Bundle Performance, Finance & Information Governance Committee 19 January 2023

1 PF23/1 Apologies

Rob Nolan - Annual leave
Phil Orwin
Sue Green - Jason Brannan to deputise
Chris Stockport

2 PF23/2 Declaration of Interest

3 PF23/3 Draft Minutes of the previous meeting held on 22.12.22 for approval

PF23.3 Draft PFIGC Minutes 22.12.22 public ssession v.04.docx

4 09:30 - PF23/4 Matters arising and table of actions

PF23.4 Table of actions.docx

5 09:41 - PF23/5 Report of the Chair

John Cunliffe

6 09:43 - PF23/6 Report of the Lead Executive

Steve Webster

7 09:45 - PF23/7 Business Case for a Long Covid Service/Community Complex Conditions Service

Gareth Evans in attendance
Recommendation
The Committee is asked to
approve Option 3. This option will provide recurrent funding for the Long Covid service and increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks.
note support for the future establishment of Option 4; a Community Complex Conditions Service in BCUHB, integrating Long COVID, Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Breathing Pattern Disorders, Persistent Physical Symptoms (PPS), and Frequent Attenders (FA) in order to improve patient outcomes, provide sustainability and address current and future demand for services and gaps in service provision.
note that funding for option 4 (the Community Complex Conditions Service) is to be considered in line with the current IMTP planning process for 2023/24.

PF23.7a Long Covid BC.docx

PF23.7b Long COVID Business Case V1.6.1.docx

PF23.7c Appendix 1 March 22 - Letter from DCMO to DoTHS re Confirming 5m Long COVID funding for 2022.23.pdf

PF23.7d Appendix 2 WEDFAN IA Covid 19_repdfd.pdf

PF23.7e Appendix 3 WEDFAN YGC Data.pdf

PF23.7f Appendix 4 Patient Feedback.pdf

PF23.7g Appendix 5 EqIA Screening Long COVID recovery v0.03.pdf

8 09:55 - PF23/8 Unscheduled Care report

Nick Lyons and Geraint Farr in attendance
Recommendation
The Committee is asked to note the update provided on the actions being taken within the Unscheduled Care improvement programme and plans for winter

PF23.8 Unscheduled Care report January V1.5.docx

9 10:05 - PF23/9 Planned care report

Nikki Foulkes in attendance
Recommendation
PFIGC is asked to note the partial assurance of the PC programme recognising that the delivery of this programme is vast and will take time in delivering the key objectives - reduction in waiting lists expected due to the volume of patients waiting and in transforming PC services. Additionally, partial assurance is given due to the unknown impact at this time of the impending industrial action and operational pressures to be faced over the winter months.
In supporting the PC recovery program is it important that all stakeholders have clear visibility of the challenge and their progression of meeting the challenges, this with the tools e.g., dashboards to facilitate service delivery.

PF23.9 Planned care update report January 2023 V5.docx

10 PF23/10 Agree Items for referral to Board / Other Committees

11 PF23/11 Agree items for Chairs Assurance report

12 PF23/12 Summary of private business to be reported in public

The Committee is asked to note the report

PF23.12 Items previously discussed in private session.docx

13 PF23/13 Date of next meeting 23.2.23

Draft minutes of the meeting of the Performance, Finance and Information Governance Committee held in public on 22.12.22 via Teams

Present:	
John Cunliffe	Independent Member / Committee Chair
Richard Micklewright	Independent Member
Linda Tomos	Independent Member
Neil Bradshaw	Assistant Director Finance – Capital (part meeting)
Nick Graham	Associate Director Workforce - Planning and Performance
Lesley Hall	Associate Director Workforce – Employment Practices
Gill Harris	Interim CEO/ Executive Director Integrated Clinical Delivery (part meeting)
Nick Lyons	Deputy CEO / Executive Medical Director (part meeting)
Molly Marcu	Interim Board Secretary
Rob Nolan	Finance Director – Commissioning and Strategy
Dylan Roberts	Chief Digital and Information Officer (part meeting)
Chris Stockport	Executive Director Transformation and Planning
Edward Williams	Deputy Director Performance (part meeting)
Angela Wood	Executive Director Nursing & Midwifery
Diane Davies	Corporate Governance Manager / Committee Secretariat
Observing	
Andrew Doughton	Audit Wales
John Gallenders	Independent Member
Dave Harries	Head of Internal Audit
Michelle Jones	Head of Financial Reporting

Agenda Item Discussed	Action By
PF22/176 Apologies Apologies were received on behalf of Sue Green, for whom Lesley Hall and Nick Graham deputised, and Phil Orwin.	
PF22/177 Declarations of Interest No declarations were received	
PF22/178 Draft minutes of the previous PFIG Committee meeting held on 27.10.22 The minutes of the meeting were approved *subject to addition of sentence "* It was understood that the IMTP process was scheduled to be discussed at the next Partnerships, People and Population Health Committee meeting." at PF22/140.	
PF22/180 Matters arising and table of actions	

There were no matters arising from the minutes. The table of actions was updated and closed actions agreed.	
PF22/181 Report of the Chair The Committee Chair advised that it had been necessary to reduce and prioritise agenda items, recognising the current pressures in regard to personnel, industrial action and winter pressures. A number of deferred items would be discussed at the January or February meetings.	
PF22/181 Report of the Lead Executive None.	
PF22/182 Finance report month 8 **PF22/182.1** The Finance Director – Commissioning and Strategy advised the Month 8 position to be £160.8m against plan of £158.9m i.e. being £1.9m adverse and the year to date position to be £1,274.4m against the plan of £1,268.1m ie being £6.3m adverse. The projected forecast position, subject to inflationary risk and receipt of WG Strategic Support and planned care monies, was reported as £10.0m deficit. In regard to Savings, the in-month position was reported as £9m against target of £2.4m i.e. £6.6m favourable and the year to date being £20.2m against target of £13.6m i.e. £6.6m favourable. However, the year end savings forecast was reported as £25.4m, including pipeline savings, against the target of £35.0m i.e. £9.6m adverse. **PF22/182.2** The Finance Director – Commissioning and Strategy reported that a Savings review had taken place which had set more realistic delivery targets which are in line with other Health Boards, albeit many were non-recurrent. He highlighted a shortfall in payroll funding which had been met through slippage of English provider contracts. The year on year growth of nurse and medical agency spending was highlighted as a significant continuing cost pressure for the Health Board. Current operational pressures had reduced momentum in addressing these issues however, whilst Integrated Health Commnity draft plans had been submitted, savings plans would be prioritised in the new year. It was noted that an internal audit of Savings had been undertaken, and was in the process of being reviewed for factual accuracy. The Committee members were informed that the draft rating of this report was 'no assurance'. The Finance Director – Commissioning and Strategy highlighted some actions were currently underway to address the gaps, and commented on potential benefits for centralised accounting. Some of the key findings in the report included issues identified in relation to the failure to remove VERS savings (agreed previously at the Remuneration and Terms of Service Committee prior to the end of the 2021/22 financial year, and carried forward into the 2022/23 budgets), as well as the nature of reporting of the annual savings target, which was inconsistent with the actual balance on the ledger of £48m. The Finance Director – Commissioning and Strategy stated that the approach to the reporting on savings was consistent with the 2022-23 planning framework and how the Health Board had treated savings in previous years, including how Divisions are expected to manage savngs not delivered from previous years. The Committee debated what was the best approach to dealing with savngs not delivered from previous years and agreed there was no simple answer.	

PF22/182.3 The Interim CEO stated that an improved and robust process would be introduced to ensure appropriate decisions agreed through the Remuneration and Terms of Service Committee where monitored for implementation, with oversight arrangements in place to detect variation from agreed actions. She advised that WG had informed BCU that day, that it would provide no more than £5m in strategic cash support. **PF22/182.4** A discussion ensued on non-delivery of savings. The Finance Director – Commissioning and Strategy and Executive Director of Transformation and Planning concurred that the transformational approach being introduced would result in recurrent savings, albeit at a slower delivery pace than necessary due to the cultural changes which were also being addressed. It was noted that a control total approach would be very beneficial. In response to the Committee, it was advised that processes to deal with financial delivery underperformance would be a priority area on commencement of an Interim Executive Director of Finance in the new year, along with addressing accountabilities and providing support. Following discussion on resource management it was agreed that the Interim Board Secretary and Finance Director – Commissioning and Strategy would work together to provide a proposal on how 'Governance and Accountability Framework' would be addressed as part of the response to the savings internal audit review.	MM/RN
PF22/182.5 In response to the Committee, the Executive Director of Nursing and Midwifery confirmed that work was being undertaken to attract more nurses to substantive roles rather than choosing agency employment. She aso advised that agency staff authorisation was now required to be issued by herself or either of her 2 deputies in order to support the right staff being in place at the right time and in accordance with nurse staffing requirements. **PF22/182.6** The Finance Director – Commissioning and Strategy agreed to address a number of typographical errors in the report and cover. It was agreed that he would liaise with the Interim Board Secretary to address the issues raised by Internal Audit within the next Savings report.	RN
PF22/182.7 In regard to the Capital Programme it was noted that the Cost Advisors (CA) of the Wrexham Continuity Phase 1 programme had advised that the target costs had risen substancially from £46.486m to £54.194m. In the CA's opinion this was due to the currrent economic crisis and market instability with the Ukraine conflict. In addition, significantly higher tenders had been submitted in regard to the Plas Gororau programme which would be considered in the later private session. **It was resolved that the Committee** noted the report	
PF22/183 Presentation Recovery Programme : Savings 23/24 Summary **PF22/183.1** The presentation encompassed : • Transactional Pipeline Opportunities – Short Term • Ring Fenced Allocations – Funds Allocated and Current Slippage in 22-23 • Savings Plan 2023-24 - DRAFT • Transformational Savings	

It was noted that there would be significant challenges in the coming year which would continue to be monitored. **It was resolved that the Committee** noted the presentation	
PF22/184 Financial Control monitoring plan update **PF22/184.1** The Committee considered the report and received confirmation that a number of specific actions were being progressed. In discussion of improving the format of the next report, the Interim Board Secretary recommended the incorporation of a risk assessment procedure to inform a robust assessment of progress, with associated RAG ratings. She advised that the Scheme of Reservation and Delegation would be reviewed regularly as part of a process of continuous improvement which would be subject to Audit Committee monitoring. **PF22/184.2** The Committee raised a number of questions. In regard to Audit Wales (AW) feedback received, the Finance Director – Strategy and Commissioning advised that no concerns had been expressed however, AW capacity would need to be explored in regard to the transactions review. In regard to the previous year's unqualified accounts, it was understood that the Interim Excutive Director of Finance, on appointment, would undertake an assessment on progress made in reducing the level of uncertainty on the opening trade creditors balance, which had formed the basis of the prior year's qualification. He also reported that finance staff were undertaking their work with great caution and there was no current slippage. **PF22/184.3** It was agreed that the Interim Board Secretary and appropriate Finance Director would work together to ensure the report was reformatted and relevant feedback included in regular reports to be scheduled for submission to the Committee. **It was resolved that the Committee** noted the report	RN RN/MM
PF22/185 Presentation : Financial Planning and Budget setting: Allocation update **PF22/185.1** The Committee was dissappointed that the Welsh Government (WG) allocation was yet to be advised to Health Boards, as the Board's discussion and planning would be extremely challenging. **PF22/185.2** Attention was drawn to Covid 19 financial support reductions, energy costs and inflation, which included a few downward forecasts due to the changing economic climate. It was noted that different ways of working arising through the pandemic required further exploration and that any potential unpredictable surges in covid cases could also affect agency costs. **It was resolved that the Committee** noted the presentation	

PF22/186 Transformation and Improvement Plan **PF22/186.1** The Exective Director of Transformation and Planning presented the report. He advised that whilst Red status schemes were reducing, they were not at the preferred pace and Amber schemes were expected to progress to Green within 4 months. None were currently reporting at Green due to the level of programme maturity. He also reported that Senior Responsible Officers (SROs) were mostly expected to change shortly to ensure capacity to discharge their responsibilities. **PF22/186.2** The Exective Director of Transformation and Planning reported confidence in implementing and integrating the pathways under development as much cultural work had been undertaken. He emphasised the importance of quantifying the benefits realisation that the new processes would deliver. He stated that the Portfolio Direction Group would be focussed initially on areas of greatest return. **It was resolved that the Committee** noted the report	
PF22/187 Quality and Performance report No questions were raised by the Committee, however it was pleased to note some improving positions within the report. **It was resolved that the Committee** noted the report	
PF22/189 People (Workforce) report **PF22/189.1** The Associate Director Workforce - Planning and Performance presented the report. In discussion of agency usage he highlighted that the financial cost was rising and not the numbers of actual personnel. Improved resource management planning involving medical and nursing staff was being focused on with the appropriate teams. The Chair of the Partnerships, People and Population Health Committee requested that this issue be referred to the PPPH Committee to consider the impacts on workforce strategy and reporting within its remit. **PF22/189.2** In response to the Committee, the Associate Directors Workforce present advised that the level of staff turnover (9.4 to 12.4%) was comparable with other Health Boards in Wales, however BCU also included groups of aging workforce, such as within nursing. Assurance was provided that 'reason for leaving' data was recorded as part of the staff leaving process. **PF22/189.3** It was agreed that the report should retain the existing format however the Associate Director Workforce Planning and Performance agreed to ensure more detailed information on Workforce Optimisation in future reports. **It was resolved that the Committee** noted the current performance position provided and provided feedback for future reporting	SG

PF22/190 Date of next meeting 19.1.23	
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.	

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

	Lead Executive / Member	Minute Reference and Action Agreed	Original Timescale Set	Update	Revised timescale/ Action status (O/C)	RAG status
	Actions from PFIGC 30.6.22					
4	SH (NB)	**PF22/79.4 Capital Programme Monitoring Report.** Regarding the provision within the programme for the significant capital investment issues requiring repair at Abergele hospital, such as roof leakages into patient areas, fire door replacement, etc, Neil Bradshaw agreed to check with Estates to see if these particular matters had been dealt with and report back.	26.8.22	Works have been completed to repair the leaks to the roofs. Further works are planned this year to the electrical and water installations and fire systems 9.11.22 (NB) Estates colleagues are planning to undertake further works to address a number of immediate issues. 12.12.22 (NB) The proposed development of Orthopaedic Services and the RTCs present the opportunity to re-locate clinical services in the medium term. It is, however, recognised that existing services will need to be maintained in the	25.8.22 Keep open – briefing requested from Neil Bradshaw	

				short term. Additional funding has been made available this year to address immediate risks with a further allocation proposed in 2023/24.		
Actions from 27 October PFIGC						
4	SH	**PF22/137 Continued – Presentation Financial Recovery** It was agreed that audit input would be clarified in the governance structure. The Committee comments included the need for a greater sense of scale, financial data and prioritisation, it was noted that the presentation appeared to reflect a framework as opposed to a plan.	11.11.22	Audit input underpins the reporting of savings and will be included within the terms of reference of future audit reports 22.12.22 The Committee questioned how this would be tracked and its was confirmed that the Office of the Board Secretary was monitoring.		
	SH	**PF22/137.7** In response to the Committee the Executive Director of Finance advised that a revised document would be provided to the Committee between meetings and also submitted to the next Board meeting – see clarification >	30.11.22	Updates are provided on Financial Recovery to the Executive Team and HBLT		
	MM/Finance Director			22.12.22 The Committee clarified the action point to be that a reformatted Financial Recovery report would be provided to future meetings, including tracking/monitoring progress on all recommendations. RAG status	February 2023 meeting	

				and risk assessment would be undertaken. An update was agreed to the next meeting		
6	RN (TW)	**PF22/156 Financial Control update** **PF22/156.2** The Committee sought assurance that meetings to discuss the recommendations were minuted and actions recorded. The Finance Director - Operational Finance confirmed that an action plan was currently being monitored, following an observation by the Head of Internal Audit it was agreed that minutes would be recorded for panel meetings going forward.	1.11.22	Minutes will be recorded for panel meetings going forward. 22.12.22 The Committee was advised the minutes would form part of the revised Financial Control reports moving forward. It was agreed that the action be closed.	Action to be closed	
7	CS	**PF22/143 Transformation report** **PF22/143.3** In response to the Committee it was noted that a more detailed RAG status report would be provided at each meeting going forward.	1.12.22	Update 9/11/22 - this will be covered by the new portfolio office assurance report format that we intend to have in place for next PFIG.	February meeting	
8	PO	**PF22/151 Planned Care** **PF22/151.2** The Deputy CEO requested that the Team lock down early what capacity opportunity existed in order to ensure going forward that clear and owned trajectories were in each of the IHC systems.	11.11.22	The Interim CEO agreed to reassess and provide within the Planned Care update to the January meeting 12.1.23 PO advises There are weekly capacity meetings now by site and for HB which look at capacity and demand and the gap, and also impact on waiting times and long wait patients. The team are	March 2023	

				also now commencing that work with diagnostics colleagues too. The March update to PFIG will update on this work		
9	SG/PO	**PF22/151 Planned Care** **PF22/151.4** The Executive Director of Workforce & OD suggested that future Planned Care and USC reports build in workforce and expenditure implications to their future reports which would include additional premium rate spend incurred as a result of direct involvement and in a planned and purposeful way supporting planned care recovery and also the risks associated with workforce. She welcomed the opportunity to be involved along with her team in order to provide a composite report	30.11.22	Update 13.12.22 (SG) – Support available to enable inclusion of workforce implications in future reporting by operational teams. 12.1.23 PO Advises: Workforce data awaited from WOD and EDWOD not available at present. However, this will be included in the February report to PFIG.	February 2023	
11	PO/AK	**PF22/151.1 Regional Treatment Centre report** **PF22/151.1.4** The Interim Board Secretary requested that the next report to the Committee contained an extended version of the plan indicating the mitigating actions undertaken to provide a greater level of assurance. The Deputy CEO agreed that this would be undertaken by the newly appointed Project Director who would also look back through the project's development to provide a lessons learned report	12.12.22	22.12.22 The Interim CEO requested that this be included within Agenda item 'RTC update' along with update on Llandudno Business Case 12.1.23 PO advises There has been a delay to the development of the business case, and there is a critical meeting on capital with WG and NHSW on 26/01/23 after which we will update PFIG members	Deferred to February meeting	

12	PO	**PF22/152 USC** **PF22/152.4** The Committee questioned capacity and capability in Emergency Care especially given that there was only one functioning MIU in the Meirionydd region of the West. The Acting Associate Director Emergency Care provided examples of alternative practices being developed and implemented eg paramedic practitioners, nurse practitioners and rotational models. The Committee requested that assurance be provided in future reports on all the solutions being implemented and developed to meet the gap in provision as concern remained on how patients in this particular rural area of North Wales were being supported with emergency care needs	12.12.22	22.12.22 Interim CEO agreed to be addressed in report for next meeting PO 12.1.23 PO advises The work, on workforce for MIUs particularly in the west is ongoing, and we will update PFIG as appropriate.	January meeting	
13	SG (JC/LT) SG	**PF22/154 Workforce report** • **PF22/154.1** The Executive Director of Workforce & OD stated that, as originally agreed, a meeting would take place with the Chairs of PFIGC and PPPHC in November to discuss the report format going forward as she raised concern that it did not currently provide • It was agreed that Committee members would receive a briefing to provide assurance on the funded establishment detail,	14.11.22 11.11.22	SG Update 13.12.22 – Meeting held with Committee Chair and Chair of PPPH to agree revised format and content of the workforce performance report together with defining what is reported and to which committee. Following this meeting, a proposed schedule was provided to the Chairs of PFIG/PPPH and RTS.	February 2023	

	SG	as briefly outlined, prior to the workforce report meeting taking place. The Deputy CEO requested that consideration also be given to drawing out staff consequences around IMTP investment and disinvestment decisions. • The Executive Director of Workforce & OD assured that robust processes were in place to ensure compliance with the nurse staffing act however, she acknowledged challenges, which included retention, and undertook to provide further detail of this in the next Workforce report.	12.12.22	Workforce Performance Report on agenda for 22.12.22 moves towards revised format and content with comments to be incorporated for the next report in 2023		
Actions from 22 December PFIGC						
1	MM / RN	**PF22/182 Finance report month 8** Interim Board Secretary and Finance Director – Commissioning and Strategy would work together to provide a proposal on how 'Governance and Accountability Framework' would be addressed as part of the response to the savings internal audit review.	February			
2	RN	**PF22/182 Finance report month 8** The Finance Director – Commissioning and Strategy agreed to address a number of typographical errors in the report and cover. It was agreed that he would liaise with the Interim Board	February meeting			

		Secretary to address the issues raised by Internal Audit within the next Savings report.				
3	Rob Nolan Rob Nolan/ Molly Marcu	**PF22/184 Financial Control monitoring plan update** In discussion of improving the format of the next report, the Interim Board Secretary recommended the incorporation of a risk assessment procedure to inform a robust assessment of progress, with associated RAG ratings **PF22/184.3** It was agreed that the Interim Board Secretary and appropriate Finance Director would work together to ensure the report was reformatted and relevant feedback included in regular reports to be scheduled for submission to the Committee	February meeting			
4	SG (NG)	**PF22/189 People (Workforce) report** **PF22/189.1** The Chair of the Partnerships, People and Population Health Committee requested that this issue (Agency Useage) be referred to the PPPH Committee to consider the impacts on workforce strategy and reporting within its remit.	>	Transferred to PPPHC table of actions	Action for PFIGC to be closed	

