Bundle Audit Committee 14 December 2021

1 10:00 - OPENING BUSINESS - OPEN SESSION

1.1 10:00 - AC21.73: Apologies for Absence

Apologies received from the Executive Director Nursing & Midwifery / Deputy Chief Executive

1.2 10:01 - AC21.74: Declarations of Interest

1.3 10:02 - AC21.75: Procedural Matters

1. confirm the Minutes of the last meeting of the Committee held on 28/09/21 as a correct record and to discuss any matter arising;
2. review the Summary Action Log;
3. note the details of breaches (in terms of publication of Board/Committee papers) to the Standing Orders;
4. to note the revised Terms of Reference for the Remuneration and Terms of Service Committee.
5. to note a verbal update from the Operational Director of Finance re the Public Procurement (Agreement on Government Procurement) (Thresholds) (Amendment) Regulations 2021.

AC21.75a: Draft Public Session Minutes - Audit Committee 28.09.21 v0.1.docx

AC21.75b Public Summary Action Log_Audit Committee_live.docx

AC21.75c Breach Log 14.12.21.docx

AC21.75d RTS Committee ToRs update Dec 2021 v8.01 draft Coversheet.docx

AC21.75d2: Appendix 1 RATS ToR V8.01 draft Nov 2021.docx

1.4 10:17 - AC21.76: Issues Discussed in Previous Private Session

The Audit Committee is asked to note the report.

AC21.76: Private Session Items Reported in Public_Dec_21.docx

1.5.1 10:18 - AC21.77: Chair's Assurance Report: Risk Management Group

The Audit Committee is asked to note the report

AC21.77 RMG Meeting - Chair`s Assurance Report - v0.1.docx

1.6 10:33 - AC21.78: Board Assurance Framework

The Audit Committee is asked to note the six monthly review of the full Board Assurance Framework (BAF) and the progress on the Principal Risks as set out in the BAF.

AC21.78a BAF cover report - Audit Committee.docx

AC21.78b BAF Appendix 1 for Audit Dec 21 V2.0.pdf

AC21.78c BAF Appendix 2 Risk Key Field Guidance Dec 21.docx

AC21.78d BAF Appendix 3 Overview of all BAF risks leads and scores.docx

1.6.1 10:53 - AC21.79: Review of Corporate Risk Register

The Audit Committee is asked to:

1) Review and note the progress on the management of the Corporate Tier 1 Operational Risks.

AC21.79a Audit - CRR Cover Report V0.1-Public.docx

AC21.79b Appendix 1 - Full Corporate Risk Register.pdf

AC21.79c Appendix 2 Full List Corporate Risks.pdf

AC21.79d Appendix 3 Risk Key Field Guidance V2-Final.pdf

2.1 11:13 - AC21.80: Internal Audit Progress Report

The Audit Committee is asked to:
• Receive the progress report;
• Receive and discuss the Limited Assurance Report - Establishment Control: Leaver Management
• Note the potential gap in assurance on major capital and capital schemes in the Health Board; and
• Approve the deferment of the following reviews for inclusion in the risk planning process for the 2022/23 plan:

** Digital Strategy*
** Unscheduled Care*
** Transformation of Services*
** Preparedness for Climate Change / Decarbonisation*

AC21.80a BCUHB Internal Audit Committee cover sheet December 2021.docx

AC21.80b BCUHB Audit Committee progress report December 2021.docx

AC21.80c Final Internal Audit Report - Leaver Management_2122.pdf

2.2 11:33 - AC21.81: Audit Wales Update Report

The Audit Committee is requested to:

1. Receive and discuss the Audit Wales Update report
2. Receive and discuss the BCUHB Structured Assessment Phase 2 Report
3. Receive and discuss the BCUHB Review of Eye Care Services Report
4. Note the Taking care of the carers report
5. Note the Picture of Healthcare report

AC21.81a Audit Wales coversheet.docx

AC21.81b Audit Wales Update report Dec 2021.docx

AC21.81c BCUHB_Structured_Assessment_Phase_Two_2021_Eng.pdf

AC21.81d BCUHB Eye care review.pdf

AC21.81e Taking-Care-of-the-Carers-October-2021-English.pdf

AC21.81f POPS-Healthcare-Eng.pdf

2.5 11:53 - AC21.82: Schedule of Financial Claims (Public)

The Committee is asked to receive this report for assurance.

AC21.82 Schedule of Financial Claims (Public).docx

3.3 12:03 - AC21.83: Issues of Significance for reporting to Board

Members are asked to raise any issues of significance for reporting to the Board via the Chair's Assurance Report.

3.4 12:04 - AC21.84: Date of Next Meeting: 15/03/21

3.5 12:04 - AC21.85: Exclusion of Press and Public

Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

AUDIT COMMITTEE PUBLIC MEETING DRAFT
Minutes of the Meeting Held on 28 September 2021
Via Microsoft Teams - the Health Board has determined that the public are excluded from attending the Committee's meeting in order to protect public health during the pandemic.

Present	
Richard Medwyn Hughes	Independent Member (Chair)
Jacqueline Hughes	Independent Member
Lyn Meadows	Independent Member

In Attendance	
Tony Benton	Senior Dental Contracts Manager (*for Minute AC21.62*)
Louise Brereton	Board Secretary
Simon Cookson	Director of Audit and Assurance, NWSSP
Andrew Doughton	Performance Audit Lead, Audit Wales
Simon Evans-Evans	Interim Director of Governance
Sophie Ffoulkes	Finance Graduate Trainee, NWSSP
Dave Harries	Head of Internal Audit, NWSSP
Sue Hill	Executive Director of Finance
Nicola Jones	Acting Deputy Head of Internal Audit, NWSSP
Matthew Joyes	Acting Associate Director of Quality Assurance *(for Minute AC21.59*)
Dawn Sharp	Deputy Board Secretary & Assistant Director *(from Minute AC21.59)*
Tom Stanford	Finance Director, Operational Finance
Brenda Thomas	Office of the Board Secretary
Joana Watson	Good Governance Institute (observing)
Jo Whitehead	Chief Executive
Kamala Williams	Interim Director of Performance *(for Minute AC21.60)*
Tim Woodhead	Finance Director of Operational Services

The minutes have been recorded following sequence of items on the agenda and not in the order discussed at the meeting. Agenda item AC21.56: Emergency Scheme of Reservation and Delegation was discussed after item AC21.60.

Agenda Item	**Action**
AC21.51: Opening Business and Apologies for Absence **AC21.51.01** The Chair welcomed Members and attendees to the meeting. **AC21.51.02** The following attendees were introduced:	

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• Brenda Thomas, who has joined the Office of the Board Secretary to support specific pieces of work, while the Deputy Board Secretary & Assistant Director proceeds on a planned sick leave; • Tim Woodhead the new Finance Director of Operational Services; • Nicola Jones, Acting Head of Internal Audit, NWSSP; • Sophie Ffoulkes, Finance Graduate Trainee, NWSSP; and • Joana Watson, Good Governance Institute (observing). **AC21.51.03** Apologies for absence were received from Gill Harris, Deputy Chief Executive & Executive Director of Nursing; and Bethan Wassell, Statutory Compliance, Governance & Policy Manager. **AC21.51.04** The Executive Director of Finance provided an update on the issue raised at the last Board meeting regarding a contractor on the contractor framework that had gone into administration. The Committee was assured that this contractor showed interest in the original tender, but did not progress to the invitation to tender (ITT) stage, and was therefore not on BCU's list of approved contractors. A check was conducted which confirmed that BCU had not entered into any contract with the contractor. A pan-Wales check will be performed in future when suppliers go into administration, to determine their contracts already in place with other NHS Wales organisations.	
AC21.52: Declarations of Interest No declarations of interest were made at the meeting.	
AC21.53: Procedural Matters **RESOLVED:** That 1. the Minutes of the last meeting of the Committee held on 10 June 2021 be confirmed as a correct record; 2. the updates to the Summary Action Log be noted; 3. the details of breaches (in terms of publication of Board/Committee papers) to the Standing Orders be noted; 4. it be noted that the Health Board Scheme of Delegation was currently being updated and will be submitted to the Audit Committee via Chair's action prior to final approval at Board, together with the updated EASC and WHSCC Standing Orders and revisions to the Health Board's Standing Orders following the recent publication of an updated model issued by Welsh Government recently; and 5. it be noted that at the September Quality, Safety and Experience Committee, the Chair had reflected that the Committee had previously raised the need to consider the consistency of scoring both for the Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) - in particular regarding the impact to the service, should the risk be realised. She suggested that this be raised with the Audit Committee through her Chair's report to enable all Corporate Risks and BAF risks to be considered as a whole. This	

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will be addressed by the Audit Committee at its next meeting when it will consider the next iteration of the BAF and CRR.	
AC21.54: Issues Discussed in Previous Private Committee Session **RESOLVED:** That the report on issues discussed in the previous Private Committee session be noted.	
AC21.55: Chair's Assurance Report: Risk Management Group **AC21.55.01:** The Interim Director of Governance presented this item, which provided a summary of the meetings of the Risk Management Group (RMG) held on 15 June and 16 August 2021. Both meetings were quorate with good representation. The operations of the RMG have been reset, with increased meeting frequency; more time allocated at beginning of meetings to carry out deep dives on a rolling basis of individual risks within the BAF and tier 1 of the CRR; and a focus on bringing divisions to discuss tier 2 risks. Seven new risks were agreed to be escalated to the Board Committees for agreement to be managed at Tier 1. Further to the deep dive on the BAF Covid risk, the COVID-19 high-level risks were continuing to be presented to the Executive Incident Management Team (EIMT), with the Risk Lead in attendance at the RMG to provide updates. **AC21.55.02:** An Independent Member praised the report, commenting that it was very detailed and clear that the issues raised were being addressed. The Independent Member raised concern about the archiving of the surge/ winter plan risk and its outstanding actions transferred to the unscheduled care risk; and queried the reference to cyber security risk presented for oversight at the Digital and Information Governance Committee (DIGC), which is no longer existent. The Interim Director of Governance advised, in relation to the cyber security risk, that reporting was done to the DIGC at the time, but now reporting to the Partnerships, People & Population Health (PPPH) Committee, and noted that this risk was not reported in public given its commercial sensitivity. The Independent Member expressed further concern that further work was needed on the inability to deliver a fit testing programme to meet demand before escalation could be considered. The Interim Director of Governance advised that this risk was currently not deemed sufficient for escalation; however, it was kept under constant review via normal operating business and as part of the Covid risks. **AC21.55.03:** The Chair requested an explanation for the decision to archive the surge/winter plan risk and transfer outstanding actions to the unscheduled care risk, despite the concerns raised severally by the Independent Member. The Board Secretary assured the Committee that the unscheduled care risk, now a BAF risk, has been expanded to include winter planning and mid-to long-term management of unscheduled care demands. This risk was being given due consideration and a deep dive is scheduled to take place at the next RMG meeting in October.	

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AC21.55.04: Regarding winter surge capacity, the Chief Executive assured the Committee that in addition to risk discussion, the actuality of creating surge capacity was also being discussed. An Independent Member argued that the winter plans were about more than secondary care, and include cross relationships with the ambulance service and voluntary sectors; therefore, incorporating into unscheduled care could lead to losing sight of external focus. The Chief Executive further assured that active conversation was ongoing about the involvement of other First Responders, as well as working creatively with the housing and voluntary sectors to provide support. **AC21.55.05:** An Independent Member referred to the fit testing query earlier raised and noted that when this risk is escalated, consideration should be given to the new guidance to staff in relation to FFP3 masks usage, which would impact on the fit testing programme. **RESOLVED**: That the report be received.	
AC21.56: Emergency Scheme of Reservation and Delegation **AC21.56.01:** The Deputy Board Secretary presented the report, noting that following a review by Internal and External Audit of the initial governance arrangements in response to the first wave of the pandemic, it was suggested that an Emergency Scheme of Reservation and Delegation (SORD) be drafted. The draft Emergency SORD would be deployed in the event of the standing up of the Gold Command structure and Cabinet. Given emergency investment tend to require accelerated timescales, it is not possible to comply with the full requirements of the Procedure Manual for Managing Capital Projects. In the event of this Emergency SORD being enacted, the Manual would be suspended but provide the principles of good practice that should be considered within the constraints of the accelerated timescales. **AC21.56.02:** An Independent Member queried whether Chair's action was taken for capital decisions over £1m during the course of the pandemic. The Deputy Board Secretary advised that this occurred in relation to the field hospitals, which was subsequently approved by the Board. The Executive Director of Finance added that the emergency SORD have been reviewed in light of the Covid pandemic and the extraordinary expenditure in relation to the field hospitals and enable preparation for future eventualities. The Board Secretary further added that the Chair's action process was not limited to the Emergency SORD; this functionality was part of procedures to enact swift decision making when necessary. The Standard Operation Procedure (SOP) for the Chair's action was recently updated and is kept under review to ensure decisions taken via Chair's action are appropriate. As and when Chair's actions are used, a report is submitted to the relevant Committee and subsequently to the Board. **AC21.56.03:** An Independent Member queried whether the emergency SORD could be enacted for any emergency, given that the terms of	

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reference (ToR) were specific to the COVID-19 Cabinet meetings, and whether the ToR would be amended to be future proof and reviewed annually. The Board Secretary advised that this provided the structure for flexibility and ToR would be flexible as needed to meet the demands of the time, and would be under continuous review. **RESOLVED**: That the Emergency SORD be recommended for approval to the Board.	
AC21.57: Internal Audit progress Report **AC21.57.1** The Head of Internal Audit presented the progress report, which had been produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2060 - Reporting to Senior Management and the Board. **AC21.57.2** The progress report summarised 11 assurance reviews finalised since the last Committee meeting in June 2021, with the recorded assurance as follows: • Substantial assurance (green) – one; • Reasonable assurance (yellow) – five; • Limited assurance (amber) – none; and • Assurance not applicable (grey) – two. **AC21.57.3** The report also detailed reviews issued at draft reporting stage and work in progress. Overall, the report was positive. **AC21.57.4** The Committee's attention was drawn to paragraphs 13 and 14, and Table 3 of the report, which noted positive status across two indicators; however, management response to draft reports was red, with a decrease from 76% to 50%. This was based on two reports where management responses were due. It has been agreed with the Board Secretary to amend reporting arrangements going forward to improve management response times. **AC21.57.5** The last Quality, Safety and Experience (QSE) Committee, where the wider challenges impacting the Health Board were raised, has necessitated the need for a review of the internal audit plan, in relation to how to alleviate some of the pressures on the Executive Directors and frontline staff. The proposals would be subject to approval by the Audit Committee. **AC21.57.6** The Chair stated that BCU has a Service Level Agreement (SLA) of 20 days for management response, which was not being met in some cases, in contrast to 15 days for other Health Boards in Wales, and queried how BCU compared with other Health Boards in relation to their management response given the Covid pandemic. The Interim Director of Governance advised that the average across Wales (Health Boards and Trusts) at the end of August 2021 was 78% response rate within the agreed timescale. BCU achieved 77% response rate in 2020/21. The Board Secretary reassured Members that work was being undertaken with	

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Internal Audit to improve this position and was confident that the next Audit Committee meeting in December will see an improved picture. **AC21.57.7** The Chair highlighted the review of the Performance measure reporting to the Board: Accuracy of information (20/21), and queried whether the variances in the reporting of data between some months should be of concern. The Head of Internal Audit commented that the variance identified was for 242 patients and there was no explanation for the change in the reporting methodology. The Executive Director of Finance took an action to find out the reason for the change and to confirm the correct way of doing it. **RESOLVED:** That 1. the progress report be received; and 2. the revised arrangements for the distribution of discussion and draft internal audit reports outlined at paragraph 14 be approved.	**SH**
AC21.58: External Audit - Audit Wales Reports **AC21.58.1** The Performance Audit Lead, Audit Wales presented the report, which included the regular audit update alongside reports finalised since the last Audit Committee. The report also included the statutory work undertaken on the Health Board financial accounts and the result of that work; provided an overview of progress of the external audit programme; and performance audit reviews provided assurance and opinion on the effectiveness of arrangements in key areas as are described within the report. <u>Audit Wales programme update</u> **AC21.58.2** In considering the reports the following points were noted:- • The Auditor General for Wales signed off all the necessary accounts and accompanying financial returns for 2020/21 submitted to the Welsh Government in June. A similar timetable is expected for the 2021/22 financial returns; therefore, Audit Planning work is set to take place between January and April 2022, with the audit of the financial statements taking place in May 2022. • The audit of the 2020-21 Funds Held on Trust Accounts will take place during December 2021 and January 2022, a month later than earlier planned given the additional flexibilities on the local government audit. • Two areas of work were completed; Rollout of the COVID-19 vaccination programme in Wales and Use of Strategic Support Funding from Welsh Government. • Work currently being undertaken were progressing well. <u>Assessment of the Health Board's plans for the £297 million Welsh Government strategic financial allocation</u> **AC21.58.3** An Independent Member queried what steps were being taken to ensure the concerns detailed under the Emerging Conclusions and Next	

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Steps section were being addressed. The Executive Director of Finance advised that the business case review process has been streamlined and business case trackers introduced to monitor the progress of the major capital and revenue investments contained in the plans. The trackers are discussed at every Performance, Finance and Information Governance (PFIG) Committee meeting. The Independent Member further queried whether additional support was required to ensure the speed fits with the timescale and remarked that money be spent wisely to ensure optimum impact and provision made for monitoring. The Executive Director of Finance advised that the transformation agenda was progressing well and all necessary steps were being taken to achieve best results. The Performance Audit Lead added that this would be reviewed in the round and the necessary action taken depending on the audit risk based planning for 2022/23. Additional monies was expected from the Welsh Government for the foreseeable future, therefore thought should be given to business case preparation at an earlier stage. In relation to monitoring, he advised on the importance of having monitoring arrangement at Committee level. Rollout of the COVID-19 vaccination programme in Wales **AC21.58.4** In considering the report, the following points were noted:- • This was an all-Wales report issued in June 2021. Overall, very good progress has been made, with milestones met. • Some challenges were identified with some of the patient cohorts, with lessons to be learnt on wider immunisation planning. • The biggest message was around vaccine inequity, with vaccination take-up lower in deprived and Black, Asian and minority ethnic (BAME) communities. • Vaccine wastage has been exceptionally low to date. • The Public Accounts and Public Administration Committee (PAPAC) will receive the report in the autumn and consider progress. **AC21.58.5** An Independent Member noted the achievement was laudable and commented that the next stage was to take forward the plans for the booster injections and to ensure that the inequities highlighted are addressed. The Executive Director of Finance assured the Committee that this formed part of the planning and would be under focus. The Chair remarked that this achievement was a credit to all staff. Management response to the Review of Welsh Health Specialised Services Governance Arrangements **AC21.58.6** The Performance Audit Lead advised that this report had been presented at an earlier Audit Committee; however, the management response had not been received at the time. He commended the engagement of the specialised services committee officers in their preparation and taking forward the recommendations. The PAPAC would receive an update later in the autumn. Progress update against the recommendations would be presented in January/ February 2022.	

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Wellbeing of Future Generations Report The Performance Audit Lead recalled that at a previous Audit Committee, there was an update on the recommendations for this report and work was undertaken prior to the COVID-19 pandemic. The Committee had requested that extra work be undertaken to ensure the update met the needs of the Committee. A number of meetings were held with Health Board officers, and it was agreed to recast recommendations to ensure they are beneficial for the future. These have been included in the tracker, and allocated to senior officers, with a target date for completion in January. **RESOLVED**: That 1. the Audit Wales programme update be received; 2. the audit reports be received; 3. the Welsh Health Specialised Services Governance Arrangements management response be noted; and 4. the verbal update on the approach for the Wellbeing of Future Generations report be noted.	
AC21.59: Schedule of Financial Claims **AC21.59.1** The Acting Associate Director of Quality Assurance joined the meeting and provided an overview of the public section of the report, noting that it provided a summary of all the claims over £50k that have been closed in the previous financial quarter. The Committee was assured that all of the claims have been signed off and there were no issues of concern to be raised. The Committee was further assured that these claims were managed in accordance with the national scheme set out by the Welsh Risk pool, which require the submission of both the case management report and learning from events report; and claims are settled by Welsh Risk pool, once both their team and the National Learning Panel have reviewed them. The 2020/21 internal audit of claims management have been completed and Substantial Assurance was given with no recommendations made. **AC21.59.2** An Independent Member congratulated the team for this achievement and requested the learning document for cross reference. **RESOLVED:** That the claims and payments listed in the schedule be noted and reported to the Board as part of the Chair's assurance report.	**MJ**
AC21.60: Performance Accountability Report **AC21.60.1** The Chair reminded Members that the Committee in December 2020 had requested a report on the impact and effectiveness of the Performance Accountability Framework (PAF). The Interim Director of Performance joined the meeting to present this report, following an introduction by the Executive Director of Finance who noted that the report detailed progress over the last circa nine months.	

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AC21.60.2 The Interim Director of Performance noted that the PAF was agreed and implemented in November 2020. She talked through the report, highlighting the summary of performance and management cascade and the various structures and processes outlined in the PAF, setting out an assessment of current position in relation to each of the key components: Accountability and performance management structures; Clearly defined reporting arrangements and expectations; and Agreed and well understood routes for escalation of concerns. The Executive Director of Finance added that the Executive Divisional Accountability meetings are more constructive, with good engagement and dialogue. A review of the divisional accountability arrangement was being carried out to benchmark the process with other Health Boards and best practice. The Chief Executive highlighted the need to replicate at these meetings, the good practice at Board meetings of having patient stories, meeting effectiveness review and risks conversations. **AC21.60.3** The Head of Internal Audit informed the meeting that as per the requirement of the Standing Financial Instructions (SFIs), an Accountability Framework was required to be agreed and signed on annual basis. This would be presented to the Committee at a future meeting. **AC21.60.4** An Independent Member queried that whilst recognising the difficulty in measuring impact, the report failed to address the issues of impact and effectiveness of the PAF and did not specify whether there has been any improvement since its implementation. It was further queried that the PAF attached as appendix 2 was out of date as it was due for review in March. The Interim Director of Performance advised that there was discussion to carry out a review in March; however, the then Director of Performance was of the view that a review in March did not give sufficient time to enable a review; and that a 12 months review was more appropriate. **AC21.60.5** An Independent Member queried whether the PAF was making a difference and leading to improvement. The Interim Director of Performance advised that improvements have been seen in some areas; however, there were significant areas where performance have been below the anticipated level. The PAF provides a framework for identifying areas for improvement; however, there were ongoing challenges for performance improvement to be realised. The Independent Member further queried that the title of the report did not cross-reference to its detail. The Interim Director of Performance apologised for this disparity and noted that in terms of impact, there was better engagement; however, it was difficult to make a judgement in relation to effectiveness. The Chief Executive cited an example of where discussion at a recent Divisional Accountability meeting on access for gynaecology to additional theatre sessions to deliver Covid backlog, made a difference and could lead to improved performance; however, re-echoed there were ongoing performance challenges. The meetings provide an invaluable opportunity for engagement from an improvement perspective, debate achievements and challenges, which is valued by the Divisions. In relation to the requirement of having an	

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Accountability Framework, the Chief Executive suggested that a golden thread of team-based and individual-based accountability agreements would be beneficial. **AC21.60.6** The Executive Director of Finance and Interim Director of Governance provided clarity on the Budget Accountability Framework (BAFr) and the PAF, noting that the latter set out individual accountability agreement specific to support delivery of the Corporate Priorities. Circa 94% of the BAFr, issued this year have been approved. The Head of Internal Audit commented that this provided an opportunity for management to revisit and build in the PAF into the mandatory framework. He further noted that the report focussed on the Divisions, and questioned how the corporate functions were subject to similar scrutiny and held to account on performance. The Interim Director of Performance advised that the arrangement currently in place for corporate functions differ from the Divisions; therefore, an area to be reviewed. **AC21.60.7** The Chair concluded that the report did not address the purpose, and reiterated the point earlier made that the content of the report and the title were disparate; therefore, did not provide the needed assurance. It was suggested that the Chief Executive, Executive Director of Finance, Board Secretary and Interim Director of Performance discuss how to action effectiveness and measure the impact of the PAF and report back at the Committee meeting in March. **RESOLVED:** That the Performance Accountability Report be noted.	**SH** **JW/SH/KW**
AC21.61: Annual Review of Gifts & Hospitality and Declarations of Interest Registers The Deputy Board Secretary presented the report, noting that this was an annual update provided to comply with Standing Orders 8.1-8.7. Board Members' submitted declarations of interests for the 2020/21 period was presented at appendix 1, and a copy of the electronic Gifts and Hospitality Register for the same period presented at appendix 2. Whilst an improvement in the number of declarations from the previous year was noted (58% in 2020/21 compared to 40% in 2019/20), the position was still far below the target, with the impact of Covid continuing to have some bearing. Further actions were being taken to ensure further improved compliance levels during the current year, in addition to those already in place. Discuss inclusion of further information in the guidance for appraisers, which will be referenced in the orientation pages and induction for new non-medical staff in the first instance. There are ongoing discussion on how to progress with medical staff. In relation to gifts and hospitality, the numbers declared seemed far are less than those actually received. Going forward, an extract from the Charitable Funds Gifts and Hospitality register, which has a separate declaration system in place, will be appended to the report.	

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AC21.61.1 An Independent Member queried the exclusion of departmental gifts, and noted there were a number of discrepancies in the offer description; and advised on specificity with the explanation. The Deputy Board Secretary advised that declarations made with a value of £25 or below have not been included as per the threshold set by the Standard of Business Conduct policy. The Independent Member further queried that the gifts declared seemed light and that the cumulative amount of some of the departmental gifts could be above £25. The Board Secretary assured the Committee that all declarations have been reviewed by the Head of Counter Fraud and that steps were being taken to build in good practice around reporting, declaring gifts and hospitality, including those declined. Internal Audit will be carrying out a review of the Standards of Business Conduct. **RESOLVED:** That the Annual Declarations of Interests/Gifts and Hospitality for 2020/21 report be received.	
AC21.62: Dental Assurance Report **AC21.62.01** The Senior Dental Contracts Manager highlighted key areas from the report, noting that the situation continued to be dynamic, but adapting expectations as best as possible. New directive from the Welsh Government was expected for the new financial year. **AC21.62.02** An Independent Member's query was around real life issues, opposed to the contractual aspect, which the Audit Committee reviews. The Chair noted that there had been earlier discussion about the content and presentation of this report to the Audit Committee. The Board Secretary advised that the presentation and frequency of reporting would be reviewed. **RESOLVED:** That: 1. The Dental Contracts continue to be monitored for delivery and performance across four key areas of service provision - Quality, Finance, Access and Activity is noted; 2. The Covid pandemic has, and continues to impact significantly on service provision by primary care dental providers to the extent that the metrics previously used to monitor activity (UDA) are no longer valid and have effectively been discontinued is noted; 3. The Welsh Government have developed and introduced a set of "expectations" for the Health Boards and contractors to work toward and achieve during the recovery phase of the pandemic is noted; 4. The "expectations" provided a broad framework for the Health Board to engage with contractors to deliver dental services in accordance with Welsh Government and Health Board aims and priorities; however, the expectations are not written into the General Dental Service (GDS) regulations/legislation and accordingly are applied by the Health Board in a supportive rather than punitive manner is noted;	

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5. Contractors who are unable or unwilling to meet the “expectations” will be considered for a contract payment adjustment by the Dental Contracting Team on behalf of BCUHB is noted; and 6. Contractors retain the right to revert to the UDA system and be monitored and paid in accordance with their performance on that system is noted.	
AC21.63: Issues of Significance for Reporting to Board **RESOLVED:** That the Chair prepare his assurance report for the Board.	
AC21.64: Date of Next Meeting: 14 December 2021.	
AC21.65: Exclusion of Press and Public **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.	

Audit Committee Summary Action Log: Meeting in Public

Officer	Minute Reference and Action Agreed	Original Timescale	Latest Update Position	Revised Timescale
Sue Hill	**AC21.57: Internal Audit progress Report** Review the reason for the variances in reporting data on the Accuracy of information (20/21), and confirm the correct way of doing it.	December	The Cardiology data was omitted in error from the QaP report in February 2021; the process for producing the report has been more clearly defined to prevent his happening again.	close
Matthew Joyes	**AC21.59: Schedule of Financial Claims** Circulate the learning document for cross-referencing.	December	In progress. To be circulated asap.	
Sue Hill	**AC21.60: Performance Accountability Report (PAF)** Review and build in the PAF into the mandatory framework.	December	The PAF is being incorporated into the accountability framework, which may be subject to change in line with the revised operating model.	Jan 2022
Jo Whitehead/ Sue Hill/ Gavin Halligan-Davies	**AC21.60: Performance Accountability Report** Review arrangement in place for holding corporate functions to account on the PAF, to align with the Divisions.	December	The accountability framework schedule is being revised to include a corporate function review for the next round of quarterly meetings	Feb 2022

Audit Committee

14.12.21

Record of Breaches of Publication of Committee Papers since last reported to Audit Committee, not in accordance with Standing Orders

Meeting Date	Body	Standard	Issue/Reason for Breach	Details of papers
23.9.21	Health Board	Publication of papers 7 days before meeting	1 follow on paper (was published 1 day late)	Maintaining good governance during Covid
21.10.21	Remuneration & Terms of Service Committee	Publication of papers 7 days before meeting	Whole agenda breached as all substantive items bar 1 were not received/approved by publication date. Agenda was published a day late.	All apart from professional registration paper
28.10.21	Performance, Finance & Information Governance Committee	Publication of papers 7 days before meeting	4 papers to follow, rest of agenda published after close of business on publication day	USC / Winter preparedness Planned Care ED Workforce business case RISP
2.11.21	Quality, Safety & Experience Committee	Publication of papers 7 days before meeting	Range of papers not signed off by publication date. Some published day after, some 2 days after.	BAF Covid 19 Vascular Morfa Ward, LIGH SOHSG chair's report Nurse staffing

Kate Dunn

Head of Corporate Affairs

18.11.21	Health Board	Publication of papers 7 days before meeting	Range of private papers not signed off by publication date - published 2 working days after. Covid slides prearranged to follow as per usual arrangement. Welsh translation of 2 documents not available on publication day.	Welsh September minutes Welsh PFIG report Covid 19 RTC update - private Robotics update - private

Kate Dunn

Head of Corporate Affairs

Cyfarfod a dyddiad: Meeting and date:	Audit Committee – 14.12.21
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Revised R&TS Committee Terms of Reference
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton, Board Secretary
Awdur yr Adroddiad Report Author:	Liz Jones, Assistant Director, Corporate Governance
Craffu blaenorol: Prior Scrutiny:	*N/A*
Atodiadau Appendices:	Appendix 1 – Revised Terms of Reference

Argymhelliad / Recommendation:

The Committee is asked to approve the revised Terms of Reference for onward submission to the Board for ratification, in accordance with Schedule 1 of the Standing Orders.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

The September 2021 Internal Audit report on Upholding Professional Standards in Wales (UPSW) included the recommendation that *the R&TS Committee Terms of Reference are updated to include a [Designated Board Member] DBM as a formal member of the Committee, thus providing independent assurance to Committee/Board on the UPSW process.* This was agreed in the management action plan. This paper presents the revised Terms of Reference addressing this amendment, and a small number of other revisions, for approval on behalf of the Board.

Cefndir / Background:

The Internal Audit of UPSW found that the R&TS Committee Terms of Reference did not specify the need for at least one Independent Member to be a Designated Board Member, as is required for compliance with the regulations. The R&TS Committee agreed the revised Terms of Reference at its meeting on 2.12.21.

Asesu a Dadansoddi / Assessment & Analysis

The changes made to the Terms of Reference are as follows:

3.2.1, second bullet point – 'his' replaced by 'their'

3.2.8 - 'safe haven' replaced by 'Speak Out Safely'

6.1.1 - now reads '*a minimum of three Independent Members of the Board, at least one of whom should be a Designated Board Member who can provide additional assurance on the Upholding Professional Standards in Wales (UPSW) process'*

6.2.1 – addition of wording 'declare an interest'

7.2.1 – 'bi-monthly' replaced by 'quarterly'.

Goblygiadau Strategol / Strategy Implications

None.

Opsiynau a ystyriwyd / Options considered

Compliance is mandatory.

Goblygiadau Ariannol / Financial Implications

None.

Dadansoddiad Risk / Risk Analysis

None.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Compliance with Standing Orders.

Asesiad Effaith / Impact Assessment

None.

Remuneration and Terms of Service Committee

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Terms of Reference and Operating Arrangements

1. INTRODUCTION

1.1. The Board shall establish a committee to be known as the Remuneration and Terms of Service Committee (RaTS). The detailed terms of reference and operating arrangements in respect of this Committee are set out below.

2. PURPOSE

2.1. The purpose of the Committee is to provide

2.1.1. Advice to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government;

2.1.2. Assurance to the Board in relation to the Health Board's arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales; and

2.1.3. Specific functions as delegated by the Board and listed below.

3. DELEGATED POWERS

3.1. The Remuneration and Terms of Service Committee is required by the Board, within the remit of the Committee to:

3.1.1. Provide evidenced based assurance that there is compliance with The Equalities Act 2010.

- In discharging its duty the Committee will have 'due regard' to the Public Sector Equality Duty, to eliminate discrimination, to advance equality of opportunities and foster good relations when carrying out all functions and day-to-day activities.

- In discharging its duty the Committee will have 'due regard' to the Socio-economic Duty, to consider how strategic decisions might help reduce the inequalities associated with socio-economic disadvantage.

3.1.2. Provide evidenced based assurance that BCUHB Policies are compliant with relevant legislation.

3.1.3. Provide evidence based and timely advice to the Board on developing strategies.

3.1.4. Provide evidence based and timely advice to the Board on the delivery of strategies.

3.1.5. Oversee and provide evidence based and timely advice to the Board on relevant risks and concerns.

3.1.6. Receive the results of relevant audits (clinical and non-clinical) and any other relevant investigations and provide the Board with evidence based impact assessment of the implementation of the recommendations.

3.2. The Remuneration and Terms of Service Committee is authorised by the Board to:

3.2.1. Comment specifically upon:

- The remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;
- And to be sighted on the objectives set by the Chief Executive for ~~his~~their immediate team, confirm that Directors have had objectives set, and that appropriate and timely performance reviews have taken place
- Proposals to make additional payments to consultants;
- Proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.
- Removal and relocation expenses

3.2.2. Consider and approve Voluntary Early Release S~~s~~cheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.2.3. Monitor compliance with issues of professional registration, including the revalidation processes for medical and dental staff and registered nurses, midwifes and health visitors and registered professionals.

3.2.4. Monitor and review risks from the Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place;

3.2.5. Consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business including approval of Workforce policies.

3.2.6. Consider reports on behalf of the Board giving an account of progress where any exclusion in respect of Upholding Professional Standards in Wales (UPSW) has lasted more than six months.

3.2.7. Consider reports on behalf of the Board giving an account of progress on performers list regulatory cases.

3.2.8. Consider reports on behalf of the Board on the position as regards whistleblowing and ~~Safe haven~~Speak Out Safely.

4. AUTHORITY

4.1. The Committee may investigate or have investigated any activity (clinical and non-clinical) within its terms of reference. It may seek relevant information from any::

- Employee - and all employees are directed to cooperate with any legitimate request made by the Committee; and,
- Other committee, sub-committee or group set up by the Board to assist it in the delivery of its functions.

4.2. It may also obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements;

4.3. It may consider and where appropriate, approve on behalf of the Board any policy within the remit of the Committee's business concerning Quality, Safety and Patient Experience matters.

4.4. It will review risks from the Board Assurance Framework and Corporate Risk Register that are assigned to the Committee by the Board and advise the Board on the appropriateness of the scoring and mitigating actions in place.

5. SUB-COMMITTEES

5.1. The Committee may, subject to the approval of the Health Board, establish sub-committees or task and finish groups to carry out on its behalf specific aspects of Committee Business.

6. MEMBERSHIP

6.1. **Members**

6.1.1. A minimum of three Independent Members of the Board, at least one of whom should be a Designated Board Member who can provide additional assurance on the Upholding Professional Standards in Wales (UPSW) process.

6.1.2. The Chair of the Audit Committee will be appointed to this Committee either as Vice-Chair or a member.

6.2. **In attendance**

- Chief Executive Officer
- Executive Director of Workforce and Organisational Development (Lead Director)
- Executive Medical Director

6.2.1. Directors/Officers should declare an interest and leave the meeting when their personal remuneration or terms of service are being discussed.

6.3. Right of Attendance

6.3.1. Upon giving notice to the Committee Chair the following have the right to attend any meeting as an observer:

- Chair of the Board.
- Board Secretary.

6.4. **By Invitation**

- A staff representative.

6.4.1. Other Directors/Officers will attend as required by the Committee Chair, as well as any others from within or outside the organisation who the Committee considers should attend, taking into account the matters under consideration at each meeting.

6.4.2. Trade Union Partners are welcome to attend the public session of the Committee.

6.4.3. The Executive Director of Finance may be invited to attend as required, and will be consulted on any paper to be submitted to the Committee that may have financial implications.

6.5. Member Appointments

6.5.1. The membership of the Committee shall be determined by the Chair of the Board taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government. This includes the appointment of the Chair and Vice-Chair of the Committee who shall be Independent Members.

6.5.2. Appointed Independent Members shall hold office on the Committee for a period of up to 4 years. Tenure of appointments will be staggered to ensure business continuity. A member may resign or be removed by the Chair of the Board. Independent Members may be reappointed up

to a maximum period of 8 years.

6.6. Secretariat

6.6.1. The Secretariat will be determined by the Board Secretary.

6.7. Support to Group Members

6.7.1. The Board Secretary, on behalf of the Committee Chair, shall arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role and ensure the provision of a programme of development for Committee members as part of the overall Board Development programme.

7. COMMITTEE MEETINGS

7.1. Quorum

7.1.1. At least two Independent Members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice-Chair. In the interests of effective governance, it is expected that a minimum of two Executive Directors will also be in attendance.

7.2. Frequency of Meetings

7.2.1. Meetings shall normally be held ~~bi-monthly~~quarterly, but may be convened at short notice if requested by the Chair.

7.3. Withdrawal of individuals in attendance

7.3.1. The Committee may ask any or all non-board members who would normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7.4. Conduct of Meetings

7.4.1. Meetings may be held in person where it is safe to do so or by video-conferencing and similar technology.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1. Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

8.2. The Committee is directly accountable to the Board for its performance in exercising the functions set out in these Terms of Reference,

8.3. The Committee, through its Chair and members, shall work closely with the Board's other Committees including joint committees/Advisory Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business; and
- Sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4. The Committee shall embed the corporate goals and priorities through the conduct of its business, and in doing and transacting its business shall seek assurance that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations Act.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1. The Committee Chair shall:

9.1.1. Report formally, regularly and on a timely basis to the Board on the Committee's activities via the Chair's assurance report and an annual report.

9.1.2. Ensure appropriate escalation arrangements are in place to alert the Health Board Chair, Chief Executive or Chairs of other relevant committees of any urgent/critical matters that may affect the operation and/or reputation of the Health Board.

9.1.3. The Board Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation. In doing so account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1. The requirements for the conduct of business as set out in the Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

11. REVIEW

11.1. These terms of reference and operating arrangements shall be reviewed annually by the Committee and any changes recommended to the Board for approval.

Version number 8.01 Draft	
	Date of approval
Audit Committee	~~10.6.21~~
Health Board	~~15.7.21~~

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 14/12/21**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Summary of Business Considered in Private Session to be Reported in Public
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary
Awdur yr Adroddiad Report Author:	Statutory Compliance, Governance & Policy Manager
Craffu blaenorol: Prior Scrutiny:	Board Secretary
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Audit Committee is asked to note the report.

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

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

If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Orders require 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.

The issues listed below were considered by the Audit Committee at the private Committee meeting of 10/06/21:

- Minutes of the Private Session of Audit Committee held on 28/09/21 and Action Log
- Financial Conformance Report

- Schedule of Financial Claims
- Counter Fraud Progress Report
- Update on Internal/External Audit Actions (Tracker Tool).

Asesiad / Assessment & Analysis

Strategy Implications

This report is purely administrative. There are no associated strategic implications other than those that may be included in the individual reports.

Financial Implications

This report is purely administrative. There are no associated financial implications other than those that may be included in the individual reports.

Risk Analysis

This report is purely administrative. There are no associated risk implications other than those that may be included in the individual reports.

Legal and Compliance

Compliance with Standing Orders

Impact Assessment

This report is purely administrative. There are no associated impacts or specific assessments required.

Audit Committee

14th December, 2021

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

To improve health and provide excellent care

Chair's Assurance Report

Name of Group:	Risk Management Group (RMG)
Meeting dates:	11th October, 2021
Name of Chair:	Gill Harris, Deputy Chief Executive Officer / Executive Director of Nursing and Midwifery
Responsible Director:	Simon Evans-Evans, Interim Governance Director
Summary of business discussed:	The Risk Management Group (RMG) met on the 11th October 2021. The Group was quorate with good representation. Following discussions with the Executive Team regarding the Chair of the Risk Management Group, it was agreed for this to change to the Executive Medical Director. A further review of the RMG Terms of Reference is therefore underway. This report summarises the activity of the RMG and members noted: **1. Minutes** The minutes from the meeting on the 16th August 2021 were approved as an accurate record. Please note the next meeting of the RMG is on the 13th December, where October minutes will be presented for approval. **2. Meeting Action Tracker** Scrutiny of the Risk Management Action Tracker took place, with proposals for comprehensive action chasing to take place outside of future meetings. Outstanding actions are then to be escalated to the RMG Chair prior to the next meeting taking place. This will then allow focussed discussions on risks and reports being presented during the meeting. **3. Terms of Reference** RMG members approved the proposal from the Executive Team to nominate the Executive Medical Director as the new Chair. The Chair and Risk Lead agreed to undertake further work outside of the meeting to consider nominations for the Vice-Chair role and will present the final revised version for approval in the December RMG meeting. **4. Board Assurance Framework (BAF) Risk Reviews** A review was undertaken on the BAF risks, noting that meetings are continuing with the lead risk officers. Recommendations from

	RMG on the risks continue to be presented to the Executive Team for agreement before presentation to the appropriate Board level Committee for approval and oversight. Controls and mitigations were checked and challenged, and assurance was provided that further work was continuing to align all the BAF risks to the revised Health Board's Risk Appetite Statement. A new IMTP risk has been created and is a combination of the previous annual plan risk with the development of the annual budget, merging the 2 risks together to form a more strategic BAF risk, which will be presented during the next RMG in December for approval. It was also noted that the Living Healthier, Staying Well Strategy once finalised with clear strategic objectives will reset the BAF risks. In particular deep dive sessions took place with regards to following risks, with assurance and further updates being provided by the risk lead officers: • BAF21-12 – Security Risk – evidence to support the current risk score of 20 remaining the same as the inherent risk score despite controls being in place, was discussed including the volume of security related incidents reported and the capacity of the health and safety team to review these incidents on a daily basis. A business case for additional capacity was approved by the Executive Team in August and once recruitment has taken place the situation should improve. Confirmation was also received regarding the impending HSE Inspection for November of which security will form part of the review. Discussions also took place regarding the identification of longer term actions to support a further reduction in the risk score in line with the target risk due date. A further comprehensive review of the risk will be undertaken by the risk lead officer to consider the controls and current scoring, identification of further actions and also to consider including PPE elements to the risk. • BAF21-13 – Health and Safety Risk – the lead officer confirmed that all health and safety risks had been presented and discussed at the Occupational Strategic Health and Safety Group meeting. It was noted there had been an increase in the reporting of muscular-skeletal disorders amongst staff and that the lack of manual handling training accommodation had resulted in 48% of staff having not received training. It was confirmed that the training was re-commencing now that accommodation had been secured. Manual Handling will also be included in the HSE Inspection in November. Further discussions took place regarding the leadership and management of local health and safety issues and how this needed to be shared and reported via the local quality, safety or risk groups in place. A further review of the risk will be

undertaken by the risk lead officer to consider the controls and scoring in line with the risk appetite.

5. Review of the Tier 1 Corporate 1 Risk Register

A review was undertaken on the CRR risks, noting that meetings are still in place with the lead risk officers. Recommendations from RMG on the risks continue to be presented to the Executive Team for agreement before presentation to the appropriate Board level Committee for approval and oversight. Controls and mitigations were checked and challenged, alongside a review of the scoring in line with the current Health Board's Risk Appetite Statement. Feedback has been provided to all individual Executive Directors and Lead Officers to ensure all risks are updated before the next submission to the Executive Team and appropriate Committees of the Board due from November to January 2022, with presentation also to the Board in January 2022. In particular deep dive sessions took place with regards to following risks, with assurance and further updates being provided by the risk lead officers:

- CRR21-11 – Cyber Security – a meeting has been held with clinical colleagues to review and re-assess the scoring alongside the clinical risks for consistency in the application of the likelihood and impact of the risk should it occur and proposed changes will be presented to the Executive Team for consideration before onward presentation to the Board Committee for approval. Detailed further discussions took place regarding the mitigations needed to be put in place to support the reduction in the current score.
- CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients – IT was noted that the clinical lead for this risk has now stepped down and recruitment is currently taking place. Two areas of concern for this risk were raised regarding the provision and frequency of treatment for IVT patients, noting that a business case has been approved to support this and some funding has been received to progress improvements but this will take time to implement and so a request to extend the action due date was supported. Treating cataract patients with cataract hardening was becoming more difficult to treat, so outsourcing opportunities were being explored, and so an extension to the timeframes for this action was also requested to allow time to implement additional contract requirements.

6. Divisional Risk Reports

As per the RMG Cycle, the following Divisional Risk Reports were presented and discussed during the meeting. Ten Divisional reports were presented, noting the level of risk management

	maturity and compliance with the Risk Management Strategy and Policy within the Division, however it was agreed to represent one of the reports to the December meeting due to the content of the report not reflecting the current position of the Division. Six out of the ten confirmed they had updated and implemented their local RM04 – Local Risk Management Procedures, with the remaining four being supported by the Corporate Risk Team to finalise and implement their local procedures within the next 3 months. **7. Chairs Assurance Reports were received and noted from:** o Strategic Occupational Health and Safety Group o Concerns Management and Quality Systems Group **8. Once for Wales Integrated Risk Management Project** Work is continuing to harmonise language and common understanding of risk descriptors within the national system. BCUHB have provided input to colleagues in the National Programme Office on the type of risks, subtypes and descriptors we have as an organisation. Due to the maturity and use of the Risk Module in Datix, BCUHB is continuing to support and influence the new system developments in in terms of the language used by taking part in active contributions. **9. Risk Management Improvement Plan** The plan was presented noting the progress around the ongoing piece of work on encouraging a culture of horizontal and collaborative approach across services for the management of risks. To date 11 actions have been completed and they are on track to complete all actions by March 2022, hoping Covid does not compromise engagement from colleagues. **10. Risk Management Training Plan** The Plan was approved, noting the ambitious target to train 1000 staff by the end of March 2022, recognising the development of the trajectory to support keeping this on track. A drop in trajectory has already been experienced which has permitted to the Corporate Risk Team to consider further options for training delivery and increased sessions to bring this back on track.
Key assurances provided at these meetings:	• Progress with the implementation of the Risk Management Strategy and Policy. • Progress with the completion and implementation of the actions within the Risk Management improvement plan. • Progress with the continued scrutiny of the Board Assurance Framework. • Progress with the continued scrutiny of the Corporate Tier 1 Operational Risks. • Continued representation and presentation of Divisional Risk Management arrangements and escalation of risks.

Key risks including mitigating actions and milestones	1. Compliance with the Risk Management Strategy and Policy. 2. Potential delay in timely implementing the Risk Management Improvement Plan if there is a further wave of Covid-19.
Issues to be referred to another Committee	None of note
Matters requiring escalation to the Board:	None of note
Well-being of Future Generations Act Sustainable Development Principle	The work of the Risk Management Group will help to underpin the delivery of the sustainable development principles by: • Fully embedding Enterprise Risk Management to proactively manage risk to the delivery of the Health Board's planning and risk assessment processes. • Working collaboratively across Wales to deliver solutions with partners to improve planning and system delivery.
Planned business for the next meeting:	• Review of Corporate Risks. • Review of Board Assurance Framework. • Review and approve risks for escalation / de-escalation to the Executive Team. • Review of Divisional Risk Reports • Risk Management Quarterly Performance and Assurance Report • Update on Once for Wales Integrated Risk Management Project
Date of next meeting:	13th December 2021

Cyfarfod a dyddiad: **Meeting and date:**	Audit Committee 13 December 2021
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Board Assurance Framework (BAF)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Louise Brereton, Board Secretary
Awdur yr Adroddiad **Report Author:**	Louise Brereton, Board Secretary
Craffu blaenorol: **Prior Scrutiny:**	Executive Team - 8 December 2021
Atodiadau **Appendices:**	Appendix 1 – BAF Report Appendix 2 – Key field guidance/definition of assurance levels Appendix 3 – Overview of all BAF risk, leads and scores

Argymhelliad / Recommendation:

That the Committee note the six monthly review of the full Board Assurance Framework (BAF) and the progress on the Principal Risks as set out in the BAF

Please tick as appropriate

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

Y/N to indicate whether the Equality/SED duty is applicable

N

Sefyllfa / Situation:

The revised Risk Management Strategy and Policy was implemented on the 1st October 2020, and on the 21st January 2021, the Board approved the implementation of the revised Board Assurance Framework (BAF) template reporting arrangements.

The BAF currently comprises 21 risks. Each risk is aligned to a Committee and a 'cut' of the Committee linked BAF risks is presented at each Committee meeting. Prior to presentation at Committee, each BAF is subject to an individual check and challenge review with the Risk Lead and BAF risks are reviewed at the Risk Management Group which meets on a bi-monthly basis.

Appendix 1 highlights the Board Assurance Framework Risks. Members are reminded that this is a live document with reviews taking place with relevant leads on an ongoing basis. The data included within this cut of the BAF includes updates up to and including 1 December 2021.
Appendix 2 sets out the key field guidance/definition of assurance levels which has been subject to a further review in November 2021.
Appendix 3 sets out an overview of all the BAF risks, leads and scores.

Cefndir / Background:

Oversight and co-ordination of the BAF transferred to the Office of the Board Secretary from the Corporate Risk Management Team in January 2021, with the risk management system and process continuing to be managed by the Corporate Risk Team. The two teams continue to work closely to ensure alignment of the BAF and risk management systems.

Ownership of the BAF rests with the Board with individual Executives being responsible for the management of their respective risks and the Board Secretary providing the supporting processes to ensure the BAF is dynamic and reflective of the strategic risks the organisation is facing. Engagement with risk leads continues to progress well and has become a well-embedded part of the process.

The BAF is a 'live' document which continues to evolve, and has progressed with the engagement and support of the full Board. Committee Chairs have also dedicated time to supporting these processes and in continuing to refine the approach.

The development and approval of the IMPT early next year will require a 'reset' of the Board Assurance Framework to reflect the strategic risks to the delivery of the strategy objectives. To facilitate this work, it is proposed that reporting of the current BAF is paused in Q4 21/22 to allow the work on the refreshed BAF to take place with a view to seeking Board approval on the 2022/23 BAF by the Health Board in March 2022. This work will include any operational BAF risks being managed/ integrated as part of the Corporate Risk Register going forward. The Good Governance Institute will also support this process.

Key progress on each of the BAF risks is reflected within the relevant BAF overview attached.

Asesiad / Assessment & Analysis

Strategy Implications
The implementation of the Board Assurance Framework and the revised Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Options considered
Not applicable.

Financial Implications
The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and minimising the risk of claims.

Due to the improved and increased reporting frequency arrangements, the management of the BAF is resource intensive and is kept under regular review.

Risk Analysis
See the individual risks for details of the related risk implications.

Legal and Compliance
There are no legal and compliance issues associated with the delivery of the Board Assurance Framework or the Risk Management Strategy and Policy.

Impact Assessment
No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which the BAF and CRR reports are aligned.
Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Board Assurance Framework 2021/22

Strategic Priority 5: Improved Unscheduled Care Pathways

Risk Reference: BAF21-01		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Management of Unscheduled Care (formerly titled Emergency Care Review Recommendations)									
There is a 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.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↔	5	↑	20	↑	
		Target Risk	3		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Revised Unscheduled Care Improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to the Finance & Performance.	2	1) All 3 localities Health Communities have an agreed USC Improvement plan which looks at the whole system with clear priorities set. 2) Improvement and programme management support in place to support delivery of the USC improvement programme objectives 3) 111 implemented across NW in June 2021 4) USC dashboard established which captures data and monitor performance against agreed USC measures 5) Established Tactical Control Centres in place. 6) Standardised SITREP / escalation reports submitted 3 x day. 7) Urgent Primary Care Centre (UPCC) established in East 8) Priority focus within eaach workstream of the USC Improvement Programme identified 9) Business case for additional workforce in EDs has been signed off by Excecutive team 10) The SDEC development proposal has been partially funded by the WG (£1.6m/£2.7m is funded)	2	1) Ward based improvement work to focus on improving ipatient flow through facilitating earlier / timely discharges and criteria led discharge. {Update 22.11.21 New outcome focused Board rounds have been in place in a number of wards in all 3 sites 2) accurate capturing of numbers on medically fit for discharge and clear management plan for patients to return to usual place of residence 3) In line with Welsh Government (WG) directive, implement 111 (Contact) First programme that will ensure patients are seen by the right person, in the right place, first time in line with 111 implementation is ongoing to link 111 and SICAT to divert patients to the right place and manage demand. This is included within the plans for the USC improvement programme 4) In line with the agreed standards implement a uniform model for patient access to and from EDs.It is part of the national EDQDF programme which BCUHB is working with WG to deliver. 4) Fully implement Same Day Emergency Care (SDEC) services across all three acute sites. Recruitment of the additional resource to ensure consistency of the service through operating hours 5) D2R&A (discharge to rehabilitate and assess) - Home First Bureaus established in each area to support discharge planning and step up / step down model of care in the community. 6) Proposals for UPCCs to be further developed in Centre and business case for implementation in the West are included within the USC improvement programme. 7) bespoke training to upskill MIU workforce has been agreed to ensure consistancy of offer from all MIUs.	November 2021 December 2021 December 2021 December 2021 March 2022 December 2021 December 2021 December 2021
Annual Plan in place and agreed by the Board, with monthly monitoring and review through the Unscheduled Care (USC) Improvement Group.	2	1)Monthly USC Improvement Group meetings Chaired by the Senior Clinical Lead for the USC Programme 2) USC scoping review undertaken to develop strategic blueprint solution for unscheduled care	1	1) Implement recommendations of Kendal Bluck Emergency Department workforce review related to unscheduled care. recruitment campaign started 2) Executives have commissioned further work by Kendall Bluck to build in acute medical model on to the Emergency Department workforce plan, taking into account improved unscheduled care pathways currently being worked through the unscheduled care improvement plan. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care. This work is in progress as part of the SDEC development initially funded through additional fund from WG Single recruitment campaign is being developed to support delivery of workforce plans for ED and SDEC	March 2022 November 2021
Interim COO / Interim Director of USC overseeing the Annual plan in respect of USC and variance to the plan with regular reporting to the Finance and Performance Committee.	2	1) Bi-monthly report to Finance & Performance Committee to provide assurance on unscheduled care strategic developments.	2	Establish permanent substantive posts currently covered on an interim basis, providing continuity and sustained leadership for unscheduled care. (New senior clinical lead has been appointed, a programme director for the improvement programme has been appointed on interim basis, and there will be a new programme manager to support the work which is currently being advertised - will become a mitigation)	Completed

The current risk score has been increased to 20 (4x5), from 16 (4x4) in light of ongoing pressures.
Work is ongoing on the agreed priority areas in each Health Economy. The deliverables for October - December 2021 have been identified in each health economy. New governance arrangements became operationalised in August. A workforce group is working on single recruitment campaign for Emergency Department and Same Day Emergency Care workforce recruitment. This will ensure that the Health Board funds and recruits to a robust and sustainable model for urgent care.
Workshops have been set up in November and December to redesign the front door of our hospitals and develop and agree Internal Professional Standards.

It has been agreed that there will be no separate winter plan this year and that the schemes are aligned to the USC improvement programme. Proposed winter schemes are being reviewed within the following criteria:
1. Do the proposals align directly with the ambition of the USC plan?
2. Has it been done before and what metric demonstrated that it was successful?
3. Is there a realistic chance to recruit the staff against the timeline?

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**22 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-02		Risk Rating	Impact		Likelihood		Score		Appetite
Sustainable Key Health Services									
There is a risk that the Health Board may not be able to deliver sustainable key population health services to the wider population of North Wales due to demand exceeding capacity.		Inherent Risk	5	↔	4	↔	20	↔	Low
		Current Risk	5	↔	3	↔	15	↔	1 - 8
		Target Risk	5	↔	2	↔	10	↔	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1.Health Improvement & Reducing Inequalities Group (HIRIG) provides strategic direction and monitors delivery of the Population Health Services. HIRIG reports to Executive Team.	2	Health Board commitment to establishing priority services including: Programme management and recruitment to posts. Fully integrated Smoking Cessation Service	2	1) Implement a Tier 3 Children's Obesity service [In situ but some recruitment issues hindering full implementation.] 2) Implement a Healthy Weight pathway T1-3. 3) Implement and deliver the Immunisation Strategy. 4) Implement and deliver the Infant feeding strategy. 5) Implement and deliver a suite of Building a Healthier North Wales projects.	31 March 2022 31 March 2022 31 March 2023 31 March 2023 31 December 2022
2.Strategy, Partnership and Population Health Committee have oversight via standard reports by exception on progress.	2	Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place.	2	Embed BCUHB North Wales population health priorities within its operational and strategic plans.	1 April 2022
3.Welsh Government has oversight of Smoking Cessation, Building a Healthier Wales, Infant Feeding, Healthy Weight Healthy Wales, Immunisation programmes and provide an element of funding.	3	HIRIG provide reports nationally regarding expenditure and performance.	3	Standardised reporting and meet submission requirements once national reporting requirements determined. [Mid year reports due in October]	30 November 2022
4.The Executive Director of Public Health provides consistency to the regional strategic approach for North Wales in the form of expertise and prioritisation and through leadership of the Local Public Health Team.	2	Regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact. Recent appointments of Consultants in Public Health have increased expertise and support across the region [3, one part time]	3	1) Embed Public Health Outcomes approach into local planning through local partners and Health Board. 2) The Recovery Co-ordination Group (RCG) is focussing on Public Health actions as part of the recovery plan for North Wales. 3) Population Needs Assessment will provide local analysis for informing plans	31 March 2022 31 March 2022 31 May 2022

Review comments since last report:
A number of the updates remain largely unchanged since the last iteration of this BAF.
In respect of the first control, Tier 3 Children's Obesity service has recruited to all posts except the Psychologist post. This has been advertised twice and the service lead is reviewing further options. The service cannot be fully operational until the post is appointed to. In terms of the third control, clarification has been added to the gap column, to note that mid year reports are due in October, and the date column reflects this full 6 month effect, the national reporting format has not yet been received therefore the date has been changed to November 2022 to reflect delayed reporting. An additional mitigation has been added to the fourth control, to reflect the fact that recently appointed Consultants in Public Health have increased the expertise and support across the region. Given that its findings inform the strategic approach, completion of the next Population Needs Assessment has been added to the gap column, with a date of 31 May 2022.
The Risk Lead notes that:
• the population health risk increased due to lockdown, as a result of delays in services, forecast and unknown effects of COVID-19, and resource limitations affecting areas such as smoking cessation and obesity monitoring (many of the operational staff for lifestyle services were redeployed to support the COVID-19 response and vaccination programme)
• population Health is dependent upon system-wide commitment and actions through the Health Board's joint working with a range of partners including local authorities, the Third Sector, Education, Housing - all of which have been impacted by the need to respond to COVID-19 thus it is documented that health inequalities have worsened due to the pandemic e.g. smoking cessation and obesity monitoring.
These risks remain, therefore the risk scoring remains unchanged at the present time. Given the challenges of delivering sustainable key population health services to the wider population of North Wales within the context of increasing demand exceeding capacity, it is felt that achievement of the target risk score is a long term goal, potentially in 5-10 years. It is also acknowledged that this score is currently higher than the risk appetite.

