Bundle Finance Committee 26 May 2020

5.1 COVID-19 Financial Reporting and Forecasting Principles

Presenter: Rebecca Hayes

5 1 COVID-19 Financial Reporting and Forecasting Principles - Month 1 2020-21 SBAR.docx

5 1 Appendix 1 COVID-19 Financial Reporting and Forecasting Principles Report.docx

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR CYLLID
FINANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	26 May 2020
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	COVID-19 Financial Reporting and Forecasting Principles
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Rebecca Hayes, Senior Finance Business Partner

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Ar Gyfer Trafodaeth/For Discussion

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The purpose of the report (Appendix 1) is to outline the Health Board's approach to the internal and external reporting and forecasting of the financial implications arising from the response to the COVID-19 pandemic, which will be submitted to the various stakeholders in financial governance and assurance, as well as being included as a response in the "Financial Implications" section of the Q1 Operational Plan requested by Welsh Government (WG).

Cefndir / Background

Guidance has been received from WG outlining the external expectations of the organisation's ability to record and report the costs incurred in the local response to COVID-19 pandemic - both gross and net costs (ie. costs exceeding available funding).

WG have provided a monitoring template, which constitutes a monthly reporting requirement for 2020/21. Recording and reporting mechanisms that are implemented locally will need to conform by design to this requirement, as well as to any further internal requirements.

Asesiad / Assessment

The high level principles are expected to be relatively fixed, subject to material changes in guidance from WG. The methodology utilised in delivering the reported output however, is expected to evolve and to be refined, especially in the first quarter of the year. This is due to the pace at which the organisation has needed to respond to COVID-19 and the fluidity of plans as the situation progresses.

Argymhelliad / Recommendation

The Finance Committee is asked to note the reporting principles and to discuss and agree an appropriate Forecasting Framework, as detailed in the "Forecasting" section. This will be noted as a fundamental update to the finance assurance and framework principles, given the significant impact COVID-19 has brought to the Health Board, its staff and patients.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	N/A
Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	All Health & Care Standards Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners. 5. Deliver, as a minimum requirement, outcome and delivery framework work targets and specifically eliminate the need for unnecessary travel & waiting times, as well as return the organisation to a sound financial footing over the lifetime of this plan
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	COVID 19 – Decision making & Financial Guidance
Rhestr Termau: Glossary of Terms:	Included within the body of the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw : Parties / Committees consulted prior to Gold Strategic Group:	Not Appicable

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial values noted within the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Not Applicable
Gweithlu: Workforce:	Not Applicable
Risg: Risk:	Financial risk is highlighted within the report
Cyfreithiol: Legal:	Not Applicable
Enw Da: Reputational:	Not Applicable
Gyfrinachedd: Privacy:	Not Applicable
Cydraddoldeb: Equality:	Not Applicable

Key Principles

Appendix 1: COVID-19 Financial Reporting and Forecasting Principles Report

The overarching principles described in the guidance received from Welsh Government are:

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

There is a need for the ability to articulate both:

- the **gross** costs incurred in response to COVID-19 (being the total cost of additional purchases/ resources incurred extraordinarily - for example additional ventilators - plus the cost of diverting existing resources to the response to COVID-19, therefore not delivering a 'business as usual' activity); and
- the **net** ("additionality") costs incurred in response to COVID-19 (being costs incurred in excess of the Health Board's available funding).

At a high level, this would mean:

- The need to track both the additional costs arising from COVID-19 and reductions in expenditure (i.e. reduced elective activity).
    - Financial information must be auditable, evidenced and supported by documentation of key decisions;
    - There will be no draw-back of underspends against ring-fenced allocations where the funds are diverted to the COVID-19 response;
    - ICF funds should be collectively re-purposed (with Local Authorities) to support discharge to the community;
    - Costs of significant programmes co-ordinated on a 'Once for Wales' basis will be centrally funded;
    - Any specific additional costs incurred above the core allocation will require a submission to WG explaining the nature and likely timeframe of the cost and why it cannot be met within the existing allocation.
- Decisions to commit resource to COVID-19 must be robust and appropriate, with Value for Money considered.
    - Proposed service delivery solutions in response to COVID-19 must have appropriate NHS Indemnity arrangements and advice from the Welsh Risk Pool;
    - Quotations and tender processes under Standing Financial Instructions (SFIs) may not be possible, but any new arrangements must be clearly documented and decision making justifiable.
- No new revenue business investments should be progressed unless related to the response to COVID-19 or with express WG permission.
    - It is recognised that delivering savings will not be prioritised unless they are supportive of the current situation. Organisations should review and identify which schemes will and will not continue;
    - Organisations are expected to provide a clear assessment of their forecast outturn position, having considered non-delivery of planned savings and other variables.
- Primary Care contractors:
    - Organisations must protect contractors' income under existing contractual arrangements if routine contracted work has to be substituted;

Key Principles

- WG will reimburse any additional costs in relation to COVID-19.

