Bundle Performance, Finance & Information Governance Committee 23 December 2021

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

1.0 PF21/42 Apologies

Chris Stockport (deputies supporting individual papers where required), Sue Green (deputy Nick Graham in attendance)

2.0 PF21/43 Declarations of Interest

3.0 09:30 - PF21/44 Draft Minutes of the previous meeting held on 28.10.21 for approval and table of actions

PF21.44a PFIGC 28.10.21 draft minutes v.02 public session.docx

PF21.44b PFIG Table of actions_Public session.doc

4.0 09:35 - PF21/45 Report of the Chair

John Cunliffe

5.0 09:36 - PF21/46 Report of the Lead Executive

Sue Hill

6 09:37 - PF21/47 Presentation : Integrated Medium Term Plan - financial focus

Sue Hill
Recommendation
The Committtee is asked to review the financial update on the draft IMTP financial plan, ahead of the scrutiny session at the January PFIG Committee.
Presentation to be provided on day of the meeting

PF21.47 IMTP Financial Focus December 2021 v2.docx

7 09:54 - PF21/48 Quality and Performance report

Sue Hill
Recommendation
The Performance, Finance & Information Governance Committee is asked to scrutinise the report and to advise whether any areas should be escalated for consideration by the Board

PF21.48a QaP report v2.docx

PF21.48b QaP Report (November Position) FINAL.pdf

8 10:14 - PF21/49 Finance report months 8 and 7 - for discussion

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

PF21.49a Finance Reports -M08_07 Cover sheet - Final.docx

PF21.49b Finance report App1a M08-22 - Draft 09-12-2021 EMG.pdf

PF21.49c Finance report App1b M07-22 Appendix 1 - Draft 30-11-202.pdf

PF21.49d Finance report App2 Performance Monies Tracker 2021-22 at Month 8.pdf

9 10:34 - PF21/50 Primary Care Academy

Clare Darlington and Gemma Nosworthy in attendance
Recommendation
The Performance, Finance & Information Governance Committee is asked to approve the business case for Progressing the Primary and Community Care Academy for submission and consideration by the Board.

PF21.50a Academy business case.docx

PF21.50b Academy business case Appendix 1 Business Case.docx

11 10:43 - PF21/51 WG Monitoring report - for information

Sue Hill
Recommendation
The Committee is asked to note the contents of the report that has been made to Welsh Government about the Health Board's financial position for Months 7 & 8 of 2021/22.

PF21.51a Monthly Monitoring reports M07.07.08-22 - Final.docx

PF21.51b MR Report App1 M7 2021-22 - Draft.pdf

PF21.51c MR Report App2 M8 2021-22 - Draft.pdf

12 PF21/52 Review of risks highlighted in the meeting for referral to Risk Management Group

13 PF21/53 Summary of private business to be reported in public

The Committee is asked to note the report

PF21.53 Previous private session items reported in public report.docx

14 PF21/54 Date of next meeting 27.1.22

15 10:43 - Private session

DRAFT minutes of the meeting of the inaugural Performance, Finance and Information Governance Committee held in public on 28.10.21 via Teams

Present:	
John Cunliffe	Independent Member / Committee Chair
Mark Polin	Health Board Chairman
In Attendance:	
Neil Bradshaw	Assistant Director Capital (part meeting)
Keith Dibble	Planned Care Programme Lead (part meeting)
Sue Green	Executive Director Workforce and Organisational Development (OD) (part meeting)
Gill Harris	Deputy Chief Executive / Executive Director Nursing & Midwifery
Sue Hill	Executive Director of Finance
Nick Lyons	Executive Medical Director
Tom Stanford	Interim Finance Director – Operational Finance
Chris Stockport	Executive Director of Primary Care & Community Services
Paolo Tardivel	Director of Transformation and Improvement (part meeting)
Brenda Thomas	representing Board Secretary
Clive Walsh	Interim Director of Delivery (part meeting)
Jo Whitehead	Chief Executive
Tim Woodhead	Finance Director – Operational Finance (part meeting)
To observe:	
Mark Butler	Good Governance Institute representative
Dave Harris	Head of Internal Audit

Agenda Item Discussed	Action By
PF21/1 Terms of Reference	
PF21/2 Apologies for absence Apologies were received from Louise Brereton for whom Brenda Thomas deputised	
PF21/3 Declaration of Interests None were received	
PF21/4 Draft minutes of the previous Finance and Performance meeting held on 26.8.21 The minutes of the final Finance and Performance Committee meeting were approved subject to the amendment of a typographical error on page 2.	
PF21/5 Matters arising and table of actions	

PF21/5.1 There were no matters arising from the minutes. **PF21/5.2** The Finance and Performance Committee summary action plan was agreed and all open actions transferred to the Performance, Finance and Information Governance table of actions. **PF21/5.3** The BCU Chairman advised that he had not received adequate time to prepare for PF21.18 Winter Preparedness or PF21.9 Planned care reports due to be considered as they had not been submitted on time.	
PF21/6 Chair's report **PF21/6.1** The Committee Chair welcomed members to the inaugural Committee meeting and whilst looking forward to the newly introduced governance arrangements, he raised concern regarding the length of the agenda. **PF21/6.2** He advised that Chair's action had been undertaken on 13.9.21 to approve the lease of office accommodation for the Children and Adult Mental Health Service (CAMHS) Targeted Intervention and Improvement Framework Team for an initial period of 6 months to commence from 17.9.21 or as soon after that date as possible.	
PF21/7 Lead Director's report The Lead Director reported that arrangements were in hand with Executive colleagues to address the length of the agenda and ensure appropriate papers were being submitted to the newly established Committee.	
PF21/8 Transforming services report : Planned and Unscheduled Care **PF21/8.1** The Executive Director of Primary Care and Community Services introduced the Committee to the newly appointed Director of Transformation and Improvement who presented the report. He stated that the report provided a 'helicopter view' of the current position and the team was in an early stage of formation. He clarified the approach was one of Transformation dealing with large projects eg Regional Treatment Centres (RTCs) – doing fewer things better, and Improvement - dealing with smaller changes, which would be supported seperately. There would be a focus on outcomes and provision of clear narrative to explain the work going forward that would provide consistency, avoid double counting and ensure an effective audit trail along with rigour on risk. **PF21/8.2** In response to the BCU Chairman's comments regarding the content's focus on Improvement progress, the Director of Transformation and Improvement confirmed that a greater level of detail on transformation would be provided going forward. He also advised that there would be measurements provided as schemes were progressed which would enable comparative impacts that were not just financial. The Executive Director of Primary Care and Community Services undertook to ensure future reports provided updates on transformational progress only and not	CS

improvement programmes on USC/Planned care which are to be addressed in other reports provided to the Committee. **It was resolved that the Committee** **noted** the report	
PF21/9 Transformation and Finance delivery group A verbal update was provided on the establishment of the executive delivery group for Transformation and Finance and the chair's report will be provided to the next committee.	

PF21/10 Information Governance annual report 2020/21
As the presenter was unfortunately unable to join the meeting the Deputy Chief Executive agreed to arrange for the IG Team to address the following points in a briefing note to be circulated to members following the meeting:
• Provide progress update on the Level 0 and Level 1 Toolkit requirements (red & amber)
  ○ CCTV
  ○ Corporate Records Management
• Provide assurance that the final Caldicott Outturn report undertaken by self assessment and resulted in a 5 star rating has had the involvement of Internal Audit
 	
PF21/10.2 The Executive Medical Director gave assurance that clarification work was being progressed in relation to Caldicott responsibilities between the Office of the Medical Director and Information Governance Teams. The Executive Director of Finance gave assurance that regular meetings were taking place in line with her responsibilities as Senior Responsible Officer.
 	
It was resolved that the Committee
noted the report
	GH

PF21/11 Information Governance Key Performance Indicator report As the presenter was unfortunately unable to join the meeting the Deputy Chief Executive agreed to arrange for the IG Team to provide an update on increased non-compliance of responses to subject access report requests, given the numbers of requests had decreased. **It was resolved that the Committee** **noted** the report	GH
FP21/129 Board Assurance Framework (BAF) The Board Secretary representative agreed to ensure comments discussed regarding 21.15 and 21.21 were considered and reflected in the submission to the next meeting and to provide assurance that 21.17 had undergone a deep dive at the next Risk Managment Group meeting. It was noted that further work to review and update the	LB/BT

BAF key field Guidance was continuing, including consultation with the Good Governance Institute for their recommendations and feedback. **It was resolved that** the Committee **approved** • the consolidation of the previous Annual Plan and Budget risks, to create a refreshed risk BAF21-20 - Development of an Integrated Medium Term Plan (IMTP) 2022/25, which will be monitored at the Partnerships, People and Population Health (PPPH) Committee; • increase in target risk score for BAF21-17: Estates and Assets Development from 6(3x2) to 9(3x3) to align with the risk appetite; and **noted** • further work to review and update the Key Field Guidance is continuing, including consultation with the Good Governance Institute for their advice and opinion.	
PF21/13 Finance reports - months 5 and 6 **PF21/13.1** The Executive Director of Finance presented the month 6 report, advising that BCU remained forecast to deliver a balanced position and acknowledged, with thanks, the provision of additional Welsh Government financial support. She reported confidence in delivery of the savings forecast, albeit that the majority would not be recurrent. **PF21/13.2** The Executive Director of Finance highlighted Covid19 spending including the impact of the vaccination and Test/Trace/Protect hub along with necessary safety measures. She also drew attention to transformation expenditure and the importance of providing the best care for patients close to home and with the provision of regional treatment centres. In regard to risks and opportunities the Executive Director of Finance highlighted savings, continued issues with recruitment of staff and a potential increase in energy prices given global market activity. **PF21/13.3** The Executive Director of Finance drew attention to the performance monies tracker provided. It was noted that the Health Board was in receipt of an additional £62m in 2021/22; £42m to progress the transformational programme and £20m for Covid Recovery. A number of the schemes had been delayed against the original profile and the forecast spend in Months 7-12 was £54m, of which the RTC implementation equates to c£17.5m. The Executive team were prioritising alternative schemes which could be implemented to support the 6 core objectives as described in the annual plan for 2021/22. The expectation being that the WG funding would be fully utilised and BCU was in conversation with WG to consider flexibility against the original planned programme of schemes. **PF21/13.4** In response to the Board Chairman, the Executive Director of Finance confirmed that monthly divisional savings meetings were taking place and agreed to provide a position statement and analysis of recurrent and non-recurrent savings being progressed to the next meeting.	SH

PF21/13.5 A discussion ensued on business case investment in which the Board Chairman requested that clarification of the investment strategy and prioritisation approach being undertaken be explained, along with articulating how the investment business cases fitted with BCU's overall strategy in the December report. The Chief Executive confirmed that it was widely agreed that a savings 'pipeline' needed to be in place which effectively linked with value in healthcare (improvement) that would be more effective in delivering recurring savings and investments avoided. She provided an example of falls, which impacted on both theatre utilisation and bed capacity, and the improvement that could be achieved through a focus on timely assessment. She stated that the problems were largely understood so the focus needed to continue to be on delivery in addition, the twin track approach of transformational and transactional in the short and long term needed to be moved forward, as being only 'numbers on a page' for too long had harmed patients. **PF21/13.6** The Committee Chair emphasised the need for business cases to be clearly identifiable within the annual plan, he sought the provision of clear statements, against appropriate objectives, that highlighted dependency on progression of individual named business cases within the annual plan monitoring report. **PF21/13.7** In discussion of how teams could increase the pace of delivery the Executive Director of Finance highlighted discussion taking place to look outside the Health Board, with potentially the Third Sector and partner organisations, to move forward innovatively. Further to clarity sought in regard to the 'revenue resource limit' she undertook to provide a 'plain English' statement to reflect the description in future reports. **PF21/13.8** The Committee Chair was provided with assurance that there was no risk in regard to the flexibility sough with WG, advising that an accountable officer letter was being sent in regard to slippage. The Chief Executive advised that, following learning from the current year, there would be more consolidation regarding business case going into the following year's expenditure plans and would also factor in back end funding availability. **It was resolved that the Committee** **noted** the report	SH SH SH
PF21/14 External Contracts assurance report **PF21/14.1** The Executive Director of Finance presented the report highlighting that the Health Board commissions healthcare with a range of providers, via circa 526 contracts, to a value of approximately £352 million of which circa 92% of expenditure was covered by a formal contract managed by the the Healthcare Contracting Team (HCCT). She also drew attention to contracts in place in regard to Orthopaedics and Endoscopy. **PF21/14.2** In regard to Table 3 – 2021/22 Quarter 2 Contract position (Health Board Contracting) she raised the Committee's awareness to the fact that the benefits of addressing the planned care backlog through the block contracts put in place were not currently being realised.	

PF21/14.3 The Executive Director of Finance highlighted the concerns outlined in the report in regard to the Countess of Chester maternity services provision, however she stated this had been managed well by BCU's Women's Division, especially in regard to ward closures on occassion. **PF21/14.4** The Executive Director of Finance also highlighted the fragility of the nursing home market which remained a significant challenge and monitoring / compliance activity in this area was undertaken in partnership with HB Continuing Health Care (CHC) and LA colleagues. The HCCT were actively involved in monitoring 2 nursing homes, 10 residential care homes and 1 domiciliary care provider who are in increasing/escalating concerns. It was noted that a number of historic challenges had re-emerged with a care home provider and a formal dispute process had been invoked though it was understood that a proposal of using an open book contract management approach was being jointly worked through. It was confirmed to the Committee Chair that this was close to resolution and did not involve a similar historic provider. **It was resolved that the Committee noted** • the financial position on the main external contracts as reported at Quarter 2 2021/22. • the work underway in respect of stabilising wider health / patient care contracts and key risks / related activity. • the impact of Covid-19 on external healthcare contracts. • the impact and risk posed as a result of Covid-19 revised contracting arrangements adopted for contracts with NHS Providers and Commissioners. • the work underway in respect of increasing planned care capacity • the risks associated with the current contractual arrangements with independent care home and domiciliary care providers and actions being taken • the work underway to review capacity within the team and develop robust governance and scrutiny arrangements	
PF21/15 Capital Programme report **PF21/15.1** The Assistant Director ~ Capital joined the meeting to present this item. He advised confidence remained in the forecast delivery of the Capital Resource Limit at year end. It was noted that following discussion at the board workshop additional risks with the scope of works for Wrexham Maelor (YM) had been highlighted. These were being addressed though seeking additional support from WG to fast track elements of the works. A separate business case would be submitted to the Committee (and subsequently the Board) for the business continuity aspects in due course. In addition, informed by the WM improvement works, risks had been identified with regard to ward ventilation and areas with aerosol generating procedures with the YG compliance programme. Also taking WG's decarbonisation plan into account there were therefore significant potential increases in costs. It had therefore been considered as prudent to apply an 'Optimum Bias' to costings increasing the potential range to between £250m - £300m from the original estimate of £213m. **PF21/15.2** The Chief Executive pointed out that the development of BCU's Asset Management Strategy would enable a better understanding of BCU's estate and provide clarity on the top 5 areas for prioritisation which was timely. Following a point	SH (NB)

raised by the Chairman, the Committee was assured that the additional funding was allocated to schemes that support Covid recovery. **PF21/15.3** It was clarified that the additional expendiuture required to address anti-ligature work (which had previously been completed) was due to further work required in other areas following a recent assessment. **It was resolved that the Committee** **noted** • the report • progress in regard to the Wrexham Maelor improvement programme	
PF21/16 Operational Plan 2021/22 monitoring report **PF21/16.1** The Executive Director of Finance presented this item and acknowledged that she would be working with the performance team to move the format into a more simplified and concise report for the coming year. The Committee concurred this was needed along with consideration of the adequacy of narrative provided and achievability and realism of the dates outlined. The Committee questioned whether the report demonstrated whether activities brought programmes 'back on track'. Attention was drawn to the charts on page 5 which indicated the majority of Red rated programme status to be within Planned Care which reflected the effect of Covid19 on the network and it was noted that various insourcing and outsourcing solutions were being utilised to address the situation. The Executive Director of Finance undertook to update the report on the full range of planned care prior to Board submission **PF21/16.2** The Committee highlighted that the accumulation of 28 areas of performance deterioration had not been addressed as a significant issue in itself within the OPMR by the Executive team. It was agreed that the Lead Executive would address how areas of deterioration would be reported in future reports, especially where large numbers should be reflected as of significant concern **PF21/16.3** The Executive Director of Nursing and Midwifery confirmed that some of the concerns raised by the Committee on Safe, Clean Care were being monitored through the Quality, Safety and Experience Committee. In the discussion which followed it was agreed that the Executive Director of Finance, CEO and Committee Chair would consider how reports can reflect actions undertaken by the Executive Team to address areas of concern eg behavioural. **It was resolved that the Committee** **noted** the report	SH SH SH/JW
PF21/17 Quality and Performance Report **PF21/17.1** The Executive Director of Finance presented this item, drawing attention to the Executive summary provided within the report and the measurements provided within Covid 19 reporting. It was highlighted that vaccination service provision had been moved forward positively with over £1m doses administered whihc was a	

testament to team effort, and whilst there was strong testing turnaround reported there was also increased incidents of positive tests in the region. **PF21/17.2** The Executive Director of Finance highlighted the top 5 measures of concern within the report, being: • Number of patients waiting more than 14 weeks for Therapy • Percentage of emergency responses to red calls arriving within (up to and including) 8 minute • Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time • Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge • Number of patients who spend 24 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge. **PF21/17.3** Other areas for concern highlighted were "patient discharge to review" in which there was a need to better understand interfacing between unscheduled and planned care, Planned care measure deterioration (page 17) including cancer treatment and diagnostic waiting times. It was noted that work was being undertaken to address these areas with the involvement of clinicians – especially in regard to outpatients' clinics. **PF21/17.4** In regard to stroke service deterioration the Executive Director of Nursing and Midwifery reported on various elements of work being moved forward with Executives to address this area eg ring fenced beds, introduction of a WG sponsored All Wales Stroke Improvement network **PF21/17.5** The Committee raised concern with the deterioration in Planned and Unscheduled care provision, some of which had been impacted by Covid19. The Chief Executive confirmed that focus remained strong in addressing these areas albeit that the pandemic's effect remained and had impacted business case planning. In response to the Board Chairman, the Executive Director of Nursing and Midwifery clarified meetings were taking place with leads to meet the end of quarter 4 target date and she agreed to circulate to members an updated Unscheduled Care Improvement Plan which would include where improvements were expected and set out how areas of deterioration would be addressed. **PF21/17.6** The Committee was pleased to note that additional Primary Care measures were shortly to be introduced to the report to enable monitoring improvements. In addition, assurance was provided that a Staff Welfare report would be provided to the next Partnerships, People and Population Health (PPPH) Committee, and subsequently to the Health Board, as this was an important area that the Board wished to be sighted on. The Lone Worker Policy was to be presented to QSE Committee. **PF21/17.7** The Committee's attention was also drawn to a reduction in PADR (Appraisal) completion, increased Mandatory Training and rising Sickness absence (5.6% - and Covid 0.8%) rates. It was noted that agency spend remained static. PADR rates would be followed up in the Workforce report to the PPPH Committee.	GH SG

It was resolved that the Committee **noted** and scrutinised the report.	
The Interim Director of Delivery joined the meeting for this item **PF21/18 Winter Preparedness status report** **PF21/18.1** The Executive Director of Nursing and Midwifery presented the report. BCU patients were experiencing increasing delays for unscheduled care diagnosis and treatment, and there were also delays for Welsh Ambulance Service Trust (WAST) vehicles at the Emergency Department (ED) front door, and in responding to community calls. COVID-19 continued to be a factor, albeit at a lower level than Waves 1 and 2, there was also potential for increased prevalence of RSV (Respiratory Syncytial Virus) in children and a high risk of influenza across the whole population. She explained work was being progressed with partners to ensure joined up planning and clarified the current position in regard to funding and bids which would require alignment with improvement principles and sign off by the Health Board. The Executive Director of Nursing and Midwifery emphasised the workforce challenges to be addressed and drew the Committee's attention to the Unscheduled care dashboards provided in the report. **PF21/18.2** The Interim Director of Delivery advised that the 'front door' remained pressured and, along with critical care was of highest risk which could require further work to be undertaken on the surge plan. He advised that of 77 submissions, initially the top 15 had been funded to the value of £1.2m to move forward and ensure that measureable outcomes were able to be monitored. He provided an example of capacity provision being developed within the Centre Area through residential homes. **PF21/18.3** It was noted that the Regional Planning Board had £2.1m funding available which would be considered and prioritised. The Chief Executive commented that a CEO meeing was to take place the following day to agree how resources could be shared against priorities. **PF21/18.4** The table of priorities within the report was noted. The Committee discussed the Winter Planning resource allocation in which the Executive Medical Director advised that challenging and imaginitive discussion was taking place in 'thinking outside the box' which would also take into account contingency planning. It was recognised that Winter planning was being considered at the highest levels both internally and nationally. **PF21/18.5** In response to the Health Board Chairman, the Interim Director of Delivery confirmed that a Winter Plan was in place in keeping with WG expectations. The Executive Director of Nursing and Midwifery following consultation of the Winter Plan timeline in regard to submission to the Board, she would ensure narrative to explain returns on investment and also patient experience & outcomes were included. **PF21/18.6** The Committee Chair questioned whether the acuity patients were currently presenting with had been affected by the decrease in presentations during lockdown. The Executive Director of Nursing and Midwifery advised the reasons to be multifactorial and were expected to remain the same. The Executive Medical Director advised the pattern to be very different and that Primary Care was very stretched with	GH

the greatese challenge continuing for ED, Minor Injury Units and Primary Care which BCU's plans recognised. The biggest risk to delivery remained staffing issues. **It was resolved that** the Committee **noted** and scrutinised the report.	
The Planned Care Programme Lead joined the meeting for this item **PF21/19 Planned Care Update** **PF21/19.1** The Executive Director of Nursing and Midwifery provided a situation overview including trajectories, contracts awarded (including Ophthalmology), reviewing of opportunities for out and in sourcing of planned care activities with parallel work ongoing in regard Regional Treatment Centre (RTC) progression aligned to BCU's aspiration on planned care. **PF21/19.2** The Planned Care Programme Lead assured that outsourcing would make a positive difference and could be re-modelled for other specialties eg Maxillofacial. He commented that validation work could be improved and that changes in processes would ensure patients were prioritised in the correct order. Work was being undertaken in standardising practices across the organisation's sites or to identify where this was acceptable. He informed that a great deal of clinical engagement was being undertaken. **PF21/19.3** In response to the Committee the Executive Director of Nursing and Midwifery provided greater detail on RTC development to date. In addition, it was agreed that the draft planned care action plan would be shared with the Committee Chair and Board Chairman along with detail of how Dermatology was being addressed. The Executive Director of Nursing and Midwifery assured that future reports would provide assurance on the recovery plan and progress in order that the Committee could ascertain whether progress was 'on track'. **PF21/19.4** The Executive Director of Nursing and Midwifery commented that clinicians were experiencing frustration as they were unable to provide the level of support they would wish to give due to the Covid19 situation. **It was resolved that the Committee** **noted** the report	GH GH
PF21/20 Business Cases **PF21/20.1 Welsh Patient Administration System Revenue Business Case** **PF21/20.1.1** The Executive Director of Primary Care and Community Services presented this item, providing background to the WPAS delays to date and the challenges that had arisen. He advised that there was now re-engagement and full commitment however, there had been delays with funding support. He reported that a decision had been taken to proceed at risk to recruit 13 additional staff, as per the business case, as the perceived risk that WG would reject the funding bid was	

considered to be low. The financial risk being a funding shortfall of up to £2.2M over 4 years. **PF21/20.1.2** The Committee questioned whether BCU would seek redress from Digital Health and Care Wales in regard to the delay impacts of its predecessor NWIS which was understood to be the subject of conversation. The Executive Director of Primary Care and Community Services clarified that Option 3 was recommended, instead of option 4 which could be delivered more quickly, in order to deal with mergers of existing systems separately which was perceived to be of less risk. **It was resolved that the Committee** **supported** • the Welsh Patient Administration System (WPAS) Revenue Business Case and recommendations for Option 3 for submission to Welsh Government (External Funding bid) and **noted** • following conversations between BCUHB Executive Director of Finance, and counterparts in Digital Health and Care Wales (DHCW the WPAS National IT system supplier), it was concluded that based on the perceived risk level of Welsh Government not providing funding, the project was given the go ahead to recruit the 13 additional members of staff identified within the business case to enable recommencement of the WPAS project from September onwards. • the Executive Team has expressed that they do not wish to halt the WPAS project, nor slow it down, and in the event of funding not being forthcoming from Welsh Government, the financial risk indicated in this report at a cost of £68k per month from September 2021 until when funding from Welsh Government is made available would be managed. The Chief Executive and Executive Director of Finance were supportive the project to move forward at a national level. • the financial risk as outlined **PF21/20.2 Conwy / Llandudno Junction Strategic Outline Case (SOC)** The Executive Director of Primary Care and Community Services advised that the Strategic Outline Case (SOC) sought Welsh Government approval to proceed to Outline Business Case (OBC) and to draw down fees for design and OBC development. In discussion of general estate condition, given a recent visit to services within this locality, the Board Chairman sought an update on current estate plans within the area. He was also advised that some painting work had been scheduled for completion before the end of the year. **It was resolved that the Committee** **approved** the SOC for submission to the Health Board meeting of 18 November 2021	SH
PF21/26 Business Case Tracker	

The Committee Chair requested that a specific schedule be provided timetabling when business cases were to be provided to the Committee **It was resolved that the Committee** **noted** the capital and revenue business case trackers	CS
PF21/27 Monthly Monitoring Returns months 5 and 6 reports **It was resolved that** the Committee **noted** the contents of the report that has been made to Welsh Government about the Health Board's financial position for Month 5 and 6 of 2021/22.	
PF21/28 Information Governance Group Chair Assurance Report **It was resolved that** the Committee **noted** the contents of the report	
PF21/29 Agree items for referral to the Board / other Committees Management of clinical alerts	
PF21/30 Review of risks highlighted in the meeting for referral to Risk Management Group	
PF21/31 Agree items for Chair Assurance report The Committee Chair would consider this following the meeting	
PF21/32 Review of meeting effectiveness **PF21/32.1** All present discussed the meeting effectiveness. The Executive Director of Finance, agreed to address with Executive colleagues feedback from this item including • Quality of papers • Length of meeting • Necessity of all papers • Duplication of USC/Planned care reporting within 3 forms of report to the Committee ie QaP report, Transformation update, USC or Planned Care reports • Advise whether future IG KPI reports are necessary for submission to the Committee **PF21/32.2** The Deputy Chief Executive agreed to discuss feedback with the Interim Director of Governance to ensure • no duplication of matters to be considered at separate Committees • all areas of previous Committee business have been picked up within new Committee cycles of business **PF21/32.3** The Head of Internal Audit questioned whether there were sufficient Independent Members on the Committee. The Board Chairman explained that following the resignation of a member this was a temporary issue which would be rectified shortly on commencement of newly recruited Independent Members (IM). He	SH GH

asked the Head of Internal Audit to discuss with Audit Wales the potential of an IM being appointed to both PFIG and Audit Committees and provide feedback on the matter to both himself him and the Board Secretary.	DH
PF21/33 Summary of Private business to be reported in public **It was resolved that** the Committee **noted** the report.	
PF21/34 Date of next meeting 23.12.21	
Exclusion of the Press and Public **It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

BCUHB Performance, Finance and Information Governance Committee Table of Actions arising from meetings held in public				
Responsible Executive	**Minute Reference and Action Agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
Actions transferred from Finance and Performance Committee 28.8.21 meeting				
Sue Hill	**FP21/130 OPMR** Arrange for the Committee Chair to be advised of what potential alternatives there might be to Clinical Psychologists to address " **E1.5: Enhanced recovery from critical illness** Recruitment of Clinical Psychologists has been unsuccessful	21.10.21	The narrative in the Q2 Report which relates to this action does not specifically mention recruitment of Clinical Psychologists. DoP will check with Executive Medical Director to confirm whether this remains an issue and arrange for update to Q2 OPMR if required. 28.10.21 Transferred from Finance and Performance Committee Summary action plan – re-opened The Committee Chairman clarified the requested information, which the Executive Director of Finance agreed to discuss with the Mental Health Division. The responsible Executive was also confirmed.	30.11.21
Chris Stockport	**FP21/131 QaP report** The Committee questioned whether Cancer performance rates were being affected by Primary Care behaviour which the Executive Director of Primary Care and Community Services agreed to explore further.	21.10.21	Update –12.10.21 Work has been commenced to explore this area but has not yet reached conclusion. 28.10.21 Transferred from Finance and Performance Committee Summary action plan 09.12.21 - With the general increased demand in GP practices, suspected cancer referrals for patients presenting to primary care are now above pre-pandemic levels and there are therefore increased operational pressures across the cancer pathways. The PFIG committee receive a separate performance report in relation to cancer standards which provides more detail and actions being taken. BCUHB continue to deliver performance above the all Wales average, with the continued aim of achieving the 75% target by the end of 2021/22.	30.11.21 Action to be closed
Chris Stockport	**FP21/136 Transformation report** The Committee Chair commented on the size of the font used for the example website pathway given that	30.11.21	28.10.21 Transferred from Finance and Performance Committee Summary action plan 09.12.21 - Our new BCU Pathways function will only support and endorse new pathways which encompass complete end to	Action to be closed

	it was for optometry. He also questioned how pathways would be captured beyond just a decision for surgery or how people were progressing through a pathway.		end, whole system redesign and which guide users through a journey which begins at Prevention and early symptom Self-Management, incorporates Primary & Secondary Care Intervention (including conservative management strategies), through to discharge and ongoing primary/community and self-care. Redesign teams will comprise of clinical representatives from both primary and secondary care and each will be asked for nominations to clinically lead individual pathway redesign programmes. All redesigned pathways will provide significant added value in terms of condition specific guidance/education and signposting (including alternative pathways of care i.e., Prehab, Lifestyle Management, Social Prescribing options), advice regarding shared decision making and links to clinically validated resources (including Third Sector).	
Sue Hill	**FP21/146 External Contracts** Arrange to address issues raised in regard to domiciliary care information provided	30.11.21	28.10.21 Transferred from Finance and Performance Committee Summary action plan The Providers are currently working under implied terms and interim contractual arrangements are being pursued by the West Area team supported by the Contract Team and the tender exercise will be in place to close the issue down, which will be monitored through the Healthcare Contracts Assurance Group. With regards to the wider Pre Placement Agreement, significant progress has now been made with the 6 Local Authorities and it is now expected a new agreement will be in place for April and extensions are being pursued to the current arrangement that cover the interim period.	Action to be closed
Actions from PFIGC 28.10.21 meeting				
Chris Stockport	**PF21.8 Transformation services report** Ensure future reports provide updates on transformational progress only and not improvement		Update 1/11/21 – Future reports will be addressed as per action.	Action to be closed

	programmes on USC/Planned care which are to be addressed in other reports provided to the Committee.			

Gill Harris	**Information Governance items**
	Arrange for the IG Team to address the following points in a briefing note to be circulated to members following the meeting:
	PF21.10 IG Annual report
	• Provide progress update on the Level 0 and Level 1 Toolkit requirements (red & amber)
	  ○ CCTV
	  ○ Corporate Records Management
	• Provide assurance that the final Caldicott Outturn report undertaken by self assessment and resulted in a 5 star rating has had the involvement of Internal Audit
	PF21.10 IG KPI report
	• Provide update on increased non-compliance of response to subject access reports, given the numbers of requests have decreased
			Members briefing circulated 15.12.21	Action to be closed

Louise Brereton (Brenda Thomas)	**BAF** • Ensure comments discussed re 21.15 and 21.21 reflected in submission to next meeting • Confirm 21.17 has undergone deep dive at next RMG meeting		BAF risks 21 and 17 were due for deep at December RMG however this meeting was stepped down. This will be undertaken at the February 2022 RMG. Risk 15 review will be undertaken through the forthcoming cycle	Action to be closed

Sue Hill	**PF21/ 13 Finance report** • clarification of the investment strategy and prioritisation approach being undertaken • articulate how the investment business cases fit with BCU's overall strategy • provide clear statements, against appropriate objectives, that highlight dependency on progression of individual named business cases *within the annual plan monitoring report*		The Planning Team are attending a prioritisation panel meeting on 16.12.21 –led by the Executive Director Primary Care and Community Services to discuss new schemes which will be evaluated against strategic fit etc. This will be addressed following the meeting. PFIG will also be aware of business case tracker/ status of cases which is aligned with our operational plan	February 2022
Sue Hill	**PF21/ 13 Finance report** Arrange to provide within the next report : • Position and analysis of recurrent and non-recurrent savings being progressed by Divisions • provide a 'plain English' statement to reflect revenue resource limit description provided		• an analysis of recurrent and non-recurrent savings by Division is included on slide 7. • a definition of revenue resource limit is included within slide 4	Action to be closed
Sue Hill	**PF21/15 Capital Programme report** Ensure Business Continuity business case is on PFIG and Board cycles of business		The business case is planned to be submitted to PFIG in June 2022 for support prior to formal approval by the Health Board on 21st July 2022 which have been incorporated in to PFIG and Board workplans.	Action to be closed
Sue Hill	**PF21/16 OPMR** Address how areas of deterioration will be reported in future reports, especially where large numbers should be reflected as of significant		15.12.21 The Executive Director of Finance advised that revisions of the OPMR and QaP were being worked on and this will be addressed as part of an improvement project over the next three months.	Action to be closed

	concern Consider with CEO and Committee Chair how reports can reflect actions undertaken by the Executive Team to address areas of concern eg behavioural Update the report on the full range of planned care prior to Board submission			
Gill Harris	**PF21/16 Q&P report** In response to the Board Chairman, the Executive Director of Nursing and Midwifery clarified meetings agreed to circulate to members an updated Unscheduled Care Improvement Plan which would include where improvements were expected and set out how areas of deterioration would be addressed.			
Sue Green / Louise Brereton	**PF21/16 Q&P report** Ensure staff welfare/wellbeing report, being submitted to PPPHC in December, is scheduled for discussion at following Board meeting		Submitted to December PPPH Committtee meeting and will be addressed within Chair's assurance report to January Board	Action to be closed
Gill Harris	**PF21/18 Winter Preparedness** Following consultation of Winter Plan timeline in regard to submission to the Board, ensure narrative to explain returns on investment and also patient experience & outcomes were		GH informs the plan was addressed at Cabinet meeting	Action to be closed

	included			
Gill Harris	**PF21/19 Planned Care** • Share draft planned care action plan with Committee Chair and Board Chairman • Ensure inclusion of how Dermatology is being addressed in report			
Gill Harris	**PF21/19 Planned Care** The Executive Director of Nursing and Midwifery assured that future reports would provide assurance on the recovery plan and progress in order that the Committee could ascertain whether progress was 'on track'.			
Sue Hill	**PF21/20.2 Conwy / Llandudno Junction SOC** Provide update on current estate plans in this area.		Member briefing circulated 16.12.21	Action to be closed
Chris Stockport	**PF21/26 Business Case Tracker** The Committee Chair requested that a specific schedule be provided timetabling when business cases were to be provided to the Committee		Update 15/12/21 - An expected timeline for the submission of business cases will be incorporated into the Business Case Tracker in 2022 to reflect the programme of business cases agreed in the IMTP	Action to be closed
Sue Hill	**PF21/32 Meeting effectiveness** Address with Executive colleagues feedback from this item including • Quality of papers • Length of meeting • Necessity of all papers		These matters have been discussed with the Committee Chair, the Executive team and the integrated Board. A clear direction of travel has been agreed and clear instruction around papers was included with the December meeting agenda and call for papers. This is an ongoing action, which equally applies to all Committees.	Action to be closed

	• Duplication of USC/Planned care reporting within 3 forms of report to the Committee ie QaP report, Transformation update, USC or Planned Care reports • Advise whether future IG KPI reports are necessary for submission to the Committee			
Gill Harris	**PF21/32 Meeting Effectiveness** Provide PFIGC feedback to the Interim Director of Governance to ensure • no duplication of matters to be considered at separate Committees • all areas of previous Committee business has been picked up within new Committee cycles of business			
Dave Harris	**PF21/32 Meeting effectiveness** Discuss with Audit Wales potential IM representation at both PFIG and Audit Committees, as discussed and feedback to Board Chairman and Board Secretary.		Correspondence shared with the Health Board Chairman and Board Secretary on the 29th October 2021.	Action to be closed

15.12.21

Cyfarfod a dyddiad: Meeting and date:	**Performance, Finance and Information Governance Committee 23.12.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Integrated Medium Term Plan (IMTP) – Financial Focus 2022/23 Income and Expenditure Scenarios**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Executive Director of Finance
Awdur yr Adroddiad Report Author:	Rob Nolan Finance Director – Commissioning and Strategic Financial Planning
Craffu blaenorol: Prior Scrutiny:	The Budget setting framework was considered and supported by the Executive Committee in November 2021.
Atodiadau Appendices:	The 2022/23 Budget Setting Framework is attached in Appendix 1. A presentation will be provided to the Committee at the meeting as the Welsh Government Budget is being published on 20 December and Health Board allocations are being issued by 22 December.

Argymhelliad / Recommendation:

That the Committtee review the financial update on the draft IMTP financial plan, ahead of the scrutiny session at the January PFIG Committee.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	**X**
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**Y/N**	

Sefyllfa / Situation:

The purpose of this paper is to summarise the current draft planning assumptions including savings and expenditure to be included in the 2022/23 plan.

Cefndir / Background:

Financial planning for 2022/23 is still operating with a degree of uncertainty, with the Welsh Government budget due to be published on the 20th December 2021, and the NHS Allocations to be published on the 23rd December 2021.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

To facilitate the development of the financial plan, the Health Board has identified key expenditure assumptions across Welsh Government funding commitments, optional cost pressures and new developments.

Goblygiadau Ariannol / Financial Implications
The Health Boards draft planning assumptions will consist of cost pressures across 3 areas:

1. Expenditure Assumptions – pre commitments
2. Expenditure Assumptions – options
3. Expenditure Assumptions – new developments

1. Expenditure Assumptions – pre commitments
Schemes for which we have no discretion over the use of the funding, other than the level of expenditure assumed.

2. Expenditure Assumptions – options
These are cost pressures for which core funding support will need to be agreed. Choices remain on what level of core funded cost pressures are supported and this will in part be dependent on the actual level of WG Growth Funding received.

3. Expenditure Assumptions – new developments
The level of new developments is subject to a prioritisation process to ensure all new developments reflect the priorities of the Health Board.

The funding available for new developments will be dependent on the additional income for 2022/23 and the choices to be made on core funded cost pressures.

Dadansoddiad Risk / Risk Analysis
Health Board financial risks are reported via the monthly Finance report and the Risk Register.

It is likely that the financial plan will include a level of risk with regard to achieving a breakeven position during the next three years, which will be quantified in the final version of the plan.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Not applicable.

Asesiad Effaith / Impact Assessment
Not applicable.

Appendix 1

Budget Setting Framework 2022/23

Sefyllfa / Situation:

The purpose of this paper is to provide a methodology for setting the proposed budget baseline for 2022/23, which will also be used to provide a high level plan for 2023/24 and 2024/25.

The paper was taken to Exec Team in November, where option three was recommended for approval.

Cefndir / Background:

In line with the organisation's Standing Financial Instructions (SFIs) and the Welsh Government's administrative target within the three-year planning cycle, the expectation is that the Health Board will be required to set a three-year financial plan, with detailed budget for 2022/23 in advance of the new financial year.

This paper summarises the proposed approach to budget setting for 2022/23 and further assumptions for 2023/24 and 2024/25. It will be aligned to the all Wales planning guidance, with the anticipated requirement to submit a plan to Welsh Government in early 2022, covering the period 2022-25.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

There are three options proposed for setting step one of the 2022/23 budget. These are detailed in the Financial Implications section and option three is recommended for approval.

Goblygiadau Ariannol / Financial Implications

Welsh Government Draft Budget

The Welsh Government's Draft Budget is usually published in October. However, this year, as in 2021/22, it will be delayed until after the UK Government publishes its Autumn Budget and Comprehensive Spending Review on the 27th October 2021.

In the interim, the Committees of the Welsh Parliament sought information to inform their scrutiny of the Welsh Government's 2022/23 Draft Budget proposals. They were interested in exploring expectations of the 2022/23 Budget, including financial readiness for 2022/23 and the impact of the 2021/22 Budget. In addition, the 2022/23 Draft Budget will be effected by the focus on recovery from the COVID-19 pandemic. The closing date for the consultation was the 26th November 2021.

The Welsh Government has announced it is planning to publish the outline and detailed Draft Budgets together on the 20th December 2021, with the final Budget on the 1st March 2022. The Health Board's financial plan will therefore not be finalised until after the 20th December 2021, when confirmation of its funding allocation for 2022/23 is received.

Welsh Government Income Assumptions

Based on the latest information available from Welsh Government on income for 2022/23 to 2024/25, the following assumptions are being made within the draft budget setting framework:

- A 2% allocation uplift for each year.
- Within the 2% uplift, 1% is for pay. Welsh Government will fund separately any cost pressure that arises from the pay award being above 1%.
- Funding will be made by Welsh Government for the inflation uplifts in the Primary Care and Mental Health ring-fence allocations.
- Any development funding for enhanced services in Primary Care ring-fence allocations will need to include an agreement on whether it represents a transfer from Secondary Care, therefore requiring a corresponding transfer of funding.
- The drug treatment fund will cover new drugs for the relevant year and therefore the full year effect of previous years' drugs will be cost growth.
- Funding for the Performance Fund (£30m), Transformation Fund (£12m) and Strategic Support (£40m) will be received in 2022/23 and 2023/24. There will be no funding in 2024/25.
- COVID-19 costs will be fully funded.

As further information is received on funding, the Health Board will refine its planning assumptions in line with national policy.

Health Board Operating Model

The Health Board is currently considering potential future arrangements for how it is organised and managed. Any impact of changes to the Operating Model has not been factored into the draft budget.

Following a Health Board decision on the Operating Model that is to be adopted, budgets will be realigned to mirror the new management arrangements.

Budget Methodology - Overview

The budget setting methodology for 2022/23 is proposed to follow the same process that was used in 2021/22. This focuses on a three step model:

Step One. Cost Pressures – defined as unavoidable costs; where there is no choice about whether to incur the cost or not; it is non-negotiable. A de minims value of £0.25m will be used when identifying cost pressures.

There are three options available for step one:

1. Baseline Uplift - Baseline recurrent budgets for pay and non-pay are given a 2% uplift, to fund ALL service growth pressures, inflation and the first 1% of any pay award.

OR

2. Inflation and Growth Assumptions for high cost areas plus agreed cost pressures – Assessments will be made for the following areas:
    a. High cost areas
        i. Prescribing
        ii. Continuing Healthcare (CHC)
        iii. Funded Nursing Care (FNC)
        iv. Individual packages of care
        v. External provider contracts
    b. Agreed Cost Pressures
        i. Energy Costs
        ii. Nurse Staffing Act
        iii. Emergency Department Workforce.

    The funding for the high cost areas will be held as a central reserve and allocated to individual divisions once the true level of the cost pressure becomes evident. All other cost pressures must be managed within existing resources.

OR

3. Hybrid of Options 1 and 2, with baseline recurrent budgets for pay and non-pay given a 1% uplift, to fund general service growth pressures, inflation and the first 1% of any pay award.

Step Two: Underlying Deficit Assessment - based on a framework developed by the Finance Delivery Unit (FDU).

This focuses on four main areas:

i. Core position – including forecast outturn
ii. Impact of savings non-delivery from 2020/21
iii. Additional cost of COVID-19
iv. Additional cost choices/service changes

Step Three: New Developments – defined as schemes where there is a choice about whether to go ahead with the proposal or not, so potential costs are optional.

The proposed financial impact of service changes developed and supported by approved business cases including outcomes, activity impacts and benefits realisation that are included in the Health Board's Integrated Medium Term Plan (IMTP).

The high-level financial plan for 2023/24 and 2024/25 will roll forward the agreed methodology.

The key dates in setting and approving the 2022/23 Budget Strategy are included in the draft timetable below.

Date	**Action**
29th Oct 2021	Submission of inflation and growth assumptions by CFOs

29th Oct 2021	Submission of divisional recurrent outturn and cost pressures by CFOs
5th Nov 2021	Submission of new developments (following prioritisation process by Planning)
17th Nov 2021	Exec Team review Budget Setting Framework paper
2nd Dec 2021	Board review Financial Plan, including savings programme approach
23rd Dec 2021	PFIG Committee approve draft Financial Plan
End Dec 2021	Welsh Government Allocation letter received
10th - 14th Jan 2022	Meetings between Finance and Divisions to sign off proposals
20th Jan 2022	Board approve Financial Plan
31st Jan 2022	Three year transformational savings plan developed
Feb 2022	Submission of Financial Plan to Welsh Government

Budget Methodology - Detail

Step One: Cost Pressures

The baseline pay and non-pay budgets used in step one of the model will be the recurrent budgets in the financial ledger, with the recurrent budget at Month 6 being the starting point. The majority of negative budgets arising from unallocated savings targets were cleared at the start of 2021/22 and there will be no negative savings targets carried forward into 2022/23.

There are three options available for the funding of cost pressures under step one of the model:

Option 1 - Baseline Costs

A 2% uplift will be applied to recurrent budgets, to calculate the inflationary uplift. This uplift will be used to fund service growth pressures, inflation and the first 1% of any pay award. Divisions will realign their budgets taking into account the total budget and divisional pressures identified. Pay budgets will be reconciled to staff costs and data from ESR.

Cost pressures, inflation and growth in excess of the baseline budget will be reviewed by the senior Finance team. Any additional funding provided for these will be subject to approval by the Board.

Option 2 - Growth and Inflation Assumptions, plus Cost Pressures

Recurrent budgets will be carried forward into 2022/23 at 2021/22 levels. All cost pressures (over £0.25m), inflation and growth identified and agreed by the senior Finance team will be fully funded.

An assessment of the inflation and growth assumptions for a number of high cost areas will be undertaken. The areas that will be reviewed are as follows:

- Primary Care and Secondary Care Prescribing – This includes GP and Pharmacy prescribing, as well as Secondary Care Prescribing and the full year impact of NICE approved drugs.
- Packages of Care – Continuing Health Care, Funded Nursing Care and Packages of Care are significantly influenced by the uplifts applied by Local Authorities. There is also consideration of the growth in the number of new packages.

- External Providers – including WHSSC, EASC, WAST, English Contracts and Wales LTAs, all of which are subject to national discussions and agreed the Chief Executives group.

In addition, cost pressures over £0.25m will be identified and reviewed. This will include, but not be limited to, the following areas:

- The first 1% of any pay award.
- Energy costs.
- The impact of the Nurse Staffing Act on pay costs.
- Emergency Department Workforce, including SDEC.

Option 3 - Hybrid of Options 1 and 2

As per Option 1, baseline recurrent budgets for pay and non-pay will be given an uplift, but at the lower rate of 1%. This will fund general service growth pressures, inflation and the first 1% of any pay award.

As per Option 2, an assessment of the inflation and growth assumptions, plus cost pressures will be made and these will be funded in part, following a case by case review. The funding of the 1% uplift across recurrent budgets means that, unlike in Option 2, there will not be sufficient funding available to fully fund all cost pressures identified.

For all options, prior to sign off, a comprehensive review of the individual divisional baseline budgets will be undertaken by the senior Finance team, which will validate the assumptions built into budgets for both pay and non-pay.

It is recommended that Option 3 is approved.

This is the preferred option as it recognises some of the key pressure areas and also gives base budgets an uplift. The hybrid option funds the first 1% of any pay award and allows divisions to fund their smaller service pressures through the 1% uplift to non-pay. However, it also holds back some funding for key areas with significant new cost pressures, particularly where growth and inflation are expected to lead to a substantial increase in costs that cannot be influenced by divisions. This option will in addition give the senior Finance team the ability to ensure that the overall budget is balanced and funding is only provided where it can be afforded.

Step Two: Underlying Financial Assessment

The Health Board's underlying position is updated on a monthly basis within the Monitoring Return. However, as part of developing the three-year financial plan, this will be fully reviewed.

The Health Board has received significant non-recurrent support during COVID-19, including circa £32m to cover the value of savings not delivered during the pandemic in 2020/21, and over £147m covering areas such as Stability Funding and COVID-19 National Programmes (i.e. Test and Trace, Vaccinations etc.). Some of this funding, if not supported recurrently going forward, will convert into a recurrent financial consequence as a result of COVID-19, with a significant impact on our underlying Deficit Assessment.

The underlying financial assessment will be based on a framework developed by the Finance Delivery Unit (FDU). This focuses on four main areas:

- Core position – including forecast outturn
- Impact of savings non-delivery from 2020/21
- Additional cost of COVID-19
- Additional cost choices/service changes

The key principles of this assessment are:

- Ensuring a clear alignment and triangulation to the pre-COVID-19 position and baseline, with a clear assessment of any change.
- A simple narrative that is consistent with the organisational understanding, assessment and position.
- A clear and balanced assessment of the recurrent impact of savings non-delivery from 2020/21 and any anticipated impact from 2021/22.
- Ensuring clarity over what the drivers of the deficit are.
- A recognition of changes in the recurrent cost base through changes introduced in the pandemic.
- A realistic assessment of the recurrent expenditure position, recognising current opportunities.
- Clarity on any choices to commit recurrent resources.

Step Three: New Developments

As part of the development of the IMTP, there will be a prioritisation process for all proposed new developments. Only those that reflect the agreed Health Board priorities, with clear and measurable outcomes, activity assumptions and benefits realisation will be included in the plan.

All agreed investment plans will need to be developed and supported by approved business cases, with a clear narrative on how the cost of any new investment will be recurrently funded; whether it is from new recurrent funding, funding from Welsh Government, linked disinvestment, or an additional savings target.

These new developments will be shown separately in the financial plan, with any funding held centrally until the business case has been approved in accordance with the Health Board Scheme of Delegation.

COVID-19

There is still considerable uncertainty around the impact of COVID-19 on 2022/23 and onwards. The financial plan will assume that all COVID-19 costs are fully funded by Welsh Government.

Work is being undertaken to determine the Planned Care recovery requirement and the financial impact of this will be reflected in the financial plan.

Savings

The Health Board's Annual Plan for 2021/22 identified the need to secure £17m of recurring savings. This reduced target reflected the expected impact of COVID-19 activities upon operational services. Whilst 2022/23 is still expected to be influenced by COVID-19, a more normal year of operation is anticipated and therefore a savings requirement of £35m has been set, which reflects the level of savings that the Health Board usually achieves.
The savings programme will be delivered through a combination of transactional savings at individual service and divisional level along with savings derived from transformational change, driving improvements in quality and patient experience. It is anticipated that in 2022/23, the split between transactional and transformational savings will be fairly equal, with the balance shifting to increase transformational savings over the life of the three-year plan.

A key issue for the year ahead will be the balance between recurrent and non-recurrent schemes as, in previous years, non-recurrent schemes have formed a significant part of the overall delivery. Recurrent savings are required to enable an improvement to the underlying deficit position, as part of a phased programme to enable the return to and sustaining of a breakeven position.

Opportunities to drive improvement and thereby release savings have previously been identified through benchmarking and other external comparisons, to a value between £70m and £140m. Whilst service changes implemented during the pandemic will have impacted upon this analysis, it remains a significant reference point to identify scope for improvement as services gear up once again to meeting traditional demand.

Transformation

The Transformation Programme will be driven by service transformation goals, with actions focussed on patient experience, quality and value. Financial savings will be achieved as a consequence of this approach rather than being positioned as a primary driver. This change in focus is considered critical to securing engagement from clinical teams to drive the substantial change and improvement that will be required.

Benchmarking data points to a series of areas where recurrent opportunities exist and importantly, where the potential for improvements in quality, outcomes and performance is recognised. The need for a more structured approach, which addresses a small number of key areas is recognised. The following have been identified as examples of potential opportunities:

- Planned Care - Outpatient Follow up rates and Theatres.
- Unscheduled Care - Length of stay and Ambulatory Care Sensitive Conditions.
- Workforce - Recruitment and retention of staff to ensure that use of agency and bank resources are reduced.

These potential opportunities, along with others, will be explored as part of the planning process for 2022/23 and those chosen for action will be reflected in the Board's transformation and performance plans, with an outline three-year programme completed for the end of January 2022. Bringing together planning, transformation, performance and finance around a single organisational agenda will be critical to success and offers the potential to look beyond a single year programme.

To ensure this cohesive approach to both planning and delivery, an Executive Delivery Group for Transformation and Finance will be established. The Director of Primary and Community Services will chair the Group, with the Director of Finance acting as vice-chair. This Group will be tasked with providing assurance to the Executive Leadership Team, the Board and its Committees regarding the impact of improvement as plans are implemented.

Cyfarfod a dyddiad: Meeting and date:	**Performance, Finance & Information Governance Committee 23.12.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Quality & Performance Report to 30th November 2021**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Executive Director of Finance
Awdur yr Adroddiad Report Author:	Mr Edward Williams Head of Performance Assurance
Craffu blaenorol: Prior Scrutiny:	Jo Whitehead Chief Executive Officer
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Performance, Finance & Information Governance Committee is asked to scrutinise the report and to advise whether any areas should be escalated for consideration by the Board.

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	☑	**Ar gyfer sicrwydd For Assurance**	☑	**Er gwybodaeth For Information**	☑
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

This report includes indicators from the NHS Wales Delivery Framework 2021-22. The Executive Summary is included within the Report.

Cefndir / Background:

Our report outlines the key performance and quality issues which fall under the delegated powers of the Performance, Finance & Information Governance Committee. The summary of the report is now included within the Executive Summary pages of the QAP and demonstrates the work related to the key measures contained within the 2021-22 National Delivery Framework. This framework has been revised to provide performance measures under the Quadruple Aims set out in A Healthier Wales.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The performance measures included in this report are from the NHS Wales Delivery Framework 2021-22.

Opsiynau a ystyriwyd / Options considered

Not Applicable

Goblygiadau Ariannol / Financial Implications The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on the financial recovery plan of the Board.
Dadansoddiad Risk / Risk Analysis The pandemic has produced a number of risks to the delivery of care across the healthcare system.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance This report will be available to the public once published for Performance, Finance & Information Governance Committee
Asesiad Effaith / Impact Assessment The Report has not been Equality Impact Assessed

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

Quality and Performance Report

Performance, Finance & Information Governance Committee

Position as at 30th November 2021

Presented on 23rd December 2021

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About this Report

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2020-21 NHS Wales Delivery Framework until such time as the NHS Wales Delivery Framework for 2021-22 is formally published. The NHS Wales Delivery Framework for 2021-22 was formally published on the 1st October 2021.

Report Structure

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

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

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

Performance Monitoring

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

- Performance has improved over the last 6 months
- Performance has got worse over the last 6 months
- Performance remains the same

Ongoing development of the Report

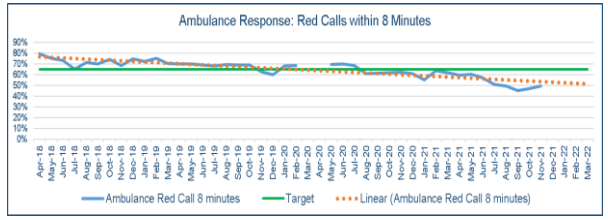
This report sees the introduction of an Overall Summary Dashboard (Page 4) where the reader can view the performance of all key measures on one page, together with timeline/ trend of performance over the last 3 years.

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

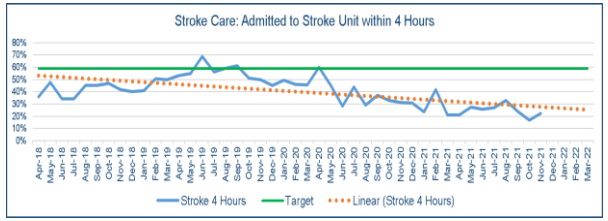
Overall Summary Dashboard

Unscheduled Care Measures

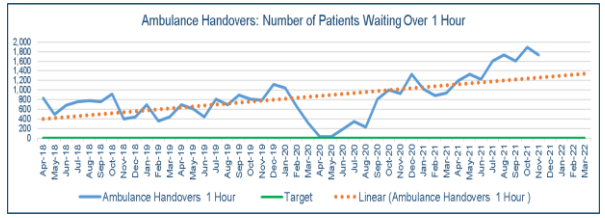
Ambulance Red Calls 8 Minutes: **49.7%**



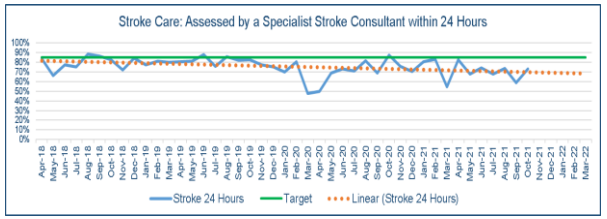
Stroke Admission 4 Hours: **22.4%**



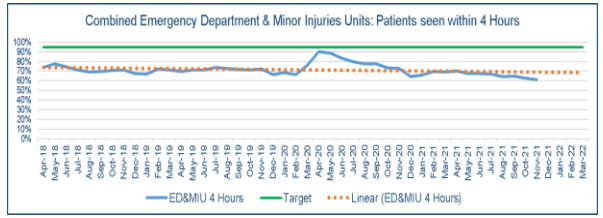
Ambulance Handovers Over 1 Hour: **1,735**



Stroke Consultant 24 Hours: **73.2%**

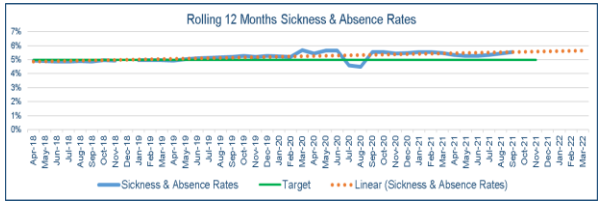


Combined ED&MIU 4 Hours: **61.13%**

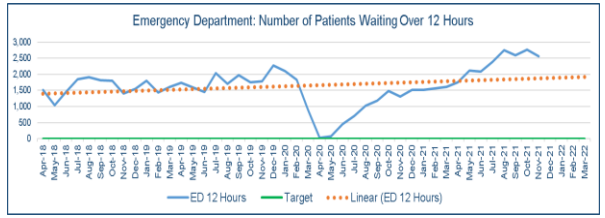


Sickness Absence

Sickness Absence Rate: **5.82%**



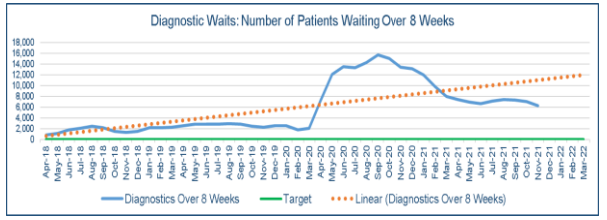
ED 12 Hours: **2,561**



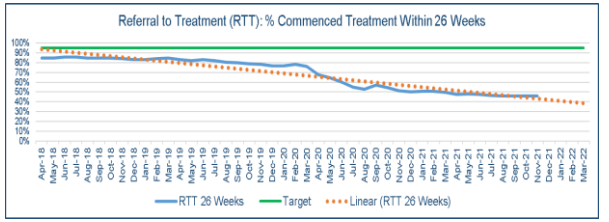
All Data presented is up to date to 30th November 2021 except for Suspected Cancer Pathway data which is reported a month in arrears.

