Bundle Quality, Safety & Experience Committee 22 August 2023

1 QS23.77 OPENING ADMINISTRATION
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2 QS23.78 Welcome, introductions and apologies for absence

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10 QS23.86 Patient and Carer Experience Report
   - QS23.86 Patient and Carer Experience Report

11 QS23.87 Infection Prevention and Control Annual Report 2022/23
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12 QS23.88 Corporate Safeguarding Annual Report
   - QS23.88 Corporate Safeguarding Annual Report 2022-23

13 QS23.89 IHC Report - East
   - QS23.89 East IHC report for QSE July 2023 v.3

14 QS23.90 Risk Register
   - QS23.90a QSE Committee Coversheet - Corporate Risk Register Public v1.0
   - QS23.90b Appendix 1 - Full Corporate Risk Register - Public
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16 QS23.92 CLOSING BUSINESS

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19 QS23.95 Date of Next Meeting - 14 September 2023

Agenda Quality Safety Experience Committee

Date 22/08/23
Time 11:00-13:00
Location Boardroom, Carlton Court, St Asaph
Chair Rhian Watcyn Jones

Agenda item	Item	Lead	Action	Paper/Verbal
1.0 OPENING ADMINISTRATION				
1.1	Welcome, introductions and apologies for absence	Chair	Information	Verbal report
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report
1.3	Minutes of the last meeting and action log	Chair	Decision	Paper
2.0 SPECIAL MEASURES				
2.1	Special Measures Report	Executive Director of Transformation, Strategic Planning & Commissioning	Assurance	Paper
3.0 QUALITY SAFETY AND IMPROVEMENT				
3.1	Clinical Effectiveness Report	Executive Medical Director	Assurance	Paper
3.2	Patient and Carer Experience Report	Executive Director of Nursing & Midwifery	Assurance	Paper
3.3	Infection Prevention and Control Annual Report 2022/23	Executive Director of Nursing & Midwifery	Assurance	Paper
3.4	Corporate Safeguarding Annual Report	Executive Director of Nursing & Midwifery	Assurance	Paper
3.5	IHC Report – East	Integrated Health Community Director (East)	Assurance	Paper
3.6	Risk Register	Interim Board Secretary	Assurance	Paper
4.0 CLOSING BUSINESS				
4.1	Reflections on meeting	Chair	Information	Verbal

Agenda item	Item	Lead	Action	Paper/Verbal
4.2	New Risks	Chair	Information	Verbal
4.3	Date of Next Meeting 14/09/23	Chair	Information	Verbal

Items for next meeting:

- Patient Story Annual Report
- Special Measures Report
- Clinical Effectiveness Update Report
- Primary Care Quality Group Report
- Duty of Candour Report
- Independent Effectiveness Reports
- Deep Dive into Falls

MEMBERS	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member
In attendance	
Jason Brannon	Deputy Director of Workforce
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Michelle Denwood	Director of Safeguarding & Public Protection (item 3.4)
Gareth Evans	Acting Executive Director Therapies & Health Science
Michelle Greene	Integrated Health Community Director (East) (item 3.5)
David Jenkins	Independent Advisor (observing)
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Chris Stockport	Executive Director of Transformation, Strategic Planning & Commissioning
Paolo Tardivel	Director of Transformation (item 2.1)
Angela Wood	Executive Director of Nursing & Midwifery (Lead Executive)

Betsi Cadwaladr University Health Board (BCUHB)

Minutes of the Quality, Safety & Experience Committee meeting held on 25 July 2023, Boardroom, Carlton Court, St Asaph

Present	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Clare Budden	Independent Member
Prof Mike Larvin	Independent Member
In attendance	
Jason Brannan	Deputy Director of Workforce
Nesta Collingridge	Head of Risk Management
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Gareth Evans	Acting Executive Director Therapies & Health Science
Michelle Greene	Integrated Health Community Director East
David Jenkins	Independent Advisor (observing)
Matt Joyes	Deputy Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Tracey Radcliffe	Head of Patient Safety
Mike Smith	Interim Director of Nursing MHLD (item QS23.69 only)
Paolo Tardivel	Director of Transformation & Improvement (item QS23.72 only)
Angela Wood	Executive Director of Nursing & Midwifery
Rachel Wright	Lead Patient Experience and Carers Service (item QS23.66 only)

Agenda item	**Action**
OPENING BUSINESS	
QS23.62 Welcome introductions and apologies QS23.62.1 Rhian Watcyn Jones, Independent Member and Chair (Chair) of the Quality, Safety & Experience (QSE) Committee welcomed everyone. QS23.62.2 Apologies were received from: • Jane Wild, Associate Member. • Chris Stockport, Executive Director of Transformation, Strategic Planning & Commissioning	
QS23.63 Declarations of interest on current agenda QS23.63.1 There were no declarations of interest noted.	
QS23.64 Minutes of the last meeting and action log QS23.64.1 The minutes of the meeting held on the 22 June 2023 were approved as an accurate record of the meeting. It was requested that the	

actions raised be more clearly identified. QS23.64.2 The Committee reviewed the action log and agreed the closure of those which had been completed.	
QS23.65 QUALITY SAFETY AND IMPROVEMENT	
QS23.66 Patient/Carer/Staff Story – learning QS23.66.1 The Chair welcomed Rachel Wright (RW), Lead Patient Experience and Carers Service presented the report and digital patient story which related to the Vascular Service. RW reported that Hugh, a retired GP, had been an inpatient of three hospitals within BCUHB for the last three years, spending time as a patient in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Llandudno General Hospital. He had been a diabetic from the age of seven, and had managed his condition for the last 68 years. QS23.66.2 Following a diagnosis of Chronic Osteomyelitis, increased infection of his foot and shinbone and not responding to antibiotic treatment, Hugh opted for a bi-lateral amputation of both legs below the knee as the only possible treatment plan to improve the situation. Hugh described his experiences as a patient within the Vascular Service, in particular with the Vascular Surgeons at Ysbyty Glan Clwyd. He praised the high level of 'excellent' nursing care across all three hospitals; Ysbyty Gwynedd, Ysbyty Glan Clwyd and Llandudno Hospital and feeling looked after 'superbly well' throughout his stay as an inpatient. QS23.66.3 Hugh shared his story, on the day before his discharge, to express his deepest gratitude to the teams involved in his care and described the positive impact of the surgery, hopefully leading to a 'pain-free existence' in the future. QS23.66.4 The Committee welcomed the report though members were shocked that Hugh had such a long stay as an inpatient. Although a complex case it was felt this should have been escalated sooner. QS23.66.5 In response to questions, RW reported that learning was shared across BCUHB at high level meetings and on intranet. The Patient Experience team also spend time with staff on the wards training them on how to engage with patients and providing additional support where required. QS23.66.6 It was noted that there were many different options on how patients can give feedback on services from online or paper. In response to a question it was reported that the Health Board carries out around150 amputations a year due to diabetes. QS23.66.7 The Committee received the report.	

QS23.67 Health & Safety Report

QS23.67.1 Jason Brannan (JB), Deputy Director of Workforce, introduced the report which was taken as read. The report had been completed to provide a summary of key health, safety and security team activities for quarter one and areas for escalation and the following were highlighted.

QS23.67.2 Health Service Executive (HSE) investigation, Hergest Unit: JB reported that following the investigation of the death of a patient by ligature in the Hergest Unit, the HSE issued a letter received on 15 March 2023 confirming the HSE's intention to take further enforcement on this matter, namely a prosecution case. A task and finish group led by the Mental Health and Learning Disabilities (MHLD) team had been working through a detailed action plan to comply with the breaches identified. The court case will take place on the 3 August 2023.

QS23.67.3 HSE Investigation, Patient Falls: The HSE has actively investigated two patient falls; in the CDU in Wrexham and Gogarth Ward, Ysbyty Gwynedd. A further patient fall remains an open investigation in Aran Ward, Ysbyty Gwynedd. The HSE has confirmed that it is also reviewing falls training completed by agency staff to see if it is in-line with the BCU falls policy. The Human Resources temporary staffing team is investigating agency staff access and compliance.