Executive Lead:	**Board / Committee:**	**24 November 2021**
Teresa Owen, Executive Director of Public Health	Partnerships, People and Population Health Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 3: Primary and Community Care

Risk Reference: BAF21-03		Risk Rating	Impact		Likelihood		Score		Appetite
Primary Care Sustainable Health Services									
There is a risk that the Health Board will be unable to ensure timely access to Primary Care (GMS) Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital. As a gateway to health care, this could result in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce.		Inherent Risk	5		5		25		Low 1 - 8
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1. Each Area Team reviews GP practice sustainability and provides bespoke support to individual practices.	1	Regular review of 5 domains matrix. Escalation tool implemented and monitored by the Primary Care Panel, chaired by the Executive Director of Primary and Community Care, with reports provided to Quality, Safety and Experience Committee.	2	Delivery of Quality Assurance Visiting Programme across all contractors, in-depth review/visits which will be supportive for practices where concerns are identified.	31 March 2023
2. Delivery of All Wales Primary Care Model in place (including innovation and new ways of working), which is monitored by the Strategic Programme for Primary Care.	3	1)Review of current workforce profiles. 2)Delivery of milestones set by the national strategic programme. Contribution and leadership in the national priorities.	2	1) Primary Care Strategy for north Wales embedded in the clinical strategy of BCUHB. 2) Further development of primary care workforce plans, with a further consideration of the impact of the pandemic on assumed GP retirements [and refreshed age profiles] 3) Increase in the number of GP Trainees in north Wales (WG Statement in December 2020 stated that GP places would remain at current levels with the ability to over recruit if needed) - an increase in the number of GP trainees will not become a mitigation until actual recruitment takes place.	31 March 2022 31 December 2021 Date tbc
3. Provision of alternative services to increase capacity in GP practices in place.	1	Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services. Primary Care Transformation Fund in place across the clusters to support local innovation in addressing planned care backlog in primary care	1	Full roll out of UPCCs, subject to national evaluation & pathways. A presentation was made to Welsh Government on 19 May 2021 with a view to securing ongoing funding for the pathfinders - Confirmation of funding from Welsh Government was received in early July for East and Centre, with a further business case being developed for the West Area. [Update 23.11.21 - the Business case was approved by the Executive Team on 17 November and features as part of Winter Plan.] Transformation Fund launched in August has funded 30 proposals at an estimated cost of just under £2.8m; these include schemes to improve access and address chronic care model backlog in primary care.	31 March 2022
4. Primary & Community Care Academy (PACCA) in place with further development and roll out planned.	2	Academy work plan 2019/22 in place, monitored by the Strategic Leadership Group for the Academy and as part of the performance monitoring of the Health Board's Operational Plan which feeds through to the PPPH Committee.	2	1) Increase in Academy outputs to have a greater impact on primary care workforce modernisation & capacity. [Update 23.11.21 - Further business case presented to the Executive Team on 13 October with further discussions with Director of Workforce and OD held on 24 November; a revised case will be re-submitted to the Executive Team on 1 December and subject to approval to PFIG on 23 December.] 2) Strengthen coordination and implementation of work placements for training, mentorship and formal internship.	31 December 2021 31 March 2022
5. The Health Board has committed to work in partnership to develop proposal for a Medical School at the Univeristy of Bangor	1	Review progress in the development of a Medical School with Bangor University with the first commitment being delivery of medical degrees in partnership with Cardiff University (see below).	1	1) Ensure Primary Care Medical Workforce requirements are reflected in the final business case 2) Engage with Primary Care to ensure training capacity is considered in the business case [Update 23.11.21 - the primary care sub group continues to work to consider this detail. Also being discussed with area Medical Directors.] 3) A clinical director lead is required for for medical education in primary care. [Update 23.11.21 Approach agreed between primary care academy and Director of Medical and Dental Education.]	31 December 2021 31 December 2021 31 March 2022
6. Delivery of Medical Degrees at Bangor University in partnership with Cardiff University	1	Cardiff University in partnership with Bangor University have C21 programme supporting students undertaking their medical degree in north Wales. Students spend 12 months in Primary Care as part of their 4 year course.	1	1) Ensure sufficient capacity with Primary Care for medical students [Update 23.11.21 - C21 current year intake has increased from 20 to 25 students and in September 2022 up to 40. Capacity will be required in primary care for internships, alongside the medical school plans.]	31 December 2021
7. The Health Board continues to work in partnership with local HE providers to secure funding for and delivery of courses and programmes of education to attract and retain the workforce in north Wales	1	The development of the North Wales Dental Academy in partnership with HEIW, WG and Bangor University will provide an essential resource and training environment for the dental practitioners include Dental Hygienists and Dentists.	1	1) Establish Dental Training Unit in Bangor [Update 23.11.21 - tender approved by the Board and awarded with plans to develop the training unit from April 2022.]	01 April 2022
8. Cluster working/Health & Social care Localities in place with further development planned, with oversight by Area Teams, Regional Partnership Board Leadership Group and Integrated Care Boards (partnerships).	2	GP clusters have increased maturity throughout Covid-19 with practices working closely together with oversight by the Area Directors.	1	1) Development of broader cluster membership with the further integration with locality services. 2) Align the Health Board's development of clusters to Welsh Government's accelerated cluster development programme; Board development session planned for December; pan-cluster planning groups to be in place by next April.	01 March 2022 01 April 2022

Review comments since last report:
Actions under key control 3 have been updated to note that the Business case was approved by the Executive Team on 17 November and features as part of Winter Plan. The Transformation Fund which was launched in August has funded 30 proposals at an estimated cost of just under £2.8m; these include schemes to improve access and address chronic care model backlog in primary care.
In relation to the 4th key control - Primary and Community Care Academy, a further business case was presented to the Executive Team on 13 October with further discussions with the Director of Workforce and OD held on 24 November; a revised case will be re-submitted to the Executive Team on 1 December and subject to approval at the Performance, Finance and Information Governance Committee on 23 December. The target date for completion of this action has therefore been extended to 31 December 2021, from 31 October 2021.
For actions 2 and 3 of key control 5, the primary care sub group continues to work to consider this detail, which is also being discussed with area Medical Directors. An approach has been agreed between primary care academy and Director of Medical and Dental Education. Target dates for completion of these actions have now been set at 31 December 2021 and 31 March 2022.
Regarding key control 6, C21 current year intake has increased from 20 to 25 students and in September 2022 up to 40. Capacity will be required in primary care for internships, alongside the medical school plans.
The tender to establish Dental Training Unit in Bangor has been approved by the Board and awarded with plans to develop the training unit from April 2022.
It is anticipated that the Target Risk Score will be achieved by 31 March 2023.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Partnerships, People and Population Health Committee	**23 November 2021**

Linked to Operational Corporate Risks:
CRR20-05 Timely Access to Care Homes

Board Assurance Framework 2021/22

Strategic Priority 2: Recovering access to timely planned care pathways

Risk Reference: BAF21-04		Risk Rating	Impact		Likelihood		Score		Appetite
Timely Access to Planned Care									
There is a risk that the Health Board may be unable to deliver timely access to Planned Care due to a mismatch between demand and capacity and Covid-19, which could result in a significant backlog and potential clinical deterioration in some patient conditions.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	4	↔	5	↔	20	↔	
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Manual validation being conducted across all three sites on a daily and end of month basis.	2	Revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Performance, Finance and Information Governance Committee. Introduction of further validation staff in Q3/4 non recurring complete. Review of validation techniques and validation SOP completed; now ready for deployment and adoption. Subject matter expert reviewing validation exercises for planned care. [Update: Introduction of patient contact validation commenced in July for stage 1 and stage 4. This is a 9 week programme until end of October.	2	1)Validation staff being recruited on a fixed term basis to continue with validation work. [Update: 22.11.21 - A review of the vaidation resource required is being undertaken, including the release of consultant time to complete a secondary and clinical exercise.] 2) newly appointed head of ambulatory care will review the validation function to address unwarrented variation and move towards a corporate function {Update 22.11 - new head of ambulatory care now in post.}	1) 31 December 2021 2) 5 January 2022
Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group.	1	1)Ensure the waiting list size is continually validated and patients appropriately communicated with. 2)System introduced that allows patients to "opt in" for treatment. allowing a communication strategy to support the Q1/Q2 plan.	1	1) Introduce risk stratification for stages 1-3 (outpatients and diagnostics). Work currently ongoing with Welsh Government. {Update: 22.11.21 Internal risk stratification has been developed, subject to further advice from Welsh Government.} 2) Sites and areas have been completing backlog clearance plans to ensure the pre-Covid backlog is cleared by March 2022. However whilst the plan is in place slippage has been identified due to operational pressures and this is the subject of recovery plans. {Update: 22.11.21 Still on target to clear cohort 1 for March 2022 whilst recognising there are some pressure points.}	1) 31st December 2021 2) 31March 2022
Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Director of Regional Delivery and bi-monthly reporting to the Performance, Finance and Information Governance Committee.	2	Bi-monthly report to Performance, Finance and Information Governance Committee to provide assurance on planned care strategic and tactical developments.	2	Introduce substantive post into the organisation, currently covered on an interim solution, thus providing continuity and sustained leadership for planned care. Currently, the post is being filled by a further interim position whilst re-advertising for a permanent position.	31 March 2022
Once for North Wales approach introduced to standardise and ensure consistent delivery of general surgery, orthopaedics, Ophthalmology (Stage 4), Urology and Endoscopy to reduce health inequalities.	2	1)Weekly operational group with Divisional General Managers (DGMs) to ensure operational co-ordination of the Once for North Wales approach. 2)Scoping of new strategic model of care known as the diagnostic and treatment centre approach for planned care. Strategic outline case to be presented to Board and Welsh Government. 3) Insourcing for ophthamology introduced in February but has now been paused. 4) Over 52 week recovery plan for the 2019/20 end of March cohort as first phase agreed. 5)Ophthamology Business Case reviewed in light of Welsh Government Strategy re Cataract Centres. 6) Additional internal activity above core has been mobilised via recovery plan. 7) Outsourcing of orthopaedic activity contract awarded to Independent Sector to assist with clearing the backlog. 8) Strategy (6 point plan agreed for planned care over the next 3 years. This will improve the business process and reduce long waiting patients.	1	1) Introduction of outsourcing to undertake activity that supports P2-3 activity and over 52 week waiters, therefore reducing the overall waiting times. There are a number of strands to this work i.e. orthopaedics, ophthamology, dental, dermatology all of which are at differing levels of procurement. {Update: 22.11.21 - Contracts in place for orthopaedics and opthalmology and renegotiation for dental and dermatology.} 2) Business case for orthopaedic modular ward and theatre on each site has been paused but the organisation has an expression of interest for Regional Treatment Centres as an alternative. {Update: 22.11.21 - Indicative timescales for the RTC development should be known by 31 December, and at that stage decisons can be taken about the feasibility of modular ward, although the case are being worked on.}	1) 31 December 2021 2) 31 December 2021

Review comments since last report:
The first action under the first key control was marked as complete in the previous iteration of this BAF. However, a review of the vaidation resource required is being undertaken, including the release of consultant time to complete a secondary and clinical exercise. This action will be reviewed again by 31 December 2021. The new Head of Ambulatory Care is now in post.
In relation to key control 2, action 1, internal risk stratification has been developed, subject to further advice from Welsh Government. This target date for completion of this action has been extended to 31 December 2021, from 31 October 2021. In regards to clearing backlog, still on target to clear cohort 1 for March 2022 whilst recognising there are some pressure points.
For key control 4, action 1, contracts are now in place for orthopaedics and opthalmology and renegotiation for dental and dermatology. The target date for completion of this action has been extended to 31 December 2021, from 1 December 2021. For action 3, indicative timescales for the RTC development should be known by 31 December, and at that stage decisons can be taken about the feasibility of modular ward, although the case are being worked on. The target date for completion of this action has been extended to 31 December 2021, from 31 October 2021.
The Strategy (6 point plan) agreed for planned care over the next 3 years has become a mitigation.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Hill, Executive Director of Finance	Performance, Finance and Information Governance Committee and Quality, Safety and Experience Committee	**22 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-05		Risk Rating	Impact		Likelihood		Score		Appetite
Effective Stakeholder Relationships									
There is a risk that our relationships (internal and external) are ineffective. This could be caused by a lack of engagement, poorer communication, a lack of a co-productive approach, lack of direction, shared purpose and culture or insufficient service and organisational development. This could lead to a lack of trust, poor morale, high staff turnover, reduced stakeholder credibility plus reduced staff and public confidence, and an impact on services.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	2		2		4		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1. Together for Mental Health (T4MH) Strategy implemented with key stakeholders which sets out the direction of travel for Mental Health and Learning Disabilities services.	2	T4MH Partnership Board (T4MHPB) which oversees implementation of the strategy and includes key partners.	2	1) Revised terms of reference for the T4MHPB were approved by the Partnership Board on 9 July 2021. The review of the Strategy is now in train and an outline plan of the refresh was approved on 28.10.21. It is proposed that a one year approach is taken to the strategy, to keep it 'live' and dynamic. A number of engagement workshops have been scheduled and procurement for facilitating these is underway. Further update will be provided at the next Partnership Board in January. 2) Population needs assessment to be undertaken across North Wales which will influence the MH Strategy. 3) Delivery of Targeted Intervention Framework outcomes for Mental Health.	31 January 2022 31 March 2022 [may need to be extended depending upon Local Authority timelines] 31 March 2022
2. Deputy Director attendance at Regional Leadership group with regular feedback into the MHLD Division to ensure two-way communication and engagement.	2	Consistent and regular communication with senior Local Authority partners in relation to service redesign. Feedback to Senior Leadership Team on key issues	2		
3. Divisional CAG meetings whereby senior clinicians and managers discuss and agree service model across the division.	2	Recommendations from meetings presented to BCU Clinical Advisory Group and presented for sign off via Divisional Finance and Performance meeting.	2	To present update of service model to BCU CAG and then to Regional Leadership Group. [Update 24.11.21 - the development around the clinical model is progressing via the Clinical Strategy Group]	31 December 2021
4. In line with Divisional Wellness, Work and Us Strategy, oversight of all vacancies and sickness overseen by Divisional Workforce Group to ensure any identified demand and capacity pressures.	1	The MHLD division has introduced a workforce group which oversees key actions and identifies and escalates risks to Divisional Directors.	1		
5. Regular and concise communication with all staff groups across the division.	1	Fortnightly divisional staff engagement newsletter which highlights significant issues/service changes and celebrates staff achievements which reduces the risk of breakdown in communication. This is now embedded practice within the Division. Meeting with Staff Side to discuss key operational and strategic staffing issues. Partnership meeting now embedded. Monthly meetings between CAMHS and MH Senior Leadership Teams continue, to ensure effective joint working and system planning being clinically and financially effective.	1		
6. Service users, carers and the public to have the opportunity to be involved in the development, planning, design and delivery of the services.	2	Divisional Patient and Carer Engagement Group re-introduced in order to listen better and use feedback from consultation and engagement to make mental health and learning disability services more relevant to service users and carers' needs. We are reviewing the CANIAD contract to ensure integrated working. Potential gap in advocacy contract arrangements addressed.	2	1) To ensure the review of the CANIAD contract is discussed with the North Wales Leadership group for the joint review. Currently out to procurement for independent review of the CANIAD contract. [Update 24.11.21 - the CANIAD contract will come to its natural end in March 2022. The division has informed the area partnership board that it is intending to undertake a series of engagement events to understand future needs for the engagement with patients and carers for the division] .	31 March 2022
7. Closer and regular working with North Wales CHC to ensure the population of North Wales have the opportunity to feedback on their experiences of local services and to contribute to the future design.	3	Safe space events started in December 2020 have been set up with CHC to engage with North Wales population to seek views/experiences of MHLD services. Deputy Director & Director of Nursing are attending the CHC AGM.	3	MHLD Division to agree process for sharing feedback from events with staff groups. An action plan is being developed following the Safe Space events facilitated by the CHC. [Update: 24.11.21 - Continuing to work closely with the CHC and engaged with the wider population].	31 March 2022

Review comments since last report:
The review of the T4MHPB Strategy is in train and an outline plan of the refresh was approved on 28 October 2021. It is proposed that a one year approach is taken to the strategy, to keep it 'live' and dynamic. A number of engagement workshops have been scheduled and procurement for facilitating these is underway. Further update will be provided at the next Partnership Board in January. The target date to complete this action has therefore been extended to 31 January 2022, from 28 October 2021.
The development around the clinical model is progressing via the Clinical Strategy Group.
The actions noted as complete in the last iteration of the BAF under key controls 5 and 6 have now become mitigations.
The CANIAD contract will come to its natural end by March 2022. The division has informed the area partnership board that it is intending to undertake a series of engagement events to understand future needs for the engagement with patients and carers for the division. The target date for completion of this action has been extended to 31 March 2022, from 31 October 2021.
Risk scores remain unchanged. The Risk Lead anticipates that the target risk date will be achieved by 31 March 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Partnerships, People and Population Health Committee	**24 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-06		Risk Rating	Impact		Likelihood		Score		Appetite
Safe and Effective Mental Health Service Delivery									
There is a risk to the safe and effective delivery of MHLD services. This could be due to unwarranted variation and inefficiencies. This could lead to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	3		3		9		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division.	1	1) Key divisional roles in governance and safety have been aligned to corporate reporting since 1.11.20. 2) Formal reporting and financial transfer of budget complete to ensure the alignment of governance and associated roles to BCUHB corporate. 3) Regular meetings are in place with Corporate Governance Leads.	2		
Partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms of Reference. The East Local Implementation Team has been re-established; work is ongoing to re-establish in the other Areas. There has been a review of the Terms of Reference of the T4MHPB)	1	Partnership working and reporting assures flow of information and raising of any concerns over delivery or equity. North Wales Community Health Council have held a number of formal stakeholder listening events for the division and a report from the CHC has now been received. The Director of Mental Health meets formally with the 6 local authority directors.	1	1) The T4MH Partnership Board is now meeting regularly. Interim Deputy Director leading this key partnership agenda.	31 December 2021
The Mental Health Learning Disabilities Divisions Senior Leadership Team in place with regular cycle of business meetings. This is a control for the delivery of safe and effective services. Regular reports are presented to the appropriate governance body.	1	1)The Mental Health Learning Disability Division has an agreed management structure (2019). It provides timely reports to the agreed Committees of the Board and the Executive Team and is held to account by them for delivery of a safe and effective Mental Health and Learning Disability Service. 2) Divisional triumvirate in place (albeit interim cover is currently in place through to September 2022). The division has created 1 Director of Operational Delivery and 1 additional deputy director for strategy and partnerships to fill operating gaps in partnership and strategy development. Head of Psychology now in post.	2	1. Work is ongoing to address the continuity of the other interim roles within the senior leadership team. 2. Delivery of Targeted Improvement Framework outcomes for Mental Health. This work is now in progress and maturing with the Targeted Improvement Evidence Group scrutinising the evidence of accomplishment of the maturity matrix.	1 September 2022 31 March 2022

Review comments since last report:
It has been made explicit under the key mitigation for the third key control that the division has created 1 Director of Operational Delivery and 1 additional deputy director for strategy and partnerships. The title of the Targeted Intervention Framework has been changed to Targeted Improvement Framework to align with the new title.
It is anticipated that the target risk score will be achieved by the end of September 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	**19 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-07		Risk Rating	Impact		Likelihood		Score		Appetite
Mental Health Leadership Model									
There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.		Inherent Risk	5		5		25		Low 1 - 8
		Current Risk	4	↓	3	↔	12	↓	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1.Substantive Senior Leaders in place and providing stable and sustainable senior management within the Division. [Interims currently in place alongside other key posts; Interim Director, Interim Director of Nursing, Interim Deputy Director and Interim Director of Operations. Each lead specific programmes and will further support and develop leadership, governance and management.]	1	Interim Leadership changes are regularly reviewed by the Executive Director to ensure the model is effective in discharging its roles and responsibilities.	2	Stabilise Senior Management with substantive posts. Sustainability needs to reviewed as a matter of priority to ensure continuity [Update 15.11.21 - Interim Senior Management arrangements agreed for a fixed term period of 12 months, to support stabilising the Division to ensure continuity.]	31 March 2022
2.Strategy approved and regular updates reported to Welsh Government via Targeted Improvement mechanisms.	2	All key actions will be further developed and underpin the required work to have a well developed, fully integrated, Integrated Medium Term Plan (IMTP), which will further strengthen and support an effective model. Oversight will be via the Clinical Advisory Group (CAG).	2	Review the Mental Health structure to ensure it is fit for purpose and reflects new clinical pathways. [Update: 15.11.21 Divisional Operational Plan agreed and updates provided to Welsh Government. The division has embraced the maturity matrix approach, and submitted evidence to show the improvement journey currently at level 1, with the aim of achieving level 2 within six months. Progress discussed and attainment level agreed at the monthly meetings with the BCU Targeted Intervention sub-group.]	31 March 2022
		Engagement has been re-established through the Pathway Development Groups (e.g. Rehab / OPMH) with regular and consistent attendance with Regional Partners and stakeholders via North Wales leadership groups.	2	Implement the Mental Health Strategy in a consistent manner across the Health Board [Update 15.11.21 Pathway groups continue to progress, submitting minutes, action logs and agendas as evidence for the maturity matrix].	31 January 2022
		Pathway groups are clinically led and partners working to deliver the strategy, patients groups are members of those groups. All pathway groups report via the Clinical Strategy Group (formerly Division Clinical Advisory Group).	2	Evaluate regional management and pathway structure approach to delivery of strategy via a pilot and report findings to the Executive Team.	31 January 2022
		Business Case developed with additional funding from Welsh Government secured. Scrutiny of financial governance monitored by Head of Finance.	1	Business case to be completed. [Update 15.11.21 Business Case completed. Transformational funding is monitored by the Head of Finance, updates provided to the Divisional Senior Leadership Team.	Completed
3.Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team.	2	Business Continuity Plans are updated within the Area with final scrutiny and approval at the Divisional monthly Finance and Performance Meeting.	1		
4.Divisional Quality, Safety and Experience Group meeting monthly, chaired by the Interim Director of Nursing to oversee Divisional governance arrangements and reporting, with oversight at the QSE Board Committee.	1	Division has actively worked to ensure that the Division's Governance Structure more accurately reflects and is coherent with BCUHB's overarching governance structure Cycle of business in place to support effective reporting to the revised BCUHB governance structure.			
5. Stronger Together Engagement across the divisions.	2	Meetings held across the divisions during the Discovery stage. Standing up of divisional training and development group. Recruitment of a MH&LD Coach.	1	Appointment of MH&LD Coach	31 January 2022

Review comments since last report:
For the first key control, Interim Senior Management arrangements agreed for a fixed term period of 12 months, to support stabilising the Division to ensure continuity. The target date for the completion of this action has been extended to 31 March 2022, given the extension of some of the interim senior posts.
For key control 2, first action, a Divisional Operational Plan has been agreed and updates provided to Welsh Government. The division had embraced the maturity matrix approach and submitted evidence to show the improvement journey currently at level 1 with the aim of achieving level 2 within six months. Update on progress is provided at the monthly meetings with the BCU Targeted Intervention sub-group. The target date for the completion of this action has also been extended to 31 March 2022 from 31 December 2021. In relation to the second action, Pathway groups are progressing and submitting minutes, action logs and agendas as evidence for the maturity matrix. The target date for the completion of this action has also been extended to 31 January 2022 from 31 December 2021. For the third action, all pathway groups report via the Clinical Strategy Group (formerly Division Clinical Advisory Group). The target date for completion of this action has been extended to 31 January 2022 from 31 December 2021 due to the Covid-19 winter pressures. Fourth action - The business case is completed and the transformational funding is monitored by the Head of Finance and update provided to the Divisional Senior Leadership Team. The target date for completion of this action has been extended to 28 February 2022 from 31 December 2021 to ensure this is on target.
A fifth key control has been added: Stronger Together Engagement across the divisions. The target date for completion of the action in relation to this (appointment of Divisional Coach) has been set at 31 March 2022.
Given the progress made so far and the stability and continuity provided as a result of the extension to some senior interim posts, the current risk score has been reduced to 12 (4x3) from 15 (5x3).

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Partnerships, People and Population Health Committee	**15 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 6: Integration and Improvement of Mental Health Services

Risk Reference: BAF21-08		**Risk Rating**	**Impact**		**Likelihood**		**Score**		**Appetite**
Mental Health Service Delivery During Pandemic Management									
There is a risk to the safe and effective delivery of Mental Health & Learning Disability (MH&LD) services. This could be due to the consequences of the COVID-19 pandemic. This could lead to changing type and level of demand across the region, a lack of appropriate staff and resources, poorer outcomes for our population.		Inherent Risk	4		4		16		Low 1 - 6
		Current Risk	3	↔	3	↔	9	↔	
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
MH&LD Covid19 Lead has been identified, and reports into the Divisional Governance meetings, Covid19 Divisional meetings and Covid19 Corporate meetings. Weekly Establishment Control meetings. Monthly operational accountability meetings.	1	1) MH&LD Covid19 Winter Plan discussed and agreed in both the Divisional and Corporate Clinical Advisory Group (CAG). 2) MH&LD Operational Covid19 Winter Plan fully implemented. (All patient transfers now progressed back to localities, although direct admission to Bryn Hesketh are being worked through due to outstanding estates works)	2	Review of 2021/22 Covid-19 winter plan underway.	30 November 2021
MH&LD Covid19 Winter Plan approved in both the Divisional Covid19 CAG meeting 3.11.20, and Corporate CAG meeting 6.11.20. Gaps in recruitment have been assessed and recruitment plan established as part of ESR.	1	MH&LD Engagement and Communication Plan in place to ensure effective and efficient communication across the MH&LD Division and also to all key stakeholders, both external and internal. This includes sharing the MH&LD Covid19 Winter plan. Monthly reporting against ESR and the divisional actions to scrutinise them through Senior Leadership Team (SLT).	2	Recruitment to vacancies identified as part of each area agreed establishment plan to be progressed. {Update: 13.10.21 Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Divisional Operational Leadership Meeting and Divisional workforce meetings. Alternative options for recruitment are being considered and implemented to enhance recruitment; for example, virtual recruitment drive.}	31 March 2022
Wellness, Work and Us Strategy launched in October 2020, to ensure staff are supported. Approved by the MH&LD Divisional Directors within the Divisional Business meeting September 2020.	1	1) Engagement sessions held across the MH&LD Division regarding the Wellness, Work and Us Strategies. Reviewed Year One priorities aligned to Covid19, ongoing implementation. 2)Approval by Corporate Business Continuity Lead for quality checking, and final sign of by the Divisional SLT at the appropriate Governance meeting of Business Continuity Plans and MH&LD Covid19 Action Cards. (East Business Continuity plan received Divisional sign off)	1	1) The year 1 priorities of the Wellness, Work and Us Strategies are being progressed. 2) A review of the covid19 action cards is underway	30 November 2021
Business Impact Analysis, Business Continuity Plans and MH&LD Covid19 Action Cards implemented November 2020.	1	1) Support being delivered by Corporate Business Continuity Lead to quality check the MH&LD Business Continuity Plans. 2)Revisit and assess gaps in recruitment processes to support additional staff requirements. 3)Heddfan Establishment review undertaken and discussed in Gold Command meeting, 5.2.21	2	Having assessed the gaps in the recruitment processes it has been agreed that a full establishment review should be undertaken to clarify future needs and resource requirements. {Update 13.10.21 - All documents have been submitted to BCU Business Continuity department. Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Divisional Operational Leadership Meeting and Divisional workforce meetings. Establishment review has commenced across all inpatient units.}	30 September 2021 31 March 2022
MH&LD Divisional PPE Task and Finish Group in place, reporting into MH&LD Divisional daily SITREP call, MH&LD Covid19 Briefing meeting and Corporate PPE Task and Finish Group.	2	1) Monitoring and reviewing PPE availability, MH&LD Divisional plan developed and monitored to ensure all staff are appropriately FIT testing as part of key mitigation, feeds into Corporate PPE Task and Finish Group. Also reports to the Corporate FIT testing Steering Group. 2) Process to ensure continuous mapping of staff to enable redeployment decisions.	2	1) Monitoring and review continues with daily PPE stock levels and fit testing staff numbers included on the daily SITREP. Divisional representation continues to attend the Corporate PPE Task and Finish Group and Corporate FIT testing Steering Group continues. 2) MH&LD staff escalation policy reaffirmed across the Division.	
Clinical Patient Pathway, approved by Clinical Advisory Group, monitored and reviewed by the MH&LD Clinical Pathway Group and changes made aligned to the Covid19 Winter Plan.	1	MH&LD SITREPS completed daily, with oversight by Covid MH&LD Lead. MH&LD SITREPS sent daily to Executive Nurse Director. Staffing pressures reviewed in daily SITREPS and Divisional Safety Huddle, any issue escalated to Corporate Staff Redeployment meeting.	1	Review of 2021/22 Covid-19 winter plan underway, which incorporates the clinical patient pathway.	
Covid 19 Training in place with compliance monitored and reviewed through Workforce Work stream.	2	The MH&LD Operational Leadership meeting in place currently meets weekly, reports into the Divisional SLT business meeting and continues to feed into EIMT corporate meeting.	2		
MH&LD Divisional Workforce meeting, currently meeting monthly to review workforce plan, reports into the DSLT business meetings.	1	1) MH&LD Covid-19 Command Structure SOP developed 21st December 2020. 2) MH&LD Covid-19 Command Structure Standard Operating Procedure (SOP) operationalised.	1		
Attend Anywhere in operation across the MH&LD Division to provide a virtual consultation platform to allow the continuation of appropriate services, approved by the Divisional Clinical Advisory Group and is part of the MH&LD Winter Plan.	1	Divisional prioritisation of IT equipment requirements completed and forwarded to IT.	1	1)This project was initially progressed as a proof of concept which has been beneficial and is therefore support by the Division for wider roll out - this project is also aligned to Information Management and Technology (IM&T) implementation. {Update 13.10.21 - Monitoring and review of Attend Anywhere utilisation taking place across divisions.}	31 December 2021

Review comments since last report:
The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised as follows:

Key Controls - MH&LD Covid19 Lead has been identified & MH&LD Covid19 Winter Plan: A review of the 2021/22 Covid-19 Winter Plan is underway, and the target date for completing the action set at 30 November 2021. Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Operational Leadership meeting and Divisional workforce meetings. Alternative options for recruitment are being considered and implemented to enhance recruitment, for example, virtual recruitment drive. The target date for actualising this action has been extended to 31 March 2022, from 31 August 2021.

Key Control - Wellness, Work and Us Strategy: The year 1 priorities of the Wellness, Work and Us Strategies are being progressed and a review of the Covid-19 action cards is underway. The target date for completing these actions have been set at 30 November 2021.

Key Control - Business Impact Analysis: All documents have been submitted to the BCU business continuity department. Divisional vacancy monthly activity report continues to be discussed, monitored and reviewed at the Operational Leadership meeting and Divisional workforce meetings. Establishment review has commenced across all inpatient units. The target date has been extended to 31 March 2022 from 30 September 2021, given the length of time the establishment review will take to complete.

Key Control - MH&LD Divisional PPE Task and Finish Group: Monitoring and review continues with daily PPE stock levels and fit testing staff numbers included on the daily SITREP. Divisional representation continues to attend the Corporate PPE Task and Finish Group and Corporate FIT testing Steering Group continues. MH&LD Staff escalation policy re-affirmed across the Division.

Key Control - Clinical Patient Pathway: A review of 2021/22 Covid-19 winter plan underway, which incorporates the clinical patient pathway.

Key Control - Covid 19 Training: The key mitigation has been revised to reflect that the MH&LD Operational Leadership meeting in place currently meets weekly, reports into the Divisional SLT business meeting and continues to feed into EIMT corporate meeting.

8th Key Control has been revised to reflect that the MH&LD Divisional Workforce meeting, currently meeting monthly (previously fortnightly) to review workforce plan, reports into the DSLT business meetings (previously reporting into the MH&LD Covid19 briefing meeting and the Divisional Governance meetings).

Key Control: Attend Anywhere: Monitoring and review of Attend Anywhere utilisation is taking place across divisions.

Executive Lead:	**Board / Committee:**	**Review Date:**
Teresa Owen, Executive Director of Public Health	Quality, Safety and Experience Committee	13 October 2021

Linked to Operational Corporate Risks:

Board Assurance Framework 2021-22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-09		Risk Rating	Impact		Likelihood		Score		Appetite
Infection Prevention and Control									
There is a risk that Health Board may not be able to deliver appropriate care to patients and they may suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		Inherent Risk	4	↔	5	↔	20	↔	Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4	↔	3	↔	12	↔	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Leadership and Governance in place to support the infection prevention and control agenda throughout the health board. Delivering a zero tolerance approach to HCAI as culture.	2	Business case approved and recruitment commenced to increase IPC team/resource. Risk register monitored and escalated via Infection Prevention Steering Group (IPSG) and Patient Safety & Quality Group. Safe, clean care harm free programme commenced, Hospital and Area directors on steering group to oversee delivery. Re-launch of senior leadership walk rounds	2	Analysis to be undertaken to ensure that there is the right leadership in place across Directorates/Divisions/Teams who understand infection prevention and the appropriate escalation arrangements in place across the Health Board. Finalise recruitment to increase IPC Team resource. Engage clinical directors in IPC to be interegal to clinical governance. Safe clean care programme support required to support and manage and assure delivery.[Update 27.7.21 - 3 posts agreed] Substantively recruit into the Director of Nursing IPC role and carry out a whole team review with a view to pulling together a new team structure by end December to be fit for present and future. Ensure harm free care is integral to accountability meetings within the Health Board.	31 December 2021 Complete 30 November 2021 31 December 2021
Buildings/Environment - to be adequate and fit for clinical purpose in reducing/preventing infection	2	Monitoring of performance and risk in place to Public Health Wales and Welsh Government guidance. Ensuring any refurbishment/new build has the right ventilation and 3.6m bed spacing. As part of Safe Clean Care, reviewing bed spacing with a view to having a risk assessed approach and to align with other improvement programmes e.g. urgent care and planned care	2	Identify decant facilities on all clinical sites to ensure an effective deep cleaning programme (Hydrogen Peroxide Vapour {HPV}) and rolling maintenance programme can be set up. {Update: 05.10.21 - The issue with securing routine decant facilities is significantly impacted by the high occupancy rate and the issues around patient flow.} Development of a real time information platform to focus improvement actions and highlight gaps. To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. Estates is redoing there original work to understand compliance and gap to 3.6m bed spacing. Areas taking a risk assessed approach to bed spacing and aligning with wider transformation work. Safe Place (Safe Clean Care Harm Free work stream) SRO now	31 October 2021 31 October 2025 31 October 2021 Complete
Equipment - making sure we have the right equipment, adequately maintained and stored correctly in each of the clinical areas	1	Having a robust tracking system to monitor equipment and maintenance	1	There is no robust way of tracking all equipment e.g. mattresses for decontamination purposes - there is a 6 monthly mattress audit programme but this lacks tracking of decontaminated mattresses; there is lack of assurance in terms of knowing whether or not mattresses are in use that should have been taken out of circulation. An IT tracking system is required (a request is to be submitted to the Executive Team, to ask for reprioritisation as this is not currently part of IT priorities, potential expansion of iFIT technology. {Update: 05.10.21 - this has been added for consideration on next year's IT annual plan.}	tbc
Cleaning - appropriate resource adequately trained are required to minimised transmission risk from equipment / environment	1	An additional £2.4m for enhanced cleaning has been agreed by Welsh Government	1	Work needs to come to fruition, so that 'nurse cleaning duties' become simply 'cleaning duties' - to allow nurses to nurse, as opposed to spending their time on cleaning. Cleaning supervision plan to support development of new and existing workforce. {Update: 05.10.21 - The recruitment process started; however, this is a significant ask given the numbers to be recruited including supervisors and training requirement.}	30 April 2022
Maintenance of buildings and equipment - maintaining to an optimum level	1	Estates backlog maintenance programme (Cross-reference to Estates risk)	1	The significant backlog of maintenance will impact on the ability to deliver - date is dependent upon roll out of the Estates Strategy. {Update: 05.10.21 - The Infection Prevention Steering Group (IPSG) will be provided with an update on the backlog programme.}	Dependent upon roll out of Estates Strategy
IPC Training, mandatory and targeted with Supervision (competency sign off) Regular observation and feedback	1	IPSG monitoring compliance through assurance section of agenda. Align training and competence compliance to study leave/PDR for all staff groups.	1	IPC mandatory training compliance is low amongst medics, and there is a lack of medical engagement at IPSG meetings - this has been escalated to the Executive Medical Director and there will be further escalation to the Executive Director of Nursing & Midwifery. {Update: 05.10.21 - The IPC team is working with the HR training department on getting a definitive list on who is not trained, specifically for doctors as they have significantly low level mandatory training level.} Only 15 mins allocated to IPC at junior doctor induction. This has been raised with Medical Director as to how to better train juniors. Low Anti Non Touch Technique (ANTT) in some areas and staff groups. Escalate through responsible directors for action via clinical leads. {Update: 05.10.21 - Work is ongoing with junior doctor colleagues on designing interactive training both for induction and ongoing training.} {Update: 05.10.21 - Developed and running regular IPC Champions training every Tuesday with the aim of every department having a trained IPC Champion working in those departments.}	31 March 2022
Behavioural change/ transformation - Ensure HB transformation programme adopt the Safe Clean Care-Harm Free principles to reduce and maintain improvements around zero tolerance approach to nosocomial infections	1	1) Every accountable area has an infection prevention 21/22 plan on a page and all have carried out 40 point self-assessments (2nd round in July 2021) - Safe Clean Care Harm Free programmes flow from this. 2) Work, policy and risk register review programmes in place. Microbiology and Antimicrobial stewardship activity overseen by Infection Prevention Sub Group (IPSG), Audit Committee/ Patient Safety & Quality Group and Quality and Safety Executive.	1	To develop the leadership (all levels) to influence culture and behaviours to ensure that infection prevention becomes habit. This is an integral part of the safe, clean care harm free programme. IT solution and information leadership required to ensure that the right data is captured which can then be transformed into intelligence, so that people delivering care can see that they are delivering safe practice (real time system) and supporting releasing time to care. Strengthening of effective reporting arrangements through outbreak control groups and IPSG Not having enough people with the right skill set to support the accountable areas undertake their service improvement and transformation programme around IPC. Working with the Transformation Team for ongoing mitigation.	31 March 2022
Policies, Audits, and observation - All IPC policies are in date and reviewed against Welsh Government guidance and best practice.	1	Learning from patient infection reviews, matrons' audits and senior leadership walk rounds to steer improvements. Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections. Audits developed to assure policies are embedded in practice.	1	Not all aspects of the system are electronic - work is underway on this to have in place the capability for instantaneous results through eforms and Office 365 apps. The reviewed infection prevention policies require final agreement from the Clinical Policies and Procedures Group. There is a need to ensure that the most effective control measures are being monitored at a local level (LIPG/Outbreak Control Meetings) and assurance reporting to IPSG/QSE Committee.	31 December 2021 Complete Complete

Review comments since last report:
The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised as follows:
Key Control - Leadership and Governance: 2nd gap/action: Recruitment to increase IPC team resource has been finalised. This action is marked as complete.
5th gap/action: This has been revised to include carrying out a whole team review with a view to pulling together a new team structure by end December to be fit for present and future.
Key Control - Buildings/Environment: 1st gap/action: Revised to note that the issue with securing routine decant facilities is significantly impacted by the high occupancy rate and the issues around patient flow.
4th gap/control: Estates have completed work on redoing the original work to understand compliance and gap to 3.6m bed spacing. This is now marked as complete.
Key Control - Equipment: This has been added for consideration on next year's IT annual plan.
Key Control - Cleaning: The recruitment process started; however, this is a significant ask given the numbers to be recruited including supervisors and training requirement.
Key Control - Maintenance: The Infection Prevention Steering Group (IPSG) will be provided with an update on the backlog programme.
Key Control - IPC Training: 1st gap/action: The IPC team is working with the HR training department on getting a definitive list on who is not trained, specifically for doctors as they have significantly low level mandatory training level.
2nd gap/action: Work is ongoing with junior doctor colleagues on designing interactive training both for induction and ongoing training.
3rd action added: Developed and running regular IPC Champions training every Tuesday with the aim of every department having a trained IPC Champion working in those departments.
Key Control - Behavioural change/ transformation: added a 4th gap/action - Not having enough people with the right skill set to support the accountable areas undertake their service improvement and transformation programme around IPC. Working with the Transformation Team for ongoing mitigation.
Key Control - Policies, Audits, and observation: The key control description '*Major Outbreak policy (IPO5) currently in place for managing Covid 19 infections* ' has become a key mitigation; while the key mitigation '*All IPC policies are in date and reviewed against Welsh Government guidance and best practice* ', has become the key control description.
2nd and 3rd gap/actions have been completed.

Executive Lead:	Board / Committee:	Review Date: 05 October 2021
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing focus

Risk Reference: BAF21-10		Risk Rating	Impact		Likelihood		Score		Appetite
Listening and Learning									
There is a risk that adverse events occur, or re-occur, in the organisation due to: 1) Lack of a clear and easy mechanism for patients or staff to raise incidents or complaints, 2) lack of a clear, effective and transparent mechanism for reviewing, addressing, sharing learning and feedback from reviews/investigations, 3) lack of trust and confidence in the systems and process. These adverse events could result in avoidable harm to patients or staff, disruption to clinical and support services, avoidable costs and loss of public and stakeholder confidence.		Inherent Risk	5		5		25		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Incident reporting and investigation procedure, systems and processes in place - includes lessons learning learned being shared and actions tracked with reporting to Patient Safety and Quality Group (PSQ) and Quality, Safety and Experience Committee (QSE).	2	Training programme implemented for staff involved in investigations and sharing of learning.	2	Implementation of new procedures and processes for incidents, complaints, claims, redress, safety alerts and inquests - new processes will focus on learning and improvement, with improved use of technology. This will address aspects 1, 2 and 3 of the risk.	Complete
Complaint reporting and investigation procedure, systems and processes in place - includes lessons learned being shared and actions tracked and fed back to patients, families and carers with reporting to PSQ and QSE.	2	Use of the Datix concerns management system to track events, investigations and actions with reporting to PSQ and QSE.	2	Implementation of the new Datix IQ Cloud system for incidents, complaints, redress, claims and mortality reviews - new system will improve the quality of information (including across Wales) and the ability to triangulate information better. This will address aspects 1, 2 and 3 of the risk.	01 April 2022
Safety alerts procedure, systems and processes (both national and local alerts) - includes actions being tracked and WG Compliance Returns completed with reporting to PSQ and QSE.	3	Reporting on patient safety and patient and carer experience to local, divisional and Health Board groups and committees.	2	Implementation of a new skills pathway and passport for those involved in investigations and sharing of learning. This will address aspects 2 and 3 of the risk.	30 September 2021
Claims and redress investigation procedure, systems and processes - includes completion of Welsh Risk Pool (WRP) Learning from Events Reports evidencing learning which are reviewed by the WRP Committee with reporting to PSQ and QSE.	3	Dashboards and information available at local, divisional and Health Board level to provide oversight of quality and safety indicators.	2	Implementation of a new digital learning library to bring together the access, cascade, and sharing of lessons learned. This will address aspects 2 and 3 of the risk.	01 April 2022
Learning from deaths procedure, systems and processes including mortality reviews, inquest coordination and interaction with Medical Examiners in place with reporting to CEG and QSE.	2	Implementation of an organisation-wide integrated Quality Dashboard.		Implementation of safety culture initiatives including development of a human factors community of practice, embedding of just culture principles into processes, embedding of Safety II considerations, learning from excellence reporting, annual safety culture survey, and safety culture promotion initiatives. This will address aspects 1, 2 and 3 of the risk.	31 March 2022
Local and organisation-wide safety culture and quality improvement initiatives based on identified themes, trends and areas of concern with reporting to PSQ and QSE.	2			Implementation of a new Quality Strategy (developed with patients, partners and staff) containing organisational improvement priorities and enabling measures aligned to the organisational strategy. This will address aspects 2 and 3 of the risk.	31 March 2022
		Implementation completed, of a new Speak out Safely process for staff to raise concerns . This addresses aspects 1, 2 and 3 of the overall risk.			

Review comments since last report: Target action dates have been reviewed and updated as appropriate, acknowledging the delay in roll out of the new Datix system and postponing the full implementation until the spring thus avoiding roll out during the height of winter pressures. The delay in the Lessons Learnt Library is to align with the launch of the new Intranet. The target risk score is aimed for 31 March 2023 reflecting that in addition to system and process improvements, culture improvement is a key component.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO / Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**27 September 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-11		Risk Rating	Impact	Likelihood	Score	Appetite
Culture - Staff Engagement						
There is a risk that the Health Board loses the engagement and empowerment of its workforce as a result of staff not feeling that it is safe and/or worthwhile highlighting concerns due to: Lack of clear mechanisms for raising concerns at any and every level, lack of a clear, effective and transparent mechanism for listening, reviewing, addressing, sharing learning and feedback, lack of trust and confidence regarding the reception of and impact of raising concerns, lack of support and guidance for all parties involved. This could lead to an impact on the organisation being able to learn from experience or improve services, which could result in poor staff morale, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board.		Inherent Risk	4	5	20	Low 1 - 6
		Current Risk	4	4	16	
		Target Risk	4	3	12	

Key Controls	level *	Key mitigations	co level	Gaps *(actions to achieve target risk score)*	Date
Key Policies: 1.Raising Concerns Policy 2.Safehaven Guidance	2	Revised new Speak Out Safely process agreed by Remuneration and Terms of Service Committee 1st February 2021. Key elements: 1. External platform for Work in Confidence now operational since July 2021 (replaced Safehaven) - this enables staff to engage in, dependent on preference, anonymous and/or two way dialogue with Speak Out Safely Guardians and/or members of wider Multi-disciplinary Team. 2. Four Speak Out Safely Guardians commenced in post on 1st October, each undertaking this role for the equivalent of one day a week. One of these Guardians is Welsh speaker. Guardians report directly to CEO, with an independent board member to support and scrutinise Guardians' role and the new Multi-Disciplinary Team is established and meets fortnightly - the role is to review concerns raised, agree actions required; and, monitor themes to identify learning; 3. Role outline for Speak Out Safely Champions has been finalised in collaboration with Trade Union partners and Champion network meetings commenced 4. Speak Out Safely internet pages, as required by the Communication and Promotion Plan are in situ; 5. WP4a policy (Raising Concerns) has been revised to reflect the transition to the new process 6. Previous concerns raised through Safehaven process have now been collaboratively managed between Safehaven team and SOS MDT to ensure they were not 'lost' during transition phase. All cases either resolved or picked up by SOS MDT; Safehaven has been closed down - summary report of final activity as part of closedown process has been provided and incorporated into review of SOS that went to R&TS Committee (Oct 2021)	1	1. Work in Confidence platform launched in early July now in operation [becomes a mitigation]. 2. Four Speak Out Safely Guardians were appointed and commenced on 1st October, each undertaking this role for the equivalent of one day a week. One of these Guardians is Welsh speaker [will become a mitigation] 3. MDT now meeting fortnightly from end of June [now becomes a mitigation] 4. SOP (including a raising concerns route process map has been written and was discusssed for sign off at SOS Task and Finish Group on 16/11/21, with one week given for any final comments. SOP includes agreed role outlines for Guardians, Speak out Safely Champions and independent member and terms of reference for MDT. The second iteration of the Raising Concerns Process Map has been completed following review by members of the SOS Task and Finish group and is now incorporated into the Standard Operating Procedure document for SOS (and will then become a mitigation). This includes all routes through which staff may raise concerns in addition to accessing the Work in Confidence platform. The process mapping has included concerns that may be raised through HR, Health and Safety, Patient Safety and Experience, the Office of the Board secretary (including anonymous concerns), Information Governance, Trade Union Partners and with Safeguarding the one area outstanding to be included. The process mapping ensures that the Speak out Safely process is inclusive of all routes to raise concerns and that a co-ordinated approach is taken to responding to and managing concerns. 5 Internet pages for Speak Out Safely have been developed and are live, as required by the Communications Plan [becomes a mitigation] 6. Evaluation metrics to monitor impact of new process under development (including use of data, and user impact surveys). 7. Ongoing concerns raised through Safehaven process have been managed via liaison between SOS MDT and Safehaven team to ensure they were not 'lost' during transition phase ; all cases in Safehaven now transferred and Safehaven has now been closed down [becomes a mitigation]. 8. The engagement with staff from across the Health Board through the Discovery phase of Mewn Undod Mae Nerth/Stronger Together and the creation of an active on-going Stronger Together community will ensure on-going engagement with staff during the co-design and co-delivery phases of Stronger Together to support the creation of a learning culture in which staff feel more confident in and supported to raise concerns. 9. Discussion on Speak out Safely being held with the BCUUnity Ethnic Minority and Overseas staff network on 17.11.21	30 September 2021[draft process mapping completed] 31st October 2021 [SOP amended to include process mapping)
3. Dignity at Work Policy - Now Respect and Resolution Policy 4. Grievance Policy	2	Assessment of cases upon submission to determine most appropriate process undertaken. Case management review takes place monthly. Thematic review in place at operational level.	1	1. Respect and Resolution Policy is now live with FAQs to support. Additional mediators to support current mediators will be trained in the next cohort as part of the all Wales rollout. 2.Training package has been developed in BCUHB for managers and is being rolled out across the organisation in partnership, from September, with dates currently available until November 2021. An all Wales training package and resources will be developed and utililised once available. 3.Joint HR and TU training day held October including Respect and Resolution training session 4.Communication plan developed to ensure regular reminders to staff 5. Joint campaign under development to link Speak out Safely with Respect and Resolution so that staff understand the range of avenues to ensure concerns are resolved effectively	30 September 2021
5.Performance & Development Review Policy	2	Monthly analysis and reporting at operational level undertaken (as well as strategic level) to enable managers to identify areas with low compliance with PADR. Staff Engagement, Organisational Development and HR Teams work with challenged areas to support and improve in terms of engagement/feedback/recognition/development.	2	1. Identify improvements to the process and documentation to support specific areas/teams. - Last changes made to the process in 2018 with extensive engagement across staff groups and roles. This resulted in simplified and lean process and paperwork along with further guidance on conducting group PADR's. Further changes to the PADR process will be part of the People and Organisational Development strategy and the co-design work for Mewn Undod Mae Nerth/Stronger Together based on the thematic analysis of the engagement undertaken during the Discovery phase. This will ensure clear links between individual and organisational goals and alignment to individual and team goals and objectives. 2. Develop a programme for "Dip testing" of quality of PADRS against key metrics/feedback. An audit programme was implemented in 2018 but due to issues raised by staff regarding confidentiality, discussions with IG concluded that this was not the best approach to assess the quality of PADR's. Quality of PADR's is emphasised in management and leadership development programmes e.g. A Step into Management, ILM, Ward Managers, Matrons development programme and any other ad hoc training. As part of on-going improvement, a peer audit tool will be developed to support assessment of the quality of PADR's which will also feature as part of the new People and Organisational Development strategy. 3. Utilise the survey function of the system implemented for Speak out safely to support identification of examples of outstanding/good and requires improvement - The Work in Confidence platform can be used to conduct pulse surveys if required in terms of assessing staff feedback on the PADR process 4. Build "role contribution" into Strategic OD programme specification. The feedback from the discovery stage of Mewn Undod Mae Nerth/Stronger Together will inform the People and Organisational Development strategy and co-design phase and will include improvements in the PADR process and documentation to ensure individual staff are fully aware of how their role contributes to team objectives and the wider orgnisational goals. 5. Review feedback from NHS Staff Survey and update divisional improvement plans. PADR and Staff Survey were standing agenda items on the Integrated Operational Workforce Groups (IOWG) which have been temporarily suspended. Divisions continue to be encouraged and supported to develop and implement local improvement plans of which PADR forms a pivotal part. The NHS Wales Staff survey platform (Qlear Site) allows divisional managers to access the data relevant to their division. Discussions are underway nationally regarding the timing and content of the next national survey. The discovery phase on Mewn Undod Mae Nerth/Stronger Together also included a review of over 80 pieces of evidence which included the results of the last national staff survey and this will also inform the new People and Organisational Development strategy and the way in which Divisional improvement plans are taken forward and monitored for impact and progress.	Draft People and Organisational Development Strategy December 2021; Co-design phase of Mewn Undod Mae Nerth/Stronger Together October 2021 - March 2022

Review comments since last report on Speak out Safely: Significant progress has been made in respect of: the launch of the Work in Confidence platform; the appointment of Speak Out Safely Guardians, the Multi-disciplinary team being set up to review concerns raised, agree actions required; and, monitor themes to identify learning; the completion of the SOP inclusive of process mapping; Speak Out Safely internet pages now live; previous concerns raised through the Safehaven process have been managed jointly by SOS MDT and Safehaven team to ensure they were not 'lost' during transition phase; and, the engagement with staff during the Discovery phase of Mewn Undod Mae Nerth/Stronger Together and creation of an on-going Stronger Together community to continue to engage in discussions with staff through the co-design and co-delivery stages of Stronger Together. This progress provides a number of key mitigations in terms of the culture/staff engagement risk, but the risk rating has not yet been changed before there is evidence of positive impact and outcomes. The current risk and target risk will again be reviewed at the next update when consideration will also be given to when the target risk score will be achieved. Comments on PADR since last report: improvements to the PADR process and paperwork, ensuring individual staff objectives and personal development plans, will form part of the new People and Organisational Development Strategy and the co-design phase of Mewn Undod Mae Nerth/Stronger Together to ensure alignment between the organisation's goals and purpose and the objectives and development plan for every member of staff and their teams. Training programme ongoing on the Respect and Resolution policy.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	PPPH Committee	**16th November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-12		Risk Rating	Impact		Likelihood		Score		Appetite
Security Services									
There is a risk that the Health Board does not provide effective security services across the organisation. This is due to lack of formal arrangements in place to protect premises and people in relation to CCTV, violence and aggression, Security Contract issues (personnel), lone working, lock down systems, access control and training that provides assurance that Security is effectively managed. This could lead to a breach in the Health Board's statutory security duties.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1) There is Security provision at the three main hospital sites with 24/7 Security staff present. The Field Hospitals have adequate external security contract in place and reviewed to support the change of use of the sites until the end of March 2022 to ensure appropriate to needs of staff, landlord and patients. The external contractor is responsible for Patient Safety & Visitors and Estates Building Management. This has been increased to support Covid safe environments. 2) New Security Contractor appointed from 1.4.21 who will undertake enhanced DBS assessments of all security staff on the DGH sites.	1	Staff Training (which is V&A, module c and module d (breakaway and restrictive physical intervention) is in place Mental Health. Risk Assessments on some areas looking at physical security. V&A Case Manager to support staff when taking criminal action against assailant 44 current cases. Additional Bank staff employed to support Covid vaccination centre work and security review. Business case to identify minimum standard approach now approved for one year.	2	1) A review of Security was undertaken in August 2019 and identified a number of shortfalls in the systems management and staffing of the current security provision for BCUHB. Limited capacity within the H&S Team to implement safe system of work. Clarity on roles required to describe an effectively managed security contract and safe systems of work in areas such as lone working, restraint training, lockdown, bomb threat management and CCTV. Resources to facilitate and support V&A Security are looking at being secured, with recruitment of Bank/Agency staff until permanent post agreed. 2) Ligature assessments require additional support to ensure safe systems of working are in place in all service areas in Mental Health and Community/Acute areas. [Update 23.11.21 A review by the HSE has identified shortfalls in ligature risk assessments and observation that may result in a prosecution. Findings to be determined in early 2022 by the HSE.] 3) Security Contractor has been extended to 1.4.22 4) HSE currently investigating suicide in Mental Health which may result in a prosecution or improvement notice which will need to be addressed. 5) HSE planned inspection regarding the prevention of V&A on 16th-18th November. [Update 23.11.21 This inspection has identified a possible notice of contravention for violence and aggression training, policy and escalation of sanctions against violent patients to executives.] 6) A full review of the Security Services provision including, lone working, staffing, in house or external service etc. will be undertaken and findings provided to the Board by March 2022.	31 March 2022 31 March 2022 31 March 2022 31 March 2022 31 March 2022
Specific restraint training is provided in specific areas such as mental health. General Violence and Aggression (V&A) training is provided by the Manual Handling Team.	1	Data capture and reporting systems for V&A. A 0.8 WTE V&A Case Manager is in post to support staff when criminal action is taken. The Obligatory Response to Crime has had a combined training event with North Wales Police. A plan is in place to review V&A training and with funding, can be implemented.	1	The lack of Policies staffing and structures poses a significant risk to staff, patients and visitors from V&A cases and security related activity. To control the risks a full review of Security services including, training particularly in restraint and restrictive practices is required. To ensure appropriate care, this particular aspect is delivered by competent staff. A full Security review was undertaken in September 2019 and previous reviews in 2017 by Professor Lepping and to date none of the recommendations have been implemented due to lack of appropriate resourcing. There is a lack of compliance with the NHS Wales Security Management Framework (NHS in Wales 2005) and Obligatory Response to Violence etc. Currently, V&A training is at 91% compliance with module B. However breakaway training required for the most high risk areas (module C) requires 768 staff to be trained and is 10% compliant. We are beguining to gather data on security incidents in Q2 this highlighted 841 incidents of which 154 where physical assaults on staff. 44 cases are currently going through the criminal justice system.	31 December 2021
There are some up to date maintained CCTV systems in place. Staff in some areas have had training on use and licencing requirements. IG aware of issues in relation to data and management of CCTV.	1	There is a system for gathering data when an incident occurs if the equipment is working effectively. A task and finish group has been established to review the current systems with a view to working up a scheme to centralise the CCTV system and improve current compliance.	2	There is a lack of a structured approach to CCTV management and control. The systems are different in many service areas. A central Policy is being developed but requires significant investment to centrally control all systems. This is likely to result in a breach of the Data Protection Act if not appropriately managed. There is often limited maintenance on CCTV systems. A full review of all systems is required. Estates have committed to upgrade CCTV systems in a number of premises. A recent review identifeid that out of 69 CCTV cameras in place across BCUHB 23 where either wrongly placed or not working at all.	31 March 2022

Review comments since last report:
The risk title has been amended to include violence and aggression. The first action for the first key control has also been amended to include mention of bomb threat management. A review by the HSE has identified shortfalls in ligature risk assessments and observation that may result in a prosecution. Findings to be determined in early 2022 by the HSE.
A planned formal inspection on 16-18 November 2021 has identified a possible notice of contravention for violence and aggression training, policy and escalation of sanctions against violent patients to executives. In light of the findings of the HSE inspection and due to the ongoing security risk including a HSE investigation into a suicide and possible enforcement action, the current risk score has remained unchaged.Timelines for action have been extended and further information on plans to review the whole service by March 2022. Q2 identified 841 security related incidents with 154 being physical assaults on staff. The business case has identified a minimum standard approach now approved for one year. The Risk Lead considers the date by which it is anticipated that the target risk score will be achieved will be March 2022. It is acknowledged that the target risk score is higher than the risk appetite due to the complexity of services including Mental Health, Community Services and Emergency Department and Prison. The target score will remain under review as the structure for security continues to improve over the next year.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	**23 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 2: Strengthen our Wellbeing Focus