Teitl adroddiad: ***Report title:***	Business Case for a Long Covid Service/Community Complex Conditions Service
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 19 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	The Committee is asked to consider a Business Case that seeks to provide recurrent funding for the Long Covid Service and further consideration of an integrated Long Covid, Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Breathing Pattern Disorders, Frequent Attenders (FAs) and Persistent Physical Symptoms (PPS) service under one umbrella.
Argymhellion: ***Recommendations:***	The Committee is asked to approve Option 3. This option will provide recurrent funding for the Long Covid service and increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks. The Committee is asked to note support for the future establishment of Option 4; a Community Complex Conditions Service in BCUHB, integrating Long COVID, Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Breathing Pattern Disorders, Persistent Physical Symptoms (PPS), and Frequent Attenders (FA) in order to improve patient outcomes, provide sustainability and address current and future demand for services and gaps in service provision. The Committee is asked to note that funding for option 4 (the Community Complex Conditions Service) is to be considered in line with the current IMTP planning process for 2023/24.
Arweinydd Gweithredol: ***Executive Lead:***	Gareth Evans, Acting Executive Director Therapies & Health Science
Awdur yr Adroddiad: ***Report Author:***	Claire Jones, Long Covid Therapy Lead Dr Rachel Skippon, Consultant Clinical Psychologist, Long Covid Psychology Lead Natasha Turner, Operations Manager Long Covid

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

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: BCUHB adopted a strong principal of co-design, working closely with people with lived experience of Long Covid and clinical practitioners to design the Long Covid Service, which meets the needs and expectations of the local population. The Long Covid Lived Experience Consultation Group is now well established and regularly well attended and similar conversations have occurred with established CFS/ME groups. The existing Long Covid service and leadership team is now established and well placed to implement the plan.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This business case seeks to address key priorities within: BCUHB's Covid 19 response and recovery Living Healthier, Staying Well Primary and Community Strategy
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Yes, please see attachment
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/a
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The top risk associated with the current service is: There is a risk is that funding may not continue after March 2023. This could result in no dedicated service available and an increased demand on other services after March 2023. This would have a detrimental effect on the physical and mental health of Long COVID patients and people suffering with other chronic health conditions. It could also cause reputational damage to the HB/WG if services are stopped. Current risk score is 15. Please see section below for links to BAF
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The financial implication of Option 3 is £1,301,407

Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The remaining vacancies can be advertised on a permanent basis thus increasing the likelihood of successful recruitment.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	**November 2021 – March 2022** – Engagement and consultation with range of key stakeholders regarding development of Long COVID service to support other conditions and services. This was following discussions within the health board and on an all-Wales basis regarding extension of Long COVID services nationally to support other similar conditions e.g. CFS/ME. **February – April 2022** – Development of this business case to secure sustainable funding for the Long COVID service and to extend to support other similar conditions as directed by Welsh Government (WG, March, 2022 – see Appendix 1). **May 2022** – Approval of business case by chair of BCUHB Long COVID Strategic Oversight Group and Acting Executive Director of Therapies and Health Sciences & Chief Finance Officer East Area (Long COVID sits within East Area for management purposes). **June 2022** – Submission to Health Board Business Case Review Team panel. **September 2022** –Approval for option 3 at Executive Team with strong support to move towards option 4.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF 1.5 Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm BAF 3.3 Risk of significant delays to access to Primary Care Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital, resulting in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** ***1. Implement in full option 3***	

Rhestr o Atodiadau:

List of Appendices:

1. Letter from WG
2. WEDFAN IA Covid 19
3. WEDFAN YGC data
4. Patient feedback
5. EQIA

Division	IHC East
Development or Scheme	**Enhancement of Long COVID Service to meet population need (Part A) & address gaps in BCUHB service provision for Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Persistent Physical Symptoms (PPS), Frequent Attenders (FA) and Breathing Pattern Disorder (BPD) by developing an overarching Community Complex Conditions Service (Part B)**
Author/s	Claire Jones, Advanced Clinical Practitioner, Long COVID Therapies Lead Dr Rachel Skippon, Consultant Clinical Psychologist, Long COVID Psychology Lead Natasha Turner, Long COVID Operations Manager
Version	1.6.1
Date	31.10.22

1. Executive Summary

The BCUHB Long COVID service opened to referrals in December 2021. In the first six months of being open, the service received over 1000 referrals. Current WG funding has been provided for the service until end of March 2023. Unfortunately, this funding is insufficient to enable the service to provide a comprehensive and timely service to the high numbers of patients being referred. The service also faces difficulty in recruiting sufficient staff to deliver the service as fixed term posts (necessary because of the nature of the funding) are less attractive to potential new staff.

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

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

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

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

This Business Case seeks to obtain recurrent funding for the current Long Covid Service and recommends further investment into integrating Long COVID, CFS/ME, Breathing Pattern Disorders, FAs and PPS services under one umbrella service. The current Long Covid Service is funded on a non-recurrent basis, but continues to receive high numbers of referrals and the evidence indicates that this service demand is likely to continue. As encouraged by WG (see Appendix 1) Health Boards have been asked to consider expanding Long Covid services to include support to people with other similar long-term conditions including CFS/ME. Without additional recurrent funding, we would be unable to meet current demand, and therefore would not be able to expand the service.

1.1 Vision

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

The Long COVID service reduces the burden of these patients on primary and secondary care services by managing challenging symptoms and reducing secondary care referrals and ensuring the appropriateness of those that are made through specialist management and close liaison with secondary care services.

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

1.2 Purpose

This business case document makes recommendations based upon an evaluation of the recently established Long COVID service and the Welsh Government (WG) directive (Appendix 1) to develop these Long COVID services to support similar conditions such as CFS/ME. Such conditions share a similar aetiology and presentation, and require similar support delivered by staff with similar skills and experience.

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

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

1.3 Recommendation

A Community Complex Conditions Service should be established in BCUHB, integrating Long COVID, CFS/ME, Breathing Pattern Disorders, PPS, and FAs in order to improve patient outcomes, provide sustainability and address current and future demand for services and gaps in service provision. In order to ensure affordability it is recommended that option 3 is supported initially, from funding identified within the current operational plan, and funding for option 4 (the full Community Complex Conditions Service) is considered through the current IMTP planning process for 2023.

1.4 Approval Process

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

2. The Strategic Case

2.1 Overview of the Business Case

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

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

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

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

The Institute of Clinical Science and Technologies launched the All-Wales guidance for Long COVID (18.06.21) to support Primary & Secondary Care practitioners. In line with this guidance, BCUHB have developed a Long COVID Pathway and Multi-disciplinary Service aligned with the All-Wales Community Pathway.

The BCUHB Long COVID service opened to referrals in December 2021. In the first six months of being open, the service has received around 1000 referrals. Current Welsh Government funding has been provided for the service until end of March 2023. Unfortunately, this funding is insufficient to enable the service to provide a comprehensive and timely service to the high numbers of patients being referred. The service also faces difficulty in recruiting sufficient staff to deliver the service as fixed term posts (necessary because of the nature of the funding) are less attractive to potential new staff. This business case seeks to address these issues with enhanced recurrent funding for the BCUHB Long COVID service. (Part A)

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

2.2 The Current Service

Part A.

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

BCUHB is currently utilising WG Adferiad Funding to deliver a pan-North Wales multi-disciplinary team (MDT) Long-COVID Service across all health board (HB) regions. The service opened to referrals on 2nd December 2021 and as of April 2022, has received in excess of 800 referrals with 720 of these being deemed as appropriate referrals. Patients can either self-refer or be referred by their healthcare professional. The Adferiad funding was originally agreed until March 31st 2022. It has since been extended for a further 12 months until end of March 2023.

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

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

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

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

However, the development of the new Long Covid Service has met with a variety of challenges including difficulty recruiting to fixed term posts (necessary due to the time limited funding from the Adferiad fund) and difficulty accessing accommodation from which to deliver the service. It was also anticipated that rates of Long COVID in the community would begin to reduce with widespread vaccination and the dominance of the perceived less severe Omicron variant of the COVID-19 virus. Unfortunately, these developments do not appear to have reduced rates of Long COVID. This is borne out in both national and international scientific literature (Ghirga, 2022) and the referral rates to the BCUHB Long COVID service, which continue to maintain a steady high rate (around 1000 referrals in the first 6 months of the service opening). Even if the service had managed to fill all of its vacant posts it would still have insufficient capacity to serve all the people who are referred into the service in a timely and comprehensive manner. It is reassuring however that if the service were to gain recurrent funding, we expect this to mitigate the recruitment risk given that there has been a lot of interest in the temporary roles previously advertised. Staff were not able to be released for secondment and we have had success in recruiting to several permanent roles within the service.

Part B.

As described above, WG have directed the Long COVID services from each health board to extend their services to also support people experiencing similar conditions (WG, March 2022, see Appendix 1). The BCUHB Long COVID service have undertaken a period of consultation with relevant stakeholders including those with lived experience to consider how best to deliver this WG directive. It has been identified that a number of conditions share a range of commonalities that suggest a more connected and integrated service would be beneficial.

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

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis

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

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

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

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

Persistent Physical Symptoms

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

Frequent Attenders

Frequent attenders (those attending an emergency department five or more times per year (RCEM, 2017)) impose substantial cost and resource burdens on Emergency Departments (EDs) as well as other first contact providers of care such as GPs. Across the three EDs in Betsi Cadwaladr University Health Board (BCUHB) there were 2724 frequent attenders in 2018 accounting for 18,918 attendances, the highest in any of the Health Boards in Wales (WEDFAN Steering Group, 2019). The mean total time in ED was 46 hours per frequent attender in BCUHB, compared to the mean of 5.2 hours per patient for all ED patient attendances across Wales.

Frequent attenders are a heterogeneous group, however some common cohorts can be identified within this group, such as people experiencing PPS, people with long term and/or complex physical or mental health problems who's scheduled care has broken down in some form and people who experience significant vulnerability (which can be due to a wide range of factors such as isolation,

insecure finances, poor housing, history of trauma, abusive relationships, substance misuse, involvement with the criminal justice system).

Existing Service for PPS and Frequent Attenders

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

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

Patients who present with PPS do not have a consistent pathway within BCUHB. They may continue to be supported long term by the initial speciality to which their initial presentation took them, equally they may end up referred to mental health services, or not supported by any service and sometimes when their frequent presentation becomes perceived as problematic by the services they attend, they may even end up in the criminal justice system. Most secondary care specialities are ill-equipped to support the long-term needs of people who present with PPS. Some exceptions to this are chronic pain services, brain injury services and psychiatric liaison (along with CFS/ME and Long COVID services) who already provide support and intervention for people who meet the criteria for small elements of the PPS population within their speciality.

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

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

The HPLT have been a member of the network since its inception and have supported the development of the model. The team have delivered the frequent attender multi-agency panel model across both the Central and East areas of BCUHB (the YG emergency department lead the West Area panel. This has been funded internally by YG). This was possible due to the receipt of several rounds of short term funding; initially from WG and subsequently from winter monies. This funding enabled the appointment of a frequent attender case manager working closely with the psychologists as part of the HPLT. HPLT participated in a WG funded project delivering the WEDFAN model. The effectiveness of the model in reducing attendances of frequent attenders and reducing their length of stay during attendances was replicated locally. (WEDFAN Winter Funding 2019/20 YGC BCUHB Data, Appendix 3)

Unfortunately, without the continuance of this funding, it has not been possible to continue providing the national WEDFAN multi-agency panel model of support for frequent attenders in the east and

central areas of BCUHB. However, the HPLT continue to work with frequent attenders on an individual basis and in collaboration with psychiatric liaison and other partners.

Breathing Pattern Disorder

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

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

A key risk is that patients living in BCUHB with BPD are not able to access support, with limited non-funded services currently only offered in the East area. This is resulting in a postcode lottery, with inequity of services and the health board incurring costs to refer patients to specialist services in England. There is a risk that the demand for BPD support services is unknown The number of patients referred to Physiotherapy service with Dysfunctional Breathing in East for 2019-20 was 33. We are already seeing a large increase in the number of respiratory referrals to Physiotherapy. There are currently 38 referrals to respiratory physio awaiting triage (longest wait = 19 weeks), with 17 being for the DBS. There have been 18 referrals for respiratory physio in the last 4 weeks. If this referral rate continues, it will equate to 216 patients compared to the 56 referred in 2019/20. It should also be noted that the majority of the referrals come from Respiratory consultants, who are selective in their referrals as they are aware of capacity issues within the service. The demand for services in Central and West areas is currently unknown. There is also potential lack of clarity & understanding of the numbers of

acute COVID-19 patients or community COVID-19 transmissions which may result in longer-term chronic health conditions, or an awareness of latent demand in the system due to asymptomatic cases in the community who may have developed long-term chronic conditions This could result in unanticipated demand pressures on Primary Care, Respiratory, Cardiology, Neurology and Pain Management Services Inherent risk score = 20 (DATIX ref 3963 / BAF ref 20-25) There is a risk that establishment of Long-COVID pathways may cause further pressures on services and patient waiting lists, including primary care, respiratory, therapies, cardiology and neurology This may be caused by increasing numbers of referrals for Long-COVID rehabilitation therapies which will add additional unexpected demand at the same time as restarting existing services This may cause an impact on patient waiting times for both Long-COVID and other existing long-term chronic health conditions Inherent risk score = 16 (DATIX ref 3965 / BAF ref 20-25).

Relevant National and Local Strategies

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

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

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

2.3 The Case for Change – Benefits of the scheme

Part A

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

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

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

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

Situating the support and intervention for people living with Long COVID in local venues enhances reconnection with their community and the resources it has to offer. All the Long COVID groups are currently delivered in local leisure centres with this intention in mind. It is hoped that by making these connections, patients are more likely to continue to develop positive well-being despite living with a long-term condition by becoming more involved in what their community has to offer. In this way sustaining the gains achieved from the group intervention and developing independent means of

maintaining their wellbeing, reducing dependence on health and care services in the longer term and creating better outcomes for the individual. These aims are in line with the aims of the WG “A healthier Wales” (2021) and BCUHB “Living healthier, staying well” (2018) strategies as well as the aims of the Wellbeing of Future Generations Act (2015) and prudent health care agenda (Bevan Commission, 2015, Welsh Government, 2019).

Part B

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

The clinical presentations of CFS/ME, PPS, BPD and FA are complex and require highly specialist provision. There is often a lack of awareness of the services delivering this care, along with poor understanding of the needs of these patient groups and the clinical interventions required to support them, within more mainstream health care disciplines and departments. This creates isolation for the staff involved and lack of opportunities for professional development, while also limiting the effectiveness of the support available to patients.

Aetiology of CFS/ME, PPS, BPD and Long COVID (all of whom may represent a significant proportion of FA) can be understood using the same explanatory framework known as central sensitisation (Fleming & Volcheck, 2015). While the presentations of these different conditions may vary, Central Sensitisation informs the interventions which are required and can be tailored to individual needs to support effective recovery and management of this umbrella of complex conditions (Gouman et al, 2021; Hussain and Chalder, 2021 and Nijs et al, 2016).

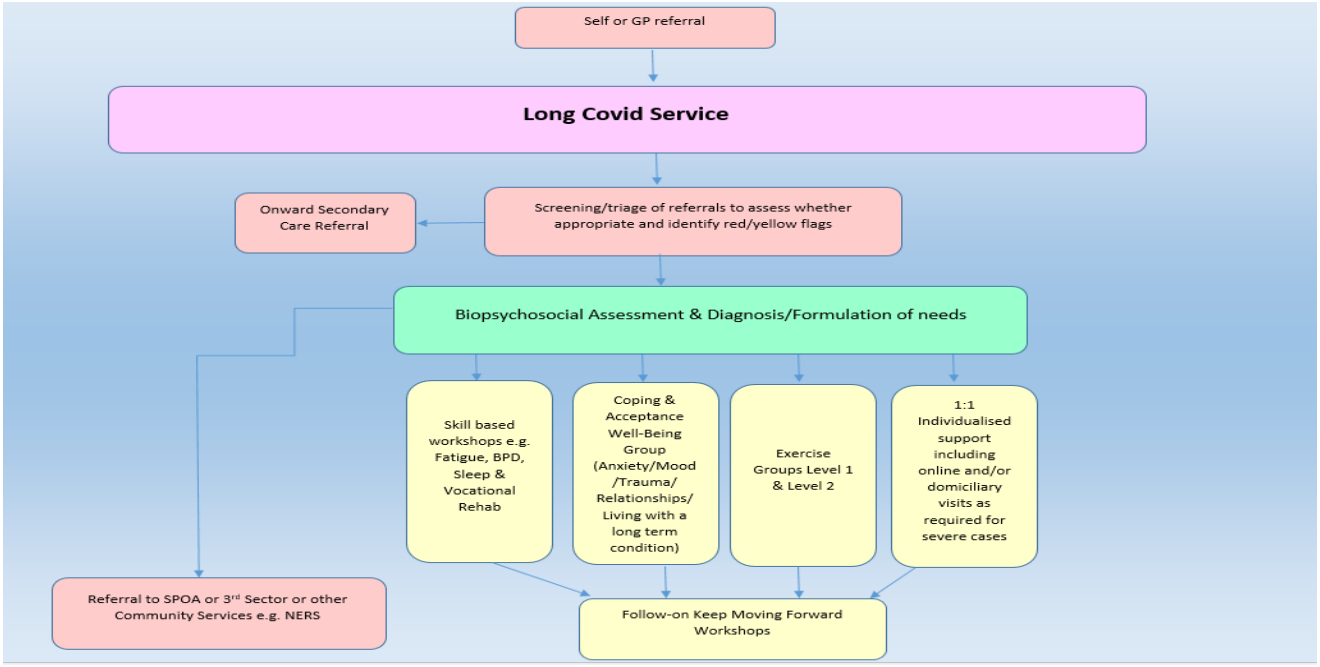
An umbrella community complex conditions service bringing together the management of these patient groups would create a range of benefits:

- Workforce Development – It enables a more experienced, well-supported team of staff.
- Sustainability - It would improve sustainability through shared resources, opportunities for staff development across a range of conditions and improve the likelihood of successful recruitment and retention.
- Community Resources - It would enable the development of greater links with communities and community resources, helping the service to transition people from clinical support to community engagement and involvement as their recovery and self-management improves.

