PWYLLGOR ADNODDAU CYNALIADWY
SUSTAINABLE RESOURCES COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 June 2023
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	Developing a Long-term Financial Projection as an Enabler for a Roadmap to Financial Balance
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Huw Thomas, Executive Director of Finance
SWYDDOG ADRODD: **REPORTING OFFICER:**	Mark Bowling, Assistant Director of Finance

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

The Health Board has a statutory financial duty to break even over a three-year period. It has never managed to uphold this statutory duty. Despite many attempts over recent years to reduce the level of financial deficit, the Health Board still spends substantially more than its fair-share allocation of funding from Welsh Government from its overall NHS financial settlement.

The current year's projected deficit is in excess of £130m – the highest reported deficit in the Health Board's history, and over 10% above its projected income allocation. Accordingly, a long-term strategy to reduce expenditure to a sustainable level is required. The process of developing a long-term strategy to has recently commenced, firstly to estimate a likely trajectory over a medium-term and act as a prompt for the Executive Team to explore and agree a scale of ambition for the significant task of reducing both current expenditure and trajectory.

Cefndir / Background

The NHS Finance (Wales) Act 2014 imposes a duty on Welsh Health Boards to ensure that their expenditure is no greater than their level of income over a rolling three-year period. To date, the Health Board has never met this duty. In the lead up to 2020, the Health Board had expended around £25m more than its income in each of the preceding three financial years.

With the significant disruption to service delivery caused by the COVID-19 pandemic, the Health Board managed to maintain its financial position at broadly that level. However, this was based upon a level of temporary financial support from Welsh Government that could not be sustained into the long-term. The pandemic-related exceptional costs were largely matched with additional short-term funding. However, whilst many of the increases in a range of costs triggered by the pandemic were discontinued, the cost base of the Health Board still increased by around 16% over the years 2020/21 and 2021/22. The legacy of the pandemic and related decisions has been:

- Significant backlog in referral to treatment times – likely leading to increased ill health and worse outcomes for patients
- Substantially increased headcount – by as much as 10% in some staff groups which, given largely static or reduced outputs overall, has resulted in worse productivity and efficiency.
- An increase in the underlying deficit, with core financial allocation largely following a relatively constrained long-term trend, but expenditure increases outstripping those increases by a significant margin.

In the autumn of 2021, the Health Board was invited to submit its plans for reducing expenditure to a sustainable level. With a relatively tight timescale to produce that plan it was through necessity, a financially-drive exercise with only limited opportunity to seek wider endorsement across the organisation. Consequently, whilst the feedback from Welsh Government was that it represented a clear statement of the issues, potential approaches to reducing expenditure through service change, and a realistic timescale, it was not felt that there was sufficient clarity on the necessary organisational support needed for successful delivery.

Subsequent to that submission, discussions have continued with Welsh Government and also with the NHS Wales Executive Financial Delivery Unit to seek an agreed path to a more financially sustainable Health Board. Given the broader deterioration in overall NHS Wales financial performance and also in our own performance, it has been agreed that an updated and revised longer term financial strategy was needed to supplement the annual efforts to improve financial performance.

Asesiad / Assessment

THE CURRENT SITUATION

As at month 1 of the current financial year, the level of deficit estimated for the year is approximately £134m.

Clearly, a deficit of this magnitude is unlikely to be significantly reduced without drastic transformational change. In previous years, a deficit of around £25m - £30m has been the typical level reported. In the past two years, the pace of increase of expenditure has been such that in 2022/23 the deficit was £59m and this year is projected to more than double to over £130m. Accordingly, more traditional methods of reducing expenditure are unlikely to yield more than relatively modest success. It should be borne in mind that there is an expectation on all Health Boards to deliver a minimum of 2%-2.5% cost reductions annually as part of the NHS Wales planning process – in effect to just stand still financially. This equates to around £19m - £22m a year. Clearly, to make any inroads to the growing deficit would require further expenditure reductions, significantly above this *minimum* expectation.