Key Principles

Defining Gross and Net ("Additionality") Costs

Gross costs

The total cost of the COVID-19 pandemic, inclusive of:

- All management time in all clinical settings in terms of managing the response to COVID-19;
- Management time in Corporate directorates, where a large number of staff have been deployed to manage specific responses to COVID-19 such as the commissioning of Field Hospitals, demand modelling, managing the supply of PPE, working with Local Authorities and Third Sector organisations, supporting workforce in roster planning and payroll in the recruitment of in excess of 750 additional fixed term and bank staff;
- Where services ceased during Month 12 in response to COVID-19, the only reduction to costs would have been in relation to Non-Pay – the staffing models continued to operate, at a minimum, on a business as usual (BAU) basis with the expectation of a sharp and imminent increase in COVID-19 patients;
- The impact of covering COVID-19 related sickness absence and staff self-isolating and unable to perform normal duties.

Net costs

This is defined as the additional costs relating to COVID-19 incurred above the financial resources of the Health Board for the year.

This relates to costs over and above **or** lower than 'business as usual'. This would include:

- Additional shifts worked by a member of staff as a direct result of COVID-19 (whether due to demand or sickness/ self-isolation issues). This may be as a result of ad hoc requirements or more formally on a COVID-19 roster;
- Changes to a staff member's pay (such as acting up or unsocial hours enhancements) in direct response to COVID-19 as a result of a COVID-19 roster;
- Non-delivery of savings due to COVID-19;
- A reduction in expenditure due to activities ceasing in response to COVID-19, for example a reduction in prosthetics within Planned Care.

It would **not** include:

- The cost of a member of staff diverted to duties in response to COVID-19 that does not materially amend their pay entitlement – for example, where the shift pattern is the same as 'business as usual'.

Reporting Mechanisms

Given the pace at which the organisation has needed to respond to COVID-19 and the fluidity of plans as the situation evolves, it is not possible at this time to report to the level of accuracy and depth required. Therefore it is proposed to adopt a phased approach, which will be implemented as the granularity of the reporting is developed over Quarter 1.

Key Principles

Pay

The overarching principle is to only charge additional (net) costs to COVID-19 cost centres.

Bank – Nursing and Healthcare Support Workers (HCSW) and Facilities
Recharges to COVID-19 cost centres will be based on the e-rostering data, where relevant shifts will be allocated with a "COVID-19" 'reason'. This will be a reasonable source for Actual information (albeit there will be an element of incomplete information as some shifts are entered retrospectively), but at present will be limited for the purposes of forecasting as any revisions to nursing ratios in response to COVID-19, and therefore rosters, have not yet been agreed by the Health Board.

Medical and AHP Agency
Both Medacs (Medical and Dental) and TempRe (Allied Health Professionals) are reporting hours attributable to COVID-19 to the Health Board, which will be coded to the relevant COVID-19 cost centre.

New Fixed Term
This cohort has been specifically recruited in response to COVID-19 and therefore will be coded at source via Payroll to 4 locality COVID-19 cost centres.

Substantive – Phase 1

- All: any enhancements to pay as a result of additional hours/ changes to rosters resulting in additional unsocial hours, or 'acting up' arrangements due to the response to COVID-19 will be recorded at source by payroll and will be charged to the relevant COVID-19 cost centre.
- Nursing: the number of wards dedicated to COVID-19 will be tracked weekly – a COVID-19 ward roster will be costed and multiplied by the number of COVID-19 wards in any given week to enable a recharge to the relevant Directorate COVID-19 cost centre.
- Medical and Dental: Workforce is co-ordinating the central collation of all proposed additional sessions from revised rosters in response to COVID-19, which will be recharged.
- Other staff groups: as rosters are not available for the majority of other staff groups, a copy of the local deployment registers have been requested and wherever available these will be used to recharge a high level cost to the relevant COVID-19 cost centre for each Directorate (i.e. one transfer charge for a Directorate, not individual by individual). The principle would be to retain the COVID-19 costs within the Directorate where staff ordinarily work regardless of the nature of the deployment (e.g. a staff member from Finance being deployed to assist with Procurement COVID-19 activities would remain charged to the Finance Directorate, but within a COVID-19 cost centre).