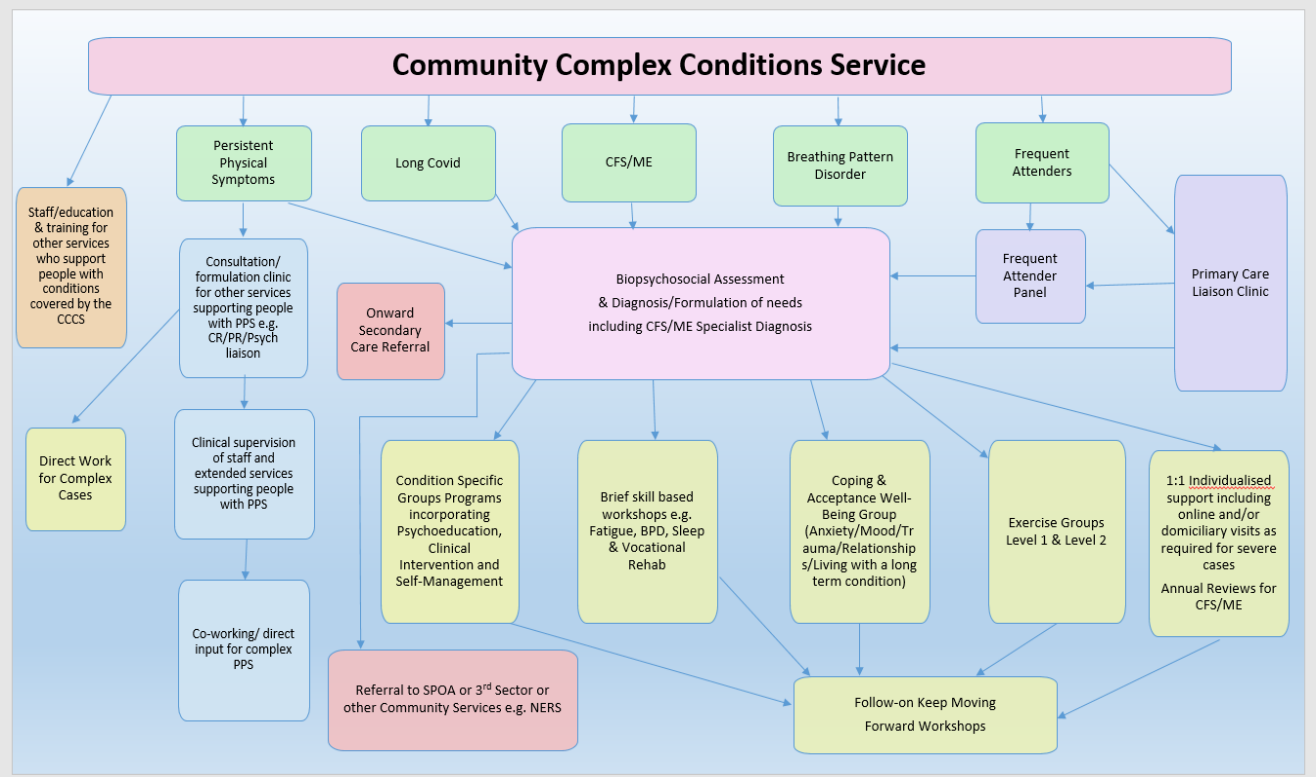
- Support for Other Services - It would increase the capacity to deliver increased support to a range of services/specialisms who find these patient groups within their services through: increasing awareness of the conditions and specialist support available for them, providing specialist advice, delivering staff education, offering consultation, supervision and co-working.
- Improved Patient Experience - For patients with these conditions there would be a more timely, equitable, comprehensive, effective and integrated clinical care pathway.
- Improved Patient Outcomes – It is anticipated that all of these improvements, enabling the meeting of best practice guidance, would lead to improved outcomes for patients

2.4 Proposed Service Development

Current model:



New model:



2.5 Areas Affected by the Proposal, Inter-dependencies

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

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

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

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

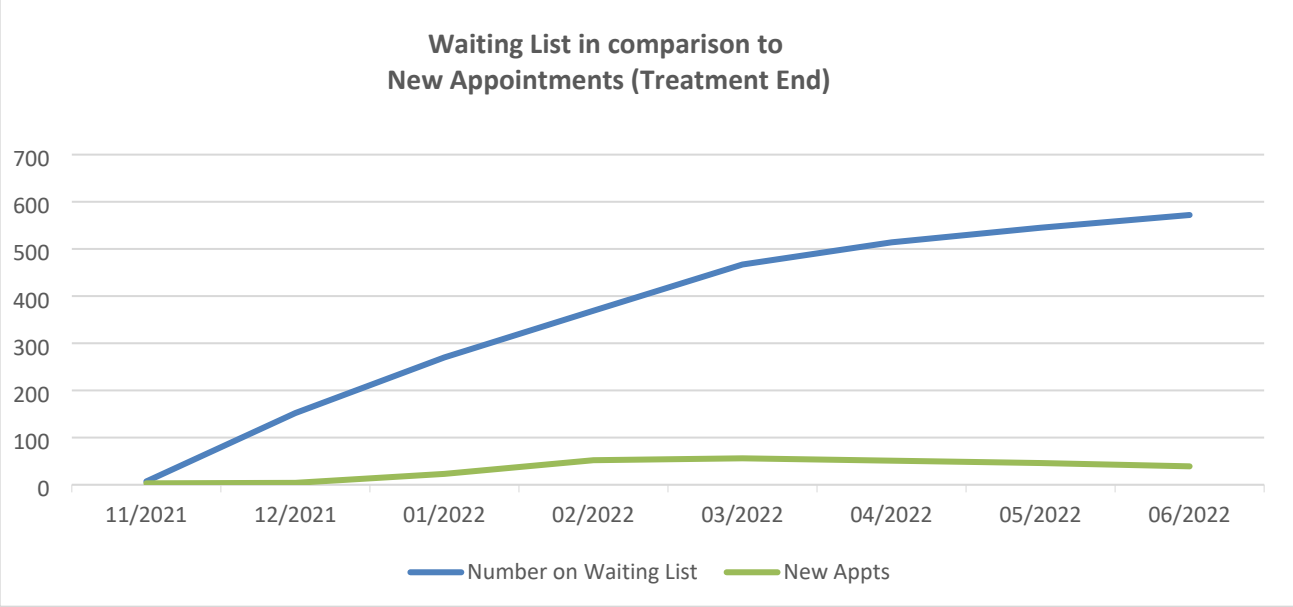
contact with the Welsh Association of ME & CFS Support (WAMES) regarding the further development of the Long COVID service to work with other similar conditions in order to implement the most up to date NICE guidance (Appendix 1).

2.6 Performance, Activity and Contracting

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

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

Since launching in early December 2021, the Long COVID service has received in excess of 1000 referrals (current figures show East – 468, Central – 401, West - 283). It was previously anticipated that the referral rates to the service would start to reduce as a result of the Omicron variant being less severe and a high rate of vaccination. However, this has not been the case, with a high and steady referral rate continuing. Recruitment has proved challenging with posts advertised on a fixed-term basis and as a result, waiting times for patients to receive a first appointment with the service are rising.



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

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

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

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

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

2.7 Milestones and Quantified and non-Quantified Benefits

Achieved Milestones and Quantifiable and non-Quantifiable Benefits

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

The recruitment of:

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

Delivering assessment, individually tailored support and both 1:1 and group interventions across all areas of BCUHB in multiple community venues.

All staff are about to complete ACT (Acceptance and Commitment Therapy) Training in June.

Almost 200 patients have been seen and managed successfully in the community.

Current capacity is increasing each month as more staff are recruited. It is anticipated that by the end of July, capacity for new assessments will be 98 per month.

Within the capacity of the existing service, several posts remain vacant, mainly due to posts being advertised on a temporary basis.

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

Future Milestones

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

Quantifiable and non-Quantifiable Benefits

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

- Self-referral option to service has reduced impact on PC
- Improved patient engagement and co-development of services through the Lived Experience Consultation Group
- Evidence suggests that COVID increases the risk of cardiovascular events and other secondary health problems (Tanne, 2022). Part of the role of the Long Covid MDT involves cardiovascular risk management and health and wellbeing promotion, which will contribute to reducing the risk of cardiovascular events and therefore reducing hospital admissions.

3. Formulation and Short-listing of Options

3.1 Overview of Options – Main Business case Options

- **Option 1:** Continue Long COVID Service with current resource level until Adferiad funding ceases (currently due to end March 2023)
- **Option 2:** Provide recurrent funding for Long COVID service at current service level
- **Option 3:** Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks
- **Option 4:** Provide recurrent funding for development of Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand (as in option 3), but also create and resource an umbrella service which would also house CFS/ME service, PPS service, FAs and Breathing Pattern Disorder Service. (Part B)

3.2 Benefits of the Options – Main Business case Options

Option 1: Continue Long COVID Service at current service level with Adferiad fixed term funding only

- Continue to provide the current service to patients until the WG Adferiad funding comes to an end

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

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

Option 3: Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks

- Benefits as option 2, with additional benefits as follows:
- Being able to meet current and predicted future service demand and reducing waiting list (current waiting times for the service continues to rise with patients referred in April 2022 expected to wait approximately 12 weeks)
- Increased patient contact with clinicians (see Appendix 4 for patient feedback)
- More clinical interventions to be provided, e.g. group sessions, workshops to support self-management for key impacting symptoms
- Better outcomes for patients
- Reduced demand on other services within secondary care through more appropriate referrals
- Reduction in GP contacts
- Better long term patient health with patients more equipped able to manage their symptoms and risk factors for disease prevention

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

- Benefits as option 3, with additional benefits as follows:
- Providing a service offering for those who come under the umbrella of CFS/ME, PPS, FAs and BPDs, pooling resources and staff expertise across the three services and addressing the service gaps for these conditions. This is also in line with most recent WG recommendations to extend current LC provision to such conditions (WG Letter to Health Board's 31st March 2022 – Appendix 1)
- Expertise of staff to be available to a wider patient group across the three services
- Address gaps in service provision
- Better outcomes for a wider group of patients across the three services e.g. improved timeliness of access to services for all these patient groups, and improved patient experience due to being able to offer a service to this patient group which meets NICE guidance
- Reduce impact upon existing services, e.g. Cardiac Rehabilitation, Pulmonary Rehabilitation where there is a lack of Psychology access, allowing them to focus more on disease specific management and hence reduce their waiting lists. It should be noted that such input from the new CCC Service would be an enhancement of what is currently offered by these existing services, and that funding for PR and CR to deal with long waiting lists and gaps in service where staffing is a barrier will need to be considered as part of a separate case.
- The development of the Community Complex Conditions service will enable BCUHB to offer a dedicated service for a range of complex, chronic health conditions including CFS/ME that

meets current NICE guidance (NG 206, October 2021), which is something that we do not currently offer now. There is currently no pathway within BCU for PPS/MUS (medically unexplained symptoms) and this would create one.

3.3 Cost and Resource Information for the Options

The IMTP included £1.3m for Long Covid. This was the estimated cost of providing the service and was included in the IMTP and Financial Plan at this amount on a recurrent basis, on the assumption that corresponding Welsh Government funding would be received. Following the submission of the IMTP, Welsh Government notified the Health Board that the Adferiad funding for 2022/23 would only be £1.043m. There is no funding available in the financial plan to cover the £0.257k difference between the assumed funding and what has actually been received. Welsh Government have also only so far issued this funding on a non-recurrent basis. The allocation letter did confirm that the Adferiad programme would be reviewed every six months and that the mid-June review would also be used to consider how further services could be integrated to support people with other long-term conditions such as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Multiple Sclerosis (MS). This would of course require a commitment from WG to increase the funding allocation.

Option 1 – continue Long COVID service at current service level with fixed term funding

Department	Band	WTE	Annual cost	Current WTE	Vacancies WTE	Current cost
ACP	7	2	£115,074	0.6	1.4	£34,034
AHP	7	5	£287,685	3	2	£172,611
Psychology	8A	2	£133,992	0	2	0
Psychology	4	6	£184,044	5	1	£153,370
Therapies	8A	1	£66,996	1		£66,996
Medical	M&D	0.2	£24,000	0.2		£24,000
Psychology	8C	0.6	£57,133	0.6		£57,133
Admin	7	1	£57,537	1		£57,537
Admin	5	1	£39,200	0	1	0
Admin	4	3	£92,022	2	1	£61,348
Total		**21.8**	**£1,057,683**	**13.4**	**8.4**	**£627,029**
Plus 10% non-pay			£105,817			£62,702.90
Accommodation lease costs			£20,400			£20,400
	Total		**£1,183,900**			**£710,131.90**

Option 2 – provide recurrent funding for Long COVID service at current service level

Staffing costs for full staffing establishment as used in option 1 with full year costs.

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

Option 3 – provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks

Staffing costs for the enhanced service staffing model.

Department	Band	WTE	Annual cost
ACP	7	2	£115,074
AHP	7	5.2	£296,216
Psychology	8A	3	£200,988
Psychology	4	4	£122,696
Therapies	4	2	£61,348
Medical	M&D	0.4	£48,000
Psychology	8D	1	£110,008
Therapies	8C	1	£96,035
Admin	7	1	£57,537
Admin	4	3	£92,022
Total		**22.6**	**£1,199,924**
Plus 7% non-pay			£70,893
Accommodation lease costs			£30,600
	Total		**£1,301,417**

Comparison of options for current service (option 2) and enhanced service (option 3)

Option	Total WTE	Total Cost	Comparison of options
Option 2: Provide recurrent funding for Long COVID service at current service level	**20.8**	**£1,183, 900**	To fund the Long COVID service with an increased staffing model to enable the service to meet the demand (option 3), will cost an additional **£117,517** with 1**.8 WTE** additional staffing. This is in comparison to option 2, which is to continue to provide the current service that we can offer with the capacity that we have. The increase of staffing in option 3 will enable us to meet the recovery targets for the national performance measures for therapies, by having no patients waiting over 14 weeks for therapy services by March 2024.
Option 3: Provide recurrent funding for enhanced level service toincrease the capacity to meet local demand within national performance target level	**22.6**	**£1,301, 417**	

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

Department	Band	WTE	Annual cost
ACP	7	3	£172,611
AHP	7	7.6	434,352
AHP	6	1	£48,805
Frequent Attenders Case Manager	7	1	£57,537
Psychology	8A	3.6	£240,698
Psychology	7	3	£172,611
Psychology	4	3	£92,022
Therapies	4	3	£92,022
Medical	M&D	0.4	£48,000
Psychology	8D	1	£114,638
Psychology	8C	1.2	£114,266
Psychology	8B	0.6	£47,895
Therapies	8C	1	£96,035
Admin	7	1	£57,537
Admin	5	1	39,200
Admin	4	3	£92,022
Admin	3	1	£26,694
Total		**31.8**	**£1,946,945**
Plus 10% non-pay			£194,694
Accommodation lease costs			£40,800
	Total		**£2,182,439**

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

CFS/ME Service	Band	WTE	Cost
Psychology	8C	0.87	82,172
Physiotherapy	7	0.6	32,814
Existing budget for HPLT			**Cost**
HPLT Psychology	8C	0.8	76,584
Psychology	8A	1.2	79,419
Total			**270,990**

When the existing budget for CFS/ME and HPLT are taken into account, the funding required for Option 4 is then: **£1,911,449.**

Comparison of options for enhanced service (option 3) and Community Complex Conditions Service (option 4):

Option	Total WTE	Total Cost	Comparison of options
Option 3: Recurrent funding for enhanced level service to increase the capacity to meet local demand within national performance target level	22.6	£1,301,417	To fund the Complex Conditions Service (option 4) to incorporate other chronic health conditions, which will include CFS/ME (as per WG directive), will cost an additional **£610,032** with **4.73 WTE** additional staffing. This is in comparison to option 3, which will only allow us to meet current demand within current Long Covid Service and not enable us to expand the service in line with what WG are asking us to do. The moderate increase in staffing will provide a high increase in patient contacts (figure included in section 3.4, table below) as a result of the service being able to offer more group based interventions to a wider patient group.
Option 4: Recurrent funding for development of Complex Conditions Service including CFS/ME and HPLT **with existing budget for CFS/ME and HPLT excluded**	28.3	£1,911,449	

The difference between option 3 and option 4 is a cost of £610,031 and only 4.73 WTE additional staff, but it will enable us to offer a service that we don't currently offer. Currently there is no defined pathway for MUS (medically unexplained symptoms) and PPS and the current CFS/ME service does not meet NICE guidance. The creation of the Community Complex Conditions service will enable us

to do this. It address the gaps in service provision for these conditions currently and will provide a better service to patients of BCUHB with a chronic health condition.

3.4 Cost and Resource information for the Options

Option		Recurrent Cost	Existing Budget	Set Up Costs (NR)	Total Investment Required	Recurrent Investment Required	Recurrent Activity
	WTE	£	£		£	£	Capacity Increased
1: Continue long COVID service at current service level with fixed term funding.	21.80	0	1,043,000	-	0	0	0
2: Provide recurrent funding for Long Covid service at current service level.	20.80	1,183,900	1,043,000	-	140,900	140,900	0
3: Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks	22.60	1,301,407	1,043,000	-	258,407	258,407	565 additional patient contacts, including assessment and groups
4: Provide recurrent funding for development of Community Complex Conditions service (in addition to existing funding for CFS/ME and HPLT service which will come	35.40	£1,911,449	1,313,990	-	868,449	868,449	1415 additional patient contacts, plus support and education for external services with addition of CFS/ME/BPD/PPS/ FAs

under the new umbrella service).							

3.5 Key Assumptions and Dependencies of the Option

Option	Key assumptions and dependencies
1: Continue long Covid service at current service level with fixed term funding.	• Existing services funded by WG Adferiad funding would continue until the funds cease.
2: Provide recurrent funding for Long Covid service at current service level.	• Recurrent funding is identified
3: Provide recurrent funding for Long Covid service to increase the capacity to meet local demand within national performance target level	• Recurrent funding is identified • Successful recruitment into permanent posts • Sufficient and comparable demand which continues into the service
4: Provide recurrent funding for development of Community Complex Conditions service (in addition to existing funding for CFS/ME and HPLT service which will come under the new umbrella service).	• Recurrent funding is identified • Successful recruitment into permanent posts • Sufficient and comparable demand which continues into the service • Successful development and continued engagement with CFS/ME and HPLT service leads

3.6 Options Appraisal

3.6.1 Criteria for Assessing the Options

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

3.6.2 Scoring framework for Assessing the Option

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

3.6.3 Selection of Preferred Option

	Option 1: Do nothing, continue Long COVID Service at current service level with Adferiad fixed term funding only	**Option 2: Provide recurrent funding for Long COVID service at current service level**	**Option 3: Provide recurrent funding for Long COVID service to increase the capacity of the service to enable it to meet local demand and ensure no patients are waiting longer than the national performance target for specified therapy services of 14 weeks**	**Option 4: Provide recurrent funding for development of Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand (as in option 3), but also create and resource an umbrella service which would also house CFS/ME service, PPS service, and Breathing Pattern Disorder Service.**
Cost (£/year)	£ 1,183,900	£1,183,900	£1,301,417	£2,182,439
Improving patient outcomes	0	2	3	4
Meeting patient and carer expectations	0	2	3	4
Improved accessibility for important health conditions	0	1	2	4
More appropriate secondary care referrals for LC, PPS & CFS/ME	0	2	4	4
Patient Experience	0	2	4	4
Specialist care closer to home (shorter care pathways)	0	3	3	4
Equity of access	1	2	4	4
Alignment with WG & HB strategic policy	4	4	4	4
Investment will provide longer term sustainable	0	3	4	4

benefit to the health board and the population we serve				
Total	**5**	**21**	**31**	**40**

Recommendation for Option 4:

Provide recurrent funding for the development of a Community Complex Conditions Service which would increase the capacity of the Long COVID service to enable it to meet local demand within national performance target level (as in option 3), but also create and resource an umbrella service which would also house CFS/ME service, PPS service, and Breathing Pattern Disorder Service. In line with the Welsh Government directive to support other similar conditions (Appendix 1).

4 The Financial Case

4.1 Costs

It's envisaged that roll-out of option 4 would take place in three phases over two years to ensure effective engagement, safe implementation and successful recruitment of staff. The following funds would be required over Y1-2 and onwards. N.B Costs are based on top of scale 2022/23 salaries. Pay awards and incremental pay points would affect final figures.

Year	Year 1 2022/23	Year 2 2023/24	
Phase	Phase 1	Phase 2	Phase 3
Recruitment	50%	75%	100%
Recurrent costs (PA)			
	£1,091,220	£818,415	£1,091,220
Current funding (assumes previous year investment approved)	£1,043,000	£1,043,000	
Total additional recurrent investment required year on year	£48,220	£866,635	
Non recurrent costs			
Total Additional Investment in year	£48,220	£866,635	

Recurrent Summary *	

Current Budget	£1,043,000
2 year recurrent Investment	£914,855
Total Recurrent Costs	**£1,957,855**

Assumptions:

- Costs are based on top of scale 2022/23 salaries in line with costed options above.
- Year 1 assumes 50% recruitment rate and associated non pay costs
- Year 2 assumes 75% recruitment rate and associated non-pay costs for first six months and fully established from October 2023 onwards.

4.2 Value for money

A Social Return on Investment (SROI) analysis was carried out by Cedar for the Adferiad Project, with two other Local Health Boards in Wales. While the Long COVID Service in BCUHB has only been running since December 2021, Cardiff and Vale UHB's and Cwm Taf Morgannwg UHB's Long COVID Rehabilitation Services have been running for slightly over one year, and also have multi-disciplinary teams including physiotherapists, occupational, speech and language therapists. There is also provision from psychologists, GPs and dietitians in some teams. Both services perform one-to-one assessments and interventions using a similar model to BCUHB. C&V UHB have used group interventions from the start and CTM UHB have carried out one face to face group, following user feedback. Additional group provision has been made available via the Welsh National Opera programme at both sites as it has in BCUHB.

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

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

referred for diagnostics and managed in-house, and any referrals, which are made, are appropriate and made following communication with secondary care clinicians.

The LC service was able to utilise funds from the last financial year to purchase 2 x portable ECG machines. This has meant that ECGs could be performed in-house, without impacting upon the already stretched secondary care cardiology services at all 3 sites in BCUHB. This has resulted in a significant reduction in patients needing to travel further access the DGHs, and with around 20% of LC patients requiring an ECG, will no doubt have significantly mitigated the risk of increasing waiting lists for those needing to be screened for serious arrhythmias. This approach provides value for money, with opportunistic diagnostics making the most of every contact and creating a more streamlined patient journey. Likewise, chest x-ray and blood tests can be requested and reviewed in house with similar benefits and releasing primary and secondary care capacity. Pulse oximeters are being purchased to allow overnight pulse oximetry for patients suspected to have Obstructive Sleep Apnoea (OSA), which could be further impacting their symptoms. This will reduce impact on diagnostic waiting lists and allow them to be referred directly for virtual review, reducing waiting times for management of OSA for this group of patients by 6 months.

4.3 Financial risk

The current funding stream outlined within the business case (£1,043,000) has been allocated on a non-recurrent basis at present; therefore, this generates a potential financial risk should the funding not be made recurrent. The financial risk is partially mitigated in year by a phased recruitment plan as referenced above. In addition, there may be a further financial risk, which is dependent upon which option is preferred. This risk has been quantified within the costed options, as additional funding required.