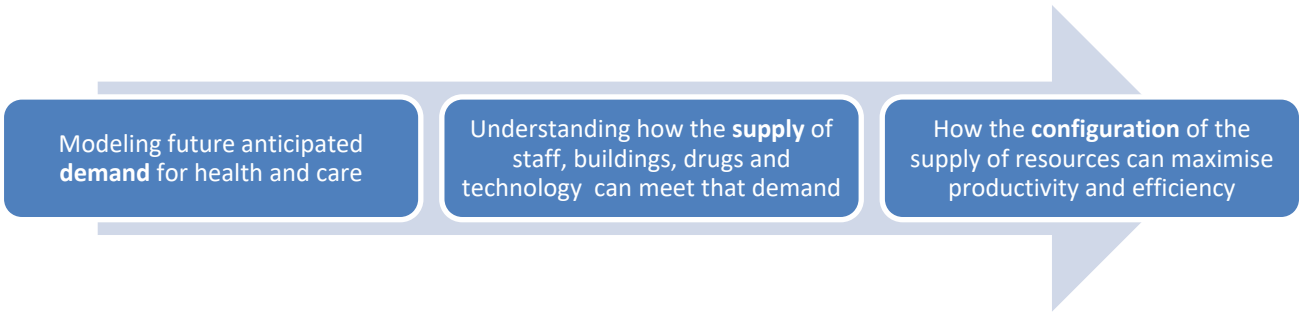
The timescale over which the expected improvement in performance is established by the NHS Wales (Finance) Act 2014. This sets out that a health board must breakeven over a three-year period. Nevertheless, a number of health boards have yet to meet this requirement – including Hywel Dda – and it is therefore consideration will not be constrained by time but the scale and pace of ambition, and then translation into operational delivery of resultant plans, in order to reduce the level of our deficit as soon as is reasonably practicable. For the purposes of illustration, it is considered appropriate to consider the actions needed between now and the end of the decade to reduce our deficit to as low a level as feasible. It is recognised that the configuration of the Health Board will be substantially altered as the implementation of significant changes in the Health Mid and West Wales plan impacts on efficiency and productivity. Accordingly, a long-term strategy is required to bridge the period between now and the opening of the new planned and urgent care hospital – anticipated to be in the early 2030s.

As outlined above, a significant amount of work has been undertaken to analyse and assess the underlying causes of the deficit, its recent movements, and the likely range of policy and operational decisions necessary to arrest the worsening financial position.
The principal messages arising from these analyses are:

- A substantial increase in staffing in recent years has not resulted in increased numbers of patients receiving treatment, indicating a decline in efficiency and productivity
- The impact of demographic change is impacting on demand. Patients display more complex needs and live longer, and thus more demand is presented for both acute and planned care services
- The configuration of the Health Board (with four district general hospitals, a number of community hospitals and - increasingly - community provision at the Integrated Care Centres (ICCs)) is a significant inhibitor of efficient provision
- A significant level of acute hospital resource is used to provide very basic (and inappropriate) care to people who do not have complex medical conditions. Put simply, many people occupy a hospital bed who would be much better cared for at home. Yet solutions are complicated as similar challenges being described by Local Authority partners.
- Some costs are rising substantially more quickly than the level of increase of funding from Welsh Government, such as drug costs, complex service commissioning via Welsh Health Specialised Services Committee (WHSSC), and the level of basic costs such as food, energy and transport.

THE APPROACH TO DEVELOPING A LONG-TERM FINANCIAL STRATEGY

There are three key aspects to developing a sustainable financial strategy



Demand trends and likely future needs
The long term trends in demand can best be explained through the level of referrals, emergency department attendances and GP appointments made.

- It is estimated that since 2009, (discounting 2020/21 due to the pandemic suppressing demand) **referrals for outpatient appointments** have increased by around **3.2%** per year
- Similarly, whilst data on GP appointments and telephone contacts is more difficult to track accurately, it is estimated that **general practice demand** has increased by **3.7%** annually
- Finally, **attendances at A&E departments** (and subsequent emergency in-patient admissions) have increased by around **1.8% to 2%** annually over the last decade

The **demography** of our resident population over the last 20 years has seen an increase in the number of older people (over 65s, and especially over 85s). This typically results in higher levels of demand for care, as it is axiomatic that the older a population is, the higher the level of both the incidence and prevalence of disease and illness, especially complex disease such as cancer. Recent trends show an increase in demand for issues potentially caused by lifestyle factors, such as diabetes, heart disease and to a lesser extent mental ill-health. This has been offset over recent years by a reduction in illness caused by smoking and reductions in occupational illness especially in areas such as mining, heavy industry and agriculture. In addition, a reduction in the number of women of child bearing age means that demand for certain services – obstetrics, gynaecology, and paediatric – may remain static or gradually decline in future years.