Risk Reference: BAF21-13		Risk Rating	Impact		Likelihood		Score		Appetite
Health and Safety									
There is a risk that the Health Board fails in its statutory duty to provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation that could result in avoidable harm or loss.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	5	↔	4	↔	20	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group.	1	Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB.	2	1)The gap analysis of 31 pieces of legislation,117 site specific inspections including Acute, Mental Health Community Services GP and Wrexham HMP identified significant areas of none compliance. The OHS team continues to have significant support from our trade union partners. Further evaluation of H&S systems has been led by Internal Audit. A clear plan and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented following business case approval. 3) Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. 4) Manual handling training compliance is not in line with the All Wales Passport. There are insufficient trainers and training rooms to be able to train all new staff (approximately 800) at this time. Business case approved but staffing and venues are still problematic.	31 December 2022 31 December 2021 31 December 2021 31 March 2022
Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE.	1	Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire.	1	1) Clearly identified issues escalated to Board via business cases have been reviewed but require approval for the Estates element. (H&S Business case has been approved). There remain gaps in Fire safety for a number of premises including YG -work is ongoing to obtain funding from Welsh Government 2) HSE are scrutinising work activity in many areas, planned Health Board inspection for Violence and Aggression and Manual Handling is likely to require additional actions. 3)Actions arising from the Legionella review to be implemented. 4) Improvement Notices served in respect of Adult In-patient falls - [Update: 23.22.21 - a large number of control measures have been implementaed as a result. However, a formal inspection by the HSE identified limited assurance that is suitable and sufiicient risk assessments can be evidenced. This is likely to result in a letter of contravention.	31 March 2022 31 March 2022 31 March 2022 31 March 2022
Lessons Learnt analysis from COVID reported to Executive Team, through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures.	2	RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews in excess of 820 RIDDOR investigations have been undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200+ site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak. Robust fit testing programme now in place and the business case for the fit testing co-ordination team has been approved for two years. There has been significant investment with fit testing equipment with an alternative respirator agreed by the Executive Team.	3	There will be a requirement to release fit testers and staff to comply with legal compliance required within all service areas. Agreed escalation process in relation to a lack of fit testers being released from their substantive roles to be reviewed again at Executive Level. Full time fit testing staff are required as the current arrangement is predicated on temporary staffing.	30 November 2022
Executive Team understand the range and types of risks identified through Annual Report and Gap analysis. Gaps in safety including areas of inefficiency to be addressed. Internal Audit have reviewed structure of meetings and Governance procedures.	1	Strategic OHS Group established to monitor performance and workshop with OD support has looked at leadership styles and developing a positive culture with partners from finance, procurement, Estates and Facilities and Occupational Health.	2	Robust action plan with clear objectives for Team difficult to deal with all elements of legislative compliance with limited capacity. Action: Recommending specialist support to review key areas of risk and attendance at operational groups to further understand significant risks. Specific reports are now being produced but will require robust implementation via appropriate Groups.	31 December 2021

Review comments since last report:
The controls, mitigations and timelines have been reviewed, and scores remain unchanged but action timelines have been revised. The target dates for all actions relating to the 2nd key control have been extended to 31 March 2022. IOSH Managing Safely and Leading Safely Modules for Senior Leadership to be implemented following business case approval {early 2022}. Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. Manual handling training compliance is not in line with the All Wales Passport. There are insufficient trainers and training rooms to be able to train all new staff (approximately 800) at this time. Business case approved but staffing and venues are still problematic {premises to be available January 2022 and difficulty resourcing staff for manual handling training}. There remain gaps in Fire safety for a number of premises including YG -work is ongoing to obtain funding from Welsh Government. HSE have identified gaps in falls, manual handling and violence and aggression likely to result in enforcement action or letters of contravention. It is anticipated that the Target Risk Score will be achieved by 31 December 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Quality, Safety and Experience Committee	23 November 2021

Linked to Operational Corporate Risks:

CRR20-01 - Asbestos Management and Control
CRR20-02 - Contractor Management and Control
CRR20-03 - Legionella Management and Control
CRR20-04 - Non-Compliance of Fire Safety Systems

Board Assurance Framework 2021/22

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-14		Risk Rating	Impact		Likelihood		Score		Appetite
Pandemic Exposure									
There is risk that patients, staff or visitors are exposed to COVID-19 due to inadequate/inappropriate resources, lack of compliance with prevention/protection measures across all settings, lack of understanding, skills, ownership of responsibilities, lack of systems and/or capacity and/or capability to identify, analyse, adapt, address immediate themes arising from intelligence both internal and external in a dynamic way. This could impact or effect avoidable harm caused to our patients, staff, visitors, increase in demand/length of stay/risk to other patients, reduction in availability of staff to support the delivery of safe care and services. This could led to prosecution for breach of statutory/legal duty and reputational damage to trust and confidence.		Inherent Risk	4	↔	5	↔	20	↔	Low 1 - 6
		Current Risk	3	↔	5	↔	15	↔	
		Target Risk	3	↔	4	↔	12	↔	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Elimination (physically removing the hazard): Covid-19 vaccine programme in place. Visitors undertaking lateral flow test before visiting. Front line staff and staff that come into contact with them undertaking routine lateral flow tests.	2	Ensuring all staff, visitors and patients are double vaccinated to reduce transmission of infection in our care giving settings.	2	Getting access to data is problematic because of how data is collated e.g. people using their personal email addresses rather than their work email addresses. Need to look at a local method for understanding who is not vaccinated and ensure appropriate risk mitigation is in place to reduce risk of potential transmission to other staff and patients. Lateral flow testing has now come in-house so managers can see how many test kits are being handed to staff. Random quality assurance for staff around lateral flow to take place by managers, alongside spot checks in technique to assure test performing quality.	30 October 2021
Substitution (replacing the hazard): A review of all buildings has taken place against new regulations/ guidance in relation to what the clinical environment should look like with regard to infection prevention, with a schedule of improvements identified. Enough isolation rooms with ensuite facilities in place to house all infected and potential infected patient. One way control through the buildings. Routine and deep cleaning in place to reduce/eliminate bioburden.	1	Review of ventilation has taken place. Ventilation and Environmental groups reporting into Infection Prevention Sub Group (IPSG) and Patient Safety & Quality Group (PSQG) with governance structure in place. Implementation of segregation and screening to clinical areas to reduce risk of transmission	1	1) Review and risk assess the improvement plans in order to address the environmental considerations necessary to meet new guidance in relation to the built environment. Some buildings are a risk due to infrastructure (dialysis and community hospitals). Improvement plans in place via Planning and Estates, approved by Board and currently with Welsh Government awaiting approval. 2) To build or purchase more isolation facilities to ensure all infected patients can be isolated within two hours. 3b) All modernisations or new builds to have single rooms and where this is not achievable beds achieve ISBN guidance (3.6m bed spacing). 4) Safe clean care programme has a front door improvement project running. 3) C4C audits to be further acted upon in particular the estates elements as is an infection and reputational risk.	Complete 31 December 2025 31 December 2021 31 December 2021
Engineering (reducing potential transmission): Reducing footfall in clinical settings, working from home where possible and self-isolation requirements in place. Risk assessed visitation, Flow through our buildings. Change facilities for all hospital based staff.	2	Managerial staff working from home where possible/peripatetic working. ~~Ten day self isolation period when come into contact with a positive case where no PPE was worn e.g. outside work, breaks etc.~~ Risk assessed visitation to our care facilities. Clear signage to areas and footfall managed by local lead.	1	1) Need to understand impact of amended WG guidance (AUG21) around self isolation and potential risk of transmission to venerable staff and patients. 2) Spot checks to be developed as part of the ward accreditation programme to test robustness of visiting risk assessments and compliance. 3) Self isolation guidance has been updated to reflect Government guideline, but this potentially puts staff and patients at risk. This has been mitigated with the guidance around FFP3 mask and strongly recommended this happens in outbreak areas.	
Administrative (change the way that work is performed): Virtual ward/board rounds and visiting, Safe break improvements. Staff and patient moments reduced	1	Virtual visiting is preferred option for visiting. IPADs available for patients use. Board rounds being reviews as part of the unscheduled care transformation programme. Wandering patient project (SCC-HF Safe Action project)	1	1) Need to link in with Unscheduled Care Programme to ensure board and ward round improvements focus also on less footfall and more virtual interfaces. 2) STREAM to be operationalised throughout acute care to support virtual board and ward rounds - options appraisal developed by IT. {Update: 05.10.21 - The target date extended to 31 March 2023, given this is a major IT project. This is now being considered by the Director of Digital to take forward and a draft business case is being developed.}	31 March 2022 31 March 2023
PPE: Adequate PPE stocks in place and maintained. Monitoring and management in place to check sufficient availability	1	PPE Steering Group (PPESG) and reporting into IPSG and PSQG with governance structure in place. In addition the formation of the Safe Clean Care Harm Free Group which now reports to Quality, Safety and Experience (QSE) Committee.	2	Continuous PPE supply is secure. Still remain an issue with masks being upgraded / discontinued which then means all staff need to be re-fit tested on new masks. PPE meetings stood down from weekly to fortnightly now because of more secure position. {Update: 05.10.21 - Whilst the risk has been lowered, the mitigation is completely out of BCU's control.}	Complete
PPE: Fit testing in place to ensure the right mask to prevent avoidable infection.	1	Fit testing programme, Accreditation training and business case in place to increase assurance monitored by PPESG. Any escalations sent through to This is monitored via IPSG and OH&SG.	2	Trainers to be part of the local workforce. To ensure fit testing becomes business as usual and is kept under continuous review by the Health & Safety Group. {Update: 05.10.21 - The fit testing programme has been funded by EIMT business case in August 2021. This will ensure a programme of systematic testing of staff and fit testing is recorded on ESR. However, this does not include temporary staff and local management make the decision to test their fit testing before starting work.}	31 March 2022
Clear **Leadership & Governance** in place to support delivery of the clinical and admin improvements required to lower the risk score through embedding mitigating actions.	1	Safe Clean Care Harm Free reports through PSQB to QSE. All accountable areas have 2020/21 plans on a page they delivering against. All accountable areas have undertaken their second HARMS self assessment with underpinning assurance and where appropriate improvement actions managed through Local Infection Prevention Groups (LIPG) through to IPSG to QSE.	1	Recruit to key posts to support delivery out in the accountable areas of their Safe Clean Care Harm Free Infection Prevention plans on a page 2021/22. Ensure accountable areas are represented at the SCC-HF steering group meetings, to drive focus, pace and grip. Ensure standardised agendas at LIPGs to align to assurances sort by IPSG.	31 December 2021

Review comments since last report:

The controls, mitigations and timelines have been reviewed, and scores remain unchanged but some actions have been revised as follows:

Key Control - Elimination: It is proposed that the target date be changed and discussion to be had around how controls could be further strengthened.

Key Control - Substitution (replacing the hazard): 1st gap/action: actions on Improvement plans are now complete.

Key Control - Engineering (reducing potential transmission): 2nd key mitigation - *Ten day self isolation period when come into contact with a positive case where no PPE was worn e.g. outside work, breaks etc.* has been removed to adhere to Government guideline.

3rd gap/action added: Self isolation guidance has been updated to reflect Government guideline, but this potentially puts staff and patients at risk. This has been mitigated with the guidance around FFP3 mask and strongly recommended this happens in outbreak areas.

Key Control - Administrative: Target date for the 1st gap/action has been included as 31 March 2022. The target date for the 2nd gap/action has been extended from 31 March 2021 to 31 March 2023, given this is a major IT project. This is now being considered by the Director of Digital to take forward and a draft business case is being developed.

Key Control - PPE: **Adequate PPE stocks:** This gap/action is now complete. However, whilst the risk has been lowered, the mitigation is completely out of BCU's control.

Key Control - PPE: **Fit testing:** The fit testing programme has been funded by EIMT business case in August 2021. This will ensure a programme of systematic testing of staff and fit testing is recorded on ESR. However, this does not include temporary staff and local management make the decision to test their fit testing before starting work. The target date has been extended to March 2022 to receive assurance that the agreed business case has been operationalised.

Key Control - Leadership & Governance: The target date has been extended to 31 December 2021 from 31 October 2021, as no internal candidates were sourced.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy CEO and Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	**25 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 5: Effective Use of Resources

Risk Reference: BAF21-15		Risk Rating	Impact		Likelihood		Score		Appetite
Value Based Improvement Programme									
There is a risk that the Health Board does not understand or use its resources effectively and efficiently due to a lack of implementing an appropriately resourced value based improvement programme. This could impact on the quality of outcomes for the services it delivers.		Inherent Risk	4		4		16		Moderate 8 - 10
		Current Risk	4	↔	3	↔	12	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Performance, Finance & Information Governance (PFIG) Committee oversight via standard reporting of opportunities and savings delivered.	2	Contribution to national benchmarking programmes, providing detailed analysis of service areas and opportunities.	3	Staff recruitment to be aligned with Annual Plan and broader transformation programme approach. Integrated quality improvement and transformation structure under development, which will include the Value Based Healthcare (VBHC) team. Structure to be finalised, job descriptions signed off and banded and recrtuiment commenced. {Update 12.10.21 - The structure and budget have now been signed off and refined to align with the overall transformation and improvement structure. Job descriptions have been drafted for banding. Recruitment process to be completed in quarter 3.}	31 December 2021
PFIG Committee oversight of benchmarking data and follow up work e.g. Mental Health.	2	Drivers of the Deficit analysis and external benchmarking data used to inform Annual Plan and to identify priorities for tackling efficiency opportunities, linked to service transformation.	1	Planning and business case approach to be reviewed to capture VBHC principles. Work ongoing to finalise , adopting learning from other Health Board approaches. August Update - an approach to capturing VBHC principles has been developed and will now feed into the overall review of business case guidance which is ongoing. {Update 12.10.21 - Further review of business case process to streamline decision making and align with improvement approach ongoing. This will consolidate VBHC principles.}	Complete
Lessons Learnt analysis from COVID reported to Executive Team, with action to mainstream innovation and value opportunities. Reporting of progress to delivering opportunities to PFIG Committee.	2	National efficiency framework analysis to identify opportunities and cascade to Improvement Groups and Divisions.	1	Steering group to be established to drive the programme of work, supported by the VBHC structure. Progress reports to be provided to the Clinical Effectiveness Group. Initial group established; the approach to be aligned with the overall transformation approach as part of the Annual Plan refresh. Update - Arrangements to be re-set in line with overall transformation programme and focus on clinical pathways.	30 November 2021
Clinical Effectiveness Group re-established with oversight of Value Based Healthcare within its brief.	1	1) Executive leadership changed to reflect alignment with the broader transformation approach; Director of Primary and Community Care to lead alongside the Director and Finance. 2) Initial priorities agreed and projects initiated.	2	Future system requirements to gather and report upon Patient Reported Outcomes under review as part of the national programme {Update: 12.10.21 - No national plan has been developed. Local consideration of approaches required alignment with the digital strategy.}	31 December 2021
Executive Team reviewing the opportunities analysis produced for Improvement Groups to identify potential areas of inefficiency to be addressed.	2	Finance Delivery Unit of Welsh Government have designed a maturity matrix for VBHC which will be used to guide and inform the programme of work.	2	Utilise the FDU maturity matrix approach to prioritise actions and subsequently undertake a formal assessment of progress. {Update: 12.10.21 - An initial desk top assessment has been undertaken and findings will support prioritisation of future actions.}	30th November 2021
		Direct support secured from the National VBHC Team to support the Health Board in developing and implementating the programme.	2		
		Resources have been secured from the strategic support allocation to resource the VBHC Team.	2		
		The June refresh of the Annual Plan provides clarification regarding the way in which the VBHC Improvement Programme supports the Health Board's transformational approach. VBHC is identified as a key principle within the Board's new quality improvement methodology.	2		

Review comments since last report:
Status of actions has been updated to reflect progress since the last update. Review of this risk by the Lead Executive has concluded that the approach defined may no longer be appropriate given the significant shift in approach which has been brought about by the alignment of VBHC with the Transformation Programme. The Transformation Programme is in the final stages of development and the controls and actions associated with this risk will be re-assessed as part of the next review cycle to ensure they are fully reflective of the agreed transformation approach.
Key Control - PFIG Committee oversight via standard reporting: The structure and budget have now been signed off and refined to align with the overall transformation and improvement structure. Job descriptions have been drafted for banding. Recruitment process to be completed in quarter 3. Target date for completion extended to 31 December 2021 from 31 August 2021.
Key Control - PFIG Committee oversight of benchmarking data: Further review of business case process to streamline decision making and align with improvement approach ongoing. This will consolidate VBHC principles.
Key Control - Lessons Learnt analysis from COVID: Target date for completion of this action extended to 30 November 2021 from 31 August 2021.
Key Control - Clinical Effectiveness Group: No national plan has been developed. Local consideration of approaches required alignment with the digital strategy. Target date for the completion of this action extended to 31 December 2021 from 30 September 2021.
Key Control - Executive Team review: (1st gap/action) An initial desk top assessment has been undertaken and findings will support prioritisation of future actions. The target date has been extended to 30 November 2021 from 30 September 2021.
A 4th key mitigation has been added - the June refresh of the Annual Plan provides clarification regarding the way in which the VBHC Improvement Programme supports the Health Board's transformational approach. VBHC is identified as a key principle within the Board's new quality improvement methodology.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary and Community Services	Performance, Finance and Information Governance Committee	**12 October 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Transformation for Improvement

Risk Reference: BAF21-16		Risk Rating	Impact		Likelihood		Score		Appetite	
Digital Estate and Assets										
There is a risk that BCUHB cannot implement digital solutions due to available resource not keeping step with an organisational wish to become more digitally focused. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, the ability to recruit and retain staff or impact on compliance with legislation resulting in significant financial penalties.		Inherent Risk	4		5		20		Open 12 - 15	
		Current Risk	4	↔	5	↔	20	↔		
		Target Risk	4		3		12			

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
1.Monthly budget reviews take place with finance. Finance attendance at Informatics Senior Management Team (SMT) on a monthly basis as part of the Cycle of Business.	1	Contribution to national informatics programmes through representation both informatics and clinical i.e. Virtual Consultations, Digital Services for Patients and the Public Programme. Development of a Digital Strategy approved by the Board on 20 May 2021.	3	1) Formal launch of Digital Strategy 2) Wider engagement to increase awareness of the Digital Strategy	Complete 31 March 2022
2. Quarterly review of Operational Plan at SMT with Committee oversight of the delivery of the Informatics Operational Plan and budget on a quarterly basis.	2	Review of required business cases through the Business Case Review Group and to the Performance Finance and Information Governance Committee (PFIG) Committee for approval.	2	Implementation of the delivery plans of the Digital Strategy Year 1 to 2.	1 March 2022
3. Capital and Revenue Programmes are in place and are reported at Committee level on a quarterly basis.	2	Resource risks are identified and go through the escalation process as documented in the Risk Management Strategy. This governance includes SMT, DIGC and Risk Management Group.	2	1) Established resource structure submitted, together with revenue and capital requirements for 2021/22 - decision taken by the Executive Team not to fund cost presssure for additional capacity. 2) Accordingly a review of the current projects is being undertaken which will be presented in due course to the Executive Team.	Closed 29 December 2021
4. Quarterly review of the Digital Strategy.		Programmes and Projects are managed using agreed standard methodologies (Tailored Prince2) and have governance structures.	1	Development of an established resource structure and revenue and capital requirements for corporate planning in line with the strategy delivery from 2022/23. {Update: 15.11.21 - This relates to action 12379 from risk CRR20-07.}	23 December 2021
		Regular meetings with Digital Health Care Wales in place to discuss local and national priorities and challenges.	3	Senior Leadership agreement of the Digital elements within the IMTP. {Update 15.11.21 - worked with planning and developed PDSAs and suported the development of the logic models.}	23 December 2021
				Development of a Management of Portfolio approach so that all digital solution change initiatives are well governed, controlled and prioritised. {Update 15.11.21 - the draft is being developed.}	28 February 2022
				Implementation Portfolio Management approach. {Update 15.11.21 - Target date extended to 30 June 2022 due to the need for alignment with the new transformation team.}	30 June 2022
				Meeting with Digital Health Care Wales has taken place to discuss the BCUHB Priorities and Risks and plan currently in development to take account of the challenges.	
				Development of the Digital Workforce Planning Strategy	31 January 2022
				Review of Governance arrangements {Update 15.11.21 - this relates to action 12380 of CRR20-07.}	31 January 2022

Review comments since last report

The development of a Digital Strategy approved by the Board on 20 May 2021 has become a mitigation.
A third action has been added for the first key control: Wider engagement to increase awareness of the Digital Strategy. The target date for completion of this action has been set at 31 March 2022. The Digital Strategy has been formally launched; this action is marked as complete. The findings of the review of the current projects will be taken to the December Executive Team meeting. The target date for completion of this action has therefore been extended to 29 December 2021.
It has been made explicit that the first gap under key control, *Quarterly review of the Digital Strategy* relates to action 12379 from risk CRR20-07, for which the Executive Team had approved closure, as it duplicated this BAF risk. PDSAs have been developed with planning and the development of the logic models supported. The draft of the Management of Portfolio approach is in development. The target date for completion has been extended to 28 February 2022. The target date for the implementation of the portfolio management approach has been extended to 30 June 2022 due to the need for alignment with the new transformation team. The review of government arrangements relates to action 12380 of CRR20-07. The target and current risk scores are currently the same. Given that the current vacancy gaps are being reviewed with the informatics heads of service to identify other avenues of delivery and prioritising programme in line with available resources, the current risk score will be revised. The expected target risk score achievement date is 30 June 2022.

Note: Risk CRR20-07 has not been formally closed so will remain a linked operational corporate risk.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary Care and Community Services	Partnerships, People and Population Health Committee	15 November 2021

Linked to Operational Corporate Risks:

CRR20-06 - Informatics - Patient Records pan BCUHB
CRR20-07 - Informatics infrastructure capacity, resource and demand
CRR21-11 - Cyber Security
CRR21-12 - National Infrastructure and Products

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-17		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets Development									
There is a risk that the Health Board does not systematically review and capitalise on the opportunity to develop its estates and assets due to changes in working practices (for example agile working) which could impact on recruitment, financial balance and the reputation of the Health Board.		Inherent Risk	3		4		12		Moderate 8 - 10
		Current Risk	4	↑	3	↔	12	↑	
		Target Risk	3		3	↑	9	↑	

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy, monitored by Capital Investment Group with oversight at Performance, Finance and Information Governance, and Partnerships, People and Population Health Committees and Health Board. [Taken from the current Estates Strategy, the Health Board's risk adjusted backlog maintenance figure is £53.4m and it is estimated that circa £838m of capital investment is required to ensure current estate is fit for purpose and of a reasonable standard. These figures will be updated when the Estates Strategy is refreshed.]	2	1.Disposal or acquisition of assets are signed off by the Board and Welsh Government in line with the BCUHB Scheme of Reservation and Delegation (SoRD). 2.The Health Board undertakes annually an assessment of investment in infrastructure improvements and compliance - annually update backlog maintenance and capital investment requirements through the estates and facilities performance management system (EFPMS). This is a pan Wales return from all Health Boards, which defines the level of investment required within the estate. This information is used annually to update the Estates Strategy and inform both discretionary capital expenditure and all Wales major capital programmes.	3	Health Board, through the Workforce Strategy, to agree the standards for workforce accommodation and changes in agile working practices through modern ways of working - Stronger Together.	31 March 2022
Workforce Strategy monitored by the Health Board.	2	Business Case process in place with oversight by the Executive Team, Capital Investment Group, Performance, Finance and Information Governance Committee and onto Welsh Government.	3	Financial Planning to be agreed and secured to support the change in working practices and a digitally enabled workforce.	31 March 2022
		Collaboration on public sector assets/corporate hubs, and regional working across North Wales.	3	Additional Resources for Asset Management function have been identified through the Health and Safety Business Case to be approved by Performance, Finance and Information Governance Committee.	31 March 2022
				Health Board agreed Estate rationalisation programme over three years 2021 to 2023. 2021-22 overview through Performance, Finance and Information Governance Committee and oversight through the Capital Investment Group. [Disposal/rationalisation will be steered by recommendations coming out of the agile working programme, which also links to Digital]	31 March 2022
				Opportunities to progress corporate accommodation hubs in partnership with North Wales Regional Public Service Providers and Local Authorities.	31 March 2022
				Update Estates Strategy to reflect demands for flexible accommodation hubs and review current and future needs for Office accommodation. {Update 11.10.21 - The output of the Estates Strategy is expected to materialise in March 2022, which will influence the Health Board's plans for 2022 and beyond.}	31 March 2022
				The Health Board is progressing a Programme Business Case (PBC) to address fire safety and infrastructure compliance for Ysbyty Gwynedd (YG). This PBC will be submitted to the Health Board for approval and progression to Welsh Government for funding approval. The scope of the PBC will address all risks for YG which are listed within the Corporate Risk Register. {Update 11.10.21 - feedback has been received from the Welsh Government on the submitted PBC. The next step is to complete the Welsh Government's Scrutiny Grid, which is in train.}	31 December 2021
				Development of enabling plans i.e. Finance, Workforce, Digital Strategy together with a refresh of Living Healthier, Staying Well [Digital Strategy now approved as a framework by the Health Board, however there is not currently funding identified for its implementation.] {Update: 11.10.21 - These plans are being refreshed for the 2022/23 planning}.	01 April 2022

Review comments since last report:
The current risk score has been increased to 12(4x3), from 9(3x3) due to significant non-compliance in backlog, and the lack of investing sufficient capital to mitigate the risks.
This risk will be further updated following the deep dive at the Risk Management Group on 13 December, ahead of the Performance, Finance and Information Governance Committee meeting.
The anticipated date that the target risk score will be achieved is 01 April 2022.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Hill, Executive Director of Finance	Performance, Finance and Information Governance Committee	**23 November 2021**

Linked to Operational Corporate Risks:
CRR20-07 Informatics infrastructure capacity, resource and demand.

Board Assurance Framework 2021/22

Aligned to Key enabler - Effective alignment of our people

Risk Reference: BAF21-18		Risk Rating	Impact		Likelihood		Score		Appetite
Workforce Optimisation									
There is a risk that the Health Board cannot attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could impact on the Board's ability to deliver safe and sustainable services.		Inherent Risk	4		5		20		Moderate
		Current Risk	4	↔	4	↔	16	↔	9 - 12
		Target Risk	4		3		12		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)G=Gap; A=Action*	Date
Establishment Control Policy and system in place. Pipeline reports produced monthly for review and action by managers across the organisation. Roster management Policy. Recruitment Policy. Safe Employment Policy.	2	1. Review of Vacancy control process underway to establish a system for proleptic/proactive recruitment against key staff groups/roles. 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention. 3.. Workforce Service Review programme commissioned and commenced.	2	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy including vacancy control and active recruitment pipeline management in place. {Update 19.11.21 Vacancy control and activity pipeline management now in place across nursing and medical staff groups.} G. Previous structure for planning and recruitment dispersed across secondary care sites, area teams, MHLD. Once for North Wales approach required. A. Revised delivery group structure developed subject to further refinement and approval. {Update 19.11.21 delayed due to changes in the operating model across the organisation.} G.Use of technology requires review and improvement A.Scope for review of systems and usage to be drafted.	31 January 2022 31 January 2022 Completed
Workforce plans for each of the core priority programmes: 1. Existing USC delivery. 2. Existing Planned Care Delivery. 3. Existing TTP delivery. 4. USC Surge Plan. 5. Planned Care Recivery Plan. 6. TTP reslience plan. 7. COVID Vaccination Plan.	1	1. Review and development of a clear Workforce planning process. 2. Workforce Service Review programme commissioned and commenced.	1	G. Workforce planning undertaken at a local/team level and requires a once for North Wales approach. G. Workforce planning skills, capacity and guidance insufficient for step change in approach and effectiveness. A. Development of a clear Wokforce Planning Process and Policy underway *and completed.* {Update 19.11.21 - delayed due to workforce organisational pressures and change in the operating model.}	31 January 2022
Temporary Staffing Policy. Medical Bank Protocol.	1	1. Temporary Staffing Solutions Plan under development. 2.Medical Bank established with contract with MEDACs in place for 2020/22.	1	G. Temporary bank primarily established to support Nursing and Health Care Support. A. Plan to establish BCU Temporary Staffing Solutions under development. Service to cover all staff groups and include "ready to work" pipeline. {Update 19.11.21 - the plan is being developed and should be in place by 31.12.21.}	31 December 2021

Review comments since last report:
Actions and timelines have been reviewed and updated accordingly. For the first key control, vacancy controls and activity pipeline management are now in place across nursing and medical staff groups. The target date for completion of this action has been extended to 31 January 2022. The delivery group structure has been developed subject to further refinement and approval. However, the target date for completion of this action has been extended to 31 January 2022, due to ongoing changes to the operating model across the organisation.
For the second key control, the development of a clear Workforce Planning Process and Policy has been delayed due to organisational pressure and their impact on workforce teams and the ongoing changes to the operating model. The target date for completion of this action has been extended to 31 January 2022. For the final key control, the plan to establish BCU Temporary Staffing Solutions is under development and should be in place by 31 December 2021. The target date for completion of this action has therefore been extended to this date.
There is an independent process review being carried out which is looking to streamline the existing recruitment process leading to efficiencies of the service and shortening the time to hire period across the Health Board. Alongside this, workforce and organisational development are carrying out a review of their operating model to support and align with the organisation's preferred operating model going forward.

Executive Lead:	**Board / Committee:**	**Review Date:**
Sue Green, Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health Committee	**19 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Strategic Priority 1: Covid 19 response

Risk Reference: BAF21-19		Risk Rating	Impact		Likelihood		Score		Appetite
Impact of COVID-19									
There is a risk that the ongoing Covid-19 pandemic will lead to the HB being overwhelmed and unable to respond to Covid healthcare needs and/or carry out its core functions due to the spread and impact of Covid-19 in North Wales. This could lead to reduced staff numbers available for work, increased demand on services (including acute, community, mental health and primary care), and suspension of planned services. This could negatively affect patient safety and quality of care, patient outcomes; delivery of the mass vaccination programme and TTP; and the Health Board's ability to deliver its plans and corporate priorities.		Inherent Risk	5		4		20		Low 1 - 6
		Current Risk	4	↔	4	↔	16	↔	
		Target Risk	4		2		8		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Divisional operational management teams' Covid response arrangements are in place. Additional workstreams established incluidng Operational Hub. Any issues requiring escalation are reported into Executive Team or the Executive Incident Management Team (EIMT) as appropriate. EIMT is currently meeting 3 times a week and Cabinet has been reconvened	2	Contingency and escalation plans are in place and operational measures taken to support the response to Covid-19 including amended care pathways; provision of PPE; remote or prioritised assessment pathways; prioritisation of treatment; escalation plans and surge capacity. Surge plans/winter resilience plans are being updated and will be tracked against modelling predictions. Revised modelling is being used to inform capacity and re-escalation plans.	2	1) Review of surge plans against WG options framework for escalation. [Update 24.11.21 - critical care surge plans is being refreshed]. 2) Development of proposals for redeployment of staff, extended capacity and other escalation options under the framework. [Update 24.11.21 - options reviewed agianst the framework and this will become a standing item at the EIMT]	~~31 October 2021~~ 30 November 2021 ~~31 October 2021~~ 31 March 2022
Covid-19 response programmes established to plan and deliver specific targeted response including Test, Trace and Protect programme; Vaccination Delivery Programme; PPE group; Operational Delivery Group for outbreak management; Ysbyty Enfys Assurance Group now stood down but reporting continues through EIMT for significant decisions.	2	1)Detailed programme plans in place for each programme area; performance indicators identified to enable monitoring and evaluation; governance structures in place to enable oversight and decision-making. 2) Strengthening of reporting processes into and from EIMT and/or Executive Team in place. 3) Establishment of clear regularised reporting structures around established workstreams.	2	1) Prevention and response plan priorities and actions reviewed again in light of revised Coronavirus Control Plan produced by WG, working with partners. 2) Vaccination booster programme underway, requires review of capacity to ensure completion consistent with WG timeline.	Completed 30 November 2021
Clinical Pathways Group established to scrutinise clinical response to the pandemic and approve amended pathways and reporting into the Clinical Effectiveness Sub-Group.	2	1) Clinical approval for service delivery proposals; approved pathways published on the BCU intranet; reporting to Executive Team and EIMT. 2) Programme and links into ET/EIMT reviewed.	2	Clinical strategy work to facilitate development of Clinical Senate. [Update 24.11.21 - Under review with the Medical Director.] Review current pathways in light of revised IPC guidance.	30 November 2021 31 December 2021 31 December 2021
Coronavirus Co-ordination Unit established to support programme reporting and strategic co-ordination, working closely with the Business Intelligence Unit (BIU) and Covid Intelligence Hub to ensure timely and accurate analysis of data and modelling of trajectories.	2	Covid dashboards to facilitate up to date review of performance; weekly reporting to executive team and IMs; monitoring of reporting to WG including SitReps, outbreak reporting, unscheduled care and hoc reports. Dashboard now consistently linked for BIU users. Mechanisms in place for ongoing surveillance, analysis and modelling after current pandemic peak.	2	1) Ensure readiness for further escalation as required in the event of further waves of Covid pandemic, in line with national modelling and revised regional projections [Update 24.11.21 - complete]	30 November 2021
Executive Incident Management Team has been established and is meeting as required, with formal reporting to the Board regularly and updates as appropriate.	2	Recording of actions and decisions via daily updates to logs; regular briefing to IMs via Board briefings; escalation of matters requiring Board approval. Frequency increased to 3 times weekly and Cabinet re-established.	2	Ongoing work to ensure all records captured and indexed. Archivist team being established and preparation for public inquiry underway	31 March 2022
North Wales LRF Strategic Co-ordinating Group and Recovery Co-ordinating Group have stood down as separate mechanism. SCG will be reconvened as and when required.	3	Risk assessment, escalation of sub-regional and regional issues, whole system response; and reporting to WG on an escalation basis.Mechanisms in place through RCG for ongoing collaborative arrangements for monitoring transition into recovery. Split agenda for RCG encompasses whole system pressures.	3	1) Prevention response plan to set out remobilisation processes	[next review point 31 October]

Review comments since last report:
Controls, mitigations, actions and timeframes have been reviewed and updated to reflect the current position on the pandemic. The current risk score relating to the impact of Covid has been increased in light of ongoing high levels of community transmission, although this needs to be balanced against the effect of the vaccination booster programme and the evidence of reduced levels of severe disease and hospitalisation. Demand on healthcare from Covid is stabilising, and the risk to staffing levels due to isolation not incresaing as absence rates appears to be stabilising (alongside revised guidance on isolation for vaccinated individuals.) The Prevention & Response Plan is being reviewed with partners, noting that there are gaps in capacity across all partners organisations to respond to potential rising community transmission and associated increases in testing and tracing. The Risk Lead is considering the date when it is anticipated that the target risk score will be achieved.

Executive Lead:	**Board / Committee:**	**Review Date:**
Gill Harris, Deputy Chief Executive and Executive Director of Nursing and Midwifery	Quality, Safety and Patient Experience Committee	**24 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-20		Risk Rating	Impact		Likelihood		Score		Appetite
Development of Integrated Medium Term Plan 2022/25									
There is a risk the Health Board fails to deliver an approved plan incorporating service, workforce, financial balance and delivery of key performance targets to Welsh Government to ensure statutory duties are met.		Inherent Risk	4		4		16		Moderate
		Current Risk	3	↓	3	↔	9	↓	**9 - 12**
		Target Risk	3		2		6		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Executive Team led planning process in place responsible for meeting the Welsh Government (WG) requirements for the development / implementation of an IMTP for 2022/25	2	1) Strong corporate, clinical, managerial and partnership engagement / collaboration with established and coordinated communication links including Welsh Government, Public Health Wales, and key internal and external stakeholders, e.g.: Executive Team, Planning Oversight Group, Stakeholder Reference Group, Regional Partnership Board. 2) Clear accountability across the organisation with health community led planning 3) agreed programmes with designated Executive lead, programme lead 4) Focus on consolidation of new schemes identified/introduced in 21/22 5) Alignment with the published NHS Wales Planning Framework	2	Development of a 2022-25 plan by December 2021 comprising - Prioritised Health Community Schemes - Financial Plan - Welsh Government allocation - Savings Plan - Workforce Plan - Capital and Estates - Digital - WG minimum dataset incorporating performance trajectories	31 January 2022
Planning cycle established with outline BCUHB Planning schedule/overall approach for 2022/2025 - plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Partnerships, People & Population Health Committee.	2	1) All new schemes for 2022/25 in place with the required Cluster Leads support. 2) Planning arrangements established to support development of a high level plan with identified support from Corporate Teams. 3) Development of commissioning intentions led by Programme Groups/ designated programme leads with input from Divisional Teams with direct reporting to the Executive Team. 3) Planning and Performance, workforce, financial and informatics functions supporting oversight of plan development.	2	Management capacity for substantive Senior Programme Leads {Update 11.11.21- Interim solution is now in place and the substantive solution will form part of the operating model review which will be completed by March 2022}	31 March 2022
Planning cycle in place that responds to national NHS Wales planning timetable and requirements.	2	Welsh Government planning framework issued. Communications/Engagement Team support to the plan to improve the engagement.	2		

Review comments since last report:
A fifth key mitigation: Alignment with the published NHS Wales Planning Framework, has been added to the first key control. The IMTP 2022-25 was discussed at the Executive away day in November. Whilst there is still work to do, the Executive Team was generally supportive of the progress of the plan, which will be submitted to the Partnerships, People and Population Health (PPPH) Committee in December. Overall, good progress has been made with the plan. Financial planning assumptions are being made whilst awaiting definitive financial allocation letter. Given that final ratification of the plan by the Board is required, the December target date has been moved to January 2022, when the formal Board meeting holds. Prior to the January meeting, the Plan will be discussed at the Board workshop in December. Confirmation has been received that the Welsh Government expects to receive the plan on 28 February 2022. The target date for meeting the second key control has been set at 31 March 2022.
The good progress made has led to a reduction in the current risk score to 9 (3x3) from 12 (4x3).
It is anticipated that the target risk score will be achieved by 31 March 2022 when the review of the operating model (which will take account of substantive solution for Senior Programme Leads) will be finalised.

Executive Lead:	**Board / Committee:**	**Review Date:**
Chris Stockport, Executive Director of Primary Care & Community Services/Sue Hill, Executive Director of Finance/Sue Green, Executive Director of Workforce & OD	Partnerships, People and Population Health Committee	**11 November 2021**

Linked to Operational Corporate Risks:

Board Assurance Framework 2021/22

Aligned to Key enabler - Making effective and sustainable use of resources

Risk Reference: BAF21-21		Risk Rating	Impact		Likelihood		Score		Appetite
Estates and Assets									
There is a risk that the Health Board fails to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding. This could impact on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation.		Inherent Risk	5		4		20		Moderate 8 - 10
		Current Risk	5	↔	3	↔	15	↔	
		Target Risk	5		2		10		

Key Controls	Assurance level *	Key mitigations	Assurance level *	Gaps *(actions to achieve target risk score)*	Date
Estates Strategy in place and approved by the Board in January 2019 with updates provided to the Strategy, Partnership and Population Health Committee. [Taken from the current Estates Strategy, the Health Board's risk adjusted backlog maintenance figure is £53.4m and it is estimated that circa £838m of capital investment is required to ensure current estate is fit for purpose and of a reasonable standard. These figures will be updated when the Estates Strategy is refreshed.]	2	1.Development for business case for key projects identified in key strategies. 2.The Health Board undertakes annually an assessment of investment in infrastructure improvements and compliance - annually update backlog maintenance and capital investment requirements through the estates and facilities performance management system (EFPMS). This is a pan Wales return from all Health Boards, which defines the level of investment required within the estate. This information is used annually to update the Estates Strategy and inform both discretionary capital expenditure and all Wales major capital programmes.	1	Secure WG funding to support Business Cases (short and long term).	31 March 2022
Annual Capital Programme in place and approved by the Finance and Performance Committee with regular reports provided to the committee.	2	Capital Investment Group with representation from all divisions with monthly updates to the Executive Team in place.	2	Rationalisation of the Health Board Estate.[Disposal/rationalisation will be steered by recommendations coming out of the agile working programme, which also links to Digital]	31 March 2022
		Capital Programme based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee.	2	Review undertaken and work is ongoing to secure capacity to deliver all the projects.	Complete
		Selection criteria signed off by the Executive Team which links back to risk, service continuity, service transformation and sustainability.	2	Development of Digital Strategy (due to be presented to the Board on 20 May 2021). [Update - Digital Strategy now approved as a framework by the Health Board, however there is not currently funding identified for its implementation.]	Now approved
		1) Project Teams in place to deliver the business case and projects. 2) 3 year Capital Programme agreed with Executive Team and approved by F&P Committee on 25 March 2021.	1	Work has commenced on developing capital programme 2022 - 2025	01 March 2022

Review comments since last report:
This risk will be reviewed within the context of the deep dive at the Risk Management Group meeting on 13 December.

Executive Lead:	Board / Committee:	Review Date:
Sue Hill, Executive Director of Finance	Performance, Finance and Information Governance Committee	**23 November 2021**

Linked to Operational Corporate Risks:
CRR20-06 - Informatics - Patient Records pan BCU
CRR20-07 - Informatics infrastructure capacity, resource and demand

Risk Key Field Guidance / Definitions of Assurance Levels

BAF / Risk Template Item	Please refer to the Risk Management Strategy and Policy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Risk Key Field Guidance / Definitions of Assurance Levels

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Appendix 2 – Full list of BAF risks with nominated Committee, Executive Lead and Risk Lead

BAF ref	BAF Risk	Exec Owner/ Risk Lead	Assurance Committee	Risk Score	Target Risk Score
BAF21-01	Emergency Care	Gill Harris, Meinir Williams	QSE,	16	12
BAF21-02	Sustainable key health services	Teresa Owen Gwyneth Page	PPPH	15	10
BAF21-03	Primary Care sustainable health services	Chris Stockport, Clare Darlington	PPPH	20	12
BAF21-04	Timely access to planned care	Gill Harris Andrew Kent	PFIG & QSE	20	12
BAF21-05	Mental Health-effective stakeholder relationships	Teresa Owen, Amanda Lonsdale	PPPH	9	4
BAF21-06	Safe and effective Mental Health delivery	Teresa Owen, Mike Smith	QSE	20	9
BAF21-07	Mental Health leadership model	Teresa Owen, Carole Evanson	PPPH	12	8
BAF21-08	Mental Health service delivery during pandemic	Teresa Owen, Carole Evanson	QSE	9	6
BAF21-09	Infection Prevention and Control	Gill Harris, Sally Batley	QSE	16	12
BAF21-10	Listening and Learning	Gill Harris, Matt Joyes	QSE	20	10
BAF21-11	Culture; staff engagement	Sue Green, Ellen Greer	PPPH	16	12
BAF21-12	Security Services	Sue Green, Peter Bohan	QSE	20	10

BAF ref	BAF Risk	Exec Owner/ Risk Lead	Assurance Committee	Risk Score	Target Risk Score
BAF21-13	Health & Safety	Sue Green, Peter Bohan	QSE	**20**	**10**
BAF21-14	Pandemic exposure	Gill Harris, Sally Batley	QSE	**15**	**12**
BAF21-15	Value Based Improvement Programme	Sue Hill, Geoff Lang	PFIG	**12**	**8**
BAF21-16	Digital estate and assets	Chris Stockport, Phil Corrin	PPPH	**20**	**12**
BAF21-17	Estates and assets development	Sue Hill, Rod Taylor	PFIG	**12**	**9**
BAF21-18	Workforce optimisation	Sue Green, Nick Graham	PPPH	**16**	**12**
BAF21-19	Impact of Covid-19	Gill Harris, Sally Baxter	QSE	**16**	**8**
BAF21-20	Development of an Integrated Medium Term Plan (IMTP) 2022/25	Chris Stockport, Sue Hill, Sue Green, John Darlington	PPPH	**9**	**6**
BAF21-21	Estates and assets	Sue Hill, Neil Bradshaw	PFIG	**15**	**10**

Cyfarfod a dyddiad: Meeting and date:	Audit Committee 14th December 2021
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: Prior Scrutiny:	• Partnerships, People and Population Health Committee on the 14th October 2021 • Quality, Safety and Experience Committee on the 2nd November 2021 • Executive Team meetings on the 25th August and 20th October 2021
Atodiadau Appendices:	Appendix 1 – Full Corporate Tier 1 Operational Risk Report Appendix 2 – Full List Corporate Risks Appendix 3 - Key Field Guidance

Argymhelliad / Recommendation:

The Committee is asked to:

1) Review and note the progress on the management of the Corporate Tier 1 Operational Risks.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

The Corporate Risk Register (CRR) demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

The design of both the Board Assurance Framework (BAF) and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other, the BAF is now be reported separately.

Each Corporate Risk has been reviewed, updated and presented to the Board Committees. The full CRR will next to go the Board in January 2022.

Cefndir / Background:

The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR reflects the Health Board`s continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

Teams reporting to the Lead Director (who is the Senior Responsible Officer for the risk) locally own and manage risks with support from the corporate risk team. The Risk Management Group has oversight of all risks and is scrutinised by the Executive Team who make the proposals for changes to the CRR to Board and Committees.

Following the inclusion of the 4 new risks onto the Corporate Risk Register in September 2021, a further risk is being developed in line with the QSE previous meeting recommendation and it is anticipated this will presented during the January 2022 for escalation approval**.** This risk is in relation to the Health Boards resilience to uncertainty, unknowns and potential unchartered territory which could be caused by a number of converging and novel factors. The risk will be assigned to the Executive Director of Primary and Community Services as it is linked to business continuity and emergency planning.

Summary Table of the Full Corporate Tier 1 Risk Report:
Current live Tier 1 Risks (full details and progress can be found in Appendix 1):

Risk Title	**Inherent risk rating**	**Current risk rating**	**Target risk rating**	***Movement**
CURRENT RISKS – appendix 1				
CRR20-01 - Asbestos Management and Control	20	15	8	Decreased
CRR20-02 - Contractor Management and Control	20	15	8	Decreased
CRR20-03 – Legionella Management and Control	20	16	8	Decreased
CRR20-04 - Non-Compliance of Fire Safety Systems	20	16	8	Decreased
CRR20-05 – Timely access to Care Homes	25	20	6	Unchanged
CRR20-06 – Informatics – Patient Records pan BCU	16	16	12	Unchanged

**CRR20-07 – Informatics infrastructure capacity, resource and demand	20	16	12	Unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	25	20	6	Unchanged
***CRR21-11 – Cyber Security	25	20	15	Unchanged
CRR21-12 – National Infrastructure and Products	20	20	12	Unchanged
CRR21-13 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	20	16	6	Unchanged
CRR21-14 - There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	25	20	6	New Risk, will be presented to the Board in January 2022
CRR21-15 – There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	20	16	12	New Risk, will be presented to the Board in January 2022
Risk ID 3893 – Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	20	16	4	New Risk, will be presented to the Board in January 2022
CRR21-17 - The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	20	16	8	New Risk, will be presented to the Board in January 2022

*movement in risk score is measured from the last presentation to Board, and not necessarily reflective of the latest committee decisions.

**Awaiting Committee approval to close this risk as the remaining outstanding content is being managing as part of the Board Assurance Risk BAF20-16

***Please note CRR21-11 – Cyber Security – is presented In-Committee to protect and maintain the security arrangements of the Health Board.

Below is a heat map representation of the current corporate risk scores for this Committee:

Current Risk Level		**Impact**				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR21-12 CRR21-14	
	Likely - 4				CRR20-03 CRR20-04 CRR20-06 CRR20-07 CRR21-13 CRR21-15 CRR21-16 CRR21-17	CRR20-05 CRR20-08 CRR21-11
	Possible - 3					CRR20-01 CRR20-02
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The implementation of the Risk Management Strategy and Policy aligns with the Health Board`s strategy to embed effective risk management in fostering its culture of safety, learning to prevent recurrence and continuous improvements in patient, quality and enhanced experience.

Opsiynau a ystyriwyd / Options considered

Continuing with Corporate Risk Register.

Goblygiadau Ariannol / Financial Implications

The effective and efficient mitigation and management of risks has the potential to leverage a positive financial dividend for the Health Board through better integration of risk management into business planning, decision-making and in shaping how care is delivered to our patients thus leading to enhanced quality, less waste and no claims.

Dadansoddiad Risk / Risk Analysis

See the individual risks for details of the related risk implications.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal and compliance issues associated with the delivery of the Risk Management Strategy and Policy.

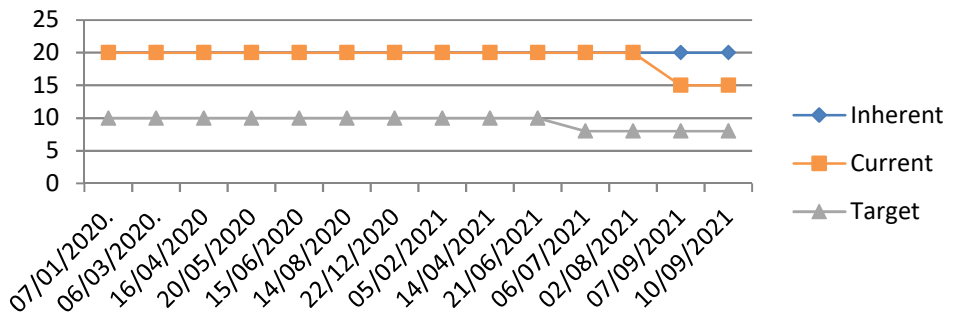
Asesiad Effaith / Impact Assessment

No specific or separate EqIA has been done for this report, as a full EqIA has been completed in relation to the new Risk Management Strategy and Policy to which CRR reports are aligned.

Due regard of any potential equality/quality and data governance issues has been factored into crafting this report.

Appendix 1 – Full Corporate Risk Register

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 September 2021
	Risk: Asbestos Management and Control	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 31 March 2022
There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	Decreased (from 20 to 15)		

Controls in place	Assurances
1. Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. 2. Annual programme of re-inspection surveys undertaken. 3. An independent audit of our annual re-inspection programme is in place. 4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. 5. Asbestos register available. 6. Targeted surveys where capital work is planned or decommissioning work undertaken. 7. An annual training programme for operatives in Estates is in place. 8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Internal Audit review undertaken against the gap analysis.

Gaps in Controls/mitigations

1. We are unable to achieve compliance with awareness and training as not everyone is able to undertake the training within a specified timescale.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 15 has been applied to the risk. 2. Following a change in the Executive Director's portfolios, the risk has been updated to reflect this change. 3. Controls and gaps in controls have been reviewed and updated to reflect the current position. 4. Further work is continuing to provide evidence to align the controls and the gaps as identified in the Health and Safety gap analysis. 5. Weakness in the asbestos management survey has been mitigated with the annual re-inspection programme.

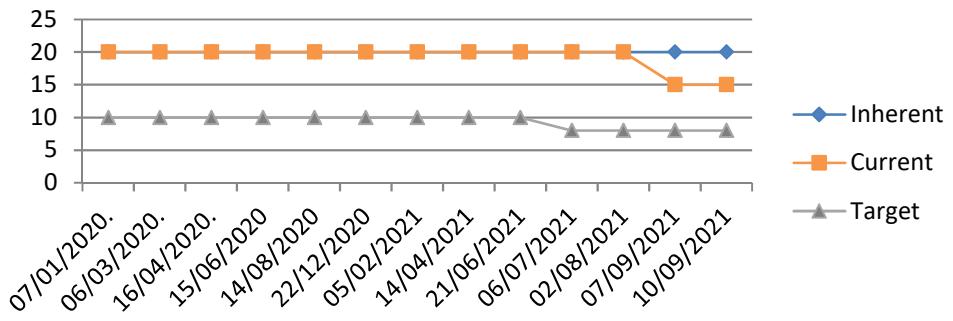
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Strengthen our wellbeing focus	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.	On track
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing any potential impact.	On track

	18298	To develop and implement a Management Action Plan in response to the Internal Audit report.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	The Management Action Plan will support current mitigation and management of the risk.	On track
	18686	Ensure 100% compliance with asbestos awareness training for Operational Estates maintenance staff.	Mr Arwel Hughes, Head Of Operational Estates - Interim	31/03/2022	Ensure compliance with training legislation and help to reach the target risk score.	On track

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 September 2021
	Risk: Contractor Management and Control	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 September 2022

There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	Decreased (from 20 to 15)		

Controls in place	**Assurances**
1. Control of contractors procedure in place. 2. Induction process being delivered to new contractors. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place. 5. Externally appointed CDMC Coordinator (Construction, Design and Management Regulations) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Gaps in Controls/mitigations
1. Lack of ongoing programme of training in line with requirements in legislation. 2. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 15 has been applied to the risk. 2. Controls and gaps in controls have been reviewed and updated to reflect the current position. 3. Further actions have been identified to address the gaps identified in the Health and Safety Gap analysis report, which will support the reduction in the current risk score. 4. Action dates have been extended following previous Executive Team agreement and noted at QSE on the 7th September 2021. 5. Following a change in the Executive Director portfolios, the risk has been updated to reflect this change.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track

	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming top site.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management	On Track

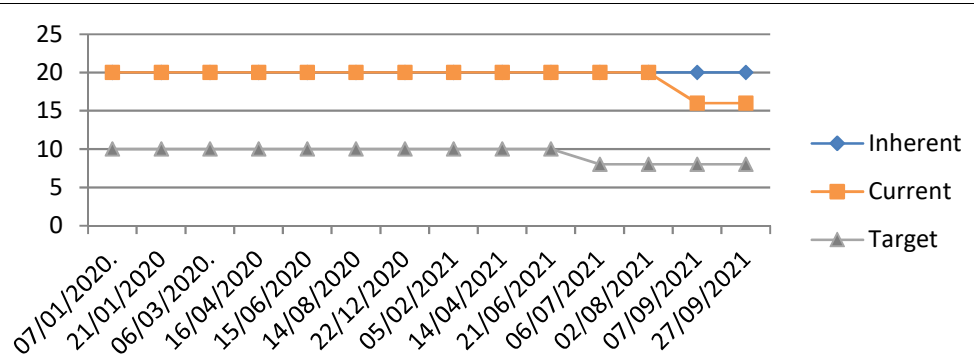
					of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	A Permit to Work system will be adopted as part of implementation of SHE software. Original action due date was	On Track

					30/09/2022. Approved reduction at QSE 07/09/2021.	
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/05/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the	On Track

					Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	
	18688	An annual review of business as usual capacity to be developed to ensure estates project management capacity is not exceeded.	Mr Arwel Hughes, Head Of Operational Estates - Interim	31/03/2022	Create assurance that there is sufficient estates management capacity and technology to ensure that projects can be delivered safely.	On Track

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 27 September 2021
	Risk: Legionella Management and Control.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 September 2022

There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	Decreased (from 20 to 16)		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team. 8. Water safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Gaps in Controls/mitigations

1. There is a weakness that little used outlets are not reported to Estates for management and control. e.g. we can have a ward shower temporarily used as a store, therefore it isn`t part of Estate flushing programme.
2. There is a weakness that alterations to pipe works are not undertaken with consent from local Estate Water Management Team.
3. BCU wide Water Safety Plan is currently being written, which will provide legal requirement under L8 for processes and controls for water safety systems.

4. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case is currently un-funded and provides supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 16 has been applied to the risk. 2. Following a change in the Executive Director's portfolios, the risk has been updated to reflect this change. 3. Risk reviewed following concerns by the corporate Health and Safety Team in relation to the reduction of the risk score from 20 to 16. Estates and Facilities Team agreed that the score should remain at 16 taking into account current control measures in place. 4. Gaps in controls updated to align with current position of the risk. 5. Action ID 12269 – Proposal to close this action as the Water Safety Group is now in place. 6. Additional action identified following a review of gaps in controls to secure funding and appointment of additional posts.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Strengthen our wellbeing focus	BAF21-13 BAF21-17

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates control. Implement MiCAD/database system to ensure all schematics are up to date and deadlegs easily identified.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	MiCAD (IT) system being rolled out on a phased basis and work has commenced on polylining site drawings (digital site drawings) for migration to MiCAD. Schematic drawings for all sites for water safety being reviewed as part of the new Water Safety Maintenance Contract, which has been approved by the Health Board in January 2021.	On Track

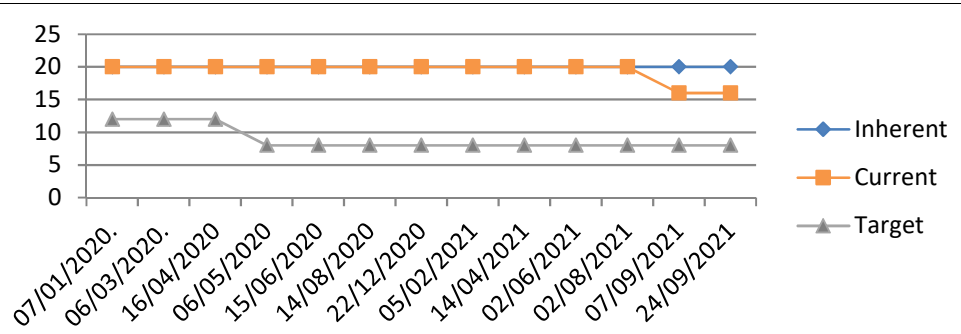
	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.	On Track
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	On Track
	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	On Track
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	On Track
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	On Track

	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document. As part of the water safety plan infection prevention will need to be integrated within key sections of the plan.	On Track
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective.	Mr Rod Taylor, Director of Estates & Facilities	29/10/2021	ACTION CLOSED - 27/09/2021 Water Safety Group provides assurance that the Policy is being effectively implemented across all sites; this requires appropriate clinical and microbiology support to be effective. The Water Safety Groups reports issues of significance and assurance to the Infection Prevention Sub-Group (IPSG) and Strategic Occupational Health and Safety Group (SOH&SG).	Completed
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track

	19015	Secure funding and appointment of 3x band 7 Senior estates officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	Provide resources to be able to manage safe water systems and have the facility to carry out departmental audits on water safety and provide assurance of compliance to the water safety group.	On Track

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 24 September 2021
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 September 2022

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	Decreased (from 20 to 16)		

Controls in place	**Assurances**
1. Fire risk assessments in place. 2. Evacuation routes Identified and evaluation drills established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUH Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain compliance with fire equipment and infrastructure. 2. Insufficient capital to upgrade fire detection and compartmentalisation of the fire safety infrastructure.

