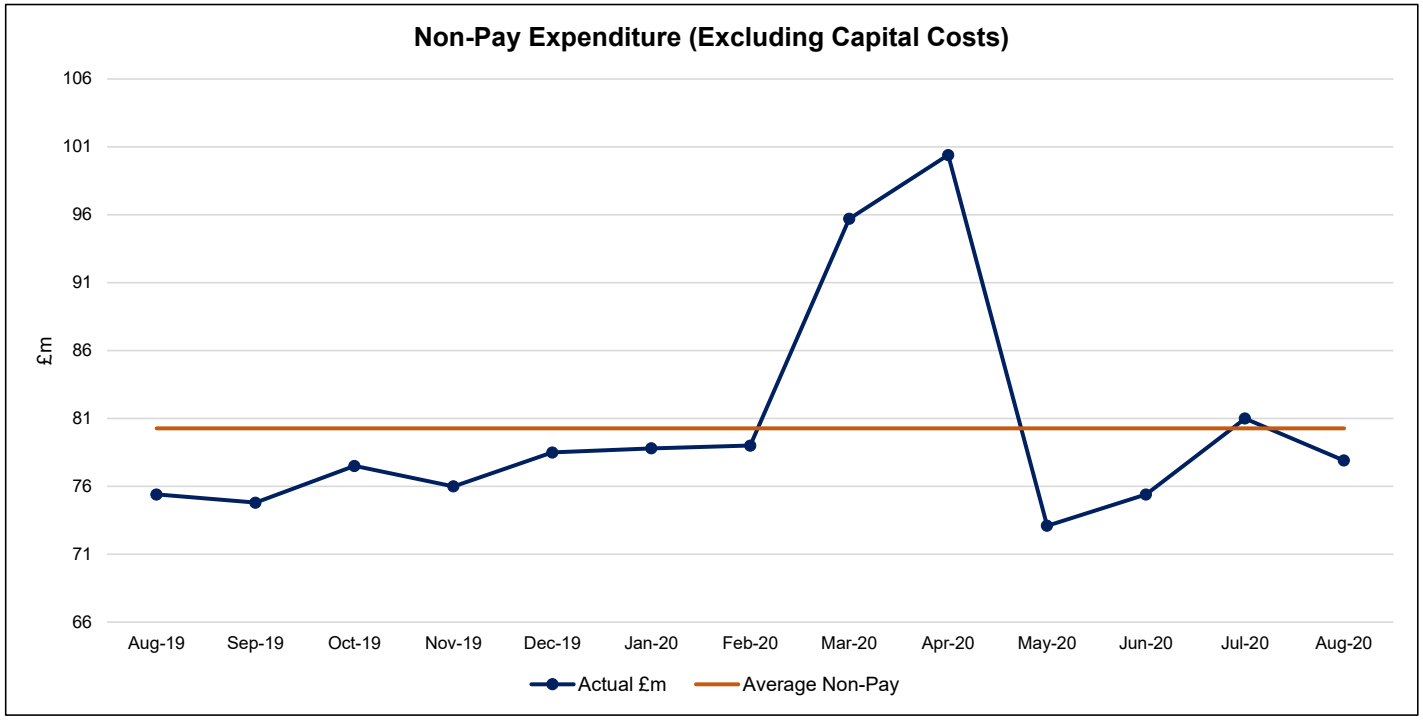
Appendix 5 – Expenditure

Non-Pay Expenditure

Costs this month are £146.8m, which is £6.1m less than in Month 4; with a year to date over spend of £16.1m.

Month 5 non-pay costs include £3.2m directly related to COVID-19 (£38.3m year to date). 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. Offsetting these costs is a reduction in planned care non-pay spend of £1.9m. There has been a small increase in elective care activity during August, but it is still at a much-reduced level. In addition, there is slippage on a number of planned investments of £0.2m.

Therefore, the net cost of COVID-19 on non-pay costs is £3.4m in Month 5 and £38.8m for the year to date. Funding included in the cumulative position for these costs is £27.4m, giving an unfunded COVID-19 cost pressure of £12.3m.