In addition, the **advances in medical science and technology** have also resulted in demand increases. For example, technologies such as magnetic resonance imaging (MRI) and computerised tomography (CT) based diagnostics have seen inexorable increases in the range of diseases and illnesses that utilise that technology. Genetic medicine has revolutionised the diagnosis and management of care given to people with inherited disorders that even a decade ago were largely untreatable. Demands that are currently unmet (or even unmeetable) are likely to see step changes resulting from the development of machine learning and artificial intelligence (AI), with new drug discoveries, enhanced diagnostic approaches and the implementation of new therapies and treatments – leading to a continuation and acceleration in the pace of demand increase. Whilst clearly welcome from the standpoint of the individual patient and society as a whole, these advances are significantly more costly than the outdated technologies they replace.

A further consideration is the **impact of mortality** on demand. People in their last year of life typically consume between 10%-12% of the total health care resources provided to them within their entire lifetime. Of that, most care is given in the last 1-2 months before death. The majority of people within Hywel Dda die within hospital, despite many surveys showing that the individual, their carers / loved ones, and the care provider agreeing that a more appropriate and "good" death would be had if they were given support to die in a different setting. As the demography of our population has shifted over the last 20 years toward an older population, this has resulted in more and more people dying in hospital.

Work undertaken by the Health Board's Data Science team shows that the number of people likely to die within the next 20 years increases significantly each year, before gently plateauing in the mid 2040s. It is therefore likely that, without a change in approach to support **people at the end of their lives**, there will continue to be significant impacts on demand for care that can be met outside hospital.

Socioeconomic factors play a significant role in determining the overall level of health and wellbeing at the population level. Income inequality, housing condition, access to healthcare at primary level, education etc all combine to lead to poorer health, whilst at the same time increasing barriers to accessing healthcare in a timely manner, ultimately increasing demand and at a later stage in a disease's progression. It is clear that these factors have accelerated post pandemic and in response to international pressures, leading Public Health Wales to declare this stepped decline as a 'cost of living crisis'.

Finally, the **expectations of society** have shifted, and are likely to continue to shift. Society has come to expect that products and services are able to be provided promptly, are personalised and specific to the individual, and are convenient to the individual. A further aspect is that of choice, where expectations are that an individual can select from different providers, sites or clinicians to provide their care: this in turn leads to underutilised capacity if there is to be sufficient choice to make the offer of alternatives meaningful.

Supply trends and likely future needs
Demand for health and care services determines the level of capacity that the health board needs to supply in order to satisfy that demand. Over the long term, as with demand, a number of trends and patterns emerge.

There are a number of key aspects of capacity that a medium-term financial strategy must encompass.

Firstly, and most importantly, is the trend and forecast of the **availability of the workforce** to meet the needs expressed. The corollary of the demographic drift in our population toward the older age groups (leading to increased demand) is a reduction in the number of people of working age that will be in the labour market and hence available to meet those demands. The number of people aged 18-45 is forecast to fall by 9% over the next 20 years. Whilst it is anticipated that demographic change would have less of an impact on the higher skilled aspects of healthcare in Hywel Dda, it is likely that demand for unskilled or semi-skilled workers in other industries may place us at a disadvantage in the local market. For example, local private sector employers may be able to increase wages further and react faster to marketplace conditions for staff such as cleaners, catering staff and other occupations such as drivers, porters and administrators.