Planned Care Measures

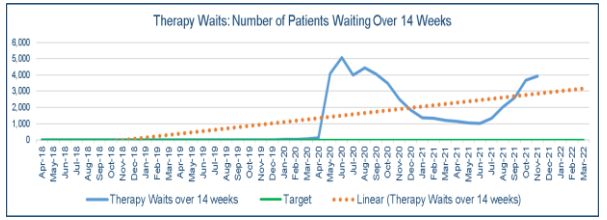
Diagnostic Waits 8 Weeks: **6,288**



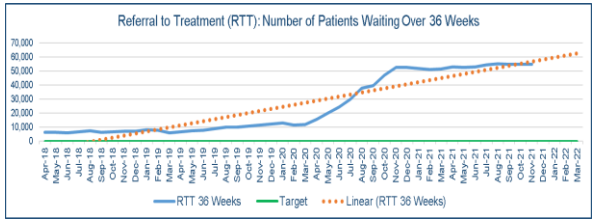
RTT within 26 Weeks: **46%**



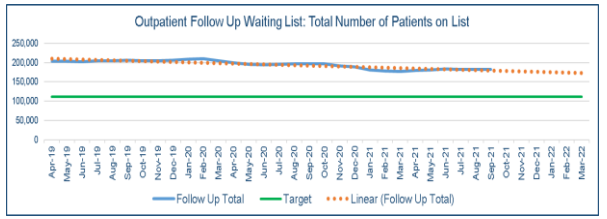
Therapy Waits 14 Weeks: **3,937**



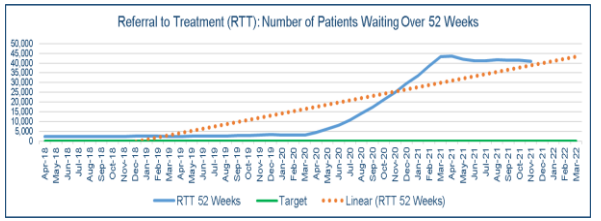
RTT Over 36 Weeks: **54,883**



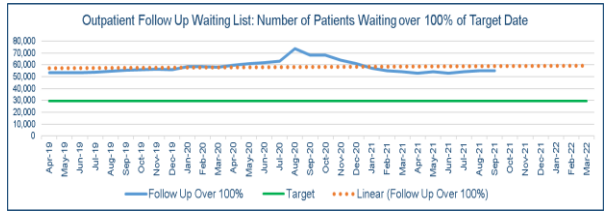
Total Follow Up Backlog: **180,188**



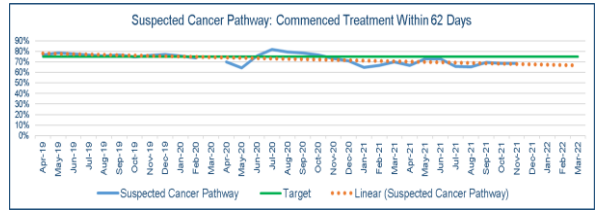
RTT Over 52 Weeks: **40,897**



Follow Up Over 100%: **53,834**



Suspected Cancer Pathway: **68%**



Executive Summary

The Committee is asked to note the following:

Quadruple Aim 2: Unscheduled Care

Pressures on the unscheduled care system continues to increase and performance remains below the 95% target of patients seen within 4 hours, 61.13% in November, compared to 64.92% in September. The number of patients waiting over 12 Hours in our Emergency Departments has fallen slightly again for the 3rd successive month at, 2,561 in November compared to 2,565 in September. The number of patients waiting over 24 hours rose has also fallen in November to 866 compared to 905 reported in September. However, the number of patients experiencing ambulance handover delays of an hour or more rose to 1,735 in November compared to 1,610 in September.

Performance against the stroke care measure continues to be poor, however performance improved to 22.4% of patients admitted to a Stroke Assessment Unit within 4 Hours compared to 17% in October. (against a target of 59%). The rate of patients reviewed by a Stroke Consultant within 24 hours improved at 73.2% in November (against a target of 85%) compared to 59% in October.

Delayed Transfers of Care (DToC) has been replaced by the Discharge to Recover & Assess (D2RA). Since the starting of reporting D2RA, there has been an increase in the number of patients being delayed whilst awaiting transferring to care homes.

Quadruple Aim 2: Planned Care

As in the rest of the UK, the disruption caused by COVID-19 continues to severely impact upon our capacity to deliver planned care services at the pre-COVID-19 rates result in increased waiting times.

Despite these challenges, in September, the number of people waiting over 36 weeks remains fairly static at 54,883 compared to 54,805 in September. The number of patients waiting over 52 weeks continues to fall at 40,897 in November, compared to 41,578 in September.

The number of patients waiting over 8 weeks for diagnostic tests continues to fall at 6,288 in November compared to 7,352 in September. Endoscopy remains the specialty with the highest number with 3,025 patients waiting over 8 weeks.

The number of patients waiting over 14 weeks for therapy has increased to 2,610 in September compared to 2,036 in August 2021.

Whilst performance against the Suspected Cancer pathway target of 75% of patients starting treatment within 62 days of suspicion remains below target at 68% it is improved from the 65.7% reported in August, BCU remains the second best performing Health Board in Wales in terms of the Suspected Cancer Pathway.

At 180,188 in November, the total number of patients waiting on the 'Follow Up' waiting list continues to fall compared to 182,526 in September 2021. The number of those patients that are more than 100% overdue their follow up date also continues to fall at 53,834 at the end of September 2021 from 55,247 in September.

Performance against the eye care measure improved to 46% in November 2021, compared to 43.1% in September. This is the biggest improvement in performance against this measure since its introduction in 2020.

Quadruple Aim 3: Workforce

The trend for staff sickness rate over the last 5 months (June to November) has been one of increase with September at 5.82%. COVID-19 related sickness remains static at to 0.6% (from 0.6% in October and 0.8% in September 2021).

PADR Rates has remained largely static over the last 3 months at 67.9% completed by end of November 2021. Mandatory Training rates have also remained largely static over the last 3 months at between 84.2% and 84.1% and remains just less than 1% below the 85% target rate.

Quadruple Aim 4: Agency /Locum Spend

In November the combined Agency and Locum cost remains fairly static at 7.6%.

Quadruple Aim 4: Adults re-attending Dental Care within 6 to 9 months.

The rate of adults re-attending dental appointments has increased in Quarter 2 of 2021/22 to 28.30%. This is the highest rate since prior to the COVID-19 pandemic.

Quality and Performance Report
Performance, Finance & Information Governance Committee

Measures

Measure	at 13th December 2021
Total number COVID-19 Vaccinations given BCU HB	**1,320,415**
Total Number who have received both 1st and 2nd doses of vaccine	**498,147**
Total number of Booster vaccines given BCU HB	**253,120**
Total number of completed tests for COVID-19 (last 7 days - between 6th and 12th December 2021)	**23,185**
% Tests turned around within 24 Hours (Last 7 days - between 2nd and 8th December 2021)	**100%**
Average turnaround time (Last 7 days - between 2nd and 8th December 2021)	**Less than 1 Hour**
COVID-19 incidence per 100,000 population (Last 7 days - between 2nd and 8th December 2021)*	**606.1**
% Prevalence of Positive Tests (Last 7 days - between 2nd and 8th December 2021)*	**19.0%**
Number of in-Hospital Deaths - Confirmed COVID-19** (between 11th and 17th October 2021)	**7**

Source: BCU IRIS Coronavirus Dashboard, accessed 13th December 2021

** PHW Coronavirus Dashboard Accessed 13th December 2021 data as at 13th December 2021*

*** Awaiting update*

COVID-19: Narrative

- Incidence rates have been sustained at a high, and in most cases, increasing rate. All Local Authority areas have incidence rates above 400 cases per 100,000. Ynys Môn now has the highest rate in Wales Local Authorities at 796.7 cases per 100,000 over the last 7 days (test results reported up to 08.12.21.) Gwynedd has the second highest incidence rate in Wales at 685.6, although the rate in Gwynedd has been falling over recent days. Wrexham, Denbighshire and Flintshire are also above the Wales average and in the highest 7 counties in Wales. Conwy remains below the Wales average at 438.6 cases per 100,000.
- The positivity rate over last 7 days varies between counties but all are over 15%, with Ynys Môn highest at 21.9%.
- Highest volume of new positive results is amongst the 0 – 15 and 30 – 49 year age groups.
- Overall GP consultations for suspected COVID-19 or acute respiratory infections have fluctuated over recent weeks but both are on an upward trend.
- Hospital admissions have been sustained at a slightly higher level, currently 144 total inpatient numbers across acute and community sites as at 13.12.21; however the rates remain lower than peaks in previous waves. As at 13.12.21 there were 9 patients with confirmed Covid-19 in critical care across North Wales.
- The number of care home numbers affected by Covid-19 outbreaks has reduced since the implementation of new guidance; there are 14 homes with 2 or more positive cases as at 10.12.21. Whole system capacity remains stretched, particularly in regard to domiciliary care capacity, and the numbers of patients who are medically fit for discharge remaining in hospital have been sustained over recent weeks..
- The vaccination booster programme has continued, with over 253,000 third and booster vaccinations having been given as at 13.12.21.
- There are concerns regarding the potential impact of influenza and other respiratory viruses during the winter period both from the perspective of managing the needs of people who may have concomitant COVID-19 and other viruses, as well as the aggregated impact alongside COVID-19. Currently the prevalence of influenza is low in North Wales.

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

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

Most of the measures in the NHS Wales Delivery Framework for Quadruple Aim One fall within the remit of the Quality, Safety and Experience Committee.

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

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

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

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

Top 5 Measures (based on movement up or down)

Period	Measure	Target	Actual	Trend
Nov 21	Number of patients waiting more than 14 weeks for Therapy	0	3,937	↓
Nov 21	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	>= 65%	49.70%	↓
Nov 21	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	>= 95%	61.1%	↓
Nov 21	Number of patients waiting more than 8 weeks for a specified diagnostic	0	6,288	↑
Nov 21	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	24,038*	53,834	↓

Quadruple Aim 2: Unscheduled Care Measures

Period	Measure	Target	Actual	Trend
Jun 21	Percentage of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within **1 hour** of their initial call being answered***	90%	**90.70%**	↓
Nov 21	Percentage of emergency responses to red calls arriving within (up to and including) **8 minutes**	>= 65%	**49.70%**	↓
Nov 21	Number of Ambulance Handovers over **1 Hour**	0	**1,735**	↓
Nov 21	Percentage of patients who spend less than **4 hours** in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	>95%	**61.13%**	↓
Nov 21	Number of patients who spend **12 hours** or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	**2,561**	↓
Nov 21	Number of patients who spend **24 hours** or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	0	**866**	↓

Period	Measure	Target	Actual	Trend
Nov 21	Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within **4 hours** of the patient's clock start time.	>= 59%	**22.40%**	↓
Nov 21	Percentage of patients who are assessed by a stroke specialist consultant physician within **24 hours** of the patient's clock start time	>= 85%	**73.20%**	↓
Nov 21	Percentage compliance against the therapy target of an average of **16.1 minutes** of Speech and Language Therapist input per stroke patient	>= 64%	**44.80%**	↓
Q2 21/22	Percentage of stroke patients who receive a **6 month** follow up assessment*	TBA	**46.20%**	↑
Aug 21	Percentage of survival within 30 days of emergency admission for a hip fracture**	>= 80%	**89.10%**	↑

**Stroke 6 month follow up Time is reported 6 months in arrears*
***Hip fracture survival reported 3 months in arrears*
****Issues with data on OoH/111 data means no update since June 2021*

Quadruple Aim 2: Emergency Departments/Minor Injury Units and D2RA

What are the key issues/ drivers for why performance is where it is?
COVID-19 challenges remain across primary care, community and acute hospitals for all 3 health communities which compounds the challenges across the already pressured unscheduled care system to deliver timely, quality care for patients at our hospital front-doors have never been more intense. This affects focus on initiating change that is necessary to allow us to deliver safe care this winter. We recognise the need for strengthening corporate communications across the programme and we will work with the communications and informatics teams to provide better opportunities for sharing learning and offering input for teams throughout the health board. The acuity of patients presenting at Emergency Departments (EDs) remains high and flow out of the department and throughout the inpatient wards continues to be challenging, due to continued extreme pressures at the back door and particularly ongoing pressures for domiciliary care provision which continues to delay patients waiting for care packages.

Collaborations with partner agencies have taken place with a facilitated Health & Social Care summit in the West Area from which priority projects were identified including to simplify referral pathways and standardise documentations, as well as reviewing workforce. A Multi-Agency Discharge Event (MADE) took place in Wrexham beginning of December the evaluation of which will be shared.

What actions are being taken to improve performance and by who?
The fifth month of the Unscheduled Care (USC) programme saw the implementation of first interventions out of the development stage:

Work stream 1 update:
- Following a training needs analysis, an educational programme for Emergency Nurse Practitioners (ENPs) has now commenced to support standardisation and consistency in the scope of minor injuries service provision across all Minor Injuries Units (MIUs) going forward, supported by educators from Bangor and Glyndwr Universities with a view to maximising MIU utilisation and support appropriate flow to MIUs from EDs.
- The 111 First service continues to support healthcare professionals including nursing homes.
- Access to Welsh Ambulance NHS Trust (WAST) C3 system and clinical training has enabled clinicians within Single Integrated Clinical Assessment and Triage (SICAT) to pull appropriate calls from the WAST stack to triage, assess and stream / signpost to alternative services and avoiding unnecessary conveyances to ED.
- Work is underway for the development of Urgent Primary Care Centres within Central and West Areas.

Work stream 1 Next Steps:
- Planning a communication campaign to rebrand and relaunch MIUs for the general public once the training has provided foundations for a predictable level of service provision across all units.
- Work is ongoing to further develop the Directory of Services ensuring inclusion of all MIUs.

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

Work stream 2 update:
- Adverts for Emergency Department (ED) and acute medical posts are live as part of the progression of the BCUHB-wide joint recruitment campaign which is overseeing the workforce requirements for Same Day emergency Care (SDEC) and ED business case models
- Standard Operating Procedures (SOP) being developed to identify suitable patients for SDEC. A process driven model aligned to NEWs and Frailty scores is being adopted to inform patients selection criteria into SDEC
- All incidences of SDEC being bedded down are reported via Datix for scrutiny and review, communications underway to emphasise the importance of SDEC units not being used as an escalation area.

Work stream 2 Next Steps:
- Ongoing recruitment of the additional required workforce
- Plans to use AMB and Frailty risk assessment tools within ED and with GPs, following sign off by clinicians and prior to roll out in acute sites.
- The group will include focus on improving ambulance handovers

Work stream 3 update:
- Whilst significant effort and progress has been made on the roll out of Board Rounds, metrics identified for inpatient care are not yet showing measurable improvements. A review of data reporting is being undertaken as well as a review of metrics to ensure the right data is measured to demonstrate impact.
- The roll out of Criteria Led Discharge has commenced as a key enabler to increasing discharges particularly over weekends.
- Weekly ward dashboards continue to be circulated for wards to review live data at a BCU and ward level.

Work stream 3 next steps:
- Work has commenced to develop Internal Professional Standards (IPS) building on existing documentation and work to date, to develop an agreed BCUHB wide IPS
- Extend the use of STREAM ward data boards at Wrexham and outstanding Ysbyty Glan Clwyd (YGC) wards.
- The impact of Board Rounds implemented to date is being reviewed and lessons learned from pilot wards to inform improvements.

Work stream 4 update:
- Additional capacity for patients who are judged to be medically fit for discharge but have not got the required support in the community is being set up across the three sites.
- Trusted Assessments being to be reinstated in some areas where available.

Work stream 4 next steps:
- Expansion of Discharge to Recover and Assess (D2RA) using the winter funding and increase of step down capacity.
- Data on the numbers of packages of care processed by Trusted Assessors to be reviewed including reassessments.

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

When performance is going to improve by and by how much?

Taking account of the site pressures and challenges across the whole unscheduled care system but also in recognition of the work that has commenced within priority projects and deliverables set out within the Unscheduled Care (USC) programme plan, it is expected that the realisation of impact against the priority projects will materialise by Q4 of 2021-22. A programme tracker is established demonstrating progress against the initial deliverables which indicates the overall progress of the status for all work streams for each health community as well as against risks and issues is reviewed and monitored at the monthly USC Improvement Group.

What are the risks to this timeline?

1. Lack of clinical engagement will inhibit necessary progress of projects aimed to deliver improvements across the USC system
2. Operational pressures across the whole system impacting on capacity to progress identified actions to deliver improvements
3. Existence of / access to Same Day emergency Care (SDEC) pathways inconsistent across the sites with patients who could be managed on an ambulatory basis still likely to be admitted
4. Bedding down of SDEC overnight impacts on SDEC service following morning.
5. Inability to discharge Medically Fit for Discharge (MFfD) patients due to lack of capacity in the community impacting on the flow improvement once any acute interventions / delays are resolved.
6. Inability to recruit to various and competing workforce requirements will impact on ability to progress

What are the mitigations in place for those risks?

1. Clinical Leads are confirmed for each of the 4 work streams and discussions are ongoing with the USC Senior Clinical Lead and Medical Directors / directorates leads
2. Priority programmes have been identified within the programme plan in recognition of capacity and competing priorities across acute and area team. Escalation process for issues and requests for support are embedded within the USC programme reporting and governance structure.
3. Pathways into SDEC have been reviewed and are being updated to adopt a process driven model aligned to severity of illness to ensure the right patients are directed to SDEC.
4. Sites are reviewing options to ring-fence SDEC capacity including relocating the unit on sites where this is a consistent issue and communications ongoing to emphasise the importance of using SDEC units as escalation areas.
5. Bridging services have been established in some community hospitals to support patients who are MFfD but whom require a package of care, to enable them to be stepped down as a transitional space between treatment and discharge, which will support patients to be in the right place and ease bed pressures.
6. BCUHB recruitment campaign ED, SDEC and acute medicine has been successful and recruitment process has started.

Quadruple Aim 2: Stroke Services

Key Drivers of performance

- Reduce time to presentation at acute site; Timeliness of referral to Computed Tomography (CT) scan; Access to Acute Stroke Beds; Improve out of hours performance; Access to Stroke Co-ordinators; Attainment of Delivery Unit Bundles key indicators; Lack of access to timely thrombolysis; Challenge in recruitment and retention of trained nurse workforce.

Actions being taken

YGC:

- Link with Welsh ambulance Service NHS Trust (WAST) via the Emergency Quadrant (EQ) weekly meeting – reduce delay from onset to arrival at acute site (Face, Arm, Speech, Time (FAST) principles).
- Weekly Acute Stroke Improvement cell attended by Medicine Lead Manger, Emergency Department (ED) Operational Manager, ED Matron and Lead Stroke Specialist Nurse assessing areas identified for improvement. Currently a Stroke Awareness and Formal Swallow training package is being delivered to ED nursing staff with a date in the new year to extend to ED medical team.
- On-going increased demand on Acute Stroke and General medical team – Medicine attend the ED huddle and site huddle to support with any escalations including if no ASU bed for next admission.
- Medicine Manager of the Day rota available to Site Management to escalate stroke delays (Mon-Fri).
- Highlight any stroke patients of concerns in incorrect medical areas due to unavailability of capacity in ASU.
- Stroke Bed availability reported at all situation reports (SITREP) meetings and actions identified if capacity isn't available, i.e. next patient to slept out.
- Actions distributed following success of funding for the Stroke Business Case. Nursing consultation document complete pending approval.
- Recruitment of additional Clinical Nurse Specialist (CNS) to increase access hrs across 7 days.
- Well attended Monthly Acute Stroke Business and Clinical Governance continues to drive the stroke agenda forward.

WMH:

- Breach analysis report sent to Stroke multi-disciplinary team for actions and ensure lessons learnt shared.
- Access to Symphony system for the Stroke Team to understand timelines on Emergency Department (ED) Stroke Pathway to enable Sentinel Stroke National Audit Programme (SSNAP) reporting.
- Working with site management team to ensure two beds are ring-fenced on Acute Stroke Unit (ASU). Sisters on ASU identifying patients each day for discharge and step down.
- Local Stroke delivery meeting monthly
- Referral pathways work ongoing along with audit in ED on use of the Stroke Proforma, time to CT scan, time to ASU & swallow screen.
- Additional porter hours in ED.

YG:

- Weekly multidisciplinary deep dive meeting to review performance and compliance of patient pathway
- New processes instigated to improve pre-alert from ED to Stroke team.
- Enhanced focus on prompt COVID-19 swabbing from admission.
- Training video to be shared with ED staff to support triage of stroke patients.

Quadruple Aim 2: Stroke Services

- **When performance is going to improve by and by how much?**

YGC:	WMH:	YG:
• Site developments to support predicted Winter Pressures should support available stroke capacity in ASU by February 2022 • Additional beds x 59 agreed for 2022: ward 10,6 and 14 (post SRU relocation) • Central Area Discharge Improvement group to support MFD Exit Block and support patient flow • Improve documentation of swallow screen within ED following recent training and awareness sessions following completion in January 2022.	Additional porter hours over the next couple of months should see time to CT improve to 58-60% and the recruitment of Stroke Co-ordinators and extended hours service to be in place by March 22; this should see time to ASU improve to 30%.	• The Directorate has committed to maintaining minimum delivery of 30% during Q4 • Once ring fenced beds have been secured, we envisage performance improving to 45% by the end of Q4. • The Directorates stretch target is to deliver 55% by the end of Q1 for 2022/23

What are the risks to this timeline?

YGC:	WMH:	YG:
• COVID-19 demand • Delay with Winter plans • Limited attendance at training due to workload of medical teams • Further increased demand on site.	• Pressures in Emergency department and winter site Pressures • Lack of Stroke Co-ordinator hours, impacted by sickness/or being allocated to ward numbers	• Site bed pressures and outbreak challenges • Workforce challenges, particularly for nurse staffing • Gaps in patient pathway created by Covid related pressures

What are the mitigations in place for those risks?

YGC:	WMH:	YG:
• Additional training sessions available to accommodate teams OOH • Continue to link with site team to support gaining stroke capacity and reducing LOS • RESTART programme: CLD, SORT etc..	• Stroke business plan, in particular recruitment plan • Explore straight to CT model • Process in place to improve availability of acute stroke beds	• Site bed escalation policy will be reviewed to highlight introduction of ring-fenced capacity • Matrons will continue to recruit to vacancies and provide on going support to retain qualified staff • Continue with weekly deep dive meeting and identify gaps within the patient pathway

Quadruple Aim 2: Planned Care Measures

Period	Measure	Target	Actual	Trend
Oct 21	Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion	75%	**68.00%**	↑
Nov 21	Number of patients waiting more than 8 weeks for a specified diagnostic	0	**6,288**	↑
Nov 21	Number of patients waiting more than 14 weeks for a specified therapy	0	**3,937**	↓
Nov 21	Percentage of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments	>= 95%	**45.60%**	↓
Nov 21	Percentage of patients waiting less than 26 weeks for treatment	>= 95%	**46.00%**	↓

Period	Measure	Target	Actual	Trend
Nov 21	Number of patients waiting more than 36 weeks for treatment	0	**54,883**	↓
Nov 21	Number of patients waiting more than 52 weeks for treatment	0	**40,897**	↓
Nov 21	Number of patients waiting for a follow-up outpatient appointment	Reduce	**180,188**	↑
Nov 21	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	24,038*	**53,834**	↓
Q2 21/22	Percentage children regularly accessing NHS Primary Dental Care	Improve	**47.20%**	↓

** end of March 2022*

Quadruple Aim 2: Referral to Treatment and Risk Stratification

What are the key issues/ drivers for why performance is where it is?

- Stage 1 tranche validation exercise was handed over to the Head of Ambulatory Care during transition period into post. As at 02/12/21, of the 20,112 patients validated 63% remain to action; > 6,000 patients that asked to 'remain' on the Waiting List (WL) and included a deterioration statement. All require clinical validation. Corporate Risk of patient harm being raised following escalation to Executive Medical Director, due to there not being the clinical capacity to review these patients and decide if they should be expedited up the S1 WL. A plan is in place for all remaining activity after discussion with operational leads on each site to safely close down the activity.
- Stage 4 tranche validation exercise is completed in East and a plan in place to close down in Central and West by end of this month at the latest.
- New targets set by Welsh Government (WG): No patients prioritised as 'urgent' waiting over 52 weeks (Jan 22); No patients waiting over 104 weeks for a first outpatient appointment (Feb 22); All those waiting over 52 weeks for a first outpatient to have received communications from the health board and validation to have been completed (Jan 22); No patients waiting over 52 weeks for a first outpatient appointment (Mar 22)

What actions are being taken to improve performance and by who?

- S1 - Temporary call centre staff trained on WCP to take all call backs to patients, increased analysis of spreadsheets to support Departments and guide progress, purge of those now removed from the WL, funding secured for Departments to support admin process, automation of outbound ROTT letters to patients who are being removed (ready to launch next week).
- S1 - Planned Care Program Lead engaging with Medical Directors on each site to identify and prioritise clinical support where activity is not taking place to support the clinical review and evaluation against deteriorating statement.
- S4 & S1 - Plans to close down are being monitored and reviewed regularly. Lessons learnt activity being planned for January 2022 to inform improved ways of working. Plans being explored to digitise and automate the patient validation process, to move away from tranche validation into business as usual (BAU).
- New targets set by WG – data has been baselined and shared with all site operational leads. Engagement pan-Wales with WG re: challenges in the target dates and to explore interventions. Monitoring established and plans/targets being prepared in the sites that will be captured to support progress monitoring *(see also as contributing actions under slide 24 – Follow Up Outpatient Waiting List: Social Distancing Limits, Hospital Initiated Cancellations (HICs), increase in outsourcing and insourcing, Trauma & Orthopaedic (T&O) modular options ahead of Regional Treatment Centres (RTCs)*

When performance is going to improve by and by how much

- S1 review and evaluation against deteriorating statement – dependent on risk (see below)
- New targets set by WG – initial engagement with sites anticipates interventions that are and will be planned will start to take affect from January 2022 onwards.
- **What are the risks to this timeline?**
- S1 - Competing priorities for the additional clinical support to review and evaluate the > 6000 patients on S1 with deteriorating statement.
- New targets set by WG – anything that prevents full utilisation of clinic appointments e.g. HICs, nursing staff being drawn away into inpatient activity, social distancing, repurposing of outpatient areas.

What are the mitigations in place for those risks?

- S1 - Planned Care Program Lead engaging with Exec Medical Director to seek support for prioritisation of clinical support
- New targets set by WG – (see slide 7 actions)

Quadruple Aim 2: Cancer

What are the key issues/ drivers for why performance is where it is?

- In October 2021, 271 out of 401 (67.6%) of patients were treated in target. Main reasons for patients not being treated in target were:
  - Complex diagnostic pathways (20%) and patient related reasons e.g. patient unavailability for next stage of pathway (13%)
  - Delay to first outpatient appointment (17%) – primarily breast, skin and gynaecology
  - Delay to surgery (17%) – primarily urology and skin
  - Delay to endoscopy (4%) and delays to other diagnostics, primarily on urology pathway (4%)
  - Delay to follow-up appointments (4%)

What actions are being taken to improve performance and by who?

- Surgical, women's and radiology services have worked together to establish additional weekly breast and gynaecology cancer clinics
- Area managers are working with dermatology teams to increase dermatology capacity across the Health Board
- All services are prioritising suspected cancer patients
- Business case developed by endoscopy team to increase endoscopy capacity

When performance is going to improve by and by how much?

- The Health Board aims to achieve the 75% target by end of 2021/22

What are the risks to this timeline?

- Suspected cancer referrals are currently 140% of pre-COVID-19 levels which is placing pressure on all parts of the cancer pathways
- Additional funding has been received for cancer recovery but the funding is non-recurrent and relies upon successful recruitment

What are the mitigations in place for those risks?

- Additional capacity created where possible and recruitment for further capacity underway

Quadruple Aim 2: Cardiology

What are the key issues/ drivers for why performance is where it is?

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

What actions are being taken to improve performance and by who?

- There is additional activity being undertaken in various guises across North Wales, primarily to support echo waiting lists, these include; Central providing additional capacity to the West to support the echocardiography waiting list.
- Recruitment of the Health Education & Improvement Wales (HEIW) training posts is now complete. Funding has now been identified from the performance monies linked to COVID-19 recovery for the PTP posts, and also for 2 additional trainer posts to support the PTPs.
- An innovation bid submission by the Community Cardiology Team to the Heart Conditions Implementation Group has been successful in achieving funding for a year up to £191,500 to provide improved community cardiology diagnostics during 2021-22.
- A waiver for the second round of outsourcing of heart monitors has been approved by Finance for across BCU.
- An SBAR for long-term outsourcing of heart monitors is currently being devised.
- A demand and capacity exercise is still on going, as this work has not previously been completed for cardiac diagnostics and is more complex than originally thought.
- A business case to fund additional radiology diagnostic tests for cardiology patients in YG, YGC and YWM is being completed, with ongoing work with Public Health Wales (PHW) to address cardiology healthcare inequalities, which will increase capacity for CMRI, CTCA, CT FFR and amyloid.

When performance is going to improve by and by how much?

- Demand and Capacity exercise – original completion planned for end of Quarter 2 of 2021/22 however this has been revised to end of Quarter 4 21/22
- Additional activity on-going – no end dates currently
- Business Case for Radiology Diagnostic Tests to be submitted Quarter 4 of 2021/22.

What are the risks to this timeline?

- Workforce restrictions – to include succession planning, sickness and expansion
- Finance delays in processing the waiver for the outsourcing of heart monitors have now been resolved
- Demand & Capacity – complexity proving difficult and a risk of the data not being as meaningful as first thought
- Continuing Pandemic implications

What are the mitigations in place for those risks?

- An additional CT session has been incorporated in job planning to increase capacity for CT in YGC.
- A new Cardiac Strategic Lead has been appointed and due to start 4th January 2022. New post holder will take forward Demand and Capacity exercise
- Plans for regional diagnostic and treatment centres for BCU will include some elements of cardiac diagnostics

Quadruple Aim 2: Diagnostic Waits - Endoscopy

What are the key issues/ drivers for why performance is where it is?
- Maximising the use of existing estate across the 3 units
- Risk stratification of patients to ensure those most at risk are prioritised
- Use of insourcing and Waiting List Initiatives (WLIs)

What actions are being taken to improve performance?
- Opening of 3rd procedure room in Wrexham in February 2022
- Insourcing of staff to allow 7 day working on all sites, continual monitoring, weekly challenge meetings with providers
- Increasing of insourcing at Ysbyty Gwynedd (YG).
- Recruitment of nursing staff to increase room utilisation in.
- Procurement of Modular Units on YG &YGC sites, plan to have on site with lead times by September/October 2022 – Network Manager/ Senior Responsible Officer (SRO) / Procurement (expression of interest completed with NHS Supply Framework.
- Aligning capacity and demand with proposals for Regional treatment centres – Network Manager / SRO.
- Increase cross site working SRO / Clinical leads/Network Manager / Unit Managers.
- Recruitment of substantive staff.

When performance is going to improve by and by how much?
- Proposals ensure that all demand and backlogs would be cleared at Ysbyty Glan Clwyd (YGC) and East by February 2023.
- Plans for Ysbyty Gwynedd (YG) include further insourcing and outsourcing options to meet current demand, backlog under review.

What are the risks to this timeline?
- Possible delays with procurement timelines.
- Insourcing utilisation.
- Project support to ensure timely recruitment, project meetings, activity monitoring and procurement.
- Fragility of decontamination facilities.
- Aging equipment.

What are the mitigations for those risks?
- Project and Clinical posts with finance for approval.
- Continuation of challenge meetings with Insourcing providers.
- Decontamination task and finish group in progress to centralising decontamination on each site.
- Endoscopy equipment requirements included in Capital programme.

Quadruple Aim 2: Diagnostic Waits – Radiology and Neurophysiology

What are the key issues/ drivers for why performance is where it is?

Radiology:
The number of patients waiting over 8 weeks for radiology diagnostics is currently 2062, a decrease of 506 on the end of October position. Further reductions in Computed Tomography (CT) (32 breaches) and slight increase Magnetic Resonance Imaging (MRI) breaches (135 breaches) together with a decrease of 455 patients waiting over 8 weeks for an Ultrasound Scan (USS) with 1,840 patients waiting over 8 weeks. The fundamental issue within the ultrasound service remains staffing, with vacancies within the service, and difficulty securing agency staff, especially at Ysbyty Gwynedd (YG), but affecting all sites. Radiology senior management team is meeting weekly to develop and implement plans to continue to steady improvement that has been achieved over the last 9 months. A major recruitment campaign is planned and further insourcing options are currently being explored. Work is also ongoing to improve further though additional validation of waiting lists to try to reduce Did Not Attend (DNA) rates.

Neurophysiology:
The number of patients waiting over 8 weeks is 246, a decrease of 203 from end October 2021 position. There are 165 electromyography (EMG) (consultant-led) breaches and 81 Nerve Conduction Studies (NCS) (physiologist-led) breaches. A temporary clinical space in Ysbyty Wrecsam Maelor (YWM) has been secured, with the locum physiologist providing regular 3 days per week mainly NCS sessions for East area patients, where most breaches exist. The expectation is that the NCS breaches will continue to reduce over the coming months. EMG insourcing from the existing contract was undertaken at the end of September, although overall waits increased slightly due to annual leave. The vacant consultant and physiologist posts will be advertised in December 2021, as will a new tender for insourcing.

What actions are being taken to improve performance and by who?
Project groups for both services, led by Divisional General Manager (DGM) in place. Range of actions being followed up to deliver sustainable service models.

When performance is going to improve by and by how much?
Continuing to forecast no 8 weeks breaches at end March 2022.

What are the risks to this timeline?
Ultrasound staffing levels, recruitment to vacant and new posts, ability to secure sufficient insourcing across all sites.

What are the mitigations in place for those risks?
Team focussed on all elements of plans i.e. contracting, recruitment, insourcing etc. to collectively manage risks.

Quadruple Aim 2: Follow Up Outpatient Waiting List

What are the key issues/ drivers for why performance is where it is?

Specialities are still holding significant backlogs due to the Covid pandemic, in some cases building on the historical backlog. This is exacerbated by the social distancing in clinics at 2m restricting face to face appointment capacity and the re-purposing of the estate to non-outpatient activity. T&O remain the biggest waiters, exacerbated by the lack of facilities in the East.

What actions are being taken to improve performance and by who?

- Social Distancing Limits – national consensus is being sought to agree a pan-Wales Infection Prevention & Control (IP&C) / Health & Safety (H&S) agreement to reducing the social distancing to 1m to increase capacity, supported by local risk assessments being undertaken in YGC and presented to the EIMT for approval that will set an approach for other sites.
- See on Symptoms (SoS) & Patient Initiated Follow Up (PIFU) – National project is being established to support HBs to scale up the take up of these pathways. Local resource has been defined to develop a team within the new Ambulatory Care Department to set the work locally within a formal project approach with clear metrics. Current month rate is 3.1% of all New & FU waiters.
- Hospital Initiated Cancellations (HICs) – baseline has been agreed nationally as March 2019; comparison against BCUs March 2021 data shows only a 8% overall reduction in HICs since March 2019. A 'drill down to reason' report is being developed to support sites/specialities to address non-compliance against standards. Exploring the British Medical Association's (BMA's) 8 weeks notice of clinical leave.
- Renewed drive planned over the next 3 months to review local metrics to support a longer term aim to establish Key Performance Indicators (KPIs) to align with national targets and inform local planning
- Seeking increase in outsourcing and insourcing to tackle the immediate Trauma & Orthopaedic (T&O) backlogs (alongside all specialities)
- East engaging with organisation on modular options ahead of Regional Treatment Centres (RTCs).

Quadruple Aim 2: Follow Up Outpatient Waiting List

When performance is going to improve by and by how much?
Head of Ambulatory Care commenced in post end November; focus on undertaking a review of activity and performance to deliver against national targets – expecting to see improvements from Q1 2022/23:

Key National Targets *(both FUWL and NEWs unless stated otherwise)*	Mar 19 Baseline	Mar 20	Mar 21	Latest Month Available (Oct)	Current Trend
95% of all patients on a **FUWL** to have a clinical review date	*Pending*	*Pending*	*Pending*	*Pending*	
The **FUWL** (total waiting in secondary care) reduced by 20% by Mar 21 and a further 20% by Mar 22	202,745	204,367 (+0.8%)	179,592 (-13%)	184,712 (+3%)	↓
Reduce the number of patients delayed >100% by at least 20% by Mar 21, a further 20% by Mar 22 and eradicated by Mar 23	53,417	58,254 (+9%)	53,077 (-9%)	54,826 (+3%)	↓
Number of HICs within 6 weeks to reduce by 50%, by Apr 23 (from baseline Mar 19)	8593*	20688 (+141%)	8291 (-4%)	7920 (-8%)	↑
DNAs across all specialities to be no more than 5%, by Mar 23 – FUWL	6.61%	8.43%	5.69%	7.28%	↓
- NEWs	6.12%	8.38%	5.59%	6.75%	↓
A min of 20% of patients seen to have an outcome of SoS and PIFU, by Dec 21	-	-	2.4%	3.1%	↑

* % decrease/increase against baseline Mar 2019 rather than rolling progress

What are the risks to this timeline?
See on Symptoms (SoS) & Patient Initiated Follow Up (PIFU) – not all specialities are suitable for SoS / PIFU, but are included in the data

What are the mitigations in place for those risks? See on Symptoms (SoS) & Patient Initiated Follow Up (PIFU) – explore local agreement to move 'routine' patients currently on FUWL un-booked over x-years onto SoS / PIFU pathways; initial target agreed nationally as Ear Nose & Throat (ENT) – re-engage.

Quadruple Aim 2: Virtual Outpatient Activity

What are the key issues/ drivers for why performance is where it is?

The Video Group Clinics (VGCs) are formally being held within Therapies and Orthopaedics in West; with the latter being used as an exemplar across Wales. Despite excellent take-up and clear success in these areas, unfortunately we are not in a position to report our activity accurately for this month's return due to technical constraints within the Patient Information & Management System (PiMS) and Therapy Manager. A 'fix' has been applied to PiMS to capture activity going forward i.e. be able place multiple patients on the one template appointment and to report the data set requested by the Welsh Government (WG); the same fix cannot be applied to Therapy Manager.

The (individual) Video Clinics (VCs) are running well with no issues in holding the clinics themselves at this time, with in excess of 12,000 consultations across 524 service providers held since January 2021. BCU are however under-reporting their success, due to the correct clinic template not being requested by the clinical team to be set up by the Informatics/Health Records template clerks within the Patient Administration System (PAS).

What actions are being taken to improve performance and by who?

VGCs

- Retrofit the activity with formal project management approach to ensure a clear baseline, governance and plan for scale up
- Therapy Manager - Establish manual data collections and engage on future plans for the system
- Reinforce the requirement for services to request the correct clinic template in PIMS
- Work with the Informatics team to apply the same fix to WPAS ahead of plans to scale up to Orthopaedics in East and then over to Central

Video Clinics

- Reinforce the requirement for services to request the correct clinic template in PIMS
- Review the project under the care of Informatics and formalise a roll out plan
- Review of all non-Attend Anywhere VCs activity to see how we can include these in the figures and how we ensure a shared standards rather than specific platform approach

When performance is going to improve by and by how much?

By March 2022;

- VGC - Pan-BCU orthopaedics on board, formal project documentation in place, roll out plan established, reporting accurate figures
- VC **–** project reviewed and roll out plan established, reporting accurate figures

What are the risks to this timeline?

Competing priorities; lack of longer-term project resource to scale up

What are the mitigations in place for those risks?

Developing strategy for Outpatients; short-term Project Manager provided from Corporate Transformation Team, longer-term model for Outpatient Transformation Programme within Ambulatory Care defined and seeking funding.

Quadruple Aim 2: Eye Care (1)

What are the key issues/for why performance is where it is?

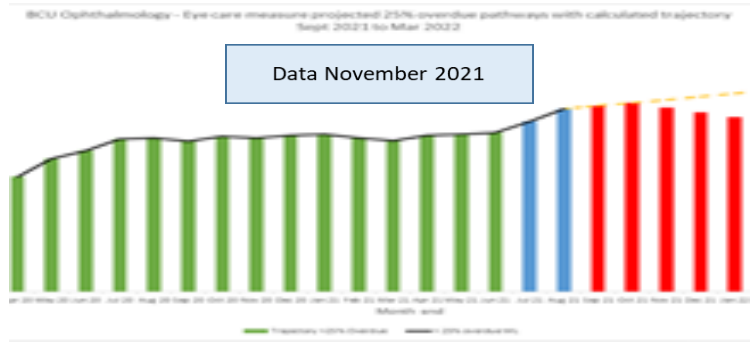
- Capacity loss due to COVID-19 social distancing mitigation (circa-2 patients capacity per clinic versus Pre-COVID-19 capacity).
- Administration constraints/capacity to recruit to non-recurring funding: limiting flow to Primary care partnership pathways & Data Quality redress action delivery.
- Historic Data Quality & Completeness impacting on accurate representation of data/performance reporting & monitoring/site confidence in data.
- Conflicting priorities impacting on consistent Clinician and Operational Management engagement.
- National Delay in delivery of Digital programme (Key enabler of Eye Care Measure sustainable/efficient pathways).
- Cataract Outpatient and theatre utility: Estate limitation / COVID-19 capacity impacting on waiting list/backlog / Referral to Treatment (RTT) v Eye Care Measure (ECM) relative priorities / Maxillo Facial theatre usage in west.

What actions are being taken to improve performance and by who? (RAG report shared/escalated to DGMs via ECCG group)

- Exploring 3-day sessions to mitigate COVID-19 capacity limitations: Pan BCU Clinical lead- outstanding) & utilisation of Primary care estates (Operational Management)
- Option appraisal/action plans to mitigate admin capacity (Operational Management- Partial achievement 1:3 sites)
- Waiting List (WL) Data Quality (DQ) / completeness multi-pronged actions: Standard Operating Procedure (SOP) (Achieved) / ”all condition” Patient Treatment List (PTL) PowerBI dashboards (On Track) (Operational Management & Informatics)
- Consistent Eye Care Measure (ECM) Pathway local delivery groups* with quorate Terms of Reference membership and ECM action logs. Ops. Managers (Partial achievement East & Central. West achieved)
- Deliver Coronavirus Cataract pathway : Regional Treatment Centre plan developed. Outsourcing & Pan BCU Patient Treatment List (Delivery phase)
- Welsh Government Recovery Business case utilising integrated Primary/Secondary care transformative Pathways (Submitted to Welsh Government/Confirmed Funding)

When performance is going to improve by and by how much?

- Recovery Bid Transformation proposals: Best-Likely* Case Scenario redress of 5000 >3000 patients waiting >25% target date. (*3000 January 22 commencement)
- Cataract: Outsourcing tender for 400 Cataracts / month.
- Clinical Lead redress: Operational Management to confirm / finalise.
- Operational Management Engagement: Eye Groups: West 100% Central > 80% East: On track to recommence.



What are the risks to this timeline

Clinical / Operational / Informatics conflicting priorities and staff resource capacity / recruitment constraints

What are the mitigations in place for those risks?

Senior management support of untangling conflicting clinical priorities and consideration of administration resource

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

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

Measures

Period	Measure	Target	Actual	Trend
Nov 21	Personal Appraisal and Development Review (PADR)	>= 85%	67.89%	↓
Nov 21	Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	>= 85%	84.16%	↑
Nov 21	Percentage of sickness absence rate of staff	< 5%	5.82%	↓
2020	Staff Engagement Score*		73.00%	↓
2020	Percentage of staff who would be happy with care by their organisation if friend/ relative needed treatment*		59.70%	↓

Data for November 2021 (unless stated otherwise)
Presented on 23rd December 2021

Quadruple Aim 3: Narrative – Sickness & Absence

What are the key issues/ drivers for why performance is where it is?

- COVID-19 related sickness absence has remained as 0.6% (0.8% in September, 0.6% in October). This reflects a decrease in staff testing positive from 369 in September to 284 in November.
- Non COVID-19 related sickness absence increased by 0.3% to 6.2% (October and November) which are the highest rates in the last 12 months.
- Stress related absence remains the biggest cause of absence with approximately 4 times more days lost than the 2nd largest cause (infectious diseases). It remains the biggest cause of absence by a considerable margin for all areas. The highest levels of sickness absence remain in Additional Clinical Services, Estates & Ancillary and Nursing & Midwifery. Additional Clinical Services sickness rates are high across the organisation, however, there has been a very slight decrease from October at 9.69% to November at 9.66%. Estates and Ancillary staff have increased their sickness levels from 8.96% in Oct to 9.91% in November. Nursing levels have reduced by 0.5% from 7.24% in October to 6.73% in November.

What actions are being taken to improve performance and by who?

- Regular meetings between Well-being, Human Resources (HR) and Occupational Health colleagues to look at hotspot areas and support options.
- Training for specific staff groups on sickness management e.g. medical staff
- Multidisciplinary Team (MDT) case management meetings have been reintroduced to provide support for staff with more complex needs and include staff, managers, occupational health, Health & Safety (H&S) and well-being colleagues as needed.
- All staff who have not previously taken up the offer of vaccination (flu and COVID-19) are being encouraged by line manager to get vaccinated in order to protect themselves, patients / service users and the wider community.
- Increased provision of staff wellbeing and support services including counselling, psychological therapies
- Increased recruitment activity to improve staffing numbers and reduce the burden on existing colleagues

When performance is going to improve by and by how much?:

- Given the evidence across the UK including Wales, it is unlikely that a significant improvement in attendance will be achieved through the winter months.

What are the risks to this timeline?

- Increase in staff overtime may lead to higher sickness levels
- Further increase in stress related absence
- Further increase in COVID-19 / flu / respiratory sickness absence
- Recent All Wales decision to extend COVID-19 sickness pay until end March 2022 or for a period of 12 months for more recent diagnoses of long COVID-19.

What are the mitigations in place for those risks?

- Regular reviews to make sure staff are not working excessive hours for prolonged periods.
- Increased communications to further promote access to the Wellbeing Services available for staff
- Increased communications to further promote take up of COVID-19 Booster across all staff groups

Quadruple Aim 3: Narrative – PADR

What are the key issues/ drivers for why performance is where it is?

- Personal Appraisal & Development Reviews (PADR) compliance for November 2021 is 67.9%, similar to reported compliance of 67.8% for September but an increase to the October compliance of 67.05%. The PADR completion rate for November 2020 was 70.5%.
- Out of the 10 largest divisions, 8 saw an increase in compliance from October 2021 to November 2021.
- The highest increase was 3.6% in the Women's Division.
- The 2 that saw a decrease in compliance from October to November were Area West (0.8% decrease) and North Wales Clinical Services (1.6% decrease).

What actions are being taken to improve performance and by who?

- League tables are shared with senior managers across the organisation highlighting PADR compliance across all divisions. This work is undertaken by the Organisational Development Team.
- Tailored local support is provided by Human Resource (HR) teams to support managers to understand any barriers that may exist to completing PADR's and how to overcome these barriers.
- Staff feedback collated on individual experiences of the PADR process and shared as part of the communication to senior managers across the organisation

When performance is going to improve by and by how much?

- The original aim of reaching 75% organisational PADR compliance by the end of March would mean a 2% increase month on month for January-March. Given the significant operational pressures across the organisation, an 0.5% incremental improvement month by month in organisational compliance would give an end of March position of circa 70% and may be a more realistic aim for sustainable improvement into 22/23.

What are the risks to this timeline?

- COVID-19 related activity increasing as well as winter pressures may reduce managerial and staff capacity to improve the rate at which PADRs are completed.

What are the mitigations in place for those risks?

- Work with divisions in a supportive manner to achieve sustainable increase and issue supportive communications across the organisation as a gentle reminder of the importance of conducting PADRs.

Quadruple Aim 3: Narrative – Mandatory Training

What are the key issues/ drivers for why performance is where it is?

- Mandatory Training compliance at level 1 has increased by 0.1 % on the October compliance and is currently at 84.12%, therefore just less than 1% below the national target of 85%.
- The Health Board remains one of the highest in Wales for compliance with mandatory training and remains the highest in the UK in relation to E-learning completions.
- Corrections to Violence & Aggression refresher periods within Electronic Staff Record (ESR) has reported an increase in completion rates of 19% related to level 2 Violence & Aggression figures.

What actions are being taken to improve performance and by who?

- Continued work to identify suitable accommodation for COVID-19 safe provision of face to face training e.g. manual handling.
- An agreed Memorandum of Understanding (MOU) between the Welsh Union Learning fund (WULF) and the Estates & Facilities Division has commenced, this is a Digital Skills training program as part of a 'going paperless' digital transformation initiative.

When performance is going to improve by and by how much?

- The MOU between BCUHB and WULF is anticipated to assist up to 1,300 staff who are working across multiple sites in a variety of non-clinical roles and will include the introduction of handheld, touch screen connected devices and associated digital processes to augment and/or replace existing working practices.

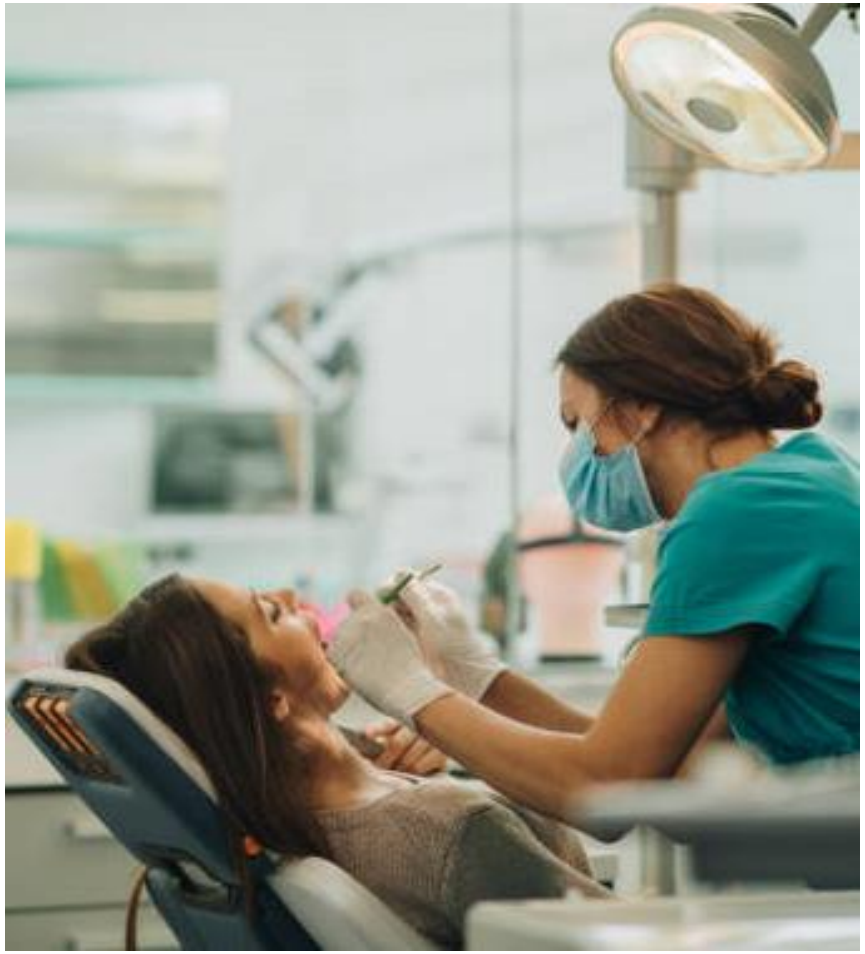
What are the risks to this timeline?

- COVID-19 and winter pressures on operational teams may impact upon training delivery and attendance.
- Social distancing restrictions affects the ability to deliver training within existing training facilities reducing the numbers who can safely attend 'face to face' classroom sessions for specific courses.

What are the mitigations in place for those risks?

- Blended training approaches are utilised wherever possible.
- Practical sessions are risk assessed with occupancy of rooms reduced to allow safe delivery.

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



Measures

Period	Measure	Target	Actual	Trend
Q2 21/22	Percentage of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months*	TBA	28.30%	↑
Q2 21/22	Percentage of critical care bed days lost to delayed transfer of care - Intensive Care National Audit & Research Centre (ICNARC) definition*	Reduce	9.50%	↑
Nov 21	Agency spend as a percentage of total pay bill	Reduce	7.60%	↓

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

Quadruple Aim 4: Narrative – Agency & Locum Spend

What are the key issues/ drivers for why performance is where it is?

- Non-core agency, bank and overtime pay spend increased from £7,649,000 in October to £11,418,000 in November 2021.
- Agency spend is up by £546k at £4,482,903 (5.9% of total pay); Locum spend is up by £633k at £2,047,474 (2.7% of total pay); Waiting List Initiatives (WLIs) spend is down by £89k at £303,562; Bank spend is steady at £2,285,047 (3.0% of total pay) against yearly average £2,541,474. There is an upward trend across non-core pay with Agency and Locum spend increasing significantly with Bank staying steady & WLIs decreased. This can be linked to the ongoing increase of staff usage across all areas of the Health Board with an uplift in the vaccination programme, ongoing activity across Planned Care and the ongoing pressure on unscheduled care.
- Medical Agency spend is up from £1.75m to £1.98m month on month (October-November) with a decrease in WLI spend of £92k month on month (October-November). The decrease in WLI spend can be linked to the pressure of COVID-19 impacting on activity across Planned Care recovery programme.
- Nursing Agency spend is steady at £1.52m with a minimal drop of £4k (October-November), bank spend has stayed steady at £394k against the yearly average £397k and overtime has increased by £487k. The increase in spend across non-core spend elements can be linked to the increase in unscheduled care activity, the ongoing pressure due to Covid and the ongoing activity across the Planned Care recovery programme.

What actions are being taken to improve performance and by who?

- Targeted recruitment campaigns for Medical and Dental consultants are ongoing with a fast-track route being implemented to facilitate Consultant recruitment. The work to secure more Physicians Associates and ST 1 doctors is being taken forward through the Doctors Direct programme. This work is being undertaken by Office of the Medical Director (OMD) / Workforce & Organisational Development (WOD) collaboratively.
- The focus on Nursing recruitment is increasing with phase 2 of the overseas nurse programme now underway and work progressing to move forward with phase 3. A major recruitment campaign is ongoing targeting band 5 nurses with a view that this will lead to increased nursing capacity across the nursing workforce. This work is being undertaken by Nursing with support from WOD.

When performance is going to improve by and by how much?

- The expected impact for both medical and nursing recruitment activity should be seen towards the end of Q3 beginning of Q4.

What are the risks to this timeline?

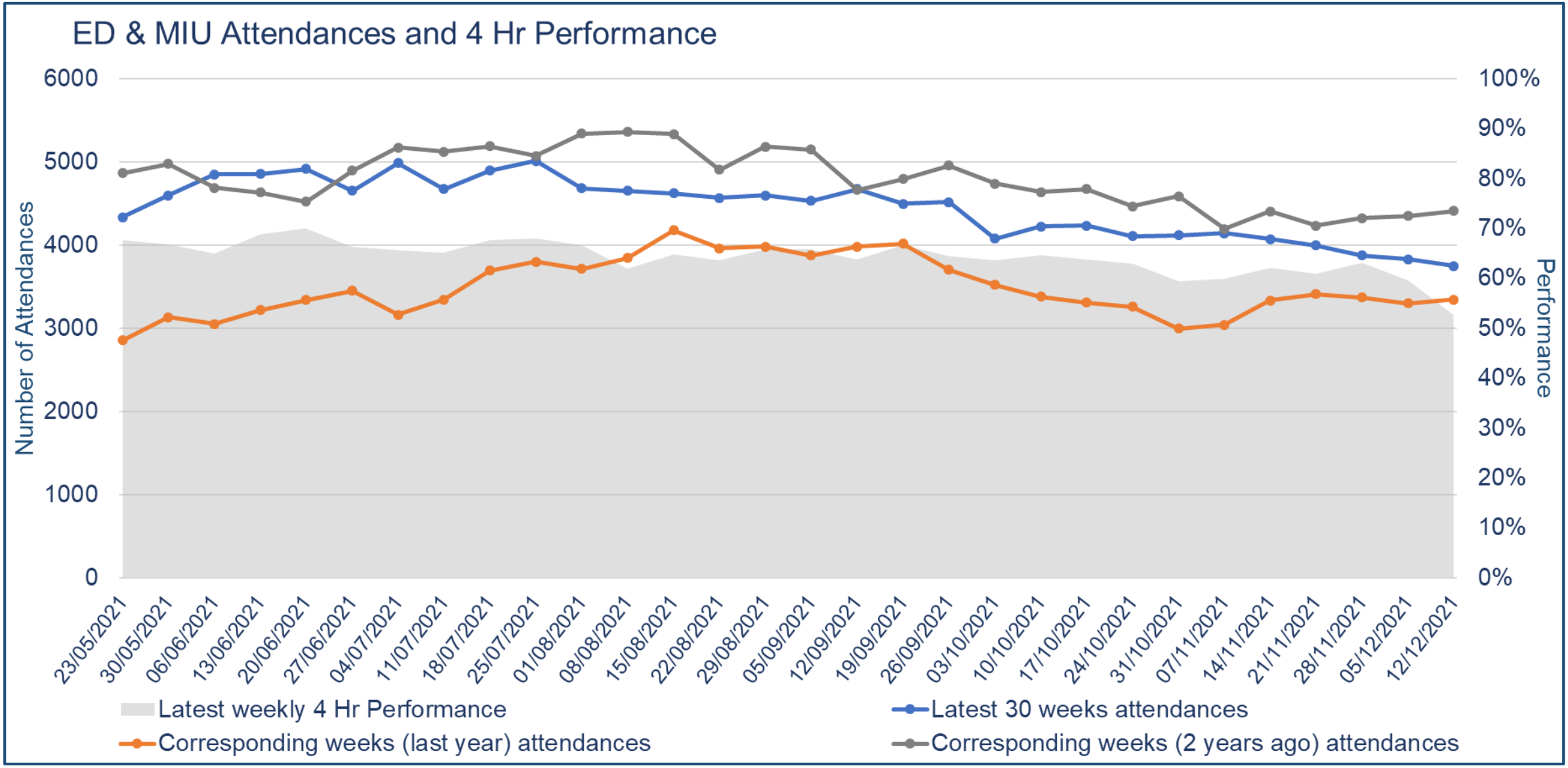
- The service delivery model and replication of predominantly bed-based services will continue to result in challenges in respect of rotas.
- It is acknowledged that there is a UK shortage of nurses (band 5 in particular), therefore recruitment campaigns will reduce rather than eradicate the vacancy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

What are the mitigations in place for those risks?