Progress since last submission
1. Following approval at the QSE Committee Meeting on the 7th September 2021, the agreed reduction in the current scoring from 20 to 16 has been applied to the risk. 2. Following a change in the Executive Director's portfolios, the risk has been updated to reflect this change. 3. Funding has been received from EFAB and statutory compliance monies to commence a programme of works. 4. Action dates have been amended following previous Executive Team agreement and noted at QSE on the 7th September 2021. 5. Action ID12279 – Proposal for a further extension to this action to 31/03/2022 due to the delay in the delivery of the manual handling training. Further discussions are progressing with the manual handling leads. 6. Action ID12554 – Proposal to close this action with evidence of audits captured within the programme of activity. 7. Action ID12555 – Proposal to close this action with evidence of reporting being provided to the Fire Safety Management Group.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Strengthen our wellbeing focus	BAF21-13 BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	Governance actions completed and operational elements are captured within the gap analysis areas below. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on	On Track

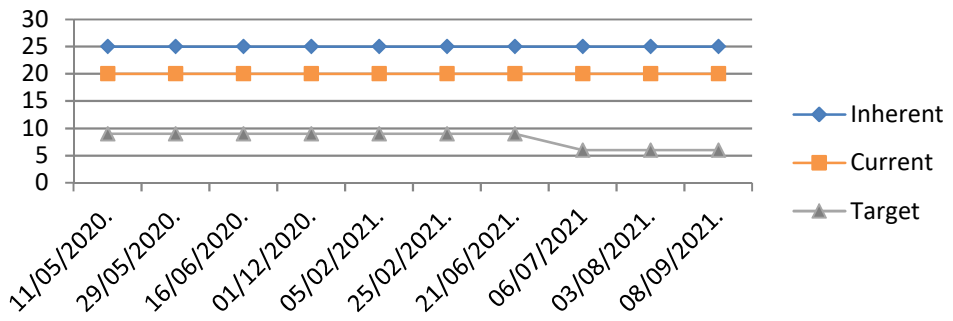
					implementation of actions outstanding. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	Database located within the fire safety files, managed and updated by the fire safety trainer. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021. Request extension until 31/03/2022 to enable completion of action, due to the delay in Manual Handling training within BCU, further	Delay

					work ongoing with Manual Handling leads.	
	12554	Commission independent shared services audits.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	ACTION CLOSED – 27/09/2021 Independent, Shared Services (Specialist Estates Services) audits commissioned on an annual basis to ensure the appropriate fire safety measures, process and procedures are in place within Acute and Community hospital sites The Health Board has now in place a programme of independent fire safety audits undertaken annually by the HB's appointed authorizing engineer - fire safety. Sites are selected based on risk and operational activity.	Completed
	12555	Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	Mr Rod Taylor, Director of Estates & Facilities	29/04/2022	ACTION CLOSED - 24/09/2021 Unwanted Fire signals (Uwfs) and fire safety data collated within an All-Wales management system and annual report collated and published. Details shared with the SOH&SG and escalated to QSE as necessary. Information reviewed as part of the annual Fire Risk	Completed

					Assessment process and appropriate action taken. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021. Report on fire alarm activations is presented at each Fire Safety Management Meeting.	
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order.	On Track

CRR20-05	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 08 September 2021
	Risk: Timely access to care homes	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 31 December 2021

There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	3	2	6
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	unchanged		

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance. 4. Unified “One contact" data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice. 9. Home first bureaus established and embedded across the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular fortnightly formal communication channels with care homes at a local level and across BCU.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight via Gold and Silver Strategic Emergency Planning. 3. Oversight as part of the Local Resilience Forum via SCG. 4. Oversight by the Recovery Group.

11. North Wales care home escalation and support tool that complements national work programmes has been implemented, monitored as part of the North Wales care homes single action plan at RPB. 12. Communication with care homes at a local level and across North Wales as part of the North Wales care homes single action plan. 13. MDT Care Home group meeting daily Monday to Friday, for issue resolution for period of enhanced second covid wave pressures. 14. Re-establishment of the North Wales Silver Health and Social care group reporting into the Strategic Control group, to identify where joint responses are required and shared learning. 15. Contribution to the incident management teams in outbreaks/incidents within care homes.	

Gaps in Controls/mitigations
1. It remains unclear who is leading on outbreaks in Independent Hospitals which are mainly MH hospitals. 2. There is a massive shortage in accessing domiciliary care support. 3. There is a real issue sorting out staff for Agency last minute cancellation when a home turns red or has a positive case. 4. Changes in Government Strategy is affecting the Nursing Homes. 5. Lack of standardised reporting across North Wales for cause/delay in discharge for MFD patients.

Progress since last submission
1. Proposal put forward to move the target risk due date from 31/12/2021 to 30/06/2022 due to continued waves in the pandemic and the requirement to support the care sector. 2. Controls in place reviewed and updated to align with current position. 3. Gaps in controls have been reduced with the implementation of standardised ways of working across North Wales eg. BCU chairing MDT meetings and implementation of standardised risk assessments. 4. Care homes cell has been reviewed and membership extended.

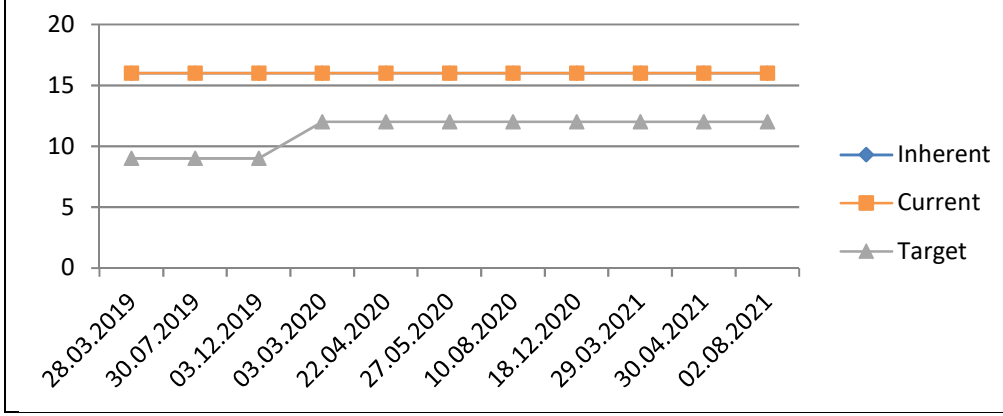
Links to	
Strategic Priorities	**Principal Risks**
Primary and community care	BAF21-03

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14943	Deliver a revised financial support package for care homes.	Kathryn Titchen, Commissioning Manager CHC	02/08/2021	ACTION CLOSED 04/08/2021 This action will support access to care homes with a standardised rate agreed for care homes.	Completed
	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	28/02/2022	This will help eradicate delays in discharge through better co-ordination. Draft framework is in place and we have setup 6 different work streams to implement the various strands of the Quality Assurance Framework. Extension to the original action due date from 30/06/2021, approved at QSE 07/09/2021.	On Track
	18024	To work with LAs to review domiciliary care resource across North Wales.	Ms Jane Trowman, Care Home Programme Lead	28/02/2022	It will improve patient flow by enabling patients to be discharged to their own homes.	On Track
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/12/2021	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge.	On Track

	18646	MFD - Work with local authorities and care provides to implement an agreed action plan	Ms Jane Trowman, Care Home Programme Lead	31/12/2021	Improved flow and discharge of patients in a more timely manner, and improve the quality of care to patients.	On Track

CRR20-06	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 02 August 2021
	Risk: Informatics - Patient Records pan BCU	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 30 September 2024

There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2021	unchanged		

Controls in place	**Assurances**
1. Corporate and Health Records Management policies and procedures are in place pan-BCUHB. 2. iFIT RFID casenote tracking software and asset register in place to govern the management and movement of patient records. 3. Escalation via appropriate committee reporting. 4. Key performance indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. (New) Centralised Team to manage 'Subject Access Requests' for Patient Records pan-BCUHB established with project complete March 2021, ensuring compliance with legislation and supporting the rectification of commingling within patients clinical notes (Action ID 12422). 6. (New) Standard Operating Procedure in place pan-BCUHB and off-site storage secured to manage the increased storage demands in response to the embargo on the destruction of patient records (in line with retention) due to the infected blood inquiry. 7. (New) Medical Examiners Service (MES) support teams established on each site to respond to the new requirements for providing scanned patient records to the MES in line with their standard operating procedures.	1. Chairs reports from Patient Record Group. 2. ICO Audit. 3. HASCAS Audit.

Gaps in Controls/mitigations
Funding to deliver digital transformation is competing across many emerging priorities, with many support teams starting from a low baseline with already stretched capacity. Main issue across our projects is with recruitment, which are exacerbated by the inability to utilise common job descriptions across Welsh NHS organisations under Agenda for Change – escalated to the DHR Project Board, with Finance Executive Director exploring.

Progress since last submission
Full progress report from the Patient Records & Digital Integration Department, Informatics: *New Controls Achieved* ~ Subject Access Requests (SARs) for Patient Records - following ICO recommendations in June 2018, significant progress has been made to meet the DPA2018 and GDPR in respect of the safe and appropriate management of an individual's right of access to their medical records. The project to centralise the team in Llandudno Hospital completed in March 2021; digitising, streamlining and improving the process for the requesters. This team works pan-BCU across requests for all patient record types dealing with circa 400 requests per month, with strict timescales to avoid reportable breaches - since the full go live there was only 2 breaches in Q1 (0.3%). The team members have received specialist training at GDPR Foundation/Practitioner level, that also enables them to respond to and manage specific requests from the Police, Courts and GMC; and addresses requests across record types for rectification. This work responds to the previous HASCAS/Ockenden recommendation to put controls in place for commingled records, with a focus on significant quality checks prior to the release of any record to a requester. ~ Medical Examiners Service (MES) - In the last 6 months, the Department has also responded to a request to support changes brought in by the MES, which required support teams to be established on each site to respond to the new requirements for providing scanned patient records to the MES in line with their standard operating procedures (SOP). The demands of the SOP are specific and exacting - feedback from the MES is very positive on the quality and standard of the scanned records being provided by BCUHB. *Progress on the Digitisation of Acute Patient Records* ~ Digital Health Records (DHR) Project - following a robust and commercial tender process, the Full Business Case was approved at the Health Board meeting in July 2020, and subsequently the Welsh Government gave approval in September to award the contract to Civica UK Ltd with their 'Cito' system. This will deliver a single digital place for the 'acute' patient record, supporting integration with local and national systems in Wales and beyond; over a four year project (started) November 2020. The appointed early adopters Vascular Surgery and Paediatrics are due to go into pilot in the Autumn following engagement carried out with a range of staff across the three site Departments. Cito environments are in place and Data Migration/Integration testing shows data quality and acceptability to be high. Whilst not back scanning our entire libraries, we do carry out scanning across records types in BCUHB; we are preparing to procure a new scanning contract to ingest any scanning of patient records into Cito and where possible bring over scanned records from obsolete and legacy software. Work is also underway following initial

negotiations to ensure a copy of all clinic letters are provided to Cito from EPRO (digital dictation system), with seamless access across the two systems; technical specifications are also being prepared to engage with DHCW to ensure seamless access across Cito and the WCP.
~ Digitised Clinic Letters - digital clinic letters are key to achieving the wider move from paper to digital patient records and we are well on our way to deliver one system pan-BCUHB that will support the digital dictation and transcription of clinic letters. Roll out in the West has completed in July - 2 months ahead of schedule, and we will be building on the original pilots Departments in Central with the aim to complete the roll out to this area by end November 2021. Planning for and engagement with East is already underway to drive forward for a full project completion by June 2022. Future plans to pilot speech recognition and use of mobile phones for dictations are being explored.
~Results Management Project - BCU are working in partnership with DHCW to improve the assurance of results management and deliver a fit for purpose solution that will improve patient safety and stop printed results. Whilst this work will support the digital agenda for a patient records, the main focus is to address the serious issues derived from the low assurance for the safe management of results; resulting in examples of harm to patients, due to results not being available or viewed. This project's key workstream is awaiting funding. The Business Case has been reviewed by the HBRT in July 2021 to provide the required funding that will fully digitise the process within the WCP, enabling us to stop printing results. Alongside this key workstream in the project, work is progressing to ensure take up of Electronic Test Requesting and to enable seamless e-requesting and validation of radiology. Future pilots will be considered in the future to view test results on mobile phones.
~ Welsh Nursing Care Record Project (WNCR) - The long term objective of this project is to standardise and develop a full suite of digital nursing. Following a pilot of the national WNCR product undertaken on the Bonney Ward and the Arrivals lounge at Wrexham Maelor Hospital earlier in the year, BCU's Senior Nursing Lead Informatics Specialist has presented a Business Case to the HBRT in July 2021, with work now underway to strengthen the case. A key deliverable of this project is to ensure a copy of the nursing notes are available within the local DHR to deliver resilience for the cohesive record and provide sound business continuity.

Physical Environments
~ Relocation of the YGC File Library – The YGC File Library Programme Board needs to develop a single business case for a new pan-central file library to relocate (as a minimum) the acute records from both the Ablett and the portacabin – taking account of the plans for a DHR, by April 2021 in line with the Mental Health Service Business Case. We are of a delay of approximately 20 weeks with the Mental Health OBC to the Welsh Government; due to this it is expected that the scheme will commence in early 2023 and be completed towards the end of 2024. The plan for YGC Medical Records File Libraries will be to submit a mini business case to try and secure the whole Ablett site, but this will be on hold until the Mental Health plans progress beyond the Full Business Case stage. We are currently fine where we are in the portacabin and the Ablett following significant remedial work a few years ago; but the portacabin is beyond its life span and the most sensible way forward is for us to secure the entire Ablett Mental Health building to move from the portacabin into.

Links to	
Strategic Priorities	**Principal Risks**

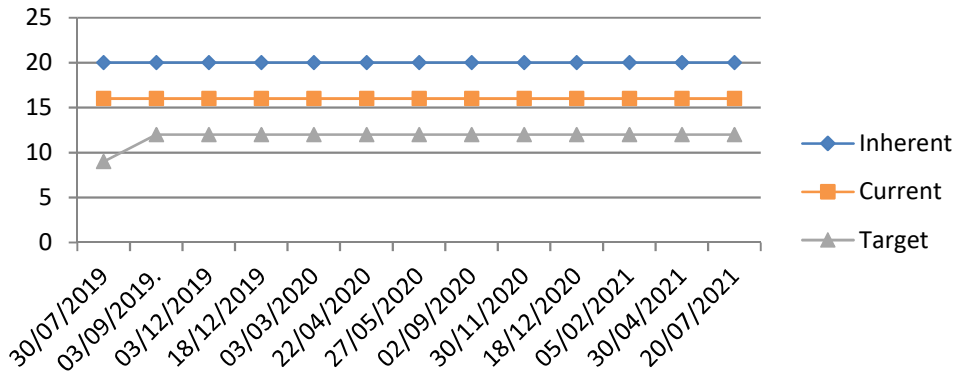
Effective use of our resources	BAF21-16 BAF21-22

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12423	Development of a local Digital Health Records system.	Mrs Danielle Edwards, Head of Digital Records	30/09/2024	29.03.21 (DE) UPDATE Mar 2021 - Project remains on track with key deliverables for this quarter: Project Board agreed a formal project start of 1st March 2021 with an established Project Team; Phase 2.0 Project Plan has been agreed to deliver a Minimum Viable Product and implement with two early adopters with key targets for 2021 - Infrastructure ready by late Spring, Test Environment by early Summer, Early Adopters Go Live early Autumn; Engagement with a Clinical Task & Finish Group to design and development of the Cito product for BCU delivered the folder structure; risk sub-group is established with register baselined; DPIA in place.	On track
	12424	Improve the assurance of Results Management.	Mrs Danielle Edwards, Head of Digital Records	30/09/2021	29.03.2021 (DE) - UPDATE Mar 2021 - (WS1) - WCP 3.11.4 (moved on version) has been through UAT and whilst all showstoppers for RN have been addressed to a level that can be managed through SOPs, there are some other areas of the release that are still being reviewed. Business Case in process of being submitted to secure the funding required to deliver the project. (WS2) - for the 10 users that have the access (provided directly by NWIS which will in future need to come with the Project Board agreement to ensure readiness to govern and support) plans are being formed to test an 'Acceptable Use statement to ensure safe practice. (WS3) ETR - improved forms that have been developed by NWIS with local SME engagement will be available in WCP 3.12. (WS4) Radis 2.4 upgrade planned for later in Spring.	On track

	12425	Digitise the clinic letters for outpatients.	Mrs Danielle Edwards, Head of Digital Records	30/06/2022	29.03.20 (DE) - UPDATE Mar 2021 - Project remains on track - (West) the recovery activity for the PiMs integration is complete with the integration running well. Cancer Services, Pain Team went live 08/03 followed by the Anaesthetics Team on 15/03. The full roll out is in development with the West Operational leads, with an aim to run on a weekly go live schedule. (Central) Care of the Elderly team went live with EPRO on the 25/01, Gastro team on the 02/02, closely followed by Renal team 03/02 and Community Paediatrics planned 12/04. The Project team will take advantage of any gaps to the West roll out plan by seizing the opportunity to address the soft roll out list for Central if and when possible.	On track
	12426	Digitise nursing documentation through engaging in the WNCR.	Mrs Danielle Edwards, Head of Digital Records	30/09/2024	10.06.21 (DE) - Update Jun 2021 - Pending business case approval by the Board and full implementation within three years.	On track
	12429	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Danielle Edwards, Head of Digital Records	31/01/2023	10.06.21 (DE) - UPDATE Jun 2021 - We are on hold until the Mental Health Business Case is progressed with the WG (5 case business case) – break ground circa 2023, we will not be able to start the work to explore if the Ablett can be retained and redesigned for health records until the business cases are signed off. The date for the Mental Health FBC is Sept 2022.	On track

CRR20-07	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 28 March 2019
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 20 July 2021
	Risk: Informatics infrastructure capacity, resource and demand	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 15 December 2021

There is a risk that digital services within the Health Board are not fit for purpose. This may be due to:
(a) A lack of capacity and resource to deliver services / guide the organisation.
(b) Increasing demand (internally from users e.g. For devices/ training and externally from the public, government and regulators e.g. Growing need for digital services).
(c) the moving pace of technology.
This could lead to failures in clinical and management systems, and a failure to support the delivery of the Health boards strategy / plans impacting negatively on patient safety/outcomes. It may also pose a greater risk to the Health board of infrastructure failures and cyber attack.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2021	unchanged		

Controls in place	**Assurances**
1. Governance structures in place to approve and monitor plans. Monitoring of approved plans for 2019 2020 (Capital, IMTP and Operational. Approved and established process for reviewing requests for services. 2. Integrated planning process and agreed timescales with BCU and third party suppliers. 3. Key performance metrics to monitor service delivery and increasing demand. 4. Risk based approach to decision making e.g. Local hosting v's National hosting for WPAS etc. 5. National Infrastructure Review (Independent Welsh Government Review undertaken by Channel 13). 6. Digital Strategy has been developed and approved 7. DUO and O365 have enabled staff to work differently	1. Annual Internal Audit Plan. 2. WAO reviews and reports e.g. structured assessments and data quality. 3. Scrutiny of Clinical Data Quality by CHKS. 4. Auditor General Report - Informatics Systems in NHS Wales. 5. Regular reporting to DIGC (for Governance).

Gaps in Controls/mitigations
The lack of sustainable funding is a limiting factor to reduce this risk. Short term funding results in the recruitment of staff on short fixed term contracts, this results in instability in projects and business as usual.

Progress since last submission
The Digital Strategy has been approved and implementation has started. Business cases have been developed for: - WNCR - Results Management - WPAS The understand phase of the Informatics Workforce Planning Strategy has been completed. The Governance arrangements are under review and work has started to develop the Informatics Governance and Assurance Framework that will align with the new Corporate Governance Framework. It is requested that this risk is closed as it duplicates some of the elements within the BAF Risk. A review will be undertaken on where any outstanding actions fit and a new Informatics workforce risk will be developed.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF21-16 BAF21-17 BAF21-22

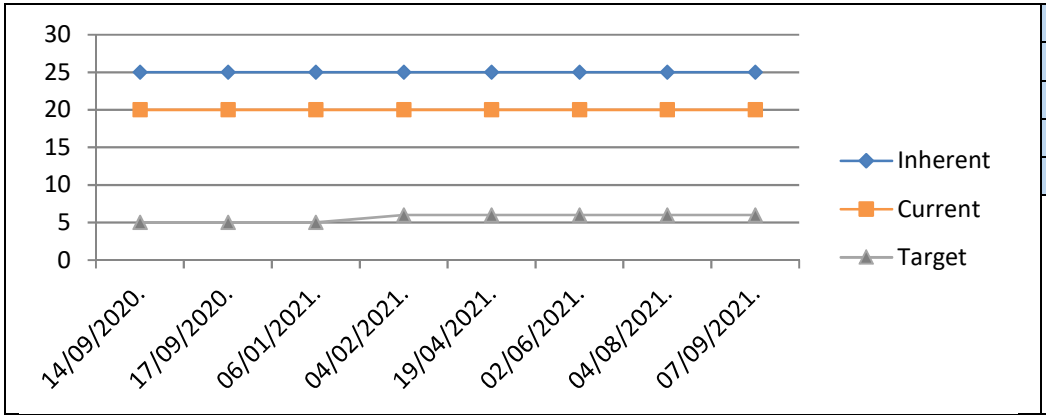
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status

Actions being implemented to achieve target risk score	12379	Review workforce plans and establish future proof informatics/digital capability and capacity.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/09/2021	The development of a Workforce Planning Strategy will take into account the service capability and capacity to deliver on the Digital Strategy.	On track
	12380	Review governance arrangements e.g. DTG whose remit includes review of resource conflicts has not been replaced (April 2020).	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/09/2021	This will be undertaken now the Digital Strategy has been approved and will ensure appropriate governance arrangements are in place to monitor implementation of the strategy.	On track

CRR20-08	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 September 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 28 February 2022

There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.

This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	3	2	6
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2021	unchanged		

Controls in place	**Assurances**
1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process. 4. More clinic slots are being made available to accommodate clinically pressing patients. 5. Diabetic retinopathy now in place across all 3 sites.	1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative group. 3. Monthly reports to WG against KPI's for eye care measure and KQI's. 4. All Wales and MIAA audits have taken place. In addition, two clinical condition audits are undertaken annually by Welsh Government.

Gaps in Controls/mitigations
1. They are continuing to stratify patients into R1, R2 and R3 to enable prioritisation of permanent sight lost. However, further table-top risk stratification is challenged by reduced OBD (Office Based Decision) making by clinicians as a consequence of their return to expanded clinical activities. 2. Surgery has recommenced but the Pan-BCU cataract PTL (to reduce inequality) has yet to be operationalised. 3. Diabetic retinopathy in place in two of the three Sites with West Site still to achieve flow to Primary Care. 4. Current partnership pathways which mitigate waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition, however, a significant number of patients do not have a clinical condition logged on the system (Central 2290; East 3600 and West 910). 5. Guidance for number of cataracts being undertaken per list is currently set to 6-8, the health board is running at 3.6-4, differences in national standards between numbers of cataract procedures per list.

Progress since last submission
1. Following a review of the Target Risk Score, Target Risk Date, the outstanding actions to be implemented and the delay in receiving the Business Case Approval, a request to extend the target risk date to the 30/06/2022 has been put forward to allow the achievement of the actions to support the reduction in the risk score. 2. Approval from the Health Board to outsource cataract services has been received and work has commenced. 3. Controls have been updated to include that Diabetic Retinopathy is now in place across all 3 sites. 4. Gaps in controls have been reviewed and updated with the risk lead to reflect the current position.

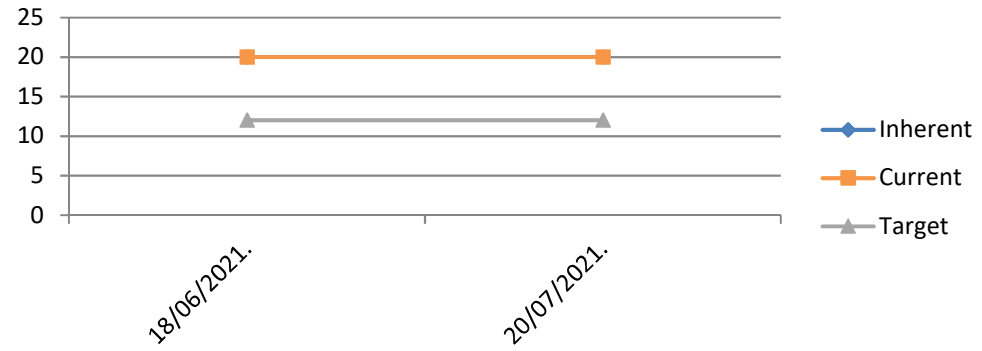
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Recovering access to timely planned care pathways	BAF21-02 BAF21-04

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	SINGARAM, Mr SRINIVAS - Specialty Doctor	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	On Track
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	SINGARAM, Mr SRINIVAS - Specialty Doctor	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	On Track

CRR21-12	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 23 October 2017 (re-opened
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 20 July 2021
	Risk: National Infrastructure and Products	**Date of Committee Review:** 18 June 2021
		Target Risk Date: 31 March 2022

There is a risk that the national infrastructure, technical architecture and products are not fit for purpose and do not allow the organisation to deliver benefits when planned. This may be caused by
a) A one size fits all approach.
b) Products which are not delivered as specified (e.g. time, functionality and quality).
c) The approach of the National Programme to mandate/design systems rather than standards.
d) Poor resilience and a "lack of focus on routine maintenance".
e) Supplier capacity leading to commitment or delivery delays.
f) Historic pricing models that are difficult to influence / may not be equitable.
g) DHCW Lack of alignment with BCUHB planning cycles and an understanding from a DHCW perspective.

This could result in negative impacts in several key areas including:- Patient outcomes. An inability to support the strategic direction of the Health Board. Delays to delivery of transformational change. Inefficient work flows, poor system usage. Increased costs as we maintain multiple systems / pay inequitable prices. Delays with the delivery of cost saving schemes.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2021	unchanged		

Controls in place	**Assurances**
1. Scrutiny of DHCW by DIGC who escalate any areas of concern to the Health Board. 2. Project Management Framework with strong governance in place. 3. Technical Oversight Group for WPAS and other National Programme Groups in place.	1. Public Accounts Committee Review of NWIS. 2. Reports from the Digital Transformation Group to IGIC / EMG. 3. WAO - review.

	4. National Architecture and Informatics Governance Reviews.

Gaps in Controls/mitigations
One of the key limitations to reduce this risk is that BCUHB does not have any control over the work delivered by Digital Health Care Wales. WPAS implementation which is a national project has not had confirmed funding yet from WG.

Progress since last submission
DHCW provided a report for the June DIGC with an update on all projects/work. The joint BCUHB and DHCW plan is nearly finalised and will be ready to be presented to DIGC in September. The WPAS Technical Oversight Group continues to meet and to monitor implementation progress.

Links to	
Strategic Priorities	**Principal Risks**
Effective use of our resources	BAF21-16

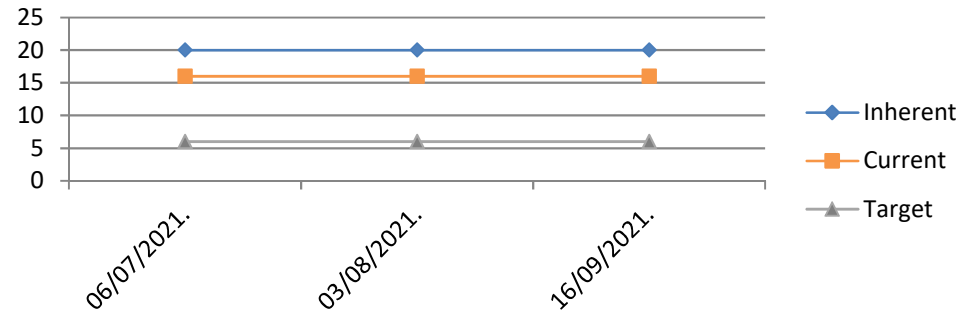
Risk Response Plan Actions being implemented to achieve	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	15284	A joint digital plan to be developed with Digital Health and Care Wales for 2021/22 which will include all projects and upgrades.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/07/2021	Having an agreed plan in place will enable better monitoring of delivery and scrutiny by DIGC.	Delay

target risk score	15285	To meet with DHCW on a quarterly basis to review delivery of agreed plan.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	This will enable performance management of the plan and escalations can be made sooner.	On track
	15286	Action Plan to be scrutinised by DIGC quarterly.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	30/06/2021	Increased performance management of supplier to reduce the likelihood of the risk. Reconsidering the date for completion under the new committee structure.	Delay
	15287	To strengthen the governance by agreeing escalation levels within existing and new national projects.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	Having agreed escalation levels will result in issues being dealt with quicker.	On track
	15474	CCIO & CIO to influence the National Strategic Direction through National Groups.	Mr Dylan Williams, Assistant Director of Informatics	31/03/2022	Influencing the National Strategy should increase alignment with BCUHB Digital Plans.	On track
	17753	Local business cases to be developed for national projects.	Ms Andrea Williams, Head of Informatics Programmes, Assurance and Improvement	31/03/2022	Having a local business case will ensure the national projects can be delivered.	On track

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 September 2021
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 30 December 2022

There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.

This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2021	Unchanged		

Controls in place	**Assurances**
1. Safe Care supports the daily review of staffing in Acute and Community Areas across the Health Board to ensure safe deployment in line with existing Safe Staffing Act. 2. Double sign off of nursing rosters to ensure effective deployment. 3. Nurse staffing policy outlines standards and escalation. 4. Safe staffing legislation being extended into Paediatric inpatient areas from Q3 2021. 5. District Nursing principle compliance review undertaken bi annually in line with AW approach. 6. Biannual staffing Inpatient reviews - reviewing establishments and association of harms with reports to QSE/Board. 7. Workforce recruitment and retention strategy in place. 8. Recruitment and Retention operational group in situ with HB wide representation. 9. Targeted Recruitment Campaign for Band 5 nurses developed and rolled out.	1. Risk is regularly reviewed and monitored at the Site Quality and Safety meeting. 2. Bi-annual nurse staffing review undertaken that is overseen by Quality, Safety and Experience Committee as the designated committee, as well as the approval of the Nurse Staffing policy. 3. Risk is regularly reviewed and monitored at the Senior Nursing Meeting.

10. Annual Commissioning requirements calculated triangulating service development / staffing review and national planning information. 11. International Nurse recruitment programme in place informed by data analysis. 12. Clinical Fellows for Nursing programme being rolled out. 13. ADN appointment to lead and support nurse recruitment. 14. Workforce/Service planning process to triangulate requirements. 15. Introduction of new roles to support e.g. Band 4 roles across the HB where applicable. 16. Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge. Currently twice weekly. 17. MDT staffing support across the Health Board during surge due to inability to respond to demand. 18. Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity. 19. Pandemic surge plan approved by Executive Director of Nursing and Midwifery, the plan has been implemented within the Health Board. 20. Workforce nursing utilisation dashboard developed and introduced to senior nursing teams to optimize nurse staffing rostas. 21. Band 4 roles review completed with actions identified to progress identified roles through to fast track nursing studies resulting in band 5 positions going forwards.	4. Welsh Government oversight of nurse staffing as well as tri-annual summary submission.

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to application of rotas, approval and KPIs. e.g. Annual Leave. 2. There are some instances of reliance on paper-based rotas rather than electronic rotas which lead to manual checking of staffing on a daily basis which wastes time and is less efficient. 3. Not all Nursing staff groups are on electronic rotas and not everyone is IT literate, due to personnel changes there is a requirement for refresher training. 4. Whilst the recruitment and retention strategy and plan are in place, there are extenuating circumstances outside of the Health Board's control which could impact on the programme.

Progress since last submission
1. Controls in place and Gaps in controls have been updated to reflect the current situation in relation to the recruitment and retention strategy and plan. 2. Additional control added for the management of the pandemic nursing plan. 3. Additional control added as a result of the closure of actions relating to nursing roster KPI's and nurse band 4 roles. 4. New actions identified as a result of closed actions relating to nursing roster KPI's and nurse band 4 roles. 5. Action ID 17509 - request an extension to the due date of the action to 30/11/2021 to enable full completion of the action. 6. Action ID 15635 - request an further extension to the due date of the action to 30/11/2021 to enable full completion of the action.

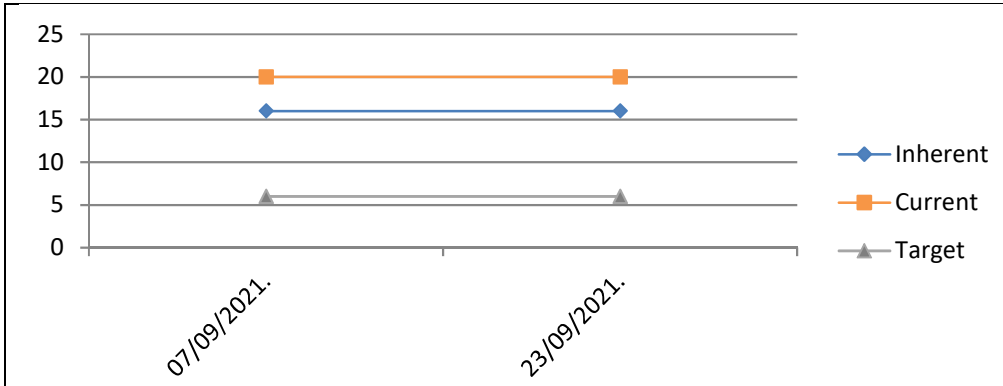
Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler) Strengthen our wellbeing focus	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce Optimisation Advisor	30/09/2021	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and KPIs of the business case are linked to the relevant sections of our corporate risk register. Request extension until 30/11/2021 to enable completion of action.	Delay
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.	On Track

	17508	Development of collaborative Career Clinics supported by Workforce & Organisational Development.	Mrs Anne-Marie Rowlands, Associate Director Professional Regulation	31/08/2021	ACTION CLOSED - 31/08/2021 This action will continue to further develop career pathway opportunities and aid stability within the current workforce	Completed
	17509	Exploration of the Global Learning Programme.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	31/08/2021	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development Request extension until 30/11/2021 to enable completion of action.	Delay
	18834	Introduce targeted monitoring across rosters, through KPI management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Workforce Optimisation Advisor	31/12/2021	Effective utilisation of substantive staff.	On Track
	18835	Support and progress existing band 4 roles through to fast track nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	30/12/2022	This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce.	On Track

CRR21-14	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 20 August 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 23 September 2021
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 01 April 2022

This may be caused by the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for deprivation of liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	5	20
Target Risk Score	3	2	6
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in – New Risk not presented to Board.	New Risk		

Controls in place	Assurances
1. Formal reporting and escalation of activity, mandatory compliance and exception reports are reported to the Mental Health Act Committee, Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory training is in place for MHLD and key departments and is included within the mandatory adult at risk level 2 and 3 training. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised DoLS Procedure [SOP] is in place and it provides a clear process and guidance to reduce legal challenge [21a]. 5. DoLS COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding

	Adults Board to scrutinise safeguarding mortality reviews.

Gaps in Controls/mitigations
1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not in our control. We have developed training and guidance for 16/17 year olds but to achieve compliance as a result of Cheshire West and the pending new Liberty Protection Safeguards is dependent upon capacity and available resource and expertise. 2. The increase in safeguarding activity, with enhanced complexity has resulted in the prioritisation of aspects of service delivery. This is supported by the data reporting activity and the identification of risk. This has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. 3. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated, this is due to the challenge and inability of safeguarding specialists / Deprivation of Liberty Team members attendance at all of the requested BCUHB meetings. 4. The development of multi-agency guidance and intervention as a result of new Legislation and National guidance, overseen by the North Wales Safeguarding Boards support collaboration with partner agencies. However, Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. 5. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the DoLS co-ordinator to wards relating to timescales and legal duties, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training, however, the complexity of cases and the outcome of audits and reviews recognise increased training provision at ward/unit level is required to embed understanding and improve practice.

Progress since last submission
1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register. 2. Proposal put forward to extend the target risk due date due from 01/04/2022 to 31/10/2022, due to the delay in publication of the code of practice which will come into effect on the 01/04/2022. This is a national delay in the publication which inhibits the Helath Boards ability to implement improvement/change. Whilst this proposal has been put forward, it is expected that once the code of practice has been published incremental reductions in the risk score should be achieved. 3. Following feedback from Risk Management Group on the achievement of the actions, extensions to action due dates have been implemented. 4. Action ID15709 - Further proposal to extend action to the 31/12/2021 due to the delay of the publication of the code of practice. 5. New actions identified to support the achievement of the target risk score once the code of practice has been published.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15704	The Business Case to support the structure will be presented to the Executive Team in October 2021.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the SSW[W] Act and will reduce risk.	On Track
	15705	The National Task and Finish Group Finish Group will support the implementation of the [LPS] legislation and Code of Practice ensuring National consistency for NHS organisations.	Miss Andrea Davies, Personal Assistant	31/12/2021	The National Task and Finish Group will develop indicators specific to the NHS which will reduce unlawful detention and risk.	On Track
	15706	LPS Training and guidance documentation and review of the DoLS forms has been agreed to be reviewed and developed by a leading Barrister and is supported by an agreed memorandum of understanding.	Miss Andrea Davies, Personal Assistant	31/10/2021	An informed workforce will comply with revised legislation which will reduce unlawful detention and risk	On Track
	15707	Finance to be secured due to cost pressures for S12 Dr activity, external BIA assessments and CoP activity. (To be included within the Business Case to the Executive Team in October 2021).	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable the implementation of the SSW[W] Act and compliance with the MCA and the new Mental Capacity [Amendment] Act 2019 and will reduce risk.	On Track

	15708	The DoLS Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non compliance with legislation for the both the Managing Authority and Supervisory Body.	Miss Andrea Davies, Personal Assistant	31/10/2021	The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention.	On Track
	15709	The BCUHB LPS Implementation Task and Finish Group will be implemented and will support the transition of DoLS as guided by the new LPS legislation.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable the implementation of the SSW[W] Act and Mental Capacity [Amendment] Act 2019 and will reduce unlawful detention and risk. Requesting extension of due date to 31/12/2021 to complete action and implement task and finish group due to delay in publication of the code of practice	Delay
	18117	Recruitment to new posts required due to implementation of LPS.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	Additional resource will ensure the legal requirements of LPS will be implemented and will reduce the number of unlawful detentions.	On Track
	18118	Implement and Monitor a Court of Protection Engagement and Procedure SoP for DoLS / LPS.	Michelle Denwood, Associate Director Safeguarding	31/10/2021	The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the COP and meet the needs and safeguards of service users.	On Track

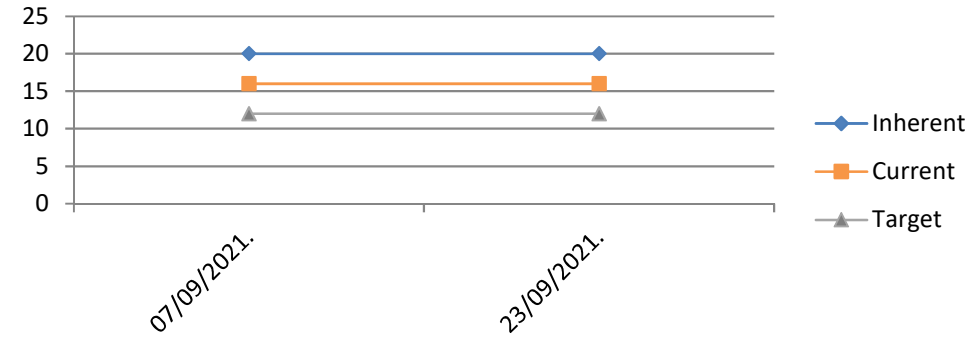
	18983	Implement changes in line with publication of new code of practice which will include revised job descriptions, training packages, audits, supervision, and strengthened court of protection activity.	Michelle Denwood, Associate Director Safeguarding	31/10/2022	Reduce the risk by improving education and implementation of legislation which will reduce unlawful detention.	On Track
	18984	Review of all policies, procedures and guidance in line with publication of the new code of practice.	Michelle Denwood, Associate Director Safeguarding	31/10/2022	BCU will be compliant with legislation and provide guidance to service users.	On Track

CRR21-15	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 23 September 2021
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 01 April 2022

There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children/Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.

This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.

This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in – New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Risk Management has been embedded into the processes of the Reporting Framework and is included as a standard item on the Safeguarding Governance and Performance Group and Safeguarding Forums Agendas. Triple A reports ensure risks are identified and reported on to support mitigation. 2. A standardised data report on key areas including Adult at Risk, Child at Risk and DoLS is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 3. All mandatory training was amended to ensure compliance with the SSW [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the

4. The Children's Division BCUHB are managing the recruitment process for the replacement of the Named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor.	safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews.

Gaps in Controls/mitigations

1. The increase in safeguarding activity, with enhanced complexity has resulted in the prioritisation of aspects of service delivery. This is supported by the data reporting activity and the identification of risk. This has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions.
2. Inability of safeguarding specialists to be in attendance at required meetings. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated.
3. The lack of comprehensive digital clinical patient records reduces the identification of risk, results in the delay of information and communication and is time consuming. Safeguarding mandatory fields are in place within Symphony and other departments which have limited digital patient records.
4. Lack of consistent approach by the 6 local authorities in north wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance.
5. Named Doctor Safeguarding Children - this post remains vacant. The additional two sessions for the Named Doctor have supported the recruitment process, the post remains vacant and the statutory meetings are supported by community paediatricians and overseen by Corporate Safeguarding Team Members, however the level of multi-agency and local clinical engagement is limited.

Progress since last submission

1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register.
2. Following a review at the Risk Management Group it was recognised that the target risk score will remain outside of the risk appetite for the Health Board. The safeguarding agenda and the multi-faceted arena is/can be outside of the HB's control. We require multi agency engagement with both research and national recognition which places safeguarding as a high risk due to the subjective nature and catastrophic outcome of abuse and harm.
3. Gaps and mitigations have been reviewed and updated to strengthen the identification of the gap and mitigations in place to support the gaps.
4. Following feedback from RMG on the achievement of the actions, extensions to action due dates have been implemented.

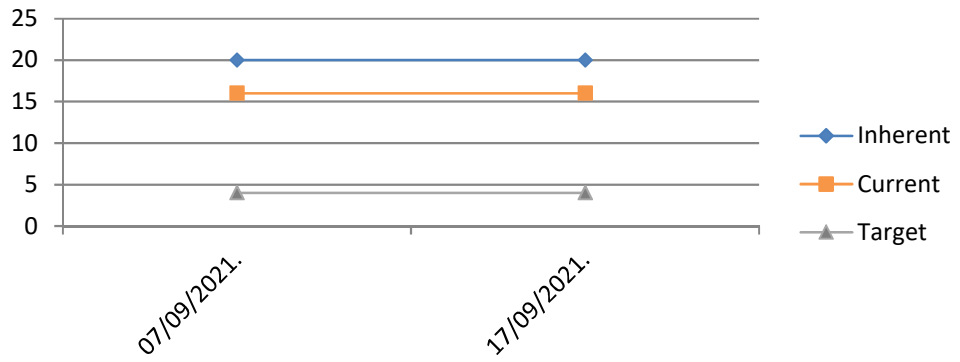
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15701	The agreement and consultation of the Safeguarding Business Case is to take place by the Executive Team in October 2021.This is to include additional sessions for the Named Dr Children at Risk (Safeguarding).	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the SSW [W] Act and will reduce risk.	On Track
	15702	The inclusion of an identified domestic abuse [VAWDASV] post to be agreed as part of the Business Case October 2021.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the VAWDASV priorities and statutory regulation and will reduce risk.	On Track
	18113	Implementation and Monitoring of Workforce Safeguarding Responsibilities SoP [SSWWACT 2014].	Michelle Denwood, Associate Director Safeguarding	20/12/2021	The process and the development of KPI's can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings.	On Track
	18115	Advertisement and Recruitment of the Named Dr Safeguarding Children/Children at Risk.	Michelle Denwood, Associate Director Safeguarding	20/12/2021	Ensure full compliance with legislation and ensure clinical strategic and operational safeguarding responsibilities are met.	On Track

	18116	To Implement and Monitor strengthened governance and reporting pathways for SARC.	Michelle Denwood, Associate Director Safeguarding	10/01/2022	Compliance with legislation and early identification of risk and harm.	On Track
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	The revised procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of Organisational risks.	On Track

CRR21-16	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 September 2021
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 20 June 2023

There is a risk that insufficent Manual Handling training could lead to staff and patient injury, lost work time, HSE enforcement action (current related Improvement Notice for Patient Falls) and reputational damage.
This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, particulary in the West region, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff.
This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	1	4
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in – New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. An additional trainer has recruited via Bank and is in place to provide additional training sessions. 2. A blended approach has been put in place for inanimate load handling, to increase training compliance for those that do not require the practical element of module B of the passport. 3. Recommenced face to face training to improve compliance took place in July 2021 and will continue where appropriate and safe to do so. 4. ESR bookings for courses for staff to self-book onto sessions, right up to the day of courses is now available. 5. Risk assessments and SOP in place for training rooms. 6. Additional rooms secured and funding agreed to allow the additional training to take place.	1. Regular oversight and review by the Occupational H&S team 2. Reviewed at the Strategic Occupational Health and Safety Group and agreement to escalate at the SOHS Group. 3. Risk Management Group oversight. 4. Local Partnership Forum

Gaps in Controls/mitigations
1. Additional trainer is currently working through bank and they are not contractually obliged to attend for work. This is a weakness for the provision of training, as may result in reduced capacity if no hours worked. 2. Training particularly in the West region has been impacted by a lack of training venues. The last dedicated training space in Llandudno Hospital has now been be recalled for use, rendering it unavailable for training/office use for both trainers. 3. The All Wales Passport sets minimum standards for training, with module B of inanimate load requiring practical training. The current blended approach does not allow for module B practical to be covered, but does cover all other elements required for module A & B from the Passport. 4. Numbers reduced due to social distancing requires increased classes to be offered and ensure the numbers of staff requiring training can attend. This is difficult to achieve without training rooms and additional trainers. 5. ESR systems not easy to use. Staff often ring trainers or email for help to book onto courses. ESR contact emails not always up to date, unable to contact attendees booked of changes to session booked or cancelled courses. 6. Review the rate of DNA's and evaluation of causes of none attendance is a gap in the system. This will be undertaken by the new band 6 roles, when in post. 7. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the MH Passport Scheme. The business case has been agreed for two years but this remains a gap in the controls until recruitment has been agreed. Current compliance for Patient Handling refresher is now at 57%. 8. Reduction in capacity within the team to deliver the training requirement, 3x staff members on long terms sickness leave. Currently recruiting an internal trainer via secondment and trainer/advisor rolls from external for an additional 6 members of staff.

Progress since last submission
1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register. 2. Controls strengthened to take into account agile working requirements in training and compliance with COVID requirements. 3. Gaps updated to include the reduction in capacity and the mitigating actions put in place. 4. Proposal to extend 3 action due dates due to time required for implementation following the length in time taken to sign contracts. 5. Additional actions also identified to support the achievement of the target risk score. 6. Proposal to reduce the likelihood score from a 4 to a 3 was discussed, and until the policy and plan has been implemented it is recommended that the likelihood score should remain at 4.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17594	Insufficient training rooms.	Ms Jillian B-J Hughes, Manual Handling Manager	30/09/2021	ACTION CLOSED - 19/07/2021 1. The additional rooms will allow the manual handling department to provide mandatory training for staff and increase compliance for manual handling to the targeted 85% required. 2. Having clinical band 6 trainers will provide BCUHB with the correct level of qualified staff as per the All Wales Passport for people handling, along with the minimum standard on ratio of trainers to attendee for classes. 5. Completing a training needs analysis to target areas that would benefit from training first. Those that have high Datix reports with training issues in inanimate load handling, or areas with patients that may require more assistance with people handling. These areas targeted to provide training earlier should result in reduced Datix, reduced potential injuries and possible work related sickness from a musculoskeletal injury.	Completed
	17978	Renting of temporary training rooms in West, Central & East. SBAR has been approved for 2 year leases on the premises, awaiting contracts to be finalised.	Ms Jillian B-J Hughes, Manual Handling Manager	31/08/2021	Request extension until 30/11/2021 to enable completion of action due to timings to sign terms and contracts. Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing an increasing the number of courses that	Delay

					can be delivered, increase the number of staff trained and increase compliance for BCUHB.	
	17979	Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Ms Jillian B-J Hughes, Manual Handling Manager	31/08/2021	Request extension until 30/11/2021 to enable completion of action and appoint to additional posts. Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB.	Delay
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Ms Jillian B-J Hughes, Manual Handling Manager	29/10/2021	Request extension until 31/12/2021 to enable completion of action, training needs analysis will be completed following appointments to new posts due to current capacity within the team. Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training.	Delay
	18859	Finalise approve and implement MH policy and plan.	Ms Jillian B-J Hughes, Manual Handling Manager	31/12/2021	Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the likelihood of injury to both patients and staff.	On Track

	18860	ESR to be reviewed to include manual handling 1A and 1B training courses for inanimate load level 1.	Ms Jillian B-J Hughes, Manual Handling Manager	31/03/2022	Support the risk and allow correct compliance and correct level of training, reducing the risk of injury for those attending class for a competency assessment.	On Track

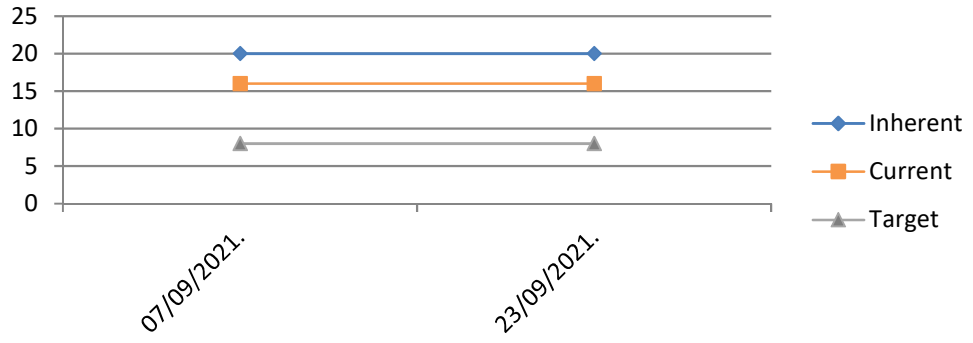
CRR21-17	**Director Lead:** Director of Primary and Community Care	**Date Opened:** 26 July 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 23 September 2021
	Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	**Date of Committee Review:** 07 September 2021
		Target Risk Date: 31 March 2022

There is a risk that Young people attending Emergency Departments, Paediatric wards in crisis and out of hours with suicidal behaviour/ideation, actual self-harm and those detained out of hours under a s136 may not always receive timely access to CAMHS to ensure highest quality patient-centred care.

This may be caused by a number of contributory factors, the list below is not exhaustive:
• Current operational hours of CAMHS is 9am-5pm over 7days a week.
• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.
• increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
• crisis presentations to A&E with associated social care placement breakdowns leading to young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.
• awaiting a CAMHS Tier 4 bed following a mental health assessment.

The environments within the Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered, age appropriate they are also not designed to meet this type of need within their environments.

This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in – New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Local individual risk assessment undertaken by nursing staff as part of the Paediatric admission process. 2. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 3. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 4. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 5. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 6. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 7. Safeguarding discharge SOP for young people in place. 8. Daily SITREP reporting between Paediatrics and CAMHS. 9. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	1. A scoping exercise or SBAR of CAMHS Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCU approach. 3. Risk also regularly discussed at the Area - Quality and safety group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with WG, joint with MH division on a quarterly basis.

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff, which has been exacerbated by the lockdown arising from Covid-19. Currently working with recruitment agency and established multi disciplinary team is already in place. 2. Lack of suitable LA placements or shared safe environments within which young people can be assessed or discharged to. 3. Lack of agreed criteria, threshold and standardisation for reporting related incidents.

Progress since last submission
1. Following approval at the QSE Committee on the 7th September 2021, this risk has been escalated onto the Tier 1 Corporate Risk Register. 2. Proposal to extend the target due date to 31/10/2022, to allow completion of all actions, whilst recognising there will be a phased reduction in the likelihood of the risk with the completion of earlier identified actions. 3. Working with lead officers to review the ligature points on Paediatric Wards and ensure appropriate environmental risk assessments are completed. 4. Currently reviewing SCH03 SOP under review (admission of young people with self harming behaviours) to ensure clear escalation process. 5. Working to finalise CAMHS pan BCU governance approach to link into area and children's services governance groups. 6. Strengthened assurance to include pre Jet Meetings with WG. 7. Gaps updated to be clear on the actual gap and mitigation in place.

Links to	
Strategic Priorities	**Principal Risks**
Improved USC pathways Integration and improvement of MH services	BAF21-01 BAF21-08

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways	On Track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing CAMHS.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to meet the needs of young people before crisis occur as most of their needs are pyscho-social and not just MH.	On Track
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	29/10/2021	Ensure a safe environment by identifying all ligature points on the ward.	On Track
	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing	31/03/2022	It will support timely access to support and treatment in relation to the demand that has been experienced. The increase in workforce will enable us to provide more out-of-hour response.	On Track

	17963	Task and Finish Group to review SCH03 policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	30/12/2021	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.	On Track
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ A&E staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing	31/03/2022	Create awareness and develop skill in assessment and improve staff morale.	On Track
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital.	On Track

Appendix 2 - Full list of all Corporate Risk Register including current risk scoring

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control	Executive Director of Finance	QSE	15
CRR20-02	Contractor Management and Control	Executive Director of Finance	QSE	15
CRR20-03	Legionella Management and Control	Executive Director of Planning and Performance	QSE	16
CRR20-04	Non-Compliance of Fire Safety Systems	Executive Director of Planning and Performance	QSE	16
CRR20-05	Timely access to care homes	Executive Director of Primary and Community Care	QSE	20
CRR20-06	Informatics - Patient Records pan BCU	Executive Director of Primary and Community Care	PPPH	16
CRR20-07	Informatics infrastructure capacity, resource and demand	Executive Director of Primary and Community Care	PPPH	16
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	Executive Director of Nursing and Midwifery	QSE	20
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			
CRR21-11	Cyber Security	Executive Director of Primary and Community Care	PPPH	20
CRR21-12	National Infrastructure and Products	Executive Director of Primary and Community Care	PPPH	20
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	Executive Director of Nursing and Midwifery	QSE	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients	Executive Director of Nursing and Midwifery	QSE	20

CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	QSE	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Executive Director of Workforce and Organisational Development	QSE	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours	Executive Director of Primary and Community Care	QSE	16

Risk Key Field Guidance / Definitions of Assurance Levels

BAF / Risk Template Item	Please refer to the Risk Management Strategy and Policy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if ….
		- This may be caused by ….
		- Which could lead to an impact / effect on ….
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Risk Key Field Guidance / Definitions of Assurance Levels

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	- People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	- A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Cyfarfod a dyddiad: Meeting and date:	**Audit Committee 14th December 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Internal Audit Progress Report 1st September to 30th November 2021
Cyfarwyddwr Cyfrifol: Responsible Director:	Louise Brereton – Board Secretary
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit Nicola Jones – Deputy Head of Internal Audit
Craffu blaenorol: Prior Scrutiny:	The progress report has been considered and approved by the Board Secretary.
Atodiadau Appendices:	Appendix 1: Progress report

Argymhelliad / Recommendation:

The Audit Committee is asked to:

- Receive the progress report;
- Note the potential gap in assurance on major capital and capital schemes in the Health Board; and
- Approve the deferment of the following reviews for inclusion in the risk planning process for the 2022/23 plan:
  - Digital Strategy
  - Unscheduled Care
  - Transformation of Services
  - Preparedness for Climate Change / Decarbonisation

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

Sefyllfa / Situation:

The progress report is produced in accordance with the requirements as set out within the Public Sector internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.

Cefndir / Background:

The progress report summarises six assurance reviews finalised since the last Committee meeting in September 2021, with teh recorded assurance as follows:

- Substantial assurace (green) – none;
- Reasonable assurance (yellow) – three;
- Limited assurance (amber) – one; and

- Assurance not applicable (grey) – two

The report also details:

- Reviews issued at draft reporting stage and work in progress;
- Reviews requested for deferment; and
- Potential gap in assurnace relating to major capital and capital schemes in the Health Board.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The Internal Audit plan for 2021/22 was approved by the Audit Committee in March 2021.

Opsiynau a ystyriwyd / Options considered

N/A

Goblygiadau Ariannol / Financial Implications

The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.

Dadansoddiad Risk / Risk Analysis

The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.5 Reviewing internal audit assignment reports.*

Asesiad Effaith / Impact Assessment

The Internal Audit report provides third line assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls.

This report does not, in our opinion, have an impact on equality nor human rights beyond what is drawn out specifically in respect of individual audits and is not discriminatory under equality or anti-discrimination legislation.

Betsi Cadwaladr University Local Health Board

Audit Committee
Internal Audit Progress Report

1st September 2021 to 30th November 2021

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2021/22 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Office of the Board Secretary.

Reports Issued

2. Several reviews have been finalised in conjunction with Health Board management. A summary of these reviews is provided below in Table 1.

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
HASCAS & Ockenden external reports: Recommendation progress and reporting Review completed July 2021 with Executive approval October 2021	Assurance Not Applicable	-	-	-	We undertook a review to ascertain whether there was adequate evidence provided to support the narrative in the closure of the recommendations mentioned above. A review of evidence to support the progress/closure for recommendations 14 & 15 of HASCAS, as stated in the in the Improvement Group Monthly Highlight Report and Quality, Safety & Experience Committee, was undertaken. Both recommendations are considered partially implemented, with the impact of COVID affecting full.
Secondary Care Division – Ysbyty Glan Clwyd Review completed November 2021 with Executive approval November 2021	Assurance Not Applicable	3	-	-	We undertook a review of the management arrangements within Ysbyty Glan Clwyd for ensuring effective governance and stewardship, including corporate and financial governance arrangements. At the outset we recognised there have been several changes within the Hospital Management Team over the last year with substantive appointments made within the leadership team recently. Key matters arising from our review were: • Lack of effective oversight and monitoring of the implementation of actions to address the Quality Governance Review recommendations.

Title	Assurance Level	High	Medium	Low	Key Messages
					• Lack of effective governance arrangements in place, with majority of reporting to secondary care, bypassing the Hospital Management Team. • There are significant challenges to delivering the savings required for the site.
Upholding Professional Standards in Wales Review completed August 2021 with Executive approval September 2021	Reasonable	-	2	-	We undertook a review to establish Health Board compliance with the *Upholding Professional Standards in Wales* guidance. Key matters arising at the time included: • Designated Board Member (DBM) does not write / present reports to the Board for exclusions over 6 months. • DBM does not receive reports from the case manager. • The Scheme of Reservation and Delegation has not been amended to record UPSW requirements. We identified good practice at the Health Board where: • The report to the RATS Committee details all cases and not just those required by UPSW, where a practitioner has been excluded or subject to formal investigation. • Two Designated Board Members have been appointed although we recognise one post will become vacant imminently and will require allocation and training.
Maternity Cross-Border Arrangements Review completed October 2021 with Executive approval November 2021	Reasonable	1	3	-	We undertook a review to determine the robustness of maternity cross-border arrangements. Key matters arising included: • Clarification of the legal rights of expectant mothers requesting to birth in England. • The robustness of application review and appeal process. • Data collection, reconciliation, analysis, and verification.

Title	Assurance Level	High	Medium	Low	Key Messages
Procurement: Contract Management and Single Tender Waivers Review completed October 2021 with Executive approval November 2021	Reasonable	1	2	-	We undertook a review to evaluate whether the Health Board is complying with Standing Financial Instructions and procedures concerning contract management, and the use of single tender and single quotation actions. Key matters arising include: • Whilst levels of monitoring for contracts were evident within the contracts we sampled; we were not able to evidence a formalised performance monitoring process for all the contracts sampled. • The NWSSP Contract database contained the incorrect contract manager details for two of the four contracts sampled. • Reasons for approval of single tender waivers sometimes include stipulations for future requests. We were unable to confirm if these are actioned.
Establishment Control: Leaver Management Review completed November 2021 with Executive approval November 2021	Limited	1	1	-	We undertook a review to establish adequacy of the leaver management process within the Health Board, including actions taken by management and the oversight of the process by Workforce & OD Key matters arising include: • Holding operational managers to account for non-compliance with Health Board procedures, particularly in ensuring submission of termination forms in a timely manner. • The Health Board is data rich and information provided to us as part of this review should be included in workforce related reports to all Divisions and Directorates, drawing attention to their poor leaver management, where it applies.