Training and upskilling of staff to enhance productivity and efficiency. Whilst not increasing the *size* of the workforce per se, training and upskilling will have much the same impact as

additional recruitment. As some healthcare tasks become more complex and require higher level skills, others remain relatively routine and susceptible to becoming more efficient through better training. Substituting higher skilled (and hence more costly) workforce with alternatives such as physician associates, nurse associates etc has already demonstrated significant advantages to the more traditional workforce composition of even just a few years ago.

Our **facilities** are a key component in the relative efficiency of operation. Some issues, such as ageing buildings, equipment, and inherent design weaknesses, are very difficult barriers to overcome to improve the cost effectiveness of our operations. Nevertheless, there are opportunities to improve the configuration of our delivery to improve from the current model. For example, specialising care onto fewer sites, and in the process reducing the number of sites from which such care is delivered, is recognised to be a key improvement aim in the A Healthier Mid and West Wales strategy. Improvements to improved patient flow through hospital are constrained by the physical limitations of our existing estate, as well as the outdated design and construction of the hospital estate itself.

It was noted above that technology innovations potentially poses a financial risk from the ability to diagnose and treat more patients. Nevertheless, from a supply-side standpoint, **technology enabled care** also has the ability to transform care delivery efficiency and release staff resource to concentrate on care that can only be delivered personally. From the routine collection and monitoring of basic patient observation data, such as blood sugar levels, oxygen levels, physical activity, reporting of symptoms of concern etc, through to more specialised and complex assessment of the interaction of differing pharmaceutical interventions, it is foreseeable that recent developments in use of technology will continue to increase safety, reduce low-level human interventions, and improve hospital flow.

Health Information System development similarly has the ability to enhance efficiency. By making better information more accessible to decision makers – and by the increasing ability to use techniques such as predictive analytics and multisite / multipartner collaboration - better and quicker outcomes for patients can be achieved. Many of our current processes have changed little over the last 20 years, particularly in administratively burdensome tasks such as booking of outpatient appointments – still largely manually driven or the dearth of information for some aspects of health and social care, including primary and community data, that will hamper opportunities to both model but also effectively transform pathways of care.

Social models of care and wellbeing are a potential response to the fact that social and structural factors represent a key determinant of health and wellbeing. As such, tackling the key social causes of ill health requires more than just a treatment and care-giving approach. Instead, an approach that seeks to prevent ill health – through concepts such as empowering communities and individuals to take an active role in their health, and collaborating with social services, education and housing providers – is aimed to stem the increase in potentially avoidable population ill-health.

Our Health Board serves a largely rural population with a relatively poorly served transport infrastructure, relatively remote from the densely populated areas of Swansea and Cardiff. **Rurality and sparsity of population** can be thought by some to be a positive attractant to potential recruits; however, it appears to place us at a disadvantage in respect of recruitment and retention of senior / highly skilled staff in particular. Agglomeration benefits derived from having a concentration of similar companies or NHS organisations, with a flow of staff, ideas and techniques between organisations, are much harder to achieve than in parts of south Wales, for example.

Finally, the level of increase in costs through **general inflation, wage inflation and other macroeconomic factors** has over the last decade until recently been relatively benign. Cost increases in drugs, supplies, services and utilities have been muted over the last decade, reflecting the wider economy and general absence of market forces pushing up pricing. Wage increases have largely been in line with the general increase in funding allocation from Welsh Government. However, over the past 18 months the noted cost of living crisis has emerged, especially after the invasion of Ukraine and the impact on world utility prices, the Health Board has seen inflation in a variety of different costs, notably energy and transport, but also in food prices and medical supplies. The Health Board has also experienced reductions in workforce availability from the pandemic, such as nurses, but also the availability of semi-skilled and unskilled labour. With unemployment at 50 year lows, if this were to continue then the recruitment into staff groups such as catering, cleaning, portering, and nursing assistants would be constrained, with an impact likely in terms of starting salaries, turnover of staff, and non-pay recruitment and retention initiatives.

Configuration trends and likely future needs

Our Health Board is unique in Wales in that we provide secondary health and care from four acute district general hospitals. This carries with it a substantial cost burden. In stark terms, we have at least one hospital too many to provide for the needs of our population. If we are to become more financially sustainable, we must address this issue. Politically challenging though this may be, we must prepare for the implementation of the A Healthier Mid and West Wales strategy that will downgrade two of the existing sites to a “community hospital plus” model of delivery. We cannot wait until the new urgent and planned care hospital is constructed to tackle the underlying cause of our significant deficit.