Appendix 5 – Expenditure

	Actual					Cumulative		
	M01	M02	M03	M04	M05	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care	17.2	17.5	15.9	17.6	17.2	87.6	85.4	2.2
Primary Care Drugs	8.9	8.6	10.5	11.0	8.7	43.9	47.7	(3.8)
Secondary Care Drugs	5.4	5.0	5.5	5.8	5.4	29.2	27.1	2.1
Clinical Supplies	4.8	3.6	4.2	4.6	4.3	24.6	21.6	3.0
General Supplies	2.7	2.6	2.1	4.7	3.0	14.2	15.1	(0.9)
Healthcare Services Provided by Other NHS Bodies	22.7	22.7	21.5	22.3	22.1	113.5	111.3	2.2
Continuing Care and Funded Nursing Care	8.4	8.2	9.1	9.0	9.0	44.0	43.7	0.3
Other	30.3	4.9	6.6	6.0	8.2	34.8	56.0	(21.2)
Non-pay costs	**100.4**	**73.1**	**75.4**	**81.0**	**77.9**	**391.8**	**407.9**	**(16.1)**
Cost of Capital	2.4	2.4	2.3	4.7	2.9	14.7	14.7	0.0
Total non-pay including cost of capital	**102.8**	**75.5**	**77.7**	**85.7**	**80.8**	**406.5**	**422.6**	**(16.1)**

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, however there has been a reduction in costs this month. 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. 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%).
- **General Supplies:** 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 pre-pandemic cost and will result in a pressure across the organisation.
- **Continuing Healthcare (CHC)**: An analysis of the position and the impact of COVID-19 is included in Appendix 6.
- **Other**: Spend against Intermediated Care Funding (ICF) has increased significantly this month, as further plans are developed and implemented. This has contributed £1.7m to the increase in expenditure. The significant over spend relates to unfunded COVID-19 expenditure totalling £5.2m, along with £14.3m of non-delivered 2020/21 savings.

Appendix 6 – Continuing Healthcare (CHC) & Funded Nursing Care

The Month 5 Continuing Healthcare (CHC)/Funded Nursing Care financial position saw expenditure rise to a year-to-date cost of £41.8m, against a budget of £40.9m. However, £3.2m has been identified as arising from the response to COVID-19 CHC Guidance and has been charged to the Health Boards 'Cost of COVID-19' (CoC) expenditure. As a result of this adjustment, the adverse variance (£0.9m over-spent) for CHC has been re-stated as a £2.2m favourable (under-spent) position.

The year-end forecast increases the CoC cost estimate to £3.5m, but with the expectation of rising CHC costs during the second half of the year, as Care Homes hopefully return to a more 'Business as Usual', the year-end forecast position reduces down to £1.9m underspent.

The Divisional positions are summarised below:

Division	Annual Budget £000	YTD M05 Budget £000	YTD M05 (Definition Sheet) £000	Transferred to Cost of COVID-19 £000	Net YTD M05 Position £000	Variance £000	Annual Forecast £000	Annual Forecast Variance £000
East Area	21,173	8,875	7,657	(507)	7,151	1,725	18,283	2,890
Central Area	21,472	9,003	8,872	(696)	8,175	828	20,201	1,271
West Area	19,559	8,201	8,173	(834)	7,339	861	18,783	775
MH	33,276	13,956	15,879	(1,125)	14,753	(797)	35,450	(2,173)
Childrens	2,098	8734	1,264	0	1,264	(390)	2,921	(824)
Total	**97,578**	**40,910**	**41,845**	**3,163**	**38,683**	**2,227**	**95,639**	**1,939**

It has not been assumed that Welsh Government (WG) will fully fund all CoC CHC costs and the Area Team have diverted ICF slippage monies amounting to £1.3m to cover some of the £.3.5m CoC forecast. This leaves a risk of circa £2.2m for the rest of the year requiring additional monies to cover the CHC CoC costs.

Appendix 6 – Continuing Healthcare (CHC) & Funded Nursing Care

COVID-19 Funding confirmed by WG - Support for Adult Social Care Providers in the Context of COVID-19 Funding Scheme Guidance for Local Health Boards

Welsh Government has confirmed an allocation of £22.4m to directly support Local Health Board (LHB) commissioned care, and LHB / Local Authority (LA) joint packages of care across domiciliary care and residential care, BCUHB has been allocated £5.0m This funding for will complement the funding for LA commissioned social care provided through the adult social care element of the Local Government Hardship Fund. In most cases it will apply from 1st April to 30th September 2020 to cater for the additional costs providers have incurred as a consequence of COVID-19. The funding will be allocated to LHBs on a formula basis to support providers in their response to COVID-19.