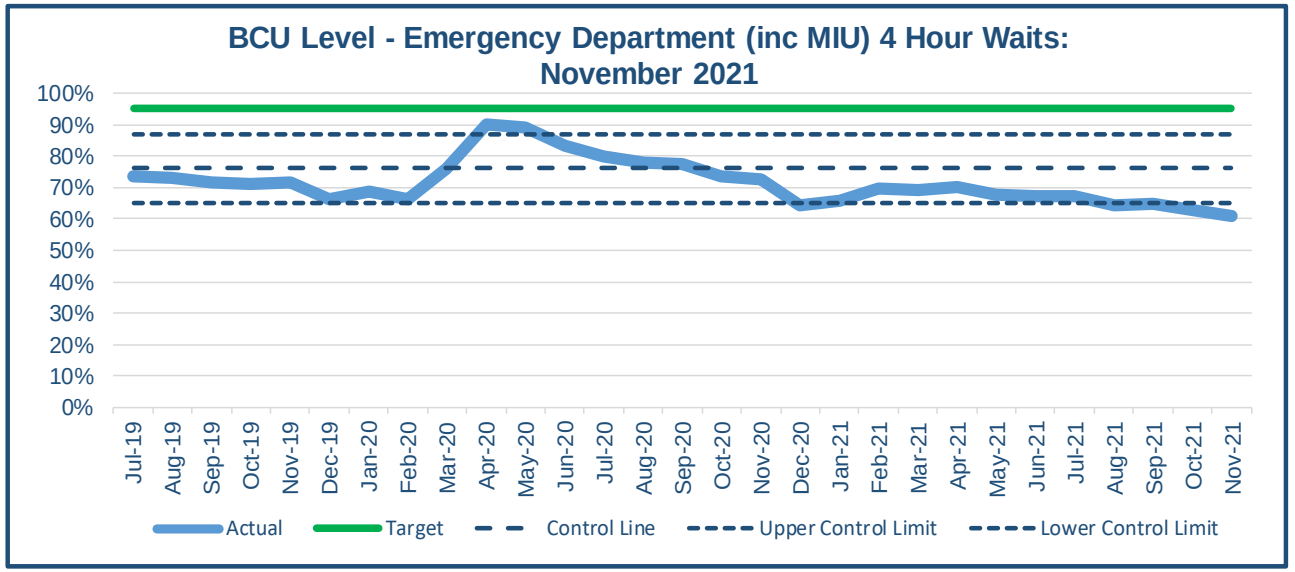
- The Clinical Workforce Service reviews alongside new recruitment initiatives ensure wherever possible pathways are aligned and aware of existing and future workforce challenges.
- Targeted support for overseas clinicians in place to focus on ensuring fast-track settlement period to mitigate any impact prolonged delay due to COVID-19 restrictions.
- Increased recruitment to identified hotspots with the implementation of the recruitment pipeline report and nursing workforce dashboard.

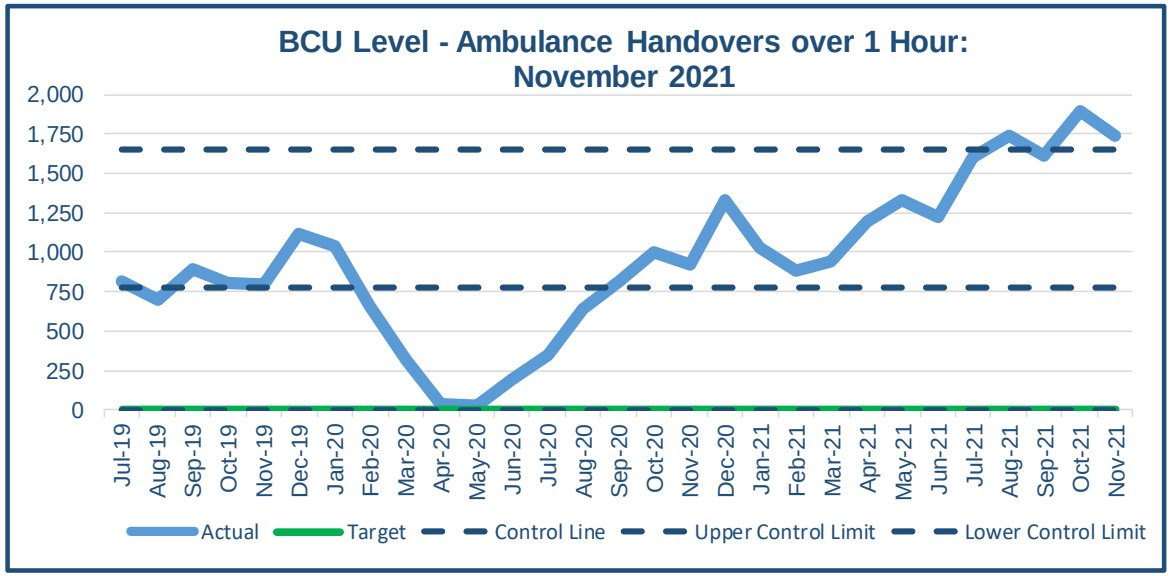
Additional Information

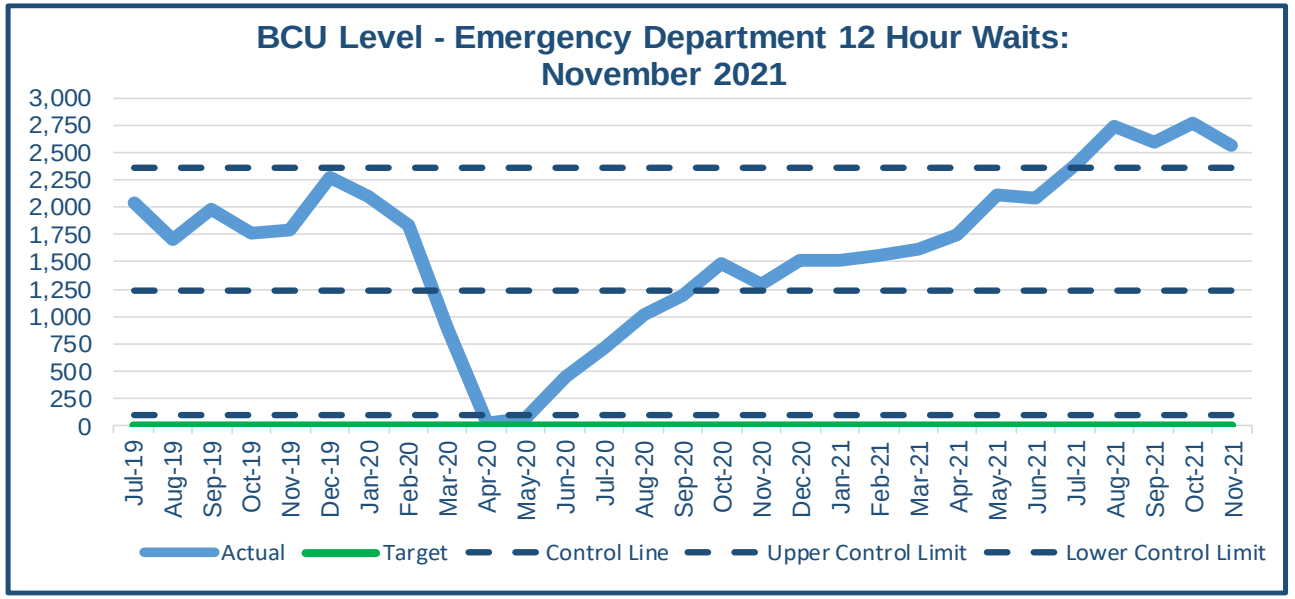
Quadruple Aim 2: Unscheduled Care: Attendances (1)



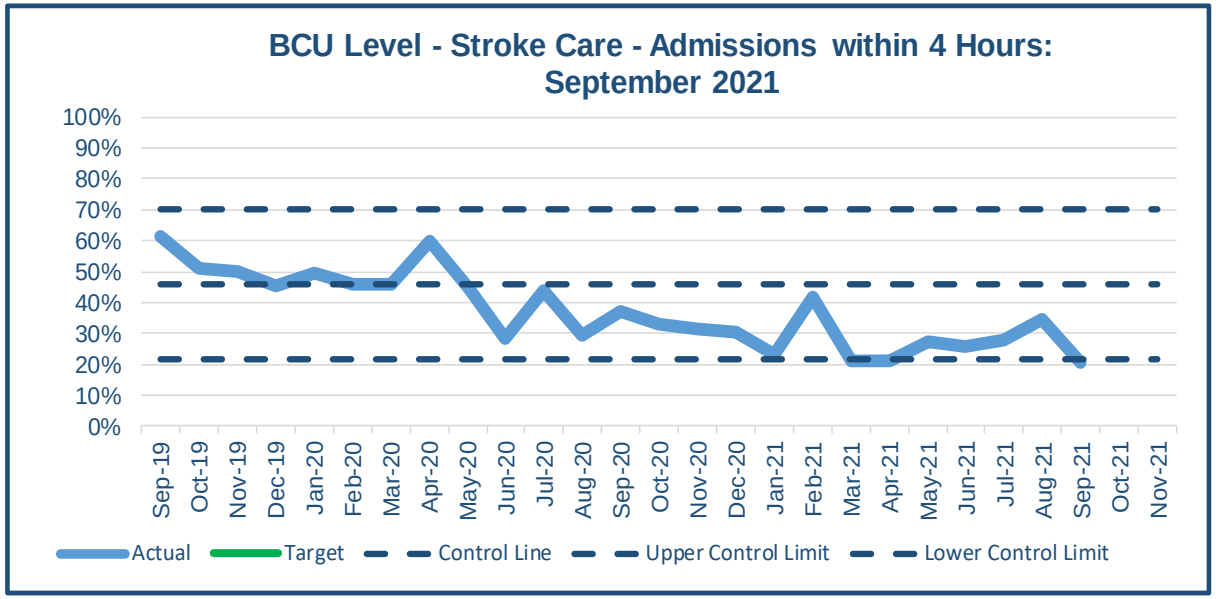
Quadruple Aim 2: Unscheduled Care (2)

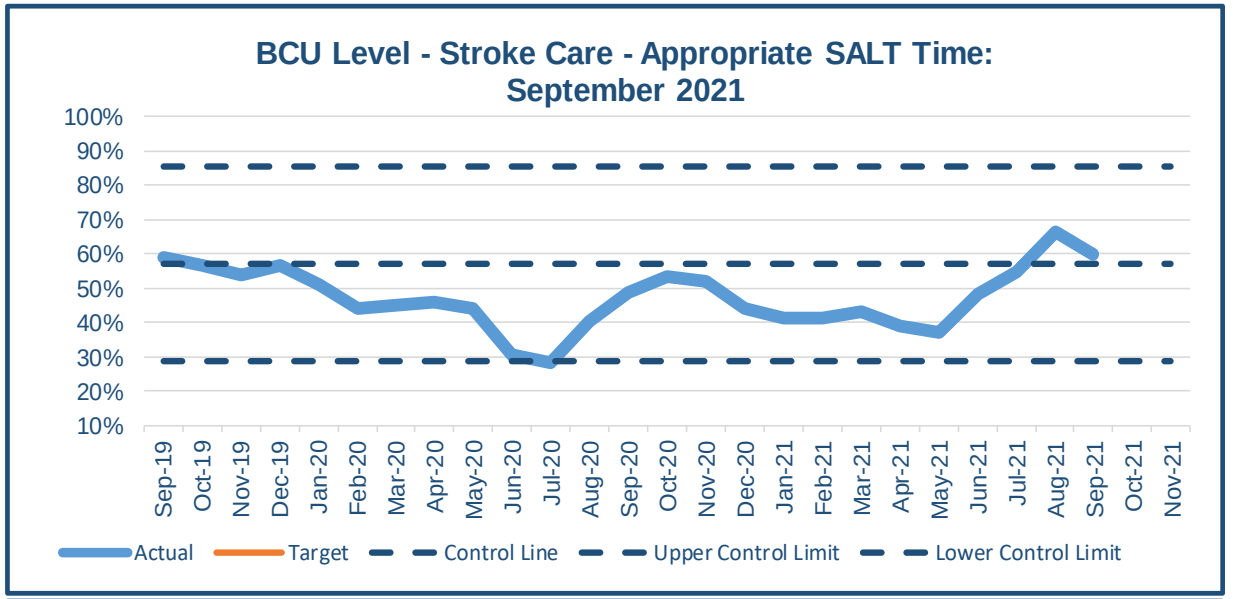


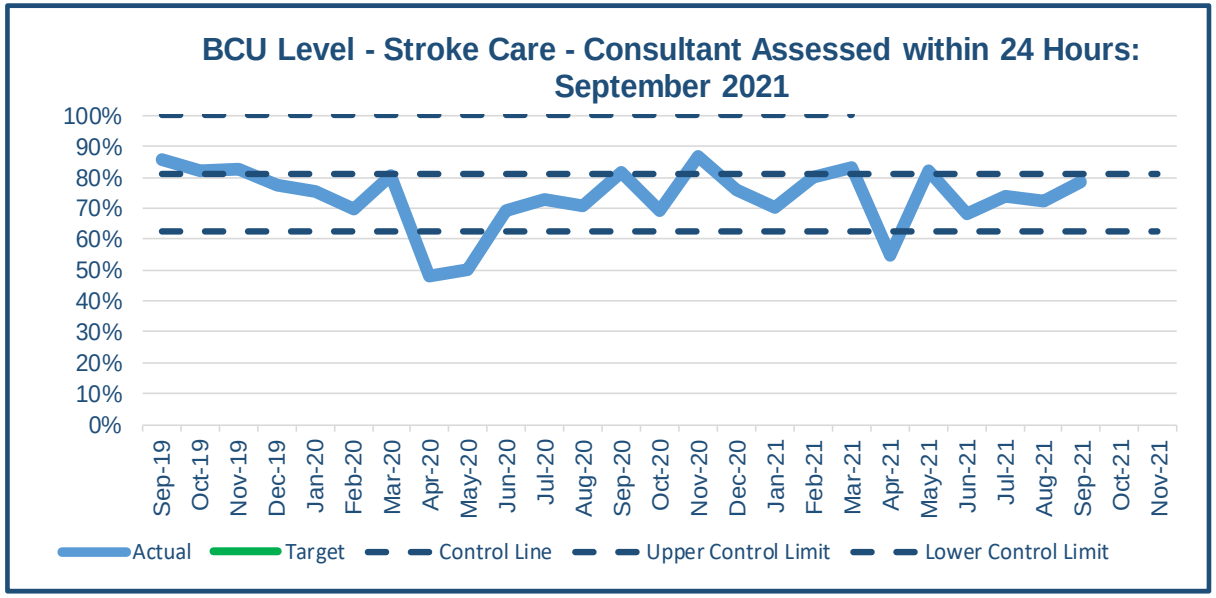


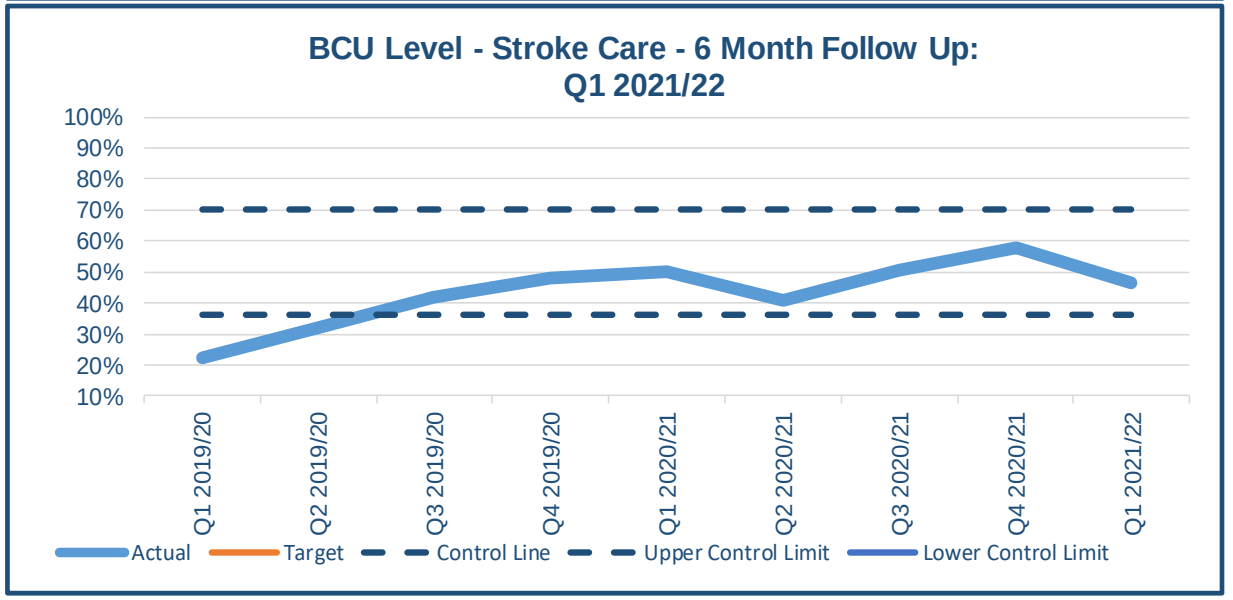


Quadruple Aim 2: Unscheduled Care (3)

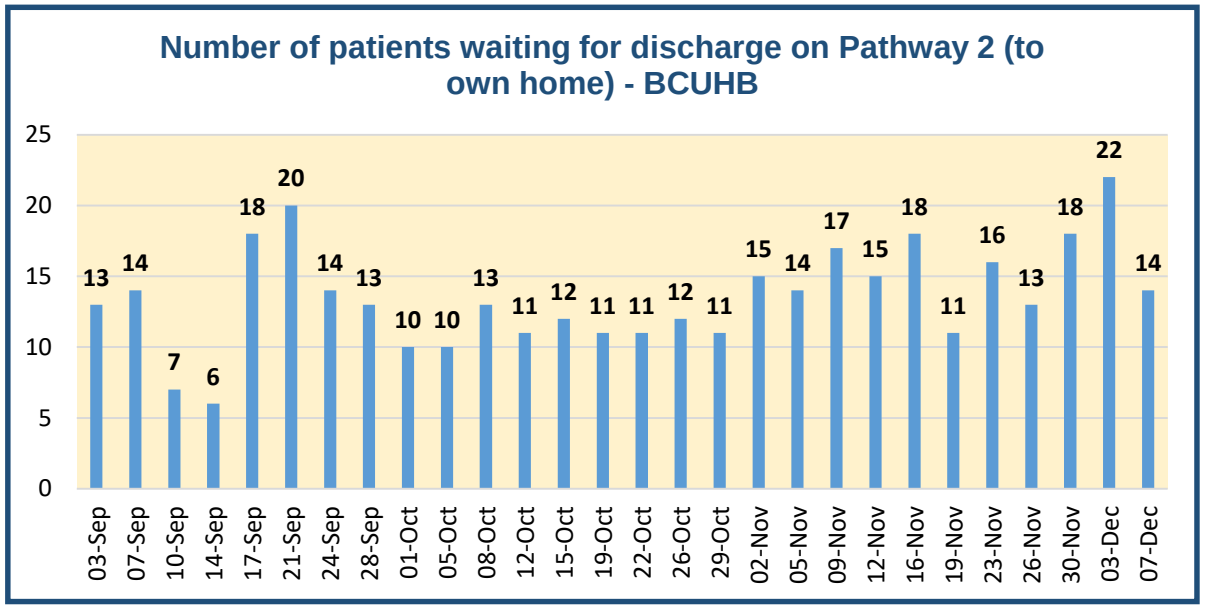


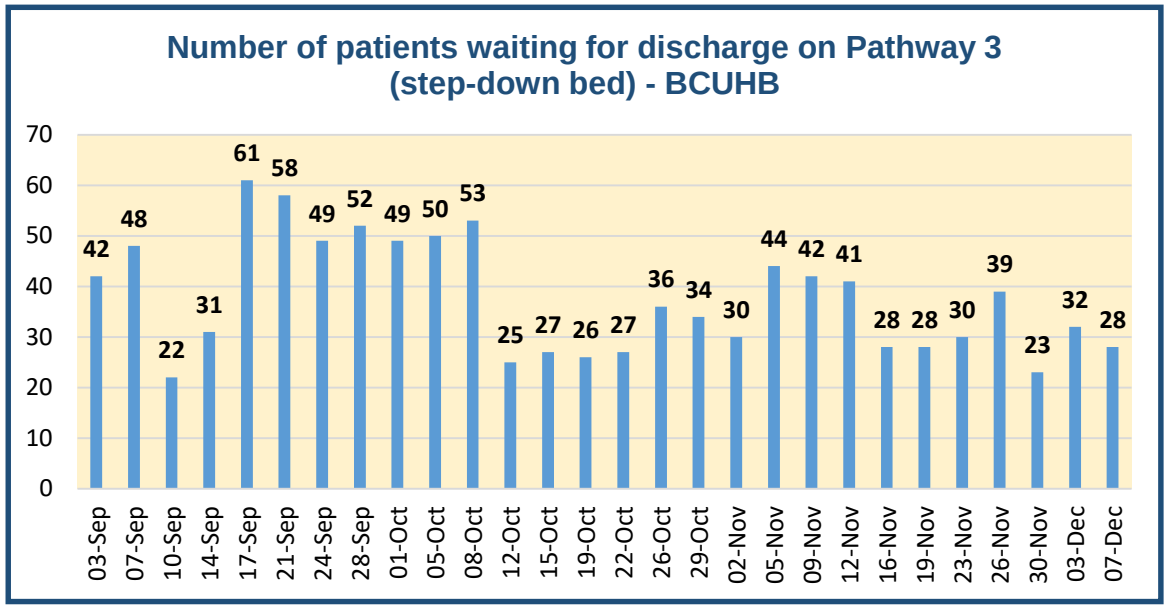


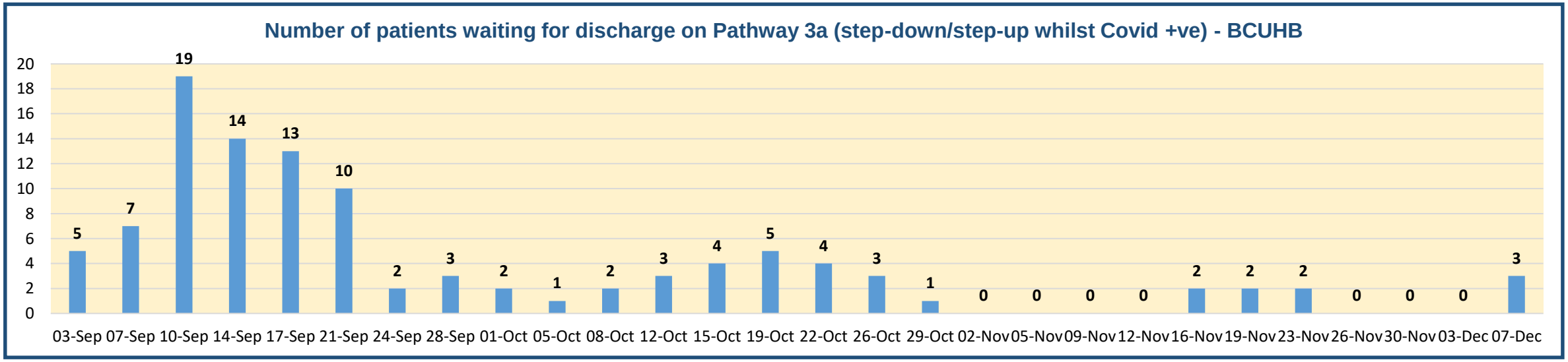




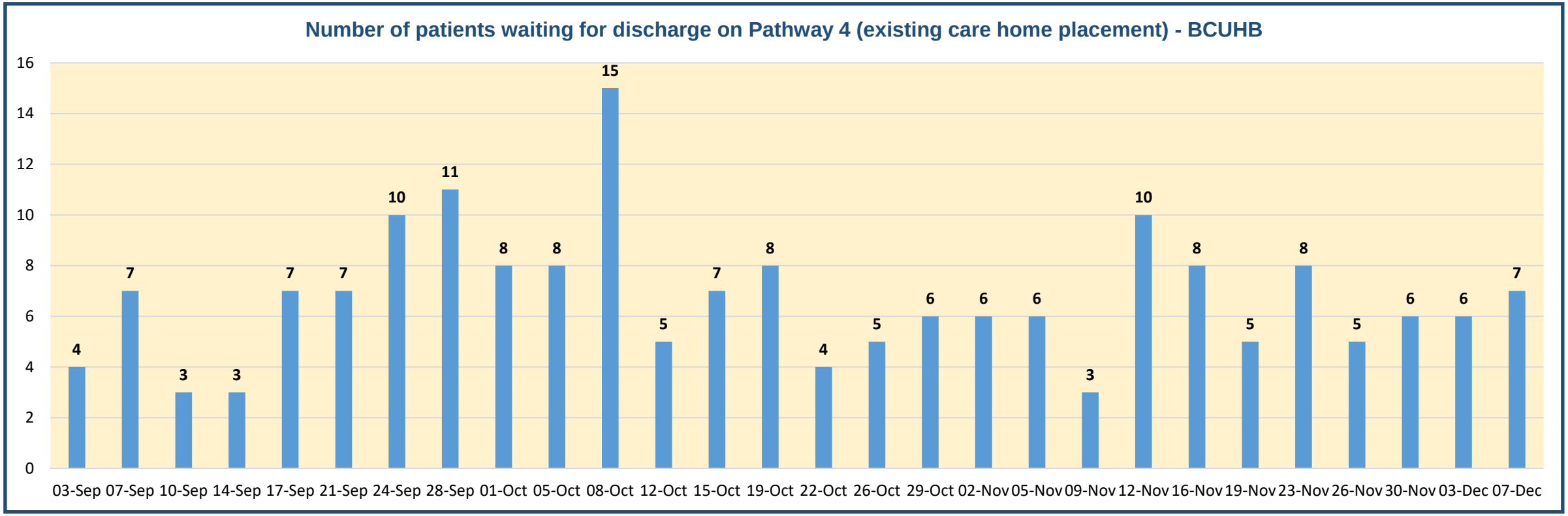
Quadruple Aim 2: Unscheduled Care (3)







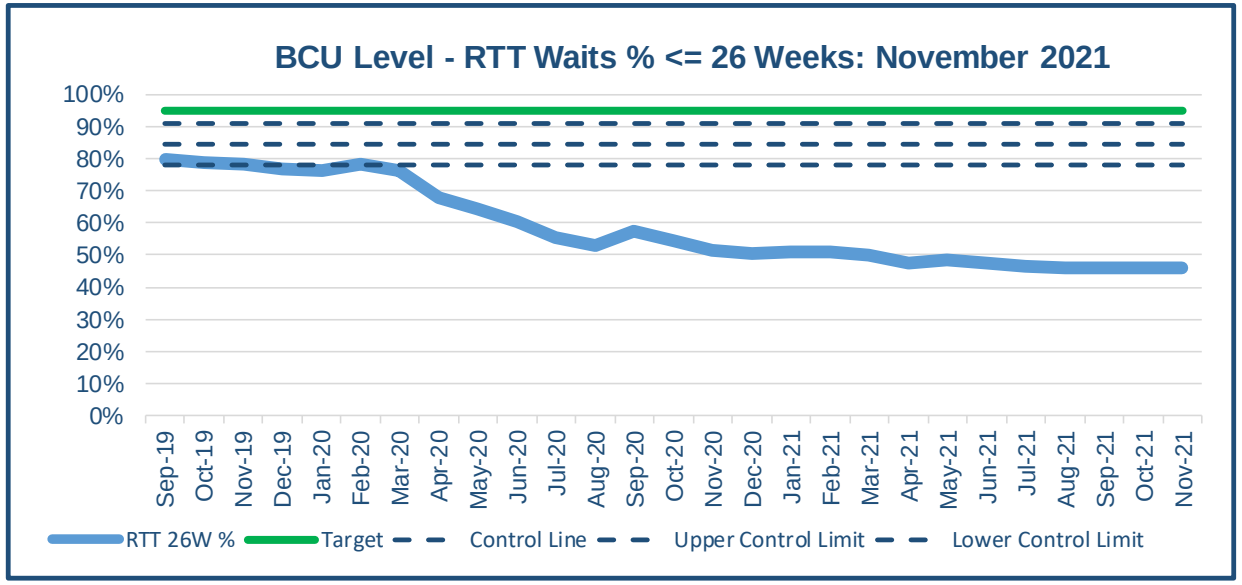
Quadruple Aim 2: Unscheduled Care (3)

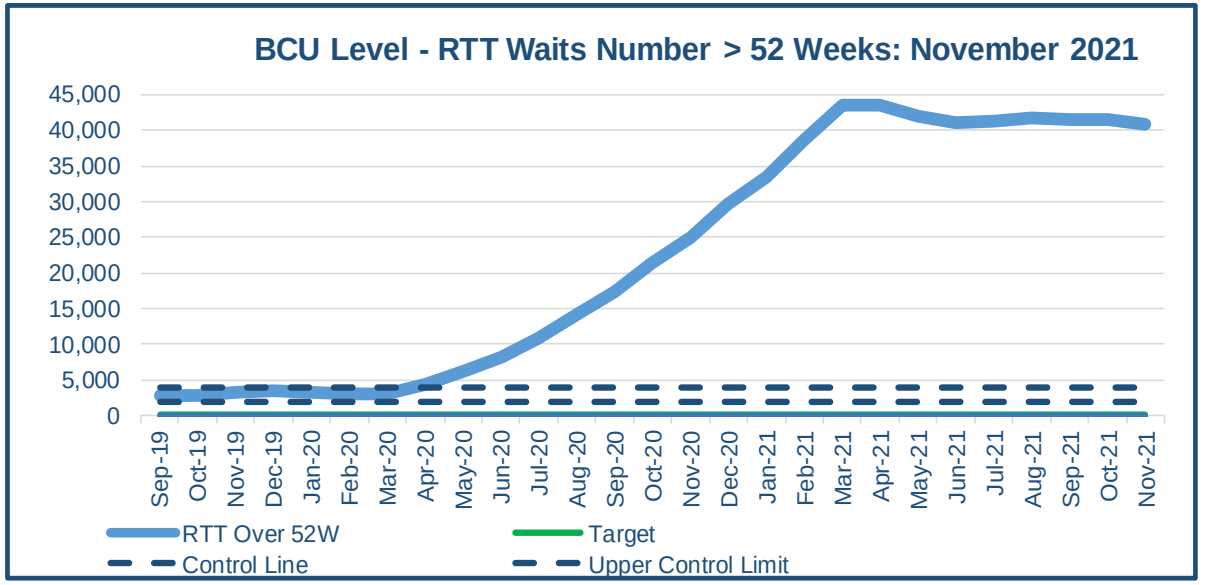


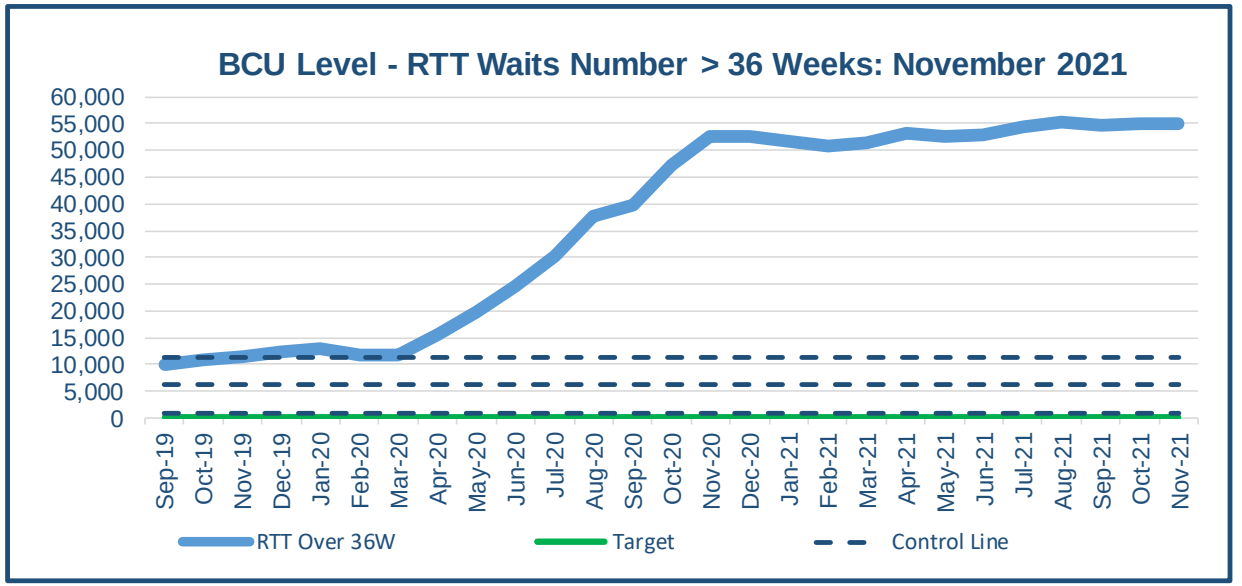
The Discharge and Flow slides demonstrate the numbers of patient delayed at the twice weekly census points (Tuesday & Friday) on Discharge to Recover then Assess (D2RA) Pathways 2, 3, 3a and 4. Further information on the D2RA process can be found at: [Hospital discharge service requirements: COVID-19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

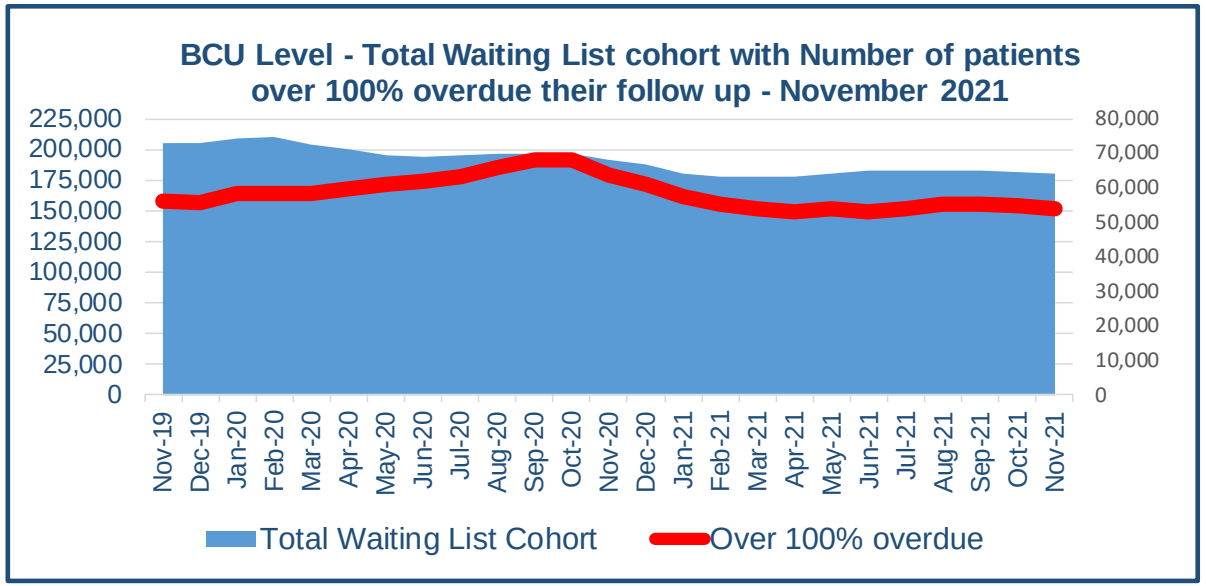
N.B.: These pathways **do not** include Mental Health patients

Quadruple Aim 2: Planned Care (1)



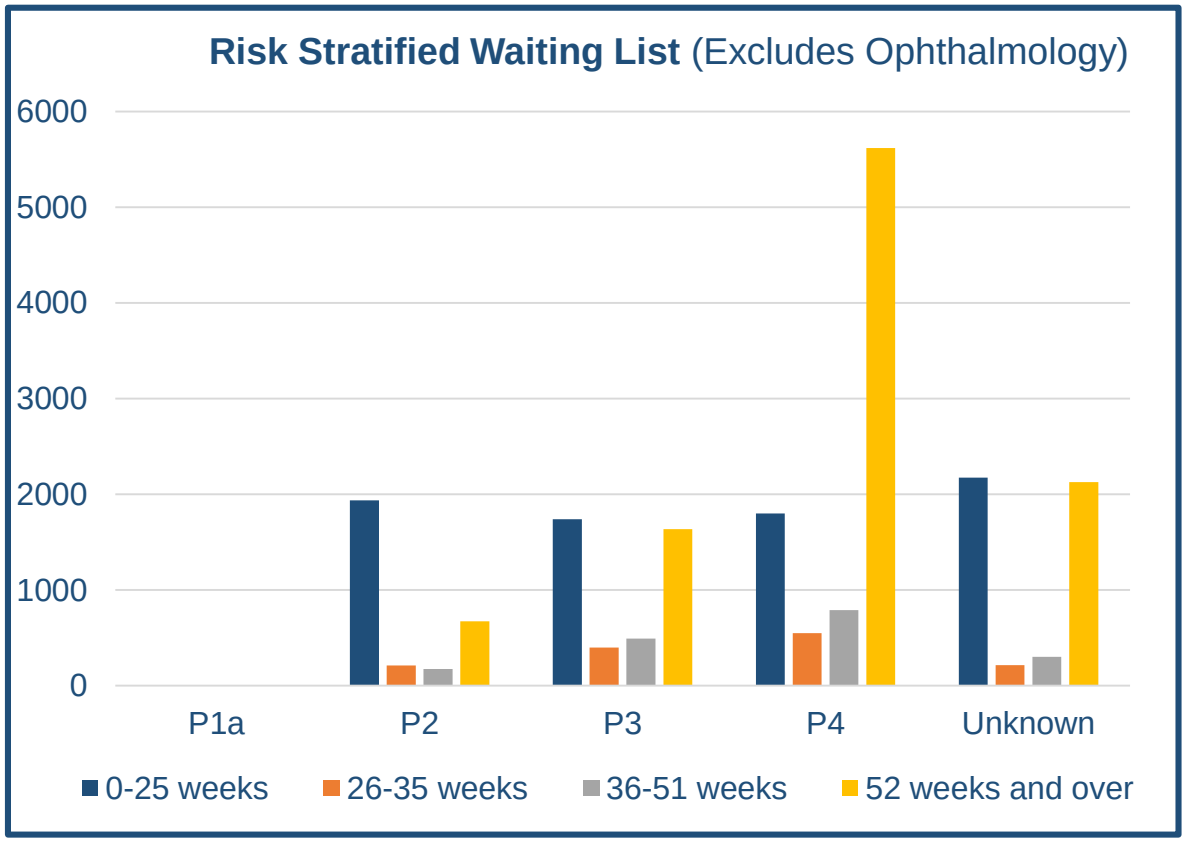




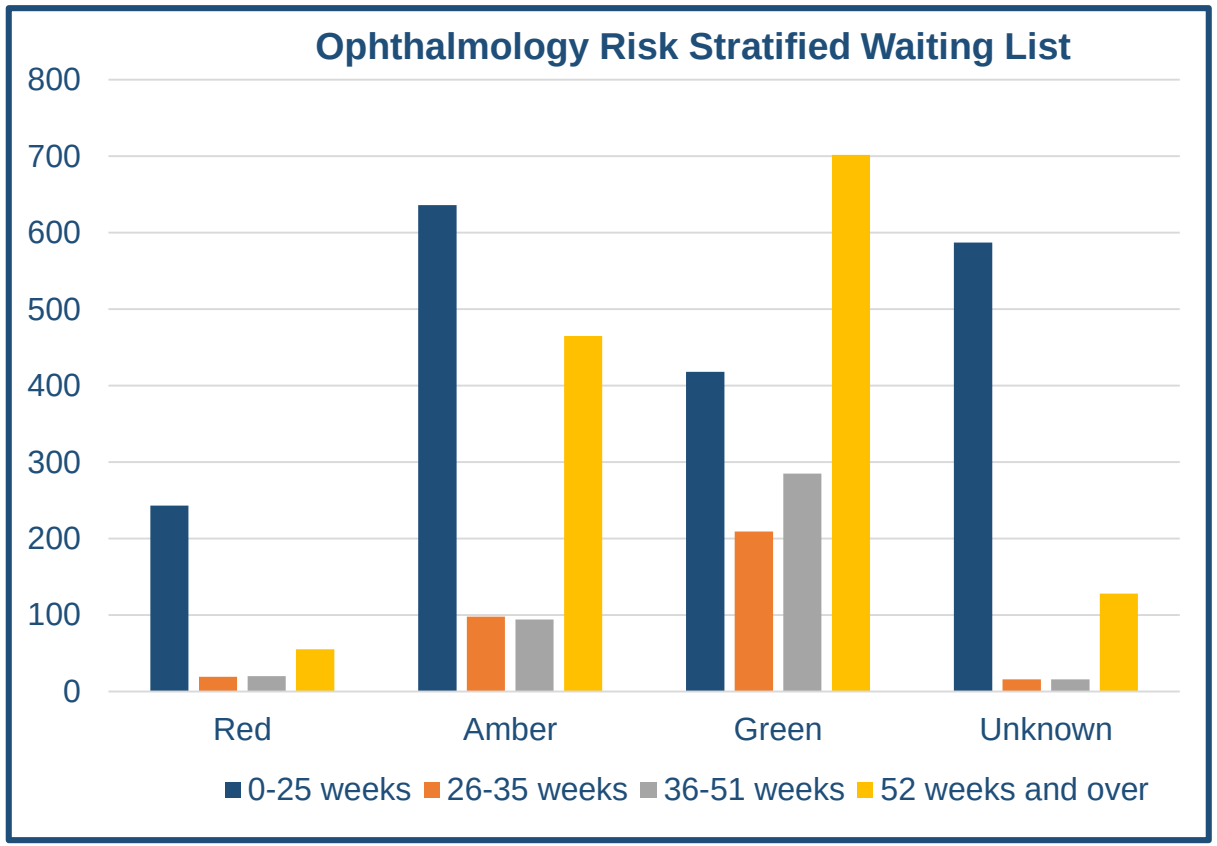


Quadruple Aim 2: Planned Care (2)

Waiting List by Risk Stratification

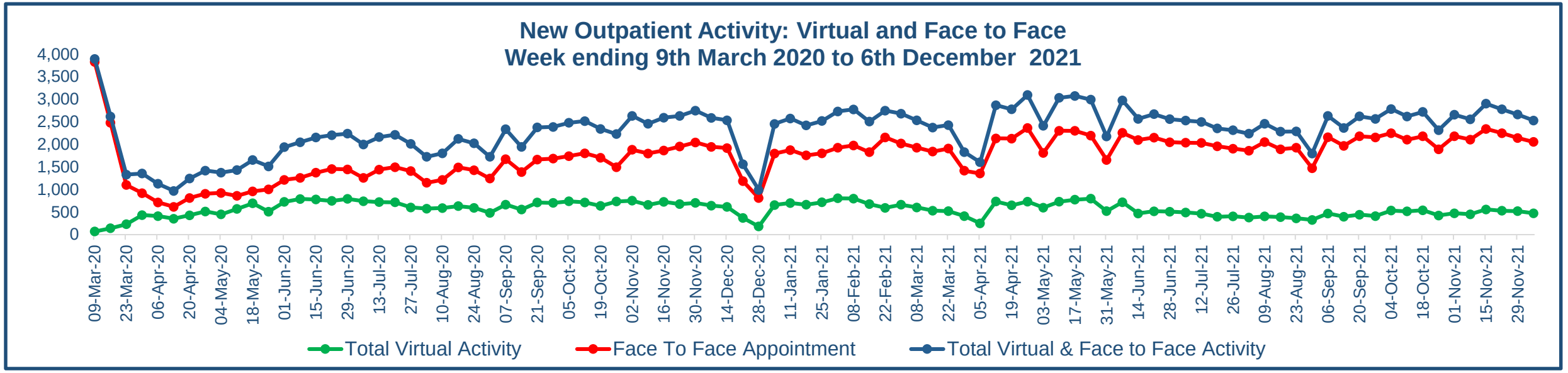


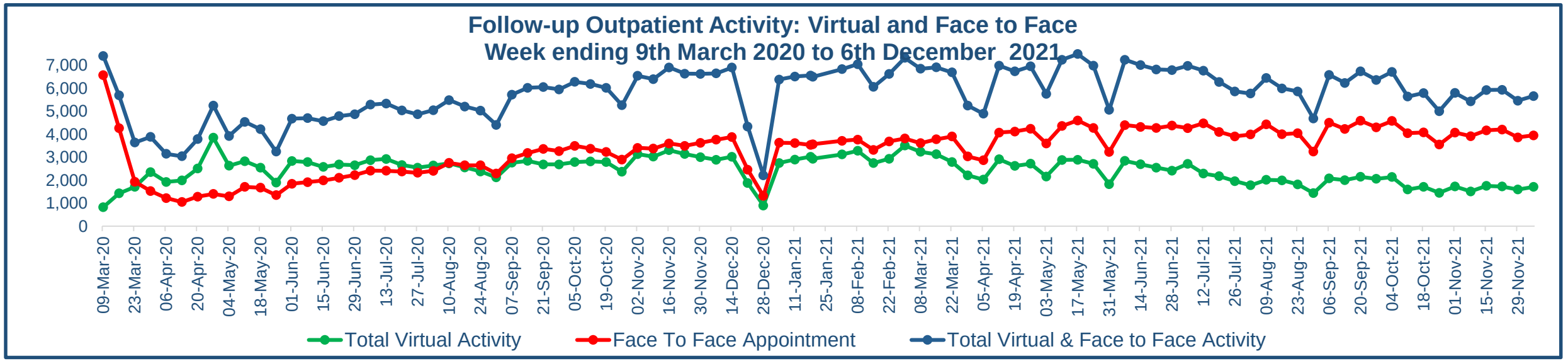
Source BCU HB IRIS : Accessed 15:30pm 13th December 2021
Data includes Admissions Waiting List for all specialties and excludes Ophthalmology



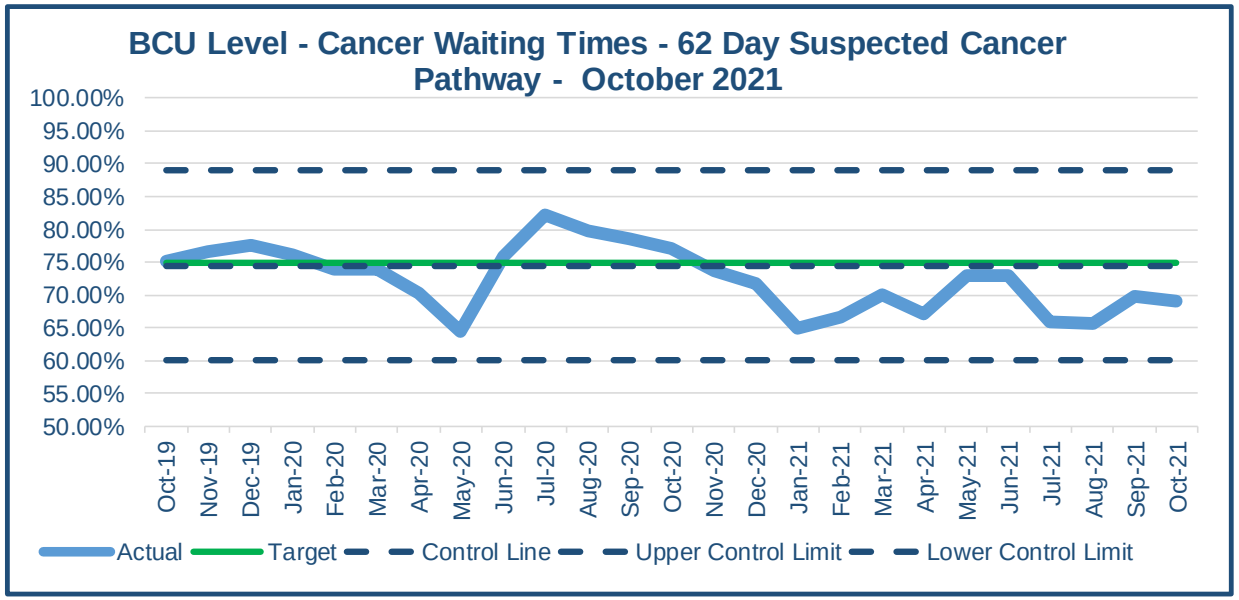
Source BCU HB IRIS :Accessed 15:30pm 13th December 2021
Data includes Waiting List for Ophthalmology Only

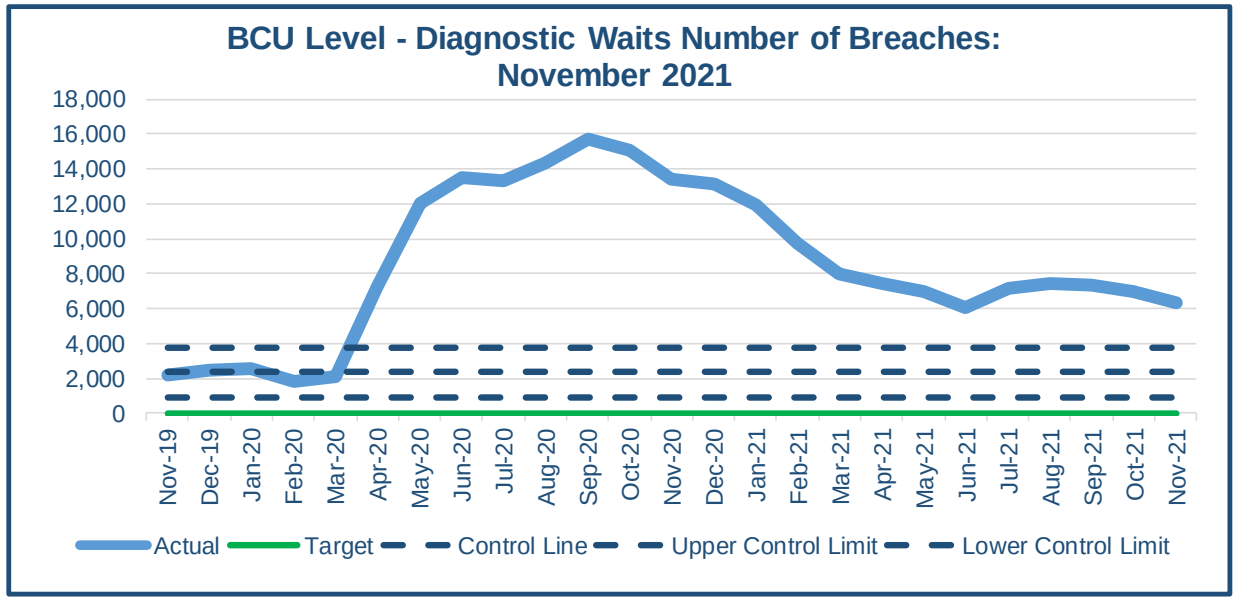
Quadruple Aim 2: Charts Planned Care (3)

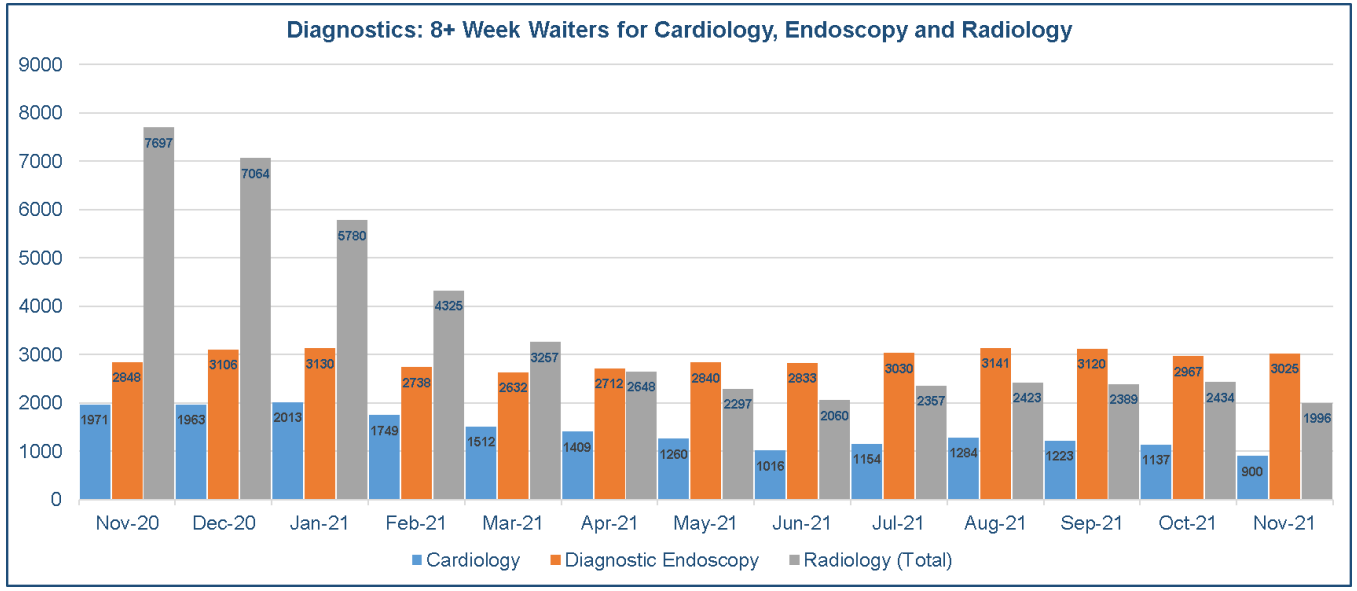




Quadruple Aim 2: Planned Care (5)

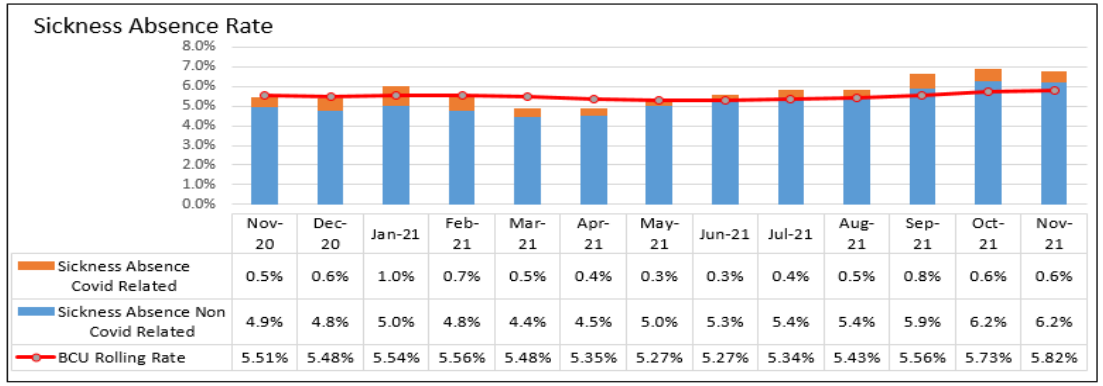




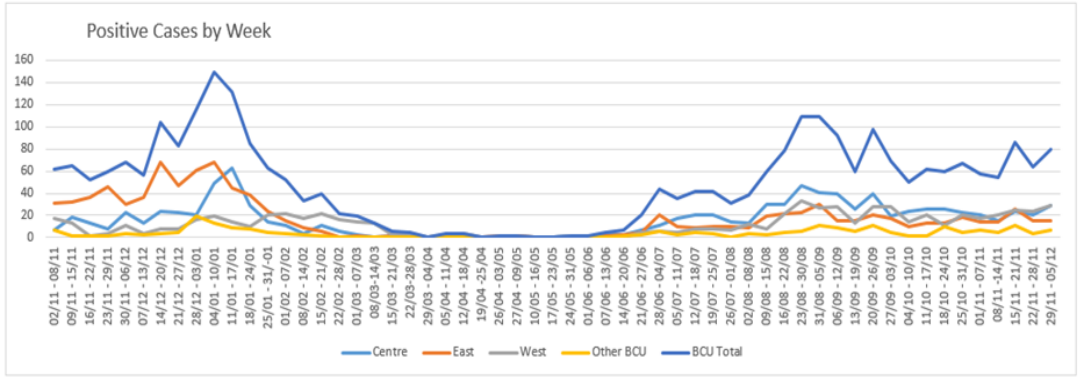


Quadruple Aim 3: Charts

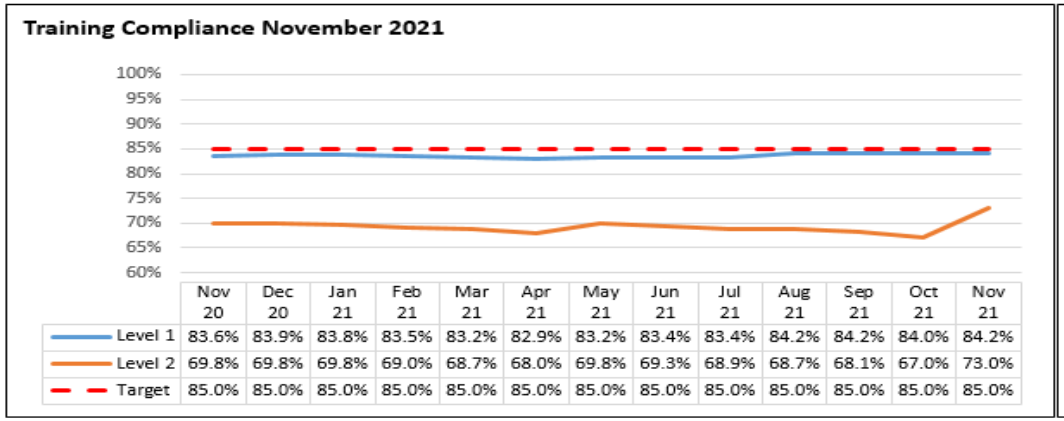
Sickness absence Rates



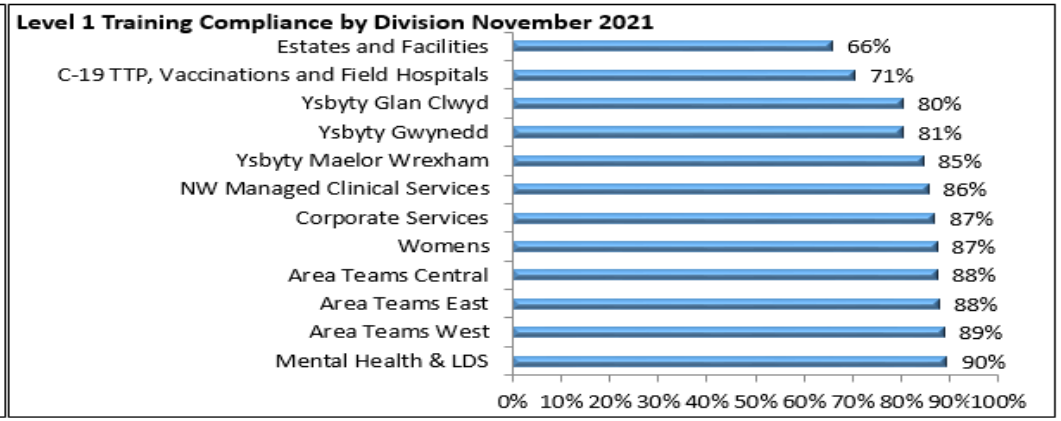
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Sickness Absence Covid Related	0.5%	0.6%	1.0%	0.7%	0.5%	0.4%	0.3%	0.3%	0.4%	0.5%	0.8%	0.6%	0.6%
Sickness Absence Non Covid Related	4.9%	4.8%	5.0%	4.8%	4.4%	4.5%	5.0%	5.3%	5.4%	5.4%	5.9%	6.2%	6.2%
BCU Rolling Rate	5.51%	5.48%	5.54%	5.56%	5.48%	5.35%	5.27%	5.27%	5.34%	5.43%	5.56%	5.73%	5.82%