QS23.67.4 HSE Investigation Hand-Arm Vibration: A diagnosis of Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) reportable Hand Arm Vibration Syndrome was received from our Occupational Health and Safety Consultant following health surveillance for staff at risk from vibration. The HSE had issued the Health Board with a Notification of Contravention letter, and a group had been set up to respond to the material breaches identified. Significant work had been undertaken since 2019 to monitor vibration exposure and to reduce the risk with a tool's replacement programme. The Health Surveillance system is in place, and Estates are working with Occupational Health and Health and Safety to identify staff at risk. A response to the HSE is required by 27 July 2023.

QS23.67.5 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR): In Q1 23/24, eight reports had been submitted under RIDDOR. This included four staff 'over seven days' related injuries with one fall, an assault and an impact injury. A staff-specified injury (fracture) was reported following an incident moving racking. There were two patient-related specified injuries reported following falls.

QS23.67.6 Fit testing: The team continue to undertake audits to check that staff are wearing their badges with information on the respirator they should be using. This was agreed as an action following an HSE Notification of Contravention, and auditors have advised that they have been met with hostility in some areas. Additional communication on the

continued importance of having a face fit test and wearing the identification badge will be sent out. Across the Health Board, 650 fit tests were completed in Q1 23/24, with a further fifteen staff completing the training to be a fit tester. QS23.67.7 Manual Handling training: The training is continuing in external training rooms; and it was noted, the two-year agreed contracts will start to end in December 2023. Alternative accommodation on the DGH sites is being sought but, if not available, the matter may need to be escalated to the Executive team. As of May 2023, there were 4,365 staff not compliant with their patient handling refresher training on ESR. The Did Not Attend (DNA) rate at the end of June was 35%, significantly impacting the patient handling refresher training programme. The Health Board is currently showing as 56.55% compliant with this training. DNAs for patient handling foundation training for new starters is also high at 30%, QS23.67.8 Personal Safety / Violence and Aggression (V&A) The V&A team is rebranding to the Personal Safety team to promote a more positive image of supporting staff and patients. The Personal Safety training programme (V&A module C) has commenced again for all clinical staff on the orientation programme. QS23.67.9 The Chair noted that the report gave only partial assurance and asked what mitigations were in place. It was noted that the Risk Register was being updated and would be brought to the next meeting. CB asked if the 73 incidents in the report were indicating trends and it was agreed that any would be highlighted in the report. QS23.67.10 Mike Larvin (ML), asked if a deep dive into why staff were not attending mandatory manual handling training was required? JB responded that there was additional data that could be provided which could be attached as appendices to future reports which would give a better understanding of issues. Non-attendance was mainly due to availability of staff and releasing them locally to attend the training. QS23.67.11 Angela Wood (AW), Executive Director of Nursing & Midwifery, reported that Internal Audit was about to start a review of compliance around falls in next few weeks, and agreed to bring a deep dive on falls to the meeting next month explaining how making change and challenge of embedding into practice. QS23.67.12 The Committee received the report. **ACTION:** • **AW to bring a deep dive on falls to the meeting next month explaining how making change and challenge of embedding into practice.** • **PM to highlight any trends in the Risk Register Report.**	**AW** **PM**

QS23.68 Patient Safety Report QS23.68.1 Tracey Radcliffe (TR), Head of Patient Safety presented the report which was taken as read. The report provided the Committee with information and analysis on significant patient safety issues arising during the prior three-month period, alongside longer-term trend data, and information on the improvements underway. TR highlighted the following points from the report: • Nationally Reportable Incidents (NRI) - From May to June 2023, 40 notifications were submitted. Of these, 13 of the incidents were before the 1 April 2023 and had been awaiting a closure form to be completed following local harms review. The total number of NRI investigations overdue as of 7 July 2023 is 29 out of the 66 total open. • Never Events – It was noted that within the designated period, no Never Events had been reported. • Patient Safety Alerts - The Health Board had no overdue alerts. QS23.68.2 It was reported that the nursing team is still working on the Quality Dashboard with the Information Technology (IT) team. This will better enable triangulation and identify issues that need to escalated to the Health Board. The requirement for Primary Care, Dentistry and community data to be included in the report was discussed. Although included in the overall data it could be broken down further for the next report. QS23.68.3 The Committee received the report. **Action : TR to include breakdowns in future reporting**	**TR**
QS23.69 Mental Health Update QS23.69.1 Teresa Owen (TO), Executive Director of Public Health introduced Mike Smith (MS), Interim Director of Nursing Mental Health and Learning Disabilities (MHLD) who presented the report which was taken as read. QS23.69.2 The report provided a high-level overview of the Quality, Safety and Experience issues in Adult Mental Health (as part of the MHLD Division) for the Committee. It was recommended going forward, the approach of “deep dive reporting” into subject areas to provide members greater clarity or assurances. It was noted that the Division had delivered engagement sessions with staff across all areas to provide an overview of the improvement plan and encouraged contribution and feedback to the proposed measures, outcomes and dashboard creation for each of the six work streams in the improvement plan:	

• Fundamentals of Care. • Leadership, Empowerment and Culture. • Safe and Effective Care. • Individual and Timely Care. • Environment, Resource and Workforce. • Audit, Outcome and Assurance. QS23.69.3 There had been ongoing activity aligned to the "Just R" marketing and recruitment campaign for staffing in MH&LD which has increased appointments to the MH&LD talent pool. There had been a "deep dive analysis" on vacancies in May 2023 by the Division which informed the development of a specific Recruitment and Retention plan. The Division is actively involved in the Boards' processes for international recruitment for Health Care professionals and during July attended the Royal College of Psychiatrists convention to raise the profile of BCUHB the Division and also to attract and recruit key senior and junior doctors. Staffing vacancies remains a pressure across all areas of the division especially for Nursing and Medical Registrants and recruitment and retention remains a focus for the Division. ACTION: The Committee received the report.	
QS23.70 Integrated Health Community (East) Report QS23.70.1 Michelle Greene (MG), Integrated Health Community Director East apologised that a report had not been produced which was due to annual leave and unexpected staff sick leave. The Chair expressed both surprise and disappointment but agreed that this would be deferred to the next meeting on the 22 August 2023. **ACTION: A written report on the Quality work of Integrated Health Community (East) to be brought to next meeting on 22 August 2023.**	**MG**
QS23.71 SPECIAL MEASURES	
QS23.72 Special Measures Report QS23.72.1 Paolo Tardivel, (PT) Director of Transformation and Improvement presented the report which was taken as read. QS23.72.2 PT highlighted the 41 deliverables for the first 90-day cycle of Special Measures against the agreed milestones. It was noted that the Patient Safety Review was still in draft and would not be completed within the first 90-day cycle which ends on the 31 August 2023. QS23.72.3 The Patient Safety Review was one of three key independent reviews currently underway, which also included the Vascular Review and Mental Health Inpatients Safety Review. It was noted that each of these reviews is currently reaching a conclusion and a report will be formally submitted. It is intended that each of the external reviewers will be invited	

to the 22 August 2023 Committee meeting to present their findings. QS23.72.4 The Quality Strategy was identified as a requirement going forward and development is underway. AW agreed to discuss with the CEO the timing of the development and launch. QS23.72.5 The Committee noted the report. **Action:** • **AW to discuss Quality Strategy with CEO regarding timings** • **The three key independent reviews to be invited to next meeting to present their findings.**	**AW** **PM**
QS23.73 CLOSING BUSINESS	
QS23.74 Reflections on meeting QS23.74.1 The Committee thought that too much time was spent on the minutes and action log. The Chair felt it important to be clear on follow up action before moving on. In future, she hoped to be able to see actions on the log more clearly. It was agreed that reports should be taken as read and this would be made clear to those presenting reports. ML suggested that the link for video for patient/staff story be made available in advance of the meeting in future. QS23.74.2 AW suggested that all reports should be taken as read with presenters only highlighting areas of concern, learning and improvement activity. This should be made clear to those presenting. QS23.74.3 TO asked about Perinatal Mental Health report and it was agreed that this could be circulated out of Committee and any questions could be brought to the next meeting. **ACTIONS:** • **RC to remind those when requesting reports that they will be taken as read and to only highlight issues of concern for the Committee.** • **TO will circulate the Perinatal Mental Health Report to Committee members who can raise questions at next meeting.**	**RC** **TO**
QS23.75 New Risks QS23.75.1 There were no new risks identified during the meeting.	
QS23.76 Date of Next Meeting QS23.76.1 The date of the next meeting is the 22 August 2023, 11:00-13:00, in the Boardroom, Carlton Court, St Asaph.	

QS23.76.1 It was agreed that reports on Duty of Candour; Primary and Community Care would be brought to the September meeting.	