The IMTP included £1.3m for Long Covid. This was the estimated cost of providing the service and was included in the IMTP and Financial Plan at this amount on a recurrent basis. Following the submission of the IMTP, Welsh Government notified the Health Board that the Adferiad funding for 2022/23 would only be £1.043m. There is no funding available in the financial plan to cover the £0.257k difference between the assumed funding and what has actually been received. Welsh Government have also only so far issued this funding on a non-recurrent basis. The allocation letter did confirm that the Adferiad programme would be reviewed every six months and that the mid-June review would also be used to consider how further services could be integrated to support people with other long-term conditions such as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS

5 Service Management

5.1 Governance

The Long COVID Service and staff will continue to be managed across BCUHB as one team. Clinical, professional and managerial leadership will be provided by a Consultant Therapist, Consultant Clinical Psychologist and an Operations Manager as part of Therapies and Mental Health & Learning Disabilities Directorates Leadership team.

All aspects of governance will be covered within Therapies and Mental Health & Learning Disabilities Directorates governance structures with close liaison and collaborations with secondary care teams. Whilst the Long COVID service sits within the Therapies Directorate, they will continue to work in close engagement with Psychology leadership from Mental Health & Learning Disability Directorate management. This model has worked well in practice – an example of effective working across management teams/structures, with staff benefitting from professional support and leadership within the Therapies and Mental Health & Learning Disability Directorate services, yet fully engaged with both PC colleagues at cluster and practice level and secondary care.

As with other teams within the Therapies and Mental Health & Learning Disabilities Directorates, effective team based working principles will be employed to maximise team effectiveness.

These government and management arrangements will stay in place when the new Operating Model comes into effect. Long Covid will continue to be hosted in the East Integrated Health Community within the Therapies Directorate, with close engagement with Psychology leadership and Mental Health & Learning Disabilities Directorate management.

5.2 Scheme Plan – Implementation Timeline

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

Year	**Year 1 2022/23**	**Year 2 2023/24**	**Year 2 2023/24**
Phase	Phase 1	Phase 2	Phase 3
Recruitment	50% of staff in post	75% of staff in post	100% of staff in post
Timescales	End March 2023	End September 2023	End March 2024

Depending on approval date:

Within Year Costs

Full year Cost Y1	£1,091,220
Total additional recurrent investment required	£48,220
Non recurrent costs Y1	
Total Additional Investment	£48,220

Full Year Cost Y2	£1,091,220
Total additional recurrent investment required	£866,635
Non recurrent costs Y2	
Total Additional Investment	£866,635

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

5.3 Monitoring Progress

A detailed roll out and implementation plan will be developed including KPIs and timescales and progress against this plan will be monitored by the Long COVID Strategic Oversight Group and reported back to HB as required. Demand date will continue to be captured and the service will report

back against the targets outlined in the BCUHB Planned Care Recovery Plan (appendix 2 of the IMTP), mapped against the draft WG Planned Care Recovery Plan with a target to ensure that no patients are waiting over the national performance target of 14 weeks for specified therapy service by March 2024.

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

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

5.4 Evaluation

Evaluation of existing services will continue to ensure a safe, effective and high quality service is delivered.

Key performance data will be collected, analysed and shared routinely at a whole service level and locally within each area. This will include:

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

An annual evaluation report will be produced containing the key information listed above, including the evaluation of existing delivery and progress against rollout plans.

In addition, service evaluation will feed into ongoing service development plans to ensure that clinical and cost effectiveness is maximised both within the pathways and services themselves but also within the wider HB.

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

6 Critical Assumptions, Risk and Issues

- It is critical that core funding is identified for the scheme to continue and expand. Evaluation demonstrates that the scheme releases Primary Care capacity, as well as reducing impact on secondary care and diagnostic services.
- The scheme is well regarded by the public and has been commended by WG. If the decision is made to not to implement, there is a risk of significant negative public and political attention.
- Expansion plans to extend and deliver the service across BCUHB need to be phased to allow for safe and effective implementation and recruitment.
- Excellent relationships have been developed and have been essential to the success of the scheme to date. These specific relationships will continue to be developed with other key stakeholders in primary and secondary care.
- There is a risk that the service may not be able to recruit to all posts, given the current rate of vacancies within the HB. To date, advertising of permanent posts to recruit to the LC service has demonstrated sufficient interest in posts with a number of suitable applicants, in contrast to when these posts were advertised on a temporary basis and sometimes did not attract any applications. It is therefore felt that permanent positions should generate sufficient interest from suitable applicants.

7 Conclusions

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

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

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Professor Chris Jones
Dirprwy Brif Swyddog Meddygol
Deputy Chief Medical Officer

Llywodraeth Cymru
Welsh Government

To: Health Board Directors of Therapies and Health Science

Cc. Chief Executives of Health Boards
Health Board Directors of Finance
Health Board Directors of Primary and Community Care
Health Board Medical Directors
Health Assistant Directors

31 March 2022

Dear Colleagues,

Additional funding to support 'Adferiad' Programme

On 31st March the Minister for Health and Social Services announced that a further £5m of Adferiad programme funding would be allocated to Health Boards in 2022/23 to support the continuation of health board's long COVID services.

This funding will also support the continued availability of the guideline for the long COVID pathway and the self-management Covid recovery app which have been effective digital tools in supporting patients to self-manage their conditions and providing healthcare professionals with up-to-date advice and learning to aid diagnosis and treatment of long COVID.

£4.7m will be distributed based on population share as set out in Annex A. £300,000 will be top sliced for the NHS Wales Collaboration to manage procurement, contractual arrangements to ensure the continued availability of the long COVID digital guideline and Covid recovery app.

Reporting

The Minister for Health and Social services has indicated that the Adferiad programme will be reviewed every six months and as such it will be necessary for us to be able to continue to monitor services and evidence how those services are responding to patient need. We will also need to provide evidence of how services are developing as we learn more, and how these have adapted to capture the needs of a range of patients with other long-term conditions such as Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Multiple Sclerosis (MS). In addition to local information, there will be a requirement to evidence how best practice has been shared and adopted across NHS Wales.

The next review point is mid-June. The next six-month returns are therefore requested by close on **Friday 15th July 2022.** The template for returns is at Annex B.

In July 2020 Welsh Government published guidance on evaluating the impact of post Covid 19 rehabilitation based on the 4 harms. The first harm captures Long COVID and this framework continues to provide the basis of the evaluation we will be asking you to complete as part of the 6 month review Evaluating the impact of rehabilitation services post COVID-19 | GOV.WALES. In addition to inclusion in the

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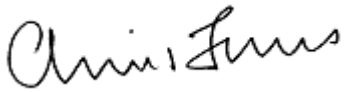
Ebost/Email:PSChiefMedicalOfficer@gov.wales

template, the use of the funding will be monitored via the narrative section of the Covid MMR schedule (financial returns).

We will use the next review to consider how services have been integrated, and could be further integrated, to support people with the other long term conditions, including those referenced above, to create the most effective long-term interventions and reduce inequalities between specific diagnosis.

Please ensure 6 month returns are submitted to the mailbox: Covid19.LongCovidCoordination@gov.wales by close of play on 15th July 2022. Please also use this mailbox for any queries you have in relation to this letter.

Yours sincerely



PROF CHRIS JONES

Annex A

The breakdown of funding is as follows:

Health Board	**Allocation £4.7m**
ABUHB	£0.887m
BCUHB	£1.043m
C&VUHB	£0.749m
CTMUHB	£0.667m
HDUHB	£0.578m
PtHB	£0.198m
SBUHB	£0.578m
Total	**£4.700m**

Annex B

Reporting Template – Adferiad programme (Period covering from mid-December 2021 to mid-June 2022)

Name of health board	
Date	
Allocation amount for full year (please see Annex A)	
Please provide a general description of the Adferiad programme within your health Board over the last 6 months. This should include any changes made as a result of learning, patient feedback and how funding has been utilised. You should also indicate here how you have ensured equity of provision across the population. This section should also include any relevant engagement activity undertaken. (**Max. 500 words).**	
Please provide summary data against the following areas in respect of population 1: **Demand** # people presenting % of those given advice/self management % of those referred to rehabilitation # referred to secondary care **Quality** Service user experience/patient feedback Responsiveness of service – referral to treatment times **Recovery** Completion of the validated tool, EQ5D5L	

Please use this space to provide two anonymised case studies/patient journeys which can be published as part of the review **(Max. 300 words per case)**
Recommendations for future service delivery. Please use this space to state your recommendations for Long COVID service provision for the next 6 months based on your learning and experience over the past 6 months **(Max. 500 words).**

WEDFAN Impact Assessment: COVID 19

SUMMARY

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

Context

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

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

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

Current status in Wales

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

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

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

The Frequent Attender Case Manager role is to:

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

National Support for this work stream

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

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

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

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

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

All of Wales

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

WEDFAN
Welsh Emergency Department Frequent Attenders Network

Average attendee

1.4 attendances per person

Frequent attenders*

6.8 attendances per person

No of Attenders vs No of visits

Length of stay

5.2 hrs per attender
3.7 hrs pervisit

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

TOTAL COST FOR ALL ATTENDEES
£401,181,420

Length of stay

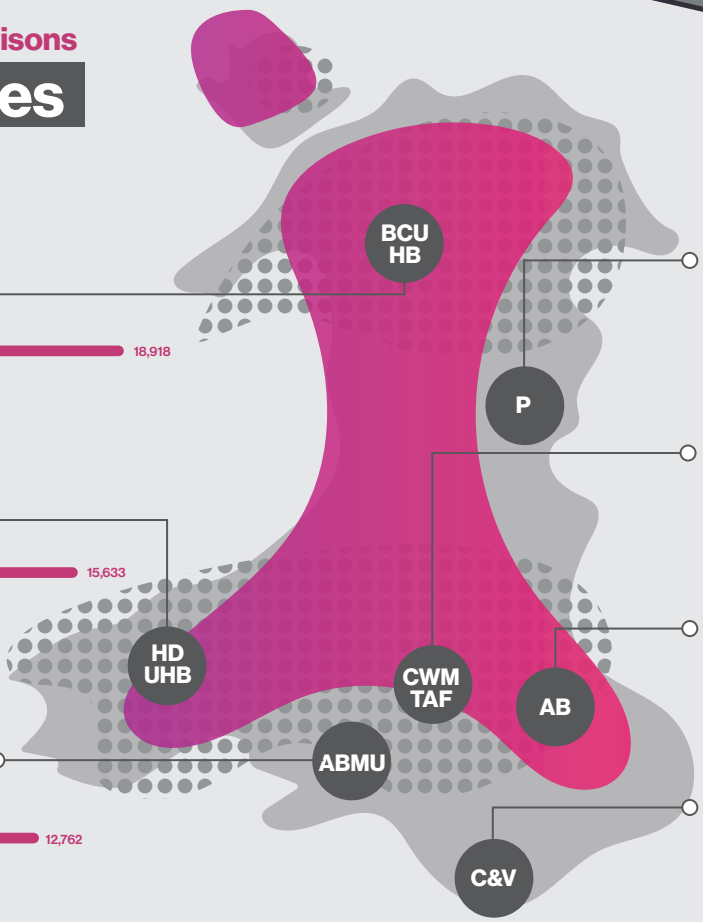
32 hrs per attender
4.6 hrs per visit

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

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

Health board comparisons

Attendences by region



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

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

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

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

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

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

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

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

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

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

WEDFAN

Welsh Emergency Department Frequent Attenders Network

WEDFAN WINTER FUNDING 2019/20

YGC BETSI CADWALDR UHB DATA

ABSTRACT

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

William Adams, Anna Sussex

WEDFAN Operational Support Manager, National Strategic Lead

POINTS OF NOTE: (YGC Data)

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

92% reduction in ED attendances during funding period

84% reduction in length of stay during funding period

75% reduction in inappropriate repetitive investigations during funding period

88% reduction in costs during funding period

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

Recruitment

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

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

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

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

Total Spend for the recruitment: £8,297.16

The role of the Case Manager is as follows;

• Reduce contacts with Unscheduled Care

• Reduce time spent in the Emergency Department

• Reduce time WAST are on scene with patients

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

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

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

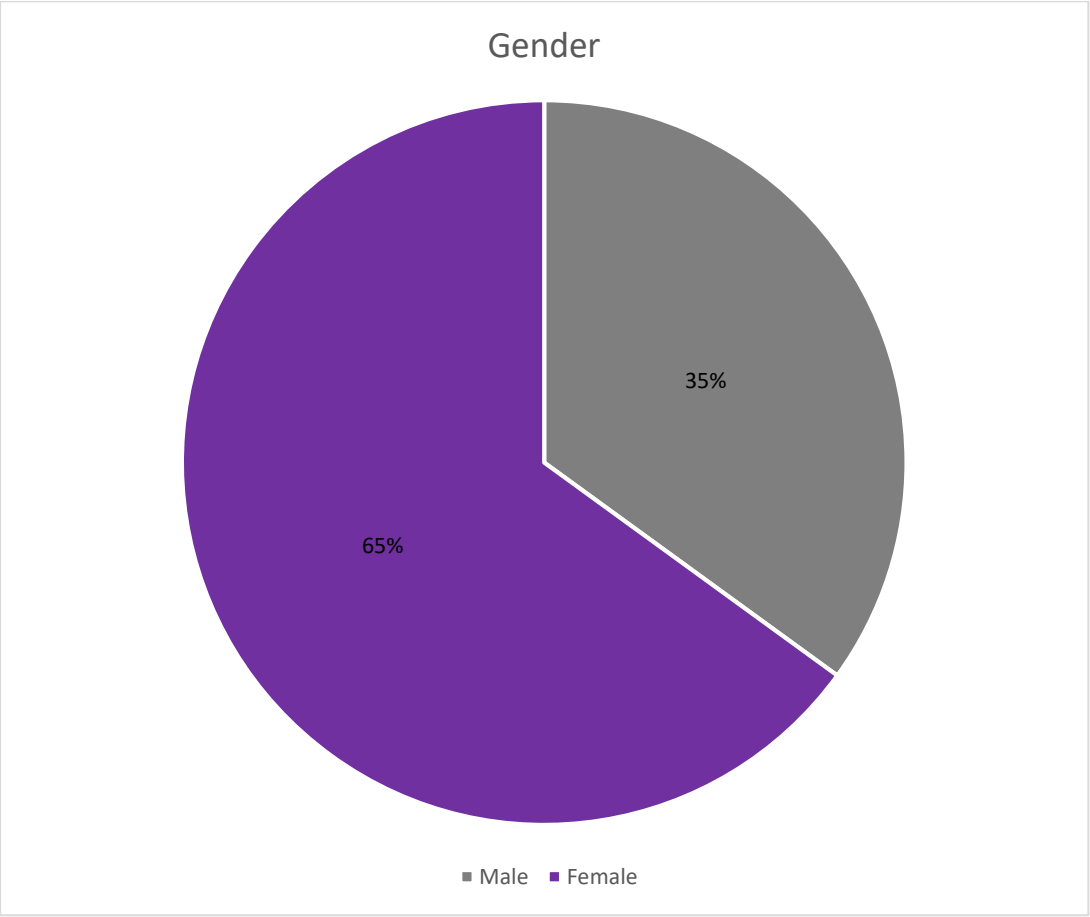
• Hold the ring on communication between agencies, promoting joint decision making

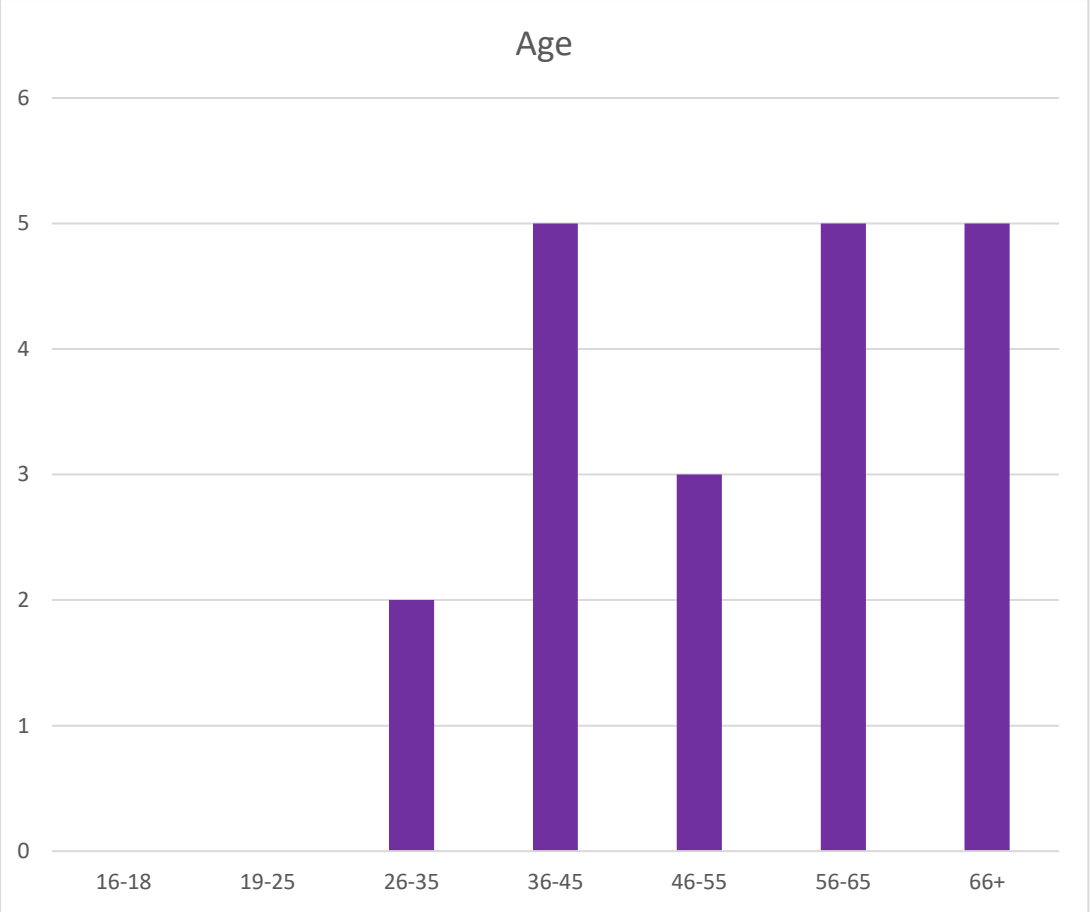
• Provide support to patients on a daily basis as a point of contact rather than 999 or ED

Data

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

Demographic





Mean Age – 50 years

If the work was to continue, it will:

Support Unscheduled Care services to decrease attendances and length of stay

Decrease admission conversion rates thereby releasing bed occupancy

Ensure patients have continued support from available or alternative community services

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

Continue to work with the other agencies remotely

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

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

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

Positive feedback from patients within the BCUHB Long Covid Service

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

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

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

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

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

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

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

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

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

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

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

Themes (Positive feedback)

Excellent support from the Long COVID service

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

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

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

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

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

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

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

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

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

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

Good support from GPs

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

Responders felt the Long COVID service was personalised around their needs

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

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

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

These forms have been designed to enable you to record, and provide evidence of how you have considered the needs of all people (including service users, their carers and our staff) who may be affected by what you are writing or proposing, whether this is:

- a policy, protocol, guideline or other written control document;
- a strategy or other planning document e.g. your annual operating plan;
- any change to the way we deliver services e.g. a service review;
- a decision that is related to any of the above e.g. commissioning a new service or decommissioning an existing service.

Remember, the term 'policy' is used in a very broad sense to include "..all the ways in which an organisation carries out its business" so can include any or all of the above.

Assessing Impact

As part of the preparation for your assessment of impact, consideration should be given to the questions below.

You should also be prepared to consider whether there are possible impacts for subsections of different protected characteristic groups. For example, when considering disability, a visually impaired person will have a completely different experience than a person with a mental health issue.

It is increasingly recognised that discrimination can occur on the basis of more than one ground. People have multiple identities; we all have an age, a gender, a sexual orientation, a belief system and an ethnicity; many people have a religion and / or an impairment as well. The experience of black women, and the barriers they face, will be different to those a white woman faces. The elements of identity cannot be separated because they are not lived or experienced as separate. Think about:-

- How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?

- Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

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

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

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

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or

promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

Remember to ask yourself this: If we do what we are proposing to do, in the way we are proposing to do it, will people who belong to one or more of each of the following groups be affected differently, compared to people who don't belong to those groups? For example, will they experience different outcomes, simply by reason of belonging to that/those group(s). And if so, will any different outcome put them at a disadvantage?

The sort of information/evidence that may help you decide whether particular groups are affected, and if so whether it is likely to be a positive or negative impact, could include (but is not limited to) the following:-

- population data
- information from EqIAs completed in other organisations
- staff and service users data, as applicable
- needs assessments
- engagement and involvement findings and how stakeholders have engaged in the development stages
- research and other reports e.g. Equality & Human Rights Commission, Office for National Statistics
- concerns and incidents
- patient experience feedback
- good practice guidelines
- participant (you and your colleagues) knowledge

Protected characteristic or group	**Will people in each of these protected characteristic groups be impacted by what is being proposed? If so, is it positive or negative? (tick appropriate below)** *for further direction on how to complete this section please click here training vid p13-18)*	**Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their**	**How will you reduce or remove any negative Impacts that you have identified?**

			website here	

Guidance for Completion

In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative. ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.***

The information that helps to inform the assessment should be listed in this column. ***Please provide evidence for all answers.***
Hint/tip: do not say: "not applicable", "no impact" or "regardless of…". If you have identified 'no impact' please explain clearly how you came to this decision.

NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. For the definitions of each characteristic please click here

	Yes	No	(+ve)	(-ve)		
Age	x		x	x	According to research published by Age UK, around 3.3. million people over 70 in the UK have had their mental wellbeing affected by the COVID-19 pandemic, experiencing feelings of worry, stress, anxiety and loneliness.	Work with Age UK via the Equality Stakeholder Group representative and with the Community Health Council to ensure guidance and materials are inclusive of those issues that may be faced by older people and

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

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

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

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

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

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

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

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

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

Socio Economic Disadvantage	x		x		Poverty and poor housing may have substantial impacts on accessibility to healthcare resources. Often it is those who have the greatest need for healthcare services who live furthest away from them. This could cause further delay in seeking help. People who are homeless may face challenges accessing care or may present late to services, so they may be more likely to have adverse outcomes to if they accessed services sooner. Stakeholders highlighted that low levels of literacy and pervasive language disorders are known to exist in communities at higher risk of COVID-19, which can create challenges seeking help. Healthcare services are	

					increasingly using digital methods for people to access care. This could create challenges for people with disabilities, low digital literacy, or people who do not have devices or connectivity to use these services. Online forms are an additional barrier to some people (for example those with communication or dexterity difficulties) in accessing healthcare. This factor may lead to some groups of peoples becoming less likely to seek help. People may feel or have experienced stigma based on their socio-economic background when accessing healthcare services that may create challenges for seeking help. Poverty may also impact on the individual's ability to access online material or apps for GP	

					appointments and health information, creating a further barrier within a health literacy and access context. One stakeholder highlighted emerging evidence of a link between social deprivation and incidences of COVID-19 that needs to be explored further. Stakeholders highlighted that inequities are faced by groups such as people in prison, Gypsies and Travellers, Armed Forces personnel and people who have been trafficked should be considered when drafting recommendations.	

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166 and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com.

The Articles (Rights) that may be particularly relevant to consider are:-

- *Article 2* *Right to life*
- *Article 3* *Prohibition of inhuman or degrading treatment*
- *Article 5* *Right to liberty and security*
- *Article 8* *Right to respect for family & private life*
- *Article 9* *Freedom of thought, conscience & religion*

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
x		x		Article 2 – Right to life	People have the right to live to the highest attainable standard of health. Feedback from patients, including recent patient stories captured on video, details the positive impact the service has had on people's life and health in comparison to how	Continued engagement with patients with Lived Experience. Continued co production and co development of the service. Continued

					things were for them before the Long Covid pathway was available. Further development of the service will capture a wider patient group of the population of NW living with a chronic health condition by addressing the current gaps in service provision for this patient group.	engagement with the Patient Experience team and the collation of patient feedback and stories.

Welsh Language:

There are 2 key considerations to be made during the development of a policy, project, programme or service to ensure there are no adverse effects and / or a positive or increased positive effect on:

Welsh Language	**Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)**				**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
	Yes	**No**	**(+ve)**	**(-ve)**		
Opportunities for persons to use the Welsh language		x			All documentation relating to the scheme will be readily available in Welsh and English.	
Treating the Welsh language no less favourably than the English language		x			All documentation relating to the scheme will be readily available in Welsh and English.	

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives,

or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

We have a legal duty to engage with people with protected characteristics under the Equality Act 2010. This is particularly important when considering proposals for changes in services that could impact upon vulnerable and/or disadvantaged people.

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)* The service was originally co-designed and co-produced with patients with Lived Experience. This has and continues to be an integral part of the service development to date. The service continues to work closely with the PALS service and engages with the Lived Experience Pathway group, which meets monthly. The views of the patients have been listened to and acted on throughout.	
Have any themes emerged? Describe them here. Patients that are digitally excluded and with language barriers, disabilities or other socio-economic disadvantages, resulting in lack of information available to these groups on the service and what is available to them.	
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations? The service works closely with the Lived Experience Pathway group and continue to listen to the views of patients. Co-design and Co-production of the service is an integral part of our service development. We will continue to work to ensure all population groups are captured and our service is accessible to everyone who requires it. Our recruitment plan has been adapted to incorporate a patient engagement officer role.	

For further information and help, please contact the Corporate Engagement Team – see their intranet page at:- http://howis.wales.nhs.uk/sitesplus/861/page/44085

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid*	Business Case Proposing Enhancement of the BCUHB Long COVID Service to meet population need (Part A) and to address gaps

p13-18)	in service provision for Chronic Fatigue Syndrome /Myalgic Encephalomyelitis (CFS/ME), Persistent Physical Symptoms (PPS) and Breathing Pattern Disorder (BPD) by developing an overarching Community Complex Conditions Service (Part B).

2. Brief Aims and Objectives: (Copy from Form 1)	The outline vision of this Programme is to enhance the existing Long COVID Service: To provide the required levels of care and support for our patients and staff to address the longer-term effects of the conditions outlined above. In addressing the issues identified and to deliver the stated vision the following objectives of this programme have been defined: Objective 1: To develop the patient pathways as required to support the local population manage the longer-term health conditions resulting from Long-COVID and improve their outcomes Objective 2: To manage the impact of Long-COVID on our health & care workforce across the BCUHB regions Objective 3: To work with partners to develop the knowledge base around Post-COVID recovery. Objective 4: To deliver sustainable service improvements for similar longer-term conditions including CFS/ME, PPS and BPD.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	

3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**		No
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: • The policy requires approval by the Health Board or subcommittee of • The policy involves using additional resources or removing resources. • Is it about a new service or closing of a service? • Are jobs potentially affected? • Does the decision cover the whole of North Wales • Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes	
4. Did your assessment		No

findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Where negative impact has been identified, mitigations are in place to proceed.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?		No
	Mitigating actions in place to address.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes	
	How is it being monitored?	Long Covid Strategic Oversight Group meets monthly to monitor implementation.
	Who is responsible?	Long Covid Service Leads
	What information is being used?	Engagement with PALS service and data from Patient Experience feedback and reports.
	When will the EqIA be reviewed?	September 2022

7. Where will your policy or proposal be forwarded for approval?	Health Board Executive Team

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Rachel Skippon Claire Jones Natasha Turner	Consultant Clinical Psychologist Long Covid Therapy Lead Operations Manager

Senior sign off prior to committee approval:	Gareth Evans	Acting Executive Director of Therapies
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan
This template details any actions that are planned following the completion of EqIA including those aimed at reducing or eliminating the effects of potential or actual negative impact identified.

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	None identified.	N/A	N/A
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	Changes to the recruitment plan	Service Leads	Complete
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in	A patient leaflet has been produced to provide information and support to people. A PALS officer for the service will help to capture patients that are digitally excluded or who have language barriers, disabilities	Service Leads	Complete

place?	or other socio economic factors affecting their ability to access information.		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	None identified. Mitigating actions are in place.	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Recruitment of a PALS officer for the service.	Service Leads	September 2022

Teitl adroddiad: ***Report title:***	Unscheduled Care Update			
Adrodd i: ***Report to:***	Finance, Performance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 19 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	*Scheduled agenda update in relation to the unscheduled care plan in line with the Six goals for Urgent and Emergency care 2021-2026* The paper sets out an update from the previous 6 months for unscheduled care and identifies areas of progression over the next 6 months for assurance.			
Argymhellion: ***Recommendations:***	The Committee is asked to note the update provided on the actions being taken within the Unscheduled Care improvement programme and plans for winter			
Arweinydd Gweithredol: ***Executive Lead:***	Gill Harris, Interim Chief Executive			
Awdur yr Adroddiad: ***Report Author:***	Geraint Farr – (Interim) Associate Director For Emergency Care. Medwyn Jones – Six Goals Programme Board Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Six Goals for Urgent and Emergency care 2021-2026 A Healthier Wales 2018			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health and Safety Executive Quality and Safety Executive
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Do/Naddo ***Y****/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments*
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	Do/Naddo ***Y****/N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* *If no please provide an explanation as to why the duty does not apply* Gweithdrefn WP68 ar gyfer Asesu Effaith Economaidd-Gymdeithasol. *WP68 Procedure for Socio-economic Impact Assessment.*
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Inability to provide safe timely care for those requiring unscheduled care.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Discussed and reviewed by Interim Regional Director of Delivery
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Appendix 1: Four & Twelve hour performance and Average Length of Stay Appendix 2: No: Medically fit for Discharge (MFD) patients within acute and community hospitals across NW by D2RA pathway Appendix 3: Ambulance performance Appendix 4: Revised Discharge to Recover & Assess Pathways Appendix 5: SAFER principles of patient flow Appendix 6: Red to Green principles of patient flow Appendix 7: Preventing deconditioning	

Performance, Finance and Information Governance Committee 19.1.23

1. Corff yr adroddiad / *Body of report*

Unscheduled Care performance

Significant pressures in unscheduled care continue across Wales with an ever-growing national deterioration in the Emergency Department 4 hour performance, Ambulance handovers and 12-hour delays. There is decreasing performance in Medically fit for Discharge (MFFD) patients that now is resulting in pure gridlock within unscheduled care that is heavily impacting flow and also on Planned care.

Attendances continue in line with trajectory, but over recent weeks a sharp increase in acuity of those attending, with a noticeable increase in frailty patients that have prolonged delays at home (long lies), whilst awaiting an ambulance response.

Infection prevention issues continue to fluctuate with bed closures across BCUHB, and areas closed due to risk of increased infection, this has reduced flow, but also reduced ability to discharge patients safely that are positive for an infectious condition.

Some of the highlighted contributing factors for the Unscheduled care performance are as follows:

i) There have been periods of escalation into Business Continuity Planning due to demand and capacity over the previous weeks, this has been because of sheer demand, lack of flow and extended periods of ambulance delays with harm occurring in the community.

ii) Increased primary care demand due to acuity has resulted in an increase in referrals for hospital assessment/admission. Due to delays in ambulances attending, that has resulted in them arriving at the hospitals later on in the day, resulting in delays in assessments, and then requiring admission via the Emergency departments.

iii) Ambulance delays have increased, which impacts on the clinical safety plan (CSP) this results in ambulances not being sent to specific call. This in turn has a double negative result in that, higher acuity patients self-present to the emergency departments, along with those that would have been assessed and discharged on scene now attending the emergency department for the same assessment and outcome.

iv) Due to the constant demand 24/7, there is now a growing picture of delays during the out of hours periods due to capacity within the three Integrated Health Communities (IHCs) and an increase in patient moves beds on wards during the out of hours period. Currently the data shows more moves out from the emergency departments during the out of hours period against the in hours period.

The numbers of patients who are medically fit for Discharge who are delayed within a hospital bed remains consistently high across the acute and community hospitals, with 1/3 of the health board beds being occupied by patients awaiting discharge, this heavily impacts on flow and performance.

Due to social care challenges to recruit into vacant posts within the current social economic position, there are conflicting recruitment campaigns ongoing for the same staff that is heavily influencing the ability to recruit. This has most recently been highlighted at the Health and Social Services Group (HSSG)

Performance Metrics:

BCUHB 4 hour performance

The 4 Hour performance for each acute site (Appendix 1) continues to remain affected by multiple factors of which patient flow is the main contributory factor as this is now evident in the 4-hour performance for those that are discharged from the emergency department. Previously it would be approximately 85% month on month, and is currently 55%.

A review of the Single Integrated Clinician Assessment tool (SICAT) is due to take place January – February 2023 to support increasing the capacity to assist with signposting as per Goal 2 of the Six Goals Programme. Alongside that, access to Physician Triage Assessment System (PTAS) is being supported to allow Nurse specialist across each Integrated Health Community (IHC) to review calls on the stack that can be supported closer to home (Goals 1 and 2 of the six goals programme). This in turn should support a reduction of ambulance arrivals, but also reduce attendances to the emergency departments.

Urgent Primary care centres (UPCCs) / Urgent treatment centres (UTCs) are functioning East and West, with ongoing discussions around increasing capacity to pull those primary care suitable patients from the emergency departments to create capacity, but also support access to the UPCC teams to SDEC to further speciality assessments.

A validated 4-hour performance dashboard is now in place to identify the variance in performance for unvalidated data against validated data.

BCUHB 12 hour performance

The 12-hour performance (Appendix 1) shows a constant trend across BCUHB of an increasing 12-hour delays for all 3 Emergency Departments. Time to clinical assessment has deteriorated resulting in a delay in decision-making, The Royal College of emergency medicine (2021) highlighted evidence that demonstrates the higher the occupancy is within the emergency departments that there is a clear coloration of admission rates within the emergency departments. There has been a clear increase in acuity of those being admitted over previous weeks that has resulted in them requiring admission to speciality wards, which have limited beds. This has also been impacted on by the limitations imposed due to infectious conditions. Performance data being developed is the ability of using Symphony to capture decision to admit (DTA), whilst not a recordable metric within Wales it is a valuable tool to support improving flow. For example, with the additional senior clinical leadership on the Six Goals Programme an area to develop is reducing the duplication on clerking that in turn would prevent delays within the emergency departments whilst awaiting speciality clerking this would result in once agreed for admission, DTA applied and patient moved to speciality ward or across to SDEC.

Ambulance Performance

Ambulance demand remains constant with noticeable peak in arrivals during the evenings and early hours. There has been a marked increase in lost hours over the previous months, with periods of delays approaching 24hrs (Appendix 2).

Local schemes were set in place to support the industrial action (IA) in December and that supported a substantial reduction in lost hours that has a positive outcome, aware of forthcoming industrial action in January 2023 with the emphasis being the same. Following on from that there will be a site management / Emergency department workshop to identify what can be done as business as usual following on from the IA.

A task and finish group in established with support from the National Collaborative & Commissioning Unit (NCCU) to develop an urgent improvement programme utilising current services in post that will report into the national Ambulance commissioning group along with local delivery unit (DU) meetings.

National feedback has been given in relation to the immediate release process that impacts on lost hours along with the clinical safety plan (CSP) that impacts on self-presenters but also the ability for Intelligence conveyances that is having a negative effect on the patient journey.

Average Length of Stay (LOS) >21 days

Average length of stay >21 days has remains consistent over recent months, which correlates against the MFD coding (see Appendix 3) for patients who are delayed on the current Discharge to Recover and Assess pathways. This data excludes those delays that are awaiting social worker assessment or internal delays.

There is a requirement for reviewing those that are stuck due to internal delays with a clear mechanism for escalation for support as pan BCU that at the beginning of January equated up to 145 patients that are within our gift to discharge.

6 Goals Programme Update

The Unscheduled Care programme within BCU is being progressed in conjunction with the Welsh Government 6 Goals Programme for improving Urgent and Emergency Care, with a scheduled plan to support all Six goals of the programme. The 6 Goals programme of work is being led by the new Programme Director (Medwyn Jones) working with Dr Chris Subbe and Dr Jim McGuigan Deputy Executive Medical Director as the Senior Clinical Leads for the programme, and also supported by Geraint Farr as the acting Associate Director for Urgent & Emergency Care pan-BCUHB. There is a clinical lead for Same Day Emergency Care services (SDEC) and data analysts also supporting the programme. Executive leads have been identified for the 6 goals as follows; Goals 1 & 2, Gareth Evans, Executive Director of Therapies & Health Sciences; Goals 3 & 4, Angela Wood, Executive Director of Nursing & Midwifery; Goals 5 & 6, Dr Nick Lyons, Executive Medical Director.

The refreshed BCUHB 6 Goals Programme Group has been established with Terms of Reference, agreed membership and meetings in place which will be chaired by Dr Nick Lyons (Medical Executive Director). Reporting framework and accountability within IHC teams and associated stakeholders are being agreed and finalised.

The 6 Goals programme team are focusing on immediate action plans to support a number of high impact interventions that aim to deliver improvements in both patient and staff experience as well as organisation performance. There will also be an emphasis on developing wider projects with the programme to support the medium and long-term aspirations for Urgent and Emergency Care over the coming years. This includes but is not limited to:

i) Working with IHC teams to support initiatives for UEC trajectory improvement in line with the 6 Goal Programme.
ii) Support Welsh Government funding opportunities for high-risk patients – work also ongoing within each IHC to identify high risk patients in line with Goal 1 to co-ordinate planning for individuals at risk.
iii) Support for patients within care homes and to support admission avoidance will be tested from January 2023 onwards. Stakeholder meetings are almost complete and contracts being prepared. This is within Goal 2 (24/7 signposting for U&EC) – This is goal 1
iv) Broader review of urgent and emergency care within community, this is underway with an appetite for collaboration but further work to conceptualise.
v) Continued focus on safe alternatives to admission (Goal 3) through SDEC and Urgent Primary Care Centre developments, which are established but further work to address space and staffing issues within SDEC and analysis of any impact from UPCC which is not yet being evidenced in EDs for the relevant disease groups. – UPCC is a goal 2 initiative
vi) Continue to drive technology support for the programme.
vii) Engage with all key stakeholders, examples include primary care, Local Authorities, WAST, Mental Health, 3rd Sector and Regional Partnership Board in preparation for winter via the EPRR planning team.

With regards to Goal 5, which focuses on optimal hospital care and discharge from the point of admission, the Minister for Health & Social Services launched the 'Optimal Hospital Patient Flow Framework' on 6th December 2022. This guidance sets out the key approaches within patient flow; Discharge to Recover & Assess (D2RA), SAFER and Red to Green (R2G), which aim to support all healthcare professionals to improve patient flow and deliver timely pathways of care. The guidance, developed through a series of national expert groups comprising of operational and managerial staff, sets out the integration of these approaches and the necessary tools required to support delivery of transformational care and safeguard against deconditioning, ensuring better outcomes and experiences for people in hospital. Appendices 1-4 describe the D2RA, SAFER and R2G principles as well as preventing deconditioning.

The guidance for all adults admitted to an acute or community hospital bed emphasises the need for discharge planning to commence from the point of admission and is based on 4 key questions around 'what matters to me', that all healthcare professionals should be able to answer for every person within their care. Patients, their families and carers must be central to all decision making and their views should always inform the answers to these 4 questions.

1. What do you think is wrong with me?
2. What is going to happen today?
3. What needs to happen to get me home and what can I do to speed things up?
4. When can I go home?

It is acknowledged that at a national level across Wales, D2RA and the fundamental elements of SAFER and Red to Green are not consistently being met, which is resulting in patients experiencing longer lengths of stay and deconditioning. The principles of these approaches have now been refined and collated to be simpler and more effective. The guidance stipulates that D2RA and SAFER principles must be custom and practice from the point of time when a decision is made to admit. R2G approach ensures that every day a person stays in a hospital bed, adds value to their care and aims to reduce a patients length of stay by highlighting 'non value' adding days and reducing avoidable delays where a patient is kept waiting for things to happen to progress their care.

Following the ministerial launch of this guidance, Health Boards are now required to develop implementation plans to roll out and embed the above principles of D2RA, SAFER, R2G and prevention of deconditioning, with a priority focus to implement the revised D2RA pathways, commencing in early 2023 with support from the Delivery Unit (DU) including supporting resource materials (posters), training and education. Draft implementation plans will be developed and submitted to the DU by the end January 2023 for review.

Delayed Pathways of Care reporting

A pilot has commenced for the 3 months from November 2022 to January 2023, to reintroduce the national census reporting of the former delayed transfers of care (DTOC), which was stood down in early 2020 due to the pandemic. The reporting process has been refined with delay codes amended to align with the revised D2RA pathways, which are to be implemented across BCUHB in the New Year.

The pathways of care delays reporting process requires the inputting of delays onto a national database of all adult patients who are '*clinically optimised, post 48 hours'* and who are delayed in an acute or hospital bed. All social care delays require validation by Local Authority partners prior to submission of data. On the third Wednesday of each month a census 'snapshot', of the data entered onto the database, is taken across Wales to identify the number of delays at a given point each month including the reasons for the delay. BCUHB and the 6 NW Local Authorities are working together to ensure accurate data is inputted and address any issues or challenges during this pilot period. The process will be fully implemented and go live from February 2023 onwards and the next phase of the reporting process going forwards will require integrated action plans to be developed to identify themes trends to inform what gaps within services require funding and support to be developed. It is expected that these action plans will be reviewed through Health Board Unscheduled Care (6 goals) groups and also at Regional Partnership Boards.

Increased Community Capacity (1000 beds campaign – across Wales)

In line with the national 1000 beds campaign work is continuing locally in partnership with the 6 Local Authorities across North Wales to progress a number of schemes identified to increase capacity over the winter months. A total of 18 schemes are in place currently with trajectories that aim to deliver 221 additional beds or placements out of the required 243 target set for North Wales. Of the 18 schemes, 7 are amber where they are not currently on trajectory and 11 are green. Key challenges to delivery of the schemes is around recruitment of additional staff. Further pipeline schemes are also being worked in each County through for additional capacity to achieve the 243 and learning is being shared between IHCs and counties of successes.