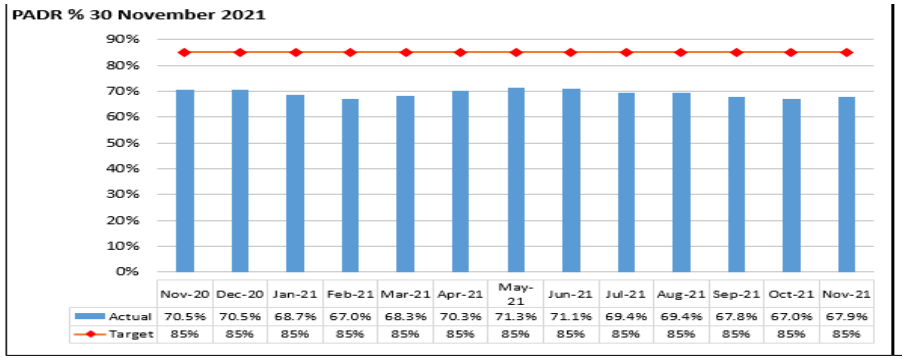
Core Mandatory Training Rate



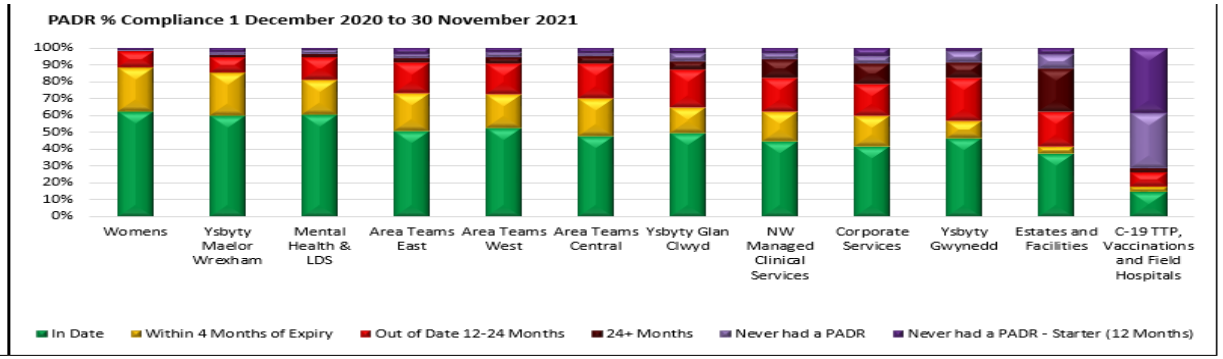
	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21
Level 1	83.6%	83.9%	83.8%	83.5%	83.2%	82.9%	83.2%	83.4%	83.4%	84.2%	84.2%	84.0%	84.2%
Level 2	69.8%	69.8%	69.8%	69.0%	68.7%	68.0%	69.8%	69.3%	68.9%	68.7%	68.1%	67.0%	73.0%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



PADR



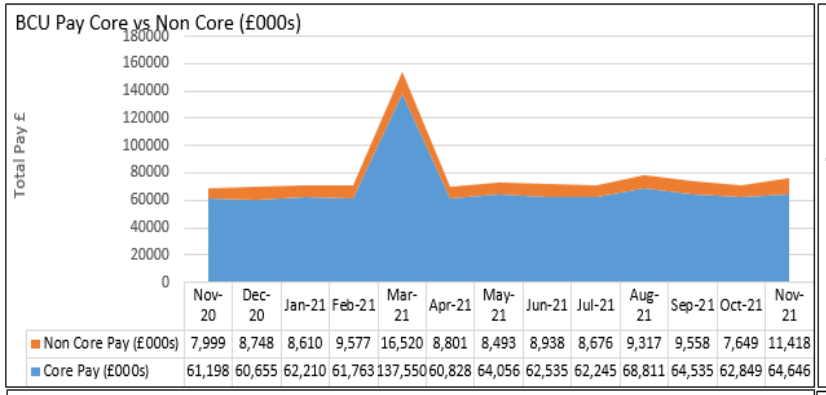
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Actual	70.5%	70.5%	68.7%	67.0%	68.3%	70.3%	71.3%	71.1%	69.4%	69.4%	67.8%	67.0%	67.9%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%



Data for November 2021 (unless stated otherwise)
Presented on 23rd December 2021

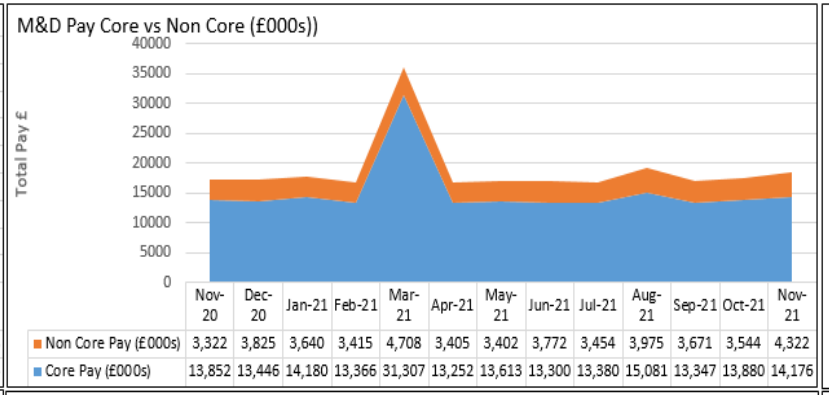
Quadruple Aim 4: Charts

BCU Pay Core vs Non Core (£000s)



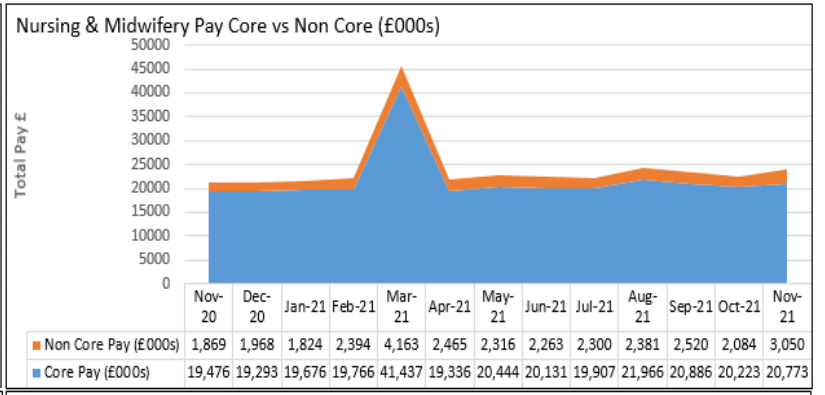
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Non Core Pay (£000s)	7,999	8,748	8,610	9,577	16,520	8,801	8,493	8,938	8,676	9,317	9,558	7,649	11,418
Core Pay (£000s)	61,198	60,655	62,210	61,763	137,550	60,828	64,056	62,535	62,245	68,811	64,535	62,849	64,646

M&D Pay Core vs Non Core (£000s))



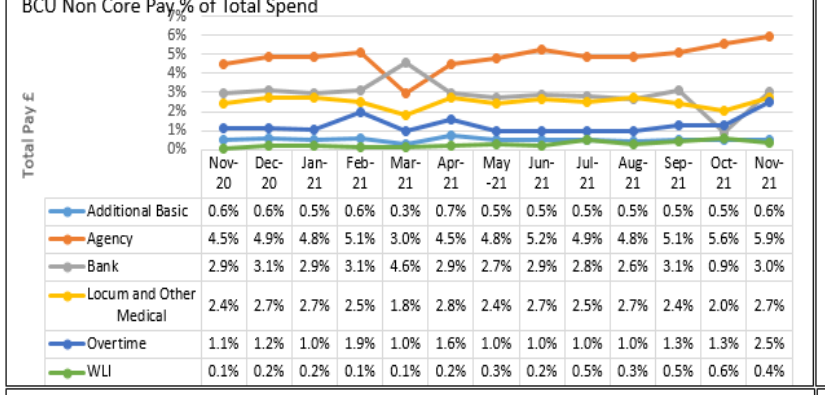
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Non Core Pay (£000s)	3,322	3,825	3,640	3,415	4,708	3,405	3,402	3,772	3,454	3,975	3,671	3,544	4,322
Core Pay (£000s)	13,852	13,446	14,180	13,366	31,307	13,252	13,613	13,300	13,380	15,081	13,347	13,880	14,176

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



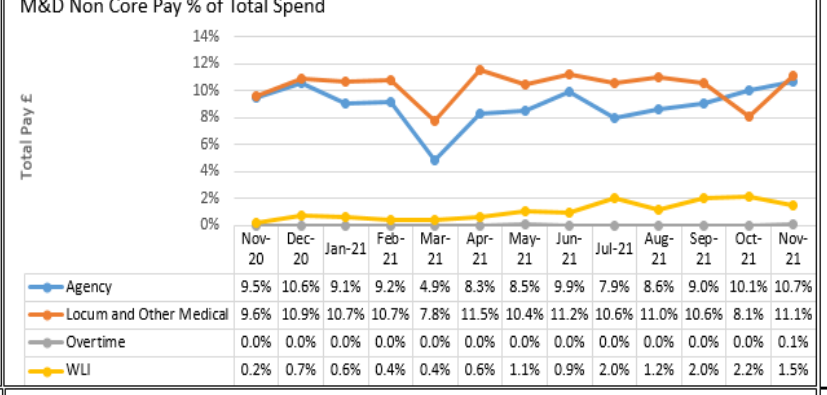
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Non Core Pay (£000s)	1,869	1,968	1,824	2,394	4,163	2,465	2,316	2,263	2,300	2,381	2,520	2,084	3,050
Core Pay (£000s)	19,476	19,293	19,676	19,766	41,437	19,336	20,444	20,131	19,907	21,966	20,886	20,223	20,773

BCU Non Core Pay % of Total Spend



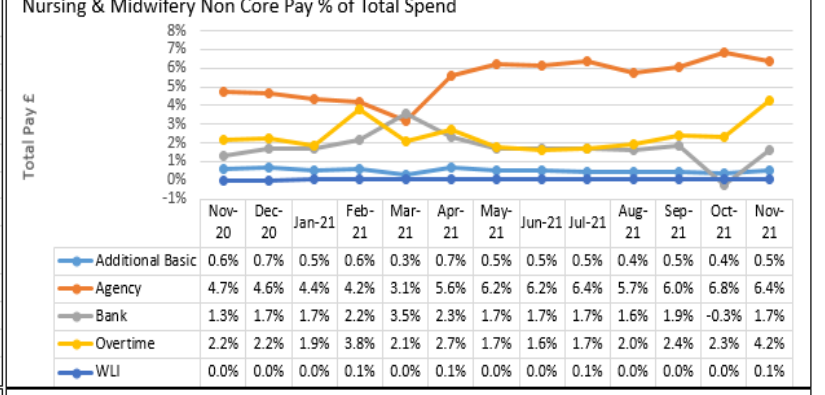
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Additional Basic	0.6%	0.6%	0.5%	0.6%	0.3%	0.7%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.6%
Agency	4.5%	4.9%	4.8%	5.1%	3.0%	4.5%	4.8%	5.2%	4.9%	4.8%	5.1%	5.6%	5.9%
Bank	2.9%	3.1%	2.9%	3.1%	4.6%	2.9%	2.7%	2.9%	2.8%	2.6%	3.1%	0.9%	3.0%
Locum and Other Medical	2.4%	2.7%	2.7%	2.5%	1.8%	2.8%	2.4%	2.7%	2.5%	2.7%	2.4%	2.0%	2.7%
Overtime	1.1%	1.2%	1.0%	1.9%	1.0%	1.6%	1.0%	1.0%	1.0%	1.0%	1.3%	1.3%	2.5%
WLI	0.1%	0.2%	0.2%	0.1%	0.1%	0.2%	0.3%	0.2%	0.5%	0.3%	0.5%	0.6%	0.4%

M&D Non Core Pay % of Total Spend



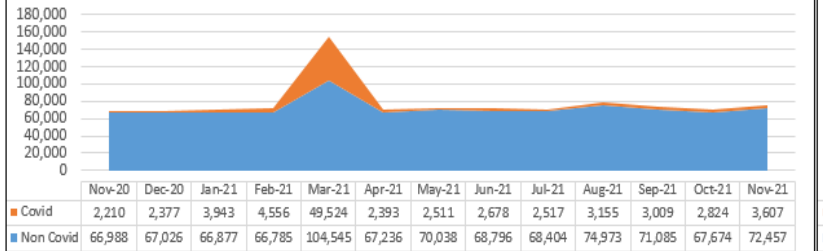
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Agency	9.5%	10.6%	9.1%	9.2%	4.9%	8.3%	8.5%	9.9%	7.9%	8.6%	9.0%	10.1%	10.7%
Locum and Other Medical	9.6%	10.9%	10.7%	10.7%	7.8%	11.5%	10.4%	11.2%	10.6%	11.0%	10.6%	8.1%	11.1%
Overtime	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
WLI	0.2%	0.7%	0.6%	0.4%	0.4%	0.6%	1.1%	0.9%	2.0%	1.2%	2.0%	2.2%	1.5%

Nursing & Midwifery Non Core Pay % of Total Spend



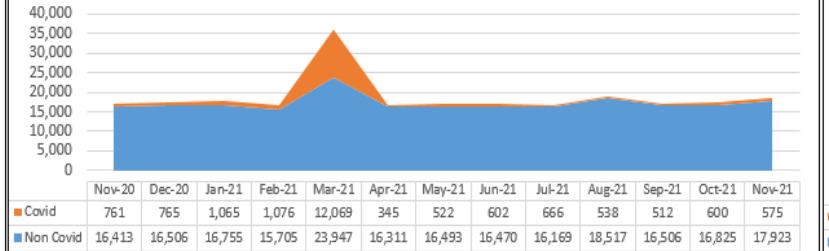
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Additional Basic	0.6%	0.7%	0.5%	0.6%	0.3%	0.7%	0.5%	0.5%	0.5%	0.4%	0.5%	0.4%	0.5%
Agency	4.7%	4.6%	4.4%	4.2%	3.1%	5.6%	6.2%	6.2%	6.4%	5.7%	6.0%	6.8%	6.4%
Bank	1.3%	1.7%	1.7%	2.2%	3.5%	2.3%	1.7%	1.7%	1.7%	1.6%	1.9%	-0.3%	1.7%
Overtime	2.2%	2.2%	1.9%	3.8%	2.1%	2.7%	1.7%	1.6%	1.7%	2.0%	2.4%	2.3%	4.2%
WLI	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%

BCU Covid v Non Covid Spend (£000s)



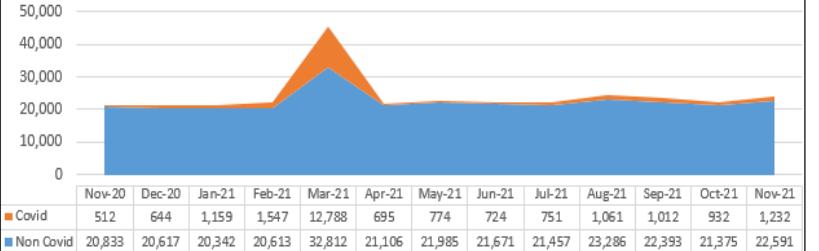
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Covid	2,210	2,377	3,943	4,556	49,524	2,393	2,511	2,678	2,517	3,155	3,009	2,824	3,607
Non Covid	66,988	67,026	66,877	66,785	104,545	67,236	70,038	68,796	68,404	74,973	71,085	67,674	72,457

M&D Covid v Non Covid Spend (£000s)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Covid	761	765	1,065	1,076	12,069	345	522	602	666	538	512	600	575
Non Covid	16,413	16,506	16,755	15,705	23,947	16,311	16,493	16,470	16,169	18,517	16,506	16,825	17,923

Nursing & Midwifery Covid v Non Covid Spend (£000s)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Covid	512	644	1,159	1,547	12,788	695	774	724	751	1,061	1,012	932	1,232
Non Covid	20,833	20,617	20,342	20,613	32,812	21,106	21,985	21,671	21,457	23,286	22,393	21,375	22,591

*Please note there is an anomaly for Oct-21 Bank Spend figure for BCU Non Core Pay and Nursing & Midwifery Non Core Pay charts. This is due to the unused element of the COVID-19 bonus accrual from the last financial year being realigned.

Data for November 2021 (unless stated otherwise)
Presented on 23rd December 2021

Further Information

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Cyfarfod a dyddiad: Meeting and date:	**Performance, Finance and Information Governance Committee 23.12.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Finance Report months 8 and 7 2021/22**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad Report Author:	Tim Woodhead, Operational Finance Director
Craffu blaenorol: Prior Scrutiny:	Executive Director of Finance
Atodiadau Appendices:	Appendix 1: Finance Report Packs months 8 and 7 Appendix 2: Performance Tracker

Argymhelliad / Recommendation:

It is asked that the report is noted.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

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

Sefyllfa / Situation:

The purpose of this report is to provide a briefing on the draft unaudited financial performance of the Health Board as at 30th November 2021.

Cefndir / Background:

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

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

We have tested our assumptions in the original plans and refreshed our forecasts accordingly with the divisional teams and will continue to do so as the operational position develops. As part of this refresh of forecasts, the Health Board identified that £10.2m worth of resources would not be utilised due to delays in recruitment and the cancellation of some services due to the on-going COVID-19 pandemic.

These resources have therefore been returned to Welsh Government.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

Not applicable – report is for assurance only

Goblygiadau Ariannol / Financial Implications

	Month 8 £m	YTD £m	Forecast £m
Actual Position	0.0	0.0	0.0
Planned Position	0.0	0.0	0.0
Variance	0.0	0.0	0.0

The in-month position is break even, which also brings the cumulative position to break even. This reflects the additional funding announced in the touchpoint meeting with Welsh Government, as well as the £10.2m agreed to be returned in month 8.

The total impact of COVID-19 in November is £9.2m (£77.7m for the year to date). Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

Dadansoddiad Risk / Risk Analysis

There are three risks to the financial position, all of which are yet to be determined. These risks are in relation to the recruitment of staff; pay awards not being fully funded and increased energy prices.

BCU risks are reported separately via the Risk Register.

There are two opportunities, one in relation to potential future one off accountancy gains and another in relation to a risk of not being to utilise additional funding provided by Welsh Government.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Not applicable.

Asesiad Effaith / Impact Assessment

Not applicable.

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

Finance Report
November 2021: M08-22

Sue Hill

Executive Director of Finance

Executive Summary

Objective

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

Positives & Key Assurances

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

Issues & Actions

- ➢ The updated forecast identified that £10.2m of resources available to the Health Board was unlikely to be spent due to delays in recruitment and the restriction of services due to the continuing COVID-19 pandemic.
- ➢ The Health Board has informed WG that it will return this funding and this has been accepted. This report takes into account the return this resource.

Key Messages

- ❖ The cumulative financial position and forecast outturn position for 2021/22 remain balanced.
- ❖ The Health Board has received additional funding totalling £32.7m to cover the impact of the undelivered savings from 2020/21, which covers the financial risk for the year that was identified in the draft financial plan.
- ❖ Expenditure related to the £42.0m funding for the Performance Fund and Strategic Support, plus the £19.9m COVID-19 Recovery Plan funding is included in forecasts based on submitted plans. The full utilisation of this funding to improve performance, reduce waiting lists and drive a programme of transformation is dependent on operational teams implementing approved plans at pace. See appendix 2 for further detail.

Summary of Key Numbers

Month 08 Position

Break even position in month.
Balanced

Cumulative position is break even.
Balanced

Forecast

Reflects Accountable Officer letter returning £10.2m to Welsh Government

Balanced

Divisional Performance Mth 08

Area Teams	£1.6m favourable
Secondary Care	£0.7m adverse
Mental Health	£0.5m favourable
Corporate	£0.8m adverse
Other	£0.6m adverse

Savings

In-month: £2.1m against plan of £1.4m
£0.7m favourable

YTD: £11.4m against plan of £11.3m
£0.1m adverse

Savings Forecast

£17.3m against plan of £17.0m

This is an increase of £0.7m compared to month 7

£0.3m favourable

COVID-19 Impact

£77.7m cost YTD
£131.8m forecast cost
Funded by Welsh Government

£nil impact

Income

£96.0m against budget of £98.7m

£2.7m favourable

Pay

£572.5m against budget of £567.7m

£4.8m favourable

Non-Pay

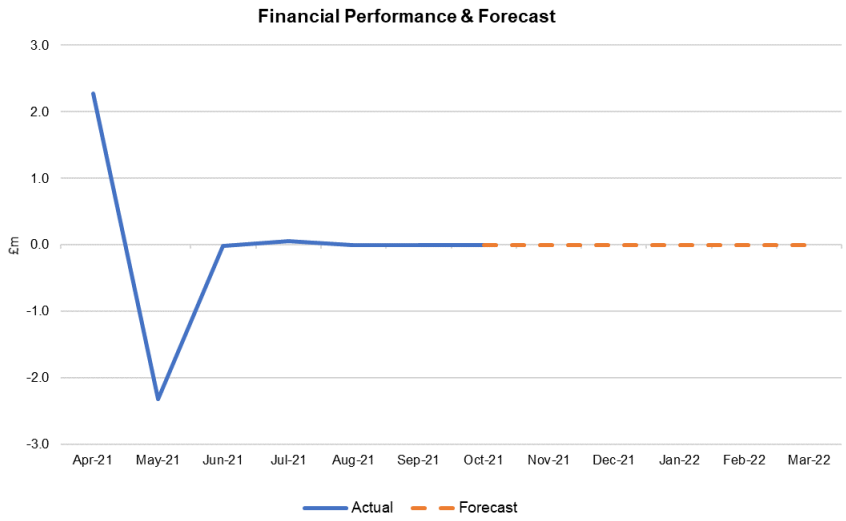
£706.6m against budget of £699.1m

£7.5m adverse

Revenue Position

- The in-month and cumulative position is breakeven. This is after the return of £10.2m or resources that the Health Board identified that it would not be able to utilise.
- The Revenue Resource Limit can be defined as the amount of revenue expenditure, net of income, that the Health Board is allowed to incur.

	Actual								Cumulative				Forecast
	M01	M02	M03	M04	M05	M06	M07	M08	Budget	Actual	Variance	Variance	Actual
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%	£m
Revenue Resource Limit	(136.7)	(147.2)	(147.1)	(148.3)	(151.4)	(148.0)	(145.8)	(151.1)	(1,175.6)	(1,175.6)	0.0	0.0%	(1,822.0)
Miscellaneous Income	(12.1)	(11.6)	(11.7)	(10.6)	(12.2)	(12.4)	(15.4)	(12.7)	(96.0)	(98.7)	2.7	(2.8)%	(143.7)
Health Board Pay Expenditure	68.2	70.2	69.7	69.0	76.1	71.9	68.6	74.0	572.5	567.7	4.8	0.8%	865.4
Non-Pay Expenditure	82.8	86.3	89.1	90.0	87.5	88.5	92.6	89.8	699.1	706.6	(7.5)	(1.1)%	1,100.3
Total	2.2	(2.3)	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0

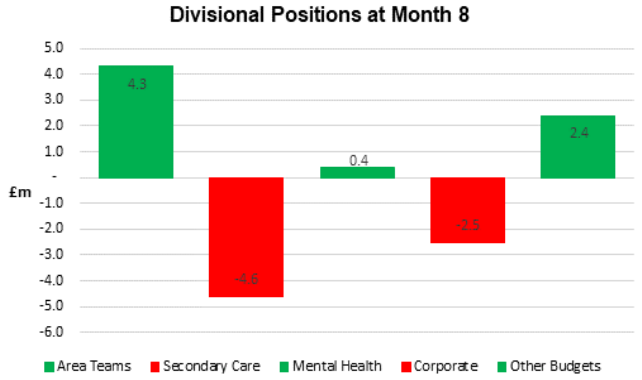


- The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.
- In line with all NHS organisations in Wales, the plan was revised during Quarter 1 to refine and develop the triangulation of activity, workforce and financial plans, while maintaining the focus on the six key objectives described in the draft plan. We continue to refreshed our forecasts as the operational position develops, although these plans will need to adapt for further waves of COVID-19 pandemic.

Divisional Positions

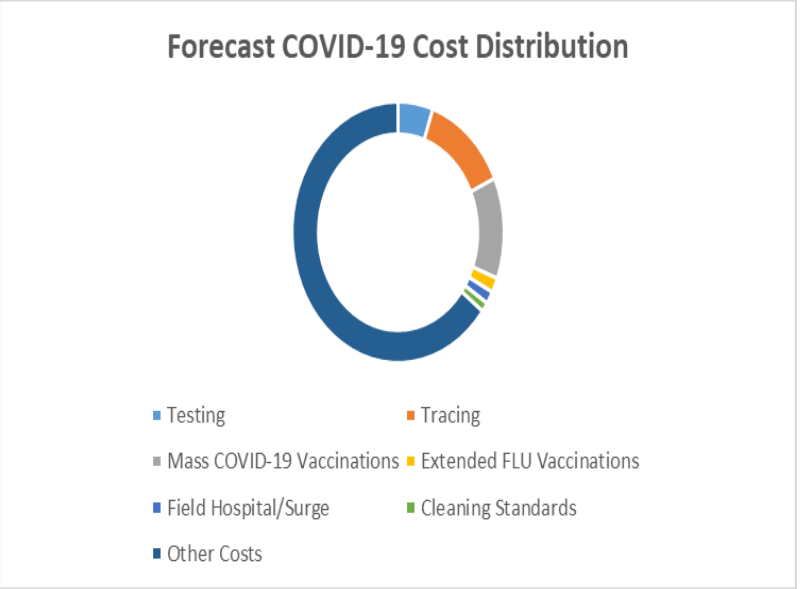
	In Month			Cumulative		
	Budget £000	Actual £000	Variance to Plan £000	Budget £000	Actual £000	Variance to Plan £000
WG RESOURCE ALLOCATION	(151,121)	(151,121)	0	(1,175,694)	(1,175,694)	0
AREA TEAMS						
West Area	14,685	14,621	64	112,546	112,359	187
Central Area	19,072	19,237	(165)	149,531	147,905	1,626
East Area	22,710	22,536	174	171,285	168,972	2,313
Other North Wales	4,035	3,334	702	29,980	29,820	160
Field Hospitals	(2,187)	(2,187)	0	(469)	(469)	0
Track,Trace,Protect & Vaccination	2,668	2,668	0	17,116	17,116	0
Commissioner Contracts	20,108	19,669	439	150,164	150,531	(367)
Provider Income	(1,624)	(1,968)	344	(14,562)	(14,949)	387
Total Area Teams	79,467	77,910	1,557	615,592	611,285	4,307
SECONDARY CARE						
Ysbyty Gwynedd	9,126	9,631	(505)	72,119	73,708	(1,589)
Ysbyty Glan Clwyd	11,713	11,433	280	90,685	90,713	(28)
Ysbyty Maelor Wrexham	9,915	10,170	(254)	76,737	79,269	(2,532)
North Wales Hospital Services	10,192	10,400	(208)	77,875	79,071	(1,197)
Womens	3,568	3,550	18	28,381	27,601	779
Total Secondary Care	44,514	45,183	(669)	345,796	350,362	(4,566)
Total Mental Health & LDS	11,870	11,340	530	91,929	91,577	352
Total Corporate	13,074	13,873	(799)	99,255	101,771	(2,516)
Total Other Budgets incl. Reserves	2,196	2,815	(619)	23,122	20,699	2,423
TOTAL	0	0	0	0	0	0

- Divisional forecasts continue to be refreshed as the operational position develops.
- Further detail relating to pay, non pay and key areas of expenditure are shown in slide 9 to 11.

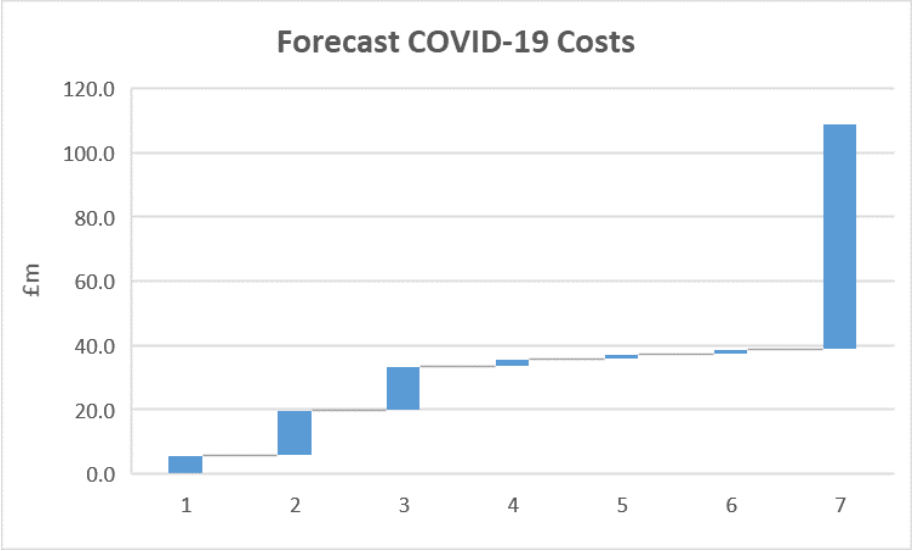


Impact of COVID-19

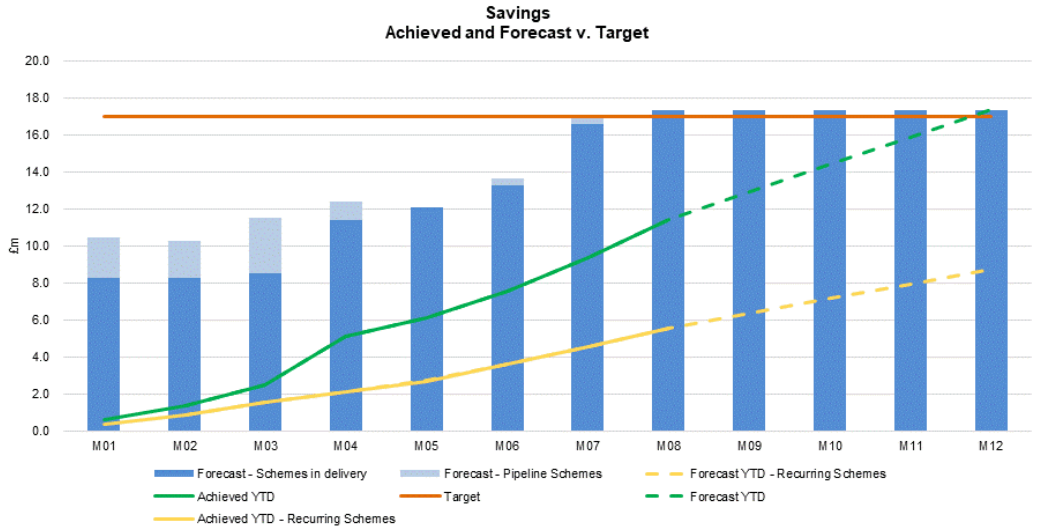
	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual M05 £m	Actual M06 £m	Actual M07 £m	Actual M08 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.2	0.3	0.4	0.4	0.4	0.3	2.3	3.9
Tracing	1.1	1.0	1.0	0.9	1.1	1.1	1.0	1.0	8.2	13.2
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	1.0	0.9	1.0	1.7	10.6	16.5
Extended Flu Vaccinations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	2.1
Field Hospital/Surge	0.3	0.7	0.2	0.5	(0.3)	0.0	0.3	(2.2)	(0.5)	(0.5)
Cleaning Standards	0.0	0.0	0.0	0.0	0.5	0.1	0.1	0.1	0.8	1.2
Other Costs	4.5	3.6	4.5	6.3	4.0	4.6	1.4	5.4	34.3	62.5
Total COVID-19 expenditure	**7.7**	**7.0**	**7.9**	**8.8**	**6.7**	**7.1**	**4.2**	**6.5**	**55.9**	**98.9**
Welsh Government COVID-19 income to cover expenditure	(7.7)	(7.0)	(7.9)	(8.8)	(6.7)	(7.1)	(4.2)	(6.5)	(55.9)	(98.9)
Other COVID-19 Support:										
Operational expenditure reductions	(0.2)	(0.7)	(0.8)	0.1	(0.6)	(0.1)	(0.7)	(0.2)	(3.2)	(3.2)
Funding for non delivery of savings in 20/21	(0.6)	(4.9)	(2.7)	(2.7)	(2.7)	(2.7)	(2.7)	(2.7)	(21.7)	(32.7)
Impact of COVID-19 on Position	**(0.8)**	**(5.6)**	**(3.5)**	**(2.6)**	**(3.3)**	**(2.8)**	**(3.4)**	**(2.9)**	**(24.9)**	**(35.9)**



- The forecast total cost of COVID-19 is currently £131.8m. Welsh Government income has been anticipated to fully cover this cost, so there is no impact on the overall Health Board position.
- The COVID-19 funding is in the main fixed at current levels, and the HB will need to live within the funding provided. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospital activity.



Savings



- The savings target for Month 8 was £1.4m, and delivery in November was £2.1m.
- The savings delivered up to Month 8 was £5.5m recurring, and £5.9m non-recurring, against the target of £17m leaving £5.6m to be delivered over the remainder of the year.

		SCHEMES IN DELIVERY									TOTAL PROGRAMME	
		Year to Date				Forecast						
	Savings Target	Savings Target	Recurring Savings Delivered	Variance in Recurring Savings	Non-Recurring Savings Delivered	Recurring Forecast	Variance	Non-Recurring Forecast	Total Forecast	Forecast FYE	Total Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Ysbyty Gwynedd	1,833	1,222	263	(959)	26	357	**(1,476)**	46	403	470	403	(1,430)
Ysbyty Glan Clwyd	2,155	1,437	71	(1,366)	230	114	**(2,041)**	258	372	237	372	(1,783)
Ysbyty Wrexham Maelor	1,922	1,281	162	(1,119)	452	253	**(1,669)**	659	913	367	913	(1,009)
Total of hospitals	**5,910**	**3,940**	**496**	**(3,444)**	**708**	**724**	**(5,186)**	**963**	**1,688**	**1,074**	**1,688**	**(4,222)**
North Wales Managed Services	1,399	933	512	(421)	409	895	**(504)**	429	1,325	1,077	1,325	(74)
Womens Services	584	352	181	(172)	295	295	**(289)**	319	614	495	614	30
Secondary Care	**7,893**	**5,225**	**1,188**	**(4,037)**	**1,412**	**1,915**	**(5,978)**	**1,711**	**3,626**	**2,646**	**3,626**	**(4,267)**
Area - West	1,387	925	710	(214)	522	1,193	**(194)**	1,077	2,271	1,264	2,271	884
Area - Centre	1,900	1,267	1,262	(5)	590	2,131	**231**	1,696	3,827	2,459	3,827	1,927
Area - East	1,861	1,241	1,035	(205)	1,745	1,479	**(382)**	2,359	3,838	1,535	3,838	1,977
Area - Other	234	156	69	(87)	141	138	**(96)**	235	373	138	373	139
Contracts	980	653	0	(653)	0	0	**(980)**	0	0	0	0	(980)
Area Teams	**6,362**	**4,241**	**3,076**	**(1,165)**	**2,999**	**4,942**	**(1,420)**	**5,367**	**10,309**	**5,395**	**10,309**	**3,947**
MHLD	840	560	1,115	555	66	1,582	**742**	102	1,684	1,606	1,684	844
Corporate	1,910	1,273	163	(1,110)	1,407	310	**(1,600)**	1,415	1,725	364	1,725	(185)
Divisional Total	**17,005**	**11,300**	**5,542**	**(5,757)**	**5,883**	**8,749**	**(8,256)**	**8,595**	**17,344**	**10,012**	**17,344**	**339**
											0	0
											0	0
											0	0
											0	0
Improvement Group Total											**0**	**0**
Total Programme	**17,005**	**11,300**	**5,542**	**(5,757)**	**5,883**	**8,749**	**(8,256)**	**8,595**	**17,344**	**10,012**	**17,344**	**339**

Income

Description	£m
Allocations Received	1798.5
Total Allocations Received	**1,798.5**

Description	£m
Allocations anticipated	
Capital	4.8
Removal of Donated Assets / Government Grant Receipts	-0.5
Total COVID-19 (see below analysis)	9.9
Substance Misuse	5.8
IM&T Refresh Programme (in line with 11-12)	1.9
Flower Case - overtime on annual leave (M1-6)	0.8
CHC Retrospective AME Imparment	-0.5
Other	1.4
Total Allocations Anticipated	**23.5**

	£m
Total Allocations Received	1,798.5
Total Allocations Anticipated	23.5
Total Welsh Government Income	**1,822.0**

COVID -19 Funding	£m
Total COVID-19 costs in 2021/22	99.1
Impact of non delivery of savings in 2020/21	32.7
Total Covid -19 funding	**131.8**

Received	122.0
Anticipated	9.9

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). The RRL is currently £1,822.0m for the year. £1175.7m of the RRL has been profiled into the position cumulatively, which is £39.0m less than eight equal twelfths (£1214.7m), primarily due to the profile of COVID-19 and performance funding.
- The RRL includes confirmed allocations to date of £1,798.5m, with further anticipated allocations in year of £23.5m.
- Miscellaneous income totals £12.7m in Month 8, £99.8m cumulatively, which is a favourable variance of £1.0m against the budget.

Expenditure

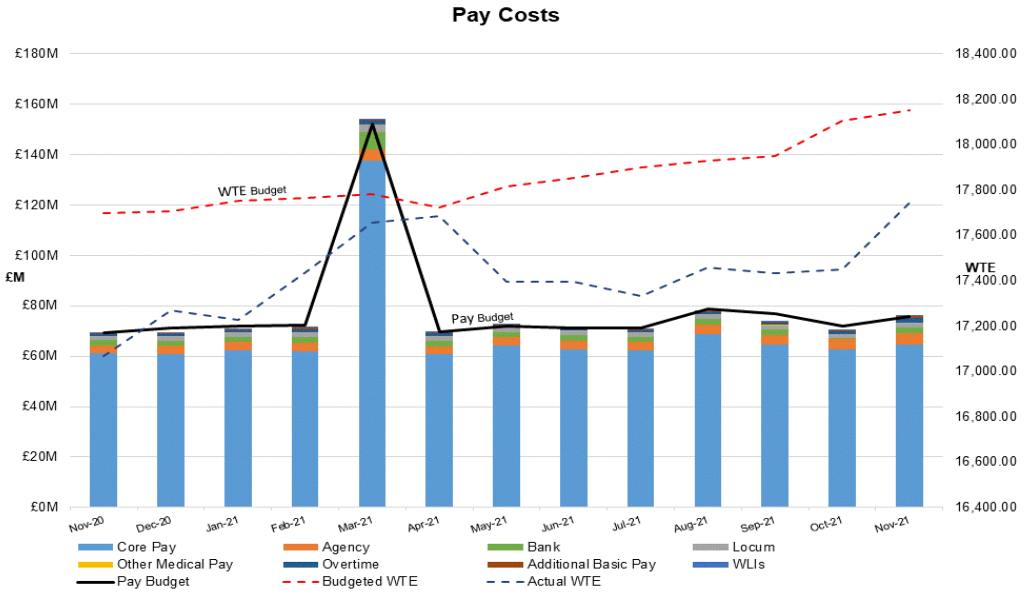
Pay Costs	Actual								Forecast				Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Cl	9.5	9.7	9.5	9.5	10.6	9.9	9.5	10.4	10.3	10.5	10.5	10.6	82.5	78.6	3.9	120.5
Medical & Dental	15.9	16.3	16.3	16.1	18.1	16.1	16.6	17.6	17.5	17.8	17.9	18.0	129.5	133.0	(3.5)	204.2
Nursing & Midwifery	21.5	22.2	22.0	21.8	24.0	23.0	22.0	23.4	23.0	23.3	23.4	23.6	187.3	179.9	7.4	273.2
Additional Clinical S	9.7	10.3	10.1	10.0	10.8	10.3	8.9	10.3	10.2	10.3	10.3	10.4	73.9	80.4	(6.5)	121.6
Add Prof Scientific	3.1	3.1	3.1	3.1	3.4	3.2	3.2	3.3	3.3	3.4	3.4	3.4	27.6	25.5	2.1	39.0
Allied Health Profes	4.0	4.0	4.0	4.0	4.2	4.4	4.0	4.2	4.2	4.2	4.3	4.3	33.6	32.8	0.8	49.8
Healthcare Scientis	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	10.0	10.0	0.0	15.2
Estates & Ancillary	3.3	3.4	3.4	3.2	3.6	3.6	3.1	3.4	3.5	3.5	3.5	3.6	27.6	27.0	0.6	41.1
Students	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.4	0.1	0.8
Health Board Tota	**68.2**	**70.2**	**69.6**	**68.9**	**76.1**	**71.9**	**68.7**	**74.0**	**73.4**	**74.4**	**74.7**	**75.3**	**572.5**	**567.6**	**4.9**	**865.4**
Primary care	1.4	2.3	1.8	1.9	2.0	2.1	2.0	2.1	2.0	2.0	2.0	1.9	14.2	15.6	(1.4)	23.5
Total Pay	**69.6**	**72.5**	**71.4**	**70.8**	**78.1**	**74.0**	**70.7**	**76.1**	**75.4**	**76.4**	**76.7**	**77.2**	**586.7**	**583.2**	**3.5**	**888.9**

Variable Pay	M01	M02	M03	M04	M05	M06	M07	M08	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Agency	3.1	3.5	3.7	3.5	3.8	3.8	3.9	4.5	29.8
Overtime	1.1	0.7	0.7	0.7	0.8	1.0	0.9	1.9	7.8
Locum	1.9	1.8	1.8	1.7	2.0	1.7	1.3	2.0	14.2
WLIs	0.1	0.2	0.2	0.4	0.2	0.4	0.4	0.3	2.2
Bank	2.0	2.0	2.1	2.0	2.0	2.3	0.6	2.3	15.3
Other Non Core	0.1	(0.1)	0.1	0.1	0.1	0.0	0.1	0.1	0.4
Additional Hours	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.4	3.2
Total	**8.8**	**8.5**	**8.9**	**8.7**	**9.3**	**9.6**	**7.6**	**11.4**	**72.9**

- Health Board pay costs total £74.0m in Month 8 which is an increase £2.3m. Variable pay costs are £11.4m. Non-pay costs total £89.8m in Month 8. Further analysis of both pay and non pay costs are shown in subsequent slides.
- Forecast expenditure related to the £30m funding for the Performance Fund, £12m Strategic Support and £19.9m COVID-19 Recovery Plan is based on the phasing of costs in submitted business cases. The amount of spend in the first eight months has been less than expected, however further plans have been developed to ensure the resources in this area are fully utilised.

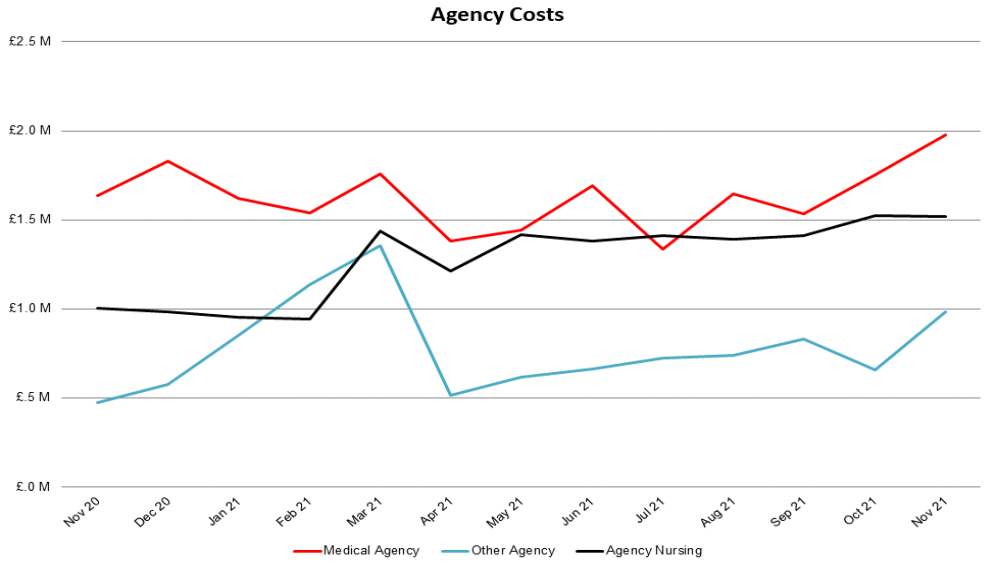
Non-Pay Costs	Actual								Forecast				Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care	18.3	18.9	19.1	19.7	18.2	18.1	18.9	18.9	18.6	18.6	18.0	18.5	150.5	150.1	0.4	223.8
Primary Care Drugs	9.2	7.9	9.3	10.4	9.3	9.8	8.8	9.1	10.5	9.2	8.7	9.8	72.4	73.8	(1.4)	112.0
Secondary Care Drugs	5.6	6.0	6.8	6.9	7.1	7.5	7.5	7.2	7.3	7.3	7.2	7.1	49.0	54.6	(5.6)	83.5
Healthcare Services Provided by Other I	22.8	22.8	23.4	24.4	23.3	23.7	23.5	24.5	23.4	23.8	23.9	23.9	188.9	188.4	0.5	283.4
Continuing Care and Funded Nursing Ca	8.2	9.2	8.5	10.2	8.6	9.0	7.4	7.1	8.9	8.9	8.4	8.8	67.4	68.2	(0.8)	103.2
Other Non-Pay (incl. General & Clinical	16.4	19.1	17.4	15.3	17.9	17.3	23.4	19.7	27.4	28.7	29.0	29.6	145.8	146.5	(0.7)	261.2
Non-pay costs	**80.5**	**83.9**	**84.5**	**86.9**	**84.4**	**85.4**	**89.5**	**86.5**	**96.1**	**96.5**	**95.2**	**97.7**	**674.0**	**681.6**	**(7.6)**	**1,067.1**
Cost of Capital	2.4	2.4	4.6	3.1	3.1	3.1	3.1	3.3	3.1	3.1	3.1	(1.3)	25.1	25.1	0.0	33.1
Total non-pay	**82.9**	**86.3**	**89.1**	**90.0**	**87.5**	**88.5**	**92.6**	**89.8**	**99.2**	**99.6**	**98.3**	**96.4**	**699.1**	**706.7**	**(7.6)**	**1,100.2**

Pay Costs

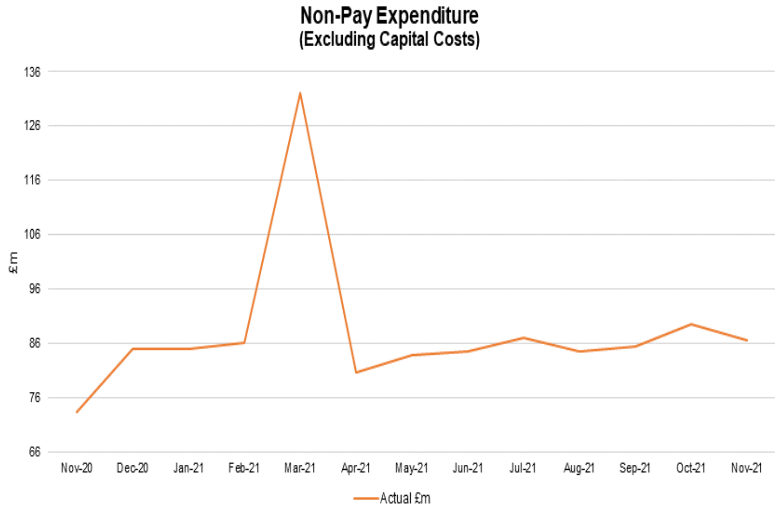


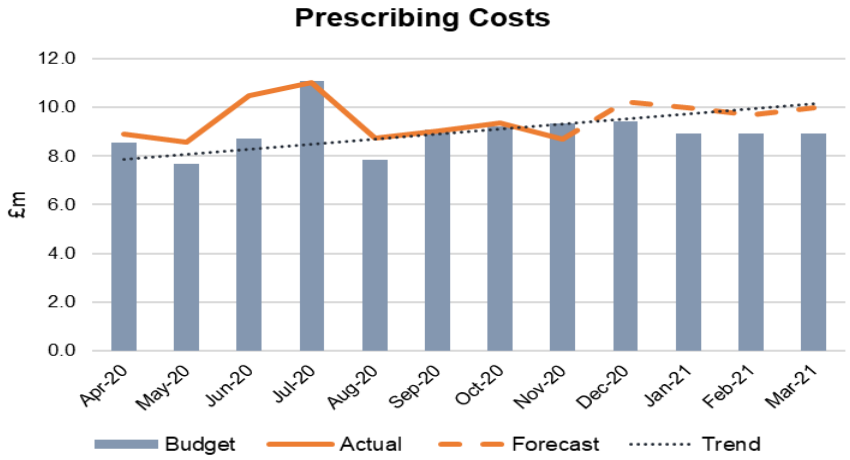
- **Total pay costs** in November are £74.0m. This includes £0.9m which relates to overtime on annual leave. There is also an additional £2.0m relating to an increase in staffing numbers across medical and nursing bring the actual establishment closer to the plan.
- COVID-19 pay costs account for £3.6m, which is £0.7m higher than in October.

Agency costs for Month 8 are £4.5m, representing 5.6% of total pay, which is higher than Month 7 and £0.8m above the monthly average expenditure in 2021-22. Agency nursing spend is £1.5m which is the same as October with medical agency showing an increase of £0.2m on last month.



Non-Pay Costs





Non-Pay Expenditure: Spend for November is £86.6m, excluding capital charges. This is £2.9m lower than October. October spend was inflated by £5.3m due to retrospective Integrated Care Fund (ICF) costs. ICF expenditure in November was £1.9m. Outsourcing costs have increased by £1.0m due to Neurodevelopment activity.

The prescribing costs encompass both the Primary Care Drugs and the Dispensing Practices drugs and overall the expenditure is £0.4m (4%) higher than in Month 7. Although the in month expenditure per prescribing days was marginally lower in November the expenditure in this area remains volatile.

The forecast outturn prescribing expenditure based on the September data, suggests a range between £123.5m and £124.5m, with the latest position being in the middle of this range at £124.0m. The reduction in CAT-M Drug prices is now showing through the data, with an overall reduction in the forecast outturn compared to last month.

Balance Sheet

Non-Current Assets	Opening Balance Beginning of Apr 21 £'m	Closing Balance End of November £'m	Forecast Closing Balance Mar 22 £'m
Property, plant and equipment	588.1	571.4	608.4
Intangible assets	0.9	0.7	0.8
Trade and other receivables	33.1	33.0	32.9
Non-Current Assets sub total	622	605.05	642.02
Current Assets			
Inventories	18.4	17.6	18.4
Trade and other receivables	77.3	136.1	115.8
Cash and cash equivalents	3.2	5.1	3.2
Non-current assets classified as held for sale	0.2	0.2	0.0
Current Assets sub total	99.05	158.99	137.42
TOTAL ASSETS	721.05	764.04	779.44
Current Liabilities			
Trade and other payables	222.9	207.5	222.0
Provisions	41.7	85.2	78.1
Current Liabilities sub total	264.65	292.66	300.09
NET ASSETS LESS CURRENT LIABILITIES	456.4	471.38	479.35
Non-Current Liabilities			
Trade and other payables	0.9	0.9	0.9
Provisions	34.3	34.3	34.3
Non-Current Liabilities sub total	35.17	35.17	35.17
TOTAL ASSETS EMPLOYED	421.23	436.21	444.18
FINANCED BY:			
Taxpayers' Equity			
General Fund	288.6	303.6	295.3
Revaluation Reserve	132.6	132.6	148.9
Total Taxpayers' Equity	421.21	436.21	444.18

Risks and Opportunities (not included in position)

	£m	Level	Explanation
Risks			
Recruitment of staff	TBC		There is a risk that due to the delays in recruiting staff, higher agency costs are required.
Risk of increased energy prices	TBC		Global increases in the wholesale price of gas fuel creates a risk that energy prices incurred by the Health Board will be significantly higher in the future. For the full year, an impact of circa £2.2m has been included in the forecast, but there is a risk that prices will increase further leading to additional costs above this.
Pay awards	TBC		Risk around ongoing pay discussions, with the agreed settlement being higher than the funded 3%. There is also potential disruption to services if unions agree to strike.

	£m	Level	Explanation
Opportunity			
Accountancy gains	TBC		As part of our due diligence around year-end, we will review our policy around accruals, once the Welsh Government Manual for Accounts has been published. This may lead to the potential for future one off accountancy gains. We would only amend national accruals following discussion with Welsh Government.
Additional funding – Risk of not being to utilise additional funding provided by WG	TBC		There is a risk that the Health Board will not be able to utilise all of the additional funding provided by Welsh Government, due to operational pressures around unscheduled care and/or further COVID-19 pressures in light of the prevalence of Omicron.

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

Finance Report
October 2021: M07-22

Sue Hill

Executive Director of Finance

Executive Summary

Objective

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

Positives & Key Assurances

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

Issues & Actions

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

Key Messages

- ❖ The cumulative financial position and forecast outturn position for 2021/22 remain balanced.
- ❖ The Health Board has received additional funding totalling £32.7m to cover the impact of the undelivered savings from 2020/21. This additional funding is anticipated to cover the financial risk for the year that was identified in the draft financial plan.
- ❖ Expenditure related to the £42.0m funding for the Performance Fund and Strategic Support, plus the £19.9m COVID-19 Recovery Plan funding is included in forecasts based on submitted plans. The full utilisation of this funding to improve performance, reduce waiting lists and drive a programme of transformation is dependent on operational teams implementing approved plans at pace. See appendix 2 for further detail.