Substantive – Phase 2
Refinements to Phase 1:

- Other staff groups: individuals deployed to other services in response to COVID-19 will be identified on the Central Deployment Register, which is being collated by Workforce for all staff groups. This would allow both the quantification of the

cost base dedicated to COVID-19 and the corresponding reductions in resource in other areas.
    - Reasonable timeframe for changes in staff movements

Other sources of Pay Intelligence

ESR Sickness Reporting
Staff sickness as a result of COVID-19 can be approximated using the automated reporting in ESR of reasons for sickness absence. This will provide a context for the level of staff sickness related COVID-19 expenditure recorded through the above means.

Ward Dashboard
The dashboards provide information by site (existing Acute and Field Hospital) on bed capacity and occupancy by ward.

Acute Hospitals:
- Wards are operationally categorised as COVID-19/Non-COVID-19. This information will be collated on a weekly basis to align staff correctly.

Field Hospitals:
- The Field Hospitals will be accounted for as COVID-19.

Cost Centre Categorisation
A cost centre-by-cost centre assessment is currently underway to assess whether the current operational activities diverted to COVID-19, are 'business as usual', or activities that have ceased/ reduced in response to COVID-19.

For Pay, this will be done on a Whole Time Equivalent (WTE) basis, as there may be a split between the categories for any given cost centre.

For Non-Pay, this should highlight where cost reductions are expected to inform the assessment of the net position as well as the gross context.

Non-Pay

Purchase Orders/ AP feed
Only directly attributable COVID-19 costs will be coded as such in the ledger (i.e net only).

- **Direct** purchases in relation to COVID-19 will be coded at source wherever possible through the Purchase Order process managed by Procurement. A daily report is produced by the Procurement Team to provide details of orders approved and cancelled, and outstanding requisitions. Finance have dedicated resource to regularly review and identify:
    - any COVID-19 orders not charged at source, correcting the source document with Procurement colleagues before feeds are entered into the ledger;

  - the number of un-receipted orders, supporting Directorates to identify if orders have been received, ensuring timely receipting on Oracle.

- **Indirect** costs will also be incurred whereby there will be an element of 'business as usual' and an element of COVID-19, and as such it would not be appropriate to allocate the full cost of a purchase to a COVID-19 cost centre at source as per the above. In these instances, to identify the additional COVID-19 related expenditure, a comparison will be made between the run-rate in expenditure in 2019-20 after accounting for notional 2% inflation (those excluding COVID-19: Months 1 to 11) and actual expenditure in each month for 2020-21. This will identify any indirect uplifts in expenditure due to COVID-19. Note: this exercise will exclude COVID-19 cost centres to prevent any duplication in identification.

  It is expected that the following subjectives will be those materially affected based on Month 12 2019/20:
  - Accessories & Equipment
  - Sterile Products
  - M&SE: General
  - M&SE: Disposable
  - Protective Clothing
  - Laboratory Equipment
  - Laboratory Chemicals
  - Laboratory Culture Media
  - Laboratory External Tests
  - Cleaning Materials
  - Laundry Materials
  - Other General Supplies and Services
  - Security Payments
  - Contract Refuse and Clinical Waste

<u>Secondary Care drugs</u>
Due to the reporting limitations of the Pharmacy system it will be difficult to accurately quantify or identify hospital level dispensing activity. Two transfer points dedicated to COVID-19 have been established to record the COVID-19 impact at source, however these will only capture drugs that are directly attributable to COVID-19, and there are likely to be changes in the types and volumes of drugs prescribed as an indirect result of COVID-19.

This indirect cost will be quantified by calculating the total average financial run rate over the past four years for the period April to September and pro-rating for the average of each given month.

<u>Service changes reducing spend</u>
There will also be reductions in Secondary Care drugs dispensing patterns due to service changes within the hospital. The same methodology as above, for additional costs, will be applied.

<u>Primary Care Contractor</u>

Key Principles

With the exception of Community Dental Services and GP managed practices, all of the services are provided by private providers and WG will provide All-Wales guidance as to the treatment of contract variation, which will influence the impact on these services and the cost to the Health Board. WG has not yet issued this guidance. Areas that are unclear until WG guidance is provided;

- GMS;
- Dental – Primary Care;
- Community Pharmacy;
- Optometry;
- Prescribing*.