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
AW	**QS23.05** Patient Story**:** Ensure that there is a year-end report received at QSE on Patient Stories.	September	Update - This will come to the September QSE meeting.	
PM	**QS23.49.2** Policies approval delegation. PM agreed that this could be incorporated into the OBS review and planned workshop.	August	PM took update from QSE to Exec Team meeting to discuss approach. It was noted that the current policy on policies doesn't enable a change without changing the policy on policies first. However it was agreed that in the short term a pragmatic approach would be for the three Clinical Execs to review and make short and clear recommendations to note in QSE" to allow for less committee time to be taken on reviewing clinical policies.	
AW	**QS23.67** AW to bring a deep dive on falls to the meeting next month explaining how making change and challenge of embedding into practice.	August	Deferred to meeting on the 14.09.23 when audit report will also be included.	
PM	**QS23.67** PM to highlight any trends in the Risk Register Report.	August	On agenda.	
TR	**QS23.68** Patient Safety Report: TR to include breakdowns in future reporting	September	Not yet due	
MG	**QS23.70** A written report on work of Integrated Health Community (East) to be brought to next meeting on 22 August 2023	August	On agenda.	
AW	**QS23.72** Special Measures Report: AW to discuss Quality Strategy with CEO regarding timings	August	AW has yet to discuss with CEO but in hand	

RC	**QS23.74** RC to remind those when requesting reports that they will be taken as read and to only highlight issues of concern for the Committee.	August	This action has been completed	
TO	**QS23.74** TO will circulate the Perinatal Mental Health Report to Committee members who can raise questions at next meeting.	August	This was circulated to QSE members on the 14.08.23 by email for information.	

RAG Status	
P	Complete
G	On track
A	Slippage on delivery
R	Delivery not on track

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	22nd August 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date on the deliverables associated to this Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the areas of challenge, the process for independently assessing evidence within the PMO, along with the plans being developed for the 2nd 90 day cycle.			
Arweinydd Gweithredol: ***Executive Lead:***	Carol Shillabeer, Chief Executive (Accountable Officer) Dr Chris Stockport, Executive Director of Transformation & Strategic Planning (Lead Executive)			
Awdur yr Adroddiad: ***Report Author:***	Geraint Parry, Special Measures Programme			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures			
Goblygiadau rheoleiddio a lleol:	Not applicable			

Regulatory and legal implications:	
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Not applicable
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Not applicable
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Not applicable
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Not applicable
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	

Quality, Safety and Experience Committee

Special Measures Update

1) Introduction

This report presents an update on the Special Measures deliverables aligned to this Committee, building on the approach outlined in the previous update.

The report reviews the progress as the first 90 day cycle draws to a close, highlighting the areas of success along with the challenges that have emerged, and how this will be taken forward to the next 90 day cycle commencing in September.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response has been covered in previous committees. It has been agreed with the Office of the Board Secretary that a brief summary will be provided each month and the committee will then invite relevant colleagues to attend for any particular deep dives that they wish to undertake.

The July QSE meeting received the first of these updates outlining early progress.

3) Progress to date

The table at the end of this paper provides an update on the relevant deliverables agreed for QSE oversight. The table has been collated from the weekly reporting received from respective teams and from the tracking against the milestones which have been agreed.

Three independent reviews, commenced within the first 90 day cycle, are relevant to QSE. A process is in place for receipt of the reviews, which includes discussion by QSE members, prior to formal themes for further action being agreed. These themes will then be scheduled into our ongoing Special Measures response.

4) PMO Assessment

The table provides details of the progress against deliverables and milestones, and is complemented by an independent assessment that is undertaken by the PMO on behalf of the organisation to ensure that a robust assurance process is in place and that progress is verified. This process is maturing as we work through the cycles.

Overall, solid progress has been made in most areas. There are some areas of challenge emerging which will need to be addressed within the next 90 day cycle – mitigation plans are either in place or being finalised, aiming to course correct moving into cycle 2.

5) Recommendations

The Committee is asked to **RECEIVE ASSURANCE** on the progress to date, acknowledging the areas of challenge, the process for independently assessing evidence within the PMO, along with the plans being developed for the 2nd 90 day cycle.

Table 1: QSE Oversight Report – QSE 22 August 2023

Outcome 1: A well-functioning Board			
Deliverable brief summary	**Lead Executive**	**Delivery Confidence**	**Update**
1.6 Risk: Commence review and revision of risk appetite and approach	Phil Meakin		**Summary extracted from team updates** The new Risk Management approach and a discussion regarding Board risk appetite took place at the Board workshop on the 22nd June. Revised risk documentation shared with CEO for review, and plans are developing for a further Board session around risk. The second milestone around the development of a risk management framework with the Audit committee has not been completed at this stage, and this will need to be a focus within the next 90 day cycle.
			PMO Assessment Whilst the self-assessment for delivery confidence is currently being reported as green, at this stage the PMO assessment is that this will not conclude in its entirety. All areas of work have commenced in line with the broad direction for this deliverable, however further detailed work will be required in the next cycle.

Outcome 3: Stronger leadership and engagement

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
3.8 Clinical Engagement: Review mechanisms for clinical engagement, drawing up recommendations for improvement.	Gareth Evans		**Summary extracted from team updates** A series of interviews have taken place as part of the fieldwork, all in line with the project plan for this cycle, with transcription and analysis of themes taking place during August. Some practical challenges have been highlighted in the ability to engage with practising clinicians at all levels which may impact on the breadth of experiences identified. However work so far is deriving broad and consistent themes.
			PMO Assessment All evidence submitted in line with agreed milestones. On track for delivery in full within the 90 days.
3.10 Address the fragmented care record concerns: Develop tactical and strategic plans for the development of an integrated electronic patient record to address issues of harms, inefficiency and quality of care.	Dylan Roberts		**Summary extracted from team updates** Project meetings have commenced with partners (BJSS) around the tactical blueprint work, including agreement around sequencing of key activities, project milestones and expectation of outputs. However, appointment of a partner to develop the Strategic Outline Case for an Electronic Patient Record (EPR) has been delayed at procurement stage.
			PMO Assessment Progress is being made with regards to this area, but this is partial due to the strategic work being delayed. The current PMO assessment is that this delay to appointing a partner is unlikely to be resolved within this cycle, and that the achievement of a draft outline case by the 31st August will be missed. However, with expedited action this lost time could be resolved within the next cycle, bring the deliverable back on track before the end of the sustainability phase. The next cycle is being rephrased accordingly.

Outcome 4: Improved access, outcomes and experience for citizens

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
4.1 Patient Safety Independent Review: Support and enable the review of patient safety care.	Angela Wood		**Summary extracted from team updates** Completion of the independent review has taken longer than initially envisaged, resulting in some delays to meeting milestone expectations. Workshop activity is planned for teams in the organisation to consider thematic review from within the final report. **PMO Assessment** The delay in progressing actions for this deliverable relate to the delay arising from the independent review process; however the team have responded to this to restructure timelines such that some time can be made up during cycle 2.
4.4 Vascular Independent Review: Support and enable the Vascular Review	Nick Lyons		**Summary extracted from team updates** Final review report awaited. **PMO Assessment** Delays in the formal receipt of the final report have limited the progression of formal responses. It is now unlikely that an action plan to address recommendations will be possible by the end of this cycle. Consequently the creation of a theme-based action plan response will roll forwards into cycle 2.
Service Improvements: Review, revise and implement clear improvement plans: **4.5a Vascular**	Nick Lyons		**Summary extracted from team updates** -Improvement plan in place -Team regularly meeting to deliver and review improvement plan The vascular network team meets weekly to review and update the vascular improvement plan, augmented by a monthly meeting between the network and the professional clinical lead regarding pathways, the National Vascular registry and other medical led actions. **PMO Assessment** Plans are progressing well which has resulted in de-escalation as a service requiring significant improvement by HIW in June 2023.

Service Improvements: Review, revise and implement clear improvement plans: **4.5b Urology**	Nick Lyons		**Summary extracted from team updates** -Improvement plan in place -Clinical lead appointed Robotic surgery provision currently outsourced to a provider in London. Work continuing to explore a solution closer to North Wales. Receiving the Royal College of Surgery review report remains delayed. **PMO Assessment** Delay in milestones related to RCS review, which is required before being able to further refresh the improvement plan.