As the funding is time limited it is important that neither LHBs nor care providers make assumptions on future Welsh Government funding, or commit expenditure after 30th September 2020 from this scheme.

Standard uplifts applicable for LHB commissioned care and jointly commissioned care are:

A. £75 per week per resident temporary fee uplift for LHB commissioned residential care (CHC) between 1st April and 30th September 2020;

B. £25 per week per resident temporary fee uplift for LHB commissioned nursing care (FNC) between 1st April and 30th September 2020;

C. £1 per hour temporary fee uplift for LHB commissioned domiciliary care and for LHB CHC commissioned in the community between 1st April and 30th September 2020; and

D. £75 per week per client temporary fee uplift for LHB and LA jointly commissioned care from 1st July to 30th September 2020 (the shorter period here is to take account of the contribution towards the costs in jointly commissioned care LAs have previously been able to provide).

In addition, the guidance includes a section on addressing market stability and the continuing challenges across the adult social care sector as a whole regarding voids and unpredictable costs. The Health Board is expected to contribute resources to address voids (beds unoccupied due to COVID-19 admission restrictions) in care homes, which have an element of LHB commissioned care, in discussion with the relevant Local Authority.

Appendix 7 – Financial Risks and Opportunities

	Issue	Description	£m	Key Decision Point & Summary Mitigation	Risk Owner
1	**Opportunity:** Red Pipeline Savings Schemes	– Red rated savings schemes that total £6.1m are currently held in pipeline and are due to start delivering over the next two months.	6.1	– Work is progressing to move these schemes into amber / green in the coming months. It is expected that all current schemes will be amber or green by the end of October:	Sue Hill, Acting Executive Director of Finance
2	**Opportunity:** Welsh Risk Pool	– 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.	0.1	– The Welsh Risk Pool forecast cost share outturn is monitored on a monthly basis via the all-Wales Deputy DoFs meetings.	Sue Hill, Acting Executive Director of Finance
3	**Risk:** Vaccination Programme for Flu and COVID-19	– The cost of the extension of the flu vaccination programme and a potential COVID-19 vaccination programme are not yet known. Depending on any funding, these may result in a cost pressure to the Health Board.		– 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.	Sue Hill, Acting Executive Director of Finance
4	**Risk:** 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
5	**Risk:** Junior Doctor Monitoring	– There was a significant test legal case focusing on how NHS organisations should address monitoring for junior doctors.		– It has not yet been determined how this case will impact on the Health Board and what the financial implications may be. Further investigations are being undertaken to quantify any potential impact.	Sue Green, Executive Director of Workforce & Organisational Development
6	**Risk:** Holiday Pay	– NWSSP Employment law team have confirmed that the holiday pay issues arising from the Flowers judgement are ongoing and the outcome of the Supreme Court appeal is awaited.		– The Health Board is monitoring the situation and will respond appropriately to any legal decision.	Sue Green, Executive Director of Workforce & Organisational Development

Cyfarfod a dyddiad: Meeting and date:	**Finance and Performance Committee 30.9.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Savings Programme Update – Month 5 20/21**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Acting Executive Director of Finance
Awdur yr Adroddiad Report Author:	Sue Hill, Acting Executive Director of Finance
Craffu blaenorol: Prior Scrutiny:	Acting Executive Director of Finance
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

That the Committee note –

- 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
- The urgent action required to finalise the development and risk assessment of existing PIDs
- The need for further savings schemes to be developed in order to reduce to projected shortfall against the Board's financial plan requirements
- Note the development of a proposal for resourcing and delivery of the PMO and Service Improvement functions which will be presented to the Committee in October

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

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

Sefyllfa / Situation:

The purpose of this report is to provide an update on the savings programme for 20/21 and to make recommendations regarding its further development.

Cefndir / Background:

The opening financial plan for 20/21 contained a cash releasing savings target of £45m, equating to 3.6% of budget. This savings requirement was set in order to support the delivery of a £40m in year deficit and a reduction in underlying deficit from £49m to £35m.