* For Prescribing
    - It should be noted that prescribing data is only available two months in arrears, and therefore, for example, the impact of COVID-19 in March 2020 will not be firmly quantifiable until May 2020. It is therefore unlikely that the reported position for Prescribing will be able to be refined until Quarter 2;
    - The acceleration in the transfer of patients from Warfarin to Direct Oral Anticoagulants (DOAC) as a result of COVID-19 will be quantified on a gross basis by comparing patient growth in 2020/21 with patient growth in 2019/20.

For Dental Community Services and Clusters the following will apply:

- Pay costs will follow the treatment outlined in the Pay section above – it is expected most staff have been/ will be deployed to support other services;
- Non-Pay costs and principles to record the reduction in costs will follow the treatment outlined in the Non-Pay section above.

PPE distributed through the top-up Health Board Primary Care hub will be accounted for in the relevant COVID-19 Primary Care cost centres.

Savings Schemes

A full review of identified savings schemes for 2020/21 has been conducted. Given that these schemes are not considered to be supportive of the current situation, the expectation is that no significant savings schemes will be pursued. This appraisal will be reviewed ahead of each month end as the situation evolves.

Capital

Capital expenditure as a direct result of COVID-19 is being tracked by using separate cost centres within the capital cost centre hierarchy, allowing them to be easily differentiated from revenue transactions.

A review will be undertaken during the monthly closedown process to ensure that any costs charged are recoded appropriately between revenue and capital.

Key Principles

In this instance, gross costs are quantified by the total spend and net costs by any expenditure in excess of the Capital Resource Limit (CRL).

Contracting

Please refer to the separate paper "***Revised Arrangements for NHS Contracting and Payment during the COVID-19 Pandemic***".

- As a result of the COVID-19 pandemic, the Welsh NHS will be redesigning its service delivery, stopping the majority of elective care and focusing on treating patients with the greatest needs.
- There are significant financial funds which flow through Long Term Agreements (LTAs), Service Level Agreements (SLAs) and Non-Contracted Activity(NCA) to support service delivery. A large proportion of these agreements relate to elective or planned services, which in all probability will be significantly below plan and under normal circumstances would not be paid for.
- Following on from the aforementioned guidance and discussion with Welsh Health Boards a 'block' approach has been adopted to contracting during Q1 for Welsh LTAs. This will be quantified by taking the Q1 expenditure and income based on 2019/20 agreed outturn + 2% + pay awards + agreed committed investments (this does not generate a performance cost variation). The cost of block arrangements will be compared with reported activity at standard cost and any variation will be accounted for as a COVID-19 cost.
- In line with guidance, HDdUHB has also entered into block contract agreements with two English Trusts, namely University Hospital Bristol and Robert Jones Agnes Hunt. Neither contract is likely to deliver value for money, as the majority of this work is elective. The full cost of these contracts will be attributed to COVID-19.
- All other English activity will be treated as non-contracted activity and paid for on a cost-per-case basis (as the guidance permits), accepting that this activity should be minimal. This would be classed as 'business as usual' expenditure.
- There will be a reduction in NCA income and expenditure. This will be quantified by calculating the total average financial run rate over the past four years for the period April to September and prorating for the average of each given month to account for the typical seasonality profile. The gross cost in this instance is also the net cost.
- There will be a loss of Private Patient Income due to the restrictions in place. This will be quantified by calculating the total average financial run rate over the past four years for the period April to September and prorating for the average of each given month.

Continuing Healthcare (CHC)

CHC package costs may be directly impacted by COVID-19 in respect of accelerating discharges from hospital settings into community settings (in order to create acute capacity for COVID-19 patients) by commissioning at a premium rate.

There are a number of scenarios which would impact on costs in relation to CHC:

a) New CHC clients as a result of COVID-19

All such instances will be attributed with a specific identifier within the CHC database, which will allow automated tracking of the relevant costs.

b) Existing CHC clients moving homes as a result of COVID-19

In these instances, the existing client package will be ended and a new client identifier created as if the client were in category a) above.

c) "Top up" costs as a result of COVID-19

"Top up" costs are not normally funded by the Health Board. Any costs arising for additional care required by an existing CHC client will be reviewed on a case by case basis and should be invoiced separately by the provider and coded using the relevant Directorate COVID-19 Cost Centre.

All of the above categories relate to net costs only, where the 'business as usual' costs would continue and only the additionality (the premium) would be categorised as COVID-19 expenditure.