Work in Progress Summary

3. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Temporary Hospitals: Follow up of KPMG recommendations	Awaiting Executive approval – Request sent 10th November 2021.	29 October 2021.
Follow up of Healthcare Inspectorate Wales (HIW)	Management response not yet due.	25 November 2021

Fieldwork

4. The following reviews are currently in progress:

- Learning Lessons – The report has been drafted and is undergoing internal quality assurance.
- Targeted intervention – Fieldwork is complete and the draft report being prepared.
- Planned Care: Waiting List Management – Fieldwork is nearing completion.
- Decommission of Ysbyty Enfys temporary hospitals – Fieldwork is underway, information to support testing has been provided.
- Integrated Service Boards – Fieldwork is underway, information to support testing has been provided.
- Standards of Business Conduct – Fieldwork is underway, information to support testing has been provided.
- Cluster working / Health and Social Care Localities governance and accountability – Fieldwork has commenced and information to support testing has been requested.
- Business Continuity Plans –Fieldwork is underway and information to support testing has been provided.
- On-Call arrangements – Fieldwork is underway and information to support testing has been provided.
- Recruitment: Employment of Medical Locum Doctors – Fieldwork has commenced and information to support testing has been provided.
- Value Based Healthcare – Initial meetings have been booked to commence fieldwork.

Follow Up

5. Follow up reviews remain in progress as and when actions are noted as 'Implemented – Final Client Approved' for limited and no assurance internal audit reviews only. The follow-up is based solely upon the evidence and narrative included within TeamCentral which supports final approval by the relevant executive lead.

6. Table 3 details the follow-up review(s) of individual recommendations undertaken in the period and whether they have been implemented (Closed – Verified) or rejected (with supporting narrative).

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Governance Arrangements – Mental Health and Learning Disabilities	Divisional governance arrangements	Closed - Verified
Salary Overpayments	Overpayments procedure	Closed - Verified
Salary Overpayments	Outstanding debts	Closed - Verified

Contingency/Organisational Support/Advice

7. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems, and processes, with increased time being used to support attendance and provide input at the three project meetings we are in attendance.

8. During the period, the following review/advice/guidance/support has been provided:

- Attendance at the Health Board Symphony/National WEDS Project Board.
- Meeting with Counter Fraud to discuss areas of concern and planned work.

Delivering the Plan

9. The additional support provided to the Health Board with focused reviews is channelled through contingency.

10. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high-level risks. Following a risk-based assessment of the current plan with the Board Secretary on the 8th October 2021, discussion with the Executive Director Primary & Community Care and Welsh Government timetable for Health Board submission, the following reviews were recommended to the Executive Team for deferment (to be risk assessed as part of the 2022/23 planning process set to commence in December 2021):

- Digital Strategy – Executive Director has advised that it would be appropriate to defer to quarter 1 2022/23 to allow the implementation of the plan to become embedded.
- Unscheduled Care – Direct impact on operational services as the impact of COVID-19 continues.
- Transformation of services – Direct impact on operational services as the impact of COVID-19 continues.
- Preparedness for Climate Change/Decarbonisation – Submission timeline set by

Welsh Government for NHS Wales organisations is March 2022 and therefore any review would not commence until April 2022 at the earliest.

11. Within the plan for 2021/22 there is a review scheduled around major capital schemes funded by Welsh Government, through which the Health Board includes the cost for audit. We have been advised by our colleagues in the Specialist Services Unit of Audit & Assurance that it is unlikely any review will commence on the planned North Denbighshire scheme this year. Consequently, there is a gap in assurance on major capital and capital schemes in the Health Board.

12. The following tables detail the planned performance indicators (Table 3) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 4) with the assurance provided.

13. Table 3 is reporting a positive status across two indicators, however the management response to draft reports has remained at 50%. This is based on eight reports where management responses have been due and is likely to level out as more draft reports are issued and the revised reporting arrangement becomes established.

Table 3 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Red	50%	80%	v>20%	10%<v <20%	v<10%
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%<v <20%	v<10%

Table 4 – Core Plan 2021-22

Planned output	Outline timing	Status	Assurance
Risk Management	Q4	Review planned for Q4 – planning meeting to be arranged.	
Governance structure	Q4	Planning meeting booked - 14th January 2022.	

Planned output	Outline timing	Status	Assurance
Targeted Intervention	Q3	Review in progress.	
Transformation of services	Q3/Q4	*Requested to Defer.*	
Impact Assessments	Q3	Brief being drafted.	
Standards of Business Conduct: Declarations	Q2	Review in progress.	
Integrated Service Boards (ISB)	Q2/Q3	Review in progress.	
Budgetary Control & Financial Reporting, including COVID-19 financial governance	Q4	Brief drafted.	
Procurement: Contract Management & Single Tender Waivers	Q1	Final report issued.	Reasonable
Value Based Healthcare	Q3	Review in progress.	
Learning Lessons	Q1/Q2	Review in progress.	
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q1/Q4	Final briefing paper issued.	Reasonable
Clinical Audit	Q2/Q3	Brief agreed.	
Planned care – Waiting list management	Q1	Review in progress.	
Network and Information Systems Regulations 2018 (NIS Regulations)	Q4	Brief issued, awaiting Executive approval.	
Digital Strategy	Q3	*Requested to Defer.*	
Cluster working/Health and Social Care Localities governance and accountability	Q2/Q3	Review in progress.	
Unscheduled Care	Q3	*Requested to Defer.*	
Business Continuity Plans	Q2/Q3	Review in progress.	
Secondary Care Division – Ysbyty Glan Clwyd	Q2	Final report issued.	Assurance Not Applicable
Maternity Cross-Border Arrangements	Q1/Q2	Final report issued.	Reasonable
Recruitment – Employment of medical locum doctors	Q3	Review in progress.	
Roster management	Q4	Review planned for Q4 – planning meeting to be arranged.	
Establishment Control – Leaver Management	Q1/Q2	Final report issued.	Limited
Upholding Professional Standards in Wales	Q1	Final report issued.	Reasonable

Planned output	Outline timing	Status	Assurance
On-Call arrangements	Q2	Review in progress.	
Statutory Compliance: Asbestos Management	Q1	Final report issued.	Reasonable
Waste Management	Q3	Brief being drafted.	
Preparedness for Climate Change/ Decarbonisation	Q4	*Requested to Defer.*	
Capital Funded Systems	Q4	Brief being drafted.	
Integrated Audit and Assurance Plans	TBC	Please refer to paragraph 11 above.	
Carry over: Temporary Hospitals – Follow-up of KPMG recommendations	Q1/Q4	Draft report issued.	
Carry over: Follow up of previous Healthcare Inspectorate Wales reports	Q1	Draft report issued.	
Contingency: Security Invoice Review	Q1	Final report issued.	Assurance Not Applicable
Contingency: Decommission of Ysbyty Enfys temporary hospitals	Q3	Review in progress.	

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

 **Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
 **Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Establishment control – Leaver management

Final Internal Audit Report

November 2021

Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	BCU-2122-24
Report status:	Final Internal Audit Report
Fieldwork commencement:	20th August 2021
Fieldwork completion:	10th November 2021
Debrief meeting/discussion draft:	16th November 2021
Draft report issued:	16th November 2021
Management response received:	25th November 2021
Final report issued:	25th November 2021
Auditors:	Principal Auditor, Deputy Head of Internal Audit, Head of Internal Audit
Executive sign-off:	Director of Workforce & Organisational Development
Distribution:	Statutory Compliance, Governance & Policy Manager Associate Director Workforce Planning and Performance Board Secretary Finance Director - Operational
Committee:	Audit Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The purpose of this audit was to review the adequacy of the leaver management process within the Health Board. This includes the actions taken by management and the oversight of the process by workforce & OD.

Overview

We have issued limited assurance on this area. The significant matters which require management attention include:

- Holding operational managers to account for non-compliance with Health Board procedures, particularly in ensuring submission of termination forms in a timely manner.
- The Health Board is data rich and information provided to us as part of this review should be included in workforce related reports to all Divisions and Directorates, drawing attention to their poor leaver management, where it applies.

Report Classification

Limited 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.

Assurance summary[1]

Assurance objectives		Assurance
1.	Termination forms are completed and submitted in a timely fashion	Limited
2.	The Health Board ensure action is taken to prevent non-compliance with agreed systems and procedures, mainly late submission of termination forms	Limited

1 The objectives and associated assurance ratings are not necessarily given equal weighting when formulation the overall audit opinion.

Key Matters Arising		Assurance objective	Control Design or Operation	Recommendation Priority
1	Leaver management controls are not being adhered to by operational management, resulting in an increase in salary overpayments as well as the risk of staff continuing to access Health Board systems after leaving.	1	Operation	High
2	We are advised that information on overpayments is included in monthly reports as part of the budget monitoring process, however Workforce & OD do not provide leaver / non-compliance data to areas in their regular reporting.	2	Design	Medium

1. Introduction

1.1 Section 13.4.3 *Payroll* of the Health Board Standing Financial Instructions (SFIs) states that appropriately nominated managers have delegated responsibility for: -

a) Submitting time records, and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the contract of Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

The ESR Exceptions Form encourages managers and employees to utilise ESR Self Service functions. This electronic form is used by managers to instruct Payroll to make the changes that cannot currently be actioned directly into ESR via manager/employee self-service, among those actions *"Termination of an assignment"*.

Salary overpayments occur when the Payroll Department continue to pay the salary to the employee at the level recorded on ESR, as they have not been informed by the Line Manager that the employee has left employment at the Health Board and is considered to be an ex-employee.

The Health Board is responsible for recovering any overpayment which occurs due to the late submission of a termination notice and which cannot be readily recovered by Payroll. Salary overpayments might lead to financial loss to the Health Board, and also creates unnecessary additional work for the Payroll Team within NHS Wales Shared Services Partnership (NWSSP), the Finance Team and Line Managers within the Health Board.

1.2 The overall objective of the audit was to review the submission of employee leaver forms for timeliness. The scope of the audit was limited to the following:

- Termination forms are completed and submitted in a timely fashion.
- The Health Board ensure action is taken to prevent non-compliance with agreed systems and procedures, mainly late submission of leavers' forms.

1.3 The potential risk considered at the outset of the review was:

- Late submission of termination forms leads to overpayment to individuals who had left the organisation, which might lead to financial loss to the Health Board.

2. Detailed Audit Findings

Objective 1: Termination forms are completed and submitted in a timely fashion

2.1 As noted above, managers should inform payroll as soon as the employee leaving date is confirmed. We requested data on the number of late termination forms for the period of 1st September 2020 to 31 August 2021.

2.2 The following table (Table 1) shows the Top 20 Late Leavers by Length of Delay and area of the organisation:

Table 1 – Details of leaver information submitted late by Division/Directorate[1]

Top 20 Late Leavers by Length of Delay and Org L7	up to 1 week	1 to 2 weeks late	2 to 4 weeks late	4 to 8 weeks late	8 to 12 weeks late	more than 12 weeks late	Grand Total
COVID 19 Vaccination	6	5	3	1	1		**16**
USC Acute Medicine YGC	11			1		1	**13**
Patient Services - East Area	6	6		1			**13**
Informatics	4	3	4				**11**
USC ED YGC	5	1	2	1		1	**10**
Radiology North Wales	6	3					**9**
Medical Director	3	5	1				**9**
E Physio	6	1	1				**8**
Patient Services - West Area	4	4					**8**
Surgical Anaesthetics YG	3	1	2		1	1	**8**
Medicine Acute Medicine YG	2	6					**8**
Emotional Health Central	1	1	1	4			**7**
USC ED YWM	4	1	1			1	**7**
GMS Central	4	1		1		1	**7**
P&MM Centre Management Costs	2	3	2				**7**
Surgical General Surgery YG	2		2		1	2	**7**
Nursing Executive	2	1	2	2			**7**
Surgical Orthopaedics YG	3			2		1	**6**
SC Admin YGC	4	1	1				**6**
C Physio	2	1	1		1	1	**6**

2.3 We reviewed a sample of twenty-seven (27) staff termination forms, covering different divisions/directorates across the Health Board for the period of September 2020 to March 2021, where the termination form was processed late.

2.4 We identified that:

- Twenty-four (89%) were not processed in time due to line manager late submissions of the leavers forms. The delay in processing forms for the selected sample varied between 1 day to 126 days.

[1] Source – Workforce & Organisational Development Leavers Summary Report 1 Sep 20 – 31 Aug 21

- One (4%) was not processed in time due to Payroll error / delay in processing form.
- Two (7%) did not result in overpayment.

Conclusion:

2.5 The process for leaver management is not effective in ensuring leaving dates are notified to Payroll Services in a timely manner. Further, the late submission of leaver information could impact on associated employment controls such as return of ID badge/revoking network access etc.

Objective 2: The Health Board ensure action is taken to prevent non-compliance with agreed systems and procedures, mainly late submission of termination forms

2.6 We are advised that due to staffing pressures during the COVID-19 pandemic, there has not been the required focus on the leaver process, with efforts focused on addressing salary overpayments.

2.7 It was noted that before March 2020, overpayments were discussed as part of a monthly review meeting between Workforce and Finance, where areas with overpayments would be reviewed. We are advised by workforce that there have been no meetings since 2020 due to ongoing work and development relating to the Establishment Control (EC) Portal, and subsequent meetings were postponed due to the COVID pandemic.

2.8 An exception report is produced by the Workforce team, which includes information such as sickness, PADR compliance, training and agency expenditure, but does not contain information pertaining to leavers or overpayments.

2.9 Workforce advised they provide Human Resources colleagues with information on fixed term contracts due to expire to assist with management and identify leavers at an early stage.

2.10 Information on overpayments is presented to the Audit Committee as part of the Financial Conformance Report. Recent data presented (September 2021) states there were 109 staff overpayments for the period of April – June 2021, with a gross value of £0.270m. There has been a decrease in the number but an increase in the value of salary overpayments in 2021/22 compared to 2020/21. The main cause of overpayments are due to failure to complete forms on time (for 62 of the 109 overpayments). The report states that internal practices are being reviewed with the intention of implementing additional scrutiny to address the inconsistent application of employment processes.

2.11 We are advised by the Associate Director Workforce Planning & Performance that there are plans to improve the management of leavers across the Health Board, however at the time of the audit these were still in development. We were provided with a draft leaver's guide, process flow and reporting which team members are currently working on. In addition, a request has been made

for a leaving date field to be added to the EC Portal, with a view to EC colleagues reviewing and reminding managers that a leaver's form should be completed.

Conclusion:

2.12 The Health Board is data rich and captures information that can assist operational managers' focus on areas of non-compliance. However, due to a number of factors, the current focus is on salary overpayments as opposed to wider leaver management and is reactive in nature. An opportunity exists to provide focused support and training across areas of highest non-compliance to address the underlying issues affecting the late submission of leaver forms.

Appendix A: Management Action Plan

Matter Arising 1 - Operational management compliance (Operation)	Impact	
There are a high number of instances of management not submitting leaver forms in a timely manner. This has resulted in 109 salary overpayments in quarter one of 2021/22, with a value of £0.270m. Whilst we are advised that overpayment breaches were included in service management reports and discussed as part of the budget monitoring process, we are advised that these meetings no longer take place. The current focus is on salary overpayments as opposed to wider leaver management and is reactive in nature. We recognise that Workforce & OD have provided evidence of future plans to improve operational compliance with the process for managing leavers, however these are still in development.	Failure to comply with controls in place may result in overpayments to employees and continued access to Health Board resources and data.	
Recommendation	Priority	
Workforce and OD should progress the plans to improve leaver management as a priority, to ensure all employment controls are adhered to by operational areas e.g. submission of staff termination form to Payroll Services; return of all Health Board property/ID badge; and Network access is revoked.	High	
Agreed Management Action	Target date	Responsible Officer
The Workforce Performance & Planning team which incorporates ESR and Establishment Control have already reviewed how terminations are actioned and concur with the above recommendation.	31 January 2022	Associate Director Workforce

The management action will be to make changes to the current processes which involve managers completing the current ESR Exception Form. This will be replaced by moving to this being actioned via ESR Self Service. The rationale for the change to ESR Self Service is that it will support through providing a prompt to the manager to request property and stop network access as part of the termination process. This will not guarantee the return, the onus would remain with the manager, however, ESR will serve as the prompt and workforce teams can monitor and escalate if compliance is not adhered to. The specific actions will be: 1. To advise the NWSSP Team, wider stakeholders i.e.; Finance, HR that with effect from the 1 February 2022 the team will be requesting all future agenda for change staff terminations to be completed via ESR Self Service. 2. Issue a BCU wide communication to advise that with effect from the 1 February 2022 all agenda for change staff terminations must be completed via the ESR Self Service system. 3. Initiate a mass upload from IBM to add against each staff member a minimum property list of ID Badge and IT equipment/Network access credentials. 4. ESR function actioned so that a notification is sent of individual staff terminations to specified colleagues/groups. This will be piloted with IT and Security to ensure the notifications are received with the relevant information i.e.: employee leaving date with a view to stop the monthly leavers report issued to IT as terminations will be notified in real-time.		Planning & Performance

Matter Arising 2 – Leaver data provided to areas / departments (Design)	Impact	
We are advised that information on overpayments is included in monthly reports as part of the budget monitoring process, however Workforce & OD do not provide leaver / non-compliance data to areas in their regular exception reporting to areas / departments.	Management of areas / departments may not be aware of issues and therefore unable to address non-compliance with the leaver process.	
Recommendation	Priority	
Information on non-compliance with the leaver process should be included in monthly exception reports that are provided to areas / departments. Where non-compliance remains high action should be taken to improve compliance i.e. additional training and monitoring by Workforce & OD.	Medium	
Agreed Management Action	Target date	Responsible Officer
There are four interventions to assist with supporting the wider leaver management reporting process: 1. The monthly production of the ESR Leavers Report compared to the ESR Change Event Log by Division. This will highlight the number of leavers terminated in ESR after the leaving date, this will be grouped by month for high level numbers. 2. The monthly review of Establishment Control requests which highlight the EC request is relating to a team member being replaced. The check to be completed will be comparing the team member noted on the EC request with the ESR Leavers Report and follow up action with the EC requestor regarding why the team member hasn't moved departments or been terminated. 3. Both interventions above will ensure that non-compliance reporting is more targeted. The enhanced reports will be included in the monthly exception reports	31 January 2022	Associate Director Workforce Planning & Performance

and shared with Heads of HR and with relevant Senior Leadership Teams. Each quarter the report will be aggregated and will include details of the supervisors who are repeat offenders. 4. Where there is a lack of compliance training and support will be put in place in conjunction with IT and IG to ensure managers are fully equipped to carry out the actions required.		

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Cyfarfod a dyddiad: Meeting and date:	**14th December 2021**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	• Audit Wales programme update • Structured Assessment Phase 2 • Review of eyecare services • Taking care of the carers • A Picture of Healthcare
Cyfarwyddwr Cyfrifol: Responsible Director:	Board Secretary, on behalf of the executive team
Awdur yr Adroddiad Report Author:	Andrew Doughton, Simon Monkhouse and Dave Thomas
Craffu blaenorol: Prior Scrutiny:	All final Audit Wales reports on Betsi Cadwaladr University Health Board have passed through a clearance process with the lead Executive Director.
Atodiadau Appendices:	

Argymhelliad / Recommendation:

The Audit Committee is requested to:

- Receive and discuss the local audit reports.
- Note the Taking care of the carers report
- Note the Picture of Healthcare report

Ticiwch fel bo'n briodol / Please tick as appropriate

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

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

Sefyllfa / Situation:

The documents include the regular audit update alongside reports finalised since the last audit committee.

Cefndir / Background:

The update provides an overview of progress of the external audit programme

The performance audit reviews provide assurance and opinion on the effectiveness of arrangements in key areas as are described within the reports.

Asesiad / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications
Opsiynau a ystyriwyd / Options considered
Goblygiadau Ariannol / Financial Implications The structured assessment highlights high-level financial performance and strategic financial risks. The review of eyecare services identifies areas to drive efficiency improvements which will, if delivered have positive financial implications.
Dadansoddiad Risk / Risk Analysis
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Asesiad Effaith / Impact Assessment .

Archwilio Cymru
Audit Wales

Audit Committee Update – Betsi Cadwaladr University Health Board

Date issued: December 2021

Document reference: 2021A2020-21

This document has been prepared for the internal use of Betsi Cadwaladr University Health Board as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting on the economy, efficiency and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

Audit Wales is the non-statutory collective name for the Auditor General for Wales and the Wales Audit Office, which are separate legal entities each with their own legal functions as described above. Audit Wales is not a legal entity and itself does not have any functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales, the Wales Audit Office and, where applicable, the appointed auditor are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

Contents

Audit Committee Update

About this document

1 This document provides the Audit Committee with an update on current and planned Audit Wales work. Accounts and performance audit work are considered, and information is also provided on the Auditor General's wider programme of national value-for-money examinations and the work of our Good Practice Exchange (GPX).

Accounts audit update

2 **Exhibit 1** summarises the status of our key accounts audit work to be reported during 2021-22.

Exhibit 1 – Accounts audit work

Area of work	Current status
Audit of 2021-22 Financial Statements.	Audit Planning work is set to take place between January and April 2022, with the audit of the financial statements taking place in May 2022.
Opinion on Financial Statements	It is anticipated that the opinion will be issued during the first half of June 2022.
Audit of the 2020-21 Funds Held on Trust Accounts	The audit will take place during December 2021 and January 2022. Our audit report will be issued in January 2022.

Performance audit update

3 The following tables set out the performance audit work included in our current and previous Audit Plans. However, given the on-going uncertainties around the impact of COVID-19 on the sector, some timings may need to be revisited.

Exhibit 2 – Work completed

Area of work	Audit Committee
Review of eyecare services	December 2021
Structured Assessment (Phase 2)	December 2021
Regional review of care home commissioning	December 2021/March 2022

Exhibit 3 – Work currently underway

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Quality Governance Executive Lead Gill Harris	This work will allow us to undertake a more detailed examination of factors underpinning quality governance such as strategy, structures and processes, information flows, and reporting. This work follows our joint review of Cwm Taf Morgannwg UHB and as a result of findings of previous structured assessment work across Wales which has pointed to various challenges with quality governance arrangements.	Report issued for clearance in December.

Topic and relevant Executive Lead	Focus of the work	Current status and Audit Committee consideration
Orthopaedic services – follow up Executive Lead – Chief Operating Officer	This review is examining the progress made in response to our 2015 recommendations. The report will take stock of the significant elective backlog challenges. Therefore, reporting has been moved to later in 2021.	Drafting report
Review of Unscheduled Care Executive Lead Gill Harris	This work will examine different aspects of the unscheduled care system and will include analysis of national data sets to present a high-level picture of how the unscheduled care system is currently working. Once completed, we will use this data analysis to determine which aspects of the unscheduled care system to review in more detail.	This review was replaced by work on Test, Track and Protect. The review is now recommencing. Data analysis currently being completed.

Exhibit 4 – Planned work not yet started

Topic	Focus of the work	Current status
Follow-up outpatients Executive Lead To be confirmed	This work will provide a high-level commentary on the overall position of the Health Board, effectiveness of adoption of new technologies and ways of working, and to consider plans for recovering follow up outpatient performance. This work will also examine progress against any outstanding recommendations from our previous review of Follow up outpatients.	Not started

Good Practice events and products

4 In addition to the audit work set out above, we continue to seek opportunities for finding and sharing good practice from all-Wales audit work through our forward planning, programme design and good practice research.

5 In response to the Covid-19 pandemic, we have established a **Covid-19 Learning Project** to support public sector efforts by sharing learning through the pandemic. This is not an audit project; it is intended to help prompt some thinking, and hopefully support the exchange of practice. We have produced a number of outputs as part of the project which are relevant to the NHS, the details of which are available here. Details of future events are available on the GPX website.

NHS-related national studies and related products

6 The Audit Committee may also be interested in the Auditor General's wider programme of national value for money studies, some of which focus on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts Committee to support its scrutiny of public expenditure.

7 **Exhibit 5** provides information on the NHS-related or relevant national studies published in the last 12 months.

Exhibit 5 – Recent NHS-related or relevant studies and all-Wales summary reports

Title	Publication date
Picture of Healthcare	October 2021
Taking care of the carers	October 2021
Rollout of the Covid-19 vaccination programme in Wales	June 2021
Cwm Taf Morgannwg Joint Review follow up	May 2021
Procuring and Supplying PPE for the COVID-19 Pandemic	April 2021

Title	Publication date
Test, Trace, Protect in Wales: An Overview of Progress to Date	March 2021
Doing it Differently, Doing it Right?	January 2021

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Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements: Betsi Cadwaladr University Health Board

Audit year: 2021

Date issued: November 2021

Document reference: 2722A2021-22

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report sets out the findings from phase two of the Auditor General's 2021 structured assessment work at Betsi Cadwaladr University Health Board (the Health Board). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004. Our 2021 structured assessment phase one report considered the Health Board's operational planning arrangements and how these are helping to lay the foundations for effective recovery.

2 The COVID-19 pandemic required NHS bodies to quickly adapt their corporate governance and decision-making arrangements to ensure timely action was taken to respond to the surge in emergency COVID-19 demand and to ensure the safety of staff and patients. Our 2020 structured assessment report considered these interim arrangements and was published in October 2020.

3 NHS bodies have continued to respond to the ongoing challenges presented by COVID-19, whilst also starting to take forward plans for resetting and recovering services affected by the pandemic. Our 2021 structured assessment work, therefore, was designed in the context of the ongoing response to the pandemic ensuring a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continued to respond to COVID-19.

4 Phase two of our 2021 structured assessment has considered how corporate governance and financial management arrangements have adapted over the last 12 months. In particular, we have provided an overview of the Health Board's de-escalation to targeted intervention and the approach that it is now taking.

5 The key focus of the work has been on the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. We have also considered how business deferred in 2020 has been reinstated and how learning from the pandemic is shaping future arrangements for ensuring good governance and delivering value for money. We have also sought to gain an overview of the Board's scrutiny of the development and delivery of the Health Board's 2021-22 Annual Plan.

6 We have provided updates on progress against any areas for improvement and recommendations identified in previous structured assessment reports.

Key messages

7 Overall, we found that **in the context of dealing with significant service pressures the Health Board has continued to evolve its governance arrangements, service planning and financial monitoring. The initial**

response to the Welsh Government's Targeted Intervention framework has been positive and it will be important that this is used to demonstrate progress against a number of long-standing challenges. The immediate focus for the Board is to effectively manage the service pressures across all divisions and to ensure its wider strategic and recovery plans both align to those pressing recovery challenges and shape the organisation for the future.

8 Following the de-escalation from special measures, the Health Board is demonstrating strong ownership of its response to targeted intervention, adopting what it is calling a targeted improvement approach. It has undertaken a balanced but critical self-assessment against the maturity framework as a basis to drive improvements. There is good alignment between the Health Board's approach to targeted intervention and its wider planning and strategy development, which should help secure the desired improvements.

9 The Board and its committees are using self-review effectively to support governance, risk management and assurance changes. The new arrangements include revised committee and executive delivery structures, evolving risk management approaches and Board Assurance Framework improvements. These will take time to embed and will also need to be managed alongside some specific risks such as independent member turnover. The Board and its Committees are, in general, sufficiently informed and this helps them discharge their duties. There is a good focus on acute services, and improving attention given to primary care services. Once organisational and clinical strategies are approved, there will be a need to reflect progress against priorities and objectives within assurance reporting, whether performance reports or monitoring of plans. The Health Board is taking steps to further strengthen its arrangements for overseeing the quality and safety of services. This is particularly important because of the continued strain on primary, community and acute care services may introduce additional quality and safety risks.

10 The Health Board is planning for service recovery, but the continued impact of COVID-19, wider unscheduled care pressures, and internal and external capacity constraints may result in service recovery which is drawn-out. The Health Board is planning for additional regional treatment centres, which if progressed and well implemented should help support some 'ring fencing' of planned care services and provide extra service capacity.

11 The Health Board did not meet its two main financial duties in terms of having an approvable medium-term plan and financial balance over three years. However, for 2020-21 it ensured expenditure was within its allocation, albeit with additional financial support. Over the last 12 months, there has been a good focus on learning from COVID-19 financial governance arrangements and implementing improvements. Financial planning is improving and there is a better link between actions set out in the Annual Plan and resources required to deliver them. The Health Board needs to secure additional capacity and to drive efficiency improvements within existing services. In some areas this will require additional

financial capital, but at present the level of capital funding may affect service recovery and efficiency.

Recommendations

12 We have made one recommendation arising from this audit in **Exhibit 1**. The Health Board's management response to this is summarised in **Appendix 1**. As highlighted in the detail of this report, there remain recommendations from previous years' structured assessment reports that are still being progressed. We will continue to follow progress against these as part of an ongoing programme of work at the Health Board.

Exhibit 1: 2021 recommendations

Recommendations
Financial reporting
R1 To support recovery, the Health Board will need to maximise the use of its own resources. While assurance reports provide good information on costs, savings and forecasts, there is little information to indicate the financial efficiency of services. **Ensure improved focus on financial efficiency of services within finance reports**. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.

Detailed report

Governance arrangements

13 Our structured assessment work considered the Health Board's governance arrangements while continuing to respond to the challenges presented by the pandemic.

14 We found that **the Health Board has made a promising start and is demonstrating strong ownership to make improvements to address targeted intervention. Governance and risk management arrangements are improving as is the approach for supporting service change and improvement. Considerable ongoing service pressures and waiting list backlogs are likely to present challenges for many years.**

Conducting business effectively

Response to targeted intervention framework

15 We found that **while at an early stage, the Health Board is demonstrating strong ownership of the targeted intervention framework and the associated improvements it is seeking to drive**.

16 In November 2020, the (then) Minister for Health and Social Services announced that the Health Board would be de-escalated to targeted intervention and supported with additional financial resource totalling £297 million for a three-and-a-half-year period ending March 2024. In March 2021, the Welsh Government set out its expectation for improvement[1] in four key domains:

- Mental Health (adult and children)
- Strategy, planning, and performance
- Leadership (including governance, transformation, and culture)
- Engagement (patients, public, staff and partners)

17 In May 2021, the Board set out an initial approach for responding to targeted intervention requirements and engaged with internal and external partners as part of this process. The targeted intervention 'improvement' approach, agreed with the Welsh Government, is based on an assessment of maturity, and supported by underpinning improvement plans. The Health Board's self-assessment to date has been an honest and critical evaluation of its current position and as such provides a good platform from which to move forward. As an example, the self-assessment in respect of mental health services highlights the challenges and concerns that persist within those services.

[1] Welsh Government, Targeted Intervention Framework for Betsi Cadwaladr University Health Board – Welsh Government Publication, March 2021

18 The Health Board has introduced a good structure to drive improvement. This is coordinated by a Targeted Improvement Steering Group underpinned by an Evidence Group and Outcomes Group, which are in turn supported by four sub-groups. The membership of each sub-group includes the senior responsible executive officer with oversight from an independent board member. The Health Board is collating evidence to help demonstrate progress and has brought in the Good Governance Institute to help provide additional independent support. The Board receives regular assurance reports on Targeted Intervention progress at every Board meeting.

19 Overall, there is a better alignment between targeted intervention improvement plans and the wider organisational Annual Plan than we found when the Health Board was in special measures. There was a general sense from those we interviewed that the Health Board properly owns the improvement process albeit with a recognition that necessary improvements would take time to effectively deliver.

Board and committee governance arrangements

20 We found that **the Board and its committees are operating appropriately, using an objective review of arrangements to drive governance improvements. The proposed changes both to committee structures and wider governance processes should strengthen arrangements but are likely to take time to embed.**

21 As identified in our 2020 structured assessment, governance arrangements returned from the temporary emergency command and control and Cabinet arrangements to pre-COVID arrangements in May 2020, albeit continuing to utilise videoconferencing. In November 2020, the Board invoked Cabinet[2] in response to significant demand to the second wave of the pandemic until April 2021. The COVID-19 Cabinet was once again reinstated in September 2021 at the request of the Executive team. These changes were approved though 'Chair's actions' and appropriately communicated to the following Board meeting on 23 September 2021. The Health Board is adapting its governance arrangements as the nature of the pandemic and wider service pressures evolve. An example of this includes the current review of the terms of reference for the COVID-19 Cabinet to ensure that it remains fit for purpose for the challenges ahead.

22 The Health Board has committed to learn lessons from the pandemic and has reviewed its serious incident planning and response, interim COVID-19 governance 'command and control' arrangements and financial 'COVID-19' governance arrangements (See **Exhibit 2**, **Recommendation 1, 2020**). Lessons

[2] The purpose of the Cabinet is to be responsible for oversight of key high-level strategic matters relating to the Health Board's response to the health emergency presented by the COVID-19 pandemic. Membership of the Cabinet includes the Health Board Chair, Vice-Chair, Audit Committee Chair and the Chief Executive. Other officers are in attendance.

identified include infection prevention measures, supporting staff to enable flexible redeployment if needed, adapting to virtual outpatients and supporting research and development. The Health Board has also commissioned an additional external evaluation of Emergency Planning, Resilience and Recovery arrangements, which is ongoing at the time of writing.

23 Our observations of various Board and Committee meetings in 2021 indicate that they are well chaired, follow expected procedures and are supported by appropriate management information in general to inform decision making. The use of technology and the etiquette around virtual meetings is well embedded.

24 Board meeting agendas are well planned, proportionate and focus on key risk and improvement areas. Independent Member contribution is balanced, supportive and where necessary challenging. The Health Board ensures the Board and committee agendas, minutes and papers are available in advance, and reports a breach to audit committee if papers are published late.

25 Performance information on acute services and some wider services in the Board's integrated quality and performance report is enabling scrutiny and provides assurance on actions to support improvement. The recent report to the Board in October on primary care services provides a useful update on the actions being taken to address service risks. There may however be a need for a more routine focus on Primary, community and population health performance. We also recommended last year that the Health Board strengthens its arrangements for reporting the outcomes from its plans and investments. Work in this area is still ongoing (See **Exhibit 2**, **Recommendation 3, 2020**).

26 While there remain challenges around public accessibility of committees, the nature of virtual meetings is starting to create opportunities. For example, senior operational managers and leads based at hospital and community sites who would not previously have been able to physically attend a meeting can join virtually. This is giving board and committee members greater insight and depth of understanding from the services where needed.

27 Over the last 12 to 18 months, we have seen some committees' agendas grow and some unnecessary overlap of agenda, particularly between the Strategy, Partnerships and Population Health and Finance and Performance Committees. The Health Board has undertaken a review of its committee governance arrangements with the aim of:

- balancing the focus on strategy, culture, and accountability;
- improving the structural line of accountability between underpinning groups, the executive team, committees, and the Board, and improving accountability and assurance flows in general from 'floor to Board'; and
- improving the focus on the people and transformation agenda.

28 The review identified some specific challenges and proposed some changes to the committee structure[3] which were approved by the Board in July 2021, and at the time of writing, are being introduced. The structural changes to the committees appear logical and should help to reduce the risk of duplication of agenda across committees. However, it is too early to determine the effectiveness of the revised arrangements, which will take time to embed.

29 The Health Board is currently seeking to recruit three new Independent Members, and there could potentially be another two or three Independent Members leaving at the end of 2021-22 depending on the re-appointment process. This turnover will create risks that will need to be managed in respect of the experience and knowledge of the independent membership and the continuity of committee chairmanship. At the same time the Health Board is continuing with its Board development group sessions. Board development activity will need to take into consideration the changes to independent membership.

Exhibit 2: progress made on the previous year recommendations relating to this report section

Recommendation	Description of progress
R1 (2020) Undertake a rapid learning exercise on COVID-19 governance to inform and adapt resilience and emergency response plans, so they can be implemented should they be required over the coming months. This should include consideration: • of any need to temporarily adapt the Scheme of Reservation and Delegation to ensure financial and decision-making authority is aligned; and • of the risk management approach adopted as part of command and control and workstream arrangements.	**Complete** An internal review of the Command and Control Framework has been completed by the Emergency Planning, Resilience and Recovery lead and taken through the Civil Contingency Forum. An additional external review is ongoing. The current governance structure for the COVID-19 response has been approved by the Board. The Partnership Prevention and Response Plan was reviewed and refreshed in June 2021 as required by the Welsh Government. The ongoing implementation of the plan is overseen by the Chairs of the six local authority Prevention and Surveillance Groups and reported to the Regional Coordination Group.

[3] Changes include removal of the Digital Information and Governance Committee, refresh of the terms of reference of committees and creation of Executive Delivery Groups and underpinning group structures.

Recommendation	Description of progress
	A refresh of the Risk Management Strategy was approved in July 2021 enhancing the focus on the Board's risk appetite during exceptional circumstances. These changes built upon a more substantial review of the risk management strategy in October 2020. An Emergency Scheme of Reservation and Delegation has been developed and was to be presented to the September 2021 Audit Committee, prior to Board approval.
R3 (2020) Ensure that impacts and outcomes achieved as a result of delivery of actions are appropriately articulated within quarterly plan and annual plan monitoring reports. This may require strengthening of underpinning business benefits analysis processes.	**Action in progress** The 2021-22 Annual Plan seeks to ensure that all actions are appropriately articulated in line with SMART principles. The Health Board has introduced more detailed guidance and a planning template that sets out the required supporting information for each action agreed and includes a requirement to consider both outcomes and return on investment.

Planning for recovery[4]

30 We found that **the Health Board is developing a logical 'six-point' approach for planned care service recovery and is strengthening its organisational development focus through its extensive 'Stronger Together' programme. However, risks and issues including the continued impact of COVID-19, unscheduled care pressures, and capacity constraints may result in the service recovery effort being drawn-out over several years.**

31 The extent of the recovery challenge, although not unique to the Health Board, is substantial. The pandemic, alongside significant unscheduled care pressures, continues to affect the available service capacity and productivity of wider services.

[4] NHS bodies are required to submit a three-year Integrated Medium Term Plan (IMTP) to the Welsh Government on an annual basis. The IMTP process for 2020-2023 was paused by the Welsh Government in March 2020, to allow NHS bodies to focus on responding to the COVID-19 pandemic. Instead, health bodies were required to submit quarterly plans during 2020-21 as well as prepare an annual plan for 2021-22 by 31 March 2021.

32 For planned care, over 50,000 patients are now waiting over 36 weeks[5]. The Health Board has prepared a 'six-point' recovery plan for planned care including the development of a diagnostic and treatment centre model. The six-point approach is logical, although we expect that recovery will be highly challenging. The Welsh Government has provided considerable additional revenue to support recovery, but we understand there is limited available capital funding. Consequently, the Health Board is exploring all possible options for revenue-based solutions. The nature of the revenue funding and the need to accelerate recovery efforts may lead the Health Board towards greater reliance on providers from outside of Wales to provide insourced, outsourced and fully managed services[6].

33 While additional contracting will assist recovery, core service and workforce productivity is essential, but may be challenging to improve. There is a clear recognition in the Health Board of the impact of the pandemic on staff and the pressures ahead. The Health Board has initiated a 'Stronger Together' programme. This is a major organisation development programme focussed on improving quality, performance, productivity, engagement, and culture and engaging more than 1,800 staff directly.

34 Sustainable recovery, both for planned and unscheduled care, will require stronger approaches for integration of services across acute sites, and integration of services between acute and community services. The Health Board has attempted for several years to drive forward such service integration, but with mixed success. For several years, we have identified concerns about the capacity available to support change and transformation. As part of the recent review of governance arrangements, the Health Board will be implementing stronger programme and transformation structures. There are three new Executive Delivery Groups which will support strategy development and drive the transformation agenda and a cross-cutting planning and strategy group. Underpinning these strategic groups, the Health Board is introducing tactical delivery groups designed to deliver transformation and improvement. This is a positive step forward.

35 The Health Board is also strengthening capacity to support change. It has recently appointed a Director of Transformation and Improvement and is strengthening its capacity for programme coordination, analytical modelling, and programme and project management support (See **Exhibit 3**, **Recommendation 3, 2019**). The Health Board is also seeking to formally incorporate 'value-based healthcare[7]' and 'getting it right first time[8]' and data modelling approaches within its change

[5] As of July 2021 – data sourced from Stats Wales.

[6] Fully managed services relate to a complete package where an external provider may develop new temporary facilities within the Health Board area but fully providing additional theatre capacity and the necessary workforce to deliver services.

[7] Value based care is aimed on maximising the value of healthcare and reducing unwarranted variation.

[8] Getting it right first time is a national programme designed to improve the treatment of care of patients through analysis, benchmarking to support service change.

structure as part of the portfolio of the Executive Director of Primary Care and Community Services (See **Exhibit 3**, **Recommendation 4, 2019**). If delivered effectively, these approaches create the potential to improve the outcomes for patients and release capacity to better support patients waiting for treatment.

36 The Health Board continues to rely on interim management in some important areas including mental health, secondary care, and planned care improvement. While there may be value for money considerations relating to interim appointments, the potentially greater issue is the effect of turnover or 'churn' of interim staff, often filling key posts. This could affect the continuity of important change programmes and continuity of leadership for acute services (See **Exhibit 3**, **Recommendations 5 and 6, 2019**).

37 While the Health Board is building additional capacity to support improvement, a range of factors and risks could affect planned care waiting list recovery. These include:

- exacerbation of levels of COVID-19 in the community, unscheduled care demand and winter pressures, as well as increased complexity of conditions.
- the extent that the workforce is able to work above and beyond to support additional internal capacity.
- ability to improve service efficiency.
- insufficient capital investment resulting in lack of physical capacity to expand services or to remedy existing estate to improve patient flow.
- revenue funding which needs to be spent within the financial year. This may potentially inhibit multi-year recovery options and could limit the extent that the funding can be effectively utilised.
- competition with the wider NHS for:
  - insourced and outsourced service providers;
  - modular theatres and/or demountable care facilities; and
  - medical and nursing staff, potentially limiting locum and agency staff availability, and impacting the ability to recruit.

38 The Annual Plan appropriately incorporates a strong focus on service recovery actions, and it is responding to the risks above, but some of those risks will present a longer-term strategic challenge. Recovery actions will not only need to bring back service performance but also help to shape services so that they are fit for the future. The Board is currently refreshing its organisational strategy, developing a clinical services plan, and preparing a three-year IMTP 2022-2025. It is currently undertaking wider engagement to support these developments (See **Exhibit 3**, **Recommendations 1 and 2, 2019 and Recommendation 2, 2020**).

Exhibit 3: progress made on the previous year recommendations relating to this report section

Recommendation (year)	Description of progress
R1 (2019) Ensure that work to develop a clinical services strategy is delivered to planned timescales and includes a fundamental review of the shape and location of clinical services across all three main hospital sites. (Further detail on this recommendation is available at the report link above).	**Action in progress** The Clinical Strategy development has undergone review since the appointment of the new Chief Executive. This approach has been approved by the Board and will lead to new thinking for a clinical services strategy which will underpin the refreshed Living Healthier, Staying Well strategy. The Health Board has set out next steps including establishment of a clinical senate, using feedback from strategy engagement and findings from the ongoing Stronger Together work. The Health Board is aiming to complete this work by the end of March 2022.
R2 (2019) Ensure clinical engagement and leadership are integral elements as part of the development of clinical strategy and associated change programmes.	**Action in progress** This will be considered within the refresh of the 'Living Healthier Staying Well' strategy, and clinical services plan.
R3 (2019) To support effective delivery of clinical strategy, introduce clear programme management structure, change programmes, and programme management methodology. This should incorporate both required central and corporate structure as well as resources to enhance division-level change management capacity.	**Action in progress** A new approach to improvement and transformation has been agreed following recognition of the need to increase investment, focus, and alignment of existing improvement approaches. This is now being led by the Executive Director of Primary Care and Community Services. A Director of Transformation has been appointed and they will lead the Transformation Support Office approach utilising a central resource through a business partner model. A Quality Improvement toolkit is in development to drive coordination and dissemination of learning which will incorporate learning from COVID-19. Some appointments within the change structure are completed and the arrangements will continue to develop through the remainder of this financial year.

Recommendation (year)	Description of progress
R4 (2019) The Health Board should review the form and function of the executive team to: • ensure that there is clear responsibility for acute care services at an Executive level; • ensure that programme leadership for service transformation has clear executive director level responsibility or responsibilities; and • increase focus on strategy, organisational design and the capacity and capability within the organisation to deliver the necessary change.	**Action in progress** The new Chief Executive of the Health Board took up position in January 2021. Since this time, a review of Executive portfolios is enabling improvements in portfolio balance and the improved alignment of some key corporate functions. The organisation is currently enhancing its leadership as part of the Targeted Improvement programme. It is undertaking a 'listening' exercise known as the Discovery Phase of Stronger Together. Early indications from that exercise and feedback suggest more extensive work is required to optimise the organisation's operating model. This could include a review of operational management structures. This work will conclude in Quarter 3 of 2021-22.
R5 (2019) As part of the Health Board's wider approach to workforce planning, aim to reduce reliance on external interim management by building the required senior manager capacity and capability within the organisation, especially in relation to service transformation and change.	**Action in progress** The refreshed Workforce Strategy will draw on themes from the Stronger Together organisation development work. Key senior leadership roles in the Executive Team and Senior Leadership Team have been substantively appointed to. However, use of interim management remains an ongoing challenge for the health Board. A Service/Workforce Review model and programme has been approved by Executive Team. This is being used, for example, to review Emergency Departments as a basis for informing a new staff model. The output of the reviews will inform the refreshed workforce strategy and plan for 2022-2025.

Recommendation (year)	Description of progress
R6 (2019) Finalise and agree the management structure for acute services.	**Action in progress** The acute management structure has been subject to some further changes, but with a number of recent key appointments. The Health Board is considering how its operating model aligns with business need as part of the Stronger Together programme. The Health Board is aiming to develop a delivery plan by the end of the calendar year.
R2 (2020) Ensure there is effective stakeholder engagement in the development of clinical strategy and any plans for significant service change.	**Action in progress** The Living Healthier, Staying Well strategy refresh includes public, staff and stakeholder engagement. The Health Board will share and discuss emerging findings with partners, stakeholders and those who contributed in November 2021.

Systems of assurance

39 We found that **the Health Board is undertaking work to embed its risk management arrangements, but because of the consistent exceptional services pressures, it will need to ensure that its quality assurance arrangements are effective from floor to Board.**

Managing risk

40 We found that **the Health Board is taking appropriate action to embed its risk management approach and board assurance framework.**

41 As identified in our structured assessment in 2020, the Health Board's approach to risk management has changed with the introduction of a three-tier model[9]. The aim was to implement the strategy and new supporting risk management arrangements in October 2020, but the impact of the pandemic resulted in some delay. The Board reviewed and agreed some further revisions to the risk management strategy in July 2021 including strengthening the focus on risk appetite, new staff

[9] Three-tier risk management reflects responsivity to manage at either tier 1 (director level), tier 2 (divisional level), tier 3 (service or project level), depending on the severity of the risk.

training and arrangements for ensuring risk intelligence is shared across services and divisions. We have seen good challenge from Independent Members on the risk management arrangements, reporting and the effectiveness of actions in place to mitigate the risks.

42 Risks relating to the pandemic are reviewed and included in the risk register. Given the dynamic COVID-19 situation, there are regular formal and informal briefings for Board members on those risks. Overall, the risks on the board assurance framework and risk management framework reflect our understanding of the Health Board's key issues and the actions that it is taking to resolve them.

43 The board assurance framework is progressing well although not yet fully mature. The Health Board is seeking to use the opportunity of strategy refresh to develop clearer corporate objectives. This should provide a platform for further strengthening the assurance framework. The framework is actively and consistently used by the board and committees, which is helping to focus on the key strategic risks that prevent delivery of objectives. The Health Board has continued to maintain its legislation assurance framework, reflecting changes to legislation and basic monitoring. However, capacity constraints over the last 18 months have proved a limitation and a more manageable risk-based approach may be required in future.

44 In relation to wider internal assurance, our work indicates:

- a comprehensive programme of internal audit delivered during the year. This was sufficient to enable a 'Reasonable' head of internal audit opinion as part of the annual report;
- clinical audit is progressing, although significant service pressures may affect delivery of the plan in full; and
- the Counter Fraud programme is progressing well, although we understand that there are lower levels of fraud reporting in the last year than prior to the pandemic.

Quality and safety assurance[10]

45 We found that **the Health Board is taking steps to secure further improvements to its quality governance arrangements.**

46 The Board receives appropriate assurance on a wide range of quality and safety matters that it is responsible for. The Health Board uses the four quadrants of harm model and understands the direct and indirect quality concerns resulting from the pandemic. These are reflected in the Quality and Performance report, risk registers

[10] We have limited the work we have undertaken on quality governance arrangements as part of our 2021 structured assessment, as we are undertaking a separate review of quality governance arrangements at the Health Board. The quality governance review will consider whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We will report our findings later in 2021.

and the board assurance framework. The agenda of the Quality, Safety and Experience Committee is comprehensive and there is good scrutiny of it. As well as receiving routine quality reports, specific areas are focussed on by the committee. Examples include Vascular, Mental Health and Ophthalmology services and the lessons learnt from COVID-19 outbreaks.

47 As part of the Health Board's governance review (**paragraph 28**), there are changes to the corporate quality structure which will be introduced over the autumn of 2021. This includes the introduction of:

- an Executive delivery group for quality improvement;
- a strategic Health and Safety Group; and
- underpinning Patient Safety, Patient Experience, Clinical Effectiveness and Infection Prevention and Control groups.

48 The new structure may take time to embed but it should help to enable specific focus in key quality areas and improve floor to board visibility. It will be essential across all divisions to maintain a strong focus on operational quality given the extent that services are currently stretched.

Tracking progress against audit and review recommendations

49 We found that **the Health Board has continued with its approach to track, review, and challenge the response to recommendations.** During the pandemic, the Audit Committee has continued to receive tracking reports on progress against key recommendations and challenge areas where progress has been limited. Whilst a number of recommendations from previous years' Structured Assessments are still to be implemented, action in these areas is ongoing, with timescales for implementation having been affected by the emergency response to the pandemic. The update is included in **Exhibits 2 and 3** of this report.

Managing financial resources

50 Our work considered the Health Board's financial performance, plans, controls, and arrangements for monitoring and reporting financial performance. We found that **additional income alongside improving financial planning is strengthening the Health Board's financial outlook, but there is a risk that limited capital funding could inhibit longer-term sustainable models of care built and resourced in North Wales.**

Achieving key financial objectives

51 We found that **while the Health Board did not meet its two main statutory financial duties, strategic financial assistance from the Welsh Government has helped achieve financial balance for 2020-21.**

52 The Health Board has not been able to achieve a balanced financial revenue position for several years. In 2020-21, the annual financial revenue funding, together with additional Welsh Government financial allocations, enabled the Health Board to balance its expenditure within its revenue resource limit. It achieved a £0.4 million surplus on net operating costs of just over £1.8 billion. The two most significant streams of additional Welsh Government revenue allocation included funding to cover the costs of COVID-19, and additional strategic financial assistance. On the latter, the (then) Minister for Health and Social Care announced his decision to de-escalate the Health Board from special measures to targeted intervention in November 2020. This announcement included a financial assistance package of £297 million over a 3½ year period of which £40 million per year is specifically for financial recovery.

53 The Health Board's COVID-19 costs for 2020-21 totalled £171.7 million (**Exhibit 4**) and were covered by the Welsh Government. This included cover for direct COVID-19 costs but also recognised the wider financial consequences of the pandemic, which included:

- under-delivery of savings plans – the Health Board achieved £18.4 million of savings against a £45 million target leaving a £26.6 million financial pressure; and
- an underspend of £20.4 million for elective services where the Health Board was expecting to fund services which were not able to be delivered.

Exhibit 4: financial impact of COVID-19 in 2020-21

Cost area	£ million
Direct cost of COVID-19 (including Field Hospitals, PPE, Vaccination, Test, Trace and Protect, Staff costs)	159.1
Lost income	10.5
Non-delivery of savings	26.6
Elective underspend (cost saving against original budget)	(20.4)
Other underspend against the budget	(4.1)
Total COVID-19-related costs	**171.7**

Source: Month 12 finance report to Board in May 2021

Financial plans

54 We found that **financial planning is improving and the Health Board understands its financial risks, but limited financial capital allocation may affect the longer-term sustainability and efficiency of services.**

55 The Health Board is improving in financial planning, which both gives a good indication of budgetary spend and a stronger link between additional service investment and the intended improvements than in previous years. The Health Board is also planning to develop a longer-term financial strategy. This will need to set out how finances will support service recovery, and how financially sustainable services can be achieved in the longer term. This is particularly important when the significant additional Welsh Government allocations for COVID-19, the targeted intervention strategic assistance, and performance recovery funding reduce.

56 The Health Board's Annual Plan outlines the basic revenue allocation for 2021-22 at £1,697 million. At the time of the approval in July 2021, the plan also anticipated additional allocations for performance improvement which when combined with this year's element of the £297 million strategic assistance totals £91.5 million. The plan sufficiently identifies at a high level how this additional Welsh Government funding is to be spent during the year. This may help to inform assessment of value from the investment. We have undertaken some specific work during the year on the additional £297 million 3½ year strategic financial assistance. This work identified:

- broadly clear plans for how it will spend the strategic financial support funding it is receiving from the Welsh Government;
- that plans appropriately consider required resources, but there is a need to prepare business cases earlier in the year as well as challenges around workforce capacity, estate, and procurement; and
- evolving arrangements in place for ongoing monitoring of plans but also a need to ensure that the funding is achieving its intended benefits.

57 As at month 5, the Health Board is forecasting a balance between expenditure and its resource allocation for 2021-22. The Health Board is anticipating COVID-19 costs of £112.8 million, and that the Welsh Government will fully cover the cost. The Health Board has a good understanding of its financial risks for the current year. These include the impact of a potential third wave of COVID-19, possible under-delivery of savings, ability to manage cost and demand growth and its ability to secure efficiencies through clinical strategy and pathway redesign.

58 Capital funding may also present a risk for the Health Board. The continued impact of COVID-19 is increasing waiting lists considerably. The Health Board is developing a recovery plan which includes options to increase its capacity using regional treatment centres. Typically, additional estate capacity would be funded through capital, but availability of capital financing across Wales is extremely pressured. The Health Board is exploring approaches for commissioning additional managed services using revenue funding. This revenue approach could help to

expand service capacity quickly, but revenue funding approaches could also introduce additional strategic risks including:

- increasing the reliance on externally contracted care may not necessarily provide the health board with service capacity which can be sustained in the longer term once contracts are concluded.
- any substantial new external contracts for additional capacity may require long-term funding. The income to support this may not be guaranteed if funded from additional annual Welsh Government allocations rather than core budgets.

59 While the availability of capital may affect the development of new service capacity, we have also heard that limited capital funding may impede the ability to adapt the existing estate to help improve patient flow and efficiency. This may also be a factor affecting sustainable and efficient recovery within existing sites. The Health Board is acutely aware of these risks and is exploring options that may help to mitigate the impact of limited capital funding.

Financial controls and wider internal controls

60 We found that **the Health Board is continuing to focus on improving its financial controls in relation to COVID-19 spend.**

61 In our 2020 structured assessment report, we identified that key financial controls have operated throughout the pandemic, and that the Health Board was undertaking further work to provide assurance on the controls. We highlighted clear processes agreed by the Board in April 2020 which set out decision-making arrangements, and delegated authority limits continued to be enforced alongside tracking and analysis of COVID-19 spend. Since last year's assessment, the health board has formed a 'financial governance cell' and undertook a review of its COVID-19 governance arrangements. The review found several strengths including COVID-19 financial controls built around existing financial systems, creation of COVID-19 cost centres and scrutiny of COVID-19 spend. Of the improvements needed, work on Business Continuity planning and the Emergency Scheme of Reservation and Delegation remains in progress. The latter was presented as a draft to the Audit Committee in September 2021 with a view of formally approving this at the next full Board meeting.

62 The pandemic has impacted on some routine internal controls and the Health Board is now strengthening arrangements:

- **policy management** – the Health Board is exploring options to secure extra capacity to strengthen its overall policy management approach, policy controls, and is reviewing out of date policies.
- **single tender waiver** use increased from 33 waivers in 2019-20 to 99 in 2020-21. Forty-three out of those 99 waivers related to COVID-19 spend. The Health Board has set up a single tender waiver group which is taking action to reduce the single tender waiver use going forward.

- **declarations of interest** – for 2020-21, 58% of the circa 1,100 declarations of interest were completed last year. The Health Board is working to improve further this year.

63 As we highlighted last year, use of Chair's actions[11] is formally recorded in the public Board meetings. Emergency pressures and the need to make rapid decisions to support recovery may necessitate this approval route in future. For assurance purposes, the Health Board could consider including further detail on the Chair's actions within the Audit Committee finance conformance report. It is positive though that the Health Board has decided to arrange an extra-ordinary Board meeting for a potentially significant contract which it is currently progressing for eye-care services.

Monitoring and reporting

64 We found that **financial reporting arrangements provide a sufficient overview on the financial position, risks, and forecasted outlook.**

65 Finance reports provide sufficient and timely information on financial position, financial performance, cost savings and progress against the capital programme. Additional deep dives into specific areas of expenditure are periodically used to support understanding and scrutiny. Where there are new or amended contracts and agreements that have a financial implication to the Health Board, the Finance and Performance Committee is appropriately informed and provides appropriate challenge.

66 As highlighted throughout this report, service recovery will be challenging. Improving the focus on the financial efficiency of existing services should help to ensure that core capacity is used to best effect. The Health Board has a track record of focussing on cost control and cost avoidance. While this has provided assurance on financial position, it has not particularly helped to create financially efficient care pathways. Over the last six months, we are seeing increasing emphasis on value, return of investment and efficiency at senior levels within the organisation. This is becoming more visible at Finance and Performance Committee, particularly within emerging business cases and is a welcome development. The Health Board should also consider how it can bring a greater focus on financial efficiency and value within its formal financial monitoring and reporting (**Recommendation 1, 2021**).

[11] Chair's actions are normally used for urgent decisions taken outside of a formal Board meeting.

Appendix 1

Management response to the audit recommendation

Exhibit 6: management response to the 2021 structured assessment

Recommendation	Management response	Completion date	Responsible officer
Financial reporting R1 **Ensure improved focus on financial efficiency of services within finance reports**. This could be achieved through periodic or thematic deep dives on financial efficiency, reporting on value-based healthcare progress, or as part of routine financial reporting.	The Health Board already produces comprehensive benchmarking data on clinical services, and this is used to help identify savings opportunities as well as initiatives to improve patient experience. We also now provide regular transformation updates (which incorporate value-based healthcare (VBHC) and service improvement projects) to the Performance, Finance and Information Governance (PFIG) Committee We have included 2 deep dives / meeting into divisional performance onto the cycle of business for the PFIG Committee.	December 2021 [first reports being presented to the Committee] December 2021 December 2021	Executive Director of Finance Executive Director of Finance Executive Director of Finance

Recommendation	Management response	Completion date	Responsible officer
	The business case process is being updated and simplified and will include an assessment of: • the relative efficiency of the specific service; • what action has been considered to improve that efficiency ahead of the business case. The programme around clinical pathways and service reviews will include an assessment of relative financial and operational efficiency and what benefits can be expected from the implementation of the new pathway.	January 2022 February 2022	Executive Director of Primary and Community Care Executive Director of Primary and Community Care

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Archwilio Cymru
Audit Wales

Review of Eye Care Services – Betsi Cadwaladr University Health Board

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

Introduction and background context

1 Ophthalmology is a branch of medicine dealing with the diagnosis, treatment, and prevention of diseases of the visual system. Eye health services are becoming more and more important as the UK population ages. An ageing population means there are more incidences of age-related eye conditions, such as cataracts, age-related macular degeneration and glaucoma. Many of these eye diseases can be successfully treated if caught early and can often be managed effectively with existing treatments and medicines. But delays can also result in increased risk of harm and irreversible sight loss.