The development of the savings programme was being driven through the Board's Recovery Programme. As a result of the response to the pandemic, work on the savings programme was suspended in March 2020. A review of the programme was undertaken in June 2020 which identified deliverable savings plans of £12.2m. Work has continued since June to increase the number of schemes and the value of the programme and this report reflects the position as at Month 5.

Asesiad / Assessment & Analysis

1. Strategy Implications

This paper aligns to the strategic goal of attaining financial balance and is linked to the effective use of resources though the adoption of a Value Based Healthcare approach.

2.1 Reviewing the Initial Savings Plan

The following table summarises the status of the savings programme at Month 5 and compares this to the original PMO programme and the position as at the June review.

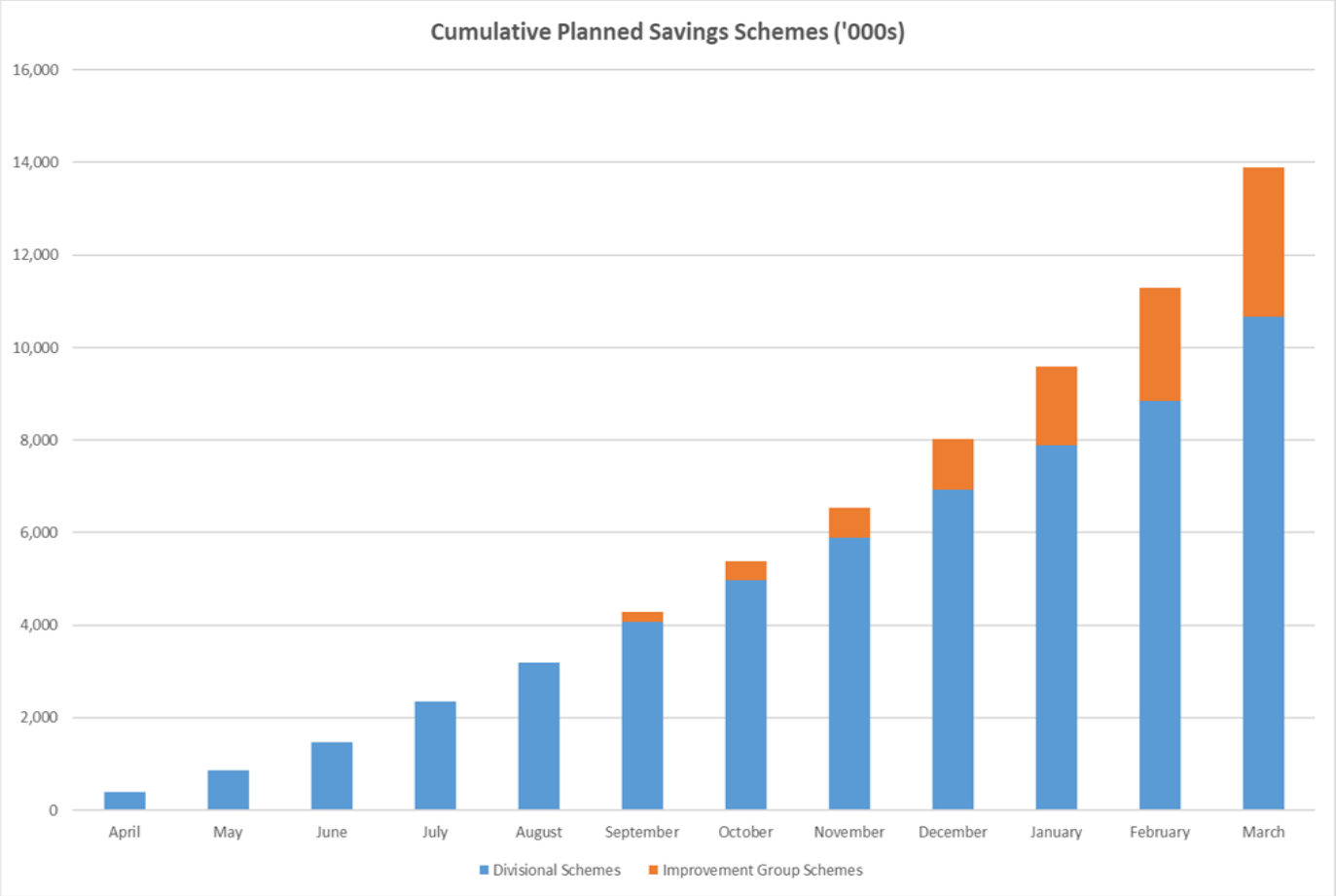
Programme Area		Original PMO Review - March 20		June 19th Review		Month 5 Position	
		No	Value (£)	No	Value (£)	No	Value (£)
Division	Area - Centre	13	1,235	8	1,320	8	2,700
	Area - East	11	976	5	784	7	1,326
	Area - Other	-	-	-	-	-	
	Area - West	4	790	6	1,615	7	1,635
	Contracts	-	-	-	-	-	
	Corporate	-	-	-	-	7	1,069
	MHLD	-	-	1	1,000	1	1,000
	Provider - NW	13	460	9	245	9	245
	Provider - NW (Cancer)	3	-	2	301	2	301
	Provider - YG	8	833	7	693	8	923
	Provider - YGC	9	1,043	3	280	6	541
	Provider - YMW	19	692	13	444	14	769
	Womens	8	421	2	152	2	152
	Sub-Total	**88**	**6,450**	**56**	**6,835**	**71**	**10,661**
Improvement Group	CHC	1	4,533	-	-		
	Procurement	1	7,000	1	2,000	1	2,000
	Unscheduled Care	1	-	-	-		
	Care Closer to Home	1	-	-	-		
	Workforce	1	4,729	1	1,436	1	1,236
	Quality	-	-	-	-		
	MHL&D	1	1,159	-	-		
	Planned care	1	-	-	-		
	Medicines Management	1	2,574	1	899		
	Estates	6	1,050	6	1,039		
	Digital	4	282	1	30		
	Health Improvement	-	-	-	-		
	Sub-Total	**18**	**21,327**	**10**	**5,404**	**2**	**3,236**
	GRAND TOTAL	**106**	**27,776**	**66**	**12,239**	**73**	**13,898**