Whilst estimates of the likely impact on the running costs have been undertaken, these are necessarily broad and non-specific. Nevertheless, there are clear advantages to a strategy that seeks to maximise scale economies, particularly in areas with relatively high volume, repeatable tasks.

For example, in terms of pathology services, diagnostic imaging, catering etc, the **standardisation and specialisation** that could take place through being undertaken on fewer sites is potentially significant. Through better utilisation of very expensive equipment, the efficiency and cost effectiveness of these services is likely to be improved.

Similarly, the provision of **operating theatre** capacity (and related services such as anaesthesiology, pre- and post-operative care, and intensive care) is sub-optimal. Recognising the competing demands of patient choice over location, accessibility, quality and patient-centred care, more focus needs to be given to ensuring that these worthwhile ambitions do not come at disproportionate cost to the taxpayer, or only provide modest benefits to individuals.

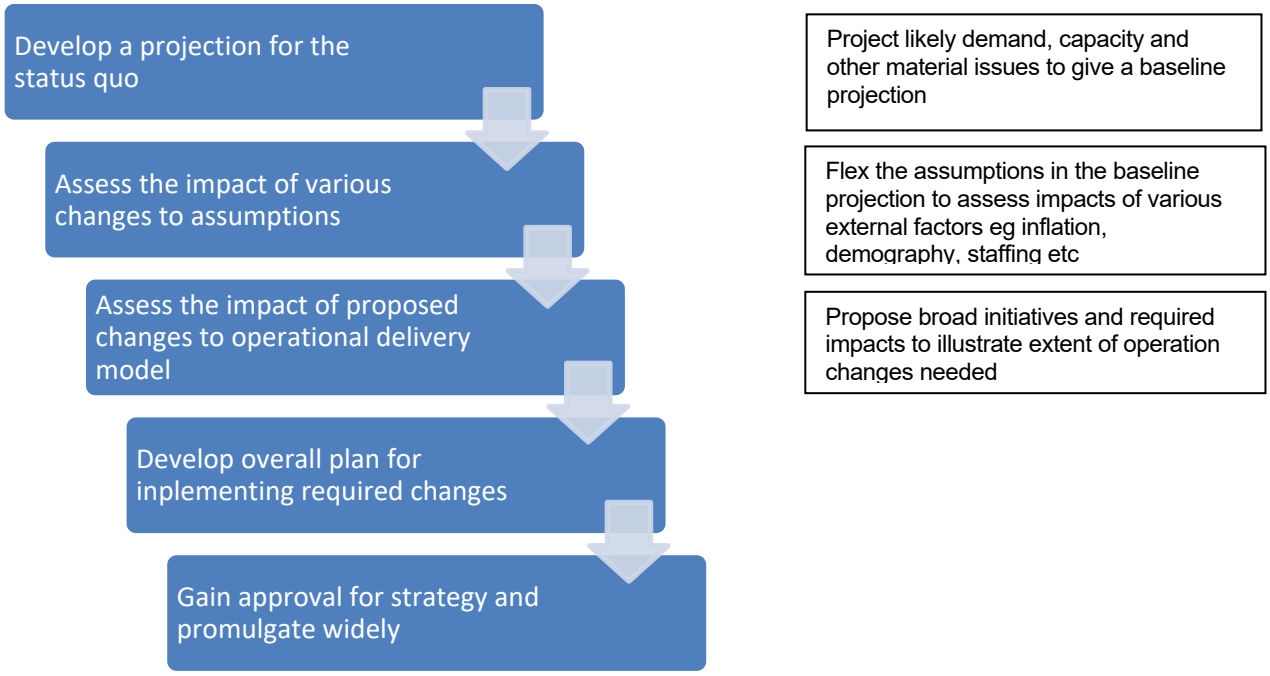
In respect of the **overall configuration of care** in the years to come, a direction of travel has already been articulated in the Healthier Mid and West Wales strategy – a reduction in the amount of care provided at acute hospitals, a reconfiguration of the remaining care to accommodate lower acuity patients, and a further change to the two legacy sites at Withybush and Glangwili General Hospitals. Aligned with these significant changes are an equally significant change to the model of care with a substantially greater level of care being provided in non-hospital environments such as care homes, community sites and people’s own homes. This will require a substantial shift of staffing to work outside hospitals, impacting on recruitment, training, management, information and communication technology (ICT), etc. As the changes to the number of acute hospital beds the Health Board anticipates providing once that configuration is implemented, they are effectively “baked in” to the strategy and business