2 In March 2021, Welsh Government published NHS Wales Eye Health Care - Future Approach for Optometry Services. The plan forecasts a long-term growth in the prevalence of major eye conditions over the next 20 years including:

- 47% increase in the numbers of people with age-related macular degeneration;
- 50% increase in the numbers of people having Cataracts;
- 44% increase in the numbers of people living with glaucoma; and
- between 20% and 80% growth in diabetic retinopathy, a complication of diabetes.

3 The pandemic has significantly impact on waiting lists across Wales and across many specialties, but this is particularly notable in ophthalmology. Ophthalmology referral to treatment waiting lists have increased by around 50% since the start of the pandemic. This significant growth in the numbers of patients waiting alongside forecasted increased demand presents strategic and operational challenges across Wales which will affect many service users.

4 Betsi Cadwaladr University Health Board (the Health Board) has three main acute sites providing specialist eye care services with four dedicated operating theatres. Two operating theatres are situated in Abergele Hospital's Stanley Eye Unit, and there is one operating theatre in both Ysbyty Wrexham Maelor and Ysbyty Gwynedd. Of the Health Board's 38 current ophthalmology medical staff, 15 are consultants, with the remainder from other grades. The Health Board's annual programme cost budgetary spend for 'Eye/vision problems' is £45.1 million of which £32.5 million is spent in secondary care and the remainder in primary and community services.

5 There are 73 privately owned and managed accredited Eye Health Examination Wales providers in North Wales. 6 primary care Ophthalmic Diagnostic Treatment Centres provide additional services, for example reviewing patients after cataract surgery and monitoring patients with glaucoma.

6 Demand for specialist eye care services is growing in Betsi Cadwaladr University Health Board (the Health Board). In the last 8 years, average number of ophthalmology referrals into the Health Board have increased from around 1,600

per month in 2013 to over 2,200 per month in early 2020. While this substantially reduced at the onset of the pandemic, it is now starting to return to pre-pandemic levels.

7 Our work sought to answer the question; 'Are eye care services in the Health Board delivered efficiently, effectively and economically, with clear plans to meet current and future population needs?'

Key messages

8 Overall, we found **that there has been a substantial deterioration in eye care service performance because of the pandemic. The Health Board is keen to improve and is adopting what is understandably a reactive response to waiting list growth caused by the pandemic alongside building on its more proactive plans that it had started to develop in 2018 and 2019. Significant challenges remain, particularly because demand is expected to be greater in future than has been seen in the past**.

9 Throughout this review we have seen the direct and indirect impact of the pandemic on services, staff, and patients. Services are stretched and service users face long delays. Whilst the Health Board is not in a unique position with the growth of the numbers of patients on ophthalmology waiting lists, it does have a particularly high proportion waiting a very long time. Whilst many of those patients with long waits may be lower risk, this is an issue that the Health Board is committed to resolving. Referral demand is now increasing at a higher rate than service capacity is recovering leading to waiting list growth. Sub-regional variation in waiting times may present a challenge and there needs to be a clearer understanding of the drivers of this variation, and measures put in place to address it.

10 Service efficiency is sub-optimal. This is notable in relation to theatre session productivity and aspects of outpatient management. Inefficiencies have been exacerbated by the pandemic, but there were clear opportunities for greater efficiencies beforehand. Adoption of the new all-Wales cataract pathway and productivity targets would help drive efficiencies. Improvements in acute service efficiency can't be 'switched on'. It will take a concerted effort which is focused on value and outcome, supported through stronger clinical leadership, engagement, stronger accountability, capital investment and cultural change.

11 The Health Board is strengthening its approach for eye care service change through its eye care business case. It has built stronger relationships with primary care services, expanding community services, and is exploring further ways to provide care closer to home. The Health Board is also seeking to develop regional treatment centres which are likely to include eye care services. That additional local capacity will take time to develop, and the Health Board has taken a logical approach by agreeing a major new contract with an external provider. This should start to recover waiting lists while sustainable acute models are developed.

12 Longer term models for acute care will require a strong workforce and an estate that supports efficient and good quality care. However:

- workforce risks within the service are significant, and the Health Board needs to ensure it has good workforce plans which are fit for the future. Vacancies in the clinical leadership structure need to be filled, and there is opportunity to consider how Ophthalmology and Optometry clinical leadership come together in a more integrated structure.
- the Health Board also needs to better consider the changes it needs to make to its estate to build capacity that is both fit for the future and supports improvements in efficiency. We heard of concerns about the estate at all three North Wales sites.

13 There are reasonable arrangements for monitoring eye care service performance. However, lines of accountability for eye care services are fragmented across hospital sites and this allows too greater variation in efficiency, productivity, adoption of new services and disparities in waits. Current operational accountabilities do not link well to the wider accountabilities for the eye care improvement programme. Financial management of 'eye care services' is also distributed making it difficult to compare and contrast financial efficiency. At present the accountability model could limit traction when it is needed most. Monitoring of the eye care business case implementation is taking place within the Health Board's Eye Care Coordination Group sufficient for it to be able to track progress. However, there needs to be stronger links into the Health Board's wider corporate programme governance structures.

14 Despite an incredibly challenging 18 months during the pandemic, the staff we met with during this review demonstrated a pride in their work and were committed to securing the further service improvement. This review highlights a need for several improvements including some associated with aspects of internal efficiency and productivity, which must be addressed. We have made 12 recommendations arising from this review. The Health Board should aim to deliver improvements within an ambitious but achievable timeframe, and include periodic progress reporting against these into the new corporate programme and transformation structure.

Recommendations

The Health Board's management response to our recommendations is set out in **Appendix 1**.

Recommendations
Subregional variation of patient waits
R1 Improve quality of referral to treatment data to ensure that the Health Board can undertake analysis of sub-regional variation in waits.
R2 Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.
R3 For as long as variation exists, include performance data on sub-regional variation in waiting times within existing performance reports to the Executive team and to Performance Finance and Information Governance Committee.
Efficiencies
R4 **Implementation of the all-Wales cataract pathway** – ensure that the all-Wales cataract pathway is effectively implemented and then routinely adhered to. As this will take time, the Health Board should set clear milestones and intermediate targets.
R5 **Service efficiencies** – develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans.
Financial monitoring
R6 Improve financial reporting to all those accountable for eye care services in the Health Board. This should include variance to budget and support value-based healthcare through a better understanding of cost, outcomes, and expenditure on its improvement plans.

Recommendations

Accountability for eye care services

R7 Undertake a review of the accountability arrangements for eye care services with the aim of:

- ensuring effective integration of services across acute sites;
- achieving better integration of services with community optometry; and
- eliminating inappropriate sub-regional variation of service delivery and improving service efficiency.

Eye care clinical leadership

R8 Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.

R9 Appoint to the clinical leadership structure.

Workforce planning for eye care services

R10 Develop a single medium-term workforce plan for eye care services (acute and NHS funded community services) that:

- links to the future intended models of care;
- builds further opportunities for working with training providers;
- includes succession planning; and
- develops a more strategic approach to recruitment.

Estate

R11 Ensure estate improvements and wider capital needs are included within Eye care business cases and plans. This should include investment to support improved efficiency and use of existing estate as well as any additional estate capacity to support the longer-term sustainability of services.

Reporting and monitoring

R12 Strengthen formal reporting into the corporate programme management structures on eye care business case milestones and impact of investment in eye-care services.

Detailed report

Waiting times

15 As highlighted in the introduction of this report, there is a clear link between long waiting times and risk of harm for some eye conditions. NHS Wales has two waiting list approaches to help manage and control these risks at a Health Board level:

- Eye Care Measure (a recently introduced 'risk-based measure' to help manage overall risk of harm as a result of a delay).
- Referral to Treatment waiting list (used for most elective/planned care).

16 We found that **while not in a unique position, the Health Board has a large and growing number of people waiting long times for eye care treatment. While risk-based prioritisation is used, the extent of waits is a significant concern**.

Eye Care Measure

A basic introduction to the eye care measure[1]

Ophthalmology patients are risk assessed based on their condition and then given a target date to be seen. If a patient who is categorised as the highest risk[2] waits 25% longer than the clinically assessed target date, then it counts as a breach.

Example: Mrs Jones has wet AMD and has been clinically assessed as needing to be seen in 4 weeks. Mrs Jones waits just over 6 weeks – therefore the target has been breached. Within 5 weeks, this would not have been a breach.

The eye care measure is the overall proportion of people on the Health Board's waiting list waiting within target date or for R1 patients, within 25% beyond their target date. The national target is for 95% of all patients on the Eye care measure waiting list to be seen by their target date or within 25% beyond their target date.

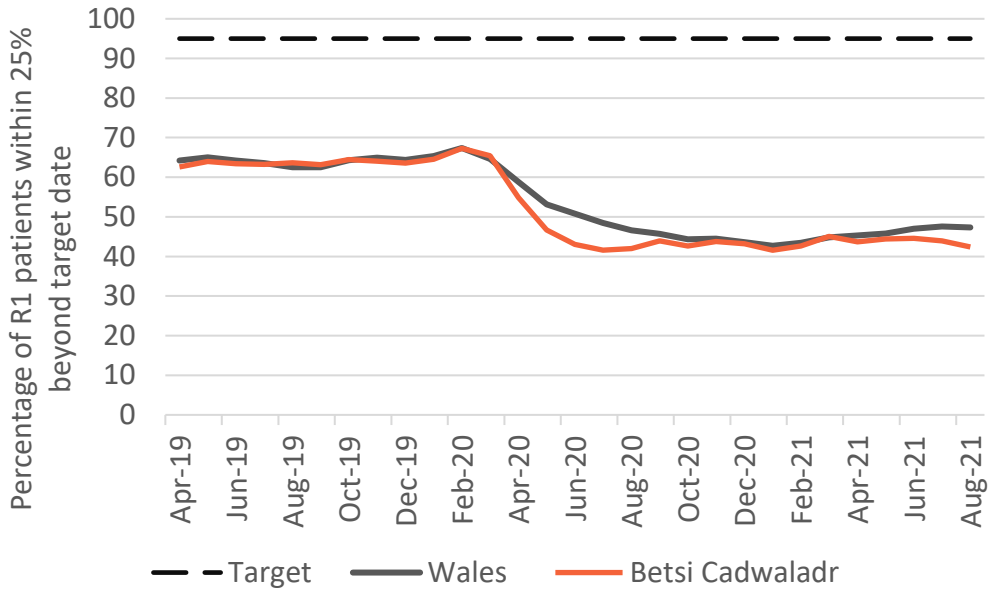
17 **Exhibit 1** on the following page shows the performance on the eye care measure, since the measure was introduced and published. It shows Betsi Cadwaladr University Health Board performance broadly aligns with the all-Wales average. Across Wales performance was stable during 2019-20 but was not meeting the national target during 2019-20. This has deteriorated because of the pandemic. But irrespective of the pandemic eye care demand is also expected to increase.

[1] Welsh Government introduced the eye care measure to help prioritise those most at risk of harm as a result of a delay in accessing services.

[2] The highest risk is known as Risk Factor 1 or **R1**.

The Health Board not only needs to recover services but develop but adapt services to ensure they can sustainably meet this growth in demand.

Exhibit 1: eye care measure waits – percentage of patient pathways, which have a target date allocated and are assessed as Health Risk Factor R1, waiting within target date or within 25% beyond target date for an outpatient appointment. (Higher is better – target is 95%)



Source: Stats Wales Eye care measure – Patients waiting to start treatment by month

18 A very high proportion of patients on the waiting list (99.5%) are risk assessed which is helping to prioritise those at most need and enables performance monitoring. Given the extent of patient waits and considering wider pressures on the health system, it is a major challenge to ensure those higher risk patients are seen and treated. 18,765 of the 32,531 patient pathways classified Risk Factor 1 were breaching the target as of August 2021.

Referral to treatment

19 Some acute eye care patients who are waiting a long time may not be at a significant risk of irreversible harm as a result of a delay. But they may be living with a condition that impedes their quality of life. Referral to treatment waiting list trends provide an indicator of the balance of service capacity and demand. It shows the extent of those waiting longest and reflects an aspect of patient experience.

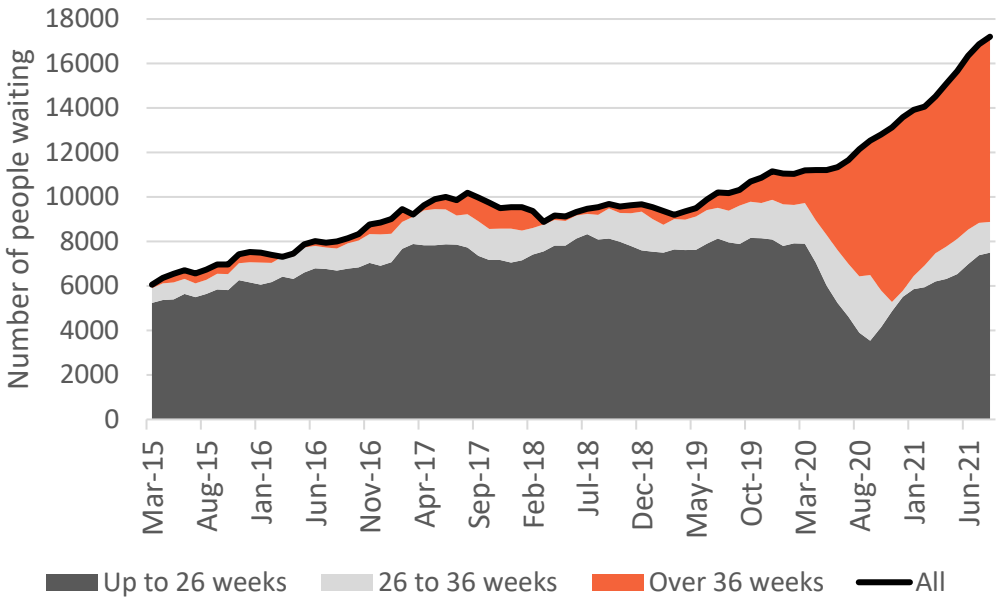
What is referral to treatment (RTT)?

RTT performance relates to the time taken from referral into the service to the point where they receive treatment. Prior to the pandemic 95% of patients should have been treated within 26 weeks and all patients within 36 weeks. RTT waiting lists do not take into consideration clinical risk in the way that they are recorded and are a simple time-based measure.

20 **Exhibit 2** below shows the number of patients waiting on the referral to treatment waiting list, grouped by weeks waiting. It shows:

- a growth in total numbers of people waiting between 2015 to March 2020, ie a notable growth prior to the pandemic;
- that overall, there are over twice as many ophthalmology patients currently waiting for treatment as there were in 2015;
- that prior to the pandemic there have been periods where the Health Board struggled to deliver services within 36 weeks; and
- that the last 24 months has had a major impact on length of waits.

Exhibit 2: number of patients waiting on the referral to treatment waiting list in North Wales, grouped by length of wait



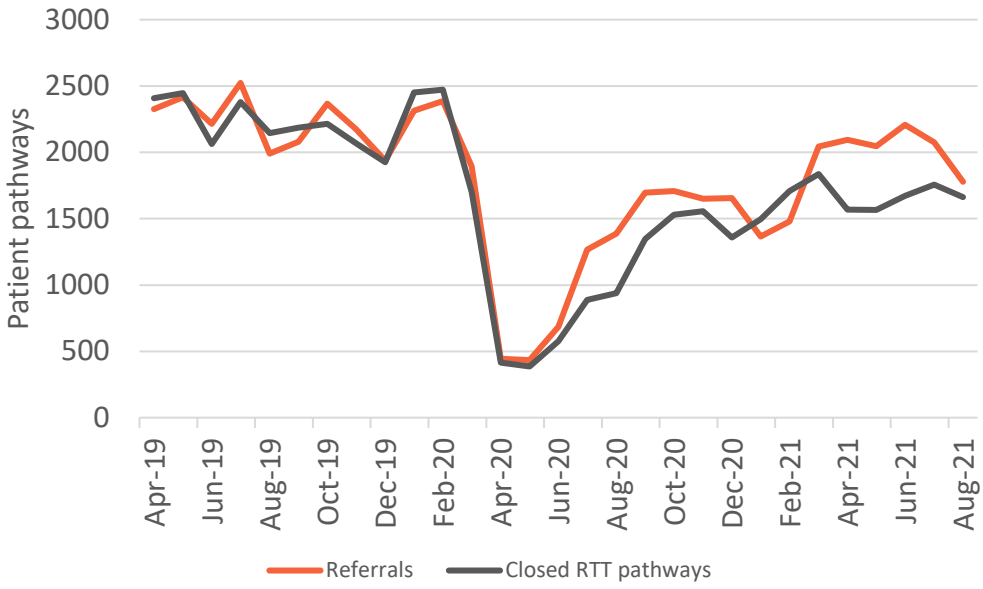
Source: Stats Wales – Patients waiting to start treatment by month

21 Staff who spoke to us also described inequity of waits across North Wales. In particular, people living in the West (Gwynedd and Anglesey) may be waiting longer than people living in other counties in North Wales. We have not undertaken analysis of this because of clinical coding issues on the waiting list[3] (**Recommendation 1**).

22 The Health Board has some extremely long waits. We looked at the proportions of ophthalmology patients waiting more than 73 weeks on the RTT waiting list (ie, waiting over twice the 36-week wait target). As of August 2021, there were 17,205 patients on the ophthalmology RTT waiting list. Of these, 5,158 were waiting 73 weeks or longer, equating to just under 30% of all patients waiting.

23 The number of closed pathways gives an indication of patients treated, comparing this to monthly referrals gives an indication of how well capacity is meeting demand. The mismatch between referral demand and productive capacity is the main contributing factor to the growth in waits. **Exhibit 3** shows that this was reasonably balanced prior to the pandemic, but there is now a clear gap as referral demand increases.

Exhibit 3: Betsi Cadwaladr – ophthalmology referrals (GP and non-GP) and closed RTT pathways



Source: Stats Wales

[3] Clinical coding enables categorisation of the waits by clinical condition. Currently, the data is not fully reliable. This means we cannot reliably compare, for example, the variation in waits for people waiting for cataract surgery.

Efficiency and productivity

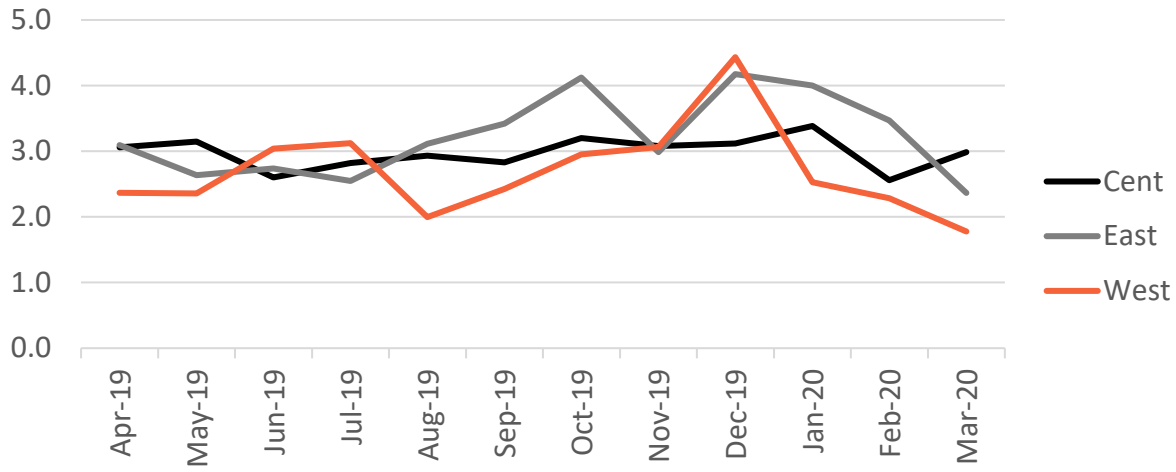
24 Productive and efficient services help to maximise the clinical benefit for those who need them. This section considers some key efficiency indicators, arrangements to support efficiency and it describes the challenges and barriers faced. This focuses particularly on acute ophthalmology services.

25 We found that **for a variety of reasons, including different working practices, booking processes, culture and estate issues, service efficiency is sub-optimal. There is a real need to drive improvement in acute service efficiency, but this can't be 'switched on'. It will take time. It will take a concerted effort supported through leadership, engagement, stronger accountability, capital investment and cultural change**.

Ophthalmology outpatients

26 Outpatient services are core to efficient ophthalmology pathways. Prior to the pandemic, the Health Board was providing around 80,000 face-to-face ophthalmology outpatient appointments each year of which around 70,000 were consultant led. The following chart shows the ratio of review (or follow up) to new outpatient appointments (**Exhibit 4**). It shows around 3 review appointments for every new outpatient appointment. New care pathway models promote the reduction of consultant-led review appointments where not clinically necessary. This could release substantial capacity to treat more of those patients who are waiting a long time.

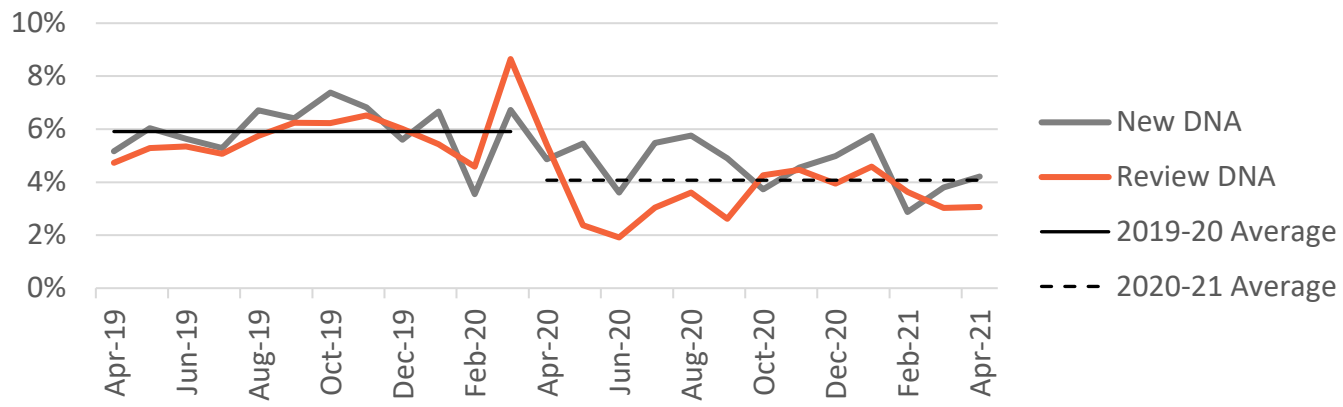
Exhibit 4: review to new ratio (all ophthalmology patients). Number of review appointments for each new appointment



Source: Health Board data

27 **Exhibit 5** shows the proportion of patients that were booked into an ophthalmology outpatient appointment slot but did not attend (DNA). Around 6% of patients (equating to around 5,000 patients) did not attend their appointment prior to the pandemic and this reduced to around 4% (around 2,400 patients[4]) in 2020-21. DNAs can waste valuable NHS resources and result in lost clinic slots that would otherwise be used by other patients. This results in patients spending longer on the waiting list. Small changes in the percentage of DNAs make a reasonable overall difference to available capacity each year, and efforts should continue to prevent the numbers of 'Did Not Attends' from returning to the previously higher levels.

Exhibit 5: ophthalmology outpatient 'did not attend' rates



Source: Health Board data

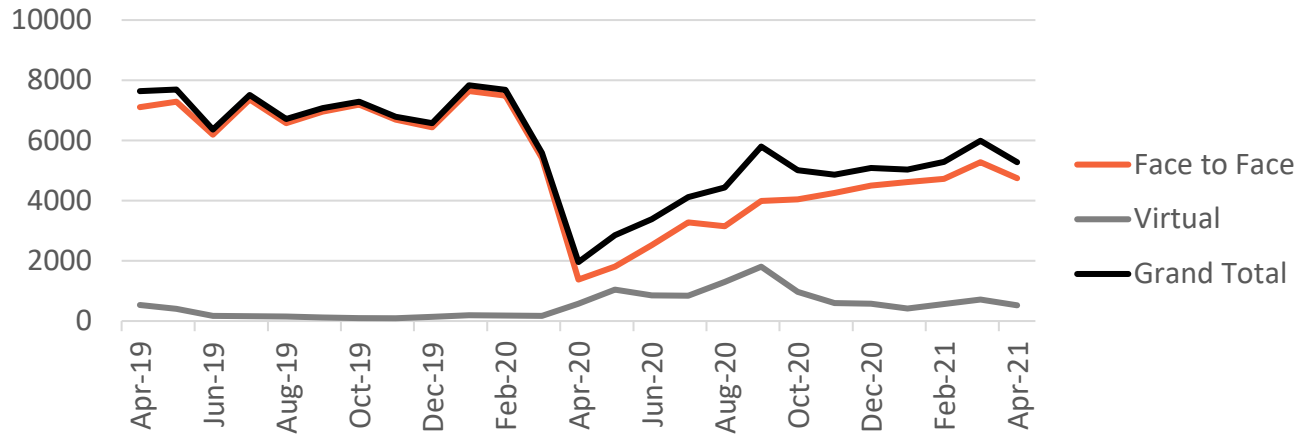
28 The pandemic has seen some outpatient services move to virtual (video or telephone) consultation appointments. The uptake of virtual appointments, while suitable for some specialties, may be less suitable for others. **Exhibit 6** shows the trend in the uptake of virtual compared to face-to-face appointments.

29 We spoke to teams across sites who indicated the need for medical staff to clinically assess in a face-to-face setting to determine the condition, clinical risk, and course of treatment. They highlighted greater opportunity to use virtual 'technology' based approaches for review than for new appointments, but also raised concerns about inefficiency caused by limited technical literacy for many patients who are more elderly or frail. Maximum benefits are likely to occur with careful selection of suitable candidates for video consultation[5]. The Health Board should explore these opportunities further.

[4] There were around 25,000 fewer ophthalmology outpatient appointments during 2020-21 than in the previous year as a result of the pandemic.

[5] Safety of video-based telemedicine compared to in-person triage in emergency ophthalmology during COVID-19 – the Lancet

Exhibit 6: number of face-to-face ophthalmology appointments versus virtual outpatient appointments

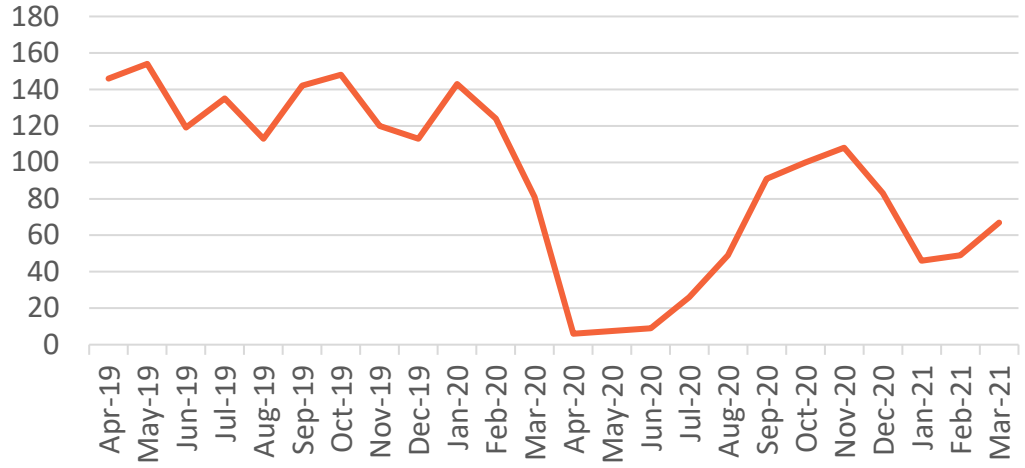


Source: Health Board data

Operating theatre efficiency

30 The pandemic reduced the number of operating theatre sessions each month (**Exhibit 7**). When sessions resumed after the first wave of COVID-19, redeployment of the workforce, staff shielding and, staff isolating because of COVID and turnover, had and may continue to have a major impact on the number of available operating theatre sessions and wider efficiency.

Exhibit 7: number of operating theatre sessions – April 2019 to March 2021 (Planned, Waiting List Initiative and Insourcing)



Source: Health Board data

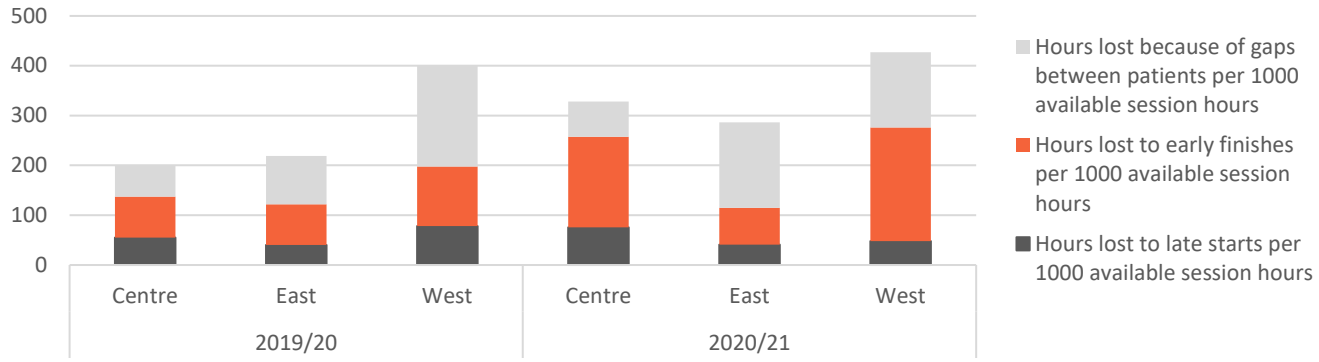
31 Another factor affecting productivity is the impact of 'on the day' cancellations of patients scheduled for surgery. On the day cancellations are routinely recorded. For 2019-2021, the overall percentage of cancellations and top four cancellation reasons are as follows:

- Wrexham Maelor (10.64%) – unfit for surgery, change of plan by surgeon, equipment failure, list overrun
- Abergele (6.03%) – illness/unfit for surgery, op not necessary, pre-existing medical condition
- Ysbyty Gwynedd (8.02%) – occurrence recorded but reason not recorded, surgeon unavailable, unfit for surgery, theatre staff not available.

32 There is some opportunity to step up proactive measures to reduce the occurrence of on the day cancellations. This could include strengthening pre-operative assessment and ensuring that all patients notify the Health Board if they are unwell at the earliest opportunity. This particularly important as it is currently more difficult to backfill short notice cancellations because of the need to ensure COVID-19 safety precautions are followed.

33 Surgical productivity is typically a challenging area to improve, but the extent of the backlog means that this must be addressed. While **Exhibit 7** shows lower numbers of theatre sessions undertaken since the onset of the pandemic, our data analysis also shows that this is compounded by sub-optimal use of theatre sessions. **Exhibit 8** shows that overall, theatre sessions are underutilised with opportunities to improve on late starts and early finishes. There was also a notable but understandable reduction in session utilisation in 2020-21 because of COVID-19, but this must be addressed to reduce long waits and ensure sustainable services.

Exhibit 8: theatre session utilisation (planned core – excluding IVT[6], Emergency, Waiting List Initiative and Insource), Betsi Cadwaladr University Health Board.



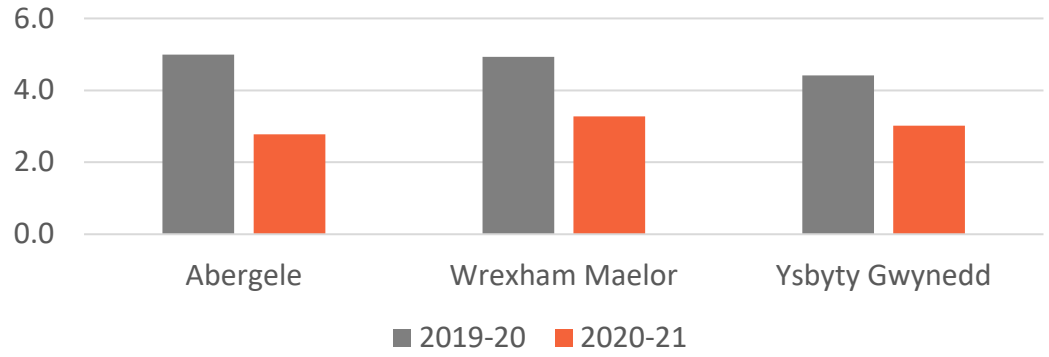
Source: Health Board data

[6] IVT (Intravitreal Treatment) – a common method for treating conditions such as age-related macular degeneration.

34 Cataract surgery represents around half of all planned ophthalmology surgery in the Health Board[7]. There are clear efficiencies that can be achieved both across the full cataract (end-to-end) treatment pathway and specifically within operating theatre productivity. The National Get it Right First Time ophthalmology review recommended that cataract operations should take a maximum of 30 minutes, and that providers develop high volume lists to increase productivity, with no fewer than 8 patients per session. That report identified specialist eye units in England that were providing between 8 and 14 cataract operations per high volume list. Its subsequent publication on resumption of Cataract Services after Covid-19 recognised that COVID-19 safety measures would impact on productivity. It suggests options to help mitigate some of this including clinical assessment, biometry[8] and surgery in one visit and bilateral simultaneous cataract surgery if clinically required and safe to do so.

35 **Exhibit 9** shows the average level of cataract productivity in the Health Board. We have analysed data for only the core planned cataract only sessions to ensure data is comparable. For cataract patients, the new all-Wales pathway includes a one stop clinic at the outset and post-surgical follow up in the community and sets expectations for surgical productivity. The new guidance indicates that Health Boards should be aiming to deliver 9 procedures per list for fully trained clinicians in a high-volume session and 6 procedures per training list. Requirements for COVID-19 infection prevention measures may mean that this is not currently achievable. Nevertheless, the analysis below indicates an average overall of under 5 cataract procedures per session in the year prior to the pandemic and around 3 procedures per session in 2020-21.

Exhibit 9: average cataract procedures per session by year and site



Source: Health Board data

[7] In 2019-20 there were 9,880 procedures of which 5,090 were prosthesis of lens operations (PEDW data sets 2019-20 by provider).

[8] A biometry is an imaging technique that involves taking measurements of the eye.

36 Constraints, such as social distancing, COVID-19 safety measures and current estate, are likely to inhibit the Health Board achieving Welsh Cataract standard of 9 procedures per list on average. COVID constraints notwithstanding, if the Health Board could increase from 5 to an average of 7 per list, then this could mean that the Health Board could deliver around 2,000 extra cataract procedures per year. Service redesign such as introduction of high flow low complexity regional hubs[9] could enable even greater efficiency. The Health Board is developing options for regional treatment centres, which may provide a platform for efficiency improvement.
The Health board should fully adopt the all-Wales cataracts pathway guidance and set an ambitious but achievable efficiency aims (**Recommendations 4 and 5**). This would make a great deal of difference for people currently waiting long times for surgery.

Managing performance, accountability, and leadership of change

Manging performance

37 We met with representatives from acute ophthalmology services at each site. We found they have a good understanding of performance, extent of waiting lists, efficiencies, and adoption of new pathways. Good performance information is routinely available and ad hoc information requests are effectively supported by the informatics team. IT dashboards provide good management information and there is further opportunity to develop these to better support day to day operational management of eye care services.

38 However, we didn't find a strong enough focus on the finances. Cost information is used when the service is seeking approval of additional expenditure but is not routinely used for operational management of eye-care services as a whole. This makes is more difficult to assess the value and financial efficiency at a site level and understand the overall financial plans for eye care services. With an overall eye care expenditure of around £45 million, there is a need for a better understanding of cost and value (**Recommendation 6**).

Operational accountability

39 At present the formal lines of accountability for eye care services are split across each hospital's management structure for acute services and the 3 geographic areas for community-based services. The Health Board also has an Eye Care Coordination Group which is responsible for eye care service development across North Wales. This group has also adopted aspects of performance monitoring, but

[9] Cataract Hubs and High Flow Cataract Lists – The Royal College of Ophthalmologists and GIRFT.

it is not its core role, nor does it have any formal accountability to challenge performance and relies instead on trying to influence improvement.

40 Ultimately this fragmented accountability allows too much variation – for theatre scheduling, different length of waits in different sites and varying adoption of new community care pathways, in particular. Our view is that the current performance accountability model for eye care services is too fragmented and is not sufficiently helping the Health Board achieve performance improvement (**Recommendation 7**). The Health Board's Annual plan for 2021-22 seeks a 'once for North Wales' approach. A collective 'once for North Wales' accountability structure could better enable the Health Board to:

- manage performance as a single service, resolving inappropriate variance;
- coordinate its existing capacity, talent, and wider resource;
- achieve economies of scale;
- ensure consistent processes, pathways, waiting list management, allowing it to balance patient risk and prioritisation fairly, and
- coordinate specialised workforce training, recruitment, multidisciplinary team development, and succession planning.

Programme management and leadership

41 The Health Board's eye care coordination group is responsible for driving service modernisation. The group has built some momentum, particularly over the last 6 months, and has a good focus on progress of specific workstreams, even though uptake of new community pathways has been slow. The group is well represented, it has a rounded agenda and has good ambition. We have noted a strengthening of leadership within the group, but also that it has little authority to ensure changes are embedded (this issue links to **Recommendation 6**). We have also identified opportunities to improve reporting progress of this group. We discuss this further in the final section of this report (**paragraph 57**).

42 Delivery of the eye care business case will require strong clinical leadership. There is a North Wales clinical lead structure but only one out of three clinical lead posts are currently filled. Given the need for eye care service recovery and sustainable services models, this clinical structure needs to provide unifying leadership across North Wales (**Recommendations 8 and 9**). We have heard that there is too much variation in adoption of new pathways and improvements that are driven by enthusiastic consultants, but when they leave the momentum goes. This points toward a need for greater continuity of clinical leadership with clinical accountability linked to this.

Service modernisation

43 Demand for eye care services is expected to increase. If pre-pandemic referral trends continue, the Health Board could find referrals increasing from around 2,200 per month to around 2,800 per month by 2026[10]. The service struggled to meet the pre-pandemic demand and, irrespective of the need for recovery of waiting lists, needs to build eye care services that can manage service demand in the future.

44 We found **the Health Board is strengthening its approach for eye care service change and improvement, but also a need for greater attention to sustainable workforce and estate planning.**

Eye care business case

45 All of those that we spoke to have a good understanding of the current demand for services and a detailed knowledge of the extent of the waiting list backlog. The Health Board is using this information to inform the development of eye care plans, building upon previous plan development through the development of an eye care business case.

46 The eye care business case includes a high-level population assessment, forecasts growth in older population and applies prudent healthcare principles[11]. It sets out anticipated key benefits including:

- maximising eye health and sight retention for the North Wales population.
- achievement of eye care measure and referral to treatment national standards including elimination of the existing waiting list backlog.
- improved patient experience and outcomes.
- improved operational efficiency and productivity.

47 The eye care business case seeks to better integrate acute and community services. This approach includes the development of new pathways with community optometry services including post-surgery cataract review, glaucoma and diabetic retinopathy monitoring, referral refinement and is working on other opportunities. Changes to glaucoma, age related macular degeneration, cataract pathways and e-referrals are expected to cost around £1.43 million in 2021-22 increasing to £2.77 million per year thereafter. The approach, however, should help to reduce demand on acute services and help manage patients' conditions in the community.

48 The Health Board currently commissions 6 Ophthalmic Diagnostic Treatment Centres (ODTCs) and is looking to expand the range of community services they provide although we understand uptake of pathways currently in place is far lower than originally expected. We were told that this was a result of issues administering patient referrals and resistance to adopt new pathways by some clinicians. We also

[10] We used a basic linear projection utilising referral data from 2012 through to March 2020 to forecast a referral trend to 2026.

[11] Prudent Healthcare are a set of principles for good value and effective care

heard of delays in payment for ODTC services which have an impact on the future engagement of optometry practices. We understand that Health Board is actively seeking to address this issue.

49 As identified earlier, there are twice as many patients waiting for treatment currently as there were in 2016. The Health Board recognises that internal capacity will not be sufficient to enable recovery of acute ophthalmology services. It is seeking additional acute capacity through insourcing, outsourcing and managed services[12] as part of wider regional treatment centre proposals to recover waiting lists. The intention is that regional treatment centres will provide services across a range of specialties including ophthalmology and in particular cataract surgery.

50 Plans for regional treatment centres are not yet agreed and will take time to implement. To meet the significant immediate need of large numbers of patients waiting, the Health Board started work on developing a specification for outsourced services in May 2021. This included setting the criteria for quality and cost. The Health Board went out to tender in September and after receiving a bid from one supplier, has entered into an agreement for the supply of eye care services with an external provider located in the North West of England. This 1-year £6 million contract can be extended for a further year. This will enable waiting list improvement while new options for local sustainable services are developed.

Workforce

51 Workforce planning is fundamental for the future sustainability of services. For many years, recruiting into North Wales has been a challenge, often leaving unfilled vacancies or use of locum and agency staff. The Health Board's eye care services are increasingly multi-disciplinary with already good use of advanced practitioner nurses providing intravitreal sessions. There is also good engagement with representatives of the optometry profession to explore advanced training opportunities. The Health Board is supporting opticians wanting to undertake additional advanced practice training. We heard that opticians are enthusiastic to support this but there is limited availability of local placements in North Wales. Some opticians have relied on finding practical work-based training placements in acute sites in England so they can fulfil their training obligation.

52 The Health Board currently has just under 15 'whole time equivalent' (wte) Consultant Ophthalmologists in post, equating to just over 2 wte per 100,000 population[13]. In 2018, the Royal College of Ophthalmologists[14] identified that 2 wte per 100,000 is average but indicated an ideal of around 3 to 3.5 wte per 100,000 population. With the waiting list backlog growing across the United Kingdom, this suggests competition for consultant resource is likely to be exacerbated. The

[12] Fully managed services relate to a complete package where an external provider may develop new temporary facilities within the Health Board area but fully providing additional theatre capacity and the necessary workforce to deliver services.

[13] Consultant data – Stat Wales, March 2021

[14] Workforce census, 2018 – Royal College of Ophthalmologists

Health Board has indicated that some consultants are nearing retirement, and while some may choose to 'retire and return', this is a particular risk area. Nursing staffing is both an area of concern and opportunity. The Health Board has indicated that it is carrying vacancies which is increasing pressure on the workforce and that recruitment is challenging. There is opportunity for greater development of specialist ophthalmologist nurses and wider specialist multidisciplinary team members. Given the time needed to train and build specialist expertise, there is a need for a robust eye care service workforce plan that aligns to new service models, maximises new training opportunities in partnership with higher education institutions and builds a talent 'pipeline' (**Recommendation 10)**.

Estate

53 Good quality estate is needed to provide efficient, productive services. Our review of the eye care business case indicated that there needed to be greater consideration of the changes needed to existing ophthalmology estate as well as new estate requirements.

54 Each team that we met with identified a need to adapt estates for differing reasons, be it to improve outpatient flow, facilities to undertake intravitreal treatment, ability to support social distancing across for outpatients and preoperative assessment or overall estate to support required surgical capacity. Across Wales, there are competing demands for capital funding. Smaller short-term capital estate investment to fix problems may not provide good value if longer-term more substantial estate solutions for eye care services are required. We didn't find a shared understanding of what 21st century ophthalmic centres would look like in North Wales. This needs to be strengthened in the business case (**Recommendation 11**).

Digital eye services

55 Digital eye care services provide options to manage patient pathways, support effective communications, see patients, and evaluate the effectiveness of treatment. The Health Board currently has three different patient administration systems, one for each acute site, which are not yet joined up. The systems enable patient booking and waiting list management, but the lack of integration makes movement to a once for North Wales approach more challenging. The Health Board is now working toward a single patient administration system, with the business case reviewed at the Performance, Finance and Information Governance Committee in October. The time required to implement the system may constrain the ability to join-up ophthalmology services, in the near future.

56 The Health Board has also committed to implementing the national OpenEyes[15] system. The system will give acute and community services access to shared clinical information to enabling closer integrated working. We are not yet clear of

[15] Welsh Government Announcement of investment in OpenEyes

the implementation date, and we understand that OpenEyes will need to link to the Health Board's patient administration system. The implementation of the system is likely to be more straightforward if integrating to a single patient administration system, once that is progressed.

Reporting on progress of the eye care business case and wider plans

57 The eye care coordination group has a good understanding of progress, risks and challenges but reporting lines into 'parent' Health Board-wide programme management structures need strengthening. There needs to be formal reporting against milestones, impacts and return of investment, and where relevant escalation of key risks and challenges (**Recommendation 12**). The Health Board has recently approved a new governance structure that includes Executive Delivery Groups and new corporate change and programme resource.
Some attention is also now needed on the connectivity between specialty level improvement groups and overall Health Board level programme management. This would also help to provide assurance to board members on the progress and impact of improvement plans.

Appendix 1

Management response

Exhibit 10: management response

Recommendation	Management response	Completion date	Responsible officer
Subregional variation of patient waits			
R1 Improve quality of referral to treatment data to ensure that the Health Board can undertake analysis of sub-regional variation in waits.	Data quality key to ensuring business analysis can support decision making.	End of Quarter 4 2021-22	Gill Harris
R2 Undertake analysis on sub-regional variation in waits, either by the Health Board's three main locality areas or by county of residence.	This links to recommendation 7 so that a North Wales view can provide overview, guidance and management utilising the patient treatment list wait information that is already available supported by the dashboards that are in progress.	End of Quarter 4 2021-22	Gill Harris
R3 For as long as variation exists, include performance data on sub-regional variation in waiting times within existing performance reports to the Executive team and to Performance Finance and Information Governance Committee.	The Health Board will consider long-term performance data for as long as there is provision on more than 1 site to ensure not only equity but also optimisation of resources. Performance already provided through Secondary Care Accountability meetings, although very high level due to the required reporting criteria, which the provision of dashboards will simplify.	End of Quarter 3 2021-22	Gill Harris

Recommendation	Management response	Completion date	Responsible officer
Efficiencies			
R4 Implementation of the all-Wales cataract pathway – ensure that the all-Wales cataract pathway is effectively implemented and then routinely adhered to. As this will take time, the Health Board should set clear milestones and intermediate targets.	All Wales cataract pathway is a shared objective across all three sites. Whilst sign up to RTC is an enabler and being clinically driven, further review to agree the incremental steps over the next 18 months is required due to the many compounding challenges identified in this report.	End of Quarter 3 2022-23	Chris Stockport
R5 Service efficiencies – develop a clear plan to improve service eye care service efficiency and productivity. Where relevant, this should be linked to wider service change/modernisation plans.	Transformation needs to be supported by continuous improvement. There are already key enablers identified with each of the sites / localities developing and agreeing key service productivity improvements pulled together from a pan North Wales to ensure standards are improved and across the Health Board.	End of Quarter 4 2022-23 (part of planned care 90-day cycle of improvement work)	Chris Stockport
Financial monitoring			
R6 Improve financial reporting to all those accountable for eye care services in the Health Board. This should include variance to budget and support value-based healthcare through a better understanding of cost, outcomes, and expenditure on its improvement plans.	Good financial management is important to both excellent clinical and operational management. Provision of key data within Eye Care sections across the Health Board but also a North Wales view supported by the appropriate responsibility and accountability (R7) to enable change.	End of Quarter 4 2021-22	Sue Hill

Recommendation	Management response	Completion date	Responsible officer
Accountability for eye care services			
R7 Undertake a review of the accountability arrangements for eye care services with the aim of: • ensuring effective integration of services across acute sites; • achieving better integration of services with community optometry; and • eliminating inappropriate sub-regional variation of service delivery and improving service efficiency.	This will be encompassed within the stronger together work which will require the local integration of acute and primary care services with regards to the vertical pathways and processes whilst there is a North Wales responsibility and accountability for services and decision making to eliminate inappropriate sub-regional variation. It is anticipated that the introduction of a new Optometry reform contract will support change, strengthening relationships but also the opportunity to provide better accountability if delegated to the Health Board.	End of Quarter 4 2021-22	Gill Harris
Eye care clinical leadership R8 Strengthen the clinical leadership structure, with a specific focus on responsibilities, and accountabilities for eye care services. As part of this, ensure that the optometry clinical leadership integrates into the existing clinical leadership structure.	Both North Wales Ophthalmology and Optometry Clinical leads are vital to developing and driving improvement. Recently these posts have become vacant and it is key to replace not only these posts but clinical leadership across sites and across the major sub-specialties; this matrix can be reviewed and tested. Vertical leadership creates potential silos whilst a more recent view of pan North Wales pathway leadership could be explored.	End of Quarter 4 2021-22	Nick Lyons and Gill Harris

Recommendation	Management response	Completion date	Responsible officer
R9 Appoint to the clinical leadership structure.	Health Board support appointment to the clinical leadership structure.	End of Quarter 4 2021-22	Nick Lyons and Gill Harris
Workforce planning for eye care services R10 Develop a single medium-term workforce plan for eye care services (acute and NHS funded community services) that: • links to the future intended models of care; • builds further opportunities for working with training providers; • includes succession planning; and • develops a more strategic approach to recruitment.	Workforce planning needs to be strengthened and will include opportunities for new roles across the whole system. As part of the RTC models of care work, which will include all elements, opportunities for retention and recruitment will support succession planning as well as current recruitment issues which need to be tackled through a North Wales approach.	End of Quarter 4 2021-22	Sue Green
Estate R11 Ensure estate improvements and wider capital needs are included within Eye care business cases and plans. This should include investment to support improved efficiency and use of existing estate as well as any additional estate	The longer-term strategy for Eye Care in terms of secondary care estate is to have re-provision within the RTC(s); this needs to progress at pace which is supported by both Welsh Government and the Health Board.	End of Quarter 4 2021-22	Sue Hill

Recommendation	Management response	Completion date	Responsible officer
capacity to support the longer-term sustainability of services.	The Eye Care Coordination Group has already identified that there is a need to review, post approval in July 2021 of the recently prioritised business case, the services and future needs. The capital plans are owned by the accountable parts of the organisation as it is important to ensure that the whole of site or community plans are understood. However, smaller short-term requirements should be identified and reported through to the formal process for capital requirements to ensure maximum resources / assets are enabled across North Wales.		
Reporting and monitoring R12 Strengthen formal reporting into the corporate programme management structures on eye care business case milestones and impact of investment in eye-care services.	Formal reporting takes place through the secondary care accountability governance structure whilst updates are provided to the Planned Care Transformation group, which is not a formal approval / decision making group. The Health Board governance structure has been reviewed and it is expected that Executive Delivery Groups, once implemented, will have oversight of major projects / programmes such as the work undertaken by the Eye Care Collaborative Group and the Business Cases produced following this audit, further reviews and planning work.	End of Quarter 3 2021-22	Chris Stockport

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Taking Care of the Carers?

How NHS bodies supported staff wellbeing during the COVID-19 pandemic

October 2021

This report has been prepared for presentation to the Senedd under section 145A of the Government of Wales Act 1998 and section 61(3) (b) of the Public Audit Wales Act 2004.

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Mae’r ddogfen hon hefyd ar gael yn Gymraeg

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Summary report

Detailed report

Background

1 This report describes how NHS bodies have supported the wellbeing of their staff during the COVID-19 pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19.

2 It is the second of two publications which draw on the findings of our local structured assessment work with the aim of highlighting key themes, identifying future opportunities, and sharing learning. The first report Doing it differently, doing it right? - describes how NHS bodies revised their arrangements to enable them to govern in a lean, agile, and rigorous manner during the pandemic.

Key messages

3 NHS staff at all levels have shown tremendous resilience, adaptability, and dedication throughout the pandemic. However, they have also experienced significant physical and mental pressures due to the unprecedented challenges caused by the crisis.

4 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic. However, the unprecedent scale and impact of the COVID-19 pandemic brought the importance of supporting staff wellbeing into even sharper focus.

5 As a result, all NHS bodies in Wales placed a strong focus on staff wellbeing throughout the COVID-19 pandemic. At the outset of the crisis, each NHS body moved quickly to enhance their existing employee assistance arrangements and to put additional measures in place to support the physical health and mental wellbeing of their staff, as much as possible, during the pandemic. Key actions taken by NHS bodies to protect staff and support their wellbeing included:

- enhancing infection prevention and control measures;
- reconfiguring healthcare settings;
- facilitating access to COVID-19 tests and, more recently, COVID-19 vaccinations;
- creating dedicated rest spaces;
- increasing mental health and psychological wellbeing provision;
- strengthening staff communication and engagement; and
- enabling remote working.

6 All NHS bodies put arrangements in place to roll out the All-Wales COVID-19 Workforce Risk Assessment Tool (the Risk Assessment Tool) as part of their wider efforts to safeguard members of staff at higher risk from COVID-19. Each NHS body promoted the Risk Assessment Tool in a number of ways. However, Risk Assessment Tool completion rates via the Electronic Staff Record (ESR) have varied considerably between individual NHS bodies. All NHS bodies utilised measures from their wider suite of wellbeing arrangements to meet the individual needs of staff at higher risk from COVID-19 as identified by the Risk Assessment Tool.

7 The boards and committees of most NHS bodies maintained good oversight and ensured effective scrutiny of all relevant staff wellbeing risks and issues during the pandemic. However, arrangements for reporting Risk Assessment Tool completion rates and providing assurance on the quality of completed risk assessments could have been strengthened in most NHS bodies.

8 Whilst the crisis has undoubtedly had a considerable impact on the wellbeing of staff in the short-term, the longer-term impacts cannot and should not be ignored or underestimated. Surveys and work undertaken by a range of professional bodies highlight the increased stress, exhaustion and burnout experienced by staff, and point to the growing risk to staff of developing longer term physical and psychological problems without ongoing support.

9 A continued focus on providing accessible wellbeing support and maintaining staff engagement, therefore, is going to be needed in the short-term to ensure NHS bodies address the ongoing impact of the pandemic on the physical health and mental wellbeing on their staff.

10 However, the COVID-19 pandemic has also created an opportunity to rethink and transform staff wellbeing for the medium to longer term. Whilst supporting the wellbeing of the NHS workforce is more necessary than ever when the service needs to respond to a crisis, investing appropriately in staff wellbeing on an ongoing basis is equally as important as a healthy, engaged, and motivated workforce is essential to the delivery of safe, high-quality, effective, and efficient health and care services.

The resilience and dedication shown by NHS staff at all levels in the face of the unprecedented challenges and pressures presented by the pandemic has been truly remarkable. It is inevitable, however, that this will have taken a considerable toll on the wellbeing of NHS staff, who now also face the challenges of dealing with the pent-up demand in the system caused by COVID-19. It is assuring to see that NHS bodies have maintained a clear focus on staff wellbeing throughout the pandemic and have implemented a wide range of measures to support the physical health and mental wellbeing of their staff during the crisis. It is vital that these activities are built upon and that staff wellbeing remains a central priority for NHS bodies as they deal with the combined challenges of recovering services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures which are expected to be greater this winter than they were last year. Taking care of those who care for others is probably more important now than it has ever been before.

Adrian Crompton
Auditor General for Wales

Recommendations

11 Recommendations arising from this work are detailed in **Exhibits 1** and **2**.

Exhibit 1: recommendations for NHS bodies

Recommendations

Retaining a strong focus on staff wellbeing

R1 NHS bodies should continue to maintain a strong focus on staff wellbeing as they begin to emerge from the pandemic and start to focus on recovering their services. This includes maintaining a strong focus on staff at higher risk from COVID-19. Despite the success of the vaccination programme in Wales, the virus (and variations thereof) continues to circulate in the general population. All NHS bodies, therefore, should continue to roll-out the Risk Assessment Tool to ensure all staff have been risk assessed, and appropriate action is taken to safeguard and support staff identified as being at higher risk from COVID-19.

Considering workforce issues in recovery plans

R2 NHS bodies should ensure their recovery plans are based on a full and thorough consideration of all relevant workforce implications to ensure there is adequate capacity and capability in place to address the challenges and opportunities associated with recovering services. NHS bodies should also ensure they consider the wider legacy issues around staff wellbeing associated with the pandemic response to ensure they have sufficient capacity and capability to maintain safe, effective, and high-quality healthcare in the medium to long term.

Recommendations

Evaluating the effectiveness and impact of the staff wellbeing offer

R3 NHS bodies should seek to reflect on their experiences of supporting staff wellbeing during the pandemic by evaluating fully the effectiveness and impact of their local packages of support in order to: (a) consider what worked well and what did not work so well; (b) understand its impact on staff wellbeing; (c) identify what they would do differently during another crisis; and, (d) establish which services, programmes, initiatives, and approaches introduced during the pandemic should be retained or reshaped to ensure staff continue to be supported throughout the recovery period and beyond. NHS bodies should ensure that staff are fully engaged and involved in the evaluation process.

Enhancing collaborative approaches to supporting staff wellbeing

R4 NHS bodies should, through the National Health and Wellbeing Network and/or other relevant national groups and fora, continue to collaborate to ensure there is adequate capacity and expertise to support specific staff wellbeing requirements in specialist areas, such as psychotherapy, as well as to maximise opportunities to share learning and resources in respect of more general approaches to staff wellbeing.

Recommendations

Providing continued assurance to boards and committees

R5 NHS bodies should continue to provide regular and ongoing assurance to their Boards and relevant committees on all applicable matters relating to staff wellbeing. In doing so, NHS bodies should avoid only providing a general description of the programmes, services, initiatives, and approaches they have in place to support staff wellbeing. They should also provide assurance that these programmes, services, initiatives, and approaches are having the desired effect on staff wellbeing and deliver value for money. Furthermore, all NHS bodies should ensure their Boards maintain effective oversight of key workforce performance indicators – this does not happen in all organisations at present.

Building on local and national staff engagement arrangements

R6 NHS bodies should seek to build on existing local and national workforce engagement arrangements to ensure staff have continued opportunities to highlight their needs and share their views, particularly on issues relating to recovering, restarting, and resetting services. NHS bodies should ensure these arrangements support meaningful engagement with underrepresented staff groups, such as ethnic minority staff.

Exhibit 2: recommendations for the Welsh Government

Recommendations

Evaluating the national staff wellbeing offer

R7 The Welsh Government should undertake an evaluation of the national staff wellbeing services and programmes it commissioned during the pandemic in order to assess their impact and cost-effectiveness. In doing so, the Welsh Government should consider which other national services and programmes should be commissioned (either separately or jointly with NHS bodies) to ensure staff continue to be supported throughout the recovery period and beyond.

Evaluating the All-Wales COVID-19 Workforce Risk Assessment Tool

R8 The Welsh Government should undertake a full evaluation of the All-Wales COVID-19 Workforce Risk Assessment Tool to identify the key lessons that can be learnt in terms of its development, roll-out, and effectiveness. In doing so, the Welsh Government should engage with staff at higher risk from COVID-19 to understand their experiences of using the Risk Assessment Tool, particularly in terms of the extent to which it helped them understand their level of risk and to facilitate a conversation with their managers about the steps that should be taken to support and safeguard them during the pandemic.