A considerable reduction in the number and value of schemes between March and June was noted in the previous report. Since June the number of schemes has risen by 7 and the value of the programme has risen by £1.7m to £13.9m. The IG schemes for medicines, digital and estates have all now moved into Divisional schemes for delivery.

This leaves a gap of £31.1m between the plans above and the savings target set out in the Board's financial plan.

2.2 Profile of Savings Schemes

The following chart and table summarise the profile of delivery associated with the £13.9m savings programme –



	April £'000s	May £'000s	June £'000s	July £'000s	August £'000s	September £'000s	October £'000s	November £'000s	December £'000s	January £'000s	February £'000s	March £'000s
Area - Centre	52	104	206	408	665	927	1,198	1,479	1,809	2,114	2,419	2,700
Area - East	45	111	199	302	409	522	640	767	903	1,044	1,178	1,326
Area - West	60	161	309	456	608	751	898	1,045	1,193	1,340	1,488	1,635
Corporate	8	15	23	72	80	127	135	142	200	202	205	1,069
MHLD	83	167	250	333	417	500	583	667	750	833	917	1,000
Provider - NW	18	37	56	97	138	180	238	297	356	419	483	547
Provider - YG	64	129	193	308	385	462	538	615	692	769	846	923
Provider - YGC	29	58	88	154	193	231	283	334	386	438	489	541
Provider - YMW	32	64	123	183	248	314	381	456	534	613	691	769
Womens	5	9	24	38	51	64	78	92	108	123	137	152
Divisional Total	**397**	**856**	**1,470**	**2,351**	**3,189**	**4,077**	**4,972**	**5,896**	**6,932**	**7,896**	**8,853**	**10,661**
	April £'000s	**May £'000s**	**June £'000s**	**July £'000s**	**August £'000s**	**September £'000s**	**October £'000s**	**November £'000s**	**December £'000s**	**January £'000s**	**February £'000s**	**March £'000s**
Procurement	0	0	0	0	0	200	400	600	900	1,266	1,633	2,000
Workforce	0	0	0	0	0	0	16	37	193	433	814	1,236
IG Total	**0**	**0**	**0**	**0**	**0**	**200**	**416**	**637**	**1,093**	**1,699**	**2,447**	**3,236**
Grand Total	**397**	**856**	**1,470**	**2,351**	**3,189**	**4,277**	**5,388**	**6,533**	**8,024**	**9,595**	**11,299**	**13,898**

The profile of savings submitted by Divisions indicates a steady increase in savings secured from month 3 onwards. Many of these schemes are now in delivery and their performance is summarised in section 2.4. The profile for IGs has significant savings building in the second half of the financial year reflecting the nature of the schemes and the limited capacity available to progress their implementation earlier in the financial year.