The remaining consideration which has not yet been determined, is whether there is a fixed point at which it would be reasonably expected that an alternative package should be secured in order to decommission the premium arrangement, returning to 'business as usual'. Discussions are on-going with service colleagues to create a weekly report and action plan.

Additional WG revenue Funding

Given the early stages of discussions with WG on the potential costs in excess of existing funding expected to be incurred, the detailed understanding of whether all additional costs will be funded by WG has yet to be finalised. Current early indications are that all costs will not necessarily be funded in full.

For the purposes of accurately reporting budgetary variances, where budget holders can evidence additional costs, two views of reporting will be made available; namely a report that excludes and includes COVID-19 cost centres to allow for the dual view and ensure financial assurance can be sought for all costs that are not impacted by COVID-19.

Following the issue of the Delegations and Finance Delivery letter in May 2020 to budget holders, there is clarity over the requirement to manage cost pressures at a Directorate level, including those arising from COVID-19. Where WG funding is available for specific qualifying expenditure the relevant budgets will be allocated to Directorates. Where no additional funding is available, Directorates should divert existing budgets to the COVID-19 response wherever possible.

Key Principles

Responsibilities

Responsibility for compiling a full year financial forecast for each Directorate remains with the relevant Service Lead in partnership with the relevant Finance Business Partner for the position *excluding* the impact of COVID-19.

Month 1 and 2 2020/21
Responsibility for compiling a full year financial revenue forecast for the Health Board for the additional costs of COVID-19 has been divided into four:

- Existing Acute (Lead: SFBP Planned Care)
- Field Hospitals (Lead: SFBP MHLD)
- Primary Care, Pharmacy and Community (Lead: SFBP Primary Care and Counties)
- Other Services (Lead: SFBP Specialist and Support Services)

These forecasts will be informed by both local intelligence from Service Leads and by the Bronze Strategic Groups. In addition, a central Workforce Register recording both supply and demand for additional resource directly in response to COVID-19 was key, and will remain thus in future months.

Month 3 2020/21 onwards
As governance is instilled, the organisation is required to move away from a rapid response model of decision-making. Budget holders are expected to continue to operate within the remit of the existing Standing Financial Instructions and Scheme of Delegation and use best endeavours to deliver value for money within their delegated budgets. This may result in the issuing of Control Totals to Directorates, especially if insufficient funding is available in order to operate necessary services and the response to COVID-19.

Decision Points

It is proposed that questions of clarity/ decision points are submitted to the Executive Director of Finance in a regular monthly cycle.

This would result in a fixed set of assumptions to form the basis of that month's financial forecast, as required for submission with the monthly monitoring return to Welsh Government which is due on the ninth working day following month end.

It is proposed that confirmations would fall into five headings:

- **Field Hospitals** (profile of intended use (bed days, acuity) / mothball of each site);
- **Elective Care** (profile and scale of elective services reinstated);
- **Workforce** (centrally co-ordinated recruitment and deployment strategy);
- **Savings** (expectation upon Directorates to deliver a savings target, to identify and maintain alternative ways of working resulting from practices adopted in response to the pandemic where clinically appropriate, appetite to apportion agreed savings target on basis of Opportunities Framework rather than a standard percentage);
- **Reserves Appraisal** (decisions as to whether to re-purpose centrally held Reserves where there is no existing committed obligation).

Key Principles

Clarification in the following key areas has not been formally sought to inform the Month 1 financial forecast, as a time-bound reporting cycle is yet to be formalised and the fluidity of the situation has led to a reliance on local intelligence and judgements:

- **Field Hospitals**: Q2-4 use based on the 2.4 Public Health Wales model at 40% compliance.
- **Elective Care**: profile and scale of elective services to be reinstated based on discounted prior year financial results rather than demand and capacity modelling.
- **Workforce**: Assurance provided by local HR contacts and service leads is not as robust as a centrally co-ordinated recruitment and deployment register; a central Workforce register recording both supply and demand for additional resource directly in response to COVID-19 is key.
- **Savings**: assumption that the majority of the savings requirement in the Financial Plan will not deliver due to the pandemic, and alternative ways of working not assumed to deliver recurrent savings, adversely affecting the underlying deficit.
- **Reserves Appraisal**: no appraisal has been conducted as the level of existing committed obligations are unknown.

Key Assumptions

The clinical model is undergoing refinement to reflect the latest demand modelling scenarios and costings are therefore subject to change.