Service Improvements: Review, revise and implement clear improvement plans: **4.5c Ophthalmology**	Nick Lyons		**Summary extracted from team updates** -Improvement plan in place -Improvement Group commenced -Clinical lead appointment progressing but not yet complete **PMO Assessment** Delayed milestones related to clinical validation of long-waits for surgery which is underway but has not yet been confirmed as complete.

Service Improvements: Review, revise and implement clear improvement plans: **4.5d Oncology**	Nick Lyons		**Summary extracted from team updates** -Improvement plan being progressed -Improvement in key clinical staffing vacancies **PMO Assessment** On track with key evidence submitted demonstrating delivery of milestones and the subsequent impact.

Service Improvements: Review, revise and implement clear improvement plans: **4.5e Dermatology**	Nick Lyons		**Summary extracted from team updates** -First Improvement group meeting taken place -Agreement for clinical engagement event (now being arranged) **PMO Assessment** Based on current evidence received the assessment is that the delivery of a refreshed integrated improvement plan will need to roll forward to the next cycle.
Service Improvements: Review, revise and implement clear improvement plans: **4.5f Plastics**	Nick Lyons		**Summary extracted from team updates** -Work underway with St. Helens and Knowsley and with GP colleagues. -Combining of previous Plastics Task & Finish group actions into single improvement plan **PMO Assessment** Work for the 2nd milestone to review and refresh outstanding agreed actions is underway, but with further assurance required before this can be marked as complete
4.7 MH Inpatients Safety Review: Receive the report of the Mental Health Inpatient Quality and Safety Inspection and commence implementation of improvement actions.	Teresa Owen		**Summary extracted from team updates** Patient Safety Action Group meeting held on 2nd August with Terms of Reference due to be ratified at next meeting. Initial draft of actions has been developed, and currently being reviewed and further strengthened. **PMO Assessment** Action plan has been developed and being progressed. This will also require triangulation with other reviews for thematic issues during cycle 2.
4.8a CAMHS Action Plan: Agree and commence implementation of a CAMHS action plan to improve CAMHS Mental Health Measure performance	Carol Shillabeer		**Summary extracted from team updates** CAMHS Governance Framework drafted and further discussions progressing with WG Advisor. Some concerns regarding external provider capacity along with risks around vacancies affecting internal core capacity. **PMO Assessment** Recovery plan not yet agreed, and thus subsequent commencement against an agreed plan. Mitigation to address is in place.

4.8b Neurodiversity Action Plan: Agree and commence implementation of an ND action plan to improve ND Assessment waiting times	Carol Shillabeer		**Summary extracted from team updates** ND Governance Framework drafted. Some concerns regarding ability to procure additional external provider capacity in interim.
			PMO Assessment ND programme plan reviewed. There is a risk that being unable to provide external capacity to help address demand/capacity gap in short-term will distract the ability to design and implement sustainable longer term solution.

Outcome 5: A learning and self-improving organisation

Deliverable brief summary	Lead Executive	Delivery Confidence	Update
5.2 Learning from Incidents: Ensure there is an effective procedure for learning from incidents, and that preparations for inquests and HSE are clear and effective	Angela Wood		**Summary extracted from team updates** • A meeting has been arranged for NHS Executive/BCUHB executives to agree the scope for the learning framework review. • A learning bulletin is in the final draft stages, supplementing the work of the Organisational Learning Forum (OLF) which is now up and running and functional. • Some specific work underway around learning from incidents in the adolescent service. **PMO Assessment** Clear evidence of good collaboration between colleagues in Quality and in Organisational Development. Awaiting final confirmation of evidence in relation to the learning framework/model before confirmation that on track.
5.3 Clinical Governance Review: Enable and support the NHS Executive to undertake a review of clinical governance	Angela Wood		**Summary extracted from team updates** This review was deemed to be dependent upon the patient safety review (4.1) and consequently the patient safety review delay means this review has not commenced. It has now been agreed that a clinical governance review will take place and this will be scheduled for cycle 2. **PMO Assessment** Review not commenced and will be deferred. As part of the scheduling for cycle 2 will need to incorporate any relevant findings from the patient safety review.

Teitl adroddiad: ***Report title:***	**Clinical Effectiveness – Assurance Paper**			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 22 August 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with an update as at end of Quarter 1 on audit activity within BCUHB			
Argymhellion: ***Recommendations:***	The committee is asked to recieve this report			
Arweinydd Gweithredol: ***Executive Lead:***	Dr N Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Dr James Risley, Deputy Executive Medical Director Joanne Read, NICE Senior Administrator			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Delivery of high-quality clinical care and patient experience			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	There are no known regulatory or legal implications for Betsi Cadwaladr University Health Board			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A			

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Any risks pertaining to the Clinical Effectiveness Group specifically, are now managed through Datix.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no direct financial costs associated with this update. Individual projects or pathways may generate added cost pressures, but these are dealt with through the operational delivery teams.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no current workforce implications associated with the delivery of clinical effectiveness, though these may be identified during the process of undertaking reviews and will be shared if so.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This paper has been written specifically for the Quality, Safety and Experience Committee, and will be reported back to the strategic Clinical Effectiveness Group's next meeting in September
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: ***Next Steps:*** *For the Committee to be assured that appropriate procedures are in place that monitor and ensure processes are followed and requiring action, decision and escalation (when necessary) to Clinical Effectiveness Group (CEG) structure on a regular quarterly basis.*	
List of Appendices: The Quarter 3, Quarter 4 Clinical Audit Reports and the Annual Clinical Audit Report for 2022-2023 were submitted to June Strategic CEG for discussion and to Quality Development Group on 14th August and now to QSE for acknowledgement	

1. INTRODUCTION

Each Integrated Health Community, Division and Sub-Group submit Exception Reports and Chair's Reports as per the Cycle of Business to discuss and review of programs such as National and Local Clinical Audits, to triangulate any identified risks against the risk register, and subsequently escalate any significant risks to the Quality Delivery Group (QDG) via the Strategic CEG Chair's Report. To date, the primary themes for risks identified have related to resource capacity, staffing and training needs required to complete the Annual Audit Plan.

2. PROCESS

Clinical audit is integral to the quality improvement process, and the Health Board receives an annual notification of the National Clinical Audit and Outcome Review Plan (NCAORP) from Welsh Government (WG), which describes priority areas for completion by all Health Boards and which are our Tier 1 mandatory audits. Tier 2 audits are those that are determined by the Health Board to be a priority for completion, and Tier 3 are audits that are recorded at a departmental level. These are incorporated within the Annual Audit Plans of each Division or Directorate and are supported by Local CEG's. These then report into Strategic CEG chaired by the Office of the Medical Director on a quarterly basis.

The Tier 1 audit plan for 2023–2024 lists forty-one audits, three of which were not applicable to the Health Board since some services are commissioned elsewhere, leaving thirty-eight audits that the Health Board is required to complete. Clinical Audit Facilitators monitor Tier 1 audit plans and the completion of SMART (Specific, Measurable, Action focussed, Realistic and Timed) actions in response to the audit findings within agreed timescales.

Clinical Audit is promoted via the BetsiNetWebpage and raising the profile of clinical audit within the Health Board and encourages audit activity through regular bulletins and webpage updates regarding training events.
https://nhswales365.sharepoint.com/sites/BCU_Intranet_CLEFF

The pilot of the Audit Management and Tracking Database (AMaT) is progressing, with Tier 1 actions being monitored through AMaT, as well as those for certain agreed Tier 2 audits. Through this, the team are engaging clinical and corporate stakeholders to deliver increased visibility of audit activity, strengthening real-time reporting, and building relationships with colleagues in other Welsh Health Boards through an AMaT Forum Group and the All-Wales Clinical Audit and Effectiveness Network Group.

The aim is to work towards 100% audit management & tracking of the NCAORP audit programme via AMaT, noting improvements made in quality and safety of patient care, sharing outcomes, experience and lessons learned, whilst identifying which actions have been followed and reported in quarterly reports to Local CEGs (Clinical Effectiveness Groups) and the Strategic CEG. The clinical engagement established during the pilot phase will be further encouraged to achieve full audit engagement with AMaT by the clinical leads, with deadlines subject to project management/clinical resources.