Introduction

12 NHS bodies in Wales have faced unprecedented challenges and considerable pressures during the COVID-19 pandemic. Throughout this crisis, NHS bodies have had to balance several different, yet important, needs – the need to ensure sufficient capacity to care for people affected by the virus; the need to maintain essential services safely; the need to safeguard the health and wellbeing of their staff; and the need to maintain good governance. In order to respond to these needs effectively, NHS bodies have been required to plan differently, operate differently, manage their resources differently, and govern differently.

13 Our structured assessment work[1] in 2020 was designed and undertaken in the context of the ongoing pandemic. As a result, we were given a unique opportunity to see how NHS bodies have been adapting and responding to the numerous challenges and pressures presented by the COVID-19 crisis.

14 This report is the second of two publications which draw on the findings of our structured assessment work, and more recent evidence gathering to highlight key themes, identify future opportunities, and share learning both within the NHS and across the public sector in Wales more widely.

15 In our first report – Doing it differently, doing it right? – we discussed the importance of maintaining good governance during a crisis and describe how revised arrangements enabled NHS bodies to govern in a lean, agile, and rigorous manner during the pandemic. We also highlighted the key opportunities for embedding learning and new ways of working in a post-pandemic world.

16 In this report, we discuss the importance of supporting staff wellbeing and describe how NHS bodies have supported the wellbeing of their staff during the pandemic, with a particular focus on their arrangements for safeguarding staff at higher risk from COVID-19. We consider the key lessons that can be drawn from the experiences of NHS bodies of supporting staff wellbeing during the COVID-19 crisis and conclude by highlighting the key challenges and opportunities for the future.

17 Whilst this report draws on the findings of our structured assessment work, it has also been informed by additional evidence gathered from each NHS body as well as information received from the Welsh Government, the British Medical Association (BMA), and the Royal College of Nursing (RCN) in Wales. Furthermore, as this report draws largely on the findings of our structured assessment work, we haven't engaged directly with NHS staff. Instead, we have referenced the findings from surveys undertaken by BMA Wales and others to provide insights into staff experiences during the pandemic.

1 A structured assessment is undertaken in each NHS body to help discharge the Auditor General's statutory requirement, under section 61 of the Public Audit (Wales) Act 2004, to be satisfied they have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources. Individual reports are produced for each NHS body, which are available on our website.

Importance of supporting staff wellbeing

18 The workforce is an essential component of the Welsh healthcare system. The NHS in Wales employs around 88,000 full-time equivalent staff (**Exhibit 3**) and staff costs accounted for 50% of total NHS spending in 2020-21[2].

Exhibit 3: NHS staff by staff group (March 2021)[3]

Staff Group	FTE
Medical and dental staff	7,294
Nursing, midwifery, and health visiting staff	36,027
Administration and estates staff	21,380
Scientific, therapeutic, and technical staff	14,947
Health care assistants and other support staff	5,806
Ambulance staff	2,709
Other non-medical staff	96

Source: StatsWales

2 Total NHS spending in 2020-21 was £9.6 billion, of which £4.8 billion was spent on staff costs. (Source: Audit Wales)

3 General Medical and Dental Practitioners are excluded as they are independent NHS contractors.

19 All NHS bodies in Wales have a statutory duty of care to protect the health and safety of their staff and provide a safe and supportive environment in which to work. However, supporting staff wellbeing is also important for several other reasons:

- **patient outcomes** – there is a strong link between negative staff wellbeing and poor patient outcomes. Research shows that negative staff wellbeing and moderate to high levels of burnout are associated with poor patient safety outcomes[4]. The Francis Inquiry Report into the Mid Staffordshire NHS Foundation Trust also highlighted the association between poor staff wellbeing and lower quality of care[5]. Supporting positive wellbeing at work, therefore, enables NHS bodies to maintain higher levels of patient safety, provide better quality of care, and ensure higher patient satisfaction.
- **organisational outcomes** – there are considerable financial costs associated with poor staff wellbeing. According to Health Education England, the cost of poor mental health in the NHS workforce equates to £1,794 - £2,174 per employee per year[6]. Furthermore, the costs associated with staff absenteeism are significant. The Boorman Review calculated the direct cost of reported absence in the NHS across the UK was around £1.7 billion a year and the indirect cost of employing temporary staff to provide cover was estimated to be £1.45 billion a year[7]. Supporting positive wellbeing at work, therefore, enables NHS bodies to reduce the number of working days lost as a result of poor staff wellbeing and achieve greater cost savings.
- **employee outcomes** – a poor experience at work is associated with negative wellbeing which, in turn, leads to lower staff engagement and motivation, greater workplace stress, higher staff turnover, and poorer patient outcomes. Research shows that staff wellbeing is impacted negatively by a workforce that is overstretched due to absences and vacancies and supplemented by temporary staff[8][9]. Wellbeing is also negatively affected when staff feel undervalued and unsupported in their roles, feel overwhelmed by their workloads, and feel as though they have little control over their work lives[10]. Supporting positive wellbeing at work, therefore, enables NHS bodies to enhance staff engagement and motivation, minimise workplace stress, and retain more of their employees.

4 Hall et al (2016) Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review

5 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

6 Health Education England (2019) NHS Staff and Learners' Mental Wellbeing Commission

7 NHS Health and Wellbeing Review (2009) Interim Report

8 Rafferty et al (2007) Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records

9 Picker (2018) The risks to care quality and staff wellbeing of an NHS system under pressure

10 West and Coia (2018) Caring for doctors, Caring for patients

How health bodies supported staff wellbeing during the pandemic

20 The NHS in Wales was already facing a number of challenges relating to staff wellbeing prior to the pandemic. The results of the 2018 NHS Staff Survey show that 64% of respondents stated they had come to work despite not feeling well enough to perform their duties (compared to 57% in 2016), and 34% stated they had been injured or felt unwell as a result of work-related stress (compared to 28% in 2016). Furthermore, the sickness absence 12-month moving average for the 12 months ending March 2020 was the highest since data started to be collected in 2008.

21 However, the unprecedented scale and impact of the COVID-19 pandemic brought the importance of supporting staff wellbeing into even sharper focus at both a national and local level in order to:

- protect the health of staff by reducing the prevalence of COVID-19 in healthcare settings and minimising their exposure to the virus;
- reduce the risk of staff transmitting the virus to colleagues, patients, family members, and other members of the wider community;
- safeguard vulnerable groups of staff at higher risk from the virus, such as older people, people with underlying health conditions, pregnant women, and people from certain ethnic minority groups;
- support staff to adapt to new ways of working and adjust to different work settings;
- help staff to cope with the challenges, pressures, uncertainties, and stresses associated with the pandemic;
- ensure NHS bodies maintain sufficient staffing levels to sustain essential services and care safely for patients affected by the virus; and
- enable NHS bodies to restart, recover and rebuild services safely, effectively, and efficiently.

22 As a result, all NHS bodies in Wales placed a strong focus on staff wellbeing throughout the crisis in line with their operational plans and Welsh Government guidance[11].

11 WHC/2020/019: Expectations for NHS Health Boards and Trusts to ensure the health and wellbeing of the workforce during the Covid-19 pandemic

23 At the outset of the pandemic, each NHS body moved quickly to plan and deliver local packages of support as part of a wider multi-layered wellbeing offer to staff. The multi-layered offer, which grew and evolved over time, gave staff free access to a range of pan-Wales services and resources, including:

- **SilverCloud** – a digital mental health platform designed to help NHS staff manage feelings of stress, anxiety, and depression.
- **Health for Health Professionals Wales** – a free, confidential service that provides NHS staff, students, and volunteers in Wales with access to various levels of mental health support including self-help, guided self-help, peer support, and virtual face-to-face therapies with accredited specialists.
- **Samaritans Support Line** – a confidential bilingual wellbeing support line for health and social care workers and volunteers in Wales.
- **online wellbeing resources for NHS staff** – Health Education and Improvement Wales (HEIW) worked with key colleagues on the Health and Wellbeing Sub-Group of the national COVID-19 Workforce Cell to curate and make resources and access to specific specialist services available through its Covid-19 Playlist – NHS Wales Staff Wellbeing Covid-19 Resource. The Playlist also signposted staff to the wellbeing resources of their respective Health Boards and Trusts. The Health and Wellbeing Sub-Group has now transitioned into the National Health and Wellbeing Network which receives leadership and programme management support from HEIW.

24 In this section, we briefly describe the measures put in place by NHS bodies in Wales to support staff wellbeing at a local level, including their arrangements for safeguarding staff at higher risk from COVID-19.

Supporting physical and mental wellbeing

25 We found that all NHS bodies enhanced their existing employee assistance programmes and services (such as Occupational Health) and put additional arrangements in place to support the physical health and mental wellbeing of their staff, as much as possible, during the pandemic. For example:

- **enhancing infection prevention and control measures** – all NHS bodies, particularly the Health Boards and relevant Trusts, introduced enhanced infection prevention and control measures such as providing more hand hygiene facilities, supplying personal protective equipment (PPE) in line with national guidance[12], and increasing the frequency of cleaning and decontaminating surfaces, areas, and equipment.

12 The Auditor General for Wales has reported on the provision of PPE in a separate report titled Procuring and Supplying PPE for the COVID-19 Pandemic (April 2021).

- **reconfiguring healthcare settings** – all of the Health Boards and relevant Trusts reconfigured as much of their healthcare settings as possible to segregate COVID-19 and non-COVID-19 care pathways and minimise patient, staff, and visitor movements between areas. However, the design of older buildings made this more challenging in some NHS bodies.
- **facilitating access to COVID-19 tests and COVID-19 vaccinations** – all of the Health Boards and relevant Trusts put arrangements in place to enable frontline staff to access tests for COVID-19 and, more recently, COVID-19 vaccinations in line with JCVI (Joint Committee on Vaccination and Immunisation) guidance[13]. Although some NHS bodies encountered a few challenges facilitating access to COVID-19 testing at the outset of the pandemic due to limited lab capacity, the situation improved gradually over time as lab capacity increased and new rapid-testing technology became more widely available. In terms of vaccinations, overall uptake amongst healthcare workers is extremely high. As of 17 July 2021, 96.3% had received their first dose and 93.2% had received their second dose[14].
- **creating dedicated rest spaces** – most of the Health Boards and relevant Trusts established designated spaces for front-line staff to rest, recuperate, and focus on their welfare. These spaces, which were predominantly based on acute sites, were referred to as 'wellbeing rooms' or 'recharge rooms' in most areas.
- **increasing mental health and psychological wellbeing provision** – all NHS bodies increased the range, availability, and accessibility of their mental health and psychological wellbeing offer to staff. Examples include:
  - providing information and resources to promote self-care, enhance personal resilience, and support staff to adjust to new ways of working;
  - delivering therapeutic programmes, such as mindfulness and arts in health;
  - facilitating access to counselling and talking services to provide support for staff with mental health concerns such as anxiety, stress, and low mood; and
  - investing in specialised provision for members of staff experiencing the adverse effects of trauma and bereavement.

13 The Auditor General for Wales has reported on the provision of COVID-19 testing and the roll-out of COVID-19 vaccinations in two separate reports titled Test, Trace, Protect in Wales: An Overview of Progress to Date (March 2021) and Rollout of the COVID-19 vaccination programme in Wales (June 2021).

14 Source: Public Health Wales Rapid COVID-19 Surveillance

- **strengthening staff communication and engagement** – all NHS bodies strengthened their internal communication arrangements and used a broad range of channels and platforms to convey information and updates to their staff on a regular basis. In addition, all NHS bodies strengthened their staff engagement arrangements during the pandemic. As well as maintaining ongoing engagement with established employment partnerships and staff networks and groups, all NHS bodies surveyed their staff on a regular basis to better understand their needs and experiences as well as to capture their views on various matters, including the effectiveness of the local wellbeing provision.
- **enabling remote working** – all NHS bodies put arrangements in place to support remote working as part of their wider efforts to ensure and maintain physical distancing, for those staff for whom home working was appropriate. Although some NHS bodies encountered a few challenges rolling-out the necessary technology and software required to support remote working at the outset of the pandemic, these were overcome relatively quickly.
- **providing other forms of support** – a range of other support measures were implemented by NHS bodies, such as:
  - rolling out risk assessment tools, such as Stress Risk Assessment Tools and the All-Wales COVID-19 Workforce Risk Assessment Tool (this is discussed in more detail in the next section);
  - providing additional information and support to leaders and managers to enable them to engage, motivate, and support their teams effectively during the pandemic;
  - providing temporary accommodation for front-line staff living with individuals at higher risk from COVID-19; and
  - enhancing Chaplaincy services to ensure staff have access to pastoral support.

Detailed examples of health and wellbeing initiatives introduced by each NHS body during the pandemic are provided in the briefing produced by Welsh NHS Confederation titled Supporting Welsh NHS staff wellbeing throughout COVID-19.

26 The BMA has surveyed its members extensively during the pandemic. Whilst the results are not representative of the NHS workforce as a whole, they do provide useful insights into the experiences of medical staff during the crisis:

- BMA members responding to the surveys felt better protected from coronavirus in their place of work as the pandemic progressed. The proportion of members stating they felt fully protected was 27% (113 of 417) and 37% (100 of 274) in December 2020 and April 2021 respectively. The proportion of members stating they didn't feel protected at all was 11% (47 of 417) and 6% (16 of 274) in December 2020 and April 2021 respectively.
- A considerable number of BMA members responding to the surveys accessed wellbeing support services (provided by either their employer or a third party) during the pandemic – 43% (117 of 407) in May 2020, 38% (120 of 314) in July, and 38% (95 of 253) in August 2020. However, when asked if they knew how to access wellbeing/occupational health support if they required them, 45% (126 of 279) stated in April 2021 they either didn't know how to access these services or weren't aware what services exist.

27 Whilst it has been positive to see so many initiatives being developed and rolled-out during the pandemic, there is evidence to suggest that some staff experienced difficulties navigating their way around the plethora of initiatives to identify the ones that would best meet their needs. In light of this, the Welsh Government recently announced it would be launching a prototype Workforce Wellbeing Conversation Framework Tool to support NHS staff to pro-actively talk openly and honestly with their managers about their ongoing wellbeing needs and to sign-post them to the support available where appropriate[15]. Whilst this is a positive development, NHS bodies should also continue to engage with their staff to better understand their experiences of seeking and accessing support and adapt and improve their arrangements as necessary.

Safeguarding staff at higher risk from COVID-19

28 All NHS bodies put arrangements in place to roll out the All-Wales COVID-19 Workforce Risk Assessment Tool (the Risk Assessment Tool) as part of their wider efforts to safeguard members of staff at higher risk of developing more serious symptoms if they come into contact with the COVID-19 virus[16].

15 Written Statement - Minister for Health and Social Services (21 July 2021)

16 The Risk Assessment Tool, which was launched in May 2020, was developed by a multi-disciplinary sub-group reporting to an Expert Advisory Group established by Welsh Government. All NHS bodies were using other risk assessments tools prior to the roll-out of the national tool.

29 The Risk Assessment Tool is based on a large and growing body of data and research which shows that an individual is at higher risk from COVID-19 if they have a combination of the following risk factors:

- they are over the age of 50 (the risk is further increased for those aged over 60 and 70 years old);
- they were born male at birth;
- they are from certain ethnic minority groups;
- they have certain underlying health conditions (the risk very high for the clinically extremely vulnerable);
- they are overweight; and
- their family history makes them more susceptible to COVID-19.

30 The risk assessment process is completed in a number of stages with the aim of encouraging a supportive and honest conversation between a member of staff and their line-manager/employer around the measures that should be put in place to ensure they are adequately safeguarded and supported. The process is summarised in **Exhibit 4**.

31 We found that NHS bodies promoted the Risk Assessment Tool in a number of ways and put a range of measures in place to encourage and support their staff to complete it. The following arrangements and approaches were considered particularly important by NHS bodies:

- **senior management support** – strong and visible support for the Risk Assessment Tool by senior managers was considered important in terms of reassuring staff that the organisation was committed to the risk assessment process and supporting staff at higher risk from COVID-19.
- **utilising workforce data** – analysing and utilising workforce data was considered important in terms of identifying staff potentially at higher risk from COVID-19, planning appropriate packages of support, and facilitating targeted messaging around the importance of completing the risk assessment process. However, several NHS bodies told us they had concerns about the robustness of Electronic Staff Record (ESR) data.
- **support for line-managers** – ongoing information, advice, and support for line-managers, particularly from HR Officers/Business Partners, was considered important not only to help them fully understand their role in the risk assessment process but also to enable them to support their direct reports in a compassionate and supportive manner.

Exhibit 4: COVID-19 workforce risk assessment process

Step 1 – Checking risk	Member of staff completes the Risk Assessment Tool to check which risks apply to them.
Step 2 – Understanding the score	Member of staff calculates their score in order to understand the likely level of risk to them personally (low, high, or very high).
Step 3 – Identifying the right action	Member of staff discusses their score and other relevant factors with their line-manager (especially if they are in the high or very high-risk category) in order to identify the actions they can take personally and/or the support their employer can provide to ensure they are adequately protected.
Step 4 –Taking the right action	Agreed actions are implemented by the member of staff and/or their employer and reviewed on an ongoing basis to ensure they remain relevant and appropriate.

Source: All Wales COVID-19 Workforce Risk Assessment Tool Guidance for Managers and Staff (February 2021)

- **occupational health input** – information, advice, and support from occupational health practitioners was considered important for both line-managers and staff alike. Occupational health input was considered particularly important for members of staff with underlying health conditions who were not required to shield or who were returning to work after a period of shielding to ensure their needs were assessed and addressed appropriately.
- **joint working with staff networks and employment partnerships** – ongoing communication and joint working with established networks, employment partnerships, and individual Trades Unions was considered important for several reasons. Firstly, they were able to use their insights to advise NHS bodies on local approaches to rolling-out the Risk Assessment Tool and supporting staff wellbeing. Secondly, they played an important role in encouraging their members to complete the Risk Assessment Tool. Thirdly, they supported individual members of staff to complete the Risk Assessment Tool and, in some cases, provided advocacy and mediation for and on behalf of their members.

- **identifying staff champions** – identifying and utilising staff champions was considered important to provide encouragement, support, and reassurance to particular groups of staff at higher risk. Indeed, staff champions proved to be particularly important in NHS bodies that did not have the relevant staff networks in place. In these bodies, staff champions were used to reach-out and support individuals and groups of staff that were unaware they were potentially at higher risk as they didn't or couldn't access the relevant information and/or they were sceptical and/or anxious about engaging with the risk assessment process.

32 Over 62,000 risk assessments were completed via ESR and the Learning@Wales platform across the NHS in Wales between June 2020 and April 2021[17]. Staff had to complete paper versions of the Risk Assessment Tool prior to its roll-out via ESR in June 2020. In October 2020, the Welsh Government asked NHS bodies to request all staff to complete the Risk Assessment Tool via ESR. Completion rates via ESR in individual NHS bodies are shown in **Exhibit 5**.

33 As **Exhibit 5** shows, there is considerable variation in completion rates via ESR. There are several reasons for this:

- completing the Risk Assessment Tool via ESR has not been mandated by all NHS bodies such as Cardiff & Vale and Swansea Bay University Health Boards;
- staff in some NHS bodies that completed the paper-based Risk Assessment Tool when it was first rolled-out in May were not asked to repeat the assessment when it became available in ESR in June 2020;
- some staff are unable to access their ESR as they either work in roles that do not require the use of a computer or they do not have general access to a computer at their place of work;
- most NHS bodies have placed a greater focus on encouraging staff at higher risk to complete the Risk Assessment Tool rather than the workforce as a whole; and
- evidence from the member surveys undertaken by the BMA suggests that some staff were unaware of any risk assessment at their place of work or had been told explicitly they did not need to be assessed[18].

17 58,552 risk assessments have been completed via ESR and 3,770 have been completed via Learning@Wales between 15 June 2020 and 8 April 2021. Individuals that have completed the Risk Assessment Tool more than once via the ESR are counted more than once in the data. (Source: NHS Wales Shared Services Partnership)

18 The BMA asked its members: 'Have you been risk assessed in your place of work to test if you might be at increased risk from contact with Coronavirus patients in your current role?' The proportion that stated they were not aware of any risk assessment in their place of work was 33% (70 of 211) and 35% (61 of 175) in July and August 2020 respectively. The proportion that stated they had been told explicitly they did not need to be assessed was 7% (15 of 211) and 6% (11 of 175) in July and August 2020 respectively.

Exhibit 5: completion rates as recorded in ESR by NHS body

NHS Body	Number of recorded assessments	% of staff with a completed assessment
Aneurin Bevan University Health Board	3,071	24%
Betsi Cadwaladr University Health Board	19,195	52%
Cardiff & Vale University Health Board	857	5%
Cwm Taf Morgannwg University Health Board	15,487	58%
Health Education and Improvement Wales	134	29%
Hywel Dda University Health Board	6,965	48%
Powys Teaching Health Board	1,789	48%
Public Health Wales	1,019	73%
Swansea Bay University Health Board	174	2%
Velindre NHS Trust	6,716	81%
Welsh Ambulance Services Trust	3,145	67%

Source: NHS Wales Shared Services Partnership (15 June 2020 - 8 April 2021)

34 Whilst low completion rates via ESR does not necessarily equate to low use of the tool, it is difficult to know how many staff across the NHS in Wales have actually completed the Risk Assessment Tool due to the variable data collection and monitoring arrangements introduced by NHS bodies when it was launched.

35 We found that all NHS bodies adopted the ‘hierarchy of control’ approach to protect and support staff at higher risk from COVID-19. Under this approach, NHS bodies identified and utilised the most suitable measures from their wider suite of wellbeing arrangements to meet the individual needs of members of staff as identified through the Risk Assessment Tool.

These measures included:

- **engineering and administrative controls** – all NHS bodies put a range of engineering and administrative controls in place to safeguard staff at higher risk who were unable to work from home because of their role, and to support staff at higher risk returning to the workplace after a period of shielding. These included creating 'COVID-19 secure settings' (areas that posed a lower level of risk) by segregating COVID-19 and non-COVID-19 care pathways; staggering shift start and end times to reduce congestion; recalling staff on a rotational basis to limit the number of people in the workplace; and offering a phased return to the workplace.
- **personal protective equipment (PPE)** – PPE was provided in line with agreed guidelines to reduce or remove any residual risk to staff not eliminated by other measures. As stated in the Auditor General's report titled Procuring and Supplying PPE for the COVID-19 Pandemic, Shared Services, in collaboration with other public services, overcame early challenges to provide health and care bodies with the PPE required by guidance without running out of stock at a national level. However, the report also acknowledges that some frontline staff have reported that they experienced shortages of PPE and some felt they should have had a higher grade of PPE than required by guidance.
- **substitution measures** – working from home was not considered a viable option for all members of staff at higher risk. For some members of staff, such as those living with an abusive partner, working from home could potentially have had a greater negative impact on their overall health and wellbeing. As a result, NHS bodies put arrangements in place to enable and support staff in these situations to work in 'COVID-19 secure settings'. For members of staff unable to perform their normal duties from home due to the nature of the work, NHS bodies put arrangements in place to enable them to work in 'COVID-19 secure settings' or to be redeployed to other suitable roles which they could undertake either from home or in 'COVID-19 secure settings' with additional support, such as retraining.
- **elimination measures** – all NHS bodies put arrangements in place to enable and support the majority of staff at higher risk to work from home, particularly during official periods of shielding. Most staff at higher risk were also supported to continue working from home when shielding periods ended if this was considered appropriate and safe to do so, and if the arrangement worked effectively for both the employer and employee.

36 All NHS bodies also encouraged and supported staff at higher risk to access mental health and psychological wellbeing services to help them adjust to new ways of working and/or manage any anxieties or worries they experienced. Detailed guidance was also provided to line-managers on how to provide effective support to staff at higher risk during the pandemic. As NHS bodies move towards the recovery period, they should continue to engage with staff at higher risk to evaluate the impact of the support and interventions they are providing and amend or improve their arrangements as necessary.

37 We found that there are a number of advantages and disadvantages to the Risk Assessment Tool, as follows:

Advantages of the Risk Assessment Tool

- the tool has ensured consistency, reduced variability, and facilitated the sharing of learning across the NHS;
- the format of the tool is simple, easy to use, and enables staff to focus on the main factors which may place them at greater risk;
- the tool helps managers appreciate the importance of addressing risks to staff in a timely and sensitive manner as well as the importance of being a compassionate and supportive manager;
- the process, if done correctly, provides reassurance to staff and gives assurance to managers and leaders that staff risks are being managed appropriately;
- the tool has galvanised organisations into adopting holistic approaches to managing staff risks; and
- the tool has generated a greater awareness and understanding of the needs of certain groups of staff, particularly those underrepresented within existing organisational structures.

Disadvantages of the Risk Assessment Tool

- the tool has made some staff feel ‘targeted’ or ‘singled out’ for special treatment;
- there have been some concerns about the use of the acronym BAME (Black, Asian, and Minority Ethnic) in the tool because it places a greater emphasis on certain ethnic minority groups (Asian and Black) and exclude others (Mixed, Other and White ethnic minority groups);
- there have been some concerns that the tool’s scoring matrix does not give sufficient weighting to certain risk factors, such as ethnicity and Type 1 diabetes;
- the tool and process have been seen and treated as a ‘tick box exercise’ by a small number of managers and members of staff; that is, the tool was completed to maintain compliance, but no real action was taken in response to the score;

- the tool does not pick-up the whole picture in one place for all staff, particularly those required to complete other risk assessments (eg stress risk assessment); and
- the ongoing development and evolution of the tool has led to a sense of 'risk assessment fatigue' amongst some members of staff.

Maintaining oversight of staff wellbeing arrangements

38 At an operational level, we found that all NHS bodies had staff wellbeing planning cells/groups in place as part of their emergency command and control structures with responsibility for planning and overseeing the delivery of local staff wellbeing provision. These planning cells/groups were tasked with working with other relevant cells/groups, such as those with responsibility for PPE and staff communication and engagement, to ensure a co-ordinated approach to supporting staff wellbeing.

39 These planning cells/groups were also responsible for monitoring COVID-19 workforce related risks and indicators and escalating key concerns and issues to the relevant group(s) within the emergency command structure as appropriate. Whilst the majority of these planning cells/groups monitored similar indicators, such as absence rates due to illness or shielding, we found that only a small number were actively monitoring risk assessment completion rates. Furthermore, we found that only NHS body had arrangements in place at an operational level to assess and monitor the quality of completed risk assessments.

40 At a corporate level, we saw evidence in most NHS bodies of good flows of information to boards and committees to provide assurance and enable effective oversight and scrutiny of all relevant staff wellbeing risks and issues during the pandemic. However, we found there was scope across most NHS bodies to strengthen the arrangements for reporting risk assessment completion rates and providing greater assurances to boards and committees around the quality of completed risk assessments.

41 We found that the crisis generated a greater awareness at board-level in all NHS bodies around the importance of supporting staff wellbeing and, in particular, the importance of understanding and addressing the needs of particular groups of staff. In some NHS bodies, this led to the creation of new staff networks and advisory groups for specific groups of staff which have traditionally been underrepresented within existing corporate structures. However, one Health Board has taken this further by establishing an Advisory Group for staff from ethnic minority groups as a formal sub-group of the board to ensure a stronger voice and involvement within the organisation for black, Asian, and minority ethnic staff. Although the Advisory Group reports formally via the Health Board's Chair, the Advisory Group's Chair and Vice-Chair are invited to attend all board meetings.

Key challenges and opportunities for the future

42 NHS staff at all levels have shown tremendous resilience, adaptability, and dedication throughout the pandemic. However, they have also experienced significant physical and mental pressures due to the unprecedented challenges presented by the crisis, including:

- working longer hours and managing greater workloads;
- operating in rapidly changing, demanding, and intensive environments;
- managing fears, concerns, and anxieties about the risks to their own health as well as the risks to the health of their loved ones;
- seeing patients, colleagues and/or family and friends falling seriously ill or even dying with COVID-19;
- contracting COVID-19, and, for some, managing the longer-term effects of the virus (long-COVID);
- adjusting to new ways of working and, in some cases, adjusting to different roles;
- dealing with the resulting impact of shielding or working from home in terms of feeling isolated and alone and/or feeling guilty about not being able to support colleagues on the front-line; and
- adapting to wider social restrictions and managing their associated impacts, such as delivering home schooling, and providing enhanced care for elderly or vulnerable relatives.

43 The crisis has undoubtedly had a considerable impact on the wellbeing of staff. For example, surveys undertaken by RCN Wales, whilst not representative of the NHS workforce as a whole, highlight the impact of the pandemic on staff wellbeing. The results of the survey undertaken in June 2020, which received 2,011 responses, found:

- 75.9% stated their stress levels had increased since the beginning of the pandemic;
- 58.4% stated that staff morale had worsened since the beginning of the pandemic; and
- 52% stated they either strongly agreed or agreed with the statement ‘I am worried about my mental health’.

44 However, the longer-term impacts cannot and should not be ignored or underestimated. Indeed, the surveys undertaken by the BMA, whilst not representative of the NHS workforce as a whole, point to some of the challenges that remain in relation to staff wellbeing:

- in April 2021, 45% (126 of 279) of members stated they were suffering from depression, anxiety, stress, burnout, emotional distress, or other mental health conditions relating to or made worse by their place of work or study compared with 40% (298 of 735) in April 2020.

- in April 2021, 33% (92 of 279) of members stated their symptoms were worse than before the start of the pandemic compared with 25% (185 of 735) in April 2020.
- in April 2021, 36% (72 of 281) of members stated their current levels of health and wellbeing were slightly worse or much worse compared with that during the first wave between March and May 2020. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 43% (205 of 480) and 48% (224 of 467) respectively.
- on a scale of one to five (where 1 equalled very low/negative, and 5 equalled very high/positive), 32% (74 of 229) of members scored their morale as either a 1 or 2 in April 2021. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 45% (203 of 454) and 47% (195 of 402) respectively.
- in April 2021, 56% (157 of 282) of members stated their current level of fatigue or exhaustion was higher than normal from working or studying during the pandemic. However, it should be noted that this is an improvement when compared with the results in October and December 2020, namely 60% (286 of 480) and 64% (297 of 467) respectively.

45 Surveys and work undertaken by other professional bodies also highlight the increased stress, exhaustion, and burnout experienced by staff. They also point to the increased risk to staff of developing longer term physical and psychological problems without ongoing support and opportunities for proper rest and recuperation.

46 Trends in sickness absence rates also point to some of the challenges that NHS bodies have faced during the crisis. After a gradual fall during 2015 to 2017, the sickness absence 12-month moving average has been rising and was 6.0% over the last year, mainly due to an increase from the April to June 2020 quarter during the pandemic. For the quarter ending 31 December 2020[19]:

- the sickness absence rate was 6.4%, up 1.3 percentage points compared to the quarter ending 30 September 2020.
- the NHS bodies with the highest sickness rates were Cwm Taf Morgannwg University Health Board at 8.5%, Welsh Ambulance Services NHS Trust at 8.4%, and Swansea Bay University Health Board at 8.3% (compared with 5.6%, 5.9%, and 6.2% respectively for the quarter ending 30 September 2020).

19 Source: StatsWales

- the staff groups with the highest sickness absence rates were the Ambulance staff group at 9.6%, the Healthcare Assistants and Support Workers staff group at 9.2%, and the Nursing, Midwifery and Health Visiting staff group at 8.1% (compared with 6.2%, 7.4%, and 6.5% respectively for the quarter ending 30 September 2020).

47 In the short-term, NHS bodies will face challenges in terms of managing seasonable absences which tend to be higher in the winter months as well as dealing with absences caused by staff requiring to self-isolate by the Test, Trace, Protect Service. However, they will also potentially face future challenges in terms of managing absence rates attributed to the longer-term physical and mental conditions caused by the pandemic unless they maintain and build upon their staff wellbeing arrangements.

48 The COVID-19 pandemic has undoubtedly brought staff wellbeing into sharper focus at both a national and local level. It has also shown that NHS bodies can respond rapidly and effectively to the challenges and pressures presented by a crisis. However, there is no doubt that the NHS workforce in Wales, which was already under pressure prior to the pandemic, is more emotionally and physically exhausted than ever before after the significant and unprecedented efforts of the last 18 months.

49 A continued focus on providing accessible wellbeing support and services and maintaining staff engagement, therefore, is going to be needed in the short-term to ensure NHS bodies address the ongoing impact of the pandemic on the physical health and mental wellbeing on their staff. Without such a focus, there is a risk the impact of the pandemic on the physical and mental health of staff will grow which could, in turn, compromise the ability of NHS bodies to deal effectively with the combined challenges of recovering and restarting services, continuing to respond to the COVID-19 pandemic, and also managing seasonal pressures which are expected to be greater this winter than they were last year.

50 However, the COVID-19 pandemic has also created an opportunity to rethink and transform staff wellbeing for the medium to longer term. Whilst supporting the wellbeing of the NHS workforce is more necessary than ever when the service needs to respond to a crisis, investing appropriately in staff wellbeing on an ongoing basis is equally as important as a healthy, engaged, and motivated workforce is essential to the delivery of safe, high-quality, effective, and efficient health and care services.

51 We have prepared a checklist to accompany this report which sets out some of the questions NHS Board Members should be asking to obtain assurance that their respective health bodies have effective, efficient, and robust arrangements in place to support the wellbeing of their staff.

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A Picture of Healthcare

Report of the Auditor General for Wales

October 2021

This report has been prepared for presentation to the Senedd under the Government of Wales Act 1998

The Auditor General is independent of the Senedd and government. He examines and certifies the accounts of the Welsh Government and its sponsored and related public bodies, including NHS bodies. He also has the power to report to the Senedd on the economy, efficiency and effectiveness with which those organisations have used, and may improve the use of, their resources in discharging their functions.

The Auditor General also audits local government bodies in Wales, conducts local government value for money studies and inspects for compliance with the requirements of the Local Government (Wales) Measure 2009.

The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg.

Contents

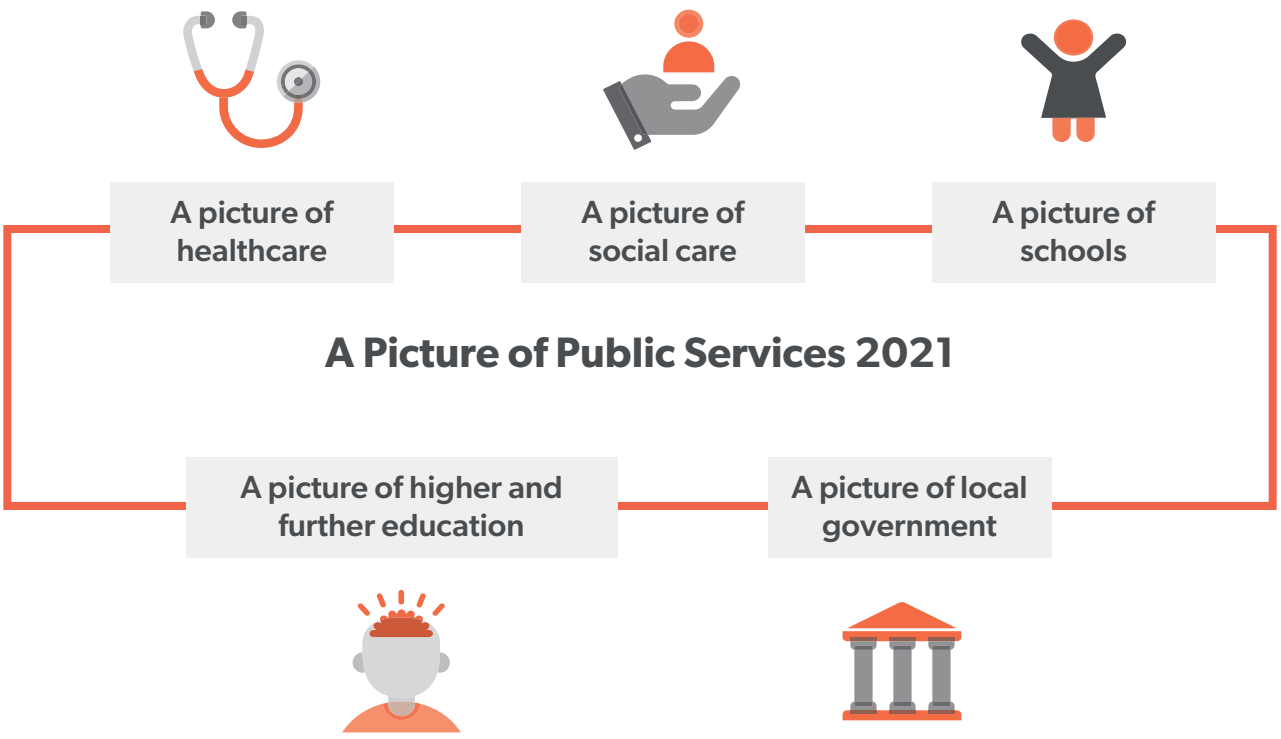
About this report

This report is part of a series of Picture of Public Services 2021 outputs. Our main Picture of Public Services 2021 report summarises some of the key trends in public finances and sets out our perspective on some of the key issues for future service delivery.

This report: A picture of healthcare summarises key information about healthcare in Wales including the strategic operating context, funding, performance and capacity. Healthcare is a hugely complex sector with specific issues affecting different parts of the system. This report is not intended to be comprehensive. It sets out what we consider to be some of the key issues for healthcare, recognising that other review bodies and commentators will have their own perspective on the key issues.

The report is based on a synthesis of our published work as well as research by other organisations.

Exhibit 1: Picture of Public Services outputs



Main report

Healthcare context

Delivering healthcare in challenging times

1 The COVID-19 pandemic has presented enormous challenges to public services and the people who deliver them. Some services were delivered differently, and others were paused. Staff had to adapt to new ways of working and many were redeployed to support the COVID-19 response. All of us at Audit Wales pay tribute to the dedication and extraordinary efforts of public servants during this difficult period.

2 At the time this report was written, the direct impacts of COVID-19 were still being felt. COVID-19 patients were still being admitted to hospitals and health bodies were trying to restart and recover their services. Work to understand the indirect impacts of COVID-19 had begun, but it was too early to gauge the scale and extent of these impacts.

3 The challenge of recovering services and addressing the indirect impact of COVID-19 will likely continue for years into the future. The problem is compounded by the fact that some healthcare services were already stretched before the pandemic. More immediately, health bodies continue to respond to the direct impact of COVID-19, operating within infection prevention control measures which limit physical capacity.

4 Despite the significant challenges ahead, there are opportunities to rebuild and deliver services differently, putting people at the centre of services, and learning from the collective response to COVID-19.

Structures and responsibilities

5 The Welsh Government sets the overall policy and strategic direction for NHS Wales. Healthcare services are delivered through seven local health boards, three NHS trusts[1] and two special health authorities[2]. Health boards are responsible for the health and well-being of their local population which includes primary, community and secondary care services. The trusts are responsible for the ambulance service, public health, blood and non-surgical cancer services for parts of Wales.

6 In Wales, health boards are both providers and commissioners of services. They have contracts with dental and GP practices, optometry providers and pharmacies to deliver local services. Health bodies and the Welsh Government have worked together to establish collaborative commissioning arrangements, including via the Emergency Ambulance Services Committee, Welsh Health Specialised Services Committee and NHS Wales Shared Services Partnership. The Welsh Government's website explains the responsibilities of each organisation including other bodies that make up NHS Wales.

1 Public Health Wales, Velindre University, and Welsh Ambulance Service NHS Trusts.

2 Digital Health and Care Wales, and Health and Education Improvement Wales.

Healthcare strategy

Overall approach

7 The Welsh Government's strategic approach has evolved to focus on joining up health and social care and the vision of prudent healthcare. For the Welsh Government, prudent healthcare[3] is about patients co-producing services with professionals based on what matters to them; prioritising people with the greatest health need first; avoiding unnecessary medical procedures; and reducing inappropriate variation by using evidence-based practices consistently.

8 The Welsh Government built on the prudent healthcare principles in its ten-year plan for health and social care: A Healthier Wales (2018). The plan aimed to create a 'whole system' approach to health and social care based on shared values and shift that system towards preventing illness, and promoting health and well-being. It intended digital technology to support transformation including sharing information between health and social care via the Welsh Community Care Information System. A Healthier Wales recognised the need to transform services by scaling up local innovation at pace. The Welsh Government set up a national Transformation Programme responsible for delivering the commitments in the plan.

9 Following the election, the Welsh Government published its new programme for government[4] in June 2021. It included a specific well-being objective to create effective, high quality and sustainable healthcare. The programme for government provides more detail on how the Welsh Government intends to achieve its ambition including providing treatments which were delayed by the pandemic, improving patients' access to health professionals, and prioritising investment in mental health. Among other things, it also intends to reform primary care by bringing together GP services with pharmacy, therapy, housing, social care, mental health, community and the third sector.

3 The Welsh Government issued guidance on using prudent healthcare to improve services to health bodies in 2016.

4 Welsh Government, Programme for Government 2021 to 2026, June 2021

NHS planning requirements

10 The NHS Finance (Wales) Act 2014 requires health bodies in Wales to break even over a rolling three-year period. Health bodies must also have a three-year Integrated Medium Term Plan (IMTP) setting out how they will deliver services with the funding available.

11 The NHS Planning Framework sets out the Welsh Government's requirements and guidance for health bodies. The Welsh Government published a National IMTP for 2019-22 which brings together health bodies' IMTPs and explains how they are responding to national priorities. The Welsh Government sets out targets for health bodies in its NHS Delivery Framework and issues guidance for reporting against the Framework.

12 The Well-being of Future Generations (Wales) Act 2015 places a well-being duty on health boards and two of the three NHS trusts to set and publish well-being objectives. The duty requires the relevant bodies to carry out sustainable development by considering five ways of working: long-term; prevention; integration; collaboration, and involvement.

13 The Act established statutory Public Services Boards, of which local health boards are a member. NHS trusts are not statutory members of the Boards but work with them and other partners to plan and deliver services. Public Services Boards must undertake a local well-being assessment every five years, using local and national data to understand local need. The assessment informs a local well-being plan setting out the Public Services Boards' well-being objectives and the steps it will take to meet them.

14 The Social Services and Well-being (Wales) Act 2014 also requires health boards to work with councils in Regional Partnership Boards to assess the care and support needs in their area and identify what services are needed.

COVID-19 and beyond

15 In March 2020, the Welsh Government worked with NHS Wales to prepare for COVID-19. It relaxed targets and monitoring arrangements, provided emergency funding, and agreed with health bodies essential services to be maintained, and non-urgent activity to be paused[5]. The Welsh Government also told health bodies to work on a quarterly, six monthly, and then annual plans rather than three-year planning cycle. It also paused the requirement for health bodies to have a three-year IMTP. Since summer 2020, health bodies have been re-starting non-urgent activity where possible. Some stopped non-urgent activity again in the autumn of 2020 as infection rates rose.

16 Since 2020, the Welsh Government has worked with health boards, principal councils[6], Public Health Wales and other partners to provide Test, Trace, Protect[7] services. More recently, it has worked with Digital Health and Care Wales, health boards, Public Health Wales, NHS Shared Services, the Welsh Blood Service and other public and voluntary sector partners to deliver the COVID-19 vaccination programme[8].

17 In 2021, the Welsh Government expects NHS Wales to address the direct and indirect harms associated with COVID-19. Its Annual Planning Framework 2021-22[9] instructs health bodies to deliver services to prevent the 'four harms' (**Exhibit 2**). The Framework requires health bodies to balance their COVID-19 response with recovery planning.

5 Based on guidance in the World Health Organisation Essential Services Framework.

6 Principal councils are local government authorities in Wales which carry out statutory duties in their area. The term does not include town or community councils. All references to councils in this report refer to principal councils.

7 Auditor General for Wales, Test, Trace, Protect in Wales: An Overview of Progress to Date, March 2021

8 Auditor General for Wales, Rollout of the COVID-19 Vaccination Programme in Wales, June 2021

9 The Welsh Government's quarterly planning guidance for quarters 2, 3 and 4 for 2020-21 also required health bodies to set out how they would prevent the four harms.

Exhibit 2: the four harms

Source: NHS Wales Annual Planning Framework

18 The Welsh Government published an over-arching vision[10] for recovering health and social care in March 2021. The document sets out the Welsh Government's priorities for health and social care as it looks towards recovery including:

- continued delivery of Test, Trace, Protect and the vaccination programme;
- addressing the impact of COVID-19 on the health and social care workforce and wider population;
- developing responsive primary and community care;
- developing supportive mental health services;
- delivering efficient and effective hospital services;
- developing a resilient workforce; and
- delivering a digital transformation programme in 2021.

19 The visioning document for health and social care includes specific priorities for planned care, cancer care, diagnostics, and social care. It also identifies opportunities to deliver services differently, particularly building on stronger use of technology and collaboration to respond to COVID-19. In May 2021, the Welsh Government committed to spend £1 billion to support its recovery plan. The Welsh Government has allocated £100 million of initial funding to fund immediate actions in its plan. Health boards have submitted plans to the Welsh Government setting out how they intend to use their share of the initial funding.

10 The Welsh Government, Health and Social Care in Wales – COVID-19: Looking Forward, March 2021

20 In March 2021, the Welsh Government published its National Clinical Framework. The Framework sets out planning and delivery arrangements for clinical services but also provides more detail on the Welsh Government's plans to set up an NHS Executive. It describes the future NHS Executive as a 'central guiding hand' over clinical services. In time, the Executive will incorporate existing national networks, programmes and support units.

Healthcare finances

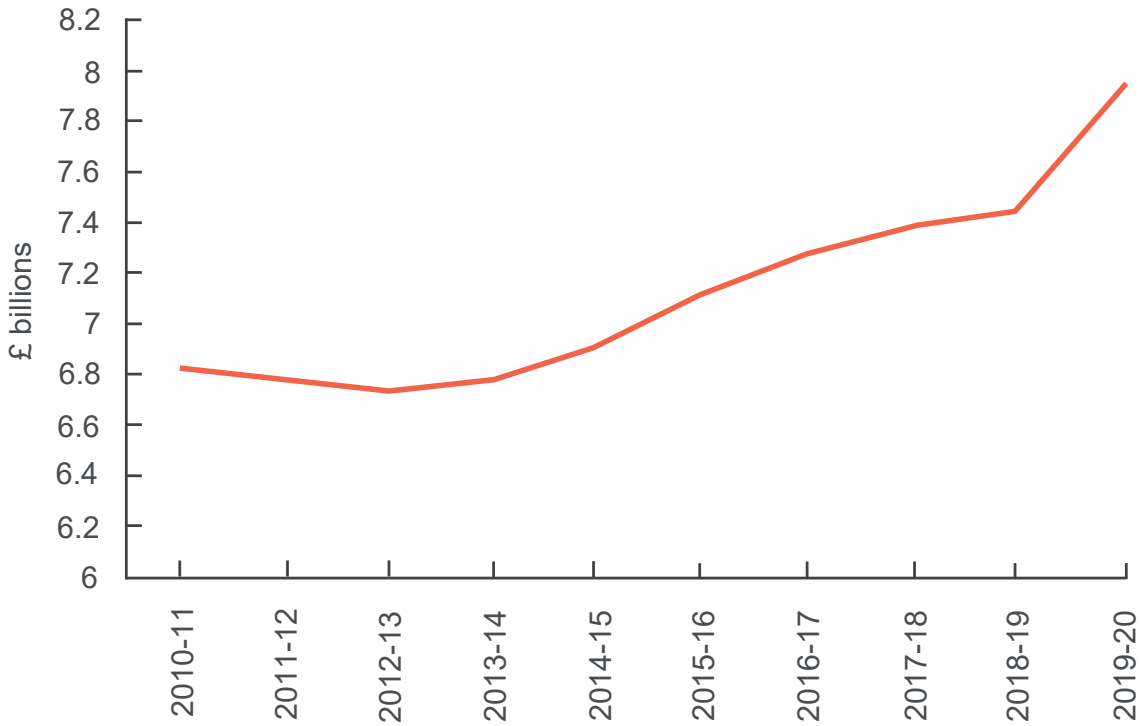
21 The Welsh Government sets the budget for health bodies in Wales. Our Guide to Welsh Public Finances[11] explains how the Welsh Government allocates funding and key issues for public bodies in setting their budgets.

22 The Welsh Government's budget for the day to day running of NHS services rose to almost £8 billion in 2019-20 – a real terms[12] increase of 16% since 2010-11 (**Exhibit 3**). In 2020-21, the health revenue budget increased by around £1.6 billion (a 13% increase in real terms), mostly due to extra funding to support the response to COVID-19. In early September, the UK Government announced additional funding for health and social care, which is expected to result in around £700 million extra annual funding for Wales by 2024-25, comprising UK-wide spending as well as funding through the Barnett formula.

11 Auditor General for Wales, Guide to Welsh Public Finances, July 2018

12 Real terms figures are adjusted to take account of inflation.

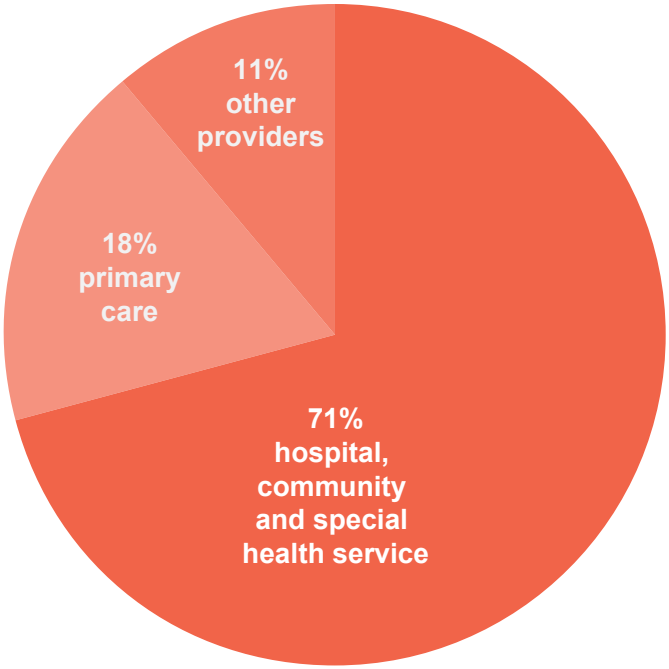
Exhibit 3: health revenue funding in real terms 2010-11 to 2019-20 (2019-20 prices)



Source: Audit Wales NHS Finances Data Tool

23 In 2019-20, almost three quarters of health revenue spending went on hospital, community and special health services (**Exhibit 4**).

Exhibit 4: health revenue spending by category 2019-20



Note: Hospital, Community and Special Health Services relates to spending on healthcare services that are provided in hospital, and a wide range of community services such as district nursing. Primary Care relates to spending on services provided by dentists, GPs, optometrists, pharmacists and other health professionals. Healthcare from other providers relates to spending on healthcare services provided by other organisations, not NHS Wales.

Source: NHS (Wales) Summarised Accounts Local Health Boards, NHS Trusts and Special Health Authority in Wales 2019-20

24 Despite increasing budgets, some health bodies have consistently failed to meet their financial duty to break even. Prior to the pandemic some were carrying large deficits. Our interactive data tool includes detailed information on NHS finances including spending on COVID-19. In July 2020, the Minister for Health and Social Services announced that to support COVID-19 recovery, the Welsh Government would write off £470 million of debt some health boards had amassed after failing to operate within their budgets.

25 Independent reviews in 2014 and 2016[13] showed that the NHS faces cost pressures of around 3 to 4% each year on top of inflation. Between 2010-11 and 2019-20, funding for the NHS increased by an average of 1.7% a year, in real terms. These demand and cost pressures are part of the story that explains why, despite increased funding, the NHS has had to improve productivity and deliver cost savings each year and some health boards have struggled to live within their means.

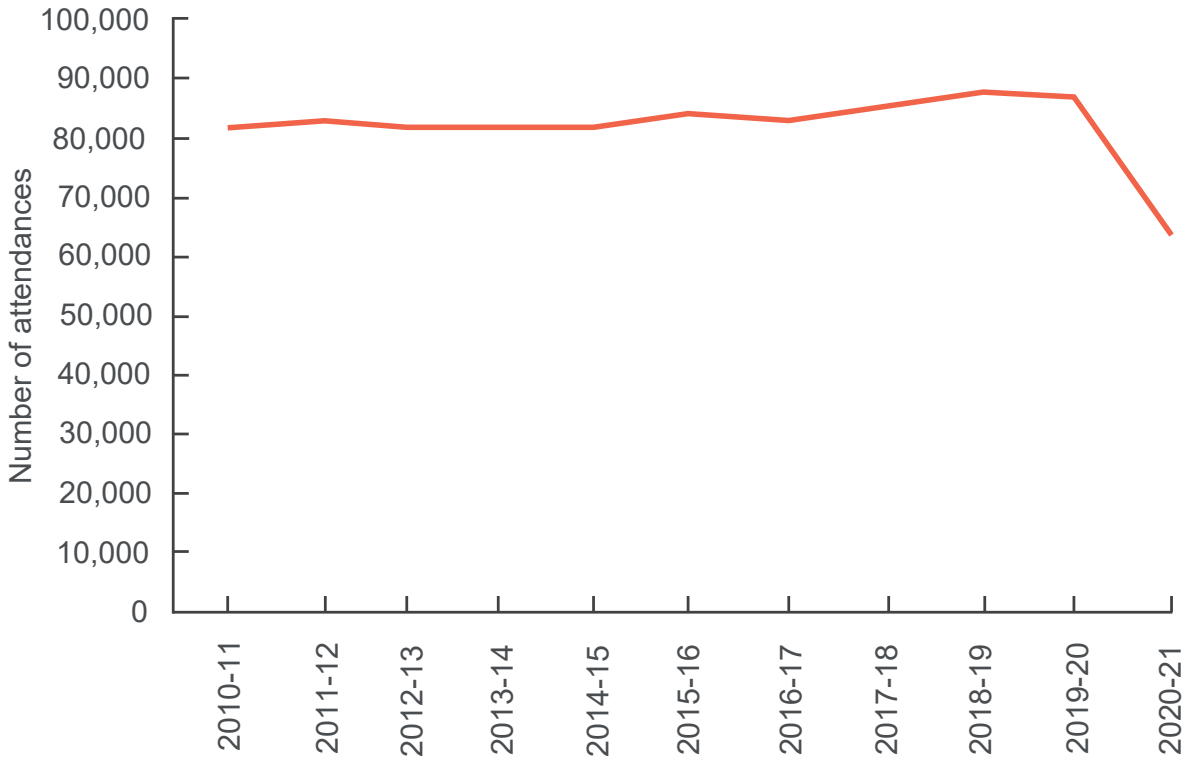
13 Nuffield Trust, A decade of Austerity in Wales? The funding pressures facing the NHS in Wales to 2025/26, June 2014; and Health Foundation, The path to sustainability: funding projections for the NHS in Wales to 2019/20 and 2030/31, October 2016

Healthcare: demand and capacity

Demand for some health services has steadily increased

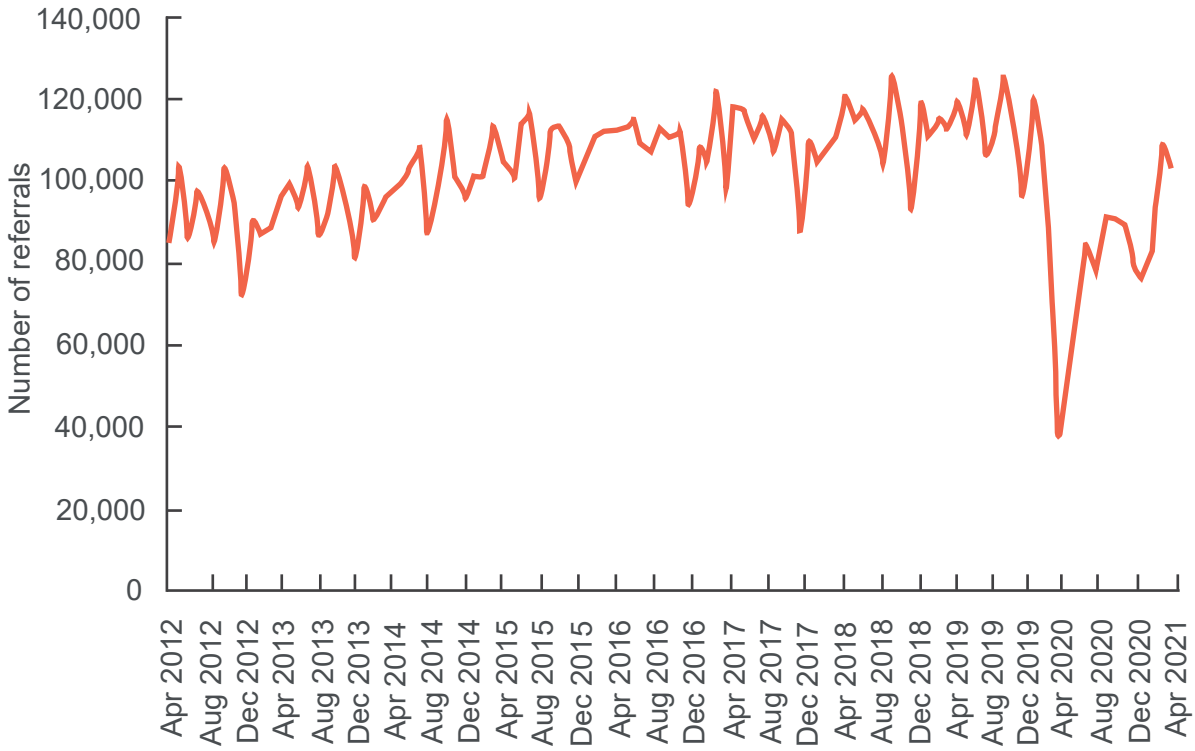
26 Welsh Government data shows that in the years before the pandemic, demand for key NHS services has been steadily increasing. Before the pandemic, the number of people attending emergency departments was increasing (**Exhibit 5**), and more people were being referred for a first outpatient appointment (**Exhibit 6**). As well as rising numbers, the NHS had also been seeing a shift in the age of patients, with the proportion of older people attending emergency departments steadily rising. COVID-19 had a dramatic impact on many parts of NHS Wales in March 2020, but activity has started to increase since then.