Current highlights from the schemes include;

- recruitment of micro-providers in Denbighshire to support increased provision of domiciliary care in the county;
- significant overseas recruitment within a care agency in Wrexham which to date has reduced the number of hours of packages of care awaiting in the County.
- Peripatetic service in Conwy set up to respond to urgent demand for provision of short to medium term personal care and support to individuals within their own homes, working closely with the reablement team to pick up new packages of care in the County and support hospital discharges.
- The Tuag Adref (Homeward Bound) and District Nursing service in the West IHC is supporting with the provision of a number of packages of care where the Local Authorities have confirmed they are unable to provide the PoC within the required timeframe. Recruitment process has successfully appointed additional Health Care Support workers to Tuag Adref and the service is also in the process of becoming registered as Domiciliary care provider with Care Inspectorate Wales (CIW).

Work is ongoing to commission targeted care home placements to provide specialist step down to recover rehabilitation beds and step-up, short-term rehabilitation support through block purchasing arrangements. Following an exercise to invite Expressions of Interest from over 300 residential and nursing care homes, responses were received from only 7 homes across North Wales totalling 35 placements. An evaluation process was undertaken of the applications received which resulted in 5 of the 7 homes being awarded contracts for a total of 21 additional placements, some of which were not suitable due to being under review by Care Inspectorate Wales or subject to escalating concerns. Further review will be undertaken once these circumstances change. It is also anticipated that further placements will be available from additional submissions from care homes, which did not submit within the deadline.

Alongside the 6 goals work stream and as part of the operational focus on the unscheduled and Emergency care framework:

- Demand Management – The electronic dashboard is now live, and being amended to the new national OPEL reporting levels. A trial this was successfully tested during the recent BCI events when on discussion with WG it was identified nationally an inaccuracy on reporting pan Wales. The actions on escalation require embedding across BCUHB to support a constant approach of de-escalating down rather than the constant firefighting.
- ICAP (Integrated Commissioning Action Plan) is a joint piece of work with WAST/ NCCU and BCUHB to support actions associated with improving ambulance handovers. The next step in the work is to utilise the Emergency Department staff as part of the group to develop the solutions going forwards.

- Joint reviews of any Appendix B's to support joint working along the improvement programme. The process within BCUHB to review Appendix B's has been identified as the gold model and being rolled out across Wales. Since the introduction, there has been a reduction in allocations of Appendix B's. Theme and trends are now being identified as part of Goals 1,2 5 and 6 of the 6 goals programme to support care closer to home, safer discharge planning, and early escalation.

- Emergency care Owing to the increase in demand a review of staffing for the emergency departments is being completed to identify if there is a requirement to commence planning for

a future business case (Capital / revenue) to support the different ways in working but also due to the demand on the emergency departments/Same day emergency care for the next 5 years.

- Capacity management – Review of hospital full protocols and setting of a benchmark of acceptance ie: 90% with local escalation and demand management, 95% occupied then enactment of hospital full protocol, but need formal review process on de-escalating to identify any missed opportunities.

- Developing a 7 days discharge lounge in line with 7day NHS services, and reviewing capacity of discharge lounges to reduce restriction.

- Joint work with Local Authorities to support :
  i) Better utilisation of step down capacity;
  ii) Develop joint solutions for additional capacity e.g. NHS funded care home / step down as part of the 1000 beds programme;
  iii) To progress an integrated workforce to ensure sustainable care workforce; iv) Work together to improve communication and engagement.

Winter plans

A number of proposed winter schemes have been identified by each Health Community for 2022-23 separate to IMTP bids, with an agreed joint communication between planned care/Unscheduled care and planning to prevent duplication and supporting realistic expectation that is still awaiting ratification.

Whilst we have not received any specific guidance from WG on any USC funding, it is their expectation that we do not have a separate winter plan this year and that the schemes are aligned to the USC improvement programme as part of the 6 goals programme for urgent and emergency care in conjunction with IMPT bids going forwards once funding has been confirmed then the respective IHC's can enact their plans.

A separate winter resilience plan is provided.

2. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

Opsiynau a ystyriwyd / Options considered

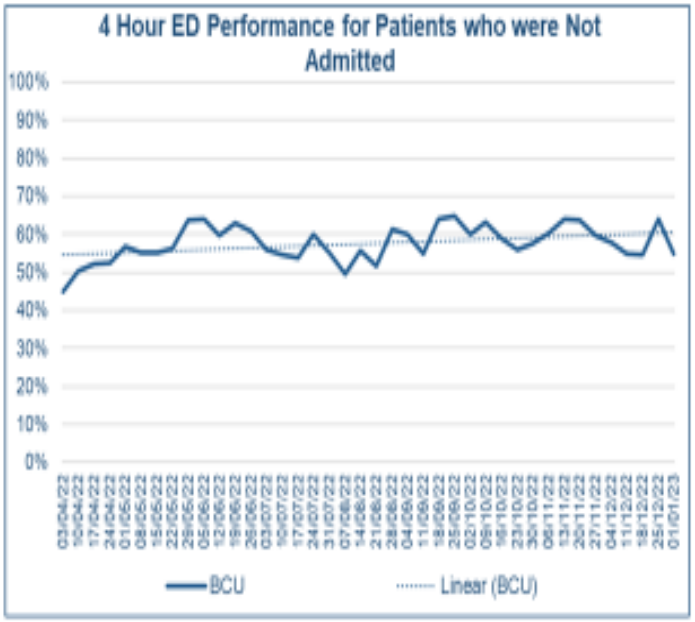
N/A

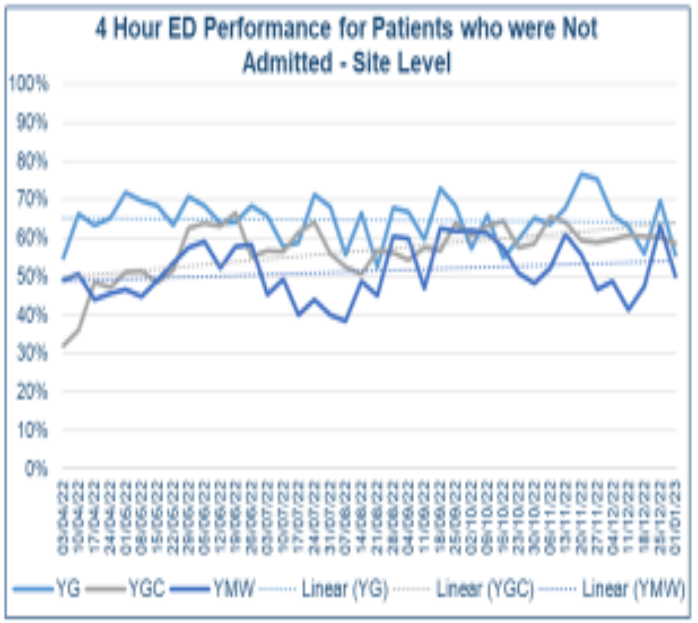
3. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

The Funding to support projects against the Welsh Government £25m for Urgent and Emergency care in line with the 4 key deliverables: Contact First, Urgent Primary Care Centres, Same Day Emergency Care models and Remote clinical support and optimising conveyance as well as funding for programme management support have had been received in the financial year 2021-2022. A further review is ongoing to identify any additional costs aligned to developing Urgent and Emergency care in line with planned care structure.

4. Rheoli Risg / Risk Management
Board Assurance Framework (BAF) 20-02 for Safe and Effective Management of Unscheduled Care within strategic priority 1 for Safe Unscheduled Care, describes the risk that "…*the Health Board may not be able to deliver safe and effective care due to being unable to commit support processes. This could negatively impact on the quality of patient care provided*". Mitigating actions to reduce harm, improve patient outcomes and better patient and staff experience across the urgent and emergency care system are in the process of being confirmed in line with the improvement programme of work and revised governance and reporting arrangements.
5. **Goblygiadau Cydraddoldeb ac Amrywiaeth /** ***Equality and Diversity Implications***
n/a

Emergency Department Attendances but Not Admitted, for BCU and by Site to 01.01.2023





- Overall trajectory is for improvement in performance
- Centre, and East linear trajectories are increasing
- West linear trajectory is decreasing

BCUHB ED Trajectory Submission

Date: 17/10/2022 – 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	2209	2146	2006	2173	2118	2101	2155	2096	2165	1919	1972	942
Minor ED Attendances	1087	1127	946	1016	1031	1104	1090	1168	1144	1028	1131	494
Average Time to Triage (mins)	35.0	39.6	31.5	37.5	35.8	35.4	42.4	50.1	52.4	39.3	48.4	39.3
Average Time to ED Clinician (mins)	194.7	224.2	188.5	187.9	177.4	199.2	219.0	236.3	225.4	165.6	205.3	142.2
4 Hour Performance	45.9%	48.6%	51.9%	54.7%	54.9%	51.0%	49.8%	46.9%	47.6%	54.1%	48.4%	55.0%
12 Hour Breaches	755	830	651	660	666	633	724	795	796	665	794	248
More Than 21 LoS	517	504	481	456	433	444	427	421	442	453	406	432
% Occupancy > 21 LoS	16.0%	16.0%	14.9%	14.1%	13.5%	13.9%	13.2%	13.1%	14.3%	14.6%	14.8%	16.7%
Less Than 21 LoS	2706	2645	2738	2782	2769	2758	2808	2799	2642	2660	2333	2160
% Occupancy < 21 LoS	84.0%	84.0%	85.1%	85.9%	86.5%	86.1%	86.8%	86.9%	85.7%	85.4%	85.2%	83.3%
ED Left Without Being Seen	364	452	308	286	323	303	429	489	448	287	350	142

Ysbyty Gwynedd:

BCUHB ED Trajectory Submission

Date: 17/10/2022 – 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	742	766	638	687	690	672	731	662	748	612	644	322
Minor ED Attendances	261	248	223	231	260	257	249	308	283	248	268	88
Average Time to Triage (mins)	44.1	41.9	36.9	47.9	35.6	36.6	43.0	34.8	66.1	52.0	69.6	31.6
Average Time to ED Clinician (mins)	204.5	192.3	161.6	167.1	135.5	147.5	179.3	191.1	263.4	169.8	220.0	112.9
4 Hour Performance	49.3%	54.4%	52.1%	55.1%	64.4%	60.7%	54.4%	53.5%	44.4%	54.6%	44.8%	59.8%
12 Hour Breaches	226	199	198	178	166	173	197	214	307	221	247	61
More Than 21 LoS	219	186	192	188	159	161	163	156	167	178	160	176
% Occupancy > 21 LoS	17.6%	15.7%	15.9%	16.2%	12.7%	13.1%	12.9%	12.2%	14.1%	14.5%	15.9%	17.9%
Less Than 21 LoS	1022	997	1018	974	1092	1070	1101	1125	1014	1046	846	806
% Occupancy < 21 LoS	82.4%	84.3%	84.1%	83.8%	87.3%	86.9%	87.1%	87.8%	85.9%	85.5%	84.1%	82.1%
ED Left Without Being Seen	111	116	80	61	68	43	75	121	167	85	115	31

Ysbyty Glan Clwyd:

BCUHB ED Trajectory Submission

Date 17/10/2022 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	752	738	651	745	693	723	702	738	777	692	675	309
Minor ED Attendances	448	450	393	433	414	442	407	442	414	403	492	221
Average Time to Triage (mins)	25.7	25.5	21.9	29.1	29.2	32.9	35.0	37.0	31.1	28.2	39.9	33.9
Average Time to ED Clinician (mins)	182.9	200.9	152.5	160.5	168.4	185.3	181.8	183.6	169.3	153.3	203.0	143.5
4 Hour Performance	44.4%	46.9%	51.7%	48.9%	47.1%	46.9%	46.1%	47.5%	49.5%	48.9%	45.8%	54.1%
12 Hour Breaches	306	324	243	311	302	282	283	312	274	281	375	124
More Than 21 LoS	101	105	98	101	103	114	102	100	99	99	88	85
% Occupancy > 21 LoS	10.7%	11.6%	11.1%	10.5%	11.9%	12.8%	11.5%	11.5%	11.6%	12.0%	10.6%	11.5%
Less Than 21 LoS	842	798	783	861	765	777	787	766	751	725	744	656
% Occupancy < 21 LoS	89.3%	88.4%	88.9%	89.5%	88.1%	87.2%	88.5%	88.5%	88.4%	88.0%	89.4%	88.5%
ED Left Without Being Seen	85	104	70	73	87	82	93	89	77	77	87	32

Wrexham Maelor:

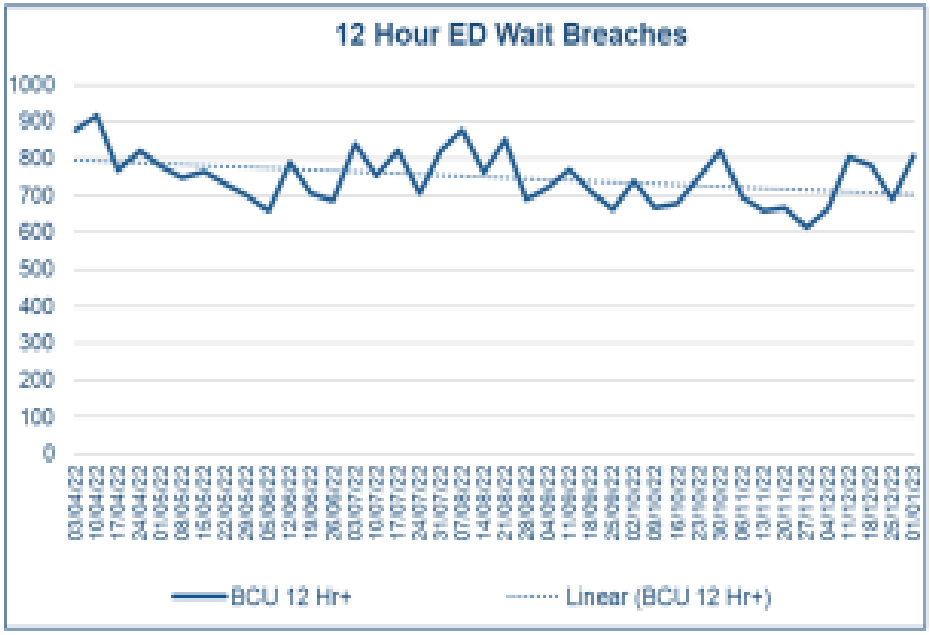
BCUHB ED Trajectory Submission

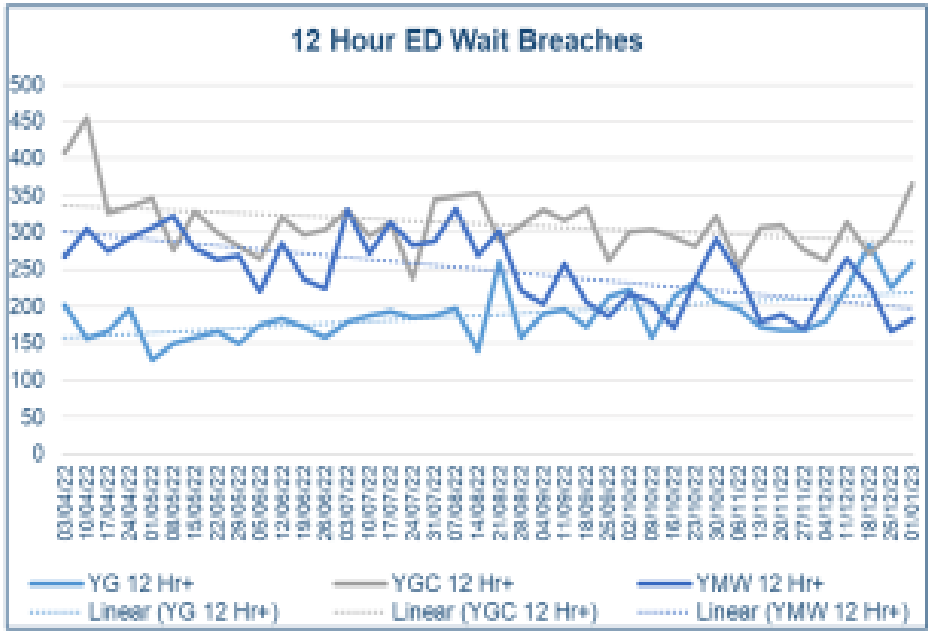
Date 17/10/2022 02/01/2023

Hospital: Ysbyty Gwynedd; Ysbyty Glan Clwyd; Wrexham Maelor Hospital

	17/10/2022	24/10/2022	31/10/2022	07/11/2022	14/11/2022	21/11/2022	28/11/2022	05/12/2022	12/12/2022	19/12/2022	26/12/2022	02/01/2023
Major ED Attendances	715	642	717	741	735	706	722	696	640	615	653	311
Minor ED Attendances	378	429	330	352	357	405	434	418	447	377	371	185
Average Time to Triage (mins)	36.9	52.9	36.7	37.9	42.7	36.9	49.1	77.3	62.9	40.6	39.4	51.6
Average Time to ED Clinician (mins)	199.4	286.1	254.1	240.2	227.6	263.6	298.9	345.8	255.1	176.8	194.5	165.1
4 Hour Performance	44.6%	45.1%	51.9%	60.4%	54.4%	47.1%	49.6%	40.9%	48.5%	59.2%	54.4%	52.0%
12 Hour Breaches	223	307	210	171	198	178	244	269	215	163	172	63
More Than 21 LoS	197	213	191	167	171	169	162	166	176	176	158	171
% Occupancy > 21 LoS	18.8%	19.9%	16.9%	14.9%	15.7%	15.6%	14.9%	15.4%	16.6%	16.5%	17.5%	19.6%
Less Than 21 LoS	850	857	940	952	916	915	925	911	882	891	746	702
% Occupancy < 21 LoS	81.2%	80.1%	83.1%	85.1%	84.3%	84.4%	85.1%	84.6%	83.4%	83.5%	82.5%	80.4%
ED Left Without Being Seen	168	232	158	152	168	178	261	279	204	125	148	79

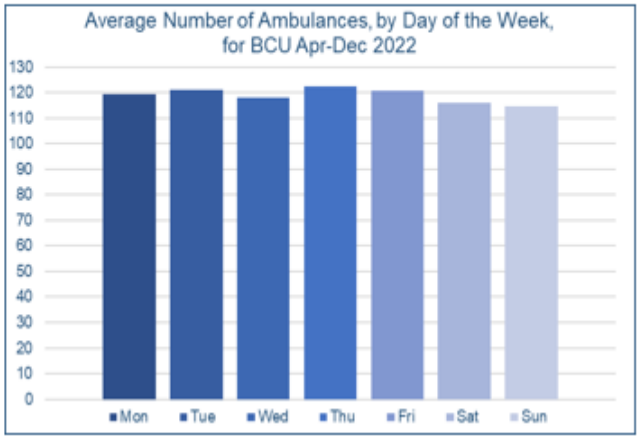
Weekly Number of 12 Hour Wait Breaches in ED, for BCU and by Site, to 01.01.2023

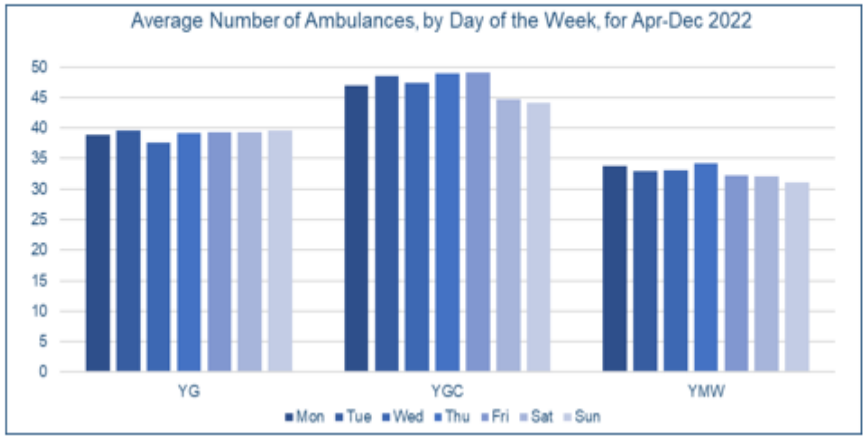




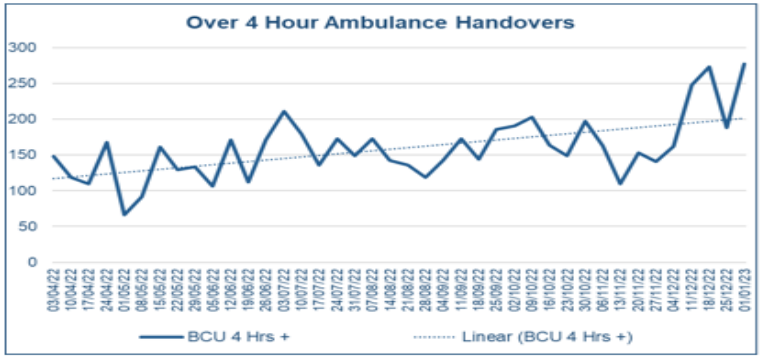
- Overall trajectory is for decreasing numbers of 12 hour wait breaches in ED (this trend is the same when breaches are observed as a proportion of total attendances)
- Centre and East linear trajectories are decreasing
- Centre has the higher number of breaches
- West linear trajectory is increasing