Within each quarterly report the following is noted:

- Updated information on Tier 1 reports published by the host organisation which has analysed the data and written a report that is published in public domain
- Performance against National benchmarks and the previous BCUHB report
- Progress and completed actions
- Any outstanding issues, lack of engagement and details of what has been escalated to local CEGs

The reports provide benchmarked performance which will enable appropriate reflection, action, and learning. Evidence of where information is shared for lessons learnt will now be captured within future quarterly reports to provide an understanding of audit activities across BCUHB.

3. POSITION

Tier 1 Overview of **Quarter 1** - Clinical Audit Activity 2023-2024

	Q1 Apr-Jun	**Q2 Jul-Sep**	**Q3 Oct-Dec**	**Q4 Jan-Mar**
Estimated publications due*	6	11	10	6
Actual publications	6	0	0	0
Service** assessments due	2	8	9	12
Service assessments received	1	0	0	0
Service assessments overdue	1	0	0	0

*Remainder of 38 audit reports not captured in table above will fall in the following year and captured in the Annual Audit Report.

** Service assessments are due/received after publication of a cycle of the audit (National Audit Report). Majority of the audits are continuous.

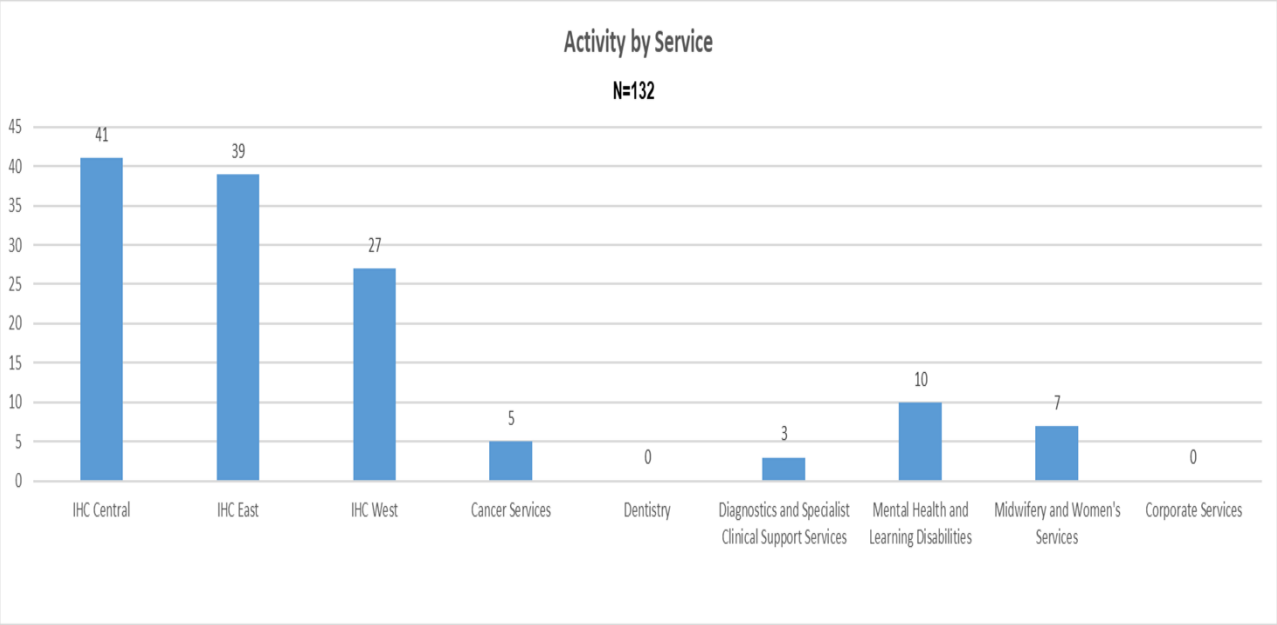
Tier 2 Audit Plan for BCUHB 2023-2024 each audit is monitored by a Local CEG, and updates are included in the reports to Strategic CEG and Quality Development Group.

Audit Ref No.	Project Title	Frequency	Accountable Lead(s)	Responsible Corporate Group	Risk	Monitored By	Clinical Effectiveness Facilitator
1.	DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) Audit	Annual	Dr Ben Thomas, AMD Law and Ethics	Clinical Law and Ethics	High	BCUHB Clinical Effectiveness Group	Sue Yorwerth
2.	Peer review of consent to examination and treatment process	Annual	Dr Ben Thomas, AMD Law and Ethics	Consent & Capacity Strategic Working Group	Critical	BCUHB Clinical Effectiveness Group	Chris Jones
3.	Record Keeping - to include reference to documentation of Multi-Disciplinary Teams (MDTs) as well as general note entry.	Six monthly	IHC MDs - Dr Karen Mottart, Dr Emma Hosking, Dr Tom Davies,	Local Clinical Effectiveness Groups/Quality	Critical	BCUHB Clinical Effectiveness Group	Jodie Williams
4.	Antimicrobial Point Prevalence Audit (Inpatients)	Annual	Charlotte Makanga, Consultant Antimicrobial Pharmacist Dr Karen Mottart, IHC MD	Antimicrobial Steering Group	High	BCUHB Clinical Effectiveness Group	Sue Yorwerth
5.	Antibiotic Review Kit (ARK)/Start Smart then Focus	Quarterly	Charlotte Makanga, Consultant Antimicrobial Pharmacist Dr Karen Mottart, IHC MD	Antimicrobial Steering Group	High	BCUHB Clinical Effectiveness Group	Sue Yorwerth
6.	Safety Checklist (LocSSIPs)	Six monthly	IHC Medical Directors; Dr Emma Hosking, Dr Tom Davies, Dr Karen Mottart	Local Clinical Effectiveness Groups/Quality	High	BCUHB Clinical Effectiveness Group	Chris Jones
7.	Discharge Notification	Quarterly	IHC Medical Directors; Dr Emma Hosking, Dr Tom Davies, Dr Karen Mottart	Local Clinical Effectiveness Groups/Quality	High	BCUHB Clinical Effectiveness Group	Angela Taylor
8.	Ward Manager Weekly Audit	Continuous	IHC Nurse Directors	Multiple	Critical	BCUHB Patient Safety Group	Angela Taylor
9	Sepsis	Quarterly	Matthew Joyes, Deputy Director of Quality	Reports from the STEAR Group into the Strategic Patient Safety Group	High	BCUHB Patient Safety Group	Angela Taylor
10.	Annual Accessible Healthcare Audit	Ongoing	Rachel Wright	Patient Experience Team	High	BCUHB Patient Safety Group	Chris Jones
11.	Hospital Acquired Thrombosis	Quarterly	IHC MD - Dr Karen Mottart, Dr Emma Hosking, Dr Tom Davies, Lead Thrombosis Nurse: - Chrissie Wellburn	LDG (Quality)	High	BCUHB Clinical Effectiveness Group	Jodie Williams

Tier 3 Audit Activity

This activity relates to those audits that are agreed by the service/specialty and included within their local Annual Clinical Audit Plan. Activity is captured through our self-registration database; project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During Quarter 1, 132 projects were registered across the Health Board. The largest proportion of tier 3 audit topics were linked against NICE (National Institute for Clinical Excellence) Guidelines (17.4%). Of the remainder: 15.2% were re-audits, 15.2% in response to National guidelines and 9.8% were service evaluations. There was a total of 59 projects completed during the Quarter 1.