Field Hospitals

The profiling is based on the 2.4 Public Health Wales (PHW) model at 40% compliance, amended for local information regarding non-COVID-19 patients. This reflects a 'worst case' scenario, when compared to the current actual numbers of COVID-19 patients. The demand model forecast might also be subject to change based on the local assessment of the likely impact of revised WG guidelines in respect of relaxing 'lock down'. PHW modelling assumes demand ceases by the end of November 2020, however applying local intelligence extends the Health Board's forecast to the end of January 2021.

- Staff costs have been modelled on a substantive cost basis - no premium for Agency workers has been built in. An assessment of whether this model could be fulfilled by the market has not yet been completed, but this is a key risk;
- Staffing ratios assumed in the model could be subject to change should the need arise;
- Non pay costs are based on a Carmarthenshire model of 750 beds scaled up or down where specific site details are not yet known;
- Drugs cost assumption is based on a respiratory ward and does not necessarily reflect the cost of a COVID-19 acuity ward;
- Further Non-Pay costs are expected for Transport, IT, and PPE. Insufficient information is currently available to estimate these costs and therefore no provision has been made;

Key Principles

- All capital costs and contractually committed costs (i.e licences to operate and associated running costs such as rates) are considered to be sunk costs. If notice were served on Bluestone, it is assumed that it would take 4 months to complete restoration works;
- The planning assumptions are that the Design, Build and Restoration costs are being treated as revenue as there will be no long term assets involved;
- In line with discussions at the Capital Review Meetings with WG, the Health Board has currently capitalised the initial equipping of the Field Hospitals in the same way as it would normally capitalise the initial equipping of a new or refurbished ward. The cost of oxygen is also currently listed as a capital cost. Most of the items capitalised will have a use on the acute sites following the pandemic.

Existing Acute Sites

- The latest HR recruitment tracker has been used as the basis for forecasting purposes. The number of offered and accepted posts has been used as the basis of the Month 2 forecast. The demand requirement as per the HR demand tracker has been used from Month 3 onwards.
- Currently the phased restarting of some Planned Care activity is being discussed. At this moment there is insufficient detail available to cost this accurately.
- Any bank and agency staff used in April are assumed to continue in May.
- The general position continues to be fluid across a number of staff groups across the Health Board; our working assumptions are being clarified and confirmed as and when decisions are made.
- The impact of the recent Medical and Dental circular regarding out-of-hours enhanced payments has been costed where the rota impact is known. However, a minimum of 50% of the rotas are **omitted** from the forecast, as the additionality has not yet been validated and quantified.
- Some A4C working areas have amended working patterns to ensure safety in the workplace is maintained. It is not clear, however, if there is a significant financial impact to these changes.
- Non-Pay: The forecast from Month 2 onwards is based on the actual costs incurred in Month 1, less any known non-recurring expenditure. Other specific non pay costs have also been included as follows:
    - Transportation: additional cost of commuting and the continued use of the winter pressures vehicle has been included.
    - Accommodation: any known additional accommodation costs in terms
    - of hotel costs for staff are included.
    - Additional drugs costs: these costs relate primarily to home care drugs where specific information has been provided.

It should also be noted that, whilst the assumption for Field Hospitals is that at present the running costs are variable, the Health Board has recruited fixed term staff for a period of six months which should be considered as a sunk cost. The Health Board's recruitment plans amounted to a monthly cost of £4.6m, of which the majority have been fulfilled. The monthly estimated cost of fixed term staff already recruited is £3.4m, which over a period of six months would amount to £20.3m.

Key Principles

Savings

- The non-delivery of the majority of our savings plans for the current anticipated duration of the outbreak.

Contracting

- Includes assessment of the impact of lost NCA income, NCA and English Provider expenditure, loss of over-performance typically achieved in Central Income, and an anticipated increase in CHC costs. This is offset by Welsh Health Specialised Services Committee (WHSSC) slippage in Q1 only in line with guidance from the FDU.
- Confirmation is outstanding as to any cost to the Health Board on the commissioning of Werndale via WHSSC and additional Welsh Ambulance Service NHS Trust services (no provision in this submission).

Primary Care

- 'Additional costs in Primary Care':
    - Includes an estimate of the impact of the Bank Holiday Enhanced Service and accelerated transfer to New Oral Anti-Coagulants (NOACs);
    - Detailed guidance is awaited from WG to understand how any variation from contract rules is to be treated;
    - Accounting treatment of Community Pharmacy increase in dispensing requires input from WG;
    - Prescribing data is two months in arrears, and therefore cannot yet be quantified e.g. for March 2020 until June 2020, and further guidance regarding the accounting treatment of any additional costs is awaited from WG/ Wales Audit Office (WAO).