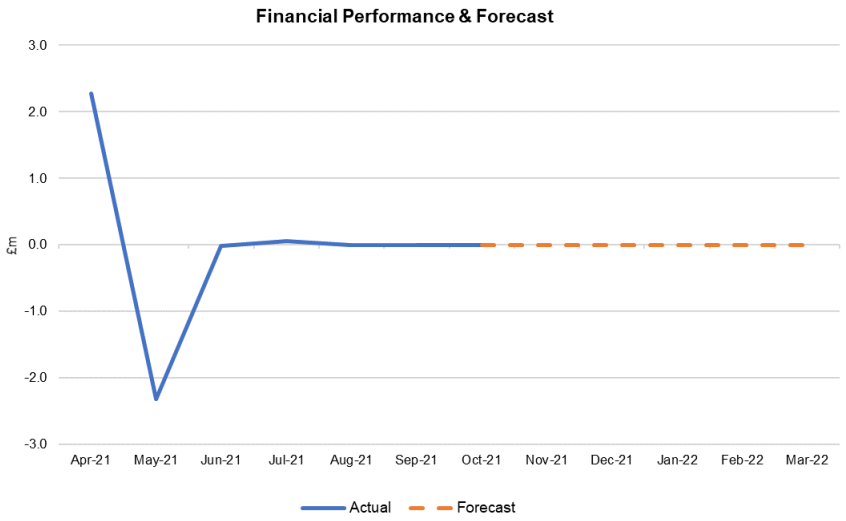
Summary of Key Numbers

Month 07 Position	Forecast	Divisional Performance Mth 07
Break even position in month. **Balanced** Cumulative position is break even. **Balanced**	Reflects additional funding to cover the impact of the undelivered savings from 2020/21 **Balanced**	Area Teams £0.7m favourable Secondary Care £0.6m adverse Mental Health £0.0m favourable Corporate £0.3m adverse Other £0.2m favourable
Savings In-month: £1.7m against plan of £1.4m **£0.3m favourable** YTD: £9.3m against plan of £9.9m **£0.6m adverse**	**Savings Forecast** £16.6m against plan of £17.0m This is an increase of £2.9m compared to month 6 **£0.4m adverse**	**COVID-19 Impact** £49.5m cost YTD £109.2 m forecast cost Funded by Welsh Government **£nil impact**
Income £85.7m against budget of £84.7m **£1m favourable**	Pay £493.6m against budget of £498.6m **£5m favourable**	**Non-Pay** £616.6m against budget of £610.6m **£6m adverse**

Revenue Position

- The in-month and cumulative position is breakeven. This includes the additional £32.6m funding received by the Health Board to cover the impact of the undelivered savings from 2020/21.
- The total impact of COVID-19 in October is £4.2m (£49.4m for the year to date). Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

	Actual							Cumulative				Forecast
	M01	M02	M03	M04	M05	M06	M07	Budget	Actual	Variance	Variance	Actual
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	%	£m
Revenue Resource Limit	(136.7)	(147.2)	(147.1)	(148.3)	(151.4)	(148.0)	(145.8)	(1,024.5)	(1,024.5)	0.0	0.0%	(1,832.5)
Miscellaneous Income	(12.1)	(11.6)	(11.7)	(10.6)	(12.2)	(12.4)	(15.4)	(85.1)	(86.0)	0.9	(1.1)%	(143.2)
Health Board Pay Expenditure	68.2	70.2	69.7	69.0	76.1	71.9	68.6	498.9	493.7	5.2	1.0%	870.3
Non-Pay Expenditure	82.8	86.3	89.1	90.0	87.5	88.5	92.6	610.7	616.8	(6.1)	(1.0)%	1,105.4
Total	**2.2**	**(2.3)**	**0.0**	**0.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**		**0.0**

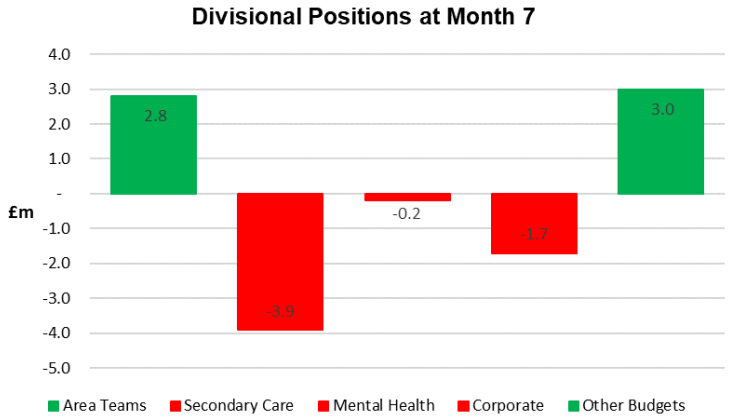


- The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.
- In line with all NHS organisations in Wales, the plan was revised during Quarter 1 to refine and develop the triangulation of activity, workforce and financial plans, while maintaining the focus on the six key objectives described in the draft plan. We have tested our assumptions in the original plans and continue to refreshed our forecasts accordingly as the operational position develops.

Divisional Positions

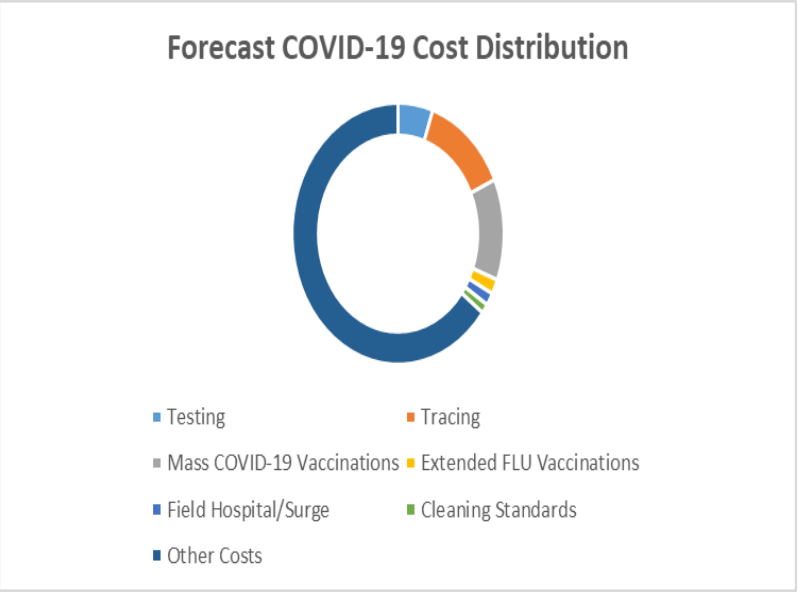
	In Month			Cumulative		
	Budget £000	Actual £000	Variance to Plan £000	Budget £000	Actual £000	Variance to Plan £000
WG RESOURCE ALLOCATION	(145,869)	(145,869)	0	(1,024,573)	(1,024,573)	0
AREA TEAMS						
West Area	14,107	14,045	62	97,861	97,738	124
Central Area	18,793	18,600	193	130,459	128,669	1,791
East Area	21,043	20,383	661	148,576	146,436	2,140
Other North Wales	3,822	3,953	(131)	25,944	26,486	(542)
Field Hospitals	307	307	0	1,718	1,718	0
Track,Trace,Protect & Vaccination	2,204	2,204	0	14,448	14,448	0
Commissioner Contracts	18,731	18,818	(87)	130,055	130,861	(806)
Provider Income	(1,624)	(1,640)	16	(12,938)	(12,982)	44
Total Area Teams	77,384	76,670	714	536,125	533,375	2,750
SECONDARY CARE						
Ysbyty Gwynedd	9,078	9,392	(314)	62,993	64,077	(1,084)
Ysbyty Glan Clwyd	11,580	11,637	(57)	78,972	79,280	(308)
Ysbyty Maelor Wrexham	9,714	9,792	(78)	66,822	69,099	(2,277)
North Wales Hospital Services	9,983	10,104	(122)	67,682	68,671	(989)
Womens	3,491	3,498	(7)	24,813	24,051	762
Total Secondary Care	43,846	44,425	(579)	301,282	305,179	(3,897)
Total Mental Health & LDS	11,925	11,968	(43)	80,059	80,237	(178)
Total Corporate	9,972	10,310	(339)	86,181	87,898	(1,717)
Total Other Budgets incl. Reserves	2,742	2,497	246	20,926	17,884	3,042
TOTAL	0	0	0	0	0	0

- Divisional forecasts continue to be refreshed as the operational position develops.
- Further detail relating to pay, non pay and key areas of expenditure are shown in slide 9 to 11.

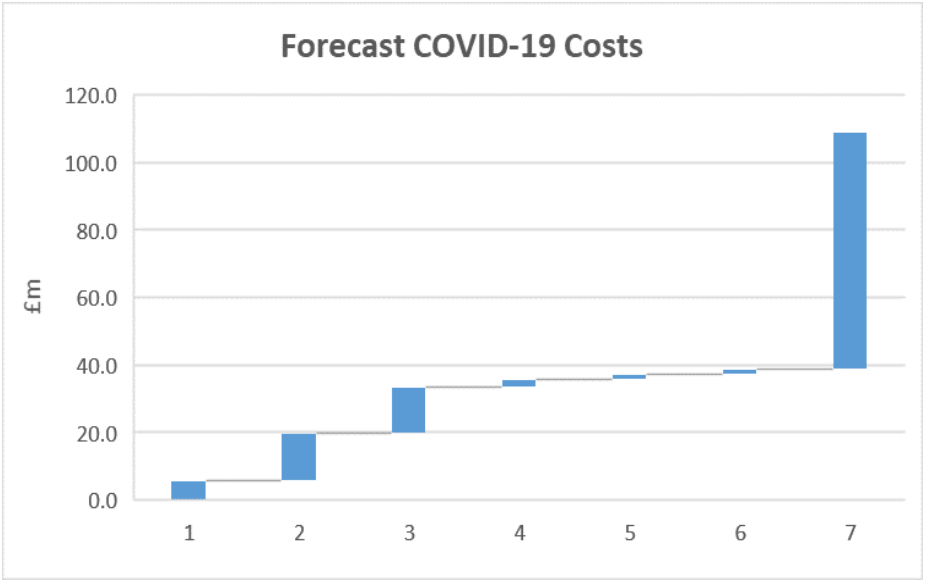


Impact of COVID-19

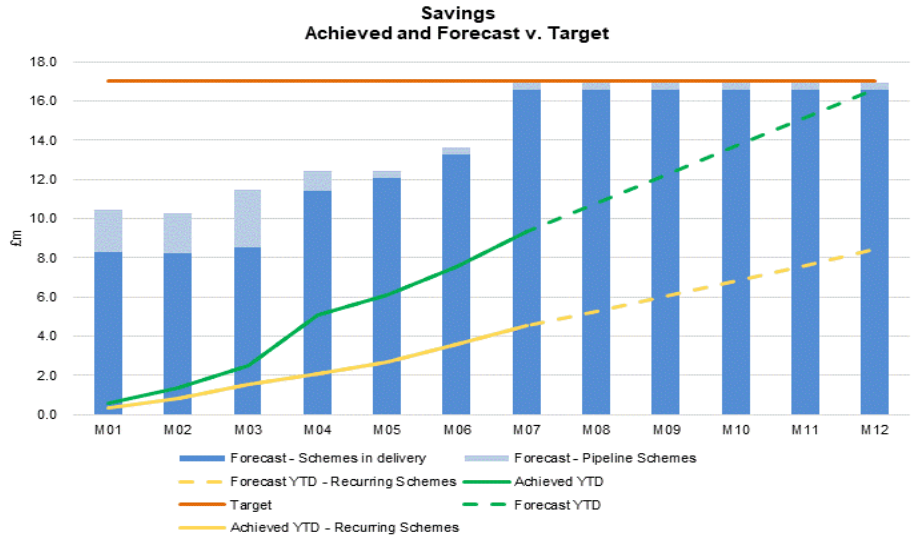
	Actual M01	Actual M02	Actual M03	Actual M04	Actual M05	Actual M06	Actual M07	Actual M08	Actual M09	Actual M10	Actual M11	Actual M12	Actual YTD	Forecast 2021/22
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Testing	0.1	0.2	0.2	0.3	0.4	0.4	0.4	0.8	0.8	0.8	0.7	0.7	2.0	5.8
Tracing	1.1	1.0	1.0	0.9	1.1	1.1	1.0	1.1	1.4	1.4	1.4	1.7	7.2	14.1
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	1.0	0.9	1.0	1.0	0.9	0.9	0.9	0.9	8.9	13.7
Extended FLU Vaccinations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.4	0.4	0.3	0.2	0.0	2.0
Field Hospital/Surge	0.3	0.7	0.2	0.5	(0.3)	0.0	0.3	0.0	0.0	0.0	0.0	0.0	1.7	1.7
Cleaning Standards	0.0	0.0	0.0	0.0	0.5	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.7	1.3
Other Costs	4.5	3.6	4.5	6.3	4.0	4.6	1.4	8.3	8.2	8.4	8.4	8.3	29.0	70.6
Total COVID-19 expenditure	**7.7**	**7.0**	**7.9**	**8.8**	**6.7**	**7.1**	**4.2**	**12.1**	**11.8**	**12.0**	**11.9**	**12.0**	**49.5**	**109.2**
Offset by Covid income to cove	**(7.7)**	**(7.0)**	**(7.9)**	**(8.8)**	**(6.7)**	**(7.1)**	**(4.2)**	**(12.1)**	**(11.8)**	**(12.0)**	**(11.9)**	**(12.0)**	**(49.5)**	**(109.2)**
Other COVID-19 Support														
reductions	(0.2)	(0.7)	(0.8)	0.1	(0.6)	(0.1)	(0.7)	(0.1)	(0.1)	(0.1)	0.0	0.0	(3.0)	(3.4)
savings in 20/21	(0.6)	(4.9)	(2.7)	(2.7)	(2.7)	(2.7)	(2.7)	(2.8)	(2.7)	(2.7)	(2.7)	(2.7)	(19.0)	(32.7)
Impact of COVID-19 on Positior	**(0.8)**	**(5.6)**	**(3.5)**	**(2.6)**	**(3.3)**	**(2.8)**	**(3.4)**	**(2.9)**	**(2.8)**	**(2.8)**	**(2.7)**	**(2.7)**	**(22.0)**	**(36.1)**



- The forecast total cost of COVID-19 is currently £109.2m. Welsh Government income has been anticipated to fully cover this cost, so there is no impact on the overall Health Board position.
- As additional modelling data for COVID-19 is received, this forecast is regularly reviewed, revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospital activity.



Savings



- Savings in month totalled £1.7m, giving a cumulative saving of £9.3m at month 7. This is £0.6m below the year to date target of £9.9m
- Savings of £16.6m are forecast in 2021/22 for schemes currently in delivery, a shortfall of £0.4m against the £17m target.
- All schemes are now in amber / green status.
- Further opportunities continue to be identified both within Divisions and across BCU to optimise the delivery of the savings in line with the financial plan.

		SCHEMES IN DELIVERY									PIPELINE SCHEMES				TOTAL PROGRAMME	
		Year to Date				Forecast										
	Savings Target	Savings Target	Recurring Savings Delivered	Variance in Recurring Savings	Non-Recurring Savings Delivered	Recurring Forecast	Variance	Non-Recurring Forecast	Total Forecast	Forecast FYE	Recurring Plan	Non-Recurring Plan	Total Plan	Plan FYE	Total Forecast	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Ysbyty Gwynedd	1,833	1,069	239	(831)	22	362	(1,471)	48	410	442	57	0	57	57	467	(1,366)
Ysbyty Glan Clwyd	2,155	1,257	63	(1,194)	34	117	(2,038)	69	186	234	228	0	228	253	414	(1,741)
Ysbyty Wrexham Maelor	1,922	1,121	143	(978)	397	259	(1,663)	656	915	366	57	0	57	106	972	(950)
North Wales Managed Services	1,399	816	400	(416)	389	911	(488)	415	1,326	1,077	0	0	0	0	1,326	(73)
Womens Services	584	295	152	(142)	290	296	(288)	319	615	495	0	0	0	0	615	31
Secondary Care	**7,893**	**4,558**	**996**	**(3,562)**	**1,132**	**1,945**	**(5,948)**	**1,506**	**3,451**	**2,614**	**342**	**0**	**342**	**416**	**3,793**	**(4,100)**
Area - West	1,387	809	555	(254)	343	1,163	(224)	1,037	2,200	1,210	0	0	0	0	2,200	813
Area - Centre	1,900	1,108	945	(163)	292	1,895	(5)	1,634	3,529	2,217	0	0	0	0	3,529	1,629
Area - East	1,861	1,086	868	(218)	1,478	1,415	(446)	2,226	3,641	1,465	0	0	0	0	3,641	1,780
Area - Other	234	137	52	(85)	118	138	(96)	235	373	138	0	0	0	0	373	139
Contracts	980	572	0	(572)	0	0	(980)	0	0	0	0	0	0	0	0	(980)
Area Teams	**6,362**	**3,711**	**2,420**	**(1,291)**	**2,230**	**4,611**	**(1,751)**	**5,133**	**9,743**	**5,030**	**0**	**0**	**0**	**0**	**9,743**	**3,381**
MHLD	840	490	975	485	58	1,559	719	102	1,662	3,432	0	0	0	0	1,662	822
Corporate	1,910	1,114	128	(986)	1,406	315	(1,595)	1,417	1,732	364	0	0	0	0	1,732	(178)
Divisional Total	**17,005**	**9,873**	**4,520**	**(5,354)**	**4,827**	**8,429**	**(8,576)**	**8,158**	**16,588**	**11,440**	**342**	**0**	**342**	**416**	**16,930**	**(75)**
											0	0	0	0	0	0
											0	0	0	0	0	0
											0	0	0	0	0	0
											0	0	0	0	0	0
Improvement Group Total											**0**	**0**	**0**	**0**	**0**	**0**
Total Programme	**17,005**	**9,873**	**4,520**	**(5,354)**	**4,827**	**8,429**	**(8,576)**	**8,158**	**16,588**	**11,440**	**342**	**0**	**342**	**416**	**16,930**	**(75)**

Income

Description	£m
Allocations Received	1791.9
Total Allocations Received	**1,791.9**

Description	£m
Allocations anticipated	
Capital	6.6
Removal of Donated Assets / Government Grant Receipts	-0.8
Total COVID-19 (see below analysis)	21.8
Substance Misuse	5.8
IM&T Refresh Programme (in line with 11-12)	1.9
MSK Orthopaedic Services - Secondary Care funding	1.2
2022 ICF Allocations - Anticipated Dementia Fund	2.2
Other	2.0
Total Allocations Anticipated	**40.6**

	£m
Total Allocations Received	1,791.9
Total Allocations Anticipated	40.6
Total Welsh Government Income	**1,832.5**

COVID -19 Funding	**£m**
Total COVID-19 costs in 2021/22	109.2
Impact of non delivery of savings in 2020/21	32.7
Total Covid -19 funding	**141.9**

Received	120.2
Anticipated	21.8

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). The RRL is currently £1,832.5m for the year. £1024.5m of the RRL has been profiled into the position cumulatively, which is £44.5m less than seven equal twelfths (£1069m), primarily due to the profile of COVID-19 and performance funding.
- The RRL includes confirmed allocations to date of £1,791.9m, with further anticipated allocations in year of £40.6m.
- Miscellaneous income totals £15.1m in Month 7, £85.7m cumulatively, which is a favourable variance of £1.m against the budget.
- The impact of COVID-19 has resulted in lost income of £0.3m in September (£2.3m year to date) relating to General Dental Services (GDS) patient income. This is included as a cost of COVID-19.

Expenditure

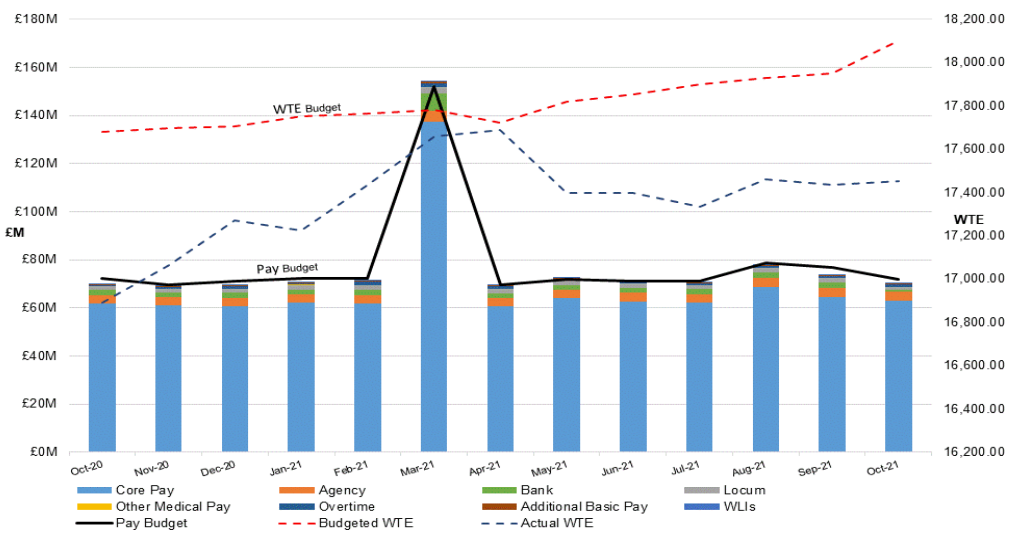
Pay Costs	Actual							Forecast					Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Administrative & Cl	9.5	9.7	9.5	9.5	10.6	9.9	9.5	10.2	10.6	10.7	10.7	10.8	71.8	68.2	3.6	121.2
Medical & Dental	15.9	16.3	16.3	16.1	18.1	16.1	16.6	17.3	17.9	18.2	18.2	18.3	113.0	115.4	(2.4)	205.3
Nursing & Midwifery	21.5	22.2	22.0	21.8	24.0	23.0	22.0	22.8	23.6	23.9	23.9	24.1	163.0	156.5	6.5	274.8
Additional Clinical S	9.7	10.3	10.1	10.0	10.8	10.3	8.9	10.1	10.4	10.6	10.6	10.6	64.4	70.1	(5.7)	122.4
Add Prof Scientific	3.1	3.1	3.1	3.1	3.4	3.2	3.2	3.3	3.4	3.4	3.4	3.5	24.2	22.2	2.0	39.2
Allied Health Profes	4.0	4.0	4.0	4.0	4.2	4.4	4.0	4.1	4.3	4.3	4.3	4.4	29.3	28.6	0.7	50.0
Healthcare Scientis	1.2	1.2	1.2	1.2	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	8.7	8.7	0.0	15.2
Estates & Ancillary	3.3	3.4	3.4	3.2	3.6	3.6	3.1	3.4	3.6	3.6	3.6	3.6	24.1	23.6	0.5	41.4
Students	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.3	0.1	0.8
Health Board Tota	**68.2**	**70.2**	**69.6**	**68.9**	**76.1**	**71.9**	**68.7**	**72.6**	**75.2**	**76.1**	**76.1**	**76.7**	**498.9**	**493.6**	**5.3**	**870.3**
Primary care	1.4	2.3	1.8	1.9	2.0	2.1	2.0	1.9	1.9	1.9	1.9	1.9	12.1	13.5	(1.4)	23.0
Total Pay	**69.6**	**72.5**	**71.4**	**70.8**	**78.1**	**74.0**	**70.7**	**74.5**	**77.1**	**78.0**	**78.0**	**78.6**	**511.0**	**507.1**	**3.9**	**893.3**

Variable Pay	M01	M02	M03	M04	M05	M06	M07	Total
	£m	£m	£m	£m	£m	£m	£m	£m
Agency	3.1	3.5	3.7	3.5	3.8	3.8	3.9	25.3
Overtime	1.1	0.7	0.7	0.7	0.8	1.0	0.9	5.9
Locum	1.9	1.8	1.8	1.7	2.0	1.7	1.3	12.2
WLIs	0.1	0.2	0.2	0.4	0.2	0.4	0.4	1.9
Bank	2.0	2.0	2.1	2.0	2.0	2.3	0.6	13.0
Other Non Core	0.1	(0.1)	0.1	0.1	0.1	0.0	0.1	0.4
Additional Hours	0.5	0.4	0.4	0.4	0.4	0.4	0.4	2.8
Total	**8.8**	**8.5**	**8.9**	**8.7**	**9.3**	**9.6**	**7.6**	**61.4**

- Health Board pay costs total £71.4m in Month 7, but are offset by a refund of £2.7m in Bank pay, relating to the adjustment of the prior year accrual regarding the bonus. Variable pay costs are £10.3m prior to the £2.7m adjustment. Non-pay costs total £92.6m in Month 7. Further analysis of both pay and non pay costs are shown in subsequent slides.
- Forecast expenditure related to the £30m funding for the Performance Fund, £12m Strategic Support and £19.9m COVID-19 Recovery Plan is based on the phasing of costs in submitted business cases. This cost profile is dependent on operational teams implementing approved plans at pace. The amount of spend in the first seven months has been less than expected.

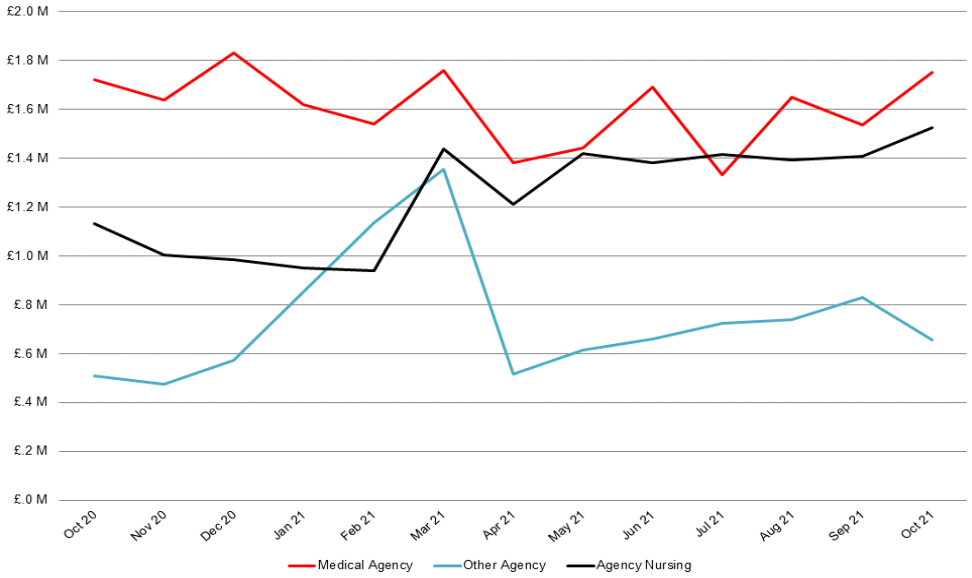
Non-Pay Costs	Actual							Forecast					Cumulative			Full Year
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	YTD Budget	YTD Actual	YTD Variance	Forecast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Primary Care	18.3	18.9	19.1	19.7	18.2	18.1	18.9	18.5	18.8	18.9	18.3	18.9	131.6	131.2	0.4	224.6
Primary Care Drugs	9.2	7.9	9.3	10.4	9.3	9.8	8.8	9.4	9.8	9.2	8.7	9.8	63.2	64.7	(1.5)	111.6
Secondary Care Drugs	5.6	6.0	6.8	6.9	7.1	7.5	7.5	7.3	7.3	7.3	7.2	7.3	42.6	47.4	(4.8)	83.8
Healthcare Services Provided by Other I	22.8	22.8	23.4	24.4	23.3	23.7	23.5	23.6	23.6	23.6	23.6	23.6	163.9	163.9	0.0	281.9
Continuing Care and Funded Nursing Ca	8.2	9.2	8.5	10.2	8.6	9.0	7.4	8.2	8.7	8.7	8.2	8.6	59.6	61.1	(1.5)	103.5
Other Non-Pay (incl. General & Clinical	16.4	19.1	17.4	15.3	17.9	17.3	23.4	26.9	26.7	27.4	27.5	29.9	128.0	126.8	1.2	265.2
Non-pay costs	**80.5**	**83.9**	**84.5**	**86.9**	**84.4**	**85.4**	**89.5**	**93.9**	**94.9**	**95.1**	**93.5**	**98.1**	**588.9**	**595.1**	**(6.2)**	**1,070.6**
Cost of Capital	2.4	2.4	4.6	3.1	3.1	3.1	3.1	3.1	3.1	3.1	3.1	0.7	21.8	21.8	0.0	34.9
Total non-pay	**82.9**	**86.3**	**89.1**	**90.0**	**87.5**	**88.5**	**92.6**	**97.0**	**98.0**	**98.2**	**96.6**	**98.8**	**610.7**	**616.9**	**(6.2)**	**1,105.5**

Pay Costs

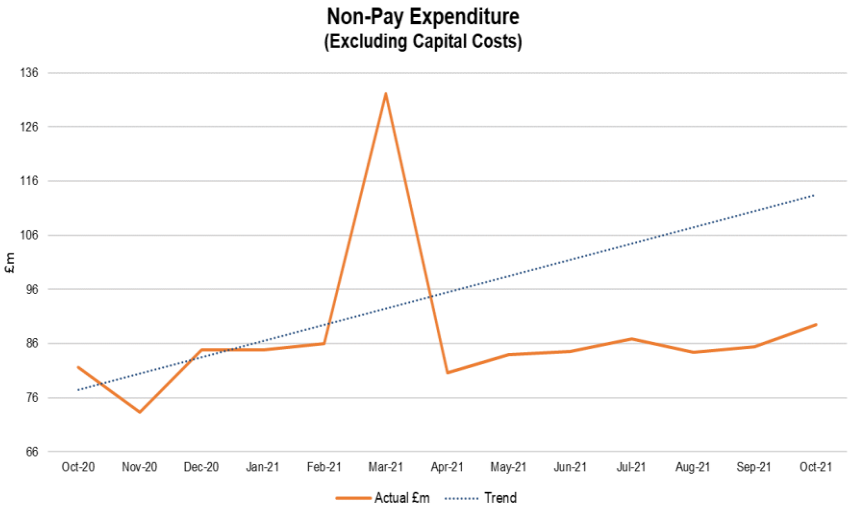


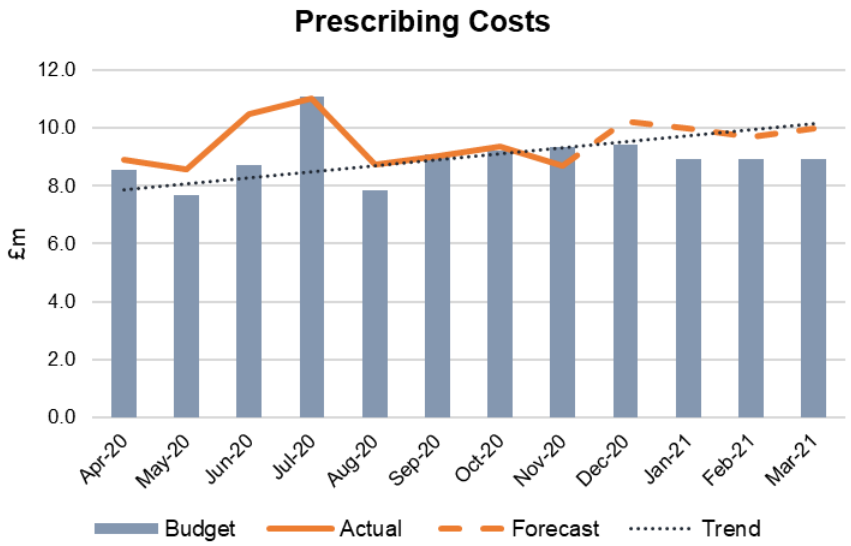
- **Total pay costs** in October are £70.5m, with Provided Services accounting for £68.5m, which is £3.5m (4.8%) less than last month.
- Bank Nurse costs in month reflect a £2.7m non recurring reduction, relating to an adjustment to the accrual of the prior year bonus payment.
- COVID-19 pay costs account for £2.9m, which is £0.2m lower than in September. The bonus adjustment is also offset against the COVID-19 costs.

Agency costs for Month 7 are £3.9m, representing 5.6% of total pay, which is higher than Month 6.



Non-Pay Costs





Non-Pay Expenditure: Spend for October is £89.5m, excluding capital charges. This is £4.1m higher than September. Other Non pay costs have a material in-month increase of £6.1m, and this relates to additional ICF payments to LA's, for which the funding has been received through additional Miscellaneous Income. Primary Care costs have increased by 0.8m, offset by reductions in CHC £1.6m in month and Primary Care Drugs, reduction of £1m.

The prescribing costs encompass both the Primary Care Drugs and the Dispensing Practices drugs and overall the expenditure is £0.5m (4%) lower than in Month 6, partially due to 1½ less Prescribing days in October (21) than there was in September (22.5), and partially due to a small reduction in the average cost of the prescribing day.

The forecast outturn prescribing expenditure based on the August data, suggests a range between £122.8m and £124.5m, with the latest position being in the middle of this range at £123.5m. The reduction in CAT-M Drug prices is now showing through the CASPA data, with an overall reduction in the forecast outturn of £1m compared to last month.

Balance Sheet

Non-Current Assets	Opening Balance Beginning of Apr 21 £'m	Closing Balance End of October £'m	Forecast Closing Balance Mar 22 £'m
Property, plant and equipment	588.1	573.4	602.8
Intangible assets	0.9	0.7	0.8
Trade and other receivables	33.1	33.0	32.9
Non-Current Assets sub total	622	607.1	636.47
Current Assets			
Inventories	18.4	18.7	18.4
Trade and other receivables	77.3	120.2	118.1
Cash and cash equivalents	3.2	7.6	-23.8
Non-current assets classified as held for sale	0.2	0.2	0.0
Current Assets sub total	99.05	146.71	112.71
TOTAL ASSETS	721.05	753.81	749.18
Current Liabilities			
Trade and other payables	222.9	199.5	197.7
Provisions	41.7	85.0	80.6
Current Liabilities sub total	264.65	284.43	278.3
NET ASSETS LESS CURRENT LIABILITIES	456.4	469.38	470.88
Non-Current Liabilities			
Trade and other payables	0.9	0.9	0.9
Provisions	34.3	34.3	34.3
Non-Current Liabilities sub total	35.17	35.17	35.17
TOTAL ASSETS EMPLOYED	421.23	434.21	435.71
FINANCED BY:			
Taxpayers' Equity			
General Fund	288.6	301.6	290.3
Revaluation Reserve	132.6	132.6	145.4
Total Taxpayers' Equity	421.21	434.21	435.7

Risks and Opportunities (not included in position)

	£m	Level	Explanation
Risks			
Recruitment of staff	TBC		There is a risk that due to the inability to recruit clinical staff higher agency costs are required.
Anticipated income	TBC		There is a risk that the anticipated income shown in Table E will not be fully funded.
Risk of increased energy prices	TBC		Global increases in the wholesale price of gas fuel creates a risk that energy prices incurred by the Health Board will be significantly higher in the future.

	£m	Level	Explanation
Opportunity			
Accountancy gains	TBC		There is a potential for future one off accountancy gains.
Additional funding – Risk of not being to utilise additional funding provided by WG	TBC		There is a risk that the Health Board will not be able to utilise the additional funding provided by Welsh Government, for example, performance fund monies, due to plans not being identified and approved.

SUMMARY

Figures at Month 8

	Funds Available	Plan Spend	Plan Slippage	Plan YTD	Actual YTD	Slippage YTD	Plan M9 - M12	Forecast M9 - M12	Slippage M9 - M12 YTD	Forecast Spend 2021/22	Forecast Slippage 2021/22
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
PERFORMANCE - OTHER (£15m)	15,268	15,010	(258)	7,458	3,515	(3,943)	7,552	11,266	3,714	14,781	(487)
PERFORMANCE - PLANNED CARE (£15m)	12,546	12,550	5	6,215	1,856	(4,359)	6,335	9,867	3,532	11,723	(822)
PERFORMANCE - PLANNED CARE SLIPPAGE	2,187	436	(1,751)	187	580	393	249	2,848	2,598	3,428	1,241
TRANSFORMATION (£12m)	12,000	10,551	(1,449)	5,687	2,027	(3,660)	4,864	9,989	5,125	12,016	16
WG BID (£20m)	19,942	14,965	(4,977)	8,272	5,721	(2,551)	6,693	14,222	7,529	19,942	0
RECOVERY FUND (£2.4m)	1,309	0	(1,309)	0	0	0	0	1,309	1,309	1,309	0
Total	**63,251**	**53,512**	**(9,739)**	**27,819**	**13,698**	**(14,121)**	**25,693**	**49,500**	**23,808**	**63,199**	**(52)**

Cyfarfod a dyddiad: Meeting and date:	**Performance, Finance and Information Governance Committee 23.12.21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Progressing the Primary and Community Care Academy**
Cyfarwyddwr Cyfrifol: Responsible Director:	Chris Stockport, Executive Director Primary Care & Community Services Sue Green, Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Gemma Nosworthy, Academy Manager Clare Darlington, Acting Associate Director Primary Care (Strategy)
Craffu blaenorol: Prior Scrutiny:	Health Board Review Team Executive Team August 2021 / October 2021 / December 2021
Atodiadau Appendices:	Appendix 1: Business Case - Progressing the Primary and Community Care Academy

Argymhelliad / Recommendation:

The Performance, Finance & Information Governance Committee is asked to approve the business case for *Progressing the Primary and Community Care Academy* for submission and consideration by the Board.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

An equality impact assessment has been undertaken.

Sefyllfa / Situation:

The development of the Primary and Community Care Academy was highlighted in the Health Board's Integrated Medium Term Plan (IMTP) 2021/22 and listed as a priority to be supported subject to business base approval.

The Business Case to further develop the Academy received strong support from the Executive Team in December 2021.

Given the level of investment required, the case is now presented to the Performance, Finance and Information Governance Committee for approval.

Cefndir / Background:

There is a clear direction set by Welsh Government detailing the national Model for Primary Care (April 2019). This 'Primary Care Model for Wales' provides the national strategic direction for primary care and is entirely consistent with our local innovation in recent years, with a focus on a multi-professional workforce so patients can be seen by the right person to best meet their needs.

Indeed, BCUHB is able to demonstrate a number of exemplar projects that have significantly contributed to setting the pace and breadth of thinking within the Primary Care Model for Wales. In particular, the work achieved in developing a range of innovative primary care advanced practitioner roles within nursing, physiotherapy, pharmacy, audiology, paramedics, occupational therapy, and more recently physicians associates, all which have informed the Primary Care Model as it has evolved.

However, there continues to be challenges across Primary Care; our ability to meet patient expectations and increasing demands on services, coupled with a strategic priority to shift care out of hospitals, alongside a reduction in the number of newly qualifying doctors entering primary care and an increasing number of GPs retiring.

A detailed workforce analysis for General Practice in north Wales has been undertaken, with the conclusion that we need to continue to drive forward the multi-professional workforce model, alongside the training and recruitment of more doctors for primary care.

The sustainability of primary care services, specifically GP Practices, is identified as a key risk and is included in the Board Assurance Framework. The risk is described below:

BAF20-04 – Primary Care Sustainable Health Care

There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in a deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.

The further development of the Primary and Community Care Academy is seen as a key mitigating action to address this risk, as well as support the delivery of the national model.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The Academy supports the Health Board to meet the ambition of *A Healthier* Wales (2018) to ***Make Wales a great place to work in Health and Social Care.***

It is also a key enabler to evidence the Health Board's response to several key strategic documents including those published by WG and Health Education & Improvement Wales (HEIW), as well as the delivery of its own internal plans to include:

- ✓ A Healthier Wales (2018)
- ✓ Health Education and Improvement Wales (January 2019 & October 2020)
- ✓ Primary Care Model for Wales (April 2019)
- ✓ Strategic Programme for Primary Care (November 2018)
- ✓ Multi professional roles within the Transforming Primary Care Model in Wales (2018)
- ✓ Prudent Healthcare
- ✓ BCUHB Three Year Outlook and the IMTP 2021/22

The Academy's **objectives and action plans** have been developed to ensure that they respond to the needs of the north Wales Primary and Community services and that they are aligned to the overall Strategic Direction for the development of these services.

The Academy is focusing on the achievement of the following objectives:

- Implementation of a recruitment and retention strategy for primary care in north Wales
- Increasing the workforce capacity with Primary and Community care settings to meet the needs of the population
- Increasing the number of Education and Training programs designed to meet the needs of our workforce in Primary and Community Service
- Development, testing and evaluation of new ways of working to ensure the sustainability of Primary and Community services and bring care closer to home
- Increasing the number of Research and Development studies within Primary and Community Services

Furthermore the Academy is already strongly aligned to other local and national developments as detailed below:

Stronger Together

The Stronger Together programme has identified a number of key themes that are already inherent in the way in which the Academy has designed its schemes and in the way in which we treat each other and our partners.

Health Education & Improvement Wales (HEIW)

The development of HEIW's Multi Professional School for Primary Care is moving forward with pace and recently shared proposals for priorities for the school include areas that our own Academy has already developed and have shared with HEIW.

North Wales Medical and Health Sciences School (NWMHSS)

The Academy is well placed to support the development and delivery of the NWMHSS.

The Training Hubs, Professional Leadership and proposed programme of education and training to upskill the current workforce is crucial in ensuring that there are suitably trained competent practitioners, mentors, clinical supervisors and educators to develop the level of capacity to deliver the ambition of the School.

It is essential that we focus our efforts to developing capacity in Primary Care now to ensure the success of the School.

North Wales Dental Academy

The business case recognises the relationship with the North Wales Dental Academy, and is fully engaged with its development via the recently approved procurement process.

Opsiynau a ystyriwyd / Options considered

Do Nothing - All schemes would cease and core Academy Team members would need to be re-deployed. Primary Care Investment Funds would be released to test new ways of working and could be expanded to other contractor professions.

Do No More Than is Currently Being Done or the Do 'Something' Option - Continue to fund a number of the proposed schemes using the current funding source this will add a small number of practitioners to the workforce over time but not at the pace required, to have the impact and outcomes required.

Do 'All of It' Option - The Do All of It Option will allow for the development of the practitioners within primary and community services with pace without undermining the other training places required i.e. GP Registrar training, C21 Medical Students etc.

The Do 'All of It' Option is the preferred option presented in the business case.

Goblygiadau Ariannol / Financial Implications

In summary this Business Case seeks approval from the Health Board to provide a recurring budget of **£2,864,539,** from **April 2022** which includes the Primary Care Investment Fund (PCIF) recurring allocation of **£970,087** already being utilised, with this increasing to a recurrent budget (including PCIF Grant allocation) of **£3,605,547** from **April 2023.**

Therefore the:

Additional Funding Requested in 2022/2023 is **£1,894,452**

Additional Funding Requested in 2023/2024 increasing to **£2,635,459**

Dadansoddiad Risk / Risk Analysis

Primary Care Sustainable Health Services' is identified as a key risk on the Health Board's corporate risk register, featuring in the Board Assurance Framework (risk reference BAF20-04, current score 20), with the provision of a scaled up Academy and implementation of the all Wales Model of Primary Care, as two of the overarching mitigating actions.

A benefits realisation plan is being developed which will provide evidence of the outcomes of the investment, and therefore the impact on addressing the sustainability risk, should this business case be approved.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

This Business Case will form the basis of the Academy Annual Report, performances measure will be developed and approved via the Governance structure described in detail in this paper.

Asesiad Effaith / Impact Assessment

An EQIA has been completed and is available on request.

Division / Area / Department	**Exec Director Primary Care & Community Services corporate department**
Development or Scheme Title	**Progressing the** **Primary and Community Care Academy**
Author/s	**Gemma Nosworthy, Academy Manager** **Robyn Watson, Primary Care Development Manager** **Clare Darlington, Acting Associate Director Primary Care (Strategy)**
Executive Sponsor	**Chris Stockport, Executive Director Primary Care & Community Services**
Version	**14**
Date	**1st December 2021**

1.	**Executive Summary**
	The Primary & Community Care Academy, (hereafter to be referred to as the 'Academy'), was established in 2019 with the appointment to, two key roles, the Academy Manager and Development Manager. However, the ambition for an Academy was first set out as part of the development of the model that was adopted in Healthy Prestatyn Iach (HPI) in 2016, when the Health Board became directly responsible for the delivery of GMS services for the largest GP practice in north Wales. This Business Case seeks support for additional recurring funding to sustain, expand and further develop the Academy. The Academy supports the Health Board to meet the ambition of *A Healthier* Wales (2018) to ***Make Wales a great place to work in Health and Social Care.*** It is also a key enabler to evidence the Health Board's response to several key strategic documents published by WG and HEIW, as well as the delivery of it's own internal plans.

The Academy's **objectives and action plans** have been developed to ensure that they respond to the needs of the north Wales Primary and Community services and that they are aligned to the overall Strategic Direction for the development of these services.

The Academy is focusing on the achievement of the following objectives:

- Implementation of a recruitment and retention strategy for primary care in north Wales
- Increasing the workforce capacity with Primary and Community care settings to meet the needs of the population
- Increasing the number of Education and Training programs designed to meet the needs of our workforce in Primary and Community Service
- Development, testing and evaluation of new ways of working to ensure the sustainability of Primary and Community services and bring care closer to home
- Increasing the number of Research and Development studies within Primary and Community Services

As such, since September 2019 the Academy has achieved the following:

- Development and roll out of the Physician Associates in Primary Care Internship (5 PAs currently working in Primary Care)
- Establishment of a Training Hub with Clinical Practice Development Lead GP and Trainee Posts (1x GP & 3 Trainees)
- Implementation of the WAST/BCU Collaborative Developing Rotational Models in Primary Care with WAST Advanced Practice Paramedics (16 x APPs on rotation)
- Delivery of a new to primary care education framework to provide new to Primary Care practitioners education sessions to complement the clinical skills and knowledge gained in primary care (20 practitioners completing this programme)
- Placement of 4 x WAST Trainee APPs in Primary Care
- Supported over 10 Trainee/ACP qualified practitioners in Primary Care to return to practice or gain new skills in Primary Care

In addition, the Academy has had a number of abstracts and posters accepted at national conferences including:

- Royal College of General Practitioners (RCGP) 2021
- EMS 999 (Emergency Medical Services)
- International Round Table of Paramedicine
- Health Care Research Wales

Most recently the Physician Associates that were participating in the Internship were awarded Best Poster in the Service Design category at the RCGP Conference 2021.

Learning from Others

The Academy looks to the other nations to learn and adopt new ways of working and thinking. Links have been established with NHS England to share the learning from the BCUHB/WAST Collaborative Project: Developing a Rotational Model in Primary Care for

	Advanced Paramedic Practitioners and the Academy recently presented at the Health Research Conference 2021 to share the findings of this project. The Academy has looked to NHS Scotland to learn more about their approach to recruiting GPs in rural Scotland and will be recommending through the GP recruitment strategy the adoption of a number of similar programmes, they will of course be tailored to Wales. The Academy continues to contribute in Wales, working closely with Health Education Improvement Wales (HEIW) and the National Strategic Programme for Wales, having contributed to the (soon to be published) report on the development of Allied Health Professionals in Primary Care in Wales. **Model for Primary Care** There is a clear direction set by Welsh Government detailing the national Model for Primary Care (April 2019). This 'Primary Care Model for Wales' provides the national strategic direction for primary care and is entirely consistent with our local innovation in recent years. Indeed, BCUHB is able to demonstrate a number of exemplar projects that have significantly contributed to setting the pace and breadth of thinking within the model for Wales. In particular, the work achieved in the managed practices in Prestatyn, in Blaenau Ffestiniog, and across a range of innovative primary care advance practitioner roles within nursing, physiotherapy, pharmacy & occupational therapy; all have informed the Primary Care Model as it has evolved. Along with the development of the Academy, our workforce modelling, cluster development, and promotion of the social model of care philosophy are key pieces of work contributing to our rollout of the model. This builds upon a multi-disciplinary approach that strives to ensure that GPs deliver primary and community based interventions that only they have the skills to deliver, also promoting the de-medicalisation of care. There is therefore a requirement to develop a multi-disciplinary workforce to meet the needs of the patient population on a 24/7 basis. **Sustainability of Primary Care** Primary Care services, specifically General Practice, continue to face sustainability issues; patients presenting with multi co-morbidities, patient expectations and increasing demand on services (along with a shift of care out of hospitals), coupled with a reduction in the number of newly qualifying doctors entering primary care and the increasing number of GPs retiring. This is not just an issue for General Practice; this is an issue for all independent Primary Care Contractor services (Community Pharmacy, Dental and Optometry). A detailed workforce analysis for General Practice has been undertaken and workforce projections for General Practice in north Wales over the next decade are forecasting a deficit of between 150 to 240 whole time equivalent GPs and assumes a non-transformed primary care model. This analysis will be regularly refreshed and updated. The sustainability of primary care services, specifically GMS is therefore identified as a significant risk and is included in the Board Assurance Framework, with the further development of the Academy as one of the mitigating actions. The risk is described as below: ***BAF20-04 – Primary Care Sustainable Health Care***

	There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in a deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce. In order to be able to meet the statutory requirements placed on the Health Board to ensure Primary Care services are available for the population of north Wales, we need to work with our independent contractors to ensure the short and long-term sustainability of all Primary Care Contractor services. **Stronger Together** The Stronger Together programme has identified a number of key themes described below. The principle or themes are ones that are already inherent in the way in which the Academy has designed its schemes and in the way in which we treat each other and our partners. **Our Ways of Working** We have listened and continue to listen to our trainees, partners and stakeholder and shape our programme to address improve patient outcomes, examples include the qualitative evaluation of our Advanced Clinical Practice (ACP) Programme, the ACPs shared their experienced with us and we have restructured the programme to reflect these experiences **Strategic Deployment** All schemes in the Academy are developed based on the purpose and goals of the Health Board, its partners and stakeholders, we ensure there is a clear strategic drive behind each scheme. These can be found in further detail in this document. **How we organise ourselves** We endeavour to organise the Academy in the most effective and efficient manner avoiding duplication and maximising opportunities to work collaboratively and collectively. **The best of our abilities** Developing of workforce to meet the needs of our population and ensure the best possible care is at the heart of the Academy and drives the schemes we offers. In order to do so we must look within the current workforce and ensure that our colleagues are supported and developed to the best of their and our ability in a safe and supported environement.. We also recognise that not all skills required to deliver our services are within the current workforce, and we must work in partnership with our partners to ensure that we do not de-stabilise other services and compromise patient care. Examples of this include the collaborative with WAST. We must also grow our own and consider how we can support our practitioners from the outset of their careers to ensure a safe and supported learning / nurturing environment and our Physician Associates in Primary Care Internship programme does that. **How we improve & transform** Innovation and transformation are a key enabler in the delivery of the schemes proposed in this business case. Each of the schemes have been developed locally taking learning

from other areas in some cases because we do not need to re-invent the wheel, but in the main our schemes are ones that have developed locally. We currently deliver 2, first in Wales programmes, one of which is a first in the UK.

Developing the Workforce

It is evident that there is a need for new professionals and more practitioners to not only meet the projected workforce deficit but also to deliver the national Model for Primary Care.

This business case focuses predominately on the development of practitioners in General Practice and but also includes Community Pharmacy; the development of a North Wales Dental Academy is subject to a separate business case but will be hosted under the scope of the Academy.

The delivery of the national Primary Care model, alongside the delivery of more care within community settings will require a significant increase in advanced clinical practitioners and new professions working within Primary and Community care settings.

There is a shortage of suitable advanced clinical practitioners as well as GPs, but there is not a shortage of ambitious and capable potential applicants for training placements. Our work in recent years has clearly shown that advanced clinical practice professionals working within Primary Care need to train within Primary Care environments and that if done in a supportive environment they can flourish.

The Academy provides the ability to oversee this and provide mentorship, primary care experience and coordination, but to train sufficient individual practitioners we will need to think more creatively in order to fund their training placements. The nature of Primary Care means that training will require periods of time when the trainee is supernumerary, and the nature of independent contractors is such that practices will not shoulder the risk of salary costs to train a practitioner who can then move to another independent practice before they have seen a return on their investment. The Health Board has a critical role in unlocking these challenges.

North Wales Medical School (NWMS)

The Academy is well placed to support the development and delivery of the NWMS.

The Training Hubs, Professional Leadership and proposed programme of education and training to upskill the current workforce is crucial in ensuring that there are suitably trained competent practitioners, mentors, clinical supervisors and educators to develop the level of capacity to deliver the ambition of the NWMS.

It is essential that we focus our efforts to developing capacity in Primary Care now to ensure the success of the School.

Academy Funding Model

The Academy has therefore been established to support the sustainability of Primary Care and Community services through Education and Training, Innovation and Improvement, and Research and Evaluation, as well as lead targeted recruitment campaigns.

The Academy budget is currently sourced from the recurring Primary Care Investment Funds (PCIF) grant and Welsh Government Pacesetter Programme, with no core funding from the Health Board. This PCIFgrant funding is awarded on a recurrent basis to the

Health Board to test new ways of working within Primary Care with the aim of permanently implementing successful schemes supported by core funding.

The PCIF allocation awarded internally to the Academy in 2021/2022 and funds a number of the schemes, which are detailed in the table below and described further within this business case.

- GP Recruitment Strategy
- PC Sustainability and Innovation
- Physician Associate Internship Programme
- Academy Infrastructure
- Training Hub

In addition, the Welsh Government Pacesetter Funding of £840,000 is awarded to Health Boards for the purpose of testing new ways of working; it is recurrent but with the proviso that new initiatives are tested each year. It is currently being utilised to test the rotational model of working with WAST Advanced Practice Paramedics and to pilot a training model for practitioners at Level 7 moving into Primary Care.

This funding will cease with effect from April 2022 and a request for recurrent funding for this rotational training model for Advanced Clinical Professionals is included in this Business Case. The rotational model is one that can be applied across a number of professional groups and settings including but not limited to:

- District Nursing
- Community Pharmacy
- Ambulance Service

Additional funding is sought to increase the number of practitioners on the schemes and broaden the offer across the professional groups working within the wider Primary and Community Care MDT. In addition, funding is also required to expand the Academy Team, to further the development of the faculty and embedded evaluation, audit and research into the schemes, and to develop the professions to Consultant practice level.

This Business Case seeks approval from the Health Board to provide a recurring budget of **£2,864,539,** from **April 2022** which includes the PCIF Grant allocation of **£970,087**, with this increasing to a recurrent budget including PCIF Grant of **£3,605,547** from **April 2023**

Subject to approval recruitment to key roles will be undertaken during the financial year 2021/2022 utilising slippage from the current schemes

The roles key for the delivery of this business case are:

- Clinical Medical Lead
- Clinical Development Lead GP(s)
- Clinical Director for Medical Education
- Professional Leads for Nursing, Pharmacy & Meds Management and the Allied Health Professional workforce
- Non-Registered Workforce and Nurse Development Lead
- Non-Clinical Workforce Lead (this includes all contractors)
- Lead Research / Evaluation Officer
- Senior Admin Officer

The Academy also recognises that as it matures and develops, the Primary Care (GMS) landscape will also be changing. The schemes described within this business case are designed to flex to meet the needs of emerging models and changes in national and local policy and strategy. However, in order to enable the Academy to respond effectively and efficiently funding is sought to appoint to a number of posts on a permanent basis in 2021, noting that all other schemes will subject to regular review and evaluation to ensure that they continue to meet the strategic and operational objectives of the Health Board.

Through the development of the evaluation framework for the current programmes, we have been able to refine our areas of focus for evaluation and will further develop our approach to evaluation and demonstrating the benefits of the Academy model. The Academy has developed the following 7P Impact Evaluation Model for its programmes. The Academy through its evaluation of the programmes will seek to demonstrate an impact on

1. **P**atients
2. **P**rofession
3. **P**ractice
4. **P**eers
5. **P**artners
6. **P**erformance
7. **P**ublication Strategy

Implementation

If approved, a phased approach to the implementation of the full business case and schemes will be adopted. However, a number of schemes have already been established and will be up scaled.

First stage will include the appointment to the key roles noted above and the identification of the preferred site for the second and third training hub and its establishment, with already established schemes continuing to run alongside.

Recruitment to training roles will be prioritised to ensure that post holders are in post prior to commencing the MSc in Advanced Clinical Practice in Sept 2022.

SUMMARY

In summary there are 5 distinct elements to this business case:

1. Academy Management and Infrastructure

Additional investment required to fully implement the Academy Business Case and to provide a robust professional and management structure to support all of the programmes described in the Business Case. The Team will work closely with HEIW and the development of the Multi Professional School for Primary Care, the Universities and the North Wales Medical School Programme Group and in breaching the gap between Primary and Secondary Care and the gap between Primary Care Contractors.

2. Academy Training Hubs & Spoke Programme

This programme focus on fixed term supernumerary training roles and dedicated trainers in larger multi professional Health Board training practices focused on training and developing the next generation of clinical practitioners. Training Hubs will accommodate a range of trainees including undergraduate and postgraduate students alongside Trainee

Posts following MSc modules. This programme will include Physician Associates, Nurses, Pharmacist, Paramedics, Medical Students and GP Trainees

3. Developing Advanced Clinical and Consultant Practice Programme

This programme incorporates the Community Pharmacy scheme, Developing Advanced Practice through a Rotational Model scheme and the range of peer to peer programmes. This programme will be linked to the Hub and Spoke Programme specifically in developing the Spoke sites. This programme incorporates development of Nurses, Pharmacists (Practice and Community), Paramedics and Physiotherapy. Further details can be found within the embedded document – Delivery Plan 2021/2022 below.

Delivery Plan 2021 - 2022

4. Skills and Training Programme

This programme area focuses on the development of practical skills and training for the Practice Nurse, Health Care Assistant and the non-clinical administrative and management staff in Primary Care

5. Primary Care Sustainability and Quality Improvement

This scheme includes the GP / PC Recruitment & Retention Plan, Improving Quality with the Royal College of General Practice and Improving Access.

Primary and Community Care Academy Business Case						
Scheme	Proposed Budget FYE (2023/2024)	PCIF Funds	Additional Funding Requested 2022/2023	Additional Funding Requested 2023/2024	Fixed Costs	Flexible Costs
Academy Management and Infrastructure	530,132	136,747	393,385	393,385	530,132	-
Training Hub & Spoke Schemes	1,737,937	380,165	928,932	1,357,772	640,809	1,097,128
Developing Advanced Clinical Practitioners Programme (Level 7)	719,335	-	407,167	719,335	-	719,335
Developing Practice Nurse	349,246	184,278	164,968	164,968	64,968	284,278

	and HCA Workforce						
	Improving Access, Quality and Recruitment & Retention	268,897	268,897	-	-	123,897	145,000
	TOTAL	**3,605,547**	**970,087**	**1,894,452**	**2,635,459**	**1,359,806**	**2,245,741**

2. The Strategic Case

2.1 Strategic Fit

Welsh Government published the **"Model for Primary Care"** (The Model) in April 2019, with an expectation that this is adopted and implemented at a local level. The Model focuses on a number of principles to ensure that the right care is available at the right time, at the right place - at home or nearby. In order to be able to meet the principles of the Model and implement these at a local level, there is need to develop increased capacity and a workforce skilled in the Primary Care setting to be able to ensure **seamless, integrated working and effective care on 24/7 basis**.

There is therefore a need to focus on developing value based care by ensuring that the workforce fits the needs and circumstances of patients and avoids wasteful care and in accordance with the **principals of prudent healthcare**

Any service or individual providing a service should:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production
- Care for those with the greatest health need first, making the most effective use of all skills and resources
- Do only what is needed, no more, no less; and do no harm
- Reduce inappropriate variation using evidence-based practices consistently and transparently."

Value Based Healthcare is Healthcare that fits the needs and circumstances of patients and avoids wasteful care, the schemes proposed in this business case are designed to ensure that practitioner are able to benefit the whole system in which they work, are multi setting practitioners and who are able to play an active role in a multi-disciplinary team with the aim of providing care closer to home, avoiding unnecessary admissions to secondary care services and improving patient outcomes.

The Workforce Challenge in Primary Care

A recent report profiling the current and projected workforce for primary care in north Wales over the coming decade suggests that between 150 and 240 more GPs are required than are forecast to be available in the current system. Based on this projected GP deficit alternative roles are required to maintain and sustain Primary Care services, along with the ongoing delivery of medical education.