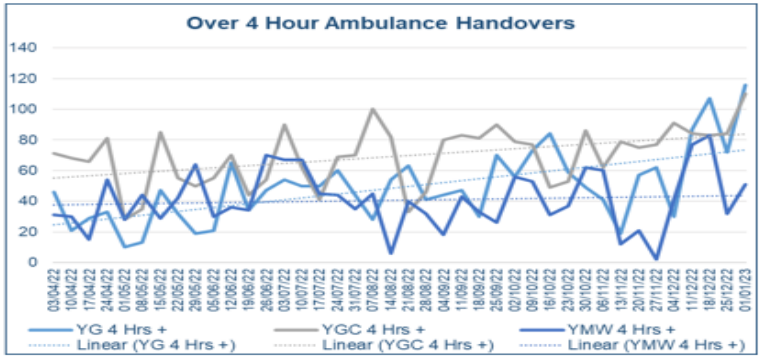
Average Number of Ambulance Conveyances by Day of Week for BCU and by Site to 31.12.2022



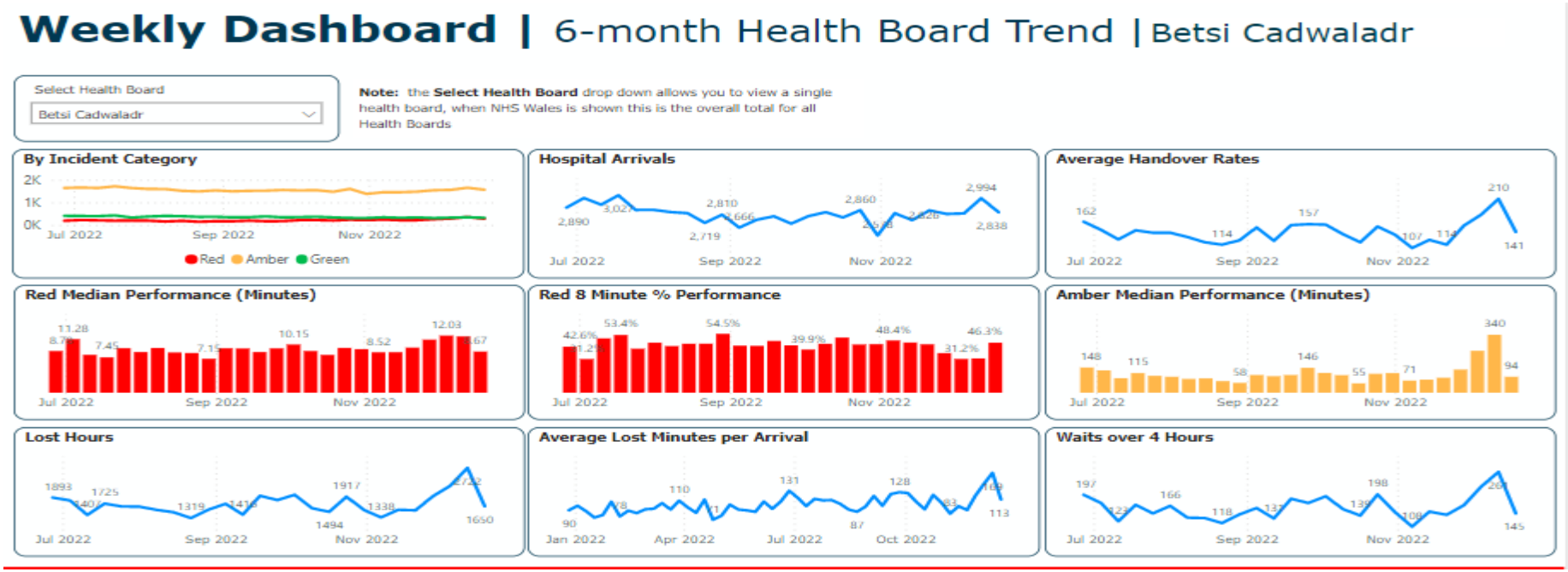


Weekly Number of Ambulance Handover Delays, Over 4 Hours, for BCU and by Site, to 01.01.2023



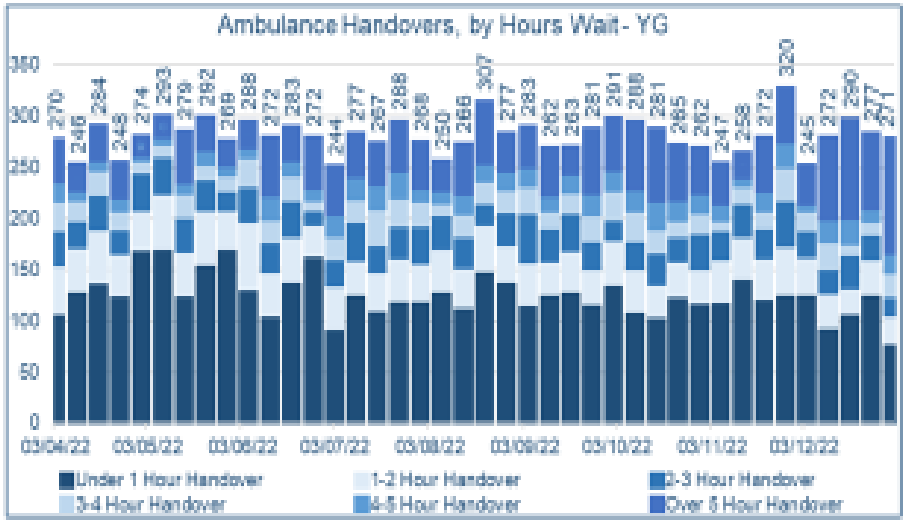


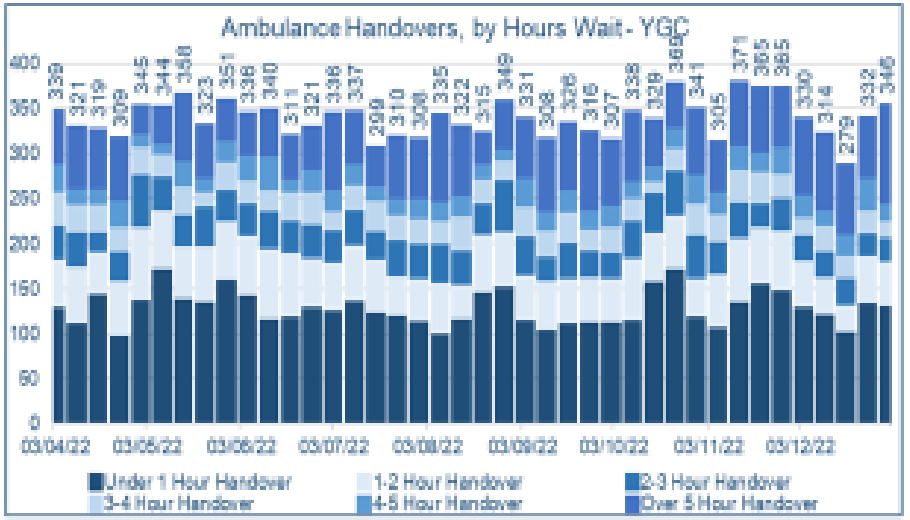
- Overall trajectory is for increasing number of ambulance handover delays of 4 hours or more
- West, Centre and East linear trajectories are all increasing
- West have the sharpest increase, with December performance affecting the trajectory quite significantly

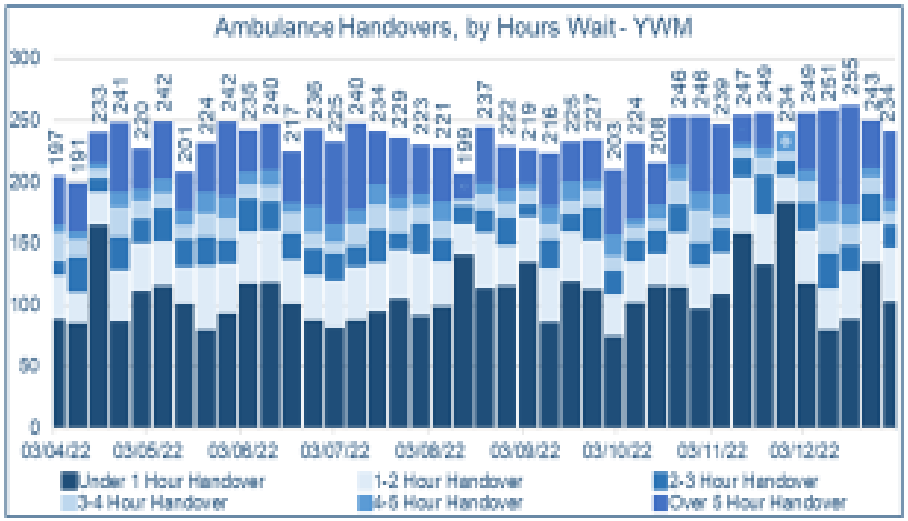


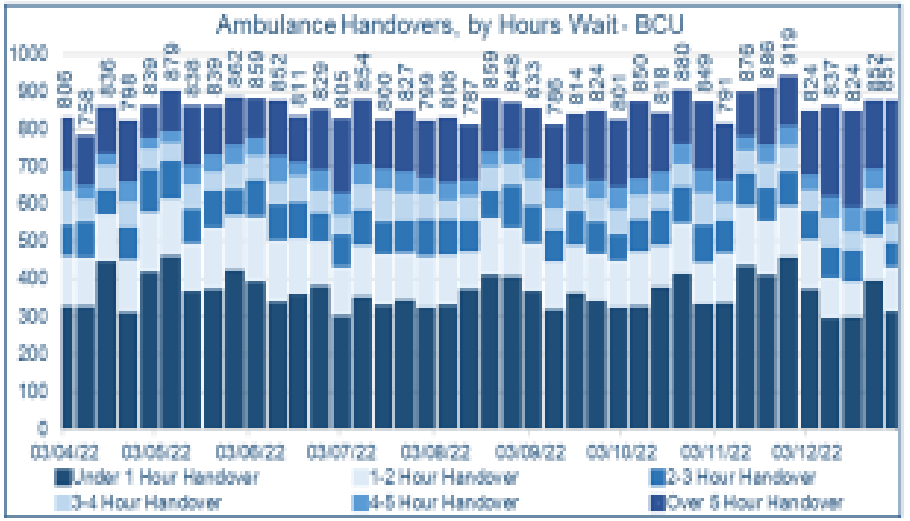
Red release BCUHB:

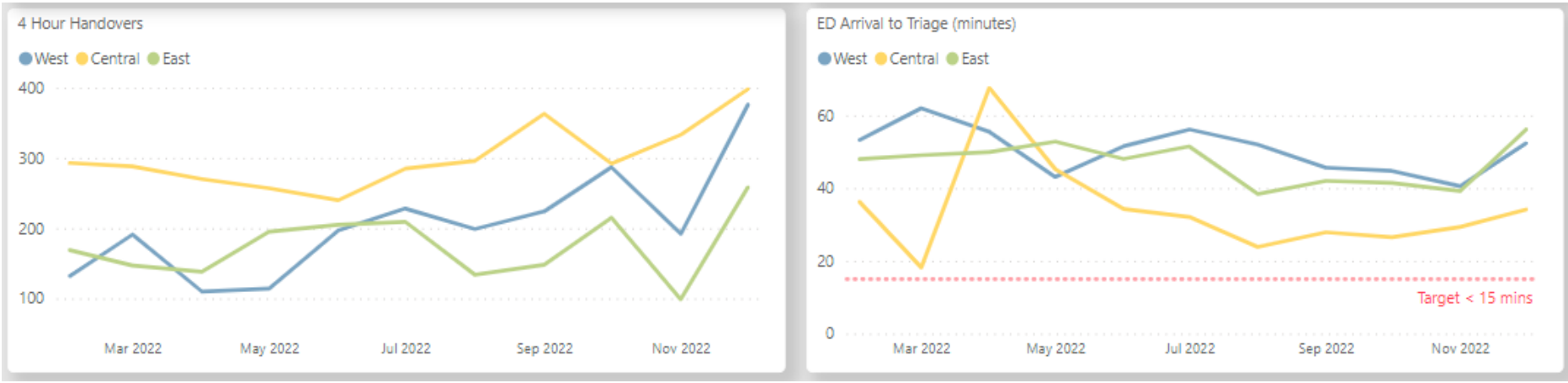
Weekly Number of Ambulance Handovers, by Handover Time, for BCU and by Site, to 01.01.2023










4 Hour Handovers
West
Central
East
400
300
200
100
Mar 2022
May 2022
Jul 2022
Sep 2022
Nov 2022
ED Arrival to Triage (minutes)
West
Central
East
60
40
20
0
Target < 15 mins
Mar 2022
May 2022
Jul 2022
Sep 2022
Nov 2022

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

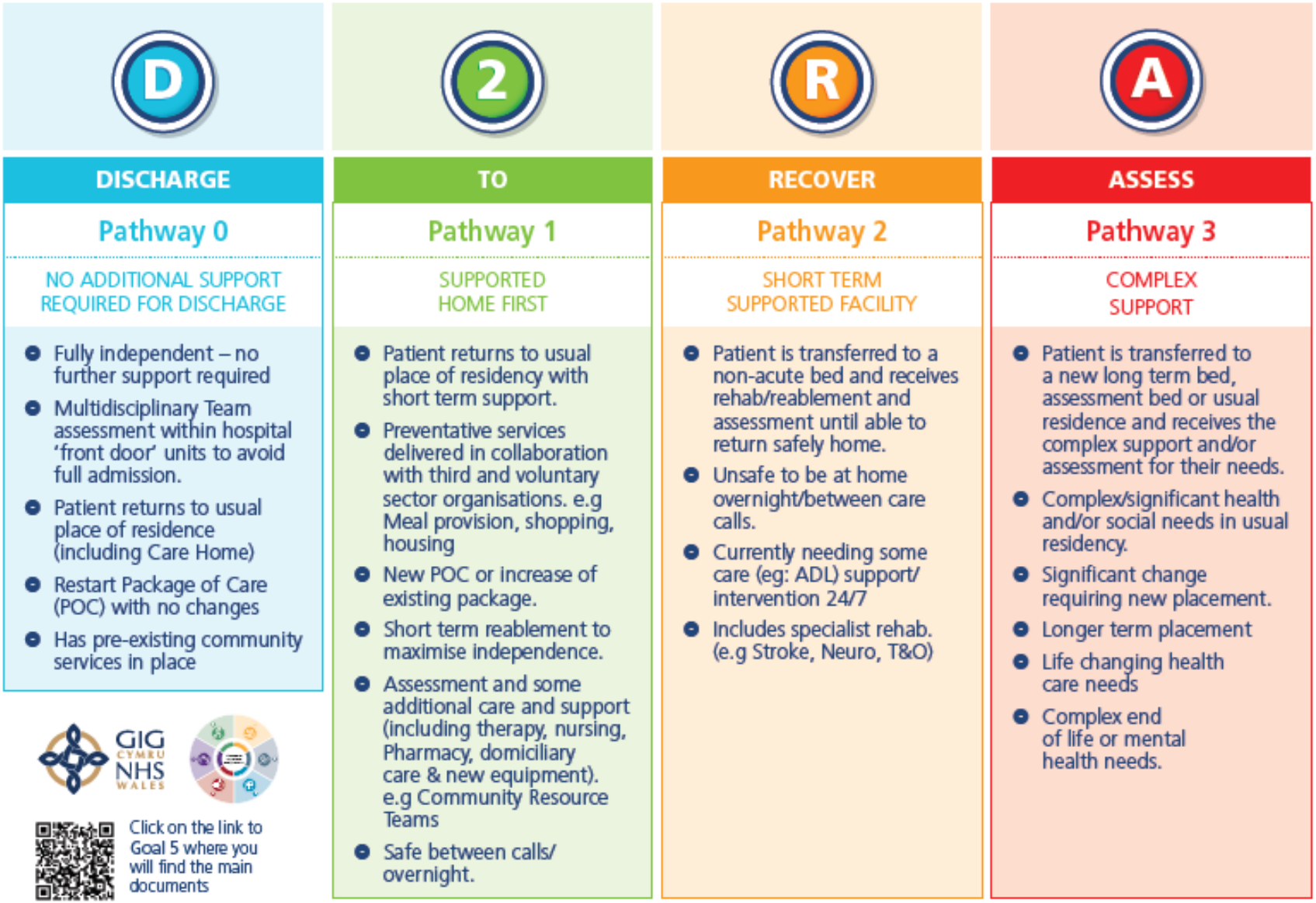
Number of Medically Fit for Discharge Patients Acute & Community Hospitals – North Wales

Date	Pathway 0 Voluntary sector support	Pathway 2 Discharge own home	Pathway 3 Discharge step down bed	Pathway 3a stepdown / step up (covid +)	Pathway 4 Existing Care Home placement	Court of Protection delays	No awtg packages of care (D2RA)	No of people awaiting permanent Care Home placement	No awaiting equipment/ adaptations	No awaiting packages of care	No of patients awaiting permanent Care Home placement	Other	Total
02/08/2022	0	30	82	0	10	4	101	60	2	9	33	2	333
09/08/2022	0	31	70	0	11	1	99	54	2	11	28	2	309
16/08/2022	0	29	70	0	10	2	99	58	3	11	36	4	322
23/08/2022	0	24	58	0	16	2	97	42	1	14	31	2	287
30/08/2022	0	22	39	0	11	3	92	41	2	17	30	1	258
06/09/2022	0	21	44	0	11	1	105	44	1	13	37	2	279
13/09/2022	0	20	50	1	11	2	97	42	0	14	33	0	270
20/09/2022	0	15	34	0	1	0	96	43	0	4	30	0	223
27/09/2022	0	28	43	0	9	0	91	37	5	13	36	2	264
04/10/2022	0	29	39	0	17	0	82	47	6	7	38	0	265
11/10/2022	1	27	31	2	5	0	100	53	4	14	28	0	265
18/10/2022	1	31	45	1	9	1	95	64	2	14	28	1	292
25/10/2022	0	25	34	2	9	0	77	69	6	8	22	4	256
01/11/2022	0	28	46	0	8	1	79	68	2	4	22	2	260
08/11/2022	0	27	27	0	8	0	87	62	2	9	18	1	241
15/11/2022	0	14	38	1	9	0	87	59	0	10	13	4	235
22/11/2022	1	20	34	0	3	0	83	59	4	12	27	1	244
29/11/2022	0	28	43	0	5	0	102	53	7	15	25	2	280
06/12/2022	0	18	38	0	7	0	103	57	3	12	24	1	263
13/12/2022	0	22	50	0	5	4	102	52	4	11	17	0	267
20/12/2022	0	17	51	0	3	2	121	44	3	8	16	1	266
03/01/2023	0	21	54	0	6	0	67	44	9	5	21	3	230

Note: Submission not required by WG Delivery Unit 27th Dec. Total MFFD reported by IHCs (un-validated) = 204 **Average MFFD Total from 02/08/22 = 269**

Source: Once weekly data submitted to Welsh Government

3


D
2
R
A
DISCHARGE
Pathway 0
NO ADDITIONAL SUPPORT REQUIRED FOR DISCHARGE
Fully independent – no further support required
Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission.
Patient returns to usual place of residence (including Care Home)
Restart Package of Care (POC) with no changes
Has pre-existing community services in place
TO
Pathway 1
SUPPORTED HOME FIRST
Patient returns to usual place of residency with short term support.
Preventative services delivered in collaboration with third and voluntary sector organisations. e.g Meal provision, shopping, housing
New POC or increase of existing package.
Short term reablement to maximise independence.
Assessment and some additional care and support (including therapy, nursing, Pharmacy, domiciliary care & new equipment). e.g Community Resource Teams
Safe between calls/ overnight.
RECOVER
Pathway 2
SHORT TERM SUPPORTED FACILITY
Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to return safely home.
Unsafe to be at home overnight/between care calls.
Currently needing some care (eg: ADL) support/ intervention 24/7
Includes specialist rehab. (e.g Stroke, Neuro, T&O)
ASSESS
Pathway 3
COMPLEX SUPPORT
Patient is transferred to a new long term bed, assessment bed or usual residence and receives the complex support and/or assessment for their needs.
Complex/significant health and/or social needs in usual residency.
Significant change requiring new placement.
Longer term placement
Life changing health care needs
Complex end of life or mental health needs.
GIG CYMRU NHS WALES
Click on the link to Goal 5 where you will find the main documents

S A F E R

Is the **Right Patient,** in the **Right Place,** having the **Right Care, first time?**

SEEN

SEEN BEFORE MIDDAY

Key Staff Questions:

- Clear actions and accountability with a timeframe?
- Patient waiting for a diagnostic/ treatment? Can this happen today, if not, why not?
- Is the patient clinically optimised for discharge or transfer?
- A senior support structure in place for escalation.