2.3 Risk Assessment of Schemes

All savings schemes are subject to a risk assessment process in line with the guidance issued by Welsh Government. The following table summarises the RAG status of schemes within the programme as at month 5 –

Programme Area	Total £m	Green £m	Amber £m	Red £m
Divisions				
Area - Centre	2.70	0.52	1.07	1.11
Area - East	1.33	1.29	0.00	0.03
Area - West	1.64	0.67	0.90	0.07
Corporate	1.07	0.03	0.05	0.99
MHLD	1.00	0.00	1.00	0.00
Provider - NW	0.55	0.49	0.00	0.06
Provider - YG	0.92	0.39	0.00	0.54
Provider - YGC	0.54	0.15	0.00	0.39
Provider - YMW	0.77	0.59	0.12	0.07
Womens	0.15	0.15	0.00	0.00
Divisional Total	10.66	4.27	3.14	3.25
Improvement Groups				
Procurement	2.00			2.00
Workforce	1.24			1.24
IG Total	3.24	0.00	0.00	3.24
Grand Total	13.90	4.27	3.14	6.49
% Distribution	100%	31%	22%	47%

As may be seen from the table above, £7.41m of the current programme is assessed as amber or green. This equates to 53% of the programme. Schemes which are classified as red and remain in the pipeline amount to £6.49m (47%). These require further work to ensure progression into delivery.

All pipeline schemes are under review with an expectation that they can be moved into amber / green for month 6. This requires a greater focus upon this work within Divisions to ensure that PIDs are fully developed and robust. The most significant risk within the pipeline relates to the Workforce Improvement Group scheme which has a value of £1.24m. The demands placed upon the organisation to respond to COVID-19 continue to present challenges to the mobilisation and delivery of this programme. A detailed re-assessment of this PID is being undertaken in Month 6 to ensure that the pipeline value reflects an achievable target.

2.4 Month 5 Savings Position and Forecast

Savings performance against the plan set out above is summarised below. For those schemes which are in delivery, the following table summarises the position at month 5 -

Schemes In delivery		Savings Delivered YTD			Forecast				
Includes savings delivered by schemes awaiting PIDs	Cash Releasing Allocated Budget £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	Recurring Forecast £'000	Non-Recurring Forecast £'000	Total Forecast £'000	Forecast FYE £'000	Variance to Allocated Budget £'000
Ysbyty Gwynedd	4,167	322	460	138	385	398	784	705	(3,383)
Ysbyty Glan Clwyd	5,079	109	180	71	47	329	376	111	(4,703)
Ysbyty Wrexham Maelor	4,414	248	269	21	273	375	648	333	(3,767)
North Wales Managed Services	4,300	138	209	71	478	10	488	636	(3,812)
Womens Services	1,733	51	51	(0)	152	0	152	174	(1,581)
Secondary Care	**19,692**	**869**	**1,169**	**300**	**1,335**	**1,112**	**2,447**	**1,959**	**(17,246)**
Area - West	4,402	582	710	127	1,453	395	1,848	1,516	(2,554)
Area - Centre	6,408	660	931	271	1,855	0	1,855	2,800	(4,553)
Area - East	6,464	409	758	348	158	1,340	1,498	158	(4,965)
Area - Other	607	0	0	0	0	0	0	0	(607)
Contracts	1,000	0	0	0	0	0	0	0	(1,000)
Area Teams	**18,881**	**1,652**	**2,398**	**747**	**3,467**	**1,735**	**5,202**	**4,475**	**(13,679)**
MHLD	1,000	417	582	166	1,000	0	1,000	1,000	0
Corporate	5,426	80	142	62	110	79	189	111	(5,238)
Divisional Total	**45,000**	**3,017**	**4,292**	**1,275**	**5,911**	**2,926**	**8,837**	**7,545**	**(36,162)**

Savings of £4.3m have been delivered to date against an expected value of £3m, based upon the PIDs submitted. This over-performance against the scheme plans is principally in prescribing which is showing a £1.1m positive variance at month 5. The positive performance in Mental Health relates to Packages of Care, however this is offset by shortfalls in Continuing Healthcare savings within the Area teams.