	Many GP practices continue to raise concerns about longer terms sustainability, particularly relating to availability of the clinical workforce and growing demand. Further detail is provided in **Section 2.3 – The Case for Change** The ability for primary care providers to support the **Transformation of Clinical Pathways,** and the delivery of more care out of hospital settings, as well as support the prevention of ill health requires the stabilizing, development and growth of the clinical workforce. A variety of professionals are keen to work within the Primary Care setting but the transition from one specialty to another can be difficult, as can the introduction of a completely new workforce e.g. the Physician Associate. There are few trainee posts available at any level within Primary Care and Community Services in north Wales, other than those are designed as part of the formal route to qualification (e.g. GP Trainees). In addition, it is becoming increasingly difficult to identify mentors and clinical supervisors to undertake these roles for practitioners that are not directly employed by them or are part of the GP Training scheme. Another challenge for GP practices in providing training opportunities is space within the practice to offer a practitioner. The majority of the current Primary Care Estate is not fit for purpose nor does it have the capacity to expand or suitable premises to modernise. The development of Training Hubs is one that is now being actively pursued by Health Education Improvement Wales (HEIW), however, this may require significant investment in premises in the future and in the early exploration/development stage. The first Primary Care Training Hub has been established as part of a Pacesetter Project at Healthy Prestatyn Iach with the creation of 4 Training Posts (2 x newly qualified Physician Associate posts) and 2 x Trainee Extended Practitioner posts). A small number of more resilient Health Board Managed Practices (HBMPs) are well placed to become Training Hubs addressing the capacity to offer training placements and the issue of space as there is often the issue of staffing these sites and the rotating locum workforce. With the introduction of a Clinical Practice Development GP and a small cohort of trainees this approach can quickly bring an increase in capacity and regularity and consistency of practitioner to the practice. This has already been demonstrated in HPI and in Criccieth & Porthmadog with both sites supporting a number and range of trainee practitioners. We have found through the Pacesetter Project and Physician Associate in Primary Care Internship that when placements are funded there is less resistance to engagement and when as with these 2 examples practitioners are not in practice on a full time basis it is easier to facilitate placements. The Rotational Model requires practitioners to be in the practice for just 2 days per week and the Physician Associate programme for practitioners to be in for 4 days per week with the a day for observational learning and CPD. A less traditional approach is now required to supporting placement in Primary Care as more and more undergraduate & postgraduate degrees and postgraduate modules such as non-medical independent prescribing require practitioners to spend a prolonged period of time in a Primary Care setting. Over recent years a small number of training schemes which have been developed on an adhoc/short term basis with the intention of creating opportunities that are both attractive to

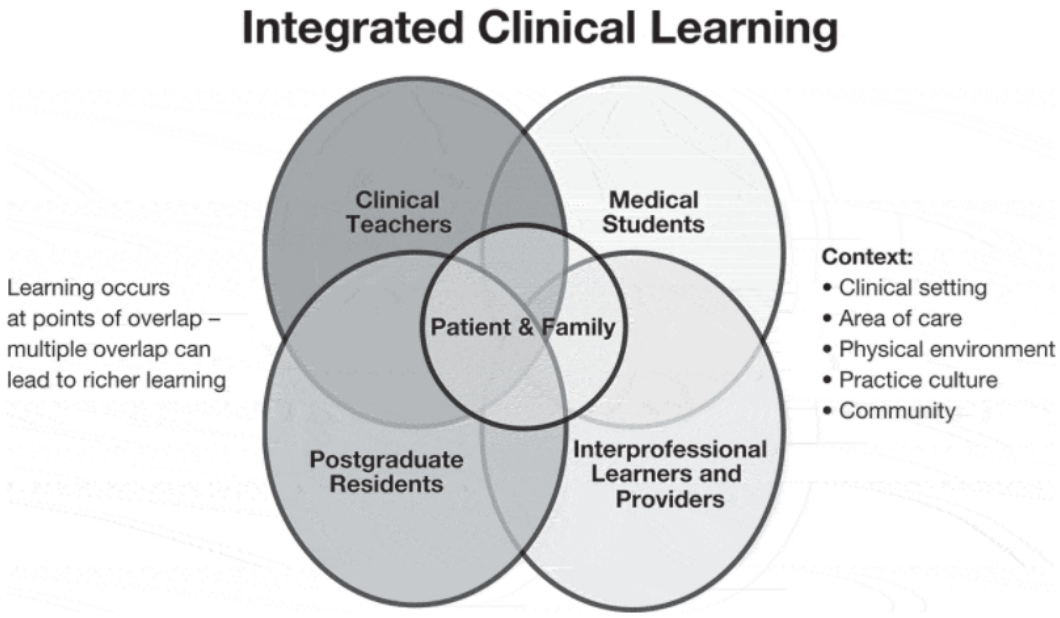
new qualified practitioners who are at the start of their careers, and for those that are looking to further develop their career in an alternative specialty.

These schemes are often short term due to the funding source but have produced great outcomes, an example of which is the Trainee Practice Nurse scheme, however this have not been adopted on a permanent basis and remain at risk year on year and is dependent on transformation funding which is not always guaranteed.

This scheme offered a fully funded post in a GP practice for Trainee Practice Nurse. Whilst a substantive post was not guaranteed at the end of the scheme, the trainees all secured posts in Primary Care.

Inter Professional Learning

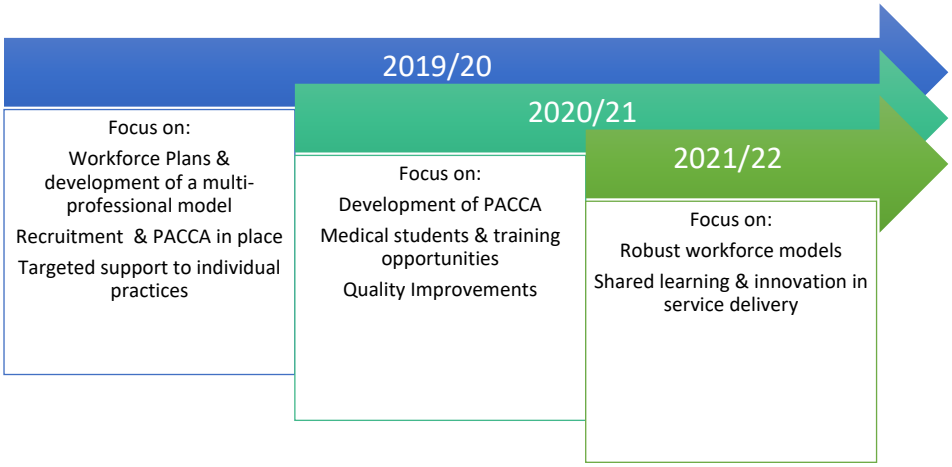
The Business Case sets out a plan to develop a range of professionals to work in a Primary Care setting. The development of Training Hubs supports the emerging practice of Inter Clinical Learning using a Team of Clinical Professionals to train and educate a team of learners from a range of professionals at different stages of their educational development. The paper *Integrated clinical learning: team teaching and team learning in primary care* Strasser and Berry (2021)



2.2	**Strategic Context** The Academy is a key enabler by which the Health Board will meet requirements of the following key strategic documents: ✓ A Healthier Wales (2018) ✓ Health Education and Improvement Wales (January 2019 & October 2020) ✓ Primary Care Model for Wales (April 2019) ✓ Strategic Programme for Primary Care (November 2018) ✓ Multi professional roles within the Transforming Primary Care Model in Wales (2018) ✓ Prudent Healthcare ✓ BCUHB Three Year Outlook and 2021/22 Plans The Academy aligns to the Health Board's Three Year Outlook Plan and is identified as an enabler to achieve the Health Board vision for a Healthy North Wales. It has been established to deliver the functions described in this document and is one mechanism by which the Health Board can deliver the *A Healthier* Wales (2018) aim to 'Make Wales a great place to work in Health and Social Care' Established to support the sustainability of GP practices and the introduction of the Model for Primary Care, the BCUHB Outlook Plan states: *To achieve this we will create an **Integrated Primary and Community Care Academy (PACCA)** learning environment that will support and provide training opportunities to a greater number of people interested in working within clusters. This approach will welcome those from partner organisations as we recognise the benefit from learning together.* Using this approach, we will provide increased training support for practitioners from a wide range of backgrounds who would like to develop advanced skills within Primary Care. These advanced practitioners, for example in nursing, therapy, pharmacy and mental health, will work alongside GPs to ensure that they have more time to concentrate upon providing care for individuals with needs that can only be met by a GP. This will contribute to our ability to recruit and retain a workforce able to meet the growing demands of our population The Academy's **objectives and action plan** have been developed to ensure that they meet the needs of the north Wales Primary and Community services and that they are aligned to the overall Strategic Direction (further detailed below) for the development of Primary and Community services. The Academy is focusing on the achievement of the following objectives: • Implementation of a recruitment and retention strategy for primary care in north Wales • Increasing the workforce capacity with Primary and Community care settings to meet the needs of the population • Increasing the number of Education and Training programs designed to meet the needs of our workforce in Primary and Community Service • Development, testing and evaluation of new ways of working to ensure the sustainability of Primary and Community services and bring care closer to home • Increasing the number of Research and Development studies within Primary and Community Services The Academy's current Delivery Plan 2019 – 2022 is embedded below

PaCCA Delivery Plan 2019 – 2022	PaCCA Delivery Plan 2019 - 2022

As noted in the BCUHB Outlook Plan, these are the actions attributed to the Academy:



The agreed actions have been completed and this Business Case sets out the next stage in the implementation of the Academy. It is anticipated that in future years additional cases will be brought forward based on the impact of this initial business case.

The following table highlights how the Academy meets the objectives of key strategic publications:

Strategy	**Objective**	**How the Academy meets this Objective**
A Healthier Wales (2018)	The Health and Social Care Workforce "This new strategy will address the Parliamentary Review's call for joint regional workforce planning with an emphasis on expanding generalist skills and enabling staff to work at the top of their skill set and across professional boundaries, in line with the philosophy of prudent health care"	Through the delivery of new training post which are based in multi-disciplinary team practices. With the development and implementation of the Primary Care Competency Framework for Enhanced/Advanced and Consultant level practice with HEIW With the testing of the MDT Training Hub, bringing together professionals across boundaries to share learning Through the development of rotational models.

Primary Care Model for Wales (April 2019)	Seamless Working Integrated Care for People with Multiple Care Needs Quality Out of Hours care	Development of multi-disciplinary teams through the education and training of professionalism working across the system in and out of hours
Strategic Programme for Primary Care (November 2018)	Development and improvement of the education and training available to health professionals and healthcare staff (e.g. pharmacists) in primary care. Framework to expand education and training in primary and community settings.	Through the development and delivery of the training posts, education and training is built into all training post Schemes already in place include: • New to Primary Care APP Rotational Model • Physician Associate Internship
Multi professional roles within the Transforming Primary Care Model in Wales (2018)	The necessity to develop supervision and mentorship should be recognised and addressed. Study leave and CDP requirements should be included in all MDT professional contracts. High quality mentoring and supervision for all MDT professionals are key to the development of the MDT and need to be developed further as the transformational model progresses. It is important to recognise that these responsibilities add to the workload pressure of those providing supervision and mentoring for extended MDT roles. A focus on developing career pathways, with standardised education and training within primary and	Introduction of Professional Development Leads (PDL) for MDT workforce to build the skills necessary in the Primary and Community care workforce to meet the needs to The Model for Primary Care. PDLs to advocate for and influence job planning and workforce modelling where appropriate. Hub and Spoke site supports the “Train Where you Work” model ensuring that local knowledge is applied to maximise the learning opportunity and to embed practitioners in the wider system building knowledge, contacts and skills that are transferrable across the system. A funding structure to enable access to quality mentorship and supervision and provision of these opportunities through the Health Board Managed practices and Training Hubs.

		community settings, is required. Clear and consistent career progression frameworks should be established for the full range of MDT professional groups, improving motivation and retention of the cluster workforce through a greater range of career opportunities for all disciplines in primary and community care.	Rotational Models which offer practitioners opportunities to work in other areas of the system to enhanced personal and professional learning and work across the Cluster system supported by a programme of education. Developing opportunities for all professionals to work and train in Primary and Community settings and to advocate and influence the development of career progression frameworks for the full range of MDT professionals.
	The Quadruple Aim	Improved population health and wellbeing Better quality and more accessible health and social care services Higher value health and social care services A motivated and sustainable health and social care workforce	Introduction of the Training Hubs and Spokes to ensure high quality education and training to improve patient's outcomes. The multi-disciplinary approach will ensure multi sector/disciplinary shared learning Supernumerary training posts and dedicated Practice Development GPs will ensure that practitioners are supported throughout their training post contract. Professional Development Leads to ensure quality of practice and ceilings of competency are achieved MDT focused placements and shared learning opportunities Schemes designed for Primary and Community settings
2.3	**Organisational Overview** **Operational Delivery** The Academy has been established to support the sustainability of Primary and Community services, with an initial focus on General Practice and the development of Advance Practice, and the introduction and implementation of new roles across the breadth of the professions including: • Advanced Paramedic Practitioners • Physician Associates		

	The Academy recognises that it has a role in supporting the totality of the education and training pathway from undergraduate to postgraduate and has established links with colleagues with responsibility for education commissioning and course content. Further work is ongoing to gather more detailed information on the education/observational placement requirements for the range of course delivered by our Education Partners. However, this case and the Academy has been directed to focus on the MSc Level practitioners with aim of bridging gap between our GP workforce modelled deficit. The Academy will provide the following functions: ***Education and Training*** • Provision of relevant training modules • Develop, deliver and commission education and training frameworks that focus on the social and medical model of health • Coordination of advance practice training opportunities • Arranging mentorship and clinical supervision for developing advance practice skills ***Improvement and Sustainability*** • Provision of a library of best practice and innovation exemplars • Packages of coordinated support and advice to practices • Individual career development advice • Develop and implement a north Wales Primary Care Recruitment Strategy ***Research and Innovation*** • Develop, test and evaluate pilot projects including Welsh Government Pacesetter Projects • Extend the knowledge base in prudent primary and community healthcare, and the multidisciplinary social model of care • Support for practitioners interested in research and innovation **Governance Structure** ***Inter Professional Education Improvement Group*** Governance has been strengthened through the inclusion of the Academy as a member of the Inter professional Education Improvement Group chaired by the Executive Director for Workforce, which in turn reports directly to an Executive Delivery Group and through to People, Professionals and Population Health Committee.. In addition, the appointment as noted above to the Professional Leads for P& MM, Nursing and Therapies will embed Primary Care into the Professional Governance structures already established in the Health Board ***Strategic Leadership Group*** The Academy has been overseen by the Strategic Leadership Group (SLG) and has been established to provide strategic direction, scrutiny and oversight to ensure the successful delivery of the Academy, the SLG will: • Be a decision maker • Provide clarity & guidance • Agree Academy priorities • Manage risks, resolve issues and remove barrier • Monitor performance

	The Interim Associate Director Primary Care and Community Services chairs the SLG. ***Operational Delivery Group*** The Operational Delivery Group membership has representatives from across the professions to ensure that this voice is included in the Academy Action Plan, this does not replace the SLG but is anticipated that this group will form the basis of the Academy Faculty Committee. ***Academy Faculty Committee / Professional Development*** It is proposed that the Academy Faculty Committee will support the SLG and Academy Management Team; membership will be drawn from across the clinical and administrative professions to support the development and the delivery of the Academy and its programmes. The appointment of Professional Leads and the Clincal / Medical Lead will provide the professional leadership for their respective professions in Primary Care. Professional Leads will be required to actively engage and integrate with the structures already established within the Health Board bringing the professional development needs of the workforce working in primary care. ***Academy Management Team*** Supported by the SLG and Academy Faculty Committee, the Academy Management Team currently consists of an Academy Manager (reporting to the Assistant Director Primary Care & Community Services), Academy Development Manager, and Clinical Practice Development GP. The Academy also hosts the Pacesetter Lead Research Officer post. The appointment to the Clinical/Medical Lead will complement the management team. The Clincal/Medical Lead will have line management responsibility of the Professional Leads and the Senior Admin Officer will provide administrative support. ***BCUHB Infrastructure to support the Team*** It is noted that this business cases seeks funding for roles that may be considered are already in place within the Health Board such as those within Education and Training, Research and Development. However, through the early establishment of relationships with key individuals in these areas it has become apparent that is a gap in the provision for Primary Care services, both in capacity and expertise, as this is often seen as the independent contractor responsibility. As the Health Board has a statutory responsibility to ensure the public have access to all primary care services, it is the commissioner of these services, as well as a significant provider through the delivery of GP Out of Hours services, urgent primary care, and Health Board Managed GP Practices, this is a gap that requires addressing. **Partnership Working** ***Strategic Programme for Primary Care*** Close working links have been established with the national Strategic Programme for Primary Care sharing the learning from the Welsh Government funded Pacesetter Project. The Phase I Evaluation Report, published abstracts and articles and approach to evaluation focused on value based healthcare and a whole system approach has been welcomed by the Programme. ***Health Education & Improvement Wales (HEIW)***

	Again, the Academy Team has worked hard to establish links within HEIW, specifically in a number of areas including the National Implementation Group for Physician Associates, the Non-Clinical HCA Development Group, the Extended, Advanced and Consultant Framework working group and most recently the development of Academies and Training Hubs. The Team maintain an active dialogue with HEIW colleagues testing new ideas and sharing learning as we progress with locally developed schemes. ***Regional Partnership Board*** Whilst established by the Health Board, the focus of the Academy is broader than its own workforce and contracted services. The sustainability of all Health and Social Care services are dependent on their staff and ability to training, re-train, recruit and retain. Links with the Regional Partnership Board have been established at a strategic and operational level ensuring that the outcome of the investment in the development of Health and Social Care Localities feed into the evolving work plan for the Academy. The recently commissioned workforce skills analysis work will feature heavily in the development of future schemes to ensure that they meet the needs of our population. As will the learning from COVID-19 and the Research, Innovation and Improvement Hub led collation of lessons learnt, innovation and most significant change work. ***Health and Social Care Localities Development*** Whilst initially focused on the development of Advance Practice in General Practice, the Academy has invited all contractor functions to complete an online questionnaire to shape the focus of the Academy. ***Clusters*** From the outset the Academy has worked with the Clusters via the Cluster Leads group and the Area Cluster Teams. Identifying opportunities to introduce new roles, establish stronger links and collaborative working. Working with the Clusters to introduce new roles through fully funded posts and practice attachment fees which recognises the need to facilitate and fund time specifically for education and training at a practice level. Clusters have been instrumental in developing the schemes to meet their local needs. ***Welsh Ambulance Service Trust*** The Academy leads the Project Management function for the Pacesetter collaborative with Welsh Ambulance Service Trust. In addition to the Pacesetter project, the Academy has been instrumental in finding and providing clinical placements for Trainee Advance Practice Paramedics across north Wales and specifically at Healthy Prestatyn Iach where the Trainee APPs have been working alongside the Multi-Disciplinary Team with a dedicated GP mentor, and in our Health Board Managed practices in Anglesey, where two Trainee APPs were based and mentored for 8 months. ***Independent and Managed Practices*** The Academy has established strong links across a number of independent and health board managed practices through the establishment of the Pacesetter Project and Internship scheme and has established the Primary Care Training Hub at Healthy Prestatyn Iach. The Training Hub with a dedicated Clinical Practice Development lead GP funded by the Academy to support a cohort of Trainees and in the delivery of a bespoke programme of education supporting the ongoing development of an Advanced Clinical Practitioner in Primary Care competency and education framework.

	Developing Partnerships Moving forward the Academy will establish and develop links with: • the Local Medical Council, • Local Dental Council • Community Pharmacy Wales This will be achieved in part through the implementation of the plans described in this business case and through local level engagement.
2.4	**Relevant National and Local Strategies** As detailed above, these include: ✓ A Healthier Wales (2018) ✓ Health Education and Improvement Wales (January 2019) ✓ Primary Care Model for Wales (April 2019) ✓ Strategic Programme for Primary Care (November 2018) ✓ Multi professional roles within the Transforming Primary Care Model in Wales (2018) ✓ Prudent Healthcare ✓ BCUHB Three Year Outlook and 2021/2022 Annual Plan ✓ Primary Care Questionnaire Feedback
2.5	**The Case for Change** **<u>Delivering the new model for primary care:</u>** Public Health Wales, Welsh Government and NHS Wales have worked collaboratively to develop the "<u>New Model for Primary Care</u>" which calls for the development of a number of areas across Primary Care including the following were the Academy can be instrumental in delivering: ***Seamless Working can be described as:*** *Staff working together across different departments; it increases efficiency and ensures the local community can access clinical, social and managerial expertise. Coordinated teams include professionals like pharmacists, community nurses, physiotherapists, social workers, paramedics, physicians' associates, occupational therapists, mental health counsellors, dieticians, third sector workers and other local authority staff, who manage the everyday needs of the local population.* *Coordinated teams break down barriers within local health and social care systems to promote integration of services and cultural change, to benefit the local community.* *Additionally, there are joint contracts, shared working spaces and learning sessions, and opportunities for professionals to rotate between different sectors. There are many models that promote more seamless or collaborative working, such as federations and social enterprise.* ***Integrated care for People with Multiple Care Needs*** *Integrated working supported GPs and advanced practitioners to have more time to care for people with multiple needs, who are often elderly with more than one illness. As a result, significantly longer consultation times are needed to assess, plan and coordinate anticipatory care.*

People with both health and social care needs can be supported by uninterrupted care from community resource teams and other integrated local health and care teams.

Welfare, housing and employment problems can be better managed through a whole system, multi-professional approach. Coordinated teams are also well placed to care for acutely ill people who can be treated at home and at community centres. These community teams can also facilitate a faster discharge from hospital.

This seamless model offers a more proactive and preventative approach to care, and when people are treated earlier, they respond better to advice and support for self-care, which results in better outcomes and experiences for people and carers.

The model can potentially offer a wider range of planned care for the community, including outpatient appointments and treatments, and diagnostic tests. It could also reduce referrals and unplanned appointments, allowing hospital staff to focus resources on those who require hospital care and on planned specialist care.

The proposed for the continued sustainability of primary care, this multi-professional workforce are required to meet the health needs of the population. These alternative professionals do not replace the GP however they are a viable substitute and complementary to the medical workforce to best meet the needs of the population.

Workforce Sustainability:

In order to address the recognised shortfall of GPs entering the workforce in the coming decade and coupled with expected number of GPs retiring from and/or leaving the workforce, the increasing complexity of the health needs and longevity of the population alternative service models are now required.

The Primary Care and Care Closer to Home Update Report (November 2019) details the current and projected workforce for primary care over the coming decade, this workforce analysis suggests that between 150 and 240 more GPs are required than are forecast in the current system.

Based on the projected GP deficit, alternative roles are required to maintain and sustain GP Primary Care services.

For the purpose of demonstrating the workforce skill mix replacement the following ratio has been developed:

1 x GP	0.5 WTE B7
	0.7 WTE B8A
	0.4 WTE B8B
	0.3 WTE B8C

Therefore based on the projections of between 150 and 240 GP deficit in the system by 2029 the following number of practitioners is required.

Band	150 GP Deficit	240 GP Deficit
Band 7	75	120
Band 8A	105	168
Band 8B	60	96
Band 8C	45	72
Total	285	456

The scenarios above suggest a “steady state” and a workforce already in place from which to work from.

Findings from the Primary Care Stakeholder Questionnaire:

94 individuals completed a questionnaire (93 English, 1 Welsh), with the majority working in Primary Care North Wales.

Primary Care contractors were advised that the survey could be completed by individuals or as a Practice, it is assumed that the majority of the Practice Managers completed on behalf of the clinical and administrative teams in the practice.

Profession	Total number of responses
Practice Management	29
Nursing	28
Medicines Management/Pharmacy	27
GP	5
Physiotherapy	2
Informatics	1

Responses were received from all Cluster and the full report can be found below

Primary Care Questionnaire Findings V4	 PC Questionnaire Findings V4

Of particular note are the following:

When asked “What Can the Academy do to support you and your practice?”

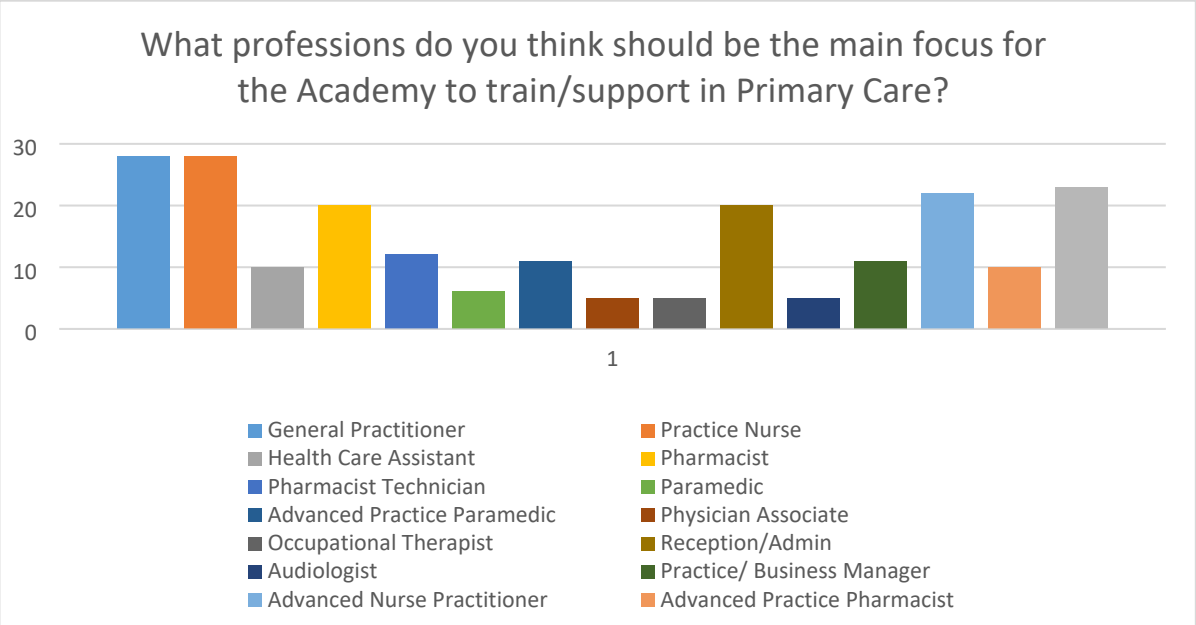
Top 6 highest scoring responses from a pick list where:

1. Provision of relevant training modules
2. Coordination of Advance Practice Training Opportunities

3. Arranging mentorship and clinical supervision for developing advance practice practitioners
4. Packages of coordinated support and advice for practices
5. Extending the knowledge base in prudent primary and community health service
6. Support for practitioners interested in research and innovation

We asked colleagues what professionals we should focus on in Primary Care, the top 6 (scoring 20 or more) are detailed below were GP, Practice Nurse, ANP & NP

GP	28
Advanced Nurse Practitioner /Nurse Practitioner	45
Advanced Pharmacist Practitioner/Pharmacist	31
Reception and Admin & Business Management	31
Practice Nurse	28
Advanced Paramedic Practitioner / Paramedic	17



In addition, we asked colleagues:

	What do you think would be the most suitable way of expanding training capacity in Primary Care? **Training hubs,** development of training hubs within a small number of practices, providing dedicated support & training to professionals. Development of clear training plans for a standardised approach to placements and training, dependent on profession. **Practice based training;** HEIW and the Academy team will support students to find placements in North Wales, and provide standardised training plans for each profession. **Stay the same;** Practice based training, with no input from the Academy team. The highest scoring option (62 votes) was Training hubs; development of training hubs within a small number of practices, providing dedicated support & training to professionals. Development of clear training plans for a standardised approach to placements and training, dependent on profession. Second option had 46 votes, Practice based training; HEIW and the Academy team will support students to find placements in North Wales, and provide standardised training plans for each profession. Both options will be developed, with a view that they could both work alongside each other, dependent on the needs of the Area or Cluster. Over 70% of practices would like to offer more training in practice, the reasons they are unable to do so are mostly down space/ Premises, Capacity and Time. The majority of practices 75% would be interested in being involved in a LES for training and education. Rotational roles were viewed positivity, as it was felt it would 'give greater understanding of the different areas of work and encourage cross working'. Other positive comments advised it would encourage networking, confident independent working, support skill acquisition and succession planning. It was noted that the rotations would have to be long term to be fully established in the role and team. Concerns raised around continuing to train staff who would then go back to work in another department who will use their new skills, and Primary Care may not benefit. Many professionals have asked for further clarity on how this would work in practice, so would need to be visited on a case by case basis. **Benefits of an Academy Model:** Introducing supernumerary fixed term trainee and internship posts, and funded fixed term Rotational Models ('try before you buy' approach) within Primary & Community settings provides the opportunity to meet the educational and training needs of practitioners either new to primary care or progressing their career to extended or advance practice safely and in an enriched environment focused on learning. This approach recognises and values the input of the practitioner and mentor to allow for time and space to bring forward practitioners who will be well prepared and experienced to work as autonomous and independent practitioners in the high paced Primary and Community care environment. The Academy model seeks to meet the needs of the workforce identified by HEIW stakeholder workshops held in 2019. **Valuing and retaining workforce**: Creating a stable workforce that feels valued, reflected by reward and recognition including opportunities for development

Workforce Shape: Ensuring a flexible and sustainable workforce in sufficient numbers to meet needs

Seamless Working: Multi professional and multi-agency working to deliver excellent services to support new person centered models

Education and Learning: Ensuring a competent, capable and confident workforce who are supported to meet current and future service needs, and advance their careers

Additional benefits include:

- Increase number of extended and advance practice clinicians working within primary care;
- Practitioners working to the ceiling of their competencies within primary care due to increased confidence to practice by gaining support from and providing support to their Primary Care and Professional colleagues;
- Increase number of professionals both clinical and non-clinical who have received education and training in their relevant fields based on a skills gap analysis;
- Attracting practitioners to train, work and live in north Wales;
- Practitioners who feel valued and are valued;
- Equal pay for equal roles;
- Improved patient outcomes;
- Reduced waiting times;
- Increased capacity within primary care health settings;
- Improved communication between primary, community and secondary care and partner agencies;;
- Multi-disciplinary team working
- Multi skills practitioners able to work in multiple settings;
- Alternative careers options within the NHS family;
- Continuity of service and terms & conditions whilst training and working in Primary Care;
- Security of role with flexibility of care setting ;
- Integrated workforce;
- Whole system approach to patient care

The following table outlines a SMART analysis of the proposal:

Specific	Measurable	Attainable	Relevant	Timely
Increase the number of clinical and non-clinical professionals in primary care through a programme of training and education opportunities developed to meet the needs of the professionals at different times	The success of this proposal will be measured as follows: • Number of professionals choosing to follow a career in Primary Care • Retention of staff post training • Retention of staff post retirement age	Subject to approval this plan is attainable Schemes have already been established on a small scale and can be expanded further subject to additional funding	• A Healthier Wales (2018) • Health Education and Improvement Wales (January 2019) • Primary Care Model for Wales (April 2019) • Strategic Programme for Primary Care (November 2018)	This business case has been developed to be delivered over a 3-5 year period. With a requirement for regular review against agreed milestones and KPI

during their career to support the sustainability of Primary Care services. To provide an evidence based approach to developing roles in primary care To contribute to the wider learning through a programme of research and evaluation based	• Increase in number of MDT professionals in Primary Care • Recruitment of suitably qualified / experience staff to vacancies in Primary Care • Increased capacity to meet patient demand in Primary Care		• Multi professional roles within the Transforming Primary Care Model in Wales (2018) • Prudent Healthcare • BCUHB Three Year Outlook and 2019/2020 Annual Plan	

Each Scheme can support a maximum number of professional per training period; this is dependent on the programme.

It is important to note that the Academy will not generate any additional capacity other than is currently already commissioned via the annual education commissioning cycle, it will however, upskill the workforce and upskill more of the workforce than previously planned for through the additional investment.

It creates supernumerary posts and associated funding for education and training for these posts.

It creates more trainee specific roles in supportive training environments and through the Health Board Training Hubs, these roles will be within multidisciplinary teams ensuring that practitioners are exposed to and learn about the role of other professionals in caring for the health and wellbeing of the population of north Wales.

This approach demonstrates the Health Boards commitment to the recruitment, retention and development of its workforce.

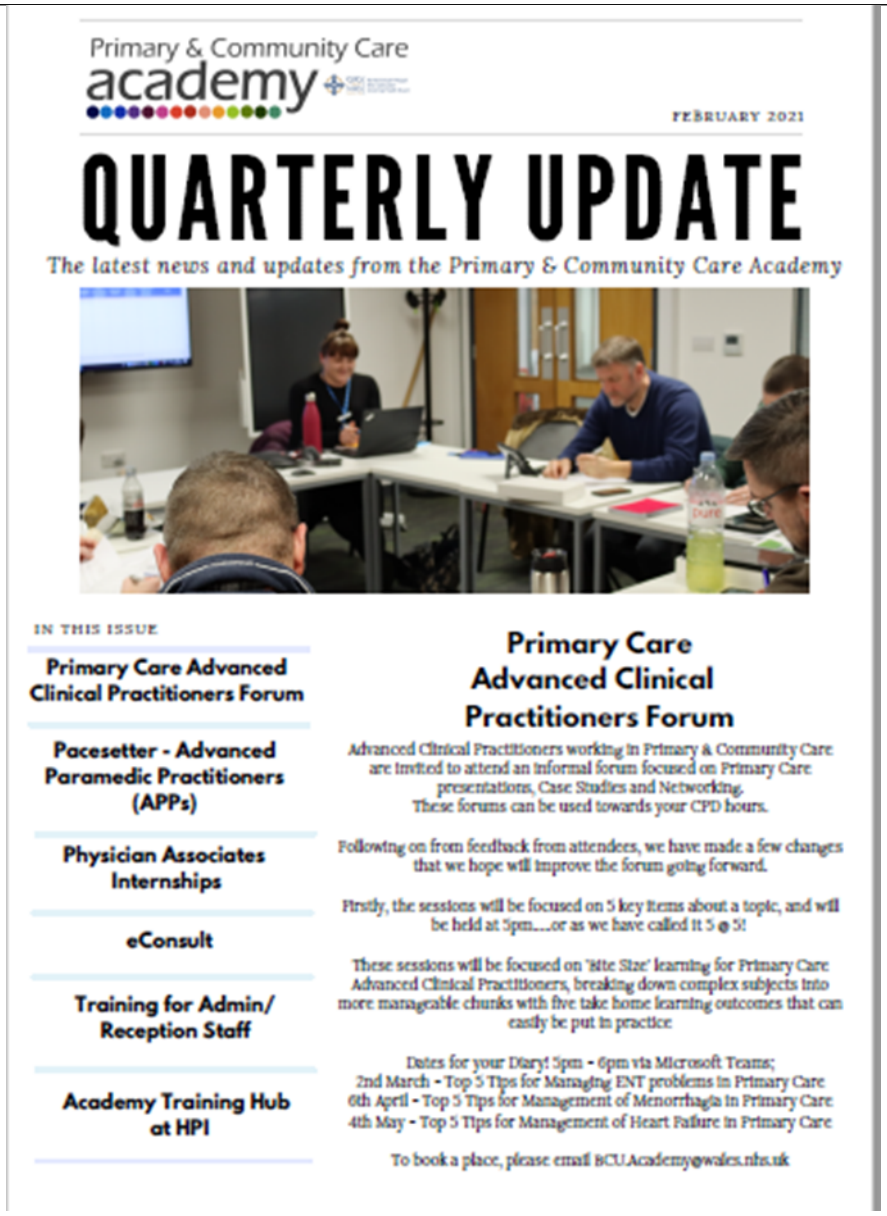
It demonstrates the Health Boards commitment to the sustainability of Primary Care through additional investment in training posts for the benefit not only of Health Board Managed Practices and the Out of Hours service but for the benefit of the Independent Practices and in the case of the rotational model other areas of the Health Service and System.

Scheme	**Number of benefitting Practitioners**	**Basis**
Physician Associate	4	Annually

Advanced Clinical Practitioners	8 (16 in the programme over a 2 year period – 8 “graduating on an annual basis)	Annually (following first year)
Community Pharmacists	15	Annually
Rotational Working Training Model	10	18 months
Total in Training	**43 (49)**	-
New to Primary Care Education Programme	12	Annually
Supporting Advanced Clinical Practice	16	Annually
Total Supported through Group Learning	**28**	-
Practice Nurse and HCA Training and Education Programme	TBC – dependent on level of funding secured	Annually
Non-Clinical Workforce	TBC – dependent on level of funding secured	Annually

2.6 **Existing Arrangements and Future Plans**

A dedicated website has been developed for the Academy which provides a good overview of the successes to date, along with twitter and Facebook social media presence. Quarterly newsletters are also disseminated both locally and nationally.



Primary & Community Care academy

FEBRUARY 2021

QUARTERLY UPDATE

The latest news and updates from the Primary & Community Care Academy

IN THIS ISSUE

- Primary Care Advanced Clinical Practitioners Forum
- Pacesetter - Advanced Paramedic Practitioners (APPs)
- Physician Associates Internships
- eConsult
- Training for Admin/ Reception Staff
- Academy Training Hub at HPI

Primary Care Advanced Clinical Practitioners Forum

Advanced Clinical Practitioners working in Primary & Community Care are invited to attend an informal forum focused on Primary Care presentations, Case Studies and Networking.
These forums can be used towards your CPD hours.

Following on from feedback from attendees, we have made a few changes that we hope will improve the forum going forward.

Firstly, the sessions will be focused on 5 key items about a topic, and will be held at 5pm....or as we have called it 5 @ 5!

These sessions will be focused on 'Bite Size' learning for Primary Care Advanced Clinical Practitioners, breaking down complex subjects into more manageable chunks with five take home learning outcomes that can easily be put in practice

Dates for your Diary! 5pm - 6pm via Microsoft Teams;
2nd March - Top 5 Tips for Managing ENT problems in Primary Care
6th April - Top 5 Tips for Management of Menorrhagia in Primary Care
4th May - Top 5 Tips for Management of Heart Failure in Primary Care

To book a place, please email BCU.Academy@wales.nhs.uk

The funding source for the Academy is the Primary Care Investment Fund Grant, it funds the following posts on permanent basis:

- Academy Manager (8A) x 1 wte
- Academy Development Manager (B6) x 1wte
- GP Clinical Practice Development Lead GP x0.8wte
- Consultant Nurse Primary Care (8C) x 0.25wte

Training schemes have been designed to ensure that training/internship posts are supernumerary and include funding for education and training, with designated clinical programme leadership input included.

It is evident from on the ground experience that staff need time and support to develop into better practitioners; it doesn't happen overnight and it doesn't happen quickly if staff are required to do the day job too.

In order to develop and train good quality practitioners at scale and with pace there must be sufficient investment in training roles across the professions working in primary and

community services and in securing mentors and clinical supervisors to support the practitioner.

1. ACADEMY MANAGEMENT AND INFRASTRUCTURE

Additional investment required to fully implement the Academy Business Case and to provide a robust professional and management structure to support all of the programmes described in the Business Case. The Team will work closely with HEIW and the development of the Multi Professional School for Primary Care, the Universities and the North Wales Medical School Programme Group and in breaching the gap between Primary and Secondary Care and the gap between Primary Care Contractors.

Additional funding is sought for:

1. Lead Research Officer to meet the Academy's function of:
   - Develop, test and evaluate pilot projects including Welsh Government Pacesetter Projects
   - Extending the knowledge base in prudent primary and community healthcare, and the multidisciplinary social model of care
   - Support for practitioners interested in research and innovation

2. Non – Registered and Practice / Community Nurse Development Lead to support the development of this workforce including (but not limited to):
   - HCA
   - Practice Nurses
   - Treatment Room Nurse

3. Skills & Training Manager to support the development of the non – clinical workforce to include (but not limited to):
   - Navigators
   - Administrators
   - Practice Managers
   - Receptionists

   This role will support all Primary Care contractor services

4. Clinical Medical Lead, this post will ensure clinical governance and oversight linking with Area Medical Directors, Clinical Leads and Clinical Directors for Medical Education in the development of the Academy and in the development of the North Wales Medical School

5. Professional leads for the development of the Extended/Advanced and Consultant workforce in Primary and Community:
   i. Nursing – 0.4wte
   ii. Pharmacy and Medicines Management – 0.4wte
   iii. AHP – 0.4wte

   These posts will provide strategic leadership and development of the workforce in line with the emerging framework for Extended/Advanced/Consultant practice. They will act as Mentors and Advocates for the MDT in Primary Care.

6. The appointment of Senior Admin Officer post to support the Core Academy Team and the Academy schemes

Office Space and Training Rooms

Office space and training rooms are at a premium within the Health Board sites and within those of our Partners. With the proposed growth of the team and schemes included in this Business Case the investment in securing offices off site with access to training rooms, shared workspace and that are easily accessible for north Wales are now required.

Suitable multiuse space has been identified in the Optic Centre, St Asaph Business Park, Denbighshire. An SBAR paper has been drafted to seek ET approval for the short term leasing of office/multi space; however this will be further reviewed in relation to possible options available as a result of changes in premises use as a result of the pandemic.

Discussions are now ongoing with colleagues leading the development of the Dinerth Road development to secure long-term office / training space.

SBAR – lease for temporary accommodation	 20201022 SBAR for the approval to secu

2. ACADEMY TRAINING HUBS AND SPOKES

This programme focus on fixed term supernumerary training roles and dedicated trainers in larger multi professional Health Board training practices focused on training and developing the next generation of clinical practitioners. Training Hubs will accommodate a range of trainees including undergraduate and postgraduate students alongside Trainee Posts following MSc modules.

Inter Clinical Learning

The establishment of Training Hubs will facilitate the development Inter Clinical Learning with the make up of students and trainees based at the Hubs from a range of different professional backgrounds and at different stages of the career development / education pathway. Wth an In House faculty of multi professional trainers/mentors the Hubs offer the perfect training and learning environment for a range of learners

The recently published paper Strasser and Berry shares the learning from Ontario and the model of Inter Clinical Learning – a team of trainers delivering learning to team of learners. The professional mix of both learner and trainer will further enforce and embed the model for primary care now and in the future of a multi professional workforce.

Healthy Prestatyn Iach Training Hub

The current Academy Training Hub is located at the Health Board Managed Practice – Healthy Prestatyn Iach; the flag ship GP practice for the Health Board based in the Central Area, promoting the new model of primary care, with a registered population of approximately 20,000 patients across a broad demographic.

This is where the multi-disciplinary team model was first established in Wales and this has since been adopted as the preferred model for “The Model for Primary Care”.

	The approach in place provides training, education and practical exposure to a broad range of patient at a large practice with a MDT and a focus on the de-medicalisation of health with a shift to the social model of health is best placed to nurture the next generation of practitioners and experience all elements of primary care practice with a broad range of practitioners. This business case seeks to provide **three additional Training Hub in north Wales**, as this is the preferred model as evidenced through the Primary Care Stakeholder questionnaire and further reinforced at a HEIW Conference held in October 2020. In addition to the Training Hub in HPI, two Training Hubs will be established in the West with the fourth site yet to be agreed. Core funding is therefore sought to establish 3 further (4 in total) Training Hubs in north Wales: 1. 16 x Supernumerary 2 year fixed term training posts (8 x posts in year 1 and a further 8 in year two, to have a rolling intake of practitioners) 2. 6.0 WTE permanent Clinical Practice Development Leads (GP/Non-Medical), to be based at the Academy Training Hub sites (1.5wte in each site) 3. The appointment of a Training Hub Manager to ensure that the implementation, learning, administrative function including recruitment etc. is managed locally (Band 7). Training Hubs will also support a variety of other professionals requiring observational / learning placements including offering a multi professional / inter professional learning environment supporting the next generation of clinical professionals. Training Hubs will host C21 Medical Students, Trainee Pharmacists and Physician Associates (both Trainee and Internship posts). **(Training Hub) and Spoke Schemes** Training/Internship Schemes based at sites in addition to the training hubs are essential to meet the workforce needs of the future. It is therefore intended that in addition to the Training Hubs that there are Academy Spokes throughout the region. Funding is sought to deliver the following schemes at the Spoke sites: 1. Physician Associates in Primary Care Internship Scheme **Physician Associates** Physician Associates are fairly new roles in Wales. This is a profession that developed quickly in England and has been introduced in Wales via a HEIW commissioned MSc course at Bangor University. The first cohort of student graduated in November 2018 and the course is now is it 5th year with the 3rd year graduating in November 2020. Planning is ongoing with the development of a Business Case, lead by Workforce and OD for the employment and deployment of the Physician Associate workforce, it is expected that this business case will be completed in 2021/2022 for 2022/2023 funding. The Bangor University graduating Physician Associates have all received a bursary from HEIW to train and subsequently work in Wales. To date, the Physician Associates that

have secured employment via the Health Board are employed on a short / fixed term basis. All PAs are expected to be employed for a minimum of 18 months in Wales and is a requirement of their bursary.

The Faculty of Physician Associates (FPA) recommend a 6-18 month Internship for all newly qualified Physician Associates (PAs).

Currently, there are three newly qualified PAs following a 12 month Internship in Primary Care. These posts were offered on a fixed term basis and substantive posts within Primary Care are yet to be identified. Feedback to date has been positive but due to the nature of the role and its newness in Primary Care in North Wales it is unlikely that newly qualified PAs posts will be advertised by Independent Practices in the immediate future or on a frequent basis until through Internships like these we have been able to evidence the value of the role.

In addition to Bangor University, the course is also offered at Chester University which would serve Primary and Community Services in the East Area.

These practitioners are graduating year on year, by the nature of their education and the role designed to be a generalist, they are very well placed to work in both In and Out of Hours Primary Care. PAs are employed routinely in Urgent Care Centers in England.

Through the development of this Internship Programme and by placing the PAs in individual practices it is envisaged that this will be an attractive option for Independent Practices to test the role in their own practice will little financial risk and a potential gain.

The Scheme requires a Clinical / Educational Lead and investment in developing the role and embedding it within Primary and Community Services through the appointment of a part time Physician Associate Ambassador. This role has been widely adopted within England to support the pastoral and professional development of the role as it becomes embedded within the Health Service.

Work is ongoing with colleagues in Secondary Care, Medical Education and WOD to development an Integrated Internship model for Physician Associates in the Health Board and a Business Case to support.

3. DEVELOPING ADVANCED CLINICAL AND CONSULTANT PRACTICE

Community Pharmacists

The role of the Community Pharmacist is becoming more important and is a central component in the sustainability of Primary Care services. Increasingly Community Pharmacy is becoming the first point of contact for Patients and more so during the recent pandemic. With this development comes the need to develop the skills and knowledge of the Pharmacists and the team to support the increased flow of patients / customers.

Non - Medical Independent Prescribers

Non-Medical Independent Prescribing is one element that is becoming increasingly important, funding for backfill for the Pharmacist and course fees is available via HEIW however securing a Designated Prescribing Practitioner (DPP) and providing financial compensation for supervision is not.

Therefore, the Academy will support up to 15 Non Medical Independent Prescribers from Community Pharmacies to support them to secure a DSMP through a £2,500 Practice

Attachment fee. Recognising that the Community Pharmacist will require a minimum of 90 hours supervised practice

In addition, a further £500 will be made available to the DSMP to conduct up to 5 (£100 per meeting) post qualification review meetings to support the Pharmacist consolidate their learning.

Prescribing in Practice

In some circumstances, and more so recently in light of Covid-19, there will be a cohort of Community Pharmacists that are qualified Prescribers but for a number of reasons will not have deployed this skill, and will require the support of a supervisor to return to previous levels of confidence. The Academy will make up to £500 per returning practitioner available to facilitate time in practice with a GP or Senior Pharmacist.

Acute Illness and Contraceptive Services

The Acute Illness and Contraceptive Services have been commissioned from Community Pharmacies. These services will become "Advanced" Services that will be made available throughout Community Pharmacies in Wales from 2022.

However, until such time these are commissioned at a local level. There is a cohort of Pharmacists in the north Wales region that will require Contraceptive Training in 2021/2022. The Academy will make £500 available to each eligible Pharmacist in 2021/2022 to upskill in order to deliver this service in their Community Pharmacy.

Developing Rotational Roles at Advanced Practice Level

The current success of the Pacesetter Project: Developing the Advanced Paramedic Practitioner through a Rotational Model has been envied from the sidelines of a number of professions. The model is proving to be successful in relation to the development of the Practitioner at Advanced Practice level and the experience that is gained during their rotation into Primary Care is being applied when they are also in their substantive WAST role. The benefits identified to date which are considered transferrable (Although this is yet to be tested) is that Practitioners are reporting that they are more Patient Focused in their decision making and not process driven, they are making more informed decisions as a result of their exposure to patients in the Primary Care setting. They are able to improve their cycle times when deployed in WAST. In addition improved communication between WAST and Primary Care has been reported. The role has brought an increased understand of WAST to Primary Care.

This model has been tested with other professional groups including Nursing, Pharmacy and Medicines Management and Out of Hours it is felt that this would provide significant benefit to these professionals practicing in the Primary and Community Care setting.

This scheme has been designed to be delivered in partnership with the professional leads / groups identifying suitable applicants for the scheme. The Academy will fund the rotational element of the post for the term of the placement (18months).

This would add value to roles in areas such as:

- District Nursing
- CRT Practitioners
- WAST

- Community Therapists
- Mental Health Services
- Pharmacy and Medicines Management Services

The Model for Primary Care is based on the development of the Multi-Disciplinary Workforce this model will enable this

The Academy already offers a range of programmes including:

- **5 @ 5 Advanced Clinical Practice Forum**

The ACP Forum, established by one of our Consultant Nurses in partnership with a GP meets on a monthly basis.
Advanced Clinical Practitioners working in Primary & Community Care are invited to attend an informal forum focused on Primary Care presentations, Case Studies and Networking and the forums can be used towards CPD hours.

We have recently changed its format to encourage attendance and have extended its membership across the region, the forum is open to all practitioners in Primary Care and is extended to our WAST partners enabling multi professional learning opportunities.

- **ACP Making Reflective Practice Real (facilitated by Nurse Consultant & CPDL GP)**

This programme has been designed to meet the ongoing development needs of the ACP workforce. Recognising that there is significant clinical supervision / mentorship investment in practitioners when following the formal MSc route or as described above as they step into Primary Care but that there are few if any opportunities for AC Practitioners post qualification.

This programme will run for 1 year on a monthly basis and will consist of a small cohort of 8 practitioners. It will be facilitated by the Academy's Clinical Practice Development Lead GP and Nurse Consultant and offers a "safe" space to bring and discuss cases, share learning and a network of peers.

- **Primary Care Advanced Practice Competency Framework**

There is a range of practitioners in Primary Care and it is important to recognise that not all practitioners are at the same point of development when they enter the Primary Care Speciality nor do they all need to be competent to the same level – competency should be role specific.

This framework will describe the competencies required across Primary Care and map them to roles and the professionals that can undertake the role in Primary Care.

This framework will provide a comprehensive range of skills and knowledge underpinned with the detail of the competency to be achieved. A tool that can be used by professional and managerial leads to identify development opportunities/needs and personal development plans.

The aim of the framework is to be multifunctional and to be used in a number of different ways including:

- One off assessment tool to identify development needs

- Assessment and monitoring tool to support ongoing development needs as part of a training role
- Assess, Monitor and evidence competency through each identified domain via the completion of the evident portfolio

The Framework has been developed by a small task and finish group brought together for developing the content and trialling the framework across professional groups within Primary Care.

The Framework recognises the range of professionals working in Primary Care, the Model for Primary Care, the Multi-Disciplinary Team and the Multi Setting Practitioner

4. SKILLS AND TRAINING

Developing the Practice Nurse and HCA Workforce

This scheme offers a funded Band 5 Trainee Practice Nurse post, the scheme has been in place for a number of years and has 100% success rate. The funding for this scheme is via the Primary Care Investment Funds. Core Funding is now sought to develop 3 x 0.5wte Practice Nurse Development roles to deliver training and skills assessment at a practice level in addition to a discretionary funding pot for the development and delivery of a range of course to support the ongoing training needs of the Practice Nurse workforce in north Wales

Developing the Non-Clinical Workforce

The non-medical workforce is one that is often overlooked, increasingly with the advent of the 20+ GMS Contract resignations it is increasingly apparent there are not just training education needs for the clinical workforce. The Model for Primary Care also calls for the navigation of patients to the right source of information/care/services which can be undertaken with training by this workforce. It is therefore imperative that funding and leadership is provided within the Academy for this large workforce. In addition, to a strategic lead, discretionary funding is also sought to design, deliver or procure the education and training to support the development of this key workforce.

5. PRIMARY CARE SUSTAINABILITY AND QUALITY IMPROVEMENT

Whilst bringing new practitioners to Primary Care is it essential for the sustainability of Primary Care service. It is also essential to support GP practices in other areas of issue including Recruitment and Quality in Practice. Therefore the following schemes are proposed:

1. Primary Care Recruitment and Retention Plan – through the recruitment of a dedicated GP and WOD support to develop bespoke packages of employment for GPs and other Primary Care practitioners, this will look to other programmes across the UK that have been successful in recruiting in hard to recruit areas; specifically NHS Scotland and Project Joy..
2. Improving quality in Primary Care in partnership with the RCGP – an in depth assessment of a practice with a detailed plan of action to improve. This has proven to be successful in England and is a service commissioned directly by the Clinical Commissioning Groups for Practices that are struggling with areas of quality

improvement or practice that have been subject to CQC inspections that have found areas of concern.

3. Improving Access – an opportunity to test news of improving patient access. Currently supporting the eConsult

In summary there are 5 distinct elements to this business case:

1. Academy Management and Infrastructure

Additional investment required to fully implement the Academy Business Case and to provide a robust professional and management structure to support all of the programmes described in the Business Case. The Team will work closely with HEIW and the development of the Multi Professional School for Primary Care, the Universities and the North Wales Medical School Programme Group and in breaching the gap between Primary and Secondary Care and the gap between Primary Care Contractors.

2. Academy Training Hubs & Spoke Programme

This programme focus on fixed term supernumerary training roles and dedicated trainers in larger multi professional Health Board training practices focused on training and developing the next generation of clinical practitioners. Training Hubs will accommodate a range of trainees including undergraduate and postgraduate students alongside Trainee Posts following MSc modules.

These Training Hubs will create additional training capacity to support the increase in C21 North Medical Student and the proposed North Wales Medical School.

3. Developing Advanced Practice Programme

This programme incorporates the Community Pharmacy scheme, Developing Advanced Practice through a Rotational Model scheme and the range of peer to peer programmes. This programme will be linked to the Hub and Spoke Programme specifically in developing the Spoke sites.

4. Skills and Training Programme

This programme area focuses on the development of practical skills and training for the Practice Nurse, Health Care Assistant and the non-clinical administrative and management staff in Primary Care

5. Primary Care Sustainability and Quality Improvement

This scheme includes the GP / PC workforce Strategy, Improving Quality with the Royal College of General Practice and Improving Digital Access.

The Academy Delivery Plan 2021/2022 describes the work of the Academy in 21/22 and includes further detail regarding the work the Academy set out to achieve in this financial year. Annual report will be available in early May 2022.

The Table below sets out the financial plan required to deliver this business case in its totality. Funding increases in Year 2 of the Business Case (2023/2024) as the number of practitioners entering programmes increase. The costs have been broken down into fixed

and flexible costs – fixed costs are those associated with the Academy Team and Infrastructure and the flexible costs are those associated with training roles that will change as practitioners step on and off the schemes.

Primary and Community Care Academy Business Case						
Scheme	Proposed Budget FYE (2023/2024)	PCIF Funds	Additional Funding Requested 2022/2023	Additional Funding Requested 2023/2024	Fixed Costs	Flexible Costs
Academy Management and Infrastructure	530,132	136,747	393,385	393,385	530,132	-
Training Hub & Spoke Schemes	1,737,937	380,165	928,932	1,357,772	640,809	1,097,128
Developing Advanced Clinical Practitioners Programme (Level 7)	719,335	-	407,167	719,335	-	719,335
Developing Practice Nurse and HCA Workforce	349,246	184,278	164,968	164,968	64,968	284,278
Improving Access, Quality and Recruitment & Retention	268,897	268,897	-	-	123,897	145,000
TOTAL	**3,605,547**	**970,087**	**1,894,452**	**2,635,459**	**1,359,806**	**2,245,741**

2.7

Issues and Risks with the Existing Arrangements – What is Wrong with the Status Quo

Primary Care Sustainability

'Primary Care Sustainable Health Services' is identified as a key risk on the Health Board's corporate risk register, featuring in the Board Assurance Framework (risk reference

	BAF20-04), with the provision of a scaled up Academy and implementation of the all Wales Model of Primary Care, as two of the overarching mitigating actions. **The Model for Primary Care** Delivering the Model calls for a multi-disciplinary workforce accessible 24/7, this will not be achievable without the investment in Training, Education and Recruitment. **Workforce Planning** The Workforce analysis projections for Primary Care in north Wales over the next decade are forecasting a deficit of between 150 to 240 whole time equivalent GPs. It is therefore evident that new professionals and a more varied pool of practitioners are required to meet this workforce deficit. Figures quoted assume a non – transformed primary care service, however, we have a very clear direction set by Welsh Government with the new model for Primary Care which is built upon a multi-disciplinary model that strives to ensure that GPs deliver primary and community based interventions that only they have the skills to deliver. With the requirement to develop a multi-disciplinary workforce to meet the needs of the patient population. **Capacity to support a shift in care from secondary to primary care services** In order to deliver the strategic ambition of Care Closer to Home and a shift in care from secondary to primary and community care setting there is a need to develop the skills, knowledge and capacity within the setting. This shift will not be immediate and will require a competent, confident and experienced workforce. The current Pacesetter Project in collaboration with the Welsh Ambulance Service Trust (WAST) aims to develop Advanced Paramedic Practitioners (APP) in multiple settings. The current cohort of practitioners are rotating between the WAST Clinical Call Centre, the APP Response vehicle and Primary Care. The clinical skills and knowledge gained in Primary Care are proving beneficial to the APPs in the WAST elements of the rotation as is the knowledge gained in the development of local level relationship in the primary and community care setting. **Inability to deliver the 'right care, at the right time, in the right place'** Without the a sustainable primary care model that can meet the demands of the population, patients who cannot access the services they need will impact on secondary care services such as EDs. Furthermore the primary care model very much supports self care and the de-medicalisation of care; patients need access to services to help them gain confidence and experience in managing their healthcare needs. **Health Board Managed Practices** As at June 2021 there are 12 Health Board Managed Practices (serving around 90K patients). There are around 20 GP vacancies within this group of practices; some practices do not have salaried GPs which contributes to increased clinical risks, the Health Boards reputation, and surrounding practice and cluster sustainability. **Supernumerary Training Posts** It is widely acknowledged that Education and Training is a key element in recruitment and retention of the workforce, there are very few supernumerary training posts within the

	Health Board, this is limiting in terms of attracting professionals to new posts and in offering development opportunities. **Developing New Professionals** In September 2017, Bangor University commenced a MSc level of course for Physician Associates, to date, the Health Board does not have workforce plan for the recruitment and deployment of these professionals. Three cohorts have graduated to date with a further cohort due to graduate in November 2021, noting that an internship programme for primary care placements has been established by the Academy in 2019. This is a MSc educated and trained generalist healthcare professional.
2.8	**Scope of the Case** The development of the Academy is in response to a number of national and local priorities as detailed above. This Business Case has been developed to: • support the education and training of a broad range of professionals to within Primary and Community settings at Enhanced, Advanced and Consultant level • support the sustainability of services in Primary Care through quality improvement and recruit and retention of the workforce; develop, test and evaluate pilot projects and extend the knowledge base in prudent primary and community healthcare, and the multidisciplinary social model of care ***Drivers for Change*** There are a number of drivers for change detailed throughout this document including: ✓ **Retiring Workforce** There is an increasing number of GPs retiring from the Primary Care workforce earlier than predicted ✓ **GPs in Alternative Roles** In many cases GPs do not work 10 sessions and often have other roles working in other roles throughout Health and Education, there are a number of Clinical Director posts within the Health Board that are held by GPs, and in Higher Education such as Clinical Programme Directors. ✓ **Mentorship and Supervision for non-medical Clinicians** Many members of the Primary Care workforce within Managed Practices have identified training/learning needs with a requirement for ongoing clinical mentorship and this is reinforced by the stakeholder engagement undertaken by HEIW (see below). There is currently no programme of formal ongoing support for practitioners post MSc and whilst practitioners are able to develop this Advance Practice skills through the ACP programme when entering a field other than which they had trained in there is an increasing need to support them as you would a trainee for a period of time and thereafter. ✓ **Recruitment and Retention** Education and Training is a key element in the recruitment and retention of the workforce, and in increasing and developing the current and future workforce.