4. SUMMARY – Tier 1 Process

Measurable policy objectives	Monitoring or audit method	Monitoring responsibility (individual, group or committee)	Frequency of monitoring	Reporting arrangements (committee or group the monitoring results is presented to)	What action will be taken if gaps are identified
A Service Assessment of compliance form is expected from Clinical / Project Leads for ALL projects relevant to the Health Board, which form the Welsh Government's annual National Clinical Audit & Outcome Review Plan (NCAORP).	Audit Spreadsheet / database	Clinical Effectiveness Facilitators will coordinate completion of the Service Assessment of compliance form with relevant Clinical/Project Leads. IHC/Division through local clinical effectiveness meetings	Continuously reviewed and updated	Audit Spreadsheet for internal monitoring only	Areas that do not complete a Service assessment of compliance form within the timeframe stipulated will be reported as not received. The outstanding project is reported with the Clinical Effectiveness exception report to Local CEGs, then submitted on Chair's report each quarter to Strategic CEG, and noted on an action tracker to be monitored monthly. The relevant IHC or Division will be responsible for following the assessment of compliance form. Escalation, if necessary, will be via Chair's report from Strategic Clinical Effectiveness Group to Quality Delivery Group
	Weekly catch up with Clinical Project Lead to review returned Service Assessment of compliance forms prior to sign off by Executive Deputy Medical Director (EDMD)		Weekly Monthly	Clinical Effectiveness Departmental meeting Clinical Effectiveness and NICE assurance Group meet to go through Tier 1, Tier 2 and all update of NICE guidance	
	Local Clinical Effectiveness Meetings for Central, East and Mental Health and Womens Division - Monthly Clinical Effectiveness exception report Local delivery Group Quality for West (LDGQ) request exception report twice a year		Monthly Twice a year but certain exceptions can be reported verbally at monthly in any other business	Local CEGs Strategic CEG (except West) Local delivery Group Quality for West (LDGQ) request	

Quarter 3

Clinical Audit Activity

2022-2023

1.0 The National Audit Programme and Clinical Effectiveness Overview

The Health Board receives an annual notification of the National Clinical Audit and Outcome Review Plan (NCAORP) from Welsh Government (WG) which describes priority areas for completion by all Health Boards regarding mandatory audits; these form our Tier 1 activity. Relevant Tier 1 (National audits) are incorporated within relevant Divisional/Directorate annual clinical plans, progress on which is then reported by the Clinical Effectiveness Department on a quarterly basis.

A new BCUHB service assessment proforma has been developed, to secure and track quality assurance capturing details from National Audit findings and recommendations, local continuous quality improvement, identifying levels of assurance and any clinical risk. The form has been piloted since early November 2022 and an update will be reported in the annual report on progress made with this new process.

2.0 Risks reported to the Clinical Effectiveness Team - Identified by the Cardiology Department

The service reported during Quarter 3, its inability to deliver timely care and treatment, which may result in poor outcomes. The services across BCUHB are addressing long waiting patients through additional lists, but this is not a sustainable solution long term. The current risks reported in quarter 3 on the register are:

- Risk for West 2304: risk associated with long waiting lists for outpatient appointments. Mitigated currently by additional waiting lists.
- Risks for East 2951: risk associated with limited cardio-respiratory workforce and 3937 inabilities to access Cardiology Outpatients
- Pan BCUHB risk 4431 heart failure provision across North Wales. Business case has been approved.

3.0 Tier 1 Overview of Quarter 3 - Clinical Audit Activity 2022-2023 The tables below show the position on 31/12/2022 (end of Quarter 3).

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2023/2024
Estimated publications due	10	9	13	7	5
Actual publications	13	9	7	0	-
Part A due	4	16	4	*	
Part A received	4	10	0		
Part A overdue	0	6	3		
Part B due	0	3	17	16	7
Part B received	0	3	11	0	-
Part B overdue	0	0	6	0	-

* November 2022 - change in assurance process to a single stage response, which removed the “Part A” element.

3.1 BCUHB Assurance returns

3.1.1 Part A returns for Quarter 3 2022-23

List of delayed & outstanding Part A returns

National Audit publication	Reason for non-response & escalation
National Paediatric Diabetes Audit (NPDA) – PREMs Report 2021	Response received from YGC, and draft response received from West. Lack of engagement to requests for a response to the publication escalated to Clinical directors, BCUHB Diabetic Lead & Head of Clinical Effectiveness.
National Hip Fracture database - Improving Understanding report on 2021	Lack of engagement to requests for a response to the publication from Wrexham Maelor has been escalated to Clinical Directors, Director of Nursing, CPG manager and Head of Clinical Effectiveness. Received draft response from YGC & YG both working towards finalising a SMART action plan.
National Early Inflammatory Arthritis Audit (NEIAA) – Year 4 Annual Report	Part A not received. Have been engaging with the lead in Llandudno, who is working on a full response on behalf of BCUHB using the new departmental service assurance proforma with a deadline for Quarter 4.

3.1.2 Part B returns

Eleven of the seventeen Part B returns due were received – please see table below.

National Audit publication	Lessons/Actions
National Maternity and Perinatal Audit (NMPA) Annual Report 2022	**BCUHB wide actions received in Quarter 3 still in discussion with Governance lead.** • Ongoing monitoring of themes and trends in readmissions reported on Datix has been commenced by Clinical Governance Lead to ensure that all findings are actioned as part of a new Integrated Governance and Patient Safety report and is presented to the North Wales Women's Board quarterly.

	• Review of the data being collected around breast feeding to be completed by the Infant Feeding Co-ordinator and reported to the Infant Feeding Strategy Group by Quarter 4 to meet the recommendation with a view to raising awareness and improving breast feeding figures. • The iDecide system-decision-making and consent tool has received an initial review within maternity services to improve the availability and quality of information about possible interventions during labour. Further discussions on its possible implementation are progressing. Action for Head of Midwifery. • Women discuss the Birth Choices options with a consultant or a midwife and are counselled and offered an episiotomy prior to experiencing a forceps-assisted birth, to reduce the chance of an Obstetric Anal Sphincter Injury. • Current maternity Quality indicators are used to identify variations in measures as recommended, this needs to progress to the identification of Indicators which require a deep dive. Due Quarter 4. • Review of data completeness to be completed by service managers to identify areas for improvement and identify when they will be added, and support implementation service managers will work with the Informatics Team to identify plan for harmonisation as recommended. Due Quarter 4.
Stroke Audit (SSNAP) – 2021 Acute Organisational Report	**BCUHB Action plan received outlining the following recommendations & actions:** • **Provide access to specialist stroke rehabilitation including early supported discharge team** - Implementation of Early Support Discharge Pathways and Teams. (Quarter 4 2022/23). • **Provide therapy 7days/week for stroke rehabilitation** - Recruitment of Multi Professional Rehabilitation Assistant roles to support the stroke rehabilitation pathway for 7 days working. (Quarter 4 2022/23). • **Access to clinical psychology as part of the multidisciplinary rehabilitation team** - Recruitment to the Clinical Psychology team (Quarter 4 2022/23). • **Provision of same day access to a diagnostic service for p people with suspected transient ischaemic attack (TIA) and minor (non-hospitalised) stroke** - Business case for investment in CT perfusion to be written, following review of same-day access to specialist assessment and MRI scanning (Quarter 4 2022/23).

NACAP: Children and Young Person Asthma – 2021 Organisational Report	**Action plan received outlining the following recommendations & actions:** • **Use of ward asthma discharge bundle** - As this is one of the key findings of the NACAP audit this has been introduced in **Central** to meet the recommendation. Data is collected and reviewed in real time and via NACAP audit process • **Provision of Respiratory Nurse Specialist** - Support to be secured to appoint asthma nurse specialist in the **West (**Quarter 3 2023/24). • **Availability of spirometry and fractional exhaled nitric oxide (FeNo) tests to aid diagnosis -** Spirometry test purchased and awaiting staff training. FeNO readings due to commence in the **West** (Quarter 3 2023/24) • **Provision of a formal transition service from Child to adult asthma services -** Transition audit in the **West** to be undertaken by Consultant to assess quality of experience (Quarter 3 2023/24)
Myocardial Ischaemia National Audit Project (MINAP) – 2022 Summary Report	**Action plan received outlining the following actions for Consultant teams and Strategic Manager:** **BCUHB wide actions:** • Demand and capacity work has been completed to review the Health Board's cardiac physiology workforce. • Network Manager has alerted operational site manager of speciality bed compliance in September. • Individual sites have a process of monitoring speciality bed compliance and report to local Hospital Management Teams, however current emergency pressures have impacted this. • Individual sites to continue to monitor audit target outliers and report to local hospital management teams regularly. • Briefing paper escalated to the executive team to alert a drop in performance of call to balloon. • Cardiology have joined the Health Board intrahospital transfer group which meets weekly to address transfers, delays etc. • Welsh Ambulance Service NHS Trust (WAST) alerted of Call to Balloon (CTB) time breaches and asked to review data and will be updated now that WAST are included in the intrahospital transfer group
National Heart Failure Audit (NHFA) – 2022 Summary Report	**Action plan received outlining the following actions for consultant teams and Strategic Manager:** • Due to increasing pressures on echocardiogram physiology and unmet demand, to mitigate the risk currently, echocardiogram physiologist attends the cardiology ward to perform bedside echocardiograms.