Exhibit 5: average annual emergency department attendances 2010/11 to 2020/21



Source: Audit Wales analysis of StatsWales: Accident and Emergency – Performance Against 4 Hour Waiting Times target

Exhibit 6: first outpatient referrals April 2012 to April 2021



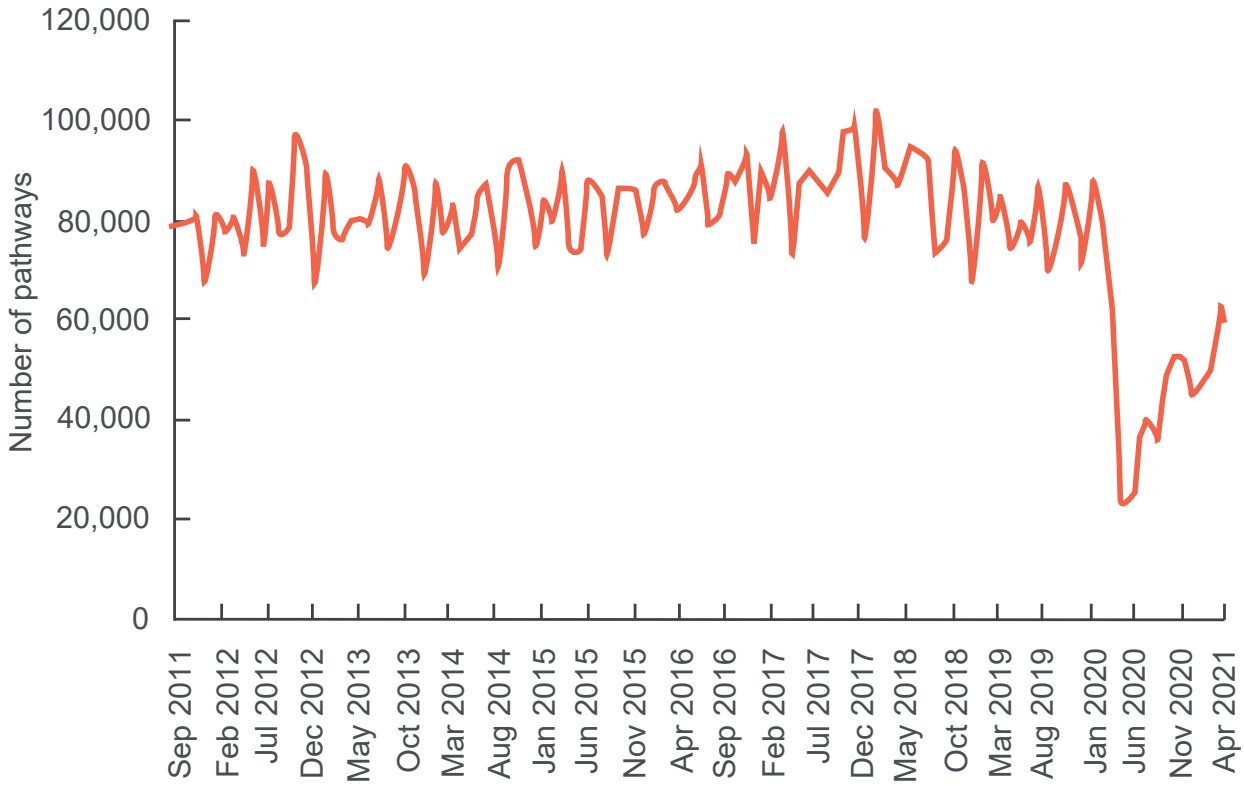
Source: StatsWales: Referrals by Local Health Board (area of residence)

27 Despite increased demand for planned care, the number of patient pathways closed[14] each month started to fall in 2019 (**Exhibit 7**). In particular, rules[15] on pension tax introduced by the UK government in 2019-20 had an impact on planned care in the months leading to the pandemic. In the past, the NHS relied on paying clinicians a premium rate to carry out work in their own time to improve waiting times. However, the new rules deterred many from taking on extra work because of the potential large tax bill it could incur.

14 A pathway is closed when a patient is admitted for their first definitive treatment, or a decision not to treat is made. Pathways are sometimes closed for other reasons such as if patients do not attend appointments.

15 In December 2019, the Welsh Government mirrored a temporary solution to the issue, implemented in England, whereby the NHS would pay for the tax liabilities. The Welsh Government's concerns are set out in a letter from the First Minister to the Permanent Secretary, directing her to implement the same approach as England.

Exhibit 7: patient pathways closed[16] during the months September 2011 to April 2021



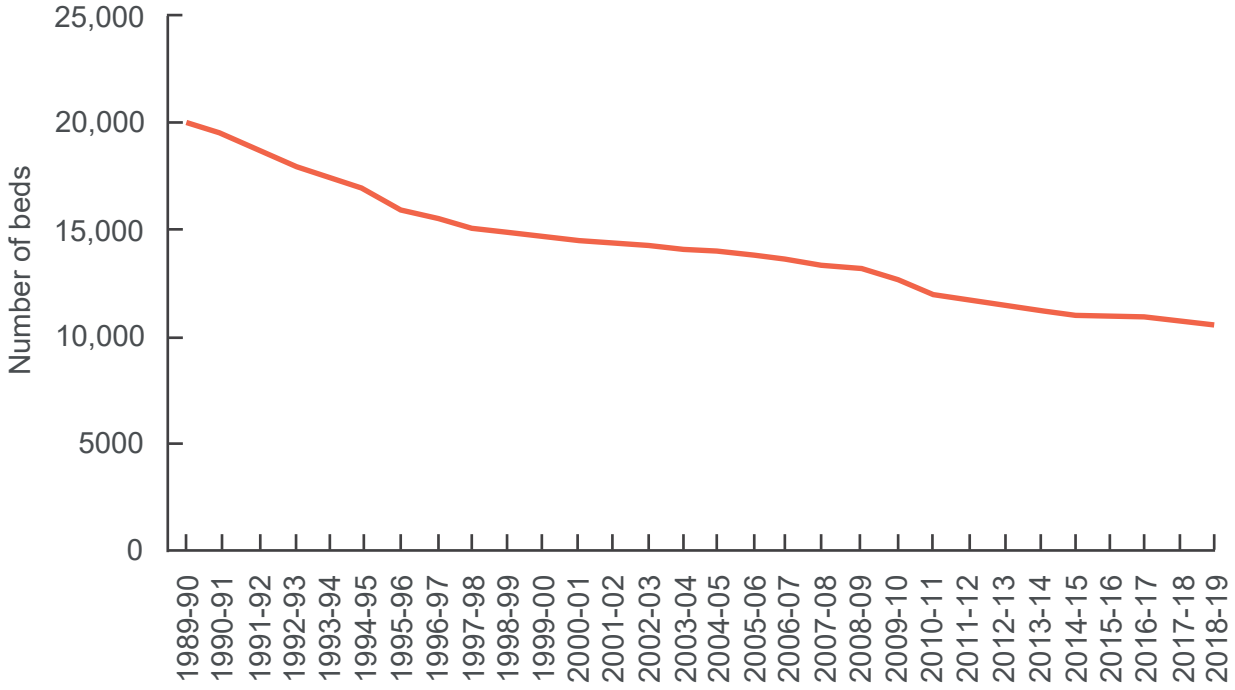
Source: StatsWales: Referral to Treatment – Closed Patient Pathways by Month

The number of NHS beds in Wales has been falling steadily for decades

28 COVID-19 put tremendous pressure on NHS services, but in many ways exacerbated problems that were already there. The number of daily available NHS beds in Wales almost halved from 1989-90 to 2018-19 (**Exhibit 8**). During this period, data on the length of time patients stayed in hospital suggests that NHS Wales made more efficient use of its beds which may account for some of the reduction in bed numbers. The Welsh Government stopped publishing bed numbers in 2019 but resumed during the pandemic. **Exhibit 9** shows bed numbers from April 2020 including temporary beds in field hospitals and other facilities. Bed data from 2020 onwards cannot be directly compared with previous years due to changes in the way health boards report bed numbers.

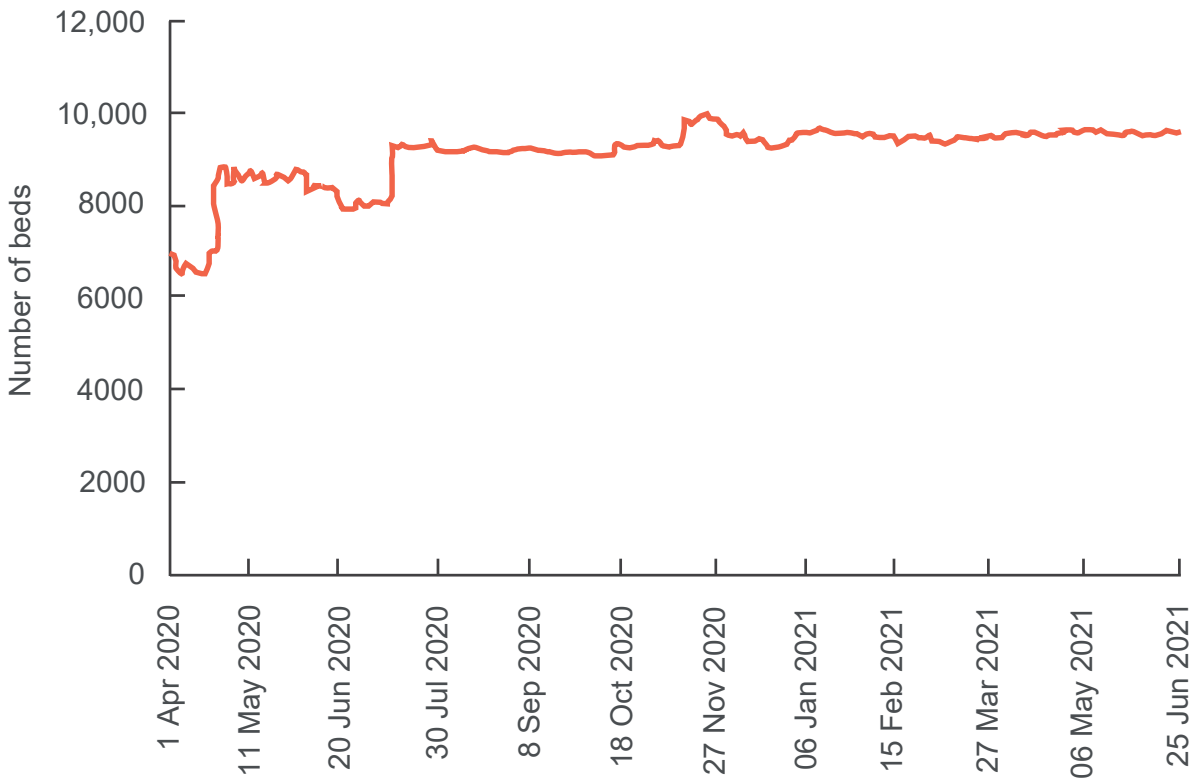
16 Patients with more than one condition can have more than one pathway.

Exhibit 8: daily available NHS beds 1989-90 to 2018-19



Source: StatsWales: NHS Beds Summary Data by Year

Exhibit 9: daily available NHS beds from 1 April 2020 to 25 June 2021



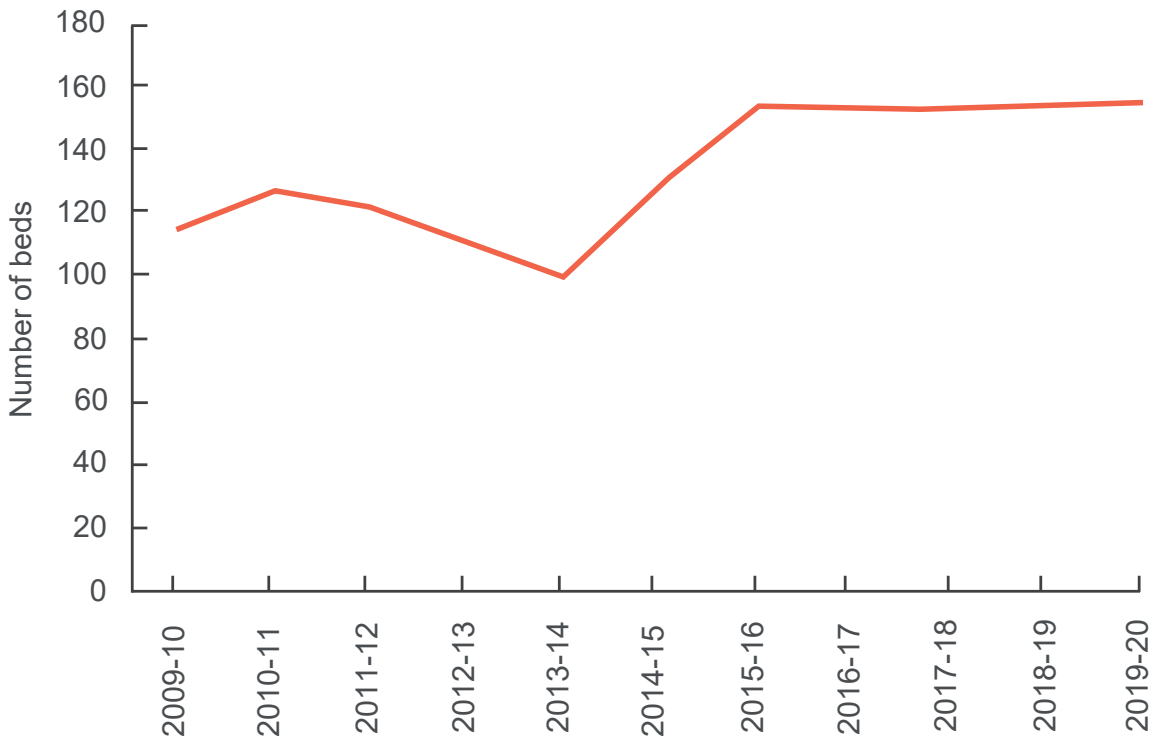
Note: StatsWales bed numbers include field hospitals from 20 April 2020 onwards, community hospitals from 23 April 2020 onwards, and mental health units from 10 July 2020 onwards.

Source: StatsWales: NHS Activity and Capacity During the Coronavirus – NHS Beds by Date and Use

29 The pandemic highlighted the low critical care bed capacity in Wales. The Welsh Government reviewed critical care capacity in 2018 and gave health boards £15 million recurring funding to increase beds and staffing. Despite investment, by 2019-20 there were 154 critical care beds (**Exhibit 10**) – the lowest per head of the population in the UK and amongst the lowest in Europe[17]. In response to COVID-19, health boards increased critical care capacity by repurposing capacity from elsewhere and cutting back on other services.

17 Faculty of Intensive Care Medicine and Intensive Care Society, Guidelines for the Provision of Intensive Care Services, June 2019

Exhibit 10: critical care beds 2009-10 to 2019-20



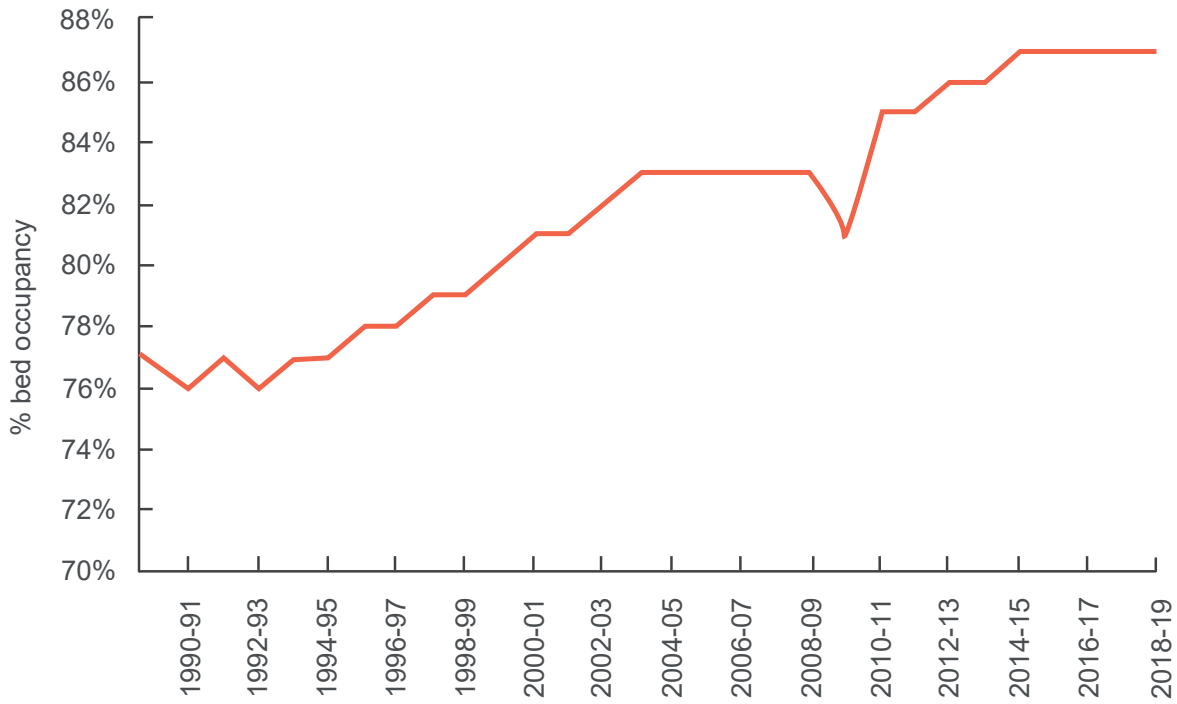
Source: StatsWales: NHS Beds by Specialty

Bed occupancy rates in Wales have been above recommended safe and efficient levels since 2012

30 The National Institute for Health and Care Excellence recommends[18] bed occupancy rates should not exceed 85% because high occupancy rates are linked to poorer patient outcomes and periodic bed crises. Bed occupancy rates in Wales have been over 85% since 2012-13 (**Exhibit 11**). The Welsh Government stopped publishing data on bed occupancy in 2018-19 and resumed in April 2020. Occupancy rates fell dramatically in the first months of 2020-21 but have been over 85% in June 2021 (**Exhibit 12**).

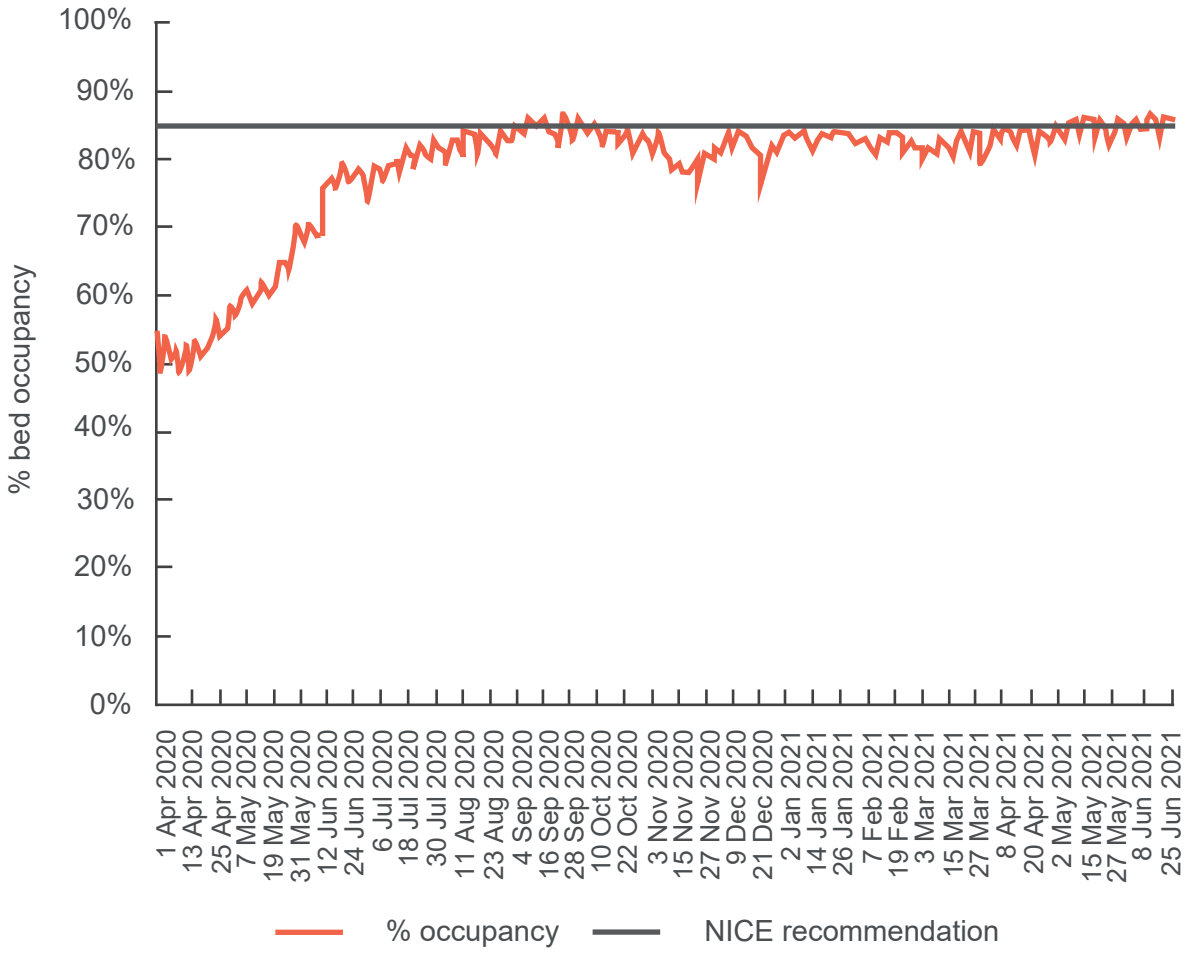
18 National Institute for Health and Care Excellence, Bed Occupancy. Emergency and Acute Medical Care in over 16s: Service Delivery and Organisation. NICE Guideline 94, March 2018

Exhibit 11: percentage bed occupancy 1989-90 to 2018-19



Source: StatsWales: NHS Beds Summary data by Year

Exhibit 12: percentage bed occupancy from 1 April 2020 to 25 June 2021



Note: The Welsh Government changed the way it reports bed occupancy several times during 2020 and 2021. It has not validated data from April 2020 onwards. One key change was to only count beds as available if there were enough staff to support them.

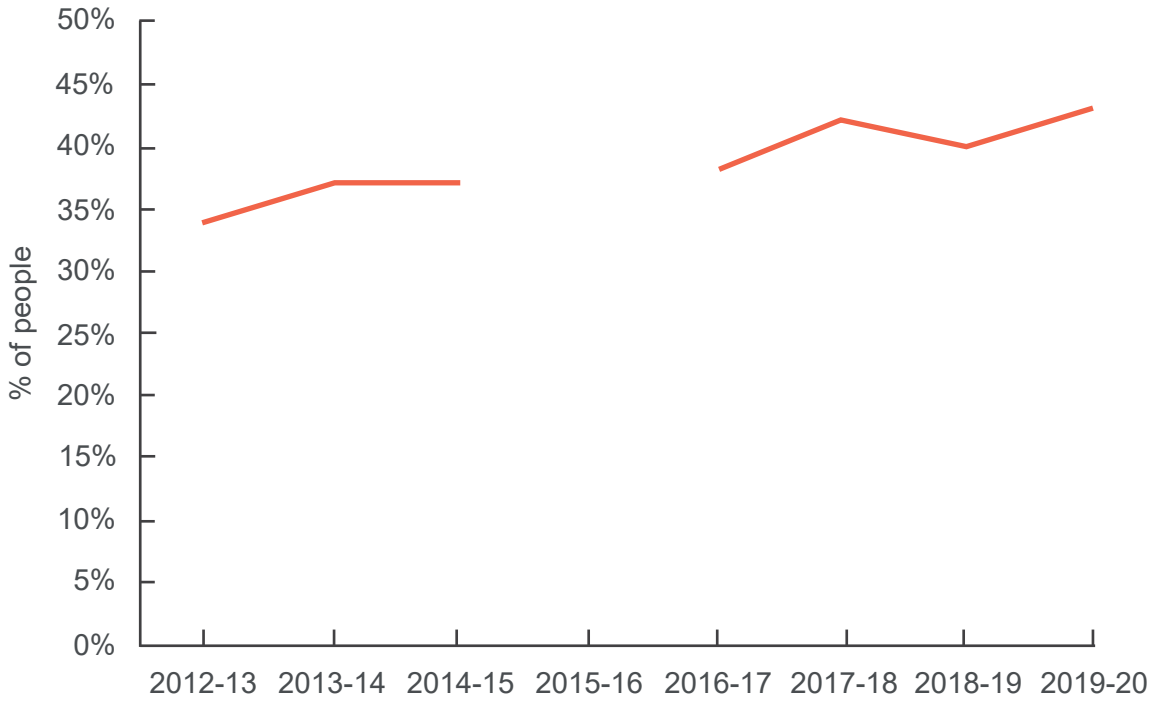
Source: StatsWales: NHS Activity and Capacity During the Coronavirus – NHS Beds by Date and Use

Prior to the pandemic, there is evidence that people struggled to get convenient GP appointments

31 For many years, primary and community care services have been a key part of the Welsh Government's focus on preventing health issues getting worse and reducing pressure on general hospitals as a result. In particular, people who cannot access a GP or dentist may go to emergency hospital departments instead.

32 The number of GP practices in Wales has fallen from 476 in 2011 to 407 in 2019. The reduction may be due in part to different working arrangements including practices merging. The Welsh Government's National Survey for Wales[19] shows that in 2019-20, 43% of respondents found it very or fairly difficult to make a convenient GP appointment (**Exhibit 13**). In 2019, the Welsh Government introduced Access to In-hours General Medical Services Standards which set eight targets for GP practices to improve accessibility to GP practices by March 2021. GP practices achieving all eight would receive a share of £5.7 million funding. The Welsh Government decided not to monitor performance against the standard as a result of the pressure on GP telephone systems during COVID-19. It allocated £3.7 million in June 2020 for practices to improve digital telephone systems.

Exhibit 13: the percentage of respondents to the National Survey for Wales who found it fairly, or very difficult to get a convenient GP appointment



Note: Data for 2015-16 is not available.

Source: StatsWales – National Survey for Wales

19 National Survey for Wales data is available on the Welsh Government's StatsWales website.

The NHS Wales workforce has increased but there are shortages in specific areas

33 The overall number of NHS Wales staff increased by 13% from 2010 to March 2020 (**Exhibit 14**). Numbers increased by another 5% from March to December 2020 as part of the response to the pandemic. Some of the additional staff are temporary. Medical and dental staffing has increased by 25% from 2010. However, representative bodies have highlighted specific gaps in the workforce including: the Royal Colleges of Anaesthetists[20], General Practitioners[21], Nursing[22], Ophthalmologists[23], Paediatricians[24], Physicians[25] and Radiology[26].

34 In the past, the Welsh Government published data on the number of GPs per 100,000 population and the number of whole term equivalents. It stopped publishing the data in 2018. The data shows that the number of GPs fell slightly (by 3%) from 2013 to 2018. Since March 2020 the Welsh Government has published quarterly data on the number of GPs employed in general practices but the data is not comparable to previous years. What the recent data does show, is that in September 2020 GP locums[27] made up a quarter of GP staff employed in GP practices contracted by health boards. Our 2019 report on primary care[28] described issues affecting the GP workforce in Wales including training, morale, pay and costs.

35 More recently, some health boards are concerned that staff are leaving or retiring early due to the pandemic. In April 2021, the British Medical Association published results from its COVID-19 tracker survey of UK doctors[29]. Almost a third of respondents said they are now more likely to take early retirement, a quarter are more likely to take a career break, and 21% are more likely to leave the NHS for another career. The Welsh Government has not yet published staff numbers since December 2020, so it is difficult to understand the impact of the pandemic on the permanent workforce.

20 The Royal College of Anaesthetists, Medical Workforce Census Report, 2020

21 The Royal College of General Practitioners Wales, Transforming General Practice, Building a Profession Fit for the Future, December 2018

22 The Royal College of Nursing, Staffing for Safe and Effective Care in the UK, 2020

23 The Royal College of Ophthalmologists, Workforce Census, 2018

24 The Royal College of Paediatricians and Child Health, 2017 Workforce Census: Focus on Wales, 2017

25 The Royal College of Physicians, The Medical Workforce BC (Before COVID-19): the 2019 UK Consultant Census, 2019

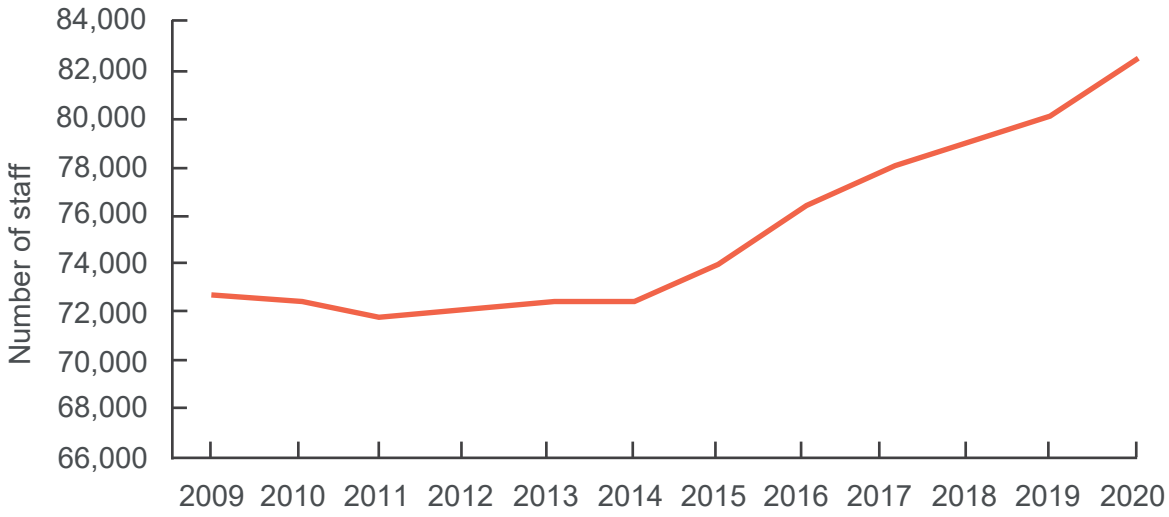
26 The Royal College of Radiologists, Clinical Radiology UK Workforce Census 2020 Report, 2020

27 GP locums are self-employed contractors who typically cost GP practices more money.

28 Auditor General for Wales, Primary Care Services in Wales, October 2019

29 The survey is based on a self-selecting sample of doctors working in the UK.

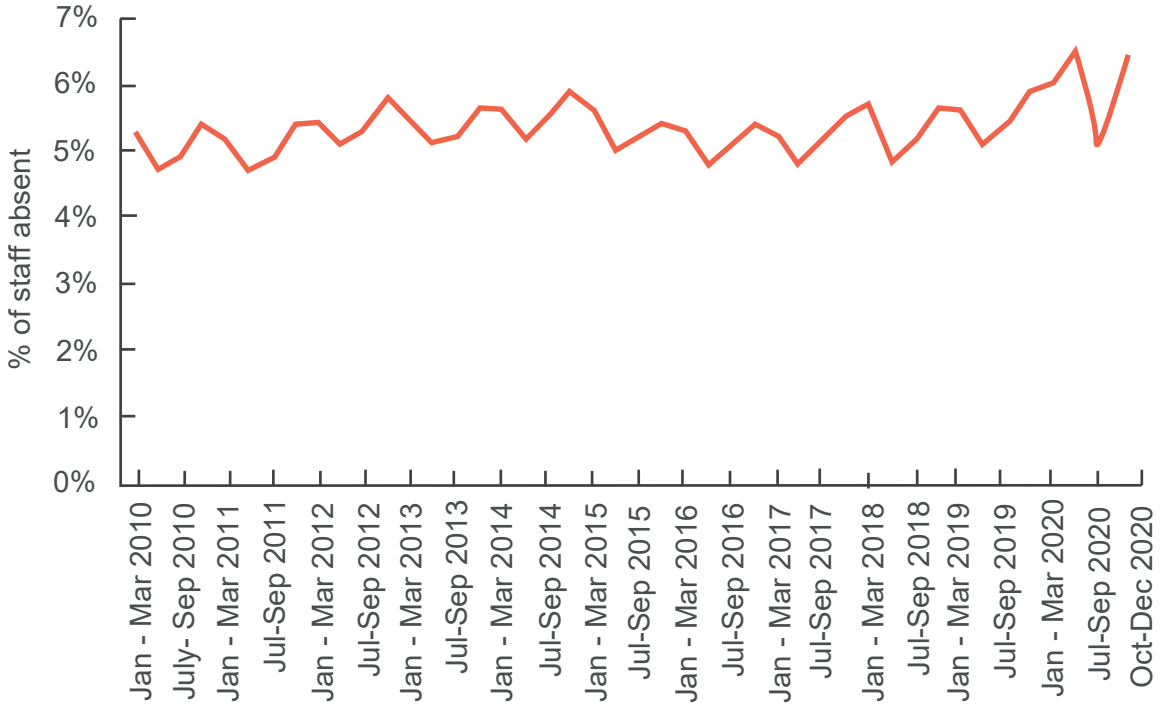
Exhibit 14: number of NHS staff 2009 to 2020



Source: StatsWales: NHS Staff Summary

36 **Exhibit 15** shows sickness absence rates (for any reason) amongst NHS staff increased during 2020. In evidence to the Public Accounts Committee in March 2021, the Chief Executive of NHS Wales described the considerable pressure the pandemic has put on health and social care staff. He warned of long-term impacts on the mental and physical health of staff including Post Traumatic Stress Disorder. Despite support mechanisms and a 5% increase in the NHS workforce, he recognised more investment is needed to ensure a resilient NHS workforce.

Exhibit 15: sickness absence rates in NHS staff from January 2010 to December 2020



Source: StatsWales: Sickness Absence – Percentage Absent by Staff Group

There are direct and indirect impacts of COVID-19 on the health and well-being of the population

37 We do not know the full impact of the pandemic on the population. Grief, trauma, isolation and loss have taken their toll, but it is too soon to understand the scale of the health issues the pandemic has caused. The NHS is still treating COVID-19 patients, rehabilitating people who experienced severe symptoms, and learning how to treat patients with long COVID.

38 Throughout the pandemic, Public Health Wales has been looking at the broader impact of COVID-19 on the population through its national engagement survey, health impact assessments, and international research. In March 2021, it published a health equity report[30] mapping the social, economic and environmental impact of COVID-19. Public Health Wales also plans to develop a dashboard of data on health and well-being trends.

30 Public Health Wales, Placing Health Equity at the Heart of COVID-19 Sustainable Response and Recovery: Building Prosperous Lives for all in Wales, March 2021

39 Stopping and reducing non-urgent activity also means that some patients on the waiting list will have developed more severe symptoms while they wait, and now need urgent treatment. Pauses to some screening programmes increase the risk of undetected cancers, or cancers not identified early enough for successful treatment. Other health conditions may have gone undetected because people were worried about going to their GP or emergency departments[31].

40 Public Health Wales' health equity report estimated between 361 and 1,231 additional lives had been lost due to delayed cancer screening, referral backlogs and restricted diagnostic capacity. The report also described spiralling demand for mental health services. **Exhibit 6** (in previous section) shows that overall referrals fell dramatically in the first months of the pandemic and have not fully returned to pre-COVID levels. We do not know why referrals have not returned to previous levels. It is possible that pent up demand will become apparent as infection levels fall and people become more confident visiting health professionals.

Healthcare performance

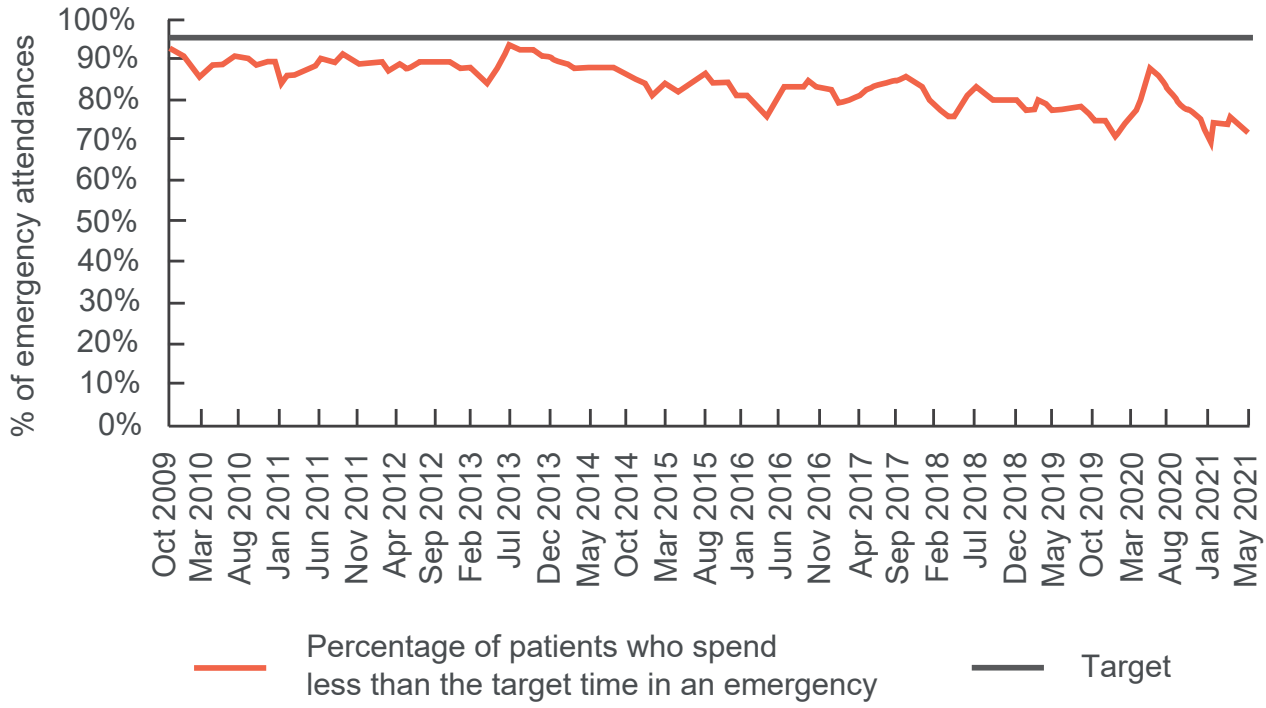
41 The Welsh Government publishes health board level data on NHS activity and performance monthly on an NHS Wales dashboard.

NHS Wales has not met some key targets for almost a decade

42 Despite increasing activity, NHS Wales has not met key targets on the timeliness of emergency and planned care, and cancer services for several years (**Exhibits 16 to 18**). Performance against targets varies considerably between health boards.

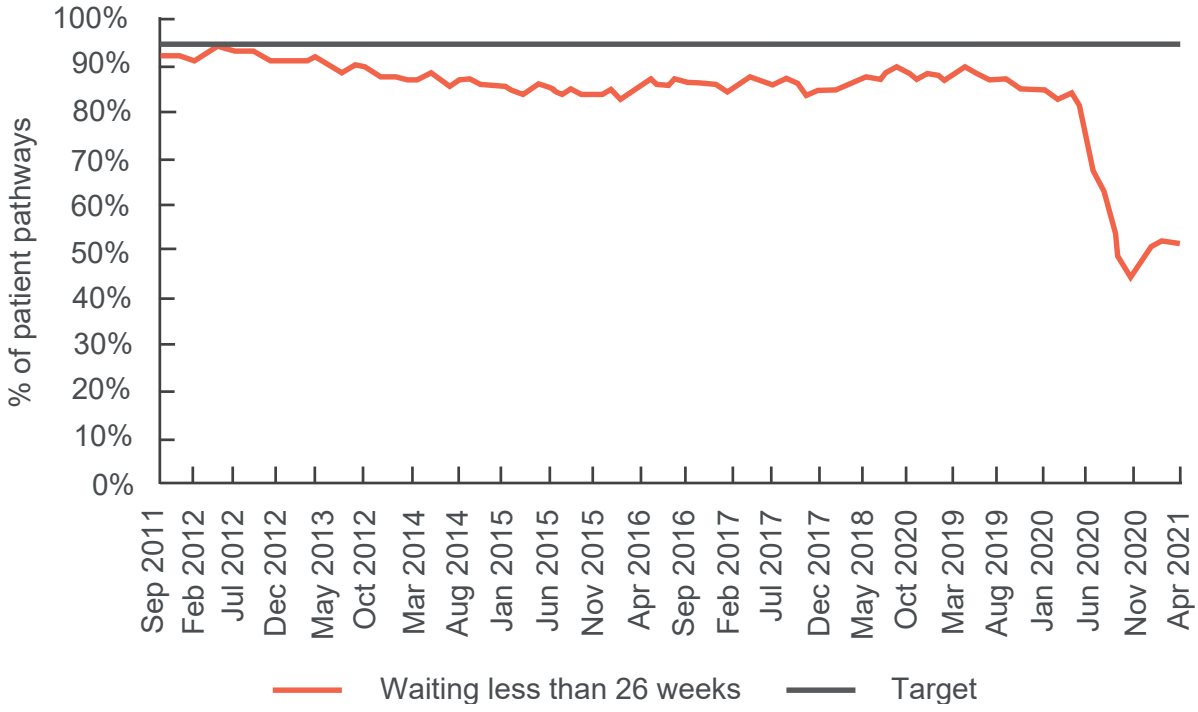
31 Although attendances at emergency departments may have reduced due to 'phone first' triage systems introduced by hospitals during COVID-19.

Exhibit 16: percentage of attendances spending less than four hours in an emergency department October 2009 to May 2021



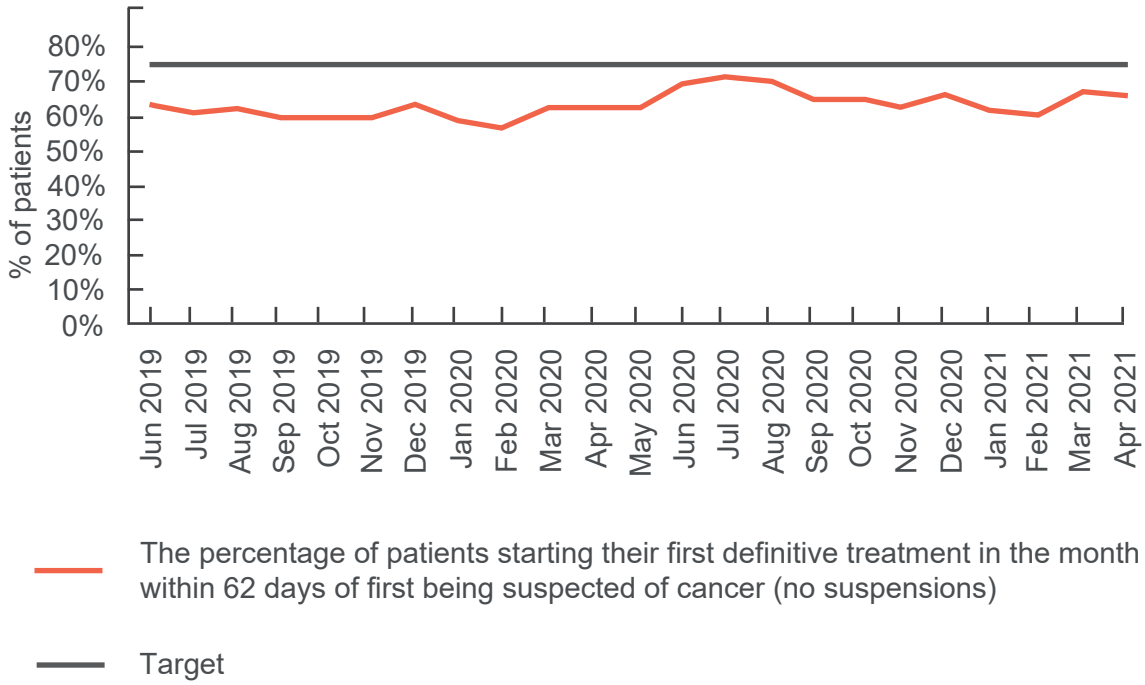
Source: StatsWales: Accident and Emergency – Performance Against 4 Hour Waiting Times target

Exhibit 17: percentage of patient pathways waiting less than 26 weeks to start treatment September 2011 to April 2021



Source: StatsWales: Patient Pathways Waiting to Start Treatment

Exhibit 18: percentage of cancer patients starting treatment in the month within 62 days of first being suspected of cancer July 2019 to April 2021

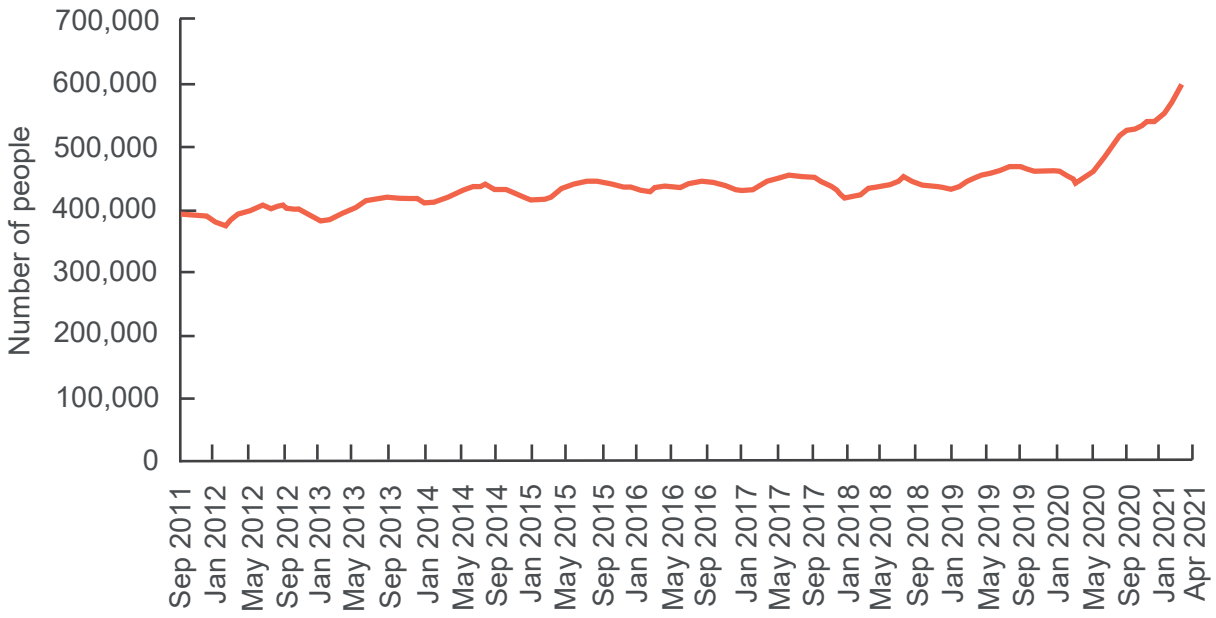


Source: StatsWales: Suspected Cancer Pathway – Closed Pathways

There are significant backlogs of patients waiting for treatment

43 As in the other UK nations and other parts of the world, pauses and reductions in non-urgent activity during the pandemic increased the backlog of patients waiting for treatment dramatically. By February 2021, there were almost 550,000 open patient pathways (**Exhibit 19**) representing huge numbers of people on the waiting list for treatment and a 19% increase from February 2020; over half had been waiting more than 26 weeks. Wales Fiscal Analysis' review[32] of the NHS and the Welsh Budget estimates that restoring NHS waiting lists to pre-COVID levels could cost between £152 million and £292 million a year over a four-year period from 2022-23.

Exhibit 19: number of people waiting for planned treatment September 2011 to April 2021

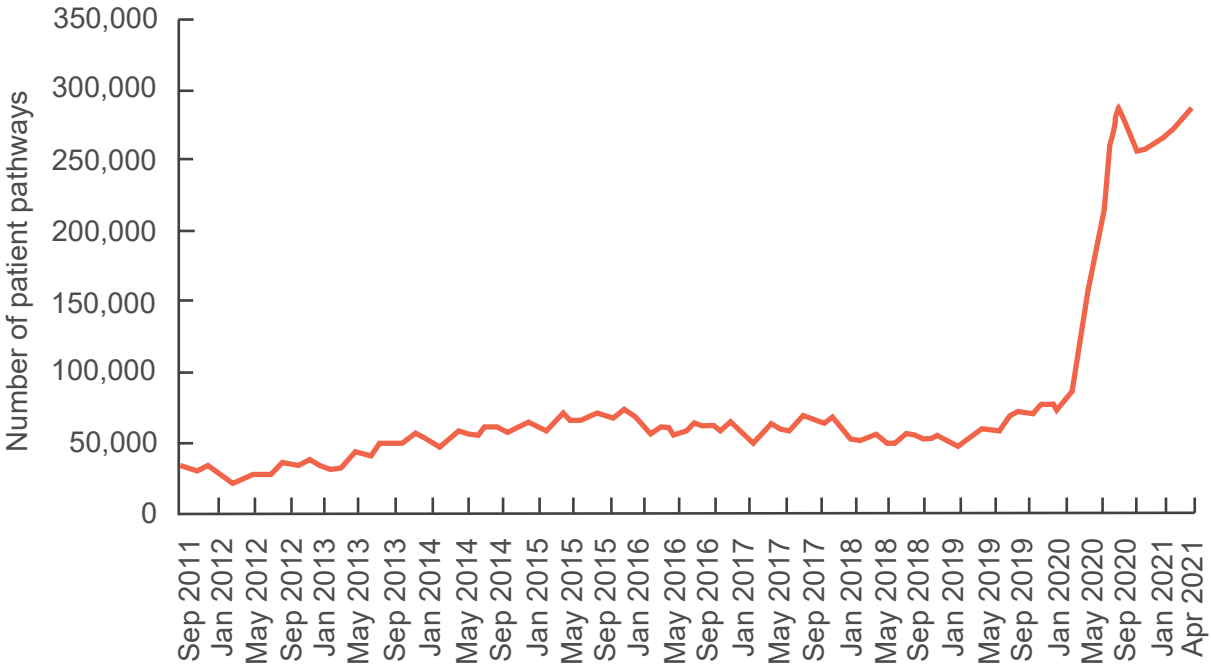


Source: StatsWales: Patients Waiting to Start Treatment by Month

44 However, pre-COVID waiting lists were already under considerable pressure. Some health boards had made progress reducing the number of patients waiting more than 26 weeks for treatment but the target across Wales had not been met and the position had been deteriorating through 2019-20. **Exhibit 20** shows that pre COVID-19 (February 2020) there were over 72,000 patient pathways waiting more than 26 weeks for treatment.

32 Wales Fiscal Analysis, The NHS and the Welsh Budget: Outlook and Challenges for the Next Welsh Government, April 2021

Exhibit 20: numbers of patient pathways waiting over 26 weeks for treatment September 2011 to April 2021



Source: StatsWales: Closed Patient Pathways by Month

Healthcare: key issues

Whole system change is overdue

45 Before the pandemic, parts of the health system, and health and social care as a 'whole system' were under great pressure. In 2016, the [then] Minister for Health and Social Services announced a parliamentary review by an independent panel of experts on the future of health and social care. The review[33] found that service delivery was not consistently good and a risk averse culture was hindering change. A Healthier Wales set out plans to address the issues in the parliamentary review and said services had to transform quickly.

46 The Welsh Government and health bodies have long recognised the need to change. Over the last decade, our reports have found positive examples of innovation and improvement across NHS Wales. So far, change has been limited to a few small areas and Welsh Government initiatives including the Planned Care Programme, and new models of care funded by the Transformation Fund and Integrated Care Fund[34], have been slow to affect system wide transformation.

47 In 2019-20, we followed up our review of NHS waiting times for elective care. Despite some progress, we found that the whole system change needed to create sustainable planned care services had not happened. Our report set out ten opportunities for resetting and restarting the planned care system[35]. Since then, the Welsh Government told us it is making progress against those opportunities, including exploring new ways of managing waiting for elective care to better focus on patient outcomes and prioritise those in greatest need.

33 Parliamentary Review of Health and Social Care in Wales, Interim Report, July 2017, and Final Report, January 2018

34 Auditor General for Wales, Integrated Care Fund in July 2019

35 Auditor General for Wales, 10 Opportunities to Reset and Restart the Planned Care System, September 2020

Learning from the COVID-19 response offers opportunities to overcome barriers to transformation

48 Positively, health bodies, principal councils and their partners moved a step closer to operating as a whole system in their collective response to COVID-19. Our reports on Test, Trace, Protect, Personal Protective Equipment[36], and the vaccination programme all describe strong collaboration between different organisations and delivery at pace. With Test, Trace, Protect, public bodies worked together to design and deliver a new service from scratch in a few months. The NHS Confederation's COVID-19 Transformation and Innovation Study[37] describes examples of innovation during the pandemic. In the COVID-19 crisis, public bodies overcame some of the barriers to successful collaboration and service delivery they have struggled with for years.

49 The pandemic accelerated digital transformation projects that could offer learning to address weaknesses in the delivery of other projects. Our reports on NHS Informatics Systems[38] and the Welsh Community Care Information System[39] described slow progress implementing digital programmes. However, during the pandemic, public bodies quickly put in place digital solutions to organise and deliver services, communicate with patients and colleagues and for collaboration. For Test, Trace, Protect, Digital Health and Care Wales worked with the private sector to develop and implement a digital platform for contact tracing at pace. Similarly, it quickly developed the Welsh Immunisation System for the vaccination programme.

There are opportunities to better focus the health system in Wales around outcomes for patients and the wider population

50 Our 2020 waiting times work (paragraph 47) said that sometimes the focus on meeting targets can distort clinical decision making and prioritising patients by need. For decades, large parts of NHS Wales have been driven by the need to meet timeliness targets rather than the outcomes for patients. There are opportunities to reflect on accountability arrangements as the Welsh Government develops its NHS Executive. In bringing national delivery, oversight and improvement functions together, NHS Wales could reflect on getting the right balance between quality, delivery and patient outcomes.

36 Auditor General for Wales, Procuring and Supplying PPE for the COVID-19 Pandemic, April 2021

37 NHS Confederation, NHS Wales COVID-19 Innovation and Transformation Study Report, June 2021

38 Auditor General for Wales, Informatics Systems in NHS Wales, January 2018

39 Auditor General for Wales, Welsh Community Care Information System, October 2020

51 Going forward, there may be opportunities to better connect health and social services with broader public services to form a whole system response to the direct and indirect harms of COVID and improving population health. The pandemic highlighted significant health inequalities across the UK, particularly around ethnicity and deprivation, that require new energy and resource to tackle. Public Health Wales' health equity report said the pandemic revealed the chronic under-resourcing of public health, disease prevention and health promotion.

52 The Welsh Government's Recovery Plan for Health and Social Care recognised the need to tackle the wider determinants of health such as housing, employment and education to prevent problems occurring or getting worse. In his evidence to the Public Accounts Committee (paragraph 36), the Chief Executive of NHS Wales said the pandemic has elevated expectations of a 'wellness' service.

Transforming services at the same time as tackling backlogs and the ongoing COVID-19 response will be challenging

53 In May 2021, the Welsh Government allocated £100 million between health boards to tackle the backlog of patients waiting for treatment. Some of the extra activity will be done by paying existing staff to work overtime. Staff are tired and many have worked long hours during the pandemic. Health boards can pay private providers to see NHS patients but private capacity in Wales is not huge and some is already being used to deliver essential services during the pandemic. In addition, private providers often use NHS staff outside their contracted hours to do the work. Recruiting additional staff relies on the right staff being available.

54 Now, with huge backlogs of patients wating to be seen, the need for transformation is greater than ever. But the challenge of achieving it is considerable. Large scale transformation takes leadership, energy and staff resources. Health bodies need breathing space to plan and do things differently. Existing workforce shortages have been compounded by COVID-19 sickness and self-isolation due to exposure to COVID-19, and by the redeployment of NHS staff into the ongoing COVID-19 response. In addition, many staff carried forward annual leave during the pandemic.

55 COVID-19 is still active across the UK and transformation must be balanced with treating and reducing the spread of the virus. Test, Trace and Protect services and the vaccination programme will continue, with plans to give booster vaccinations in the near future. Health bodies will also have to deliver the seasonal flu vaccination programme as usual. In addition, social distancing and other measures to prevent transmission limit productivity because they restrict the number of staff and patients who can safely use buildings. Even with significant investment, the NHS needs staff and safe premises to treat the backlog which will be challenging while the COVID response continues.

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Cyfarfod a dyddiad: Meeting and date:	**Audit Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Schedule of Closed Claims Over £50,000 - Quarter 2 2021/22
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery/Deputy CEO Acting Associate Director of Quality Assurance
Awdur yr Adroddiad Report Author:	Claims Lead Manager Claims Managers
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance
Atodiadau Appendices:	Schedule of closed claims and financial value for quarter 2 of 2020/21 (over £50,000)

Argymhelliad / Recommendation:

The Committee is asked to receive this report for assurance.

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

Sefyllfa / Situation:

The attached report sets out total payment information for any claims against the Health Board with a spend of over £50,000 closed during Quarter 2 (July-September) of the 2021/22 financial year. This report formally summarises to the Audit Committee, the authorities given by the Health Board's Claims Managers, Executive Team and Board.

This report is presented to the Audit Committee to support the discharge of its responsibility to ensure the provision of effective governance.

The report includes two tables – one containing summary information for the public report and a more detailed tab for the private report which includes additional information that may be patient/staff identifiable.

Cefndir / Background:

All Health Boards in Wales contribute to a liability fund and have a risk share agreement, known as the Welsh Risk Pool (WRP).

The Health Board employs a team of Claims Managers who sit within the Patient Safety and Experience Department. These legally trained staff were recruited to strengthen the management of claims. Clinical negligence and personal injury claims are managed by the Health Board on the basis of legal advice provided

by the Legal and Risk Services Department of NHS Wales Shared Services Partnership. The Welsh Risk Pool will reimburse the Health Board for all losses incurred above an excess of £25,000 on a case by case basis.

To ensure that learning and improvement is commenced and implemented at the earliest possible stage the Welsh Risk Pool has reimbursement procedures that bring the scrutiny of learning early in the lifecycle of a case. These changes become effective from 1 October 2019. The WRP procedures require a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Learning Advisory Panel and WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Should the Audit Committee require it, there is a learning document available for the cases listed within the schedule attached.

In all cases, claims have been managed by the Claims Managers within the Patient Safety and Experience Department who are all legally trained. All claims have been managed with the support and involvement of the Legal and Risk Services Department of NHS Wales Shared Services Partnership (NWSSP) and evidence of case management and learning has been, or will be, submitted to the Welsh Risk Pool.

The Quality, Safety and Experience Committee receives a separate quarterly Patient Safety Report to provide assurance on the learning and improvement following claims. This report to the Audit Committee provides assurance on the correct authorisation of payments as shown on the attached schedule for claims over £50,000.

Additionally, the Audit Committee is reminded that an annual internal audit of claims management is also undertaken which provides additional assurance on systems and process. The audit for 2020/21 has been completed and the process given **Substantial Assurance** with no recommendations made.

Asesiad / Assessment & Analysis

Please see the attached schedule for detail of individual claims. The data provided has been taken from the Datix software system through which claims are managed.

Ref	Type	Region	Specialty	Incident Date	Total (Payment summary)
CLA17-2957	Clinical Negligence	BCUHB West	Gynaecology (Secondary)	25/07/2017	£54,423.42
W09-079	Clinical Negligence	BCUHB West	Trauma/Orthopaedics (Secondary)	03/08/2008	£307,991.42
ZG-CLA16-2473	Clinical Negligence	BCUHB East	Emergency Department (Secondary)	08/03/2014	£52,422.08
CLA17-2946	Clinical Negligence	BCUHB East	Trauma/Orthopaedics (Secondary)	01/04/2017	£75,194.50
CLA18-3723	Clinical Negligence	BCUHB East	Adult Community Mental Health Services	01/01/2016	£64,799.04
CLA19-3954	Clinical Negligence	BCUHB East	General Surgery (Secondary)	07/02/2017	£151,621.97
W14-1446	Clinical Negligence	BCUHB West	Obstetrics (Secondary)	18/05/2006	£5,950,556.14
CLA16-2466W	Personal Injury	BCUHB West	Specialist Service - Medium Secure Unit	04/09/2016	£54,135.27
CLA16-2362C	Personal Injury	BCUHB Central	Urology (Secondary)	04/12/2015	£57,462.07
CLA18-3789	Clinical Negligence	BCUHB West	General Medicine (Secondary)	26/01/2016	£182,042.00
C18-3468	Clinical Negligence	BCUHB Central	Emergency Department (Secondary)	11/11/2014	£116,075.00
W13-1207	Clinical Negligence	BCUHB West	Gynae Surgery (Secondary)	21/07/2013	£118,617.10
					£7,185,340.01