The forecast full year savings for schemes in delivery amounts to £8.8m, with a full year effect of £7.9m. Set against the savings targets allocated to each Division in the financial plan, this shows a forecast shortfall of £36.2m.

In addition to the schemes in delivery, the savings pipeline shows the following forecast –

Pipeline Schemes	Forecast			
	Recurring Forecast £'000	Non-Recurring Forecast £'000	Total Forecast £'000	Forecast FYE £'000
Ysbyty Gwynedd	218	0	218	151
Ysbyty Glan Clwyd	344	0	344	360
Ysbyty Wrexham Maelor	92	27	119	168
North Wales Managed Services	59	0	59	118
Womens Services	0	0	0	0
Secondary Care	**713**	**27**	**740**	**797**
Area - West	63	0	63	50
Area - Centre	1,080	0	1,080	215
Area - East	19	15	34	33
Area - Other	0	0	0	0
Contracts	0	0	0	0
Area Teams	**1,162**	**15**	**1,177**	**298**
MHLD	0	0	0	0
Corporate	189	721	910	592
Divisional Total	**2,064**	**763**	**2,827**	**1,687**
Medicines Management IG	**0**	**0**	**0**	**0**
Procurement IG	**2,000**	**0**	**2,000**	**2,000**
Workforce IG	**1,236**	**0**	**1,236**	**4,438**
Improvement Group Holding Schemes	**3,236**	**0**	**3,236**	**6,438**
Total Pipeline	**5,300**	**763**	**6,063**	**8,125**

Note – the pipeline value above is £0.4m lower than the red risk schemes in section 2.3, due to some delivery of savings against these schemes in Divisions

The table above identifies a forecast delivery in year from pipeline schemes of £6.1m, with a full year effect of £8.1m. The combined forecast for schemes in delivery and pipeline amounts to £14.9m, which is £1m above the programme value in section 2.1, however it represents a shortfall of £30.1m against the savings target of £45m set out in the Board's financial plan. Medicines management savings account for £0.9m of the £1m excess against programme value.

2.5 Delivering Additional Savings

The current level of savings in the programme and the status of the RAG assessments is a reflection of competing pressures arising through the COVID response, the standing down of the formal recovery programme processes and the re-deployment of the PMO resource. It is critical that these issues are addressed urgently to ensure that savings identification and delivery is enhanced.

Through Executive Directors, the emphasis placed upon savings delivery will be increased utilising the monthly accountability reviews with Divisions. An urgent review of savings opportunities is being undertaken with Executive Directors and Divisional Directors during September. Whilst primarily focussed on in year opportunities, it will also identify areas for medium and long term savings which can be developed to build a savings programme for recovery which will span the next three years.

Immediate areas of focus for additional in year opportunities include –

- Review of 19/20 non-recurring savings to identify repeat opportunities
- Focus on grip and control measures which delivered significant benefit in 19/20 and can provide rapid impact.
- Procurement and medicines management
- Targeted action in high cost pay areas, building on investments made in 19/20 eg Medacs, Kendall Bluck
- Consolidating transactional benefits as a result of changes introduced in response to COVID eg travel savings
- Further review of original PMO programme to identify areas for rapid progression, subject to capacity support

In support of this approach, a number of the recommendations made by the Recovery Director with regard to the mechanisms to support financial recovery and the financial environment are being taken forward by the Executive team and include –

a) Establishment of a fit for purpose PMO to support delivery of a financial savings programme; key roles to consider are the Health Community Programme Managers along with the standard leadership structure needed and expected for a PMO function
b) Establish and maintain a clear programme structure for the delivery of financial recovery or CIP delivery to ensure the necessary focus and attention
c) Re-launch the Discretionary Non-Pay Spend Panel and the VAP/WAP process, to provide necessary grip and control process while in financial recovery
d) Establish that a strong accountability/confirm and challenge rhythm is in place to hold budget holders to account for finance performance
e) Review, amend and re-launch the organisational accountability framework to ensure better clarity on accountability and responsibility expectations and structures

Identifying opportunities and delivering savings for the medium and long term will require a structured approach and the application of PMO and Improvement resource. A proposal for the

future delivery and resourcing of the PMO and Service Improvement functions is currently in development and will be presented to the Committee in October.