Detailed below are ways in which each of these schemes are focused on the recruitment and retention of staff in primary care

Health Board Managed Practices

There has been a rapid increase in the number of Independent Practices resigning their contract over the last 4 years, often when this happens the preferred option is for the Health Board to manage the practice, whilst alternative options are explored. Often, no other alternative is available and the practices remain Health Board Managed indefinitely.

Over 20 practices have resigned their contracts for numerous reasons over the last 5 years (since April 2015) including, failure to recruitment partners, retirement and poor business management.

The Health Board now manages:

Area	**No. of Practices**
East	6
Central	3
West	3
Total	**12**

The Health Board Managed Practices offer the Academy, an opportunity to test new models and roles; however, this requires significant level of investment in supernumerary and supervisory roles. This approach has been tested in Healthy Prestatyn Iach where a GP supervisors up to 11 practitioners all at varying degrees of their training. Whilst, the majority of these practitioners are substantive post holders within HPI, moving forward as we further develop the model and subject to funding, we will envisage this model attracting trainees that also attract an income e.g. Medical Students.

Investment in the Training Hub at HPI can also offer the delivery of a bespoke programme of tutorials to meet the education and training needs of the broader Health Economy workforce.

North Wales Medical School

The announcement in September 2021 that there will be an increase in the number of C21 North Medical Students from 20 to 25 from September, with this increasing from 25 to 40 students from September 2022 requires investment in the development of additional capacity in Primary Care to ensure that the successful Longitudinal Integrated Clerkship (LIC) in Primary Care can continue.

The LIC offers Year 3 Medical Students the opportunity to spend 1 academic year in a Primary Care GP Practice. To date placements have been found for the 20 students however the number set to double in 2 years with the Sept 2022 intake requiring placements from 2023.

The recent work of the Clinical and Placement Workstream of the North Wales Medical School Programme has tasked a sub group to scope the current capacity and demand for primary care placements for all undergraduate and postgraduate placements and this sub

	group will report in early November. The Sub Group has identified a number of ideas to address capacity issues, which will require investment and these solution include Training Hubs, previously identified as a preferred solution through a 2019 Primary Care questionnaire.
2.9	**Objectives and Benefits** The Academy will focus on achieving the following objectives: • Increase the workforce capacity with Primary and Community care settings to meet the needs of the population • Increase the number of Education and Training programs designed to meet the needs of our workforce in Primary and Community Service • Develop, test and evaluate new ways of working/roles to ensure the sustainability of Primary and Community services and bring care closer to home • Increase the number of Research and Development studies within Primary and Community Services Benefits have been detailed in previous sections but include: • Improved sustainability across primary care and support to deliver the strategic principle to shift services out of secondary care • Increase number of extended and advance practice clinicians working within primary & community services • Practitioners working to the ceiling of their competencies within primary care due to increased confidence to practice by gaining support from and providing support to their Primary Care and Professional colleagues • Increase number of professionals both clinical and non-clinical who have received education and training in their relevant fields based on a skills gap analysis • Practitioners who feel valued and are valued • Equal pay for equal roles • Improved patient outcomes • Reduced waiting times and improved access • Increased capacity within primary and community care health settings • Improved communication between primary, community and secondary care and partner agencies • Multi-disciplinary team working • Multi skills practitioners able to work in multiple settings • Alternative careers options within the NHS family • Continuity of service and terms & conditions whilst training and working in Primary Care • Security of role with flexibility of care setting • Integrated workforce • Whole system approach to patient care • Recruitment and retention of the current and future workforce
2.10	**Constraints**

	There are a number of constraints that will impact the ability to deliver this ambitious programme of development to support the long term sustainability of Primary Care Services and these include: • Funding • Capacity (no of trainers/mentors) within Primary Care to support training placements • Suitably qualified professionals to provide training • Sufficient space within practice to offer training placements • Level of investment in training posts • Confidence that there will be permanent posts at the end of training contracts
2.11	**Dependencies** **Funding** • Health Board commitment to invest in Practice Development GP Mentor posts • Health Board commitment to invest in supernumerary training posts • Health Board commitment and recognition that Practices offering to undertake training should be financially compensated and that they are consistent and comparable practice attachment fees • Ability to secure training placements in Independent and Health Board Managed practices • Equal access to HEIW funding for course for Primary and Community Practitioners **Capacity / Space** • Ability to secure training places in practices due to space issues • Primary Care Estates developments to include Training Rooms • Requirement for accommodation for the Academy Management Team and delivery of training, education, supervision and mentorship. **Workforce Planning** • Ability to secure suitable posts for qualifying trainees following completion of training • Ability to recruit Practice Development GP trainers • Sufficient and timely input into workforce planning and IMTP development
3.	**Option Appraisal & Preferred Option**
3.1	**Criteria for Option Appraisal** In developing this business case, we have considered the following factors. Does it work?

Factor	Comments	Considerations
Clinical Effectiveness	Is there evidence of clinical effectiveness	There is considerable evidence to support the multi-disciplinary approach in Primary care. This approach is the basis for the New Model for Primary Care in Wales and has been developed to be delivered in both Health Board and Independent Practices within Primary Care. It is anticipated that this model will impact positively on the Secondary Care services as more services are delivered closer to home and this has been evidenced through the Advanced Practice Physiotherapists reducing demand on secondary care services. A focus on the Social Model of Care is key in the de-medicalisation of health through the multi disciplinary team approach.
Health Gain	Is there evidence of a health gain? Life expectancy, quality of life and risk factor	There is evidence of Patient Satisfaction and Patient Acceptance of the roles of advance practice practitioners from across the spectrum of professions in Primary Care. In terms of health gain, improved access to the right clinician will contribute to the Health Gains including quality of life, and risk factors
Does it add value?		
Strategic Fit	Does it reflect the Health Board Strategic Goals or is it a national priority	As detailed in previous sections the development of the Academy has been in response to the national and local strategic context
Public and Political	What is the public and political impact Need to reflect proportionality: a balance between the needs of a group of patients and that of the wider community	Extended and Advance practice practitioners are becoming more publically and politically acceptable and this is evidenced through the adoption national “new model for Primary Care”.

		Primary Care sustainability and access continues to be raised by patients and local politicians.
Health Inequalities	Does it reduce or widen health inequalities?	Potential to reduce health inequalities as the number of clinicians enter the primary care workforce is increased.
Is it the best way of delivering the service?		
Impact on services elsewhere	Is there an impact for other HB service areas or for other interventions? Is there an impact for non-HB services? Is it to be provided by the HB or be externally commissioned?	It is anticipated that the delivery of this business case will have a positive impact on other HB services areas including unscheduled care. The increase in Advance Clinical Practitioners in Primary Care settings, increasing capacity and navigating patients to the most appropriate services should reduce the number of inappropriate presentations at ED and Out of Hours. It has already been proven that the utilization of Advanced Paramedic Practitioners reduces conveyance rates, with a rotation in Primary Care it is anticipated that this further improve conveyance rates. The development of the Community Pharmacists will offer an alternative provider of services for certain conditions and as such redirect patients from GP practices. The introduction of the role of the Physician Associate has great potential to support the elderly and frail. With the move to the regulation of this profession and the introduction of prescribing rates in the coming years, this professional is key to the long term sustainability of services in the Primary and Community setting.
Workforce implications	Will it increase, decrease or change human resources and skill mix?	This will increase the human resource within the NHS in the North Wales Health and Social Care economy The role of the Extended Scope and ACP and PA is not to replace the role of the

		GP but to build resilience and capacity to ensure its sustainability. It will provide a firm and stable workforce on which to build on and will provide continuity of care for patients.
Geography	Does it address the needs of our rural population?	There are a number of schemes within this business case which will increase the number of clinicians throughout north Wales including rural areas. Schemes will developed to meet the needs of the local services, workforce planning and cluster needs analysis. One of the Training Hub Spokes is based in rural Gwynedd.
Is it a reasonable cost to the public?		
Affordability	Does it release resources for alternative uses? What are the opportunity costs for other services or interventions (including those of partners? Is it affordable?	This does not release resources for alternative users however, it is envisaged that the development and delivery of the schemes within the Academy and subsequent recruitment of trained practitioners to the Primary Care workforce will contribute to the sustainability of Independent and Health Board Managed practices; it should reduce the reliance on locum and agency staff. Increased costs associated with the Health Board Management of GP surgeries means that this model is not sustainable or an option to deliver at scale unless we are able to train sufficient numbers of practitioners to meet the needs of our population and to ensure that patients see the right professional at the right time. The opportunity lost in not supporting this business case is the loss of these professionals in Primary and Community services, the investment made by Welsh Government, Bangor University and the graduating Physician Associates being a part of the NHS workforce in north Wales. Ultimately timely, effective and compassionate care for our patients.

	Cost effectiveness	What is the funding source? 1. Existing Resources 2. Disinvestment 3. New Resource allocation 4. Existing Pathway redesign	A **new resource allocation** is required for the delivery of this Business Case.	
3.2	**Longlist of Options** 1. Do Nothing 2. Do 'Something' – a scaled down option 3. Do 'All Of It' – an option with a wide range of schemes			
3.3	**Appraisal of Longlist and Creation of Shortlist of Options** **Do Nothing Option** The Do Nothing option affords the Health Board the opportunity to stop the Academy programmes and re-deployment of the current team and for schemes currently managed by the Academy to cease. The majority of these will come to a natural end in March 2022 with the Trainee Programme concluding in February 2023. **Do No More Than is Currently Being Done or the Do 'Something' Option** The Do Something will maintain the status quo utilising the Primary Care Investment Funds to maintain a small number of schemes including: • Trainee Practice Nurses • Physician Associates in Primary Care Internship • Clinical Lead GP to provide mentorship to Trainees seeking places in Primary Care funded via alternative routes. • Project Flex focused on GP recruitment • Quality Improvement initiatives The impact would be significantly less with approximately 8 practitioners trained per year in Primary Care. The option would not facilitate the development of the Advanced Clinical Practice workforce or the ongoing development needs of the current workforce. **Do 'All of It' Option** The Do All of It Option will allow for the development of the practitioners within primary and community services with pace and within the capacity available within Primary Care, without undermining the other training places required i.e. GP Registrar training, C21 Medical Students etc. A successful Academy, fulfilling its wider functions, would also attract a new workforce to come to north Wales for employment.			

	The roll out of the programmes would be in a phased approach, with the increase in capacity in the schemes being increased during 2022/2023 and the establishment of the Training Hubs and appointment to key Academy Management roles as soon as possible. *All 3 longlisted options are included in the shortlisting exercise in section 3.4.*
3.4	**Appraisal of Shortlisted Options** **Do Nothing** All schemes currently funded via the Primary Care Investment funds would continue. **Do No More Than is Currently Being Done or the Do 'Something' Option** This option is better than the Do Nothing option, if we continue to fund a number of the proposed schemes using the current funding source this will add a small number of practitioners to the workforce over time but not at the pace required, to have the impact and outcomes required. **Do 'All of It' Option** The Do All of It Option will allow for the development of the practitioners within primary and community services with pace and within the capacity available within Primary Care, without undermining the other training places required i.e. GP Registrar training, C21 Medical Students etc. A successful Academy, fulfilling its wider functions, would also attract a new workforce to come to north Wales for employment. The roll out of the programmes would be in a phased approach, with the increase in capacity in the schemes being increased during 2022/2023 and the establishment of the Training Hubs and appointment to key Academy Management roles as soon as possible.
3.4.1	**Appraisal against Non-Financial Criteria** The following non – financial criteria have been developed for appraisal against the 3 options: • Do nothing • Do 'no more than is currently being done' or Do 'somehting' • Do 'all of it' **The Criteria are:** 1. Is the model deliverable 2. Will this impact the workforce numbers 3. Will this increase recruit to posts in Primary & Community settings 4. Will this contribute to the delivery of the new model of care 5. Will this support the shift of care **Scoring Criteria** Yes – 3 Somewhat / Limited impact – 1 No impact - 0

Option		Appraisal	Score
Do Nothing	Cease all investment in the Academy	Assuming this options is to cease all schemes currently funded by Primary Care Investment Funds	1. 3 2. 0 3. 0 4. 0 5. 0 **Total:3**
Do No More Than is Currently Being Done or the Do Something option	A Do Something option is better than the Do Nothing option, if we continue to fund a number of the proposed schemes using the current funding source this will add a small number of practitioners to the workforce over time but not at the pace required, to have the impact and outcomes required	This model is currently in place and will enable a small number of practitioners to be introduced to the workforce approximately 9 per annum, this won't impact significantly to the recruitment of practitioners to P&C, attract new practitioners or develop those that are already in post and this option will not support a further shift of care	1. 3 2. 1 3. 3 4. 1 5. 1 **Total:9**
Do All of It	The Do All of It Option will allow for the development of the practitioners within primary and community services with pace and within the capacity available within Primary Care without undermining the other training places required i.e. GP Registrar training, C21 Medical Students etc. A successful Academy, fulfilling its wider functions, would also attract a new workforce to come to north Wales for employment.	This option is deliverable with the aim of having a positive impact on the workforce, will increase recruitment to posts in primary care by developing summary numeracy training posts that ensure that new practitioners are supported through clinical supervision and education, dedicated leads and support to the practice. Access to funding for primary and community care specific training and education materials and courses. The schemes detailed in the business case bring forward practitioners from other settings to shift the care from the secondary care setting by providing opportunities for other system practitioners to	1. 3 2. 3 3. 3 4. 3 5. 1 **Total:13**

		This option would also release the funding currently used for these schemes to be invested in the development of new schemes and could be considered for developing the other areas of Primary Care including, Optometry, Dental and Community Pharmacy.	gain new skills, knowledge and experience in the P&C setting.	

3.4.2 **Comparative Costs**

This Business Case includes a number of schemes all of which can be supported by a Cost Comparison if required however one example to illustrate the Advanced Clinical Practitioner trainee scheme is detailed below.

It is acknowledged that an Advance Clinical Practitioner cannot fulfill the same role as a GP however, it is acknowledged that they can fulfill elements of the role a GP has traditionally undertaken.

We now need to move to a prudent healthcare model where we organise the workforce around the “only do what only you can do” prudent healthcare principle.

Cost Comparison

Example 1

A Locum GP in a Health Board Managed practice is paid at £600 per day or **£75 per hour,** for the purpose of this business case the hourly rate has been used. On costs including Tax, National Insurance and pension contributions **are not included in this hourly rate.**

An ACP at the top of the Band 8A scale will receive an annual salary of £63,977 which equates to **£32.80** per hour and **includes all on costs**.

Example 2

A salaried GP in a Health Board Managed practice is paid between £70,000 and £98,000 per annum (wte) dependent on length of service, experience and role played within the Practice e.g. Clinical Lead.

This example compares the salary of a salaried GP with that of a GP Locum employed on the same WTE basis.

The annual hours for a locum GP have been reduced by 300 (30 x 7.5hrs annual leave and 10 x 7.5hrs bank holiday allocation) resulting in 1,650hrs per annum at a rate of £75 per hour this equates to a salary before on costs of £123,750 with on costs this increases to £157,575 compared to a salary of £118, 602 which includes on costs for a salaried GP at the top of the DDRB.

Non-Medical Practitioners

It is noted earlier in the document the forecast deficit of GPs in the coming years and workforce modelling proposes alternative workforce 1.9wte per GP made up of the following Bands:

Band 8C	0.3 wte
Band 8B	0.4 wte
Band 8A	0.7 wte
Band 7	0.5 wte

The cost comparison for this model is as follows:

Band 8C	0.3 wte	£24,151
Band 8B	0.4 wte	£26,775
Band 8A	0.7 wte	£40,203
Band 7	0.5 wte	£25,603
		£116,732 including on costs

Salaried GP 1 wte (top of DDRB Scale)	£118, 602
Alternative workforce model (1.9 wte)	£116,732
Locum (including on costs assuming 1650 hrs per annum)	£157,575

3.4.3

Risk Appraisal

'Primary Care Sustainable Health Services' is identified as a key risk on the Health Board's corporate risk register, featuring in the Board Assurance Framework (risk reference BAF20-04), with the provision of a scaled up Academy and implementation of the all Wales Model of Primary Care, as two of the overarching mitigating actions.

As discussed throughout the document there is very little option to do nothing as Wales, and the UK face an increasing shortage of GPs and the decreasing numbers of GPs within the current and projected workforce.

The availability of quality Primary Care services to meet the needs of the whole population, is a statutory responsibility of the Heath Board and it is therefore key that we invest in developing the workforce to meet the emerging and increasing complex health and wellbeing needs of our population.

In addition, as an employer, we need to offer a vast array of roles that will attract and retain staff within services.

The following are a number of key risk all of which score highly which could be mitigated with the investment in the further development of the Primary and Community Care Academy and the proposed schemes.

Risk	**Score**
Increased number of Health Board Managed Practices	**Likelihood**: Almost Certain **Consequence**: Major
Inability to recruit / retain practitioners in Health Board managed practices	**Likelihood:** Almost Certain **Consequence**: Major
Dispersal of Patients as a result of resignation of contract or ability to deliver alternative option	**Likelihood**: Likely **Consequence**: Major
Inability to attract qualifying GPs to the region to ensure continued sustainability of Independent practice	**Likelihood**: Almost Certain **Consequence**: Major
Inability to retain staff retiring from General Practice	**Likelihood**: Almost Certain **Consequence**: Major
Inability to attract all professions to Primary Care	**Likelihood**: Almost Certain **Consequence**: Major
Inability to ensure other non medical practitioners are being supported to Advance Practice level in a safe environment	**Likelihood**: Likely **Consequence**: Catastrophic
Inability to modernize the workforce through new professionals e.g Physician Associates	**Likelihood**: Likely **Consequence**: Major

Through this business case we envisage that this risk assessment can be mitigated significantly

Risk	**Score**	**Mitigating Action**	**Score**
Increased number of Health Board Managed Practices	Likelihood: Almost Certain Consequence: Major	Development of the PA role to address workforce gaps	Likelihood: Possible Consequence: Major

		Offer fixed term training posts to address the workforce gaps in other services including Managed and Independent practices	
Inability to recruit / retain practitioners in Health Board managed practices	Likelihood: Almost Certain Consequence: Major	Development of training / internship posts will attract candidates Project Joy North Wales will have dedicated recruitment lead for GPs	Likelihood: Unlikely Consequence: Major
Inability to attract qualifying GP to the Area to ensure continued sustainability of Independent practice	Likelihood: Almost Certain Consequence: Major	Project Joy North Wales will have dedicated recruitment lead for GPs It is anticipated that the Implementation of the new model for Primary Care with sufficient workforce will be an attractive option for GPs, in addition, if GP Training practices participate as a Spoke	Likelihood: Possible Consequence: Major

		Practice, the trainee GPs will already be aware of the potential of the new model and the workforce skill set.	
Inability to retain GPs retiring from General Practice	Likelihood: Almost Certain Consequence: Major	Being able to offer roles such as the Practice Development GP role or one that is designed through Project Joy north Wales to ensure that retiring GPs maintain clinical contact	Likelihood: Likely Consequence: Major
Inability to attract all professions to Primary Care	Likelihood: Almost Certain Consequence: Major	Training roles are very attractive to professionals wanting to work in Primary Care as are bespoke roles for GP. Development of the rotational model will attract new professionals to primary care and those from other specialities	Likelihood: Possible Consequence: Major
Inability to ensure other non medical practitioners are being supported to Advance	Likelihood: Likely Consequence: Major	Through the training programmes	Likelihood: Rare

	Practice level in a safe environment		and the appointment of Practice Development GPs practitioners will be supported throughout their training post	Consequence: Major
	Inability to modernize the workforce through new professionals e.g Physician Associates	Likelihood: Likely Consequence: Major	There is currently no plan within the Health Board to appoint Physician Associates other than through adhoc opportunities	Likelihood: Rare Consequence: Major
3.4.4	**Conclusion – Preferred Option** The **'Do All of It' Option** is the preferred option, this will allow for the development of the practitioners within primary and community services with pace and within the capacity available within Primary Care without undermining the other training places required i.e. GP Registrar training, C21 Medical Students etc. It will have a greater impact on the sustainability of primary care services in north Wales, supporting improved recruitment and retention, education, training and research, promoting the region as a preferred place to work in primary care.			
3.5	**Preferred Option Detailed Analysis**			
3.5.1	**Full Description of the Preferred Option** The preferred option will include the establishment and ongoing development of: • 4 x Training Hubs in north Wales, each with a Clinical Practice Development GP Mentor providing oversight of the practitioners throughout the Training Scheme • 16 x Training Post for Advanced Clinical Practitioners on a fixed Term Contract that will complete the MSc Advanced Clinical Practice on a full time basis • Consultant Lead posts for Nursing, Pharmacy and AHP on a part time basis to lead the development of Enhanced/Advanced and Consultant Level Practice in Primary and Community Care. • A GP Clinical Lead providing clinical governance and oversight for the Academy • A lead Research Officer role to ensure that all Schemes delivered through the Academy are evaluated and learning is shared. The Lead Research Officer will be			

	responsible for working with the Trainee ACPs to develop their Dissertation proposal to ensure that it adds value to the learning. • an Internship Programme Physician Associates based at “Spoke” sites that have experience of developing the PA role in Primary Care and the establishment of a Physician Associate Ambassador Role to further embedded and develop the role of the PA in north Wales across Primary and Secondary care, supporting the development of the Society of Physician Associates in Wales (SoPAW), act as advocate for the PAs in north Wales and provide pastoral support where necessary. • The Developing Community Pharmacist scheme which will provide for the funding of Mentorship for Community Pharmacists who have been commissioned to provide Enhanced Services e.g. Minor Ailments. This scheme will not fund the University Placement, this will fund the mentorship element and time in GP. • The Rotational Advanced Clinical Practitioner programme, this scheme builds on the Pacesetter Project: Developing Advanced Paramedic Practitioners. This scheme will work with other Specialties/Professions e.g. Out of Hours to offer a rotational placement in Primary Care. The practitioner will rotate into Primary Care for 2 days per week and follow a programme of education and mentored placement. This will be a fixed term placement of 18 months. Applicants will be required to demonstrate Level 7 qualification prior to commencing this scheme. This approach is one that can also be adopted for New to Primary Care Practitioners. • A quality Improvement programme in partnership with the Royal College of General Practitioners (RCGP) to support practices who are experiencing sustainability issues or those seeking to improve Quality Outcomes at a Practice Level. And will link in with Improvement Cymru • GP Workforce Recruitment Strategy, a GP recruitment lead working with a dedicated WOD lead to develop bespoke packages of employment based on the preferences of the GP candidate (subject to organisational need). To work to develop alternative contract arrangement including block booking on/off arrangements, providing accommodation, rotational working, Mentorship, the scheme would work across Independent and managed practices. It should also be noted that this case assumes the recurrent allocation of Primary Care Investment Funds and seeks additional funding to extend the current programmes and Academy Team. The complexity of the offer of schemes will require a team well versed in Primary Care hence the requirement to have a number of part time clinical lead roles complimented by a management and administrative team. The addition of the Lead Evaluation Officer will ensure a robust approach to the collation, evaluation and dissemination of the learning from the programmes. In addition, the fixed term nature of the training posts and training budget will enable the flexibility required to meet the emerging and changing needs of the Primary Care workforce. Overall Management of the Academy Programme will be the responsibility of the Academy Manager in partnership with the Clinical and Consultant Leads for the individual schemes.
3.5.2	**Impact on Activity and Performance** A maximum 40 practitioners experienced in Primary & Community care every 18 months will have a significant impact on the provision of services, with increased capacity to provide enhanced services in Community Pharmacies, to support the continued focus on delivering Care Closer to Home, on Choose Well and Choose Pharmacy.

	Furthermore the provision of education bespoke to Primary Care will address the needs of the 'new to primary care' practitioner The establishment of leads for the non-clinical workforce will support succession planning within Primary Care as the administrative workforce is also an "ageing population". The need to train new non-clinical leaders in essential to the sustainability of the services Clinical leadership will be key to ensuring all practitioners are working to the ceiling of their competencies within a clear and appropriate governance framework noting that testing/pushing boundaries are required but good governance must be maintained at all time The focus on quality improvement and recruitment is key to ensuring the workforce of the future and in achieving the best possible patient outcomes. Introducing new professions to Primary Care ensures a rich flow of practitioners and career development opportunities. The benefits listed in section 2.3.4 demonstrate that, by having a sustainable and innovative primary care workforce would provide consequential improvements in a range of performance measure and QI indicators across the health system.
3.5.3	**Other Areas affected by the Proposal / Interdependencies / Assumptions** Areas affected by this Proposal include: • Primary Care as a whole • Community Services • Community Pharmacy • Dental Services • GMS • Welsh Ambulance Service Trust • Area Teams • Secondary Care **Assumptions**: The following assumptions have been made. That the Health Board recognises and supports: • the implementation of the all Wales 'Model for Primary Care' • the need for investment in supernumerary training roles to ensure the sustainability of primary and community services • the value of rotational models in staff satisfaction and ultimately recruitment and retention • the investment Welsh Government, HEIW and University of Bangor have made in the development and delivery of the Physician Associate role • that the role of the Physician Associate is a role that can contribute to the delivery of Healthcare services in north Wales • the value of the commitment of practitioners to undertake training • the value of training and education in the recruitment and retention of staff • its responsibility to develop new roles in Primary and Community settings

	• and values the contribution GPs and Senior clinicians have in developing, training and educating other professionals • the risk of not investing in training, education and mentorship **Interdependencies:** The following interdependencies have been identified • Ability to identify Training Hub & Spoke sites • Informed workforce plans to ensure that capacity does not exceed demand • Ability to recruit and retain Clinical Practice Development Mentorship • Adequate funding to secure mentorship • Suitably qualified MSc Practitioners • Opportunities to work with other services to develop rotational models • Substantive posts within the system for practitioners to apply for **HEIW** The Academy recognises HEIW's key role in the development of the workforce and the work undertaken to develop its strategic plan. The Academy has established links with HEIW to ensure that where possible there is no duplication of work, that the information gathered as part of the 2019 HEIW roadshows influences is reflective in the outcomes of the schemes delivered through the Academy development and to maximise opportunities that are available via HEIW. HEIW has recently held a Stakeholder Workshop (October 2020) to explore the development of Academies and Training Hubs. The workshop focused on developing the thinking, on influencing the future delivery of education and training in Primary Care to ensure the training and skilled workforce of today and tomorrow, and to shape the development of All Wales support and assistance to accelerate progress of local Primary Care Academies or Training Hubs to the deliver the Primary Care Model. The Academy team continue to develop and strengthen joint working with colleagues in HEIW, sharing learning and innovative practice. The proposed HEIW development of Locality Training Hubs is currently at the "Visioning" stage with a visioning paper published for comments in January 2021. The Academy was invited to share with the Executive Team leading on the planning for Locality Hubs in March 2021 and a draft version of this Business Case has been shared for information only with the Chief Executive of HEIW at the instruction of the Executive Director Primary and Community Care. Members of the Operational Delivery Group and the Academy are embedded within the working groups and work streams of HEIW and the Academy is well placed to be further integrated with and test the Locality Training Hub model once progressed. In deed this may offer an additional or alternative income stream in the near future releasing funding.
3.5.4	**EqIA of the Preferred Option - embedded**  Equality Impact Assessment Screenir

4.	**The Financial Case**

4.1 **Total Revenue Cost**

The following table details all the planned investment requested through this business case.

In summary this Business Case seeks approval from the Health Board to provide a recurring budget of **£2,864,539,** from **April 2022** which includes the PCIF Grant allocation of **£970,087**, with this increasing to a recurrent budget including PCIF Grant of **£3,605,547** from **April 2023**

Additional Funding Requested in 2022/2023 is **£1,894,452**

Additional Funding Requested in 2023/2024 increasing to **£2,635,459**

Primary and Community Care Academy Business Case						
Scheme	Proposed Budget FYE (2023/2024)	PCIF Funds	Additional Funding Requested 2022/2023	Additional Funding Requested 2023/2024	Fixed Costs	Flexible Costs
Academy Management and Infrastructure	530,132	136,747	393,385	393,385	530,132	-
Training Hub & Spoke Schemes	1,737,937	380,165	928,932	1,357,772	640,809	1,097,128
Developing Advanced Clinical Practitioners Programme (Level 7)	719,335	-	407,167	719,335	-	719,335
Developing Practice Nurse and HCA Workforce	349,246	184,278	164,968	164,968	64,968	284,278
Improving Access, Quality and Recruitment & Retention	268,897	268,897	-	-	123,897	145,000
TOTAL	**3,605,547**	**970,087**	**1,894,452**	**2,635,459**	**1,359,806**	**2,245,741**

A detailed breakdown is shown in the embedded excel document

	 BC V14 Proposed Budget Breakdown *A cost comparison exercise in terms of workforce roles in primary care is provided in section 3.4.2.*
4.2	**Capital Cost (If Any)** Capital costs identified include IT equipment for new members of Academy Team if required and are included in non-pay for each of the schemes.
4.3	**Affordability and Source of Funding** The case is seeking a commitment for Health Board recurring funding to ensure the sustainability and development of the Academy.

5.	**Governance and Project Management**
5.1	Approval Route 1. Chief Finance Officer 2. Business Care Review Group 3. Executive Directors/Team 4. F&P Committee 5. Board
5.2	**Project Management** The responsibility for the delivery of this Business Case will sit under the Executive Director of Primary and Community Services, specifically with the Academy Strategic Leadership Group and the Operational Delivery Group, with operational deployment of this Business Case will be the responsibility of the Academy Manager overseen by the Assistant Director Primary and Community Services (Corporate). As noted throughout the document a number of these schemes are already well established and the business cases seeks to secure “core funding” to replace the Primary Care Investment Funds grant in 2022/2023. The details of the new investment requested in 2021/2022 is detailed in the embedded document in the Executive Summary. Noting that this is an ambitious programme to deliver the recruitment to key posts will be instrumental in its delivery, however, a number of schemes are well established and this business case will provide the infrastructure to bring this work under one umbrella with the aim of benefitting all. A Stakeholder Workshop is planned for early 2022 (subject to approval of this business case). The aim of which is to ensure that the Academy is aligning new roles and professions in Primary Care with the existing professional and operational governance of the Health Board and to ensure that there is an integrated approach to the development of the current workforce and to inform future workforce planning and education commissioning requirements. The appointment to the Professional Development Leads will be a key enabler to this integration and in providing assurances to the Health Board concerning professional governance. **Governance Structure** ***Strategic Leadership Group*** The Academy is overseen by the Strategic Leadership Group (SLG) and has been established to provide strategic direction, scrutiny and oversight to ensure the successful delivery of the Academy, the SLG will: • Be a decision maker • Provide clarity & guidance • Agree Academy priorities • Manage risks, resolve issues and remove barrier

	• Monitor performance The SLG is chaired by the Executive Director of Primary Care and Community Services or nominated Deputy. ***Operational Delivery Group*** The Operational Delivery Group membership has representatives from across the professions to ensure that this voice is included in the Academy Action Plan, this does not replace the SLG but is anticipated that this group will form the basis of the Academy Faculty Committee. ***Academy Faculty Committee / Professional Development*** It is proposed that the Academy Faculty Committee will support the SLG and Academy Management Team; membership will be drawn from across the clinical and administrative professions to support the development and the delivery of the Academy and its programmes. The appointment of Professional Leads and the Clincal / Medical Lead will provide the professional leadership for their respective professions in Primary Care. Professional Leads will be required to actively engage and integrate with the structures already established within the Health Board bringing the professional development needs of the workforce working in primary care. ***Academy Management Team*** Supported by the SLG and Academy Faculty Committee, the Academy Management Team currently consists of an Academy Manager (reporting to the Assistant Director Primary Care & Community Services), Academy Development Manager, and Clinical Practice Development GP. The Academy also hosts the Pacesetter Lead Research Officer post. The appointment to the Clinical/Medical Lead will complement the management team. The Clincal/Medical Lead will have line management responsibility of the Professional Leads and the Senior Admin Officer will provide administrative support. ***BCUHB Infrastructure to support the Team*** It is noted that this business cases seeks funding for roles that may be considered are already in place within the Health Board such as those within Education and Training, Research and Development. However, through the early establishment of relationships with key individuals in these areas it has become apparent that is a gap in the provision for Primary Care services, both in capacity and expertise, as this is often seen as the independent contractor responsibility. As the Health Board has a statutory responsibility to ensure the public have access to all primary care services, it is the commissioner of these services, as well as a significant provider through the delivery of GP Out of Hours services, urgent primary care, and Health Board Managed GP Practices, this is a gap that requires addressing.
5.3	**Project Plan – Implementation Timeline** Subject to approval of this Business Case the planning for the implementation of the Training Hubs will commence in Qtr 4 of this financial year. In the main all

	programmes are well established with a clear timeline for the appointment of Physician Associates, Supernumerary Training Role and those undertaking rotational roles with recruitment commencing in Qtr 2 2022. The appointment to the Academy Management team will commence immediately to ensure appointees are in place as soon as possible and the schemes wholly funded via the PCIF Grants are already in process of appointment or role out. A detailed programme timetable will be developed upon approval to progress in order to ensure that proposed timescales and time line are in achievable and current. Key dates for the establishment of the Training Hubs is Qtr 2 2022 with the appointment to the posts ahead of the start of the academic year.
5.4	**Post Implementation Review** This Business Case will form the basis of the Academy Annual Report, performance measure will be developed and approved via the Governance structure described in detail in this paper.
6.	**Conclusions and Recommendations**

In conclusion, it is recommended that the preferred option within this Business Case is approved and fully funded on a recurrent basis. This would provide a commitment from the Heath Board for the long term support of the Academy and it's further progression to best respond to the Primary Care sustainability and workforce risks, as well as deliver strategic ambition in new models of care.

7.	**Declarations**

☐ The above information has been reviewed to ensure it is accurate and represents a true and fair view of the service to be provided, the benefits and the costs

☐ Where third parties have provided information this is in writing/e-mail format and they have confirmed it is correct to the best of their knowledge

☐ Where the business case has an impact on another Area/Division/Department the impact has been agreed with that Area/Division/Department in writing and the relevant Mangers have signed below to confirm

Signed by:

……..	……	……
Chief Finance Officer	**Executive Director**	**Asst. Director**

Cyfarfod a dyddiad: **Meeting and date:**	**Performance, Finance and Information Governance Committee** **23.12.21**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	**Monthly Monitoring Report – Month 7 & 8**
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Sue Hill, Executive Director of Finance
Awdur yr Adroddiad **Report Author:**	Tim Woodhead, Operational Finance Director
Craffu blaenorol: **Prior Scrutiny:**	The submission made to Welsh Government required Chief Executive and Director of Finance sign off.
Atodiadau **Appendices:**	Appendix 1: Month 7 Monitoring Return Narrative Report Appendix 2: Month 8 Monitoring Return Narrative Report

Argymhelliad / Recommendation:

Note the contents of the report that has been made to Welsh Government about the Health Board's financial position for Months 7 & 8 of 2021/22.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

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

Sefyllfa / Situation:

To report to the Committee the completion of monthly reporting to Welsh Government for Month 7 & 8 of 2021/22.

Cefndir / Background:

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

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

- The recovery from COVID-19 and the related workforce constraints are the main risk to the delivery of the schemes relating to the £42.0m this year and so the Health Board is actively identifying

alternative schemes which can be mobilised in order to ensure we maximise the opportunity to improve performance.

Month 8 Monitoring Return includes the return of £10.2m worth of Covid -19 funding which is not required.

Asesiad / Assessment:

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

Not applicable – report is for assurance only

oblygiadau Ariannol / Financial Implications

Financial position

- The in-month position in both month 7 and month 8 is a break-even which also brings the cumulative position to breakeven. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

Forecast

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

- The forecast total cost of COVID-19 at month 8 is £131.8m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been anticipated to more than cover this cost, with £32.7m of COVID-19 funding supporting the core position. This equates to the additional funding issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

Dadansoddiad Risk / Risk Analysis

Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Not applicable.

Asesiad Effaith / Impact Assessment

Not applicable.

MONITORING RETURN

MONTH 7 2021/22

Sue Hill

Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION & FORECAST

1.1 Financial Plan

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

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

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

- We have tested our assumptions in the original plans and refreshed our forecasts accordingly with the divisional teams and will continue to do so as the operational position develops. This may include additional outsourcing, interims or consultancy, to progress some of the larger schemes.

1.2 Actual Year to Date Position

- The in-month position is break-even which also brings the cumulative position to breakeven. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

- The total impact of COVID-19 in October is £3.5m (£46.5m for the year to date). Additional COVID-19 funding of £32.7m was issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic, and hence is classified as COVID-19 funding.

1.3 Forecast Position

- The forecast position is a balanced position for the year.

1. FINANCIAL POSITION & FORECAST

1.4 Income (Table B)

- Income totals £160.9m for October. Further details are included in Section 7.

- Integrated Care Fund (ICF) schemes have now been agreed which resulted in £5.3m retrospective adjustment recognised this month. The expenditure that relates to this amount will be distributed to local authorities.

- The impact of COVID-19 has resulted in £0.3m lost income in October, same as in September (£2.3m year to date) relating to General Dental Services (GDS) patient income. This is included as a cost of COVID-19 within the "Other" category.

1.5 Actual Expenditure (Table B)

- Expenditure totals £160.9m for Month 7 includes a non-recurrent adjustment of £2.7m in relation to the Bonus. Excluding this amount the expenditure for M7 is £163.6m. This is £3.1m more than in Month 6, with the increase being primarily attributable to increased costs for Primary Care Contractor (£0.7m), Provider Services – Non Pay (£4.4m) and Continuing Care an Funded Nursing Care (£0.6m), offset by decreases in Provided Services – Pay (£0.7m), Primary Care – Drugs & Appliances (£1.0m), Other Private & voluntary Sector (£0.3m) Healthcare Services Provided by Other NHS Bodies (£0.2m) and other miscellaneous headings (£0.2m) .

- Costs of £4.2m are directly related to COVID-19 this month (£49.5m year to date). Of this £0.2m is pay and £4.0m is non-pay.

Primary Care	• Spend of £18.8m is £0.7m higher than in September but is the same as the monthly average level in year to date. • Pressures in General Medical Services (GMS) still remain from cost of drugs and increased complexity of drugs reported through GMS Dispensing and GP Prescribing.
Primary Care Drugs	• The expenditure for Month 7 is £0.5m (4%) lower than in Month 6, however there was 1.5 less Prescribing days in October (21) than there was in September (22.5). • Following receipt of the August prescribing data, the average cost per Prescribing Day has shown a small reduction; August was £464k compared to July at £466k, representing an overall reduction of 0.8%. • The average cost per item has remained steady (a marginal decrease of 0.1%), and the overall number of items prescribed has reduced by 0.6%.

	• The reduction in CAT-M Drug prices is now showing through the CASPA data, with an overall reduction in the forecast outturn of £1.0m compared to last month. • The above currently includes spend from dispensing GP practices on drugs.
Provided Services - Pay	• Provided Services pay costs are £68.6m, which is £0.7m (1%) less than in Month 6, after accounting for bonus refund. Accounting for the refund of the bonus payment especially on bank staff at £2.7m accounts for most of the movement. • Agency costs have increased by £0.2m compared to last month. Further details on agency spend are included in section 5.1. • A total of £0.2m, which includes the £2.7m bonus refund, of pay costs were directly related to COVID-19. Where the bonus is excluded pay costs directly related to COVID-19 are £2.9m is £0.2m lower than in September.
Provider Services Non-Pay	• Spend in September is £4.4m (28%) more than in September. • The main movements are increases due to ICF schemes (£5.3m) to local authorities, contractual clinical services (£0.4m), building contracts (£0.3m), recruitment agency introduction fees (£0.2m), radiography equipment maintenance (£0.2m), and other various headings (£0.4m) offset by reductions in recruitment, training and CRB checks (£0.4m), protective clothing (£0.3m), computer maintenance (£0.3), Health and Safety (£0.3m), mechanical and service costs (£0.2m), consultancy (£0.1m) and other various headings (£0.8m) • Scheduled Care activity remains lower than expected across all sites but overall there has been a slight increase in theatre activity which has increased 3% compared to last month. The activity is approximately 76% of pre-COVID-19 levels. There has been a significant increase in Trauma (increase of 10%) and Orthopaedics (27%) which led to an increase of £0.1m on implant spend compared to last month. All three sites are experiencing staffing pressures due to lack of staff which is backfilled by agency workers as the activity levels start to increase.
Secondary Care Drugs	• Costs in Month 7 are £0.1m (1%) lower than Month 6 and is £0.8m higher than the forecast for October in the MDS. • Although drugs are lower this is offset by increased costs across other headings. This increase in costs is across specialities and is being

	driven by the increase in activity for both Scheduled Care and through Emergency Departments. • In addition, as with Primary Care Drugs, less prescribing days is the main reason for decreased spend this month.
Healthcare Services provided by other NHS Bodies	• Spend has decreased by £0.2m (1%) on last month and is £2.3m higher than anticipated in the MDS. • Block contracts with English providers remain, however there is a risk around inflation on these contracts, as well as inflation on Welsh contracts.
Continuing Health Care (CHC) and Funded Nursing Care (FNC)	• Expenditure in October is £0.6m (7%) higher than in September. • Costs have increased overall compared to last month for CHC and continues to be a pressure in Mental Health. There continues to be an underlying growth in Older People Mental Health (OPMH) costs.
Other Private and Voluntary Sector	• Expenditure relates to a variety of providers, including hospices and Mental Health organisations. • Costs have decreased £0.3m compared to last month and is in line with monthly average cost profile.
Joint Financing	• Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget. This is broadly in line with last month with a decrease of £0.1m compared to September and is the same the average monthly cost.
Losses, Special Payments and Irrecoverable Debts	• Includes Redress, Clinical Negligence, Personal Injury and loss of property.
Capital	• Includes depreciation and impairment costs, which are fully funded. • Capital costs are in line with September.

1.6 Forecast Expenditure (Table B)

- Last month the wholesale price of gas increased to almost four times the usual levels due to a variety of national and international factors to both demand and supply, including lower than usual stocks, supply issues from the continent and post pandemic increase in demand. This meant that the forecast costs increased by £1m. The supplier has indicated that the market prices have decreased from the highs of last month but no data has been received to quantify the effect. As a result the forecast assumptions remain in place. However, the forecast spend

has increased to £2.7m based on the last set of data on the prices and the proportion of pre-purchased energy. This forecast includes a change to both electricity and gas costs. The forecast assumes the price increase will affect the Health Board from quarter 4 as 90% of energy requirements for the year have already been procured before the recent wholesale price increase.

- Expenditure related to the £30.0m funding for the Performance Fund and £12.0m Strategic Support included in the forecast, based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend over the remaining months of the year. This cost profile is dependent on operational teams implementing approved plans at pace. There may be movements between pay and non-pay as schemes progress and the ability for Health Board staff to undertake additional work is assessed. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts.

	Actual							Forecast					
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.3	0.4	0.6	0.6	0.6	0.9	1.0	1.5	2.1	2.9	3.0	3.1	17.0
Non-Pay	0.0	0.0	0.3	0.0	0.1	0.0	0.4	4.2	4.7	5.0	5.0	5.3	25.0
Total	**0.3**	**0.4**	**0.9**	**0.6**	**0.7**	**0.9**	**1.4**	**5.7**	**6.8**	**7.9**	**8.0**	**8.4**	**42.0**

- A contract has just been awarded for the groundwork for the Regional Treatment Centre, with more contracts to be awarded in the future. The forecast assumes that the Regional Treatment Centre procures at pace.

- As discussed with Welsh Government, some of this £42.0m non-recurrent funding has been committed recurrently as it relates to staff posts and the recurrent element will be firmed up in future months.

- The ICF schemes have been agreed to the value of £9.1m and this has increased income and provider non pay forecasts.

- The WHSCC movement has reduced the value of the Private provider forecast.

- The pay forecast has reduced, primarily due to the £2.7m refund relating to the Bonus, as referred to within the in month position.

- The non pay forecast has increased predominately due to the impact of the additional COVID-19 funding recognised in month 7. This may be subject to movement in future months as plans relating to the new funding streams are firmed up.

1.7 Accountancy Gains (Table B)

- The Health Board is reporting an accountancy gain of £0.1m in October, the same as in August, with a forecast of £0.3m for the year.

1.8 COVID-19 (Table B3)

- The total impact of COVID-19 in September, including all costs offset by expenditure reductions, is £3.4m. Welsh Government funding has fully offset the impact of COVID-19.

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual M05 £m	Actual M06 £m	Actual M07 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.2	0.3	0.4	0.4	0.4	2.0	5.8
Tracing	1.1	1.0	1.0	0.9	1.1	1.1	1.0	7.2	14.1
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	1.0	0.9	1.0	8.9	13.7
Extended FLU Vaccinations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0
Field Hospital/Surge	0.3	0.7	0.2	0.5	(0.3)	0.0	0.3	1.7	1.7
Cleaning Standards	0.0	0.0	0.0	0.0	0.5	0.1	0.1	0.7	1.3
Other Costs	4.5	3.6	4.5	6.3	4.0	4.6	1.4	29.0	70.6
Total COVID-19 expenditure	**7.7**	**7.0**	**7.9**	**8.8**	**6.7**	**7.1**	**4.2**	**49.5**	**109.2**
Offset by Covid income to cover expenditure	**(7.7)**	**(7.0)**	**(7.9)**	**(8.8)**	**(6.7)**	**(7.1)**	**(4.2)**	**(49.5)**	**(109.2)**
Other COVID-19 Support									
Operational expenditure reductions	(0.2)	(0.7)	(0.8)	0.1	(0.6)	(0.1)	(0.7)	(3.0)	(3.4)
Funding for non delivery of savings in 20/21	(0.6)	(4.9)	(2.7)	(2.7)	(2.7)	(2.7)	(2.7)	(19.0)	(32.7)
Impact of COVID-19 on Position	**(0.8)**	**(5.6)**	**(3.5)**	**(2.6)**	**(3.3)**	**(2.8)**	**(3.4)**	**(22.0)**	**(36.1)**

- The forecast total cost of COVID-19 is currently is £109.2m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been received to cover non delivery of savings in 2020/21 of £32.7m and we have operational expenditure reductions of £3.4m.

- There are indications that the year-end accruals for decommissioning of field hospitals and local authority TTP costs maybe over accrued and a discussion would be welcomed with Welsh Government officials regarding the reporting of these items.

- Other costs have decreased to £1.4m in month from £4.6m in September due to adjustments to Other private & voluntary sector (£3.7m), unused bonus accrual and other pay (£2.8m) Secondary Care drugs (£0.1m), WHSSC pressure (£0.9m) and offset by net £1.0m on adjustments to Provider Non Pay PPE, Healthcare Services Provided by Other NHS Bodies (£1.2m), CHC (£1.1m) and Other private hospital providers £1.0m).

1. FINANCIAL POSITION & FORECAST

- Movements in the overall forecast from last month are as follows:

	Forecast at Month 6 £m	Forecast at Month 7 £m	Change £m
Testing	4.1	5.8	1.7
Tracing	14.4	14.1	(0.3)
Mass COVID-19 Vaccinations	13.7	13.7	0.0
Extended FLU Vaccinations	2.2	2.0	(0.2)
Field Hospital/Surge	1.4	1.7	0.3
Cleaning Standards	1.8	1.3	(0.5)
Other Costs	73.2	70.6	(2.6)
Total COVID-19 costs	**110.8**	**109.2**	**(1.6)**
Offset by Covid income to cover expenditure			
Other COVID-19 Support			
Operational expenditure reductions	(3.1)	(3.4)	(0.3)
Funding for non delivery of savings in 20/21	(32.7)	(32.7)	0.0
Total Impact of COVID-19	**75.0**	**73.1**	**(1.9)**

  - The main change is the decrease in the forecast for the unused bonus costs, offset by the recognition of costs on private hospital providers.

- As additional modelling data for COVID-19 is received forecasts will be revised and updated. There will however remain a degree of uncertainty around forecasts as situations develop, particularly regarding the impact of variants of concern on hospitalisations.

- Included within the Other section on Table B3 is expenditure against the £19.9m COVID-19 Recovery Plan. Forecast costs have been phased in line with submitted plans as follows:

	Actual							Forecast					
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.1	0.0	0.1	0.1	0.1	0.1	0.3	0.1	0.1	0.1	0.1	0.1	**1.3**
Non Pay	0.1	0.7	0.5	0.6	0.6	0.7	0.8	2.9	2.8	3.0	3.0	2.9	**18.6**
Total	**0.2**	**0.7**	**0.6**	**0.7**	**0.7**	**0.8**	**1.1**	**3.0**	**2.9**	**3.1**	**3.1**	**3.0**	**19.9**

1. FINANCIAL POSITION & FORECAST

- In addition to the above, £50.8m of COVID-19 costs are included in the Other section.

- Secondary Care costs are a large element of this and include all of the costs related to dealing with COVID-19 in the three acute sites, which covers expenditure on COVID-19 wards, increased staffing, drugs, PPE and critical care.

- There are significant costs included for Prescribing, CHC and Regional Treatment Centre. Forecast costs are included based on estimates from divisional finance leads. These are best estimates at the current month and subject to all of the uncertainties around COVID-19 rates, the level of hospitalisations and the acuity of patients as restrictions are eased and then heading into the winter months.

- Within Other costs is healthcare provided by other NHS bodies in England. The table below shows the costs incurred to date by English provider broken down by provider and specialty. It is expected that further information will be provided in future months.

		H1						H2						
		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
Provider	Specialty	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
COCH	General specialties	0.2	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5
RJAH	Orthopaedics	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
SATH	General specialties	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Wirral	Urology/Gynaecology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Clatterbridge	Cancer	0.2	0.0	0.1	0.0	0.0	0.0	0.1	0.2	0.1	0.1	0.1	0.2	1.1
LWH	Gynaecology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total		**0.6**	**0.2**	**0.2**	**0.0**	**0.0**	**0.0**	**0.1**	**0.2**	**0.1**	**0.1**	**0.1**	**0.2**	**1.8**

Note:
Based on month 6 data
Incomplete data has been received from COCH for 3 months due to implementation of new Patient Admin System estimate for month 6 removed as no data available
Clatterbridge H1 reported as advised but queries still being outstanding so subject to review when complete
H2 - updated estimates - actual Month 7 data not available until December

2. UNDERLYING POSITION

2.1 Movement from Financial Plan (Table A)

- The Health Board continues to face a significant underlying deficit position, which is a consequence of our residual infrastructure and delivery inefficiencies from 2019/20, combined with the impact of the non-delivery of recurrent savings in 2020/21.

- The underlying position brought forward from 2020/21 is £75.2m. The carried forward underlying deficit is £75.2m. This is primarily as a result of:

    - £32.7m undelivered savings in 2020/21, due to COVID-19. These have been funded non-recurrently in 2021/22, but they will remain a pressure in future years.

    - £40.0m strategic support funding that is non-recurrent.

- The organisation is progressing establishment and resourcing of its transformation agenda, which will support the development of a rolling three year savings programme that will deliver savings to help bring the underlying position back into balance.

- All schemes are now amber/green status and there are non red pipeline schemes recorded in Table A.

- The operational forecast outturn for the year is a £36.1m deficit, offset by a £32.7m additional funding and the £3.4m reduction operational costs.

- The plans for Post COVID-19 Rehabilitation Long COVID are still under development with projected costs and approved funding to date featured in the financial plan.

- The GMS (line 38) is forecasting a £2.1m overspend, an increase of £1.0m on September which should be rectified by increased savings over the rest of the year.

- In previous months the cost pressures and non recurrent savings were netted off. This month this has been grossed up and, therefore, both savings and cost pressures have increased.

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The below are risks to the Health Board's financial position for 2021/22. Where we are clear, for both risks and opportunities, of any costs these factored into the forecasts.

	£m	Level	Explanation
Risks			
Recruitment of staff	TBC		There is a risk that due to the inability to recruit clinical staff higher agency costs are required.
Anticipated income	TBC		There is a risk that the anticipated income shown in Table E will not be fully funded.
Risk of increased energy prices	TBC		Global increases in the wholesale price of gas fuel creates a risk that energy prices incurred by the Health Board will be significantly higher in the future.

3. RISK MANAGEMENT

- The below is are opportunities to the Health Board's financial position for 2021/22.

	£m	Level	Explanation
Opportunity			
Accountancy gains	TBC		There is a potential for future one off accountancy gains.
Additional funding – Risk of not being to utilise additional funding provided by WG	TBC		There is a risk that the Health Board will not be able to utilise the additional funding provided by Welsh Government, for example, performance fund monies, due to plans not being identified and approved.

4. RING FENCED ALLOCATIONS

4.1 GMS (Table N)

- Not required this month.

4.2 GDS (Table O)

- Not required this month.

5. AGENCY/LOCUM EXPENDITURE

5.1 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 7 are £3.9m which is an increase of £0.1m on Month 6, representing 5.6% of total pay. This is the same as Month 6 overall but the main movements are medical agency increasing by £0.2m, nursing and midwifery increasing 0.1m offset by £0.2m decrease in other agency costs. Monthly agency spend for October included £0.8m that related to COVID-19, £0.2m more than last month.

- Medical agency costs have increased by £0.2m compared to last month; to an in-month spend of £1.7m. COVID-19 costs were £0.3m in October and £0.2m in September. This is mainly due to consultants and doctors required to fill shifts.

- Nurse agency costs totalled £1.5m for the month, an increase of £0.1m on last month. Acute sites continue to carry a high level of nursing vacancies and although some overseas nurses have now started there are still pressure on the number of nurses required as business as usual returns. COVID-19 costs were £0.4m in October and £0.3m in September. The increase is due to difficulty in filling some shifts and with slightly increased ward activity.

- Other agency costs total £0.7m this month, an increase of £0.2m on last month. In October £0.1m and September £0.1m, related to COVID-19, primarily Administrative and Clerical, broadly remaining constant in total month on month.

6. SAVINGS

6.1 Savings (Tables C – C3)

- Savings in Month 7 totalled £1.7m, an increase of £0.2m over the delivery in Month 6. This gives cumulative savings delivered of £9.3m for the year to date. This is spread across a range of schemes.

- Savings of £16.6m are forecast for delivery in 2021/22 against identified amber and green schemes, an increase of £3.3m compared to Month 6. Of this non recurrent savings amount to £8.2m.

- All schemes are now in amber / green status and the red pipeline value in Table A has been removed.

- Further opportunities continue to be identified both within Divisions and across BCU to optimise the delivery of the savings in line with the financial plan.

7. INCOME ASSUMPTIONS

7.1 Income/Expenditure Assumptions (Table D)

- Table D is regularly updated to reflect agreed changes in income and expenditure within the Welsh Health economy.

7.2 Resource Limits (Table E)

- The Revenue Resource Limit (RRL) is £1,832.5m for the year. £1,024.6m of the RRL has been profiled into the position cumulatively, which is £44.4m less than seven equal twelfths (£1,069.0m), primarily due to the profile of COVID-19 and performance funding.

- Confirmed allocations to date are £1,791.9m, with further anticipated allocations in year of £40.6m. This includes £141.9m for COVID-19, of which £21.8m is included in anticipated income.

8. HEALTH CARE ARGEEMENTS & MAJOR CONTRACTS

8.1 Welsh NHS Contracts

- All Welsh healthcare agreements were agreed and signed by the deadline of the end of 11th June 2021.

9. STATEMENT OF FINANCIAL POSITION & AGED WELSH NHS DEBTORS

9.1 Statement of Financial Position (Table F)

- Key movements in the Statement of Financial Position since 2020/21 are:

  - **Non-Current Assets (lines 1 and 2)**

    Movements in non-current capital assets are included in Tables I to K of the return with additional supporting narrative included in Section 12 of this report.

  - **Current assets – trade and other receivables (line 7)**

    The most significant element of the increase in trade and other receivables during the year to date relates to sums that the Health Board would be able to recover from the Welsh Risk Pool in the event of litigation claims, particularly clinical negligence, being successful. These increased by £45.0m with a smaller net adjustment relating to other trade and other receivables.

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

  - **Current assets – Cash and cash equivalents (line 9)**

    Cash and cash equivalents have increased by £4.4m to £7.6m during the year, made up of an increase of £2.8m in revenue cash and £1.6m in capital cash.