cases. As such, our financial strategy must recognise the imperative to decommission hospital capacity and increase the capacity able to be delivered outside hospital.

Finally, over recent years, the level of expenditure and activity undertaken by other parties on behalf of our patients has massively increased. We currently spend over £170m a year on services provided by other NHS Wales providers, and WHSSC services for example exhibit double digit percentage cost growth per annum. A revised approach to **commissioning tertiary services** – coupled with renewed partnership working across organisational boundaries – is needed to help arrest the steep increases in costs seen recently.

HOW TO DEVELOP THE STRATEGY

Whilst a long and non-exhaustive list of individual contributory factors in their own right, their impact - both upon a complex health and care system and each other - will be challenging to model. Agreement of the key factors, best data sources and order of priority in application will be sought before commencing. Balancing such complexity in modelling with a need for robustness, transparency and particularly speed, if the resultant long-term financial strategy is to be robust and have the desired effect of helping the Health Board become more sustainable. This under-taking can be broken down into a series of stages, as below:



Initial baseline projection

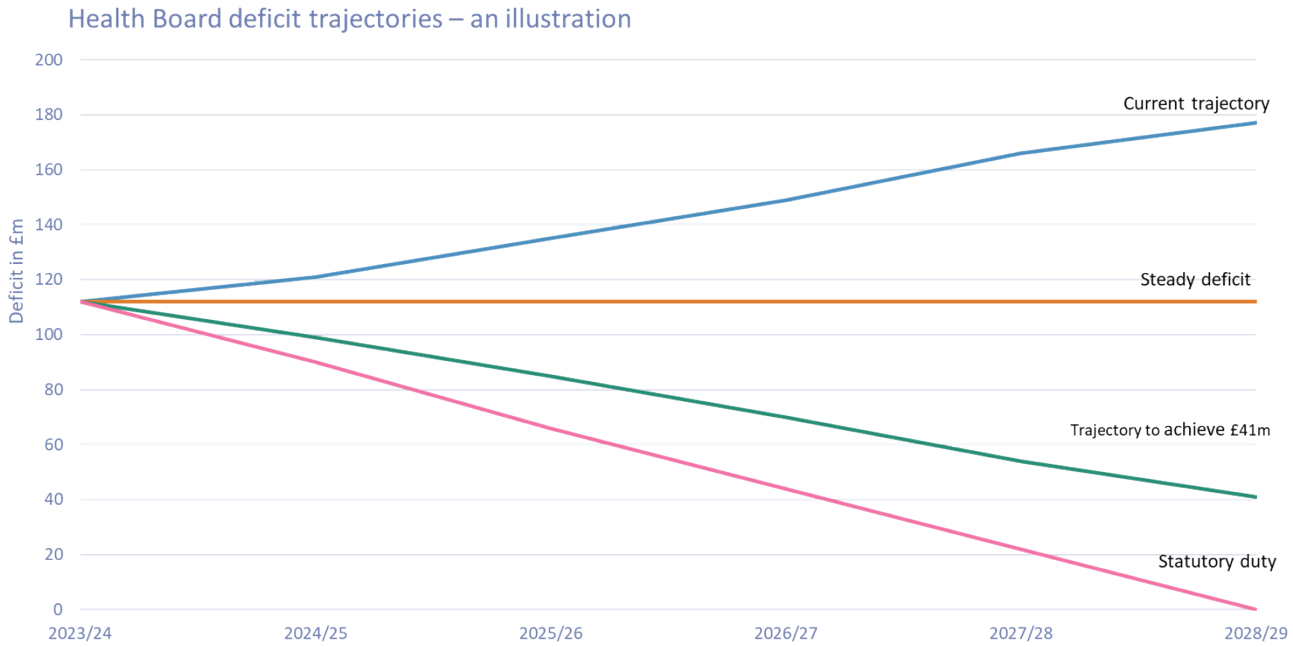
The initial starting point for the strategy is the current year's projected deficit, and the projection of recent experiences in increases in expenditure if they were to continue into the foreseeable future.