AIM

WHAT MATTERS TO ME?

Key Patient Questions:

1. What do you think is wrong with me? (Diagnosis)
2. What is going to happen to me today? (Tests, interventions etc.)
3. What is needed to get me home, and is there anything I can do to help? (Clinical criteria for discharge and Recovery Plan)
4. When can I go home? (EDD) Patient, family/ carers involved in care planning.

FLOW

RIGHT BED FIRST TIME

Prepare for early morning transfer to wards

- Front door, can admission be avoided?
- All patients on correct D2RA pathway?
- Identification of patients requiring supported discharges.
- Review discharges daily
- Are tomorrow's discharges planned?
- Patients discharged at earliest opportunity – Each day a green day.

EARLY DISCHARGE

HOME FOR LUNCH/ASAP

Ward battle rhythm set?

- Prioritise patients being discharged today.
- Pharmacy to be on board round to review medications?
- Link with Family, Friends, Carers to arrange transport.
- Key/ keycode available?
- Book patient transport service if no alternative.
- Identify, clear actions and accountability with a timeframe to avoid delays

RECOVERY

WHAT MATTERS TO ME?

- Discussion with patient on recovery goals and expectations and plan updated regularly?

Can they go home?

- Stakeholder communication: Think GPs, DNs,3rd sector, Community Services, Social Workers.
- Right support for recovery? Think : AHP, social worker, carer, volunteer support.

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Click on the link to Goal 5 where you will find the main documents

SAFER ENABLERS • Get up, Get Dressed, Keep Moving • Board Rounds • Huddles • Red2Green • Discharge Lounge • Community Liaison • Integrated Hubs (Single Point of Access)

RED TO GREEN

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

A DAY OF NO VALUE

KEY QUESTIONS

1. Can the patient care or interventions received today be delivered at HOME or in a non-acute setting? **YES – It's a RED DAY**
2. If I saw the patient in an outpatient setting, would their current 'physiological status' require an emergency admission? **NO – It's a RED DAY**

- Inadequate MDT presence at the Board Round to allow firm decisions to be made.
- The care or interventions the patient is receiving today could be delivered in a non-acute setting.
- Tests and investigations have occurred but the results have not been reviewed by the Medical team and acted upon.
- A planned investigation, clinical assessment, discharge assessment or therapy intervention for today does not occur.
- Acute - The medical care plan lacks a Senior Medic approved expected date of discharge.
- Acute - The patient is a new admission and has not yet had a medical review/there is no initial diagnosis/treatment plan.
- If a patient is due for discharge today and the discharge prescription medications are not ready (Pathways of Care Delay).
- Transport delaying discharge or causing plans to fail today.

A DAY OF VALUE

- Patient progresses towards discharge
- Everything planned and requested is done
- Patient needs this bed for Acute care

- Everything that was planned for today gets done
- The patient requires acute hospital care
- The patient requires community hospital care
- The results from tests and investigation have been reviewed by the Medical team and acted upon
- The patient is receiving active interventions to get them to be discharged by tomorrow, and the discharge prescription medications are ready by the evening before the expected date of discharge.

PREVENT DECONDITIONING

"Get Up, Get Dressed and Keep Moving"

PREVENT & IDENTIFY DECONDITIONING

- Is the patient at high risk of deconditioning?
- What is the patient's level of mobility/ bladder and bowel control/ cognitive function?
- Has there been a change in the patient's mobility/ bladder and bowel control/ cognitive function?
- Has there been a conversation with the patient and family/ carers on what they can do to prevent deconditioning and why it is important?

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

PROMOTE FUNCTIONAL ACTIVITY

- Patients should be enabled and encouraged to get out of bed, sit out in a chair and mobilise everyday if clinically able to do so
- Patients should be encouraged to wash and dress themselves when possible or with as minimal assistance as required
- The clinical environments should promote functional activity and mobility (chairs at the bedside, corridors kept clear of clutter)
- Enable and encourage patients to mobilise to the toilet and/or bathroom to use the facilities
- If patients require their glasses or a walking aid to mobilise, ensure they are within easy reach
- Encourage patients to sit out for lunch

CONTINENCE MANAGEMENT

- Patients should be encouraged and supported to use toilet facilities if clinically able to do so
- The use of bedpans and commodes at the bedside should be actively discouraged to ensure patient dignity and encourage mobility
- The use of incontinence products such as pads should be discouraged for patients with bowel/ bladder control – including at night-time
- Promote and support good nutrition and hydration
- Record bowel movements and prevent, identify and manage constipation as early as possible

COGNITIVE FUNCTION

- Focus on delirium prevention
- Ensure mechanisms are in place to orientate patients to time, date and day
- Promote establishing a day and night routine in the clinical environment
- Promote activities that will provide cognitive stimulation and social interaction in clinical areas
- With the patient's permission, promote involving family, friends and carers in their care to prevent deconditioning and delirium – review visiting times to facilitate this
- Promote and support good nutrition and hydration- monitor and record intake
- Patients with an acute change in cognitive function should be screened for delirium
- Patients that are delirium positive should have a medical review and a holistic management plan in place, including a medication review and appropriate pharmacological management of delirium

DECONDITIONING STARTS WITHIN HOURS – PREVENTION IS EVERYONE'S BUSINESS

Deconditioning is a complex process of physiological change following a period of inactivity, bedrest or sedentary lifestyle. It results in functional losses in areas such as mental status, degree of continence and ability to accomplish activities of daily living. (Gillis et al 2005)

Teitl adroddiad: ***Report title:***	Planned Care Status Report
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 19 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide partial assurance to the Health Board (HB) with the progress of the Planned Care (PC) programme in line with Welsh Governments' programme to modernise PC services and decrease waiting lists. Previous updates to PFIG have described the challenges facing BCUHB in relation to the delivery of Planned Care (PC) services, and specifically the large number of patients waiting for a new outpatient appointment, or a planned intervention/treatment, many of whom have been waiting in excess of 52 weeks and some more than 104. The origins of this precede Covid, but the pandemic has exacerbated the position significantly. After several months, where the total waiting list rose, we have seen it plateau in the last few weeks. The validated position stands in excess of 170,000, as of 9th December 2022, with 32,605 waiting over 52 weeks and 13,281 waiting over 104 weeks. The focus from Welsh Government (WG) is on the transformation of PC across Wales to drive down waiting times for our patients and reduce the number of patients waiting in excess of 52 and 104 weeks. With plans to transform PC services, WG has mandated 2 ministerial priorities for this financial year: 1. No patients should be waiting more than 52 weeks for their first outpatient appointment (Stage 1) by the end of December 2022. 2. No patients should be waiting more than 104 weeks for any stage of their pathway by the end of March 2023. This paper details the Planned Care Programme's actions to date, with next steps for the programme inclusive of the governance framework established, rigour and accountability put in within the performance arm of the programme with the performance team, its transformation agenda, and the commencement of planning for next financial year's IMTP.
Argymhellion: ***Recommendations:***	PFIGC is asked to note the partial assurance of the PC programme recognising that the delivery of this programme is vast and will take time in delivering the key objectives - reduction in waiting lists expected due to the volume of patients waiting and in transforming PC services. Additionally, partial assurance is given due to the unknown impact at this time of the impending industrial action and operational pressures to be faced over the winter months.

	In supporting the PC recovery program is it important that all stakeholders have clear visibility of the challenge and their progression of meeting the challenges, this with the tools e.g., dashboards to facilitate service delivery.			
Arweinydd Gweithredol: ***Executive Lead:***	Gill Harris – Acting Chief Executive			
Awdur yr Adroddiad: ***Report Author:***	Co Authors: Nikki Foulkes, Acting Associate Director Planned Care/Andrew Kent, Interim Subject Matter Expert: Planned Care/Andrew Oxby, Interim Subject Matter Expert: Outpatients			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This paper aligns to the Health Boards strategic goal of reducing the number of patients waiting.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not Applicable			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not Applicable			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not Applicable			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF Risk 1.5 - Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm			

Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Please refer to detail in report.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Please refer to detail in report.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Planned Care programme is reported at the Planned Care Recovery and Transformation Group (PCRTG), Executive Delivery Group (EDG): Transformation and Performance, Finance, and Information Governance Committee (PFIGC).
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF Risk 1.5 - Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*	

PFIG Committee
19.1.23

Planned Care Programme Update
1. Introduction/Background

1.1. Previous updates to PFIG have described the challenges facing Betsi Cadwaladr University Health Board (BCUHB) in relation to the delivery of Planned Care (PC) services, and specifically the large number of patients waiting for a new outpatient appointment, or a planned intervention/treatment, many of whom have been waiting in excess of 52 weeks and some more than 104. The origins of this precede Covid, but the pandemic has exacerbated the position significantly.

After several months, where the total waiting list rose, we have seen it plateau in the last few weeks. The validated position stands in excess of 170,000, as of 9th December 2022, with 32,605 waiting over 52 weeks and 13,281 waiting over 104 weeks. The focus from Welsh Government (WG) is on the transformation of PC across Wales to drive down waiting times for our patients and reduce the number of patients waiting in excess of 52 and 104 weeks. With plans to transform PC services, WG has mandated 2 ministerial priorities for this financial year;

- No patients should be waiting more than 52 weeks for their first outpatient appointment (Stage 1) by the end of December 2022.
- No patients should be waiting more than 104 weeks for any stage of their pathway by the end of March 2023.

For BCUHB, as previously indicated there are three distinct but inter-dependant stages: Restart, Recovery and Sustainability. The first has commenced, with varying degrees of completeness whilst PC are concurrently focusing on recovering the activity levels of 2019/20 and developing plans that will provide sustainability for PC services through transforming pathways, the manner in which we see and treat patients, which will see the waiting list decrease further.

The PC Programme has been designed to support teams in meeting the underlying demand and capacity deficit whilst reducing the backlog, as reflected in the IMTP. Key principles have been adopted and developed further inconjunction with future job planning being aligned to service demand.

PC should not be seen in isolation from the Unscheduled Care agenda, together with the exeptional winter pressures that are anticipating mean that progress in reducing the waiting list backlog will continue to be a risk.

2. Body of report

2.1 Strategy Implications

PC's strategic direction, is in align with the National programme, and its service delivery is a key business and safety objective for BCUHB. As previously reported the PC Recovery Plan is a combination of transactional (operational) and transformational (developmental) initiatives to enable BCU to decrease our waiting times and ensure our patient services are sustainable. Inclusive of: Validating and cleansing our Patient Tracking Lists (PTL),

realigning and increasing our capacity to meet demand, whilst transforming patient pathways and ensuring we are communicating effectively with our patients and staff. This has been supported by revising the Corporate Access meeting to ensure accountability and monitoring performance against the Key Performance Indicators (KPI)s. With the implementation of a Business Intelligent (BI) dashboard that demonstrates our performance against agreed trajectories to ensure visibility of performance to progressing the PC transformation programme further and planning for 2023/24.

2.2 Update on key projects;

a) Validation – we continue to work with the External (HBSUK) Company, in validating the patients that are on our waiting lists. HBSUK had indicated 10% - 20% patients would be removed from our waiting lists. However, the latest position is 4% of Stage 1 patients have been removed after being administratively validated.

b) SOS/PIFU – the roll-out of the SOS/PIFU continues across 10 priority areas, as suggested by WG. We continue to monitor the adoption and progress of these 10 areas to meet the 20% target by March 2023, which has been incorporated at Corporate Access. SOS/PIFU is an enabler in reducing our Follow-up waits, which we have factored into our Follow-up Reduction Programme that is being drafted.

c) Virtual consultation – Work continues to be deployed with this project, with a dedicated project manager to work with Informatics and byTech Cymru to give a national picture of video consultation volumes by speciality. We have been informed this will be available in December 2022.

d) Outpatient Efficiencies – whilst the focus has been to embed the principles of efficient outpatient clinics, inclusive of clinic utilisation and ensuring clinics are fully booked. We have turned our direction to other principles – Did Not Attend (DNA) specifically those patients who have not been discharged and the Follow Up waiting list, whilst not losing sight of initial elements focused upon.

e) Patients who have DNA’d their appointment and have not been discharged, not only impact on our available capacity but also creates additional work for our administrative teams and our ability to ensure patients are Treated in Turn. The scope of the DNA not discharged and improvement project will be instigated on appointment of a deputy medical director, with this project as part of their portfolio and supported by the Outpatients SME. Figure 1 demonstrates the current DNA position at a BCU level.

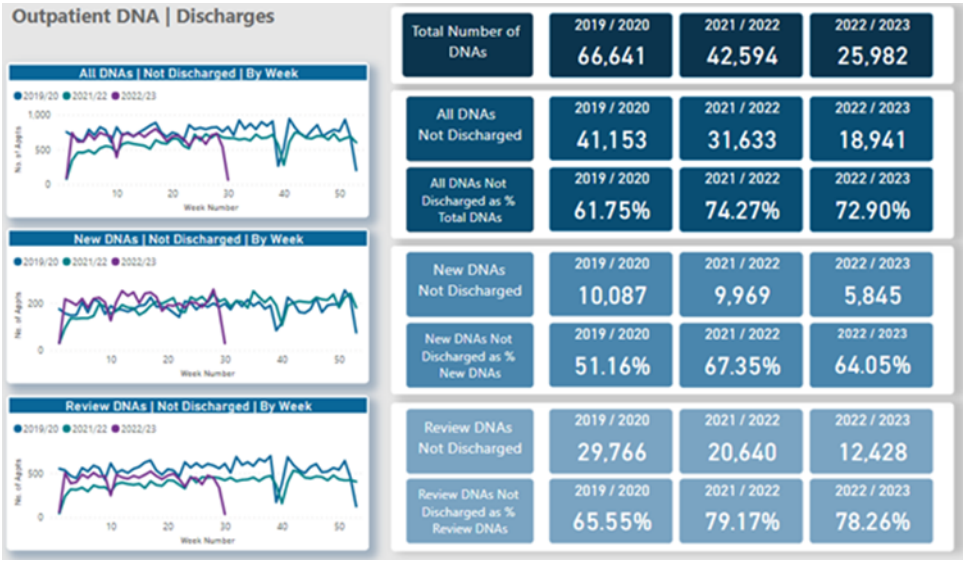
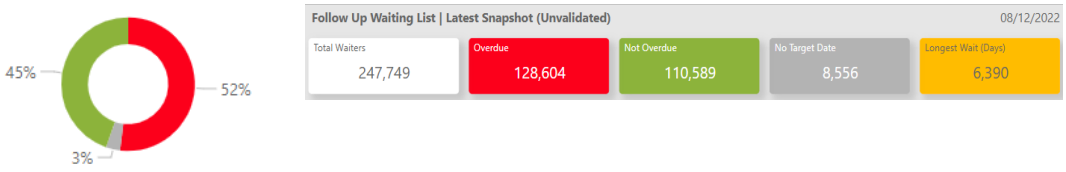


Figure 1

f) Follow-up Reduction Programme - According to WPAS (8th December 2022) the HB has 247,749 patients waiting for a follow-up appointment, of which 52% have breached their target follow-up date as can be seen in figures 2 and 3.



Figures 2 & 3

As the decision to discharge is a clinical one, the Outpatients SME is creating a follow-up reduction programme that will be designed by December 2022 when it will be presented for clinical endorsement and request for a clinical SRO. This will also be included into the Planned Care Transformation Programme 2023/24.

g) My Planned Care - a national initiative similar continues to progress with the launch of the 111 Planned Care Platform. We have reviewed our waiting times in readiness to be communicated via this initiative. With this and a Frequently Asked Questions (FAQ)s crib sheet which we will be sharing when we communicate this initiative with our staff via the PC Intranet page and our patients through this platform. The second phase will include links to National and locally recognised websites for supporting our patients whilst they wait. This is expected to be available in January 2023.

h) Additional Capacity – created through partnerships with Independent providers continues with outsourcing. However, Insourcing commences 10th December 2022. Due to a delay, due to circumstances outside our control we have had to delay full mobilisation to significantly decreasing the 'usual' mobilisation timeframe. Consequently, we have planned a smaller plan through adopting a PDSA methodology to ensure patient safety is maintained. On this basis, there will be clinics held to see our longest waiting stage 1 Orthopaedic and Colorectal patients at Ysbyty Gwynedd.

2.3 GiRFT/Clinical Pathways

GIRFT programme continues with Urology, which we are waiting for the observation report to come back. This cycle continues with General Surgery's deep dive 20th December and finally date to be confirmed for Ophthalmology's deep dive in quarter 4 with services (Orthopaedics and Gynaecology) working with the GiRFT team on implementing recommendations made.

2.4 Modular Theatres

A new development is being explored which has the potential to reduce the lead time for RTC construction by using mobile modular units for orthopaedics. Site visits are being undertaken with the relative teams and the business case has been adjusted to reflect these developments.

2.5 Ministerial Priorities

Performance against the two ministerial priorities continues to be monitored through the internal performance assurance framework and externally with monthly PC recovery meetings with WG. Whilst we are not performing against the trajectories we devised at the quarter 1 refresh. We are performing to the forecasts we devised which can be demonstrated below in Figures 4, 5, 6 and 7 with the expected number of breaches forecasted at the end of each target date;

Figure 4 & 5

Figures 4 and 5 highlights the position against the 52 week target (December 2022), which shows our waiting lists are decreasing as we see our patents for their first outpatient appointment.

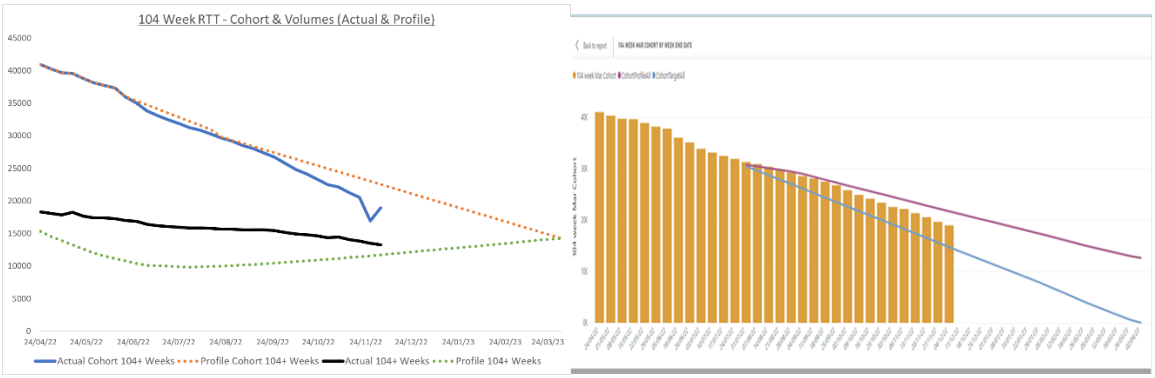


Figure 6 & 7

Figure 2 highlights the position against the 52 week target (December 2022), which shows our waiting lists are decreasing as we see our patents for any stage of their pathway.

2.6 Cancer

A cancer strategy for BCUHB is being written, which is aligned with the Welsh cancer plan. This strategy is inclusive of programmes of work for the next 3-5 years, with supporting themes of work from prevention to end of life care. Priority areas to improve performance continues within Urology and Colorectal. The straight to test (mpMRI) continues for Urology patients whilst we continue the implementation of the endoscopy business case to increase capacity and reduce waits.

2.7 IMTP 2023/24

The IHC corporate D&C Confirm and Challenge meetings have taken place, the outputs from these meetings are now being cross referenced with the HR position for each speciality, IMTP Schemes submitted and any GiRFT or speciality reports that have taken place. It is expected that a demand and capacity planning paper will be presented to PCRTG, prior to being submitted to PFIG.

3. Risk Management

3.1 The underlying risk score associated with the backlog of patients on the waiting list remains unchanged currently at 25, but the current score is based on actions to date and has been revised to 20. The various actions are designed to mitigate and reduce the risk, but it needs to be recognised that none of these will provide immediate solutions, and despite best endeavours, operational pressures may still affect progress.

4. Equality and Diversity Implications

4.1 The PC programme is designed to address health inequalities and facilitate the Board's socio-economic duty by stream-lining process, transforming services and reducing waiting lists

Teitl adroddiad: ***Report title:***	**Summary of business considered in private session to be reported in public**			
Adrodd i: ***Report to:***	Performance, Finance and Information Governance Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Thursday, 19 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The Finance, Performance and Information Governance Committee considered the following matters in private session at the October and December 2022 meetings • Contract extension • Business cases : Orthopaedics, Refurbishment works • Appointment of external support to Nuclear Medicine project • Various accommodation and lease agreements • Tender approval • Agreement to commission new tender			
Argymhellion: ***Recommendations:***	The Committee is asked to note the report			
Arweinydd Gweithredol: ***Executive Lead:***	Steve Webster Interim Executive Director Finance			
Awdur yr Adroddiad: ***Report Author:***	Diane Davies Corporate Governance Manager			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not required for a report of this nature. Items discussed in private session are supported by appropriate documentation.
Rheswm dros gyflwyno adroddiad i bwyllgor cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential Committee (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Advised in private session reports where appropriate	
Rhestr o Atodiadau: Dim	

List of Appendices:
None