	• Advanced Heart Failure Specialist Nurse to be appointed in Quarter 4 who will prescribe and action specialist treatment plans. This will ensure the correct and appropriate treatment pathways are being delivered. Funding has been agreed for Business Case (December 2022). • Data inputting to audit to be reviewed and shared in the Cardiology Steering Group which sits quarterly to develop more robust accurate data submission. • Full review and mapping of the Cardiac Rehabilitation service to be included in 2023/24 priorities to improve standards. This has begun and will be monitored in monthly meetings and through the Heart Failure Project Board. • Audit data submission to resume due to successful appointment of a nurse. • Business Case Approved to improve diagnostic process via NTproBNP usage (blood test) for suspect Heart Failure (HF) patients will enable referrals to echocardiography to be more appropriate and will remove unwarranted activity. • The Imaging Business Case for North Wales now submitted outcome due in April 2023 and will help deal with the echocardiography backlog (together with coronary computed tomography angiography (cardiac CT), magnetic resonance imaging (MRI) and nuclear testing supporting HF diagnosis) still awaiting outcome.
National Audit of Cardiac Rhythm Management Devices and Ablation (NACRM) – 2022 Summary Report	• An audit will be undertaken by Consultant Cardiologist and team in East and West to identify reasons for high rate of re-intervention. Audit findings will be provided to Clinical Effectiveness Team Q4. • Cardiac Physiologist will continue to monitor the inputting of vital audit data and this will be addressed with physiologists entering the implant on audit host website in Quarter 4. • A business case for a second pacing consultant is in progress. This will address the staffing issues. Clinical Effectiveness Team enquired how they would address the other issues in the meantime, but no response was received. • Technicians are empowered to challenge implanters decision to use Ventricular demand pacing for sinus node disease and atrioventricular node disease if patient is not frail. This is the current process aimed to minimise the use of ventricular demand pacing in line with NICE.
National Audit of Percutaneous Coronary Intervention (NAPCI)	• Consultant Interventional Cardiologist to continue to monitor performance and feedback in the quarterly Cardiac Steering group.

Audit – 2022 Summary Report	• Strategic Manager and Consultant Interventional Cardiologist to monitor recovery following COVID 19 and share findings with the Cardiac Steering Group. • Strategic Manager and Consultant Interventional Cardiologist to share Primary Percutaneous Coronary Intervention success with BCUHB and wider in Quarter 4.
National Clinical Audit of Seizures and Epilepsies for Children and Young People – 2022 Main Report	**Action plan received outlining the following actions for Consultant teams:** Pilot project to be completed implementing questionnaire to monitor emotional and mental health needs of children with epilepsy by Quarter 4 and consider roll out BCUHB wide. • To continue to audit the Valproate Prevent Programme and ensure that all patients fulfilling the criteria have annual forms completed and ongoing discussions about risks documented. • Audit discussions around Sudden Unexpected Death in Epilepsy (SUDEP) and ensure care planning for risks and participation are discussed and documented appropriately regularly in the Children's Epilepsy Advisory Group (CEAG). • CEAG to liaise with the neurophysiology Department to identify ways to provide assurance that there is sufficient capacity and pathways to achieve electroencephalogram (EEG) within 4 weeks of referral where appropriate. • Paediatricians with interest in childhood epilepsy & Children's Epilepsy Advisory Group (CEAG) to continue to work with IHC and Operations Managers to improve time and support to undertake Epilepsy12 audit work including data entry and submissions for each new case and the annual updates. To be monitored in CEAG. Due Quarter 4. • Assurance that buccolam care plans are being used appropriately and updated annually to improve patient care - CEAG to discuss co-ordinated audit across 3 IHCs which sits quarterly. • A newly appointed adult Neurologist is starting over the next few months who will have this within his job plan, with a view to re-commencing the joint-transition clinics in Central IHC by Easter 2023.
National Clinical Audit of Psychosis	BCUHB Early intervention Psychosis (EIP) service is in the process of restructuring and developing a EIP team in each of the localities. This will enable us to manage the scale of the recruitment and development safely and with all detail managed. This has been based on the predicted incidence being highest in the East with no current service and the lowest incidence in the West with some EIP provision already in place. These teams will be a full stand-alone service and each area will have the required professional mix to be able to provide the clinical and therapeutic work required for a full EIP service.

	The service will be provided for service users between 16 to 35 years - this will increase with further funding and developments and meet the required standards as per the National Clinical Audit of Psychosis. The plan is to roll this out BCUHB wide.
National Audit of Care at the End of Life (NACEL) – 2020/21 (round 3) Annual Report	**BCUHB Action plan received outlining the following recommendations & actions**: • **Communication with the dying person, families and others** - To complete the Palliative, End of Life and Bereavement Care (PEoLBC) strategy which includes improving systems and processes of communication for those who are approaching end of life. (Quarter 4 2022/23). • **Individualised plan of care and staff support** - To complete the End of Life (EoL) Decision Making Project to review and highlight where and what the need is in relation to EoL decision making including strategic, governance and operational structures together with a supporting programme of training (Quarter 2 2023/24).
NACAP: Pulmonary Rehab (PR) – 2021 Organisational Summary Report	**BCUHB wide action plan received outlining the following actions:** • **Provide PR to all people with a COPD self-reported exercise limitation Medical Research Council (MRC) grade 3–5 (90.1% of services)** - Teams have taken steps such as increase capacity, maximise throughput and improve efficiency across all BCU programmes to ensure that patients referred are able to participate in the programme. • **Provide access to transport to improve uptake to the service** - Senior Therapy management are supporting the return to venues (post COVID) and are looking at alternative venues on hospital grounds so that we can access hospital transport for patients. • **If 6-minute walk tests (6MWT) are being used to measure exercise capacity, use a 30-metre course to adhere to technical standards** - Teams (East, Central & West) are working to secure access to previously used hospital venues to deliver programmes for patients with more complex needs but gym spaces have been repurposed. Clinical teams have been unable to identify a target date. Pulmonary rehabilitation service provision is considered a priority by Physiotherapy management and is being considered for IMTP priorities for 2023/24.

List of delayed & outstanding Part B returns

National Audit publication	Reason for non-response & escalation
National Diabetes Audit - Adolescent and Young Audit (AYA) - 2017-21 Adolescent and Young Adult Type 1 Diabetes Report	**Action plan not received from all 3 sites**. Lack of engagement to requests for a response to the publication escalated to Area Medical Directors, Clinical directors, BCUHB Diabetic lead & Head of CE. Meeting with BCUHB Diabetic lead held 9th November 2022 to discuss outstanding response. Lead agreed to support progress with outstanding diabetic responses and complete in Quarter 4 2022/2023.
NACAP: Adult Asthma & COPD – 2021 Organisational Report	**BCUHB Action plan not received.** Respiratory team currently feel they are not in a position to submit an action plan as the lack of progress against many of the requirements is stark. Our services are so far behind post covid and due to loss of staff that any response to the organisational audit is far off the KPIs. Ongoing issues with participation with **East** and **West**, **Central** have employed admin for 0.5 WTE from November 2022 to help with data submission.
National Diabetes Audit: Type 1 Diabetes 2020-21 Report	**Action plan not received in West & East**, escalated to Area Medical Directors, Clinical directors, BCUHB Diabetic lead & Head of CE. Meeting held with BCUHB Diabetic lead (Nov 2022) to discuss outstanding responses, lead agreed to support progress and complete in Quarter 4 2022/2023. **Action plan received from Central outlining the following actions:** Decrease the number of patients waiting for new and review appointments (Quarter 4 2022/2023). • Revision of data input and training for staff on the use of system (Quarter 4 2022/2023). • Established short term interim Nurse Consultant role to address the waiting list times (Completed).
National Diabetes Audit - Report 1 Care Processes and Treatment Targets 20/21	**Action plan not received for all three areas**. BCUHB Diabetic Lead has drafted an action plan end of December 2022 to discuss and agree with Area management and complete in January 2023.
National Diabetes Inpatient Safety Audit (NDISA) – 2018-21 Report	**Action plan not received for all three sites**. Lack of engagement to requests for a response to the publication escalated to Area Medical Directors, Clinical Directors, BCUHB Diabetic lead & Head of CE. Meeting with BCUHB Diabetic lead took place to discuss outstanding response.

	Lead agreed to support progress with outstanding diabetic responses and complete in Quarter 4 2022/23.
National Hip Fracture database – 2021 Report	**Action Plan not received for East**. Received draft response from West and Central but returned as not SMART actions, both areas now working towards finalising on the new service assurance proforma.