Within five years, if we continue to see cost increases (and relatively low savings delivery to mitigate these increases), the deficit is forecast to reach £180m. It is likely that without drastic action, the deficit will approach £230m by the time the new planned and urgent care hospital is scheduled to open in 2022/23.

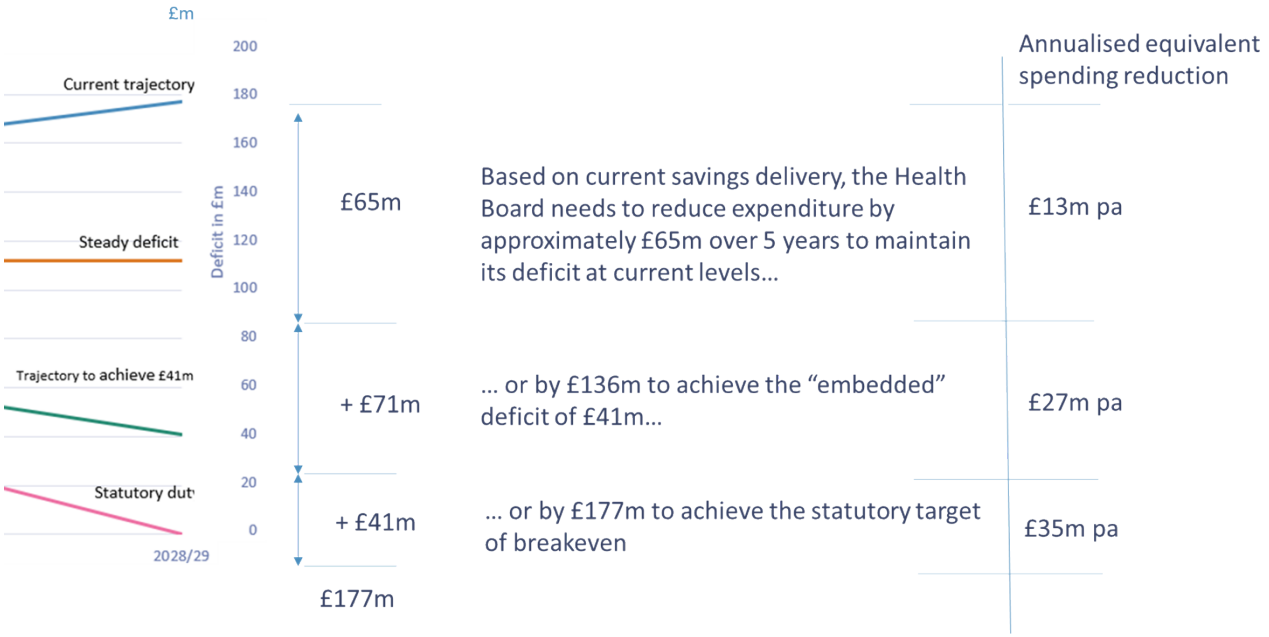
The chart below illustrates four scenarios:

- The current trajectory
- Deficit if held at the current underlying level

- Trajectory to reach £41m (determined to be the level of deficit that is "embedded" into current delivery model that will be address upon opening the new planned and urgent care hospital)
- The trajectory required to breakeven (and hence meet the statutory duty) within five years



In annualised terms, the required expenditure reductions are illustrated below:



In recent years, the level of expenditure reductions achieved annually by the Health Board has averaged around £8m - £10m. Until recently, this was — broadly sufficient to prevent the deficit from widening. However, with the recent requirement from Welsh Government to require further efficiency measures equivalent to 2-2.5%, clearly the deficit will continue to widen without a step-change in expenditure reductions.