In previous years, benchmark opportunities have been identified to highlight areas for intervention. The benchmark opportunities analysis has been updated to reflect actual savings made in 19/20 and the residual opportunities. This is set out in the table below -

Savings work streams	Deloitte Benchmarking - 3 Year Opportunity 2013		BCUHB Benchmarking - 3 Year Opportunity 2020		19/20 Total Savings Achieved	19/20 Recurring Savings Achieved	Residual Recurrent 3 year Opportunity	
	£m Low	£m High	£m Low	£m High	£m	£m	£m Low	£m High
Summary: All Improvement Groups	**22.9**	**89.7**	**130.0**	**262.0**	**35.6**	**25.3**	**105.0**	**237.0**
Total Clinical Services	**0.0**	**30.8**	**62.7**	**135.1**	**8.3**	**6.1**	**56.6**	**129.0**
Improving Health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Care Closer to Home	0.0	13.5	18.9	38.4	2.7	1.1	17.8	37.3
Together for Mental Health	0.0	1.1	14.8	27.4	4.9	4.3	10.5	23.1
Planned Care	0.0	16.2	20.6	51.4	0.5	0.5	20.1	50.9
Unscheduled Care	0.0	0.0	8.3	17.8	0.2	0.2	8.1	17.6
Total 'Centrally Managed' Services	**22.9**	**58.9**	**48.4**	**92.6**	**24.1**	**17.8**	**30.6**	**74.8**
Digital	0.0	0.0	0.0	0.0	0.6	0.3	0.0	0.0
Estates & Facilities	0.0	4.2	1.6	3.2	0.6	0.5	1.1	2.7
Workforce	0.0	25.4	12.0	30.6	8.1	5.7	6.3	24.9
Procurement	10.0	10.0	9.0	16.0	2.7	0.7	8.3	15.3
Medicines Management	2.0	5.0	17.5	26.2	7.0	6.0	11.5	20.2
Continuing Health Care	10.9	14.3	8.3	16.5	5.1	4.6	3.7	11.9
Quality	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Other	**0.0**	**0.0**	**18.9**	**34.3**	**3.2**	**1.4**	**17.8**	**33.2**
Transactional	0.0	0.0	12.0	20.0	2.7	1.4	10.6	18.6
Contracting	0.0	0.0	0.9	2.3	0.5	0.0	0.9	2.3
Structural	0.0	0.0	6.0	12.0	0.0	0.0	6.0	12.0

Note – benchmarking data did not indicate savings for digital, however efficiencies in baseline spend were delivered in 19/20. These have not been included in the calculation of residual opportunity

The table above shows a residual opportunity range of £105m - £237m after taking account of the recurring savings delivered in 19/20. As has been previously reported, the opportunities above are based on full cost and therefore the quantum of opportunity is unlikely realisable in cash terms, however there are significant gains to be made through targeted action in these areas which should drive the 3 year savings programme. Crucially, securing these benefits will require changes to clinical pathways and service delivery models which emphasise the critical need to align this work with the developing clinical strategy. Consolidating gains identified through the COVID response eg virtual consultations and new outpatient models is critical to ensure that a return to more traditional modes of delivery is avoided.

Further information regarding the approach to developing the 3 year savings plan and the priority areas to be addressed will be included in the October Committee report on Drivers of the Deficit.

3. Risk Analysis

Non delivery of the savings programme presents a risk to the Health Board's financial position and its ability to achieve its planned deficit.

4. Legal and Compliance

Not applicable.

5. Impact Assessment

Impact assessments are undertaken on individual savings schemes as they are developed and considered prior to approval of schemes for inclusion in the savings programme.

6. Recommendations

That the Committee note –

- 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
- The urgent action required to finalise the development and risk assessment of existing PIDs
- The need for further savings schemes to be developed in order to reduce to projected shortfall against the Board's financial plan requirements
- Note the development of a proposal for resourcing and delivery of the PMO and Service Improvement functions which will be presented to the Committee in October