3.2 Benchmarking

When a National Audit report includes Health Board specific data, we benchmark BCU against the National outcomes and against BCU data in previous reports.

Key	***Comparison with National Benchmark*:**	***Comparison with Last BCUHB Report*:**
R	Where BCUHB reported performance is at or above the benchmark in less than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

Seven National Audit reports have been published in Quarter 3, of which six included BCU identifiable data. The table below outlines the benchmarking information:

Tier 1 Project reference	Title	*Performance against*		*Progress / Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Long Term Conditions					
NCAORP/2022/14	Renal Registry	**A**	**A**	• Renal Registry makes **no** recommendations in its national report. Renal teams identify local recommendations for their service.	• Action plan due to be completed in Quarter 4 – Annual Report.
NCAORP/2022/15	National Early Inflammatory Arthritis Audit	**R**	**G**	• Maintained or improved compliance compared to last report.	• Action plan due to be completed in Quarter 4 – Annual report.
Older People					
NCAORP/2022/17	Sentinel Stroke National Audit Programme (SSNAP)	**A**	**A**		• Action plan due to be completed in Quarter 4 – Annual Report.
NCAORP/2022/19	In-patient Falls Audit (Falls & Fragility Fractures Audit Programme)	**R**	**A**	• Maintained compliance in line with last reported period, however performance compared to national average has dropped.	• Action plan due to be completed in Quarter 4 – Annual Report.

Tier 1 Project reference	Title	*Performance against*		*Progress / Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Heart					
NCAORP/2022/28	National Vascular Registry	**A**	**G**		• Action plan due to be completed in Quarter 4 – Annual Report.
NCAORP/2022/29	National Audit of Cardiac Rehabilitation	G	Format of data changed. Comparison is not meaningful		• Action plan due to be completed in Quarter 4 – Annual Report.
Women's and Childrens Health					
NCAORP/2022/33	National Neonatal Audit report published 10/11/2022	**A**	**A**		• Action plan due to be completed in Quarter 4 – Annual Report.

3.3 Assurance response timetable for reports published in Quarter 3 - as of 31st December 2022

Project Reference	Title of National Audit	Name of report	Date of publication	Assurance response due in Quarter Report
NCAORP/2022/15	National Early Inflammatory Arthritis Audit	Year 4 Annual Report (Data collection: 1 April 2021 – 31 March 2022)	11-Oct-22	Quarter 4
NCAORP/2022/28	National Vascular Registry	2022 Annual Report	10-Nov-22	Quarter 4
NCAORP/2022/17	Stroke Audit (SSNAP)	9th Annual Report	10-Nov-22	Quarter 4
NCAORP/2022/19	In-patient Falls Audit (Falls & Fragility Fractures Audit Programme)	Working together to improve inpatient falls prevention (2021 clinical & 2022 facilities audit data)	10-Nov-22	Quarter 4
NCAORP/2022/33	National Neonatal Audit Programme (NNAP)	National Neonatal Audit Programme summary report on 2021 data	10-Nov-22	Quarter 4
NCAORP/2022/14	UK Renal Registry	24th Annual Report	12-Dec-22	Quarter 4
NCAORP/2022/29	National Audit of Cardiac Rehab (NACR)	Quality and Outcomes Report 2022	14-Dec-22	Quarter 4

Key		
	Red	Response overdue
	Amber	Response not received but within deadline
	Green	Response received

4.0 Tier 2 Audit Program

The Tier 2 program is a suite of audits mandated across the Health Board (which are not reported nationally) related to high-risk activity and corporately agreed service improvement priorities. It is likely that the number of these audits will increase in line with evidence from Harms reviews, Concerns recommendations, Prevention of Future Death Notices, and Ombudsman reports. The CE team is working closely with the Quality Department to ensure that the correct Tier 2 audit program is in place to provide assurance across the risks which the Health Board holds. **There have been no Tier 2 reports delivered in Quarter 3 (as per the reporting schedule).**

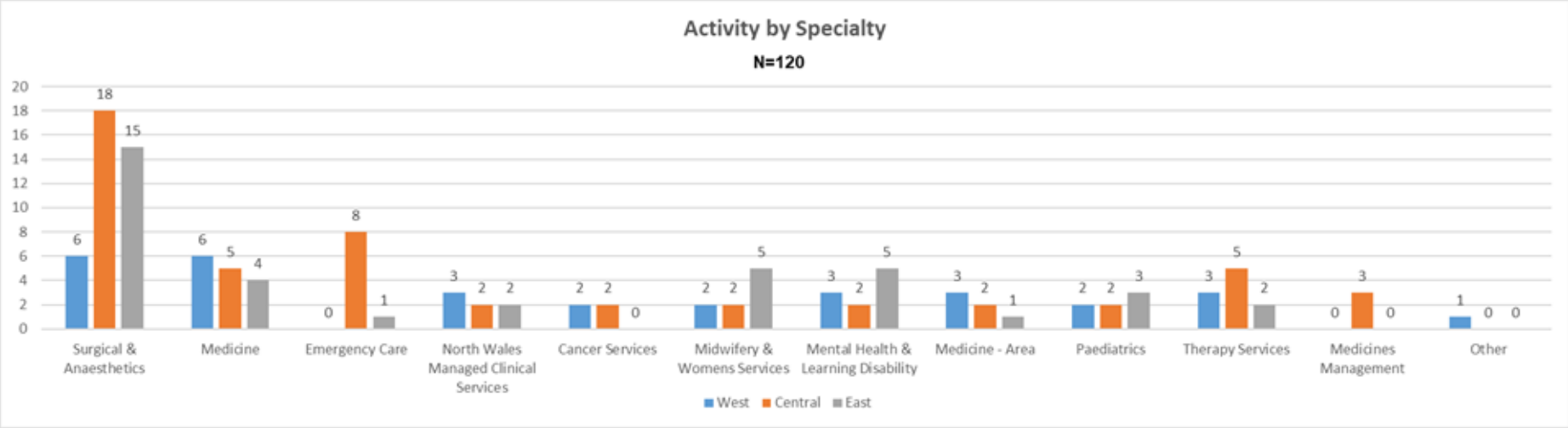
Project title	Report due	Objectives
Ward Manager Weekly Audit	**IRIS - continuous**	This audit complements the ward accreditation framework, monitoring standards across a number of areas; patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care. The output from the audits is reported on IRIS. The metrics questions are currently under review. Ownership is locally by the ward manager and site nursing hierarchy. This very broad audit reports to IPSG, Safeguarding, PQSG (Quality EDG) and ultimately QSE depending on the subject. To be updated again in the annual report.
Start Smart then Focus	**Continuous** (month by month)	Continuous online audit via Public Health Wales tool, undertaken by prescribers in secondary care. Still poor compliance with audit across BCU. Agreed at BCU strategic Antimicrobial Stewardship Group (ASG) to form a short-term working group to look at audit and make recommendations to Wales AMRDB (Antimicrobial Resistance Delivery Board). The AMRDB is the group that leads the AMR agenda for Wales as the operational delivery group with all HBs in Wales. Recommendations will be made to Welsh Government on the audits to be completed around Antimicrobial Resistance (AMR) and Antimicrobial Stewardship (AMS). Piloting of a different model of data collection and feedback at Ysbyty Gwynedd is underway and this will be presented and reviewed to the working group in January, and that group will make recommendations to the AMRDB meeting in the New Year.

Project title	Report due	Objectives
		• Start Smart then Focus audits under review. YG site are piloting a different method and way of collecting data. Due to present back early findings this month (January) to infection prevention subgroup (IPSG) and Antimicrobial Stewardship Group (ASG). Meeting with BCUHB working group to discuss the finding and take back to Antimicrobial Resistance Delivery Board (AMRDB Wales group) in March 2023.

5.0 Tier 3 Audit activity

This activity relates to those audits that should be agreed by the service/specialty and included within their local annual clinical audit forward plan. Activity is captured through our self-registration database; project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During Quarter 3, 120 projects were registered across the Health Board and there was a total of 53 projects completed during the quarter. the largest proportion of Tier 3 audit topics were linked to service evaluation (23.3%) and re-audit (14.2%). Of the remainder: 13.3% were against NICE guidelines and 7.5% in response to National guidelines.



Draft Quarter 4

Clinical Audit Activity

2022-2023

1.0 The National Audit Programme and Clinical Effectiveness Overview

The