  - **Current liabilities – Trade and Other Payables (line 13)**

    The year-to-date movement includes a reduction of £18.0m relating to the NHS bonus payment and a £7.0m reduction in accounts payable balances.

- **Current liabilities – Provisions (line 15)**

  Increases in provisions mainly relate to on-going clinical negligence litigation claims, the majority of which will be recoverable from the Welsh Risk Pool in the event of cases being successful (see above).

  This increase has been offset by a £2.2m reduction in the Agreement Framework on Overtime Payments and Pay During Annual Leave provision following payments made during August 2021.

- **Full year forecast movements**
  - **Current assets – Trade and Other Receivables (line 7)**

    As detailed above it is currently assumed that any amounts paid by the Health Board in respect of increased clinical negligence provisions will be fully recoverable from the Welsh Risk Pool and these will be amended each month based on the Legal and Risk Services quantum. The Health Board expects to settle a large clinical negligence claim for around £5.0m early in 2022 and it assumed that this will be recovered from the Welsh Risk Pool before the end of the financial year.

    Any other material movements in the Legal and Risk Services quantum will be monitored each month along with the potential impact of timing delays between payments of costs and their subsequent recovery.

  - **Current assets – cash and cash equivalents (line 9)**

    Details on the forecast cash outturn position along with cash being requested for working balance movements is provided in the narrative to Table G – Monthly Cash Flow Forecast.

  - **Current liabilities – Trade and Other Payables (line 13)**

    Trade and Other Payables are forecast to decrease by £25.2m during 2021-22 including reductions for the NHS bonus payment, decommissioning Field Hospitals/MVCs and associated consequential losses.

Allocations for these accruals were provided on a resource only basis during 2020-21. No movement in the values of capital payables is expected during 2021-22.

- **Current liabilities – Provisions (line 15)**

  Based on the latest quantum information provided by NWSSP Legal and Risk Services, clinical negligence provisions have increased by £46.3m to Month 7 2021-22. It is assumed that this will reduce by £5.0m following payments of a significant clinical negligence claim in early 2022. No other material movements in provisions are currently anticipated before the end of the financial year.

9.2 Welsh NHS Debtors (Table M)

- The Health Board held ten outstanding NHS Wales invoices over eleven weeks old at the end of Month 7 2021-22, each of which had been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales. Payment for seven of these invoices was received prior to the Monitoring Return submission date with the final three invoices expected to be paid once additional backup has been provided to the relevant debtor.

10. CASH

10.1 Cash Flow Forecast (Table G)

- The closing cash balance as at 31 October 2021 was £7.6m, which included £3.5m cash held for revenue expenditure and £4.1m for capital projects.

- The Health Board is continuing to forecast a working capital cash requirement of £27.0m in respect of allocations previously provided on a resource only basis and this has been included as a cash pressure on Table G in March 2022.

- This forecast requirement includes movements in accruals for the NHS bonus payment, decommissioning of Field Hospitals and consequential losses and a reduction in the provision for holiday pay on overtime and additional hours.

- It is currently assumed that both the capital payables and capital cash balances will remain unchanged during 2021-22 and these will be updated in future months in line with progress on the capital programme.

- Table G currently forecasts a 2021-22 negative closing cash balance of £23.8m which is made up of a negative revenue balance of £26.3m and a positive capital balance of £2.5m. As detailed above, additional working capital cash support of £27.0m would be required to return the revenue cash balance to its opening balance level of £0.7m.

10. CASH

Revenue cash requirements 2021-22	£m
Opening revenue balance	0.7
Forecast outturn position	0.0
Cash impact of reductions in working balances	(27.0)
Forecast closing revenue cash balance	**(26.3)**

Capital cash requirements 2021-22	£m
Forecast cash funding	
Opening capital balance	2.5
Approved Capital Resource limit	35.8
Donated asset income	0.8
Disposal proceeds	0.2
Forecast capital cash funding	**39.3**
Forecast cash spend	
Forecast spend on approved Capital Resource limit	(35.8)
Forecast donated asset cash spend	(0.8)
Forecast disposal proceeds cash spend	(0.2)
Total cash requirements	**(36.8)**
Forecast closing capital cash balance	**2.5**

11. PUBLIC SECTOR PAYMENT COMPLIANCE

11.1 PSPP (Table H)

- Not required this month.

12. CAPITAL SCHEMES & OTHER DEVELOPMENTS

12.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2021/22 is £35.9m. There is slippage of £1.9m against the planned spend of £8.5m at Month 7. It is anticipated that this will be recovered during the rest of the year and that the CRL will be achieved.

All Wales Schemes	CRL 2021/22 £'000	2021/22 Expenditure M7 £'000	YTD Planned £'000	Narrative
Capital Projects Approved Funding				
Ruthin	1,586	1,586	1,586	The last phase of the scheme will complete in November 2021. The CRL will be spend in full in this financial year.
North Denbighshire Community Hospital	181	41	165	The scheme is currently in design stage and fees will be due this financial year.
Substance Misuse - Holyhead, Anglesey	376	354	486	The scheme is in completion stage and final accounts will be agreed imminently.
Substance Misuse - Shotton, Flintshire	454	346	499	The scheme is in completion stage and final accounts will be agreed imminently.
PAS System	169	123	271	The WPAS project expenditure is on track this financial year and a change of approach has been agreed at project board. The full allocation will be spend this financial year.
Emergency Department Systems	335	167	307	implementation of Symphony and has moved to phase 2 to implement in the East. The forecast spend will achieve in the financial year.
Wrexham - Fees to OBC	1,397	532	817	The scheme is currently in design stage and fees will be due this financial year.
National Programmes – Fire	1,097	2	1,097	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Infrastructure	1,450	72	1,450	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Decarbonisation	1,430	231	1,430	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Mental Health	620	20	620	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Imaging	3,975	52	3,975	The quotations has been received for the equipment. Currently awaiting the tenders back for the enabling. The scheme will be completed before the year end.
ICF - Bryn Beryl	229	166	229	The scheme is due to complete and final account is being agreed.
COVID-19 Recovery 2021-22 - 24th Sept Letter	6,500	105	6,500	The additional funding is to support COVID-19 recovery projects. It is anticipated that the funding will be spent by the 31st March 2022.
National Programmes – Imaging - WMH MRI Upgrade +RF cage	792	0	792	The imaging funding is for equipment that will be purchased by the 31st March 2022.
National Programmes – Imaging – CT Scanners	22	0	22	The imaging funding is for equipment that will be purchased by the 31st March 2022.
National Programmes – Imaging – 6 DR rooms	1,656	0	1,656	The imaging funding is for equipment that will be purchased by the 31st March 2022.
National Programmes – Imaging – Fluoroscopy	672	0	672	The imaging funding is for equipment that will be purchased by the 31st March 2022.
All Wales Total	**22,941**	**3,797**	**22,574**	
Discretionary Total	12,921	2,844	13,288	Programme leads have confirmed that works have commenced, purchase orders are in place or tenders have been received to progress the planned works and that the Health Board will meet it's CRL.
Overall Total	**35,862**	**6,641**	**35,862**	

12.2 Capital Programme (Table J)

- Details of spend and forecast on a monthly basis and by scheme are included in the table. There is nothing of significance to note.

13. OTHER ISSUES

13.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.

- The Month 7 Monitoring Return will be received by the Health Board's Performance, Finance and Information Governance Committee members at the December meeting.

Jo Whitehead
Chief Executive

Sue Hill
Executive Director of Finance

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Month 5 Monitoring Return Responses

Other – Action Point 4.1 I note that you are continuing to forecast financial balance. It is disappointing however, that the delivery of this position continues to be supported by £0.398m (a positive reduction of c. £1.800m) of Red pipeline savings which do not currently meet the finalised criteria. This position is confirmed within the main body of your narrative and also within Table A; however, your response to Action Point 4.1 reports that the Month 5 gap has now been fully identified and all savings meet the Amber or Green criteria. This inconsistent message on such a key delivery area is of concern; particularly in relation to whether the accurate position has been reported to your Board. Based on the response to Action Point 4.1, it is assumed that again you did not feel it was necessary to provide the Explanatory Accountable Officer Letter which originally should have been provided at Month 3. These issues will be discussed at the Mid-Year Review session; however, I trust that you will not be reporting a savings gap at Month 7.
Response We have cleared the red scheme savings in month 7.
Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 6.1 I note that you have identified a new GMS cost pressure at Month 6 totalling £1.152m, which is being offset by Operational underspends. Further clarity was sought post the MMR submission, as to whether these mitigating underspends were finalised and what they related to, as this was omitted from your submission. The response confirmed that they were finalised, with no risk to the outturn and were within non pay areas. The ability to have identified c. £1.100m of operational underspends in such a short period was positive but unexpected, given that there remains a savings gap of £0.398m. I trust that future key items than could impact on the delivery of your forecast outturn are explained routinely in the narrative going forward, along with the necessary assurance in relation to risk.
Response The overspend in GMS is rectified by identified savings and COVID-19 operational underspends.
Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 6.2 As reported via Line 33 ‘Savings plan assumptions still to be finalised for 22/23, the forecast c/f underlying deficit position of £75.163m is currently being assisted a FYE savings aspiration totalling £3.996m. Whilst I acknowledge that this is a positive approach, as it is unsubstantiated it could lead to your forecast u/l position being understated. I wish to re-iterate that the FYE of saving schemes can only support the underlying c/f position if an element of the savings, linked to a ‘finalised’ schemes in the Tracker, will be delivered in the current financial year. Please ensure that the c/f underlying position is discussed in detail

within your supporting commentary and this should include progress on finalising the aspiration, to justify it being included at this stage.

Response

As per the November's submission made to the FDU, the Health Board anticipates the underlying position to remain at £75.2m. Where there are non recurrent schemes these will be replaced by recurrent schemes going forward.

Risks and Opportunities (Table A2) – Action Point 6.3

Your narrative and Table A2 highlight a number of risks and opportunities (including utilising Performance & Recovery funding) where the potential financial impact has not been quantified. This again is another concern linked to your forecast position where clarity is needed as soon as possible; this will be discussed at the Mid-Year Review.

Response

Some numbers are not known but where they are they have been factored into forecasts.

Monthly Positions (Table B) – Action Point 5.2

The narrative continues to highlight material movements in expenditure but does not explain the associated reasons (as raised in Action Point 5.2). For example, the opening paragraph under Section 1.5 highlights the spend area which are lower than forecast last month with no corresponding explanations provided. Please ensure that supporting explanations are provided for all key expenditure movements in future commentaries.

Response

Commentaries have expanded this month and will continue to provide additional depth, on movements in monthly positions and relation to forecasts.

Monthly Positions (Table B) – Action Point 6.4

As per the below Table, there have again been a number of material 'annual' expenditure movements between Months 5 and 6. Please provide supporting explanations for each of the material movements (including c. £11.700m private and voluntary sector once you exclude CHC reclassification of c. £3.800m) and ensure that all future annual expenditure movements are explained in your narrative. Responses such as 'highlighting spend reclassifications or revised local forecast trends' will not suffice, the corresponding reasons must also be provided**.**

	Month 6 £'000	Month 5 £'000	Movement £'000
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	221,594	226,341	(4,747)
Primary Care - Drugs & Appliances	113,955	114,861	(906)
Provided Services - Pay	873,178	870,659	2,519
Provider Services - Non Pay (excluding drugs & depreciation)	199,599	205,544	(5,945)
Secondary Care - Drugs	81,730	80,182	1,548
Healthcare Services Provided by Other NHS Bodies	281,557	279,748	1,809
Other Private & Voluntary Sector	40,979	25,484	15,495

Response

Annual Forecast Spend Movements	Covid Movement £'000	Revised holiday Pay Provision £'000	PayAward £'000	New Funding £'000	Review of forecasts relating to Strategic support, with move to RTC £'000	Change in forcast due to change in trend/local information £'000	Total movement £'000	Comments
Primary Care Contractor (excluding drugs, including non resource limited expenditure)	-3234		-1077			-436	-4,747	Dental Pay award
Primary Care - Drugs & Appliances	60					-966	-906	
Provided Services - Pay	687	1900				-68	2,519	
Provider Services - Non Pay (excluding drugs & depreciation)	-607				-5338		-5,945	Majority RTC
Secondary Care - Drugs	722					826	1,548	
Healthcare Services Provided by Other NHS Bodies	423			1900		-514	1,809	Vertex funding
Other Private & Voluntary Sector	3120				12375		15,495	Covid movement Is due to CHC, RTC from non pay plus an increase in outsourcing to absorb slippage.

Monthly Positions (Table B) – Action Point 6.5

Your narrative states that annual Primary Care drug spend based on July data suggests a range between £122.800m to £125.300m, this range is materially higher than the c. £114.000m included within your forecast. Please provide enhanced assurance that your current forecast is robust**.**

Response

The narrative relating to Primary Care Drugs spend includes the Dispensing GP Practice Drugs, which as you will be aware, has to be shown against the GMS ring-fence. The £114m forecast reported in the tables relates to the cost that has to be shown against Primary Care Drugs, with the balance reported within the GMS forecast position. We are confident the forecast in the tables is as accurate as it can be with the current information, but as with all our forecasts, these are reviewed and updated on a monthly basis to take into account any new information and emerging trends.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Covid-19 Analysis (Table B3) - Action Point 5.5 As requested via Action Point 5.5, please ensure that your narrative provides details of all the key assumptions (e.g. staffing requirements in secondary care) that support the 'Other' spend (£53.300m as quoted in your narrative) reported in Table B3. Your Month 6 narrative response where you provide a Table that splits cost between pay and non pay by Area Team does not provide the specifics being sought and therefore will not suffice.
Response Refer to narrative in section 1.8 for more information.
Covid-19 Analysis (Table B3) - Action Point 6.6 Please provide a supporting explanation for reducing the annual forecast spend in relation to Mass Vaccination Programme, by c. £2.700m and reporting a minus PPE expenditure amount of £0.861m in September.
Response On discussion with the senior members of the BCU Vaccination Tactical Group on how the booster programme would be delivered, primarily through local vaccination centres rather than via primary care contractors, the estimated costs for row 27 "Additional costs in Primary Care" was reduced significantly. There was also a review of forecast costs for vaccination from the former field hospital sites (only Deeside is still being used as a vaccination centre), offset by some increased costs for new local vaccination centre.
Resource Limits (Table E) – Action Point 6.7 Please provide an update on the progress in obtaining APB plan approval, which is required in order to release the Substance Misuse funding.
Response The APB approved plan was submitted to Tim Nunn in Welsh Government on the 16/06/21. This has been forwarded by separate e-mail.
Cash Flow (Table G) – Action Point 5.7 Following Action Point 5.7, I note that you are requesting Revenue working balances cash support totalling £27.000m. As revenue payables (Line 45 of Table F) are only forecast to

reduce by £25.194m, please confirm what the remaining balance of £1.806m relates too (e.g. is it related to a reduction in provisions?).

Response

The revenue working balances request includes £2.2m relating to provisions for Holiday Pay on Overtime and Additional Hours. This was funded on a resource only basis in previous years and cash paid in August 2021. Other minor movements in working capital balances will continue to be managed internally as in previous years.

Table H (PSPP) – Action Point 6.8

I look forward to seeing that actions such as the PO process, referenced in your narrative, improve the payment performance of NHS invoices (YTD 89.8%) within the second half of the financial year.

Response

The impact of actions taken to improve the payment performance in respect of NHS invoices will be reported in future Monitoring Return submissions.

In Year Capital Scheme (Table J) – Action Point 6.9

Please provide a supporting explanation for assessing the 'Covid-19 Recovery' scheme as Medium risk**.**

Response

The risk rating has now been revised to low. The Health Board has a fully committed programme in place that will deliver by 31 March 2022.

Non Cash Return

The Health Board submitted the November Non Cash return on 5 November 2021. All budget adjustments will be made in the month 8 monitoring return.

Covid-19 Analysis (Table B3) - Action Point 6.10

All organisations are being requested to ensure that all C19 Recovery expenditure and corresponding income (Tranche 1 & 2 and National programmes e.g. PACU etc) is reported within the 'Wales Recovery' tab of the supplementary 'Other' Covid-19 return.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Response The COVID-19 Recovery Expenditure and corresponding income will be included within the Wales Recovery Tab future returns.
Other – Action Point 6.11 Please ensure that all signed narratives are submitted by midday on Day 9.
Response Processes have been firmed up to ensure the narrative is submitted by midday on Day 9.

MONITORING RETURN

MONTH 8 2021/22

Sue Hill

Executive Director of Finance

Betsi Cadwaladr University Health Board

1. FINANCIAL POSITION & FORECAST

1.1 Financial Plan

- The Health Board's plans for 2021/22 include the £82.0m strategic support funding notified by Welsh Government last year (£40.0m to cover the deficit and £42.0m strategic support) and the £19.9m COVID-19 Recovery Plan funding. Together, these are being used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales. In addition, COVID-19 funding of £32.7m was issued to cover the impact of the undelivered savings from 2020/21, which were not achieved due to the pandemic.

- As we have progressed through the year and our clinical and operational plans have evolved and been implemented, the financial forecast has been scrutinised on a monthly basis and further developed to reflect the current and forecast prevalence of COVID-19 and our developing response. This has had a significant impact on the level of COVID-19 funding that is estimated to be required to manage the pandemic during 2021/22. The latest forecast suggests that the Health Board can reduce the level of COVID-19 funding by £10.2m. An Accountable Officer letter has been submitted and the Monitoring Return has been prepared on the basis of the return of this funding.

- In relation to the schemes funded by the £42.0m strategic support this year, recovery from COVID-19 and the related workforce constraints are the main risk to delivery. The Health Board has experienced difficulties in recruitment due to national and local factors. Staff absence has also been impacted by the persistent COVID-19 rates. The Health Board is expecting COVID-19 infection rates to continue post-Christmas and so are plans have needed to adapt and revise due to these events. In line with Welsh Government advice, the Health Board has actively identified alternative schemes that will similarly deliver the transformation and performance required and which can be mobilised in order to ensure we maximise the opportunity to improve performance. This may include additional outsourcing, interims or consultancy, to progress some of the larger schemes. We are therefore still forecasting that the £42.0m strategic support will be utilised in full this year.

1.2 Actual Year to Date Position

- The in-month position is break-even, which also brings the cumulative position to breakeven. This is in line with the refresh of the 2021/22 financial plan, which was submitted in June.

- The total impact of COVID-19 in November is £6.3m (£52.7m for the year to date).

1.3 Forecast Position

- The forecast position is a balanced position for the year.

1. FINANCIAL POSITION & FORECAST

1.4 Income (Table B)

- Income totals £163.9m for November. Further details are included in Section 7.

- The impact of COVID-19 has resulted in £0.2m lost income in November (£2.6m year to date) relating to General Dental Services (GDS) patient income. This is included as a cost of COVID-19 within the "Other" category.

- The Monitoring Return tables have been has been completed taking into account the return of £10.2m of COVID-19 funding, as per the Accountable Officer letter.

1.5 Actual Expenditure (Table B)

- Expenditure totals £163.9m for Month 8 and includes a backdated adjustment for Months 1 to 6 in relation to the overtime on annual leave payments, totalling £0.8m. Expenditure for Month 8 is £2.9m more than in Month 7. The areas of significant increase in spend are Provided Services Pay (£5.5m), Healthcare Services Provided by Other NHS Bodies (£0.9m) and Primary Care Drugs (£0.4m). Offsetting this there are significant decreases in spend in Continuing Care and Funded Nursing Care (£2.2m) and Provider Services Non Pay (£2.2m).

- Costs of £6.4m are directly related to COVID-19 this month (£56.0m year to date). Of this £3.6m is pay and £2.8m is non-pay.

Primary Care	• Spend of £18.8m is £0.1m higher than in October and just above the monthly average level for the year to date. • General Medical Services (GMS) costs have increased in month, particularly around Managed Practices. However this has been offset by a decrease in spend on General Dental Services (GDS). • Actual spend is £0.4m more that had been forecast due to the continued pressures in GMS.
Primary Care Drugs	• The expenditure for Month 8 is £0.4m (4%) higher than in Month 7, however there was one additional prescribing day in November compared to October (22 versus 21). Spend was just £0.1m less than had been forecast, as monthly forecasts are adjusted for the number of prescribing days in each month. • Following receipt of the September prescribing data, the average cost per Prescribing Day has shown a small non-material reduction; September was £0.463m compared to August at £0.464m.

	• The average cost per item has increased by 1.2% (now at £6.85; £6.80 average over 3 months), but offsetting this the overall number of items prescribed has reduced by 1.3% • The forecast outturn prescribing expenditure, including dispensing practices, based on the September data, suggests a range between £123.0m and £124.1m, with the latest position being in the middle of this range at £123.0m. These forecasts are consistent with those at Month 7, based on the August data.
Provided Services – Pay	• Provided Services pay costs are £74.0m, which is £5.5m (8%) more than in Month 7. £0.8m of this relates to the payment for overtime on annual leave arising from the first six months of the year, which was paid to staff in November. The costs for Months 7 and 8 have not yet been calculated and so are not included in the figures. • In addition, Month 7 figures were reduced due to the refund of the bonus payment, especially on bank staff, totalling £2.7m. • The remaining rise in spend of £2.0m relates to increased staffing across the Health Board, particularly in the nursing, medical and additional clinical services staff groups. This is a combination of recruitment of additional staff to help support Planned Care recovery, along with providing cover as a result of high sickness levels among staff due to fatigue and stress from the continued impact of the pandemic. As a result of these issues agency costs have increased by £0.6m compared to last month, with further details included in section 5.1. • Pay actual spend is £1.2m more than had been forecast and this is primarily due to the overtime on annual leave payment which had not been included in the forecast. • A total of £3.6m of pay costs were directly related to COVID-19.
Provider Services Non-Pay	• Spend in November is £2.2m (11%) lower than in October. • October spend was inflated by £5.3m due to a retrospective adjustment for Integrated Care Fund (ICF) schemes, where both the income and expenditure were recognised in the month, following the agreement of schemes. ICF spend in November was £1.9m, so the overall reduction related to ICF this month was £3.4m. • Excluding this adjustment, November spend is £1.2m more than last month. This relates to payments for outsourced Neurodevelopment activity provided by Healios, which is one of the Performance Fund schemes. • Scheduled Care activity remains lower than expected across all sites. Orthopaedic inpatient activity is not taking place at Ysbyty Gwynedd and Wrexham Maelor, so costs related to theatre activity and high

	cost implants are not being incurred. Theatre activity is slightly up at Ysbyty Glan Clwyd and it is expected that Abergele theatres will be fully running by the end of December. • This reduced activity is one of the reasons why actual non-pay spend is considerably lower than had been forecast (£2.9m). In addition, the impact of COVID-19 and staffing shortages has delayed the implementation of some planned recovery schemes. The Health Board has compiled a list of alternative schemes that can be delivered at pace and these are expected to increase spend over the remaining four months of the year.
Secondary Care Drugs	• Costs in Month 8 are £0.3m (5%) lower than Month 7, although still higher than the average monthly cost for the year to date. Actual spend is £0.2m lower than had been forecast. • Some of the decrease in drugs cost is related to the continued low levels of scheduled care activity, particularly with Ysbyty Gwynedd stopping orthopaedic inpatient activity this month. In addition, flu vaccine costs are £0.1m less in November, as the vaccination programme draws to a close.
Healthcare Services provided by other NHS Bodies	• Spend has increased by £0.9m (4%) on last month and is £0.9m higher than had been forecast. • The increase in spend relates to English Non-Contracted Activity (NCAs), where there has been an increase in activity. • Block contracts with English providers remain.
Continuing Health Care (CHC) and Funded Nursing Care (FNC)	• Expenditure in November is £2.2m (24%) lower than in October and £1.0m lower than had been forecast for the month. • The reduction in spend is across Area Teams (£1.2m) and Mental Health (£1.0m). Area Teams are seeing issues around getting CHC patients into placements or with appropriate packages of care, linked to COVID-19 and staffing shortages. This is creating a backlog of medically fit for discharge patients in the hospital and compounding issues in Secondary Care. • The reduction in spend for Mental Health relates primarily to a review of cases and accruals this month. In addition, there has been a reduction in the cost of placements, which has reduced spend despite there being an increase in the number of placements.
Other Private and Voluntary Sector	• Expenditure relates to a variety of providers, including hospices, Mental Health organisations and planned care activity providers.

	• Costs are £0.2m (17%) higher than last month, but £4.3m lower than had been forecast. • This relates to the outsourcing of planned care activity to private providers. A contract for outsourcing orthopaedics work has commenced this month, which has increased spend compared to October. • However, several other contracts are in place and it was hoped that activity would have started in November. Delays in identifying and contacting the cohorts of patients prioritised for treatment have meant that actual spend is considerably less than had been expected.
Joint Financing	• Includes the pay and non-pay for the Community Equipment Stores, which are jointly operated via a pooled budget. • Spend is £0.2m higher than last month, but in line with forecast.
Losses, Special Payments and Irrecoverable Debts	• Includes Redress, Clinical Negligence, Personal Injury and loss of property.
Capital	• Includes depreciation and impairment costs, which are fully funded.

1.6 Forecast Expenditure (Table B)

- Rising energy costs are still a significant risk for the Health Board. We are working with NWSSP to quantify the expected impact this year and in 2022/23. Based on some of the invoices we have received for October, the forecast spend has increased by a further £0.2m this month, a total increase of almost £3.0m. This forecast includes a change to both electricity and gas costs. The forecast assumes the price increase will affect the Health Board for the second half of the year, as 90% of gas and 75% of electricity requirements for the year have already been procured before the recent wholesale price increase. The impact on 2022/23 is particularly concerning, as we only have a small element of electricity forward purchase in 2022/23 to mitigate against the price increases.

- Expenditure related to the £30.0m funding for the Performance Fund and £12.0m Strategic Support is included in the forecast, based on the phasing of costs in submitted business cases. These indicate a stepped increase in spend over the remaining months of the year. This cost profile is dependent on operational teams implementing approved plans at pace and establishing new plans to utilise identified slippage.

1. FINANCIAL POSITION & FORECAST

	Actual								Forecast				
	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Pay	0.3	0.4	0.6	0.6	0.6	0.9	1.0	1.0	1.4	2.4	3.1	3.5	**15.8**
Non-Pay	0.0	0.0	0.3	0.0	0.1	0.1	0.4	1.7	4.0	5.9	6.2	7.5	**26.2**
Total	**0.3**	**0.4**	**0.9**	**0.6**	**0.7**	**1.0**	**1.4**	**2.7**	**5.4**	**8.3**	**4.8**	**5.8**	**42.0**

- A contract has been awarded for the groundwork for the Regional Treatment Centres (RTCs), with more contracts to be awarded in the future and this is included in the forecast. However, the RTCs are not progressing as quickly as had been hoped and so additional schemes have been developed to aid planned care recovery. As a result, forecast spend has moved from Private and Voluntary Sector to Provider Services Non-Pay. The result is a sustained increase in Non-Pay spend over the remaining four months of the year, in line with the spend profile of these new schemes.

- There may be further movements between expenditure categories and pay and non-pay, as schemes progress and the ability for Health Board staff to undertake additional work is assessed. Actual performance against submitted businesses cases will be monitored on a monthly basis and used to inform future forecasts.

- As discussed with Welsh Government, some of this £42.0m non-recurrent funding has been committed recurrently, as it relates to staff posts. The impact of the recurrent element is being incorporated into financial plan, as part of the 2022-25 IMTP.

1.7 Accountancy Gains (Table B)

- The Health Board is reporting an accountancy gain of £0.2m in November, which relates to the purchase of One-Step Nucleic Acid amplification (OSNA) equipment, where the company have written off an historical debt.

1.8 COVID-19 (Table B3)

- The total impact of COVID-19 in November, including all costs offset by expenditure reductions, is £6.3m. Welsh Government funding has fully offset the impact of COVID-19. The table below summarises actual spend and forecast by COVID-19 category.

1. FINANCIAL POSITION & FORECAST

	Actual M01 £m	Actual M02 £m	Actual M03 £m	Actual M04 £m	Actual M05 £m	Actual M06 £m	Actual M07 £m	Actual M08 £m	Actual YTD £m	Forecast 2021/22 £m
Testing	0.1	0.2	0.2	0.3	0.4	0.4	0.4	0.3	2.3	3.9
Tracing	1.1	1.0	1.0	0.9	1.1	1.1	1.0	1.0	8.2	13.2
Mass COVID-19 Vaccinations	1.7	1.5	2.0	0.8	1.0	0.9	1.0	1.7	10.6	16.5
Extended Flu Vaccinations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	2.1
Field Hospital/Surge	0.3	0.7	0.2	0.5	(0.3)	0.0	0.3	(2.2)	(0.5)	(0.5)
Cleaning Standards	0.0	0.0	0.0	0.0	0.5	0.1	0.1	0.1	0.8	1.2
Other Costs	4.5	3.6	4.5	6.3	4.0	4.6	1.4	5.4	34.3	62.5
Total COVID-19 expenditure	**7.7**	**7.0**	**7.9**	**8.8**	**6.7**	**7.1**	**4.2**	**6.5**	**55.9**	**98.9**
Welsh Government COVID-19 income to cover expenditure	(7.7)	(7.0)	(7.9)	(8.8)	(6.7)	(7.1)	(4.2)	(6.5)	(55.9)	(98.9)
Other COVID-19 Support:										
Operational expenditure reductions	(0.2)	(0.7)	(0.8)	0.1	(0.6)	(0.1)	(0.7)	(0.2)	(3.2)	(3.2)
Funding for non delivery of savings in 20/21	(0.6)	(4.9)	(2.7)	(2.7)	(2.7)	(2.7)	(2.7)	(2.7)	(21.7)	(32.7)
Impact of COVID-19 on Position	**(0.8)**	**(5.6)**	**(3.5)**	**(2.6)**	**(3.3)**	**(2.8)**	**(3.4)**	**(2.9)**	**(24.9)**	**(35.9)**

- The forecast total COVID-19 expenditure is currently is £98.9m. This is based on the assumption that COVID-19 will continue to have an impact for the whole year. Welsh Government income has been received to cover non-delivery of savings in 2020/21 of £32.7m and there are operational expenditure reductions of £3.2m.

- Movements in the COVID-19 forecast from last month are as follows:

	Forecast at Month 7 £m	Forecast at Month 8 £m	Change £m
Testing	5.8	3.9	(1.9)
Tracing	14.1	13.2	(0.9)
Mass COVID-19 Vaccinations	13.7	16.5	2.8
Extended FLU Vaccinations	2.0	2.1	0.1
Field Hospital/Surge	1.7	(0.5)	(2.2)
Cleaning Standards	1.3	1.2	(0.1)
Other Costs	70.6	62.5	(8.1)
Total COVID-19 costs	**109.2**	**98.9**	**(10.3)**
Operational expenditure reductions	(3.4)	(3.2)	0.2
Funding for non delivery of savings in 2020/21	(32.7)	(32.7)	0.0
Total Impact of COVID-19	**73.1**	**63.0**	**(10.1)**

- As estimates of COVID-19 expenditure have progressed and plans are further developed, forecast costs have changed. Where funding has been notified to cover specific costs, this has been amended in line with the changes to forecast expenditure. There has been a reduction in requirements of £6.3m in these specific funding streams this month, primarily relating to the stability funding and SDEC costs. New funding has also been offered in relation to Health and Social Care Plan and Dental. Alternative recovery related activities have been sought to utilise funds, however we have not been able to identify these costs with the key limiting factor of availability of staff,

exacerbated by a lack of capacity within NHS England Trust, which has necessitated the forecast reduction. Additionally, £2.2m worth of costs relating to the Decommissioning of Field Hospital and £0.5m relating to Track, Trace and Protect (TTP) have not been realised as anticipated in 2020/21 accounts.

- The Mass COVID-19 Vaccination forecast has been updated to reflect the vaccination booster programme. However, the Health Board has very recently received an instruction from Welsh Government to accelerate this booster programme. The plans required to enact this have not yet been finalised and so are not included in the Month 8 report. Therefore, whilst the forecast figures do include the booster programme, the quantum and phasing of these costs over the remaining months of the year is likely to change as plans are developed. Issues that may impact the forecast include:
  - Increased proportion of activity done by primary care contactors.
  - Increased rates for primary care contactors for weekend and high-risk home visits.
  - More/new vaccination sites.
  - Whether additional staffing need will be drawn internally or from additional bank/agency.
  - Availability of volunteers.
  - Pending further JCVI guidance on doses for children.

  As requested by the FDU, the Health Board is working on an updated forecast.

- Included within the Other section on Table B3 is expenditure against the £19.9m COVID-19 Recovery Plan and the £1.3m second tranche of Recovery Funding. Forecast costs have been phased in line with submitted plans. The detail by month is included in the COVID-19 Other Analysis template.

- Also within Other costs on Table B3 is healthcare provided by other NHS bodies in England. The table below shows the costs incurred to date by English provider broken down by provider and specialty, based on the latest available information.

		H1						H2						
Provider	**Specialty**	**M1 £000**	**M2 £000**	**M3 £000**	**M4 £000**	**M5 £000**	**M6 £000**	**M7 £000**	**M8 £000**	**M9 £000**	**M10 £000**	**M11 £000**	**M12 £000**	**Total £000**
COCH	General specialties	231	213	76	-	-	-	-	-	-	-	-	-	520
RJAH	Orthopaedics	184	38	-	-	-	-	-	-	-	-	-	-	222
SATH	General specialties	2	11	-	-	-	33	-	-	-	-	-	-	46
Wirral	Urology/Gynaecology	10	-	-	22	-	-	5	5	5	5	5	5	62
Clatterbridge	Cancer	171	23	63	55	6	69	60	60	60	60	60	60	747
LWH	Gynaecology	6	6	1	13	2	1	2	2	2	2	2	2	41
Total		**604**	**291**	**140**	**90**	**8**	**103**	**67**	**67**	**67**	**67**	**67**	**67**	**1,638**

Based on Month 6 data as no additional claims have been received.
Incomplete data has been received from COCH for 3 months due to implementation of new Patient Admin System.
Clatterbridge H1 reported as advised but queries still outstanding, so subject to review when complete.
H2 - updated estimates as actual Month 7 data not available until December.

- In addition to the above, £39.7m of COVID-19 costs are included in the Other section. This includes forecast spend on Long Covid (£0.4m) and SDEC (£0.8m). Secondary Care costs are

a large element of the remaining spend and include all of the costs related to dealing with COVID-19 in the three acute sites, which covers expenditure on streaming on COVID-19 wards, increased staffing, drugs, PPE and critical care. Forecast costs are included based on estimates from divisional finance leads. These are best estimates at the current month and subject to all of the uncertainties around COVID-19 rates, particularly around the new variant of concern, the level of hospitalisations and the acuity of patients.

2. UNDERLYING POSITION

2.1 Movement from Financial Plan (Table A)

- The Health Board continues to face a significant underlying deficit position, which is a consequence of our residual infrastructure and delivery inefficiencies from 2019/20, combined with the impact of the non-delivery of recurrent savings in 2020/21.

- The underlying position brought forward from 2020/21 is £75.2m. The carried forward underlying deficit is £75.2m. This is primarily as a result of:

    - £32.7m undelivered savings in 2020/21, due to COVID-19. These have been funded non-recurrently in 2021/22, but they will remain a pressure in future years.

    - £40.0m strategic support funding that is non-recurrent.

- The organisation is progressing establishment and resourcing of its transformation agenda, which will support the development of a rolling three year savings programme that will deliver savings to help bring the underlying position back into balance.

- All savings schemes are now amber/green status and there are no red pipeline schemes recorded in Table A.

- The GMS forecast overspend has increased by £0.4m this month, as reflected on line 38 of Table A. Other cost pressures forecast has increased by £0.2m, relating to the rise in expected energy costs.

- The operational forecast outturn for the year is a £36.0m deficit, offset by a £32.7m additional funding and the £3.3m reduction operational costs.

3. RISK MANAGEMENT

3.1 Risk Management (Table A2)

- The below are risks to the Health Board's financial position for 2021/22. Where we are clear of specific costs for both risks and opportunities, these are incorporated into the forecasts.

	£m	Level	Explanation
Risks			
Recruitment of staff	TBC		There is a risk that due to the delays in recruiting staff, higher agency costs are required.
Risk of increased energy prices	TBC		Global increases in the wholesale price of gas fuel creates a risk that energy prices incurred by the Health Board will be significantly higher in the future. For the full year, an impact of circa £2.2m has been included in the forecast, but there is a risk that prices will increase further leading to additional costs above this.
Pay awards	TBC		Risk around ongoing pay discussions, with the agreed settlement being higher than the funded 3%. There is also potential disruption to services if unions agree to strike.

- The below are opportunities to the Health Board's financial position for 2021/22.

	£m	Level	Explanation
Opportunity			
Accountancy gains	TBC		As part of our due diligence around year-end, we will review our policy around accruals, once the Welsh Government Manual for Accounts has been published. This may lead to the potential for future one off accountancy gains. We would only amend national accruals following discussion with Welsh Government.
Additional funding – Risk of not being to utilise additional funding provided by WG	TBC		There is a risk that the Health Board will not be able to utilise all of the additional funding provided by Welsh Government, due to operational pressures around unscheduled care and/or further COVID-19 pressures in light of the prevalence of Omicron.

4. RING FENCED ALLOCATIONS

4.1 GMS (Table N)

- Not required this month.

4.2 GDS (Table O)

- Not required this month.

5. AGENCY/LOCUM EXPENDITURE

5.1 Agency/Locum Expenditure (Table B2)

- Agency costs for Month 8 are £4.5m, which is an increase of £0.6m on Month 7, representing 5.9% of total pay. Agency spend is the highest for the year so far, reflecting the pressures on the NHS, including COVID-19, staff shortages and fatigued staff leading to high sickness levels.

- Monthly agency spend for November included £0.9m that related to COVID-19, £0.1m more than last month.

- Medical agency costs have increased by £0.2m compared to last month; to an in-month spend of £2.0m. Medical agency costs related to COVID-19 were £0.2m in November, £0.1m less than October.

- Nurse agency costs totalled £1.5m for the month, the same as last month. Acute sites continue to carry a high level of nursing vacancies and although there has been an increase in registered nurses across site this month. Nurse agency costs arising from COVID-19 were £0.4m in November, the same as the prior month.

- Other agency costs total £1.0m this month, an increase of £0.3m on last month. The increase is equally attributable to Allied Health Professionals, and Administrative and Clerical staffing groups, the latter of which primarily relates to support for planned care recovery and COVID-19. Other agency costs related to COVID-19 in November were £0.3m, £0.2m higher than last month, with Administrative and Clerical spend increasing by £0.1m.

6. SAVINGS

6.1 Savings (Tables C – C3)

- Savings in Month 8 totalled £1.9m, an increase of £0.2m over the delivery in Month 7. This gives cumulative savings delivered of £10.7m for the year to date. This is spread across a range of schemes.

- Savings of £16.6m are forecast for delivery in 2021/22 against identified amber and green schemes, £0.3m higher than in Month 7. Of this, non-recurrent savings amount to £7.9m.

- All schemes are now in amber / green status and the red pipeline value in Table A has been removed.

- Further opportunities continue to be identified both within Divisions and across BCU to optimise the delivery of the savings in line with the financial plan.

7. INCOME ASSUMPTIONS

7.1 Income/Expenditure Assumptions (Table D)

- Table D is regularly updated to reflect agreed changes in income and expenditure within the Welsh Health economy.

7.2 Resource Limits (Table E)

- The Revenue Resource Limit (RRL) is £1,882.0m for the year. £1,175.7m of the RRL has been profiled into the position cumulatively, which is £39.0m less than eight equal twelfths, primarily due to the profile of COVID-19 and performance funding.

- Confirmed allocations to date are £1,798.5m, with further anticipated allocations in year of £23.5m. This includes £131.8m for COVID-19, of which £9.8m is included in anticipated income.

- Additional income has been anticipated for Months 1 to 6 for payments of the Overtime whilst on Annual Leave multiplier.

- The Monitoring Return tables have been completed taking into account the return of the below elements of COVID-19 funding, as per the Accountable Officer letter.

	Funding required at Month 7 £'m	Funding required at Month 8 £'m	Change in funding £'m
Stability Fund	41.8	37.0	(4.8)
Single Day Emergency Care (SDEC)	1.6	0.8	(0.8)
PACU	0.5	0.0	(0.5)
Health Checks for Chronic Conditions	0.2	0.0	(0.2)
Total Refund of funding affecting Month 7	**44.1**	**37.8**	**(6.3)**
Balance sheet adjustments - not within the Month 7 position			
Decommissioning of the Field Hospital	0.0	(2.3)	(2.3)
Return of LA TTP Over accrual	0.0	(0.5)	(0.5)
	0.0	**(2.8)**	**(2.8)**
New funding since Month 8			
Dental - Additional funding to access NHS Dental Services	0.0	0.0	(0.6)
Additional Health and Social Care Plan funding	0.0	0.0	(0.5)
New funding or already requested to return	**0.0**	**0.0**	**(1.1)**
Total			(10.2)

8. HEALTH CARE ARGEEMENTS & MAJOR CONTRACTS

8.1 Welsh NHS Contracts

- All Welsh healthcare agreements were agreed and signed by the deadline of the end of 11th June 2021.

9. STATEMENT OF FINANCIAL POSITION & AGED WELSH NHS DEBTORS

9.1 Statement of Financial Position (Table F)

- Key movements in the Statement of Financial Position at Month 8 are as follows:

  - **Current assets – trade and other receivables (line 7)**
    The most significant element of the increase in trade and other receivables during the year to date relates to £47.8m that the Health Board would be able to recover from the Welsh Risk Pool in the event of litigation claims, particularly clinical negligence, being successful.

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

  - **Current assets – Cash and cash equivalents (line 9)**
    Cash and cash equivalents have increased by £1.9m to £5.1m during the year, made up of an increase of £2.3m in capital cash and a reduction of £0.4m in revenue cash.

  - **Current liabilities – Trade and Other Payables (line 13)**
    The year-to-date movement includes a reduction of £20.8m relating to the NHS bonus payment, including £2.7m unused accrual recouped by Welsh Government, and increase in accounts payable balances.

  - **Current liabilities – Provisions (line 15)**
    Increases in provisions mainly relate to on-going clinical negligence litigation claims, the majority of which will be recoverable from the Welsh Risk Pool in the event of cases being successful (see above).

    This increase has been offset by a £2.2m reduction in the Agreement Framework on Overtime Payments and Pay during Annual Leave provision for previous years, as a result of the settlement of the Flowers legal case, following payments made during August 2021.

- Key movements in the Statement of Financial Position over the whole of 2021/22 are as follows:

  - **Current assets – Trade and Other Receivables (line 7)**
    As detailed above, it is currently assumed that any amounts paid by the Health Board in respect of increased clinical negligence provisions will be fully recoverable from the Welsh Risk Pool and these will be amended each month based on the Legal and Risk Services quantum. The Health Board expects to settle two large clinical negligence claims for approximately £8.0m during December and it is assumed that these payments will be recovered from the Welsh Risk Pool before the end of the financial year.

Any other material movements in the Legal and Risk Services quantum will be monitored each month, along with the potential impact of timing delays between payments of costs and their subsequent recovery.

- **Current assets – cash and cash equivalents (line 9)**
  Details on the forecast cash outturn position are provided in the narrative to Table G – Monthly Cashflow Forecast.

- **Current liabilities – Trade and Other Payables (line 13)**
  Trade and Other Payables are forecast to increase over the remaining months of 2021/22 to negate the year-to-date reductions outlined above. It is expected that any movements on trade and other payables during the year will then be managed internally.

- **Current liabilities – Provisions (line 15)**
  Based on the latest quantum information provided by NWSSP Legal and Risk Services, clinical negligence provisions have increased by £47.3m to Month 8. It is assumed that this will reduce by £8.0m following payments of significant clinical negligence claims in late 2021. No other material movements in provisions are currently anticipated before the end of the financial year.

9.2 Welsh NHS Debtors (Table M)

- The Health Board held fourteen outstanding NHS Wales invoices over eleven weeks old at the end of Month 8, each of which had been escalated in accordance with WHC/2019/014 Dispute Arbitration Process – Guidance for Disputed Debts within NHS Wales. Payment for several of these invoices was confirmed in early December and the Health Board is not aware of any disputes with the remaining outstanding amounts.

10. CASH

10.1 Cash Flow Forecast (Table G)

- The closing cash balance at the end of November was £5.1m, which included £0.3m cash held for revenue expenditure and £4.8m for capital projects.

- The Health Board has continued to re-assess cash requirements in line with the profile of expenditure reported on Table B and is no longer forecasting a working capital cash requirement for 2021/22. It has been identified that the Health Board no longer requires the anticipated additional drawdown of £27.0m due to the bonus payments. This is due to an anticipated change in working capital balances at the year-end.

- It is currently assumed that there will be a nil cash movement during the year and that that the closing cash balance will remain unchanged at £3.2m.

- Any movements in working balances will be managed internally, with the exception of the movements in CHC provisions that formed part of the submission to Welsh Government Financial Control & Governance in November.

Revenue cash requirements 2021/22	**£m**
Opening revenue balance	0.744
Forecast outturn position	0
Forecast closing revenue cash balance	**0.744**

Capital cash requirements 2021-22	**£m**
Forecast cash funding	
Opening capital balance	2.498
Approved Capital Resource limit	36.370
Donated asset income	0.549
Disposal proceeds	0.220
Total forecast capital cash funding	**39.637**
Forecast cash spend	
Forecast spend on approved Capital Resource limit	(36.370)
Forecast donated asset cash spend	(0.549)
Forecast disposal proceeds cash spend	(0.220)
Total forecast capital cash spend	**(37.139)**
Forecast closing capital cash balance	**2.498**
Forecast total closing cash balance	**3.242**

11. PUBLIC SECTOR PAYMENT COMPLIANCE

11.1 PSPP (Table H)

- Not required this month.

12. CAPITAL SCHEMES & OTHER DEVELOPMENTS

12.1 Capital Resource Limit (Table I)

- The Capital Resource Limit (CRL) for 2021/22 is £36.4m. There is slippage of £0.6m against the planned spend of £8.4m at Month 8. It is anticipated that this will be recovered during the rest of the year and that the CRL will be achieved.

All Wales Schemes	CRL 2021/22 £'000	2021/22 Expenditure YTD M8 £'000	2021/22 Forecast £'000	Narrative
Capital Projects Approved Funding				
Ruthin	1,586	1,586	1,586	The last phase of the scheme will complete in November 2021. The CRL will be spend in full in this financial year.
North Denbighshire Community Hospital	181	47	165	The scheme is currently in design stage and fees will be due this financial year.
Substance Misuse - Holyhead, Anglesey	376	354	486	The scheme is in completion stage and final accounts will be agreed imminently.
Substance Misuse - Shotton, Flintshire	454	358	499	The scheme is in completion stage and final accounts will be agreed imminently.
PAS System	169	123	271	The WPAS project expenditure is on track this financial year and a change of approach has been agreed at project board. The full allocation will be spend this financial year.
Emergency Department Systems	335	170	307	BCUHB have now gone live in the West as part of the local implementation of Symphony and has moved to phase 2 to implement in the East. The forecast spend will achieve in the financial year.
Wrexham - Fees to OBC	1,397	499	817	The scheme is currently in design stage and fees will be due this financial year.
National Programmes – Fire	1,097	8	1,097	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Infrastructure	1,450	73	1,450	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Decarbonisation	1,430	235	1,430	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Mental Health	620	25	620	Programme leads have confirmed that works have commenced and that tenders and purchase order are being raised.
National Programmes – Imaging	3,975	57	3,975	The quotations has been received for the equipment. Currently awaiting the tenders back for the enabling. The scheme will be completed before the year end.
ICF - Bryn Beryl	229	229	229	The scheme is due to complete and final account is being agreed.
Covid 19 Recovery 2021-22 - 24th Sept Letter	6,500	122	6,500	The additional funding is to support covid recovery projects. It is anticipated that the funding will be spent by the 31st March 2022.
National Programmes – Imaging - WMH MRI Upgrade +RF cage	792	0	792	The imaging funding is for equipment that will be purchased by the 31st March 2022.
National Programmes – Imaging – CT Scanners	22	0	22	The imaging funding is for equipment that will be purchased by the 31st March 2022.
National Programmes – Imaging – 6 DR rooms	1,656	0	1,656	The imaging funding is for equipment that will be purchased by the 31st March 2022.
National Programmes – Imaging – Fluoroscopy	672	0	672	The imaging funding is for equipment that will be purchased by the 31st March 2022.
HEPMA	132	0	132	The funding is for the prescribing Wellsky software. The CRL will be spend by the end of the financial year.
Eye Care - e-referral system	127	0	127	The funding is for the National Eye care software. The CRL will be spend by the end of the financial year.
Same Day Emergency Care	199	0	199	The scheme includes a number of projects that will be delivered by the 31st March 2022.
ICF - Eryl Hospital Dementia Garden	50	0	50	ICF funding has been provided for the dementia garden part of the Stroke Services project that will be completed before the year end.
All Wales Total	**23,449**	**3,886**	**23,082**	
Discretionary Total	12,921	3,988	13,288	Programme leads have confirmed that works have commenced, purchase orders are in place or tenders have been received to progress the planned works and that the Health Board will meet it's CRL.
Overall Total	**36,370**	**7,874**	**36,370**	

12. CAPITAL SCHEMES & OTHER DEVELOPMENTS

12.2 Capital Programme (Table J)

- Details of spend and forecast on a monthly basis and by scheme are included in the table. There is nothing of significance to note.

13. OTHER ISSUES

13.1 Summary

- The figures contained within this report are consistent with the financial ledgers and internal reports of the Health Board.

- The Month 8 Monitoring Return will be received by the Health Board's Performance, Finance and Information Governance Committee members at the December meeting.

Jo Whitehead
Chief Executive

Sue Hill
Executive Director of Finance

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Month 7 Monitoring Return Responses

Other – Action Point 7.1 As you will be aware, a deadline of the 30th November has been set for organisations to confirm final positions with regards to the return of any Covid funding, which must be supported by an explanatory Accountable Officer Letter.
Response An Accountable Officer letter has been submitted and approved, and the tables and narrative are written on this basis.
Other – Action Point 7.2 Please note that we will be using the forecast values recorded in the Month 8 MMR submission, to issue the balance of the Covid 'Programme' Funding for the year. Therefore, please ensure that the data contained in Table B3 reflects a robust assessment of forecast spend and funding requirements (including the spend releases if these are being used to fund Covid Programme spend).
Response All forecasts updated monthly to take into account new information and trends, and these are as robust as possible given the fast moving environment we are operating within.
Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 6.2 I note the forecast c/f underlying deficit position of £75.163m continues to be assisted by a FYE savings aspiration, totalling £4.052m (increase of £0.056m since Month 6). I refer to your response to Action Point 6.2, where you state that non-recurring schemes will be replaced by recurrent schemes going forward. Please clarify if the plan is to review existing non-recurrent saving schemes (currently totalling £7.689m) to establish if these can deliver recurring benefits or, are you planning on developing additional recurring savings schemes. If it is the latter, I again wish to re-iterate that the FYE of saving schemes can only support the underlying c/f position if an element, incorporated as 'finalised' schemes in the Tracker (Table C3), will be delivered in the current financial year (21/22).
Response Schemes continue to be reviewed, with a several having been re-categorised as recurring in month 8. This work continues, so further reclassification is probably next month, together with a firming up of the FYE. In addition to further opportunities for increasing FYE savings are continually being sought, with the aim of removing the £4.052m.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 7.3

The annual forecast of 'in-year' savings has increased by £3.215m since Month 6; however, these savings have only resulted in an increase in the annual FYE recurring value by £0.359m. This raises concern regarding the achievability of the £4.052m FYE aspiration. With five months of the financial year remaining, I trust that the Month 8 Savings Tracker (Table C3) and your supporting narrative will provide greater assurance that the current c/f underlying deficit position is robust.

Response

As per action point 6.2, the residual value is being progressed with a view to converting savings schemes in the next couple of months.

Movement of Opening Financial Plan to Forecast Outturn (Table A) – Action Point 7.4

I note that the £1.152m of 'Operational underspends' (mainly non-pay) reported at Month 6, have been removed from Table A. Please confirm if these corresponding items are now being reported within the Savings Tracker (Table C3).

Response

Yes we confirm that the Operational underspends previously used to support the GMS overspend have been converted to savings in Month 7.

Monthly Positions (Table B) – Action Point 7.5

The annual forecast spend for Primary Care Contractor has increased by £2.828m, with c. £1.000m being attributable to GMS. Please provide a full explanation for this movement including the reasons for the GMS increase**.**

Response

A number of primary care transformational schemes have been approved for progression, which has resulted in an increase in the forecast costs for Primary Care Contractors. The detail on the exact category of expenditure is not yet fully clear, so we may see further movements as additional information becomes available.

Monthly Positions (Table B) – Action Point 7.6

The annual forecast non-pay spend has also increased by £8.046m, with c. £5.200m being attributable to Covid -19 areas and c. £1.000m as a result of increased energy prices. Please provide details of the remaining non-pay pressures totalling c. £1.800m.

Response

Energy price increases, and additional ICF costs as a result of the new income increased costs, which were partially offset by movements to the Primary Care Contractor row for the new transformation scheme as above.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Monthly Positions (Table B) – Action Point 7.7

In respect of the Performance and Strategic funding totalling £42.000m, I note that you incurred £1.400m of spend in October which was £3.100m lower than projected only last month. I trust that the current projected step up in investment will materialise in Month 8 (£5.700m) in order to provide assurance that this funding will be utilised.

Response

It is acknowledged the expenditure was less that projected in Month 7; however, the pace has increased this month. In line with Welsh Government advice, where there has been slippage on original schemes, the Health Board has replaced them with schemes that will similarly deliver the transformation and performance required.

Covid-19 Analysis (Table B3) - Action Point 7.8

Please ensure that the supplementary Mass Vaccination Template expenditure profile, reconciles to that reported within Section A3 of Table B3.

Response

Going forward we will ensure that all divisions have correctly updated the Mass vaccination template so it reconciles to Table B3.

Covid-19 Analysis (Table B3) - Action Point 5.5

You narrative again does not provide sufficient details of the c. £53.000m of 'Other' cost being reported within Section A7 of Table B3. Please ensure that your narrative provides details of all the key assumptions (e.g. staffing requirements in secondary care) that support this material 'Other' spend.

Response

The majority of pay forecast in the 'Other' costs are based upon current staff working at the existing levels, however some costs were incorporated for additional staff to support over the winter period, but given staffing constraints these forecast costs have been significantly reduced from Month 8 onwards, and are linked in with the return of COVID-19 funding (Stability).

Non-pay is expected to remain at similar levels for the remainder of the year.

Covid-19 Analysis (Table B3) - Action Point 7.9

In response to your request for reporting guidance on decommissioning of field hospitals and local authority TTP costs being over accrued in 20/21, I can confirm that any finalised credits should be reported within the corresponding expenditure sections of Table B3 (i.e. Sections A1, A2 or A5). Your narrative should then confirm the amounts (as they may be net of new pressures recorded in the table) and their line location(s) within Table B3.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Response

These items have been included in the Accountable officer letter, and are included in the narrative above. Both items are shown in table B3 in free text lines, as discussed with yourselves.

Covid-19 Analysis (Table B3) - Action Point 7.10

The forecast English Recovery breakdown in the narrative totals £1.800m; however, a lower total funding value of £1.638m is reported within the Tables. Please ensure this expenditure area is consistently reported throughout your future returns.

Response

This will be checked and corrected to ensure consistent reporting going forwards.

Movement of Opening Financial Plan to Forecast Outturn (Table A) - Action Point 7.11

Please ensure that the new in year costs pressures reported in Table A reflect those described within the supporting narrative (e.g. GMS overspend should be c. £2.100m and Energy pressures c. £1.000m).

Response

The narrative in Month 7 narrative was transposed, with GMS forecast being £1.2m, and Other cost pressures being £2m as per the tables. Additional checks will be put in place to ensure this does not happen in future.

Covid-19 Analysis (Table B3) - Action Point 7.12

Please do not include Same Day Emergency Care (SDEC)' expenditure and corresponding income within the 'Wales Recovery' tab of the supplementary 'Other' Covid-19 Template.

Response

The Welsh Recovery in table B3 has been amended to reflect this.

Resource Limits (Table E) – Action Point 7.13

For clarification purposes, please amend the current 'Covid recovery – tranche 1' description to 'C-19 Recovery - Cancer/Dermatology/ Ophthalmology/Patient support' on Line 76 of Table E.

Response

Line 76 of Table E has been amended.

APPENDIX – PRIOR MONTH MONITORING RETURN RESPONSES

Resource Limits (Table E) – Action Point 7.14 Please provide a supporting explanation for anticipating 'DDRB 20/21 for GP trainees' funding of £0.042m, as our understanding is that funding for 20/21 has been issued in the 21/22 Allocation Paper**.**
Response The 2020/21 funding for GP Trainees was issued on the 12th March 2021 on a recurring basis (BETHFS 102INT), which was some months after the allocation tables were issued, and as such it was not recognised as being within the tables. However as you have now confirmed that this was in the allocation, this item has been removed.

Cyfarfod a dyddiad: Meeting and date:	**Performance, Finance and Information Governance Committee 23.12.21**
Cyhoeddus neu Breifat: Public or Private:	Public Session
Teitl yr Adroddiad Report Title:	**Summary of business considered in private session to be reported in public**
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Executive Director of Finance
Awdur yr Adroddiad Report Author:	Diane Davies Corporate Governance Manager
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	None

Argymhelliad / Recommendation:							
The Committee is asked to **note** the report							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	✓
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesu a Dadansoddi / Assessment & Analysis

The Finance, Performance and Information Governance Committee considered the following matters in private session at the inaugural meeting held on 28.10.21

- GP Practice contract award in Conwy
- Neurodevelopment (ND) Assessment contract
- Automated Blood Sciences managed service contract award report
- Radiology Informatics System procurement programme outline business case
- Emergency Departments workforce business case

Goblygiadau Strategol / Strategy Implications This is addressed within the private session documentation
Opsiynau a ystyriwyd / Options considered This is addressed within the private session documentation
Goblygiadau Ariannol / Financial Implications This is addressed within the private session documentation
Dadansoddiad Risk / Risk Analysis This is addressed within the private session documentation
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance This is addressed within the private session documentation
Asesiad Effaith / Impact Assessment This is addressed within the private session documentation