For example, in addition to the 2.5% requirement (around £20m), the Health Board will need to deliver additional cost reductions of:

- £13m to standstill;
- £27m to achieve the deficit that is constrained by our current operating model (£41m);
- £35m a year to achieve the statutory duty of breakeven.

Illustration of the impacts on current operations is shown in the table below. It assumes the current staffing mix/proportions are retained, except for temporarily employed staff:

Current level	**Annual reduction to standstill**	**Annual reduction to achieve £41m**	**Annual reduction to achieve breakeven**
Nursing – permanent	150	250	400
Nursing – agency / bank etc	12	25	50
HCSW – permanent	10	15	20
HCSW – agency / bank etc	5	10	15
Medical – permanent	5	10	15
Admin, clerical and estates	150	300	450

As illustrated, the overall cost reduction requirement expressed in staffing terms is substantial. These are annual reductions in headcount, required every year to achieve the savings needed under the three scenarios outlined.

Controllable spend
To put into further context the magnitude of savings that will be required to restore financial sustainability, the table below illustrates those aspects of Health Board expenditure that are:

- Within its direct control, such as most expenditure on hospital and community health services
- Within its influence, such as funding made under partnership agreements with local authorities
- Outside both control and influence, such as expenditure on general medical services (which is a form of “pass-through” funding)

	£m
Net expenditure 21/22	1,155.0
Non-controllable expenditure	
- Primary Care contracts	- 125.6
- WHSSC / EASC	- 121.5
- Depreciation / amortisation	- 23.8
- Audit fees	- 0.4
Partly and fully controllable	883.7
Partly controllable	
- Prescribed drugs / appliances	- 86.7
- Other primary care	- 8.0
- Continuing care	- 49.2
- FNC	- 3.3
- Local authorities	- 20.1
Fully controllable expenditure - mainly pay costs	716.4
Savings requirement - @ £134m	**Approx 19%**

Next steps

The Committee is invited to discuss the contents of this report, and specifically feedback upon:

- the approach proposed in respect of analysis needed to develop the strategy
- whether further action in establishing a more accurate and detailed future projection is indeed needed, or whether the Health Board would prefer to use the broad indications to move more swiftly to focus efforts and attention upon taking action.
- the three aspects suggested forming the core of the strategy - likely future demand, likely future supply, and likely required configuration changes
- the multi-department requirement to contribute to the strategy, so that the whole organisation is bought-in to the process, urgency and necessary changes as possible.

Next steps, once Committee feedback has been received, would be to commence more detailed modelling as required. This would then be presented for discussion across the Health Board, and further reports presented to the Sustainable Resources Committee, as necessary.

Argymhelliad / Recommendation

The Committee is requested to note the material considerations included in the proposed method of developing our medium to long term financial strategy, and the proposed approach. The approach will be discussed at the Board Seminar meeting on 22 June 2023.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not applicable
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	6. Sustainable use of resources
Amcanion Cynllunio Planning Objectives	8c Financial Roadmap
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	10. Not Applicable

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Included within the report
Rhestr Termau: Glossary of Terms:	Included within the report
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Adnoddau Cynaliadwy: Parties / Committees consulted prior to Sustainable Resources Committee:	Included within the report

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	No specific financial impacts arising directly, although will have a significant overall impact on our use of resources.

Ansawdd / Gofal Claf: **Quality / Patient Care:**	No direct impact
Gweithlu: **Workforce:**	No direct impact, although workforce change is integral in the delivery of a revised financial trajectory.
Risg: **Risk:**	No direct risks beyond limited number of staff developing the strategy
Cyfreithiol: **Legal:**	This will aim to achieve the statutory requirement to break even financial as required by the NHS Wales (Finance) Act 2014.
Enw Da: **Reputational:**	If a satisfactory strategy can be designed, agreed and subsequently approved by Welsh Government, this will likely enhance the Health Board's reputation. However, resulting changes from the strategy are potentially unpopular and may adversely impact on reputation.
Gyfrinachedd: **Privacy:**	No impact on privacy
Cydraddoldeb: **Equality:**	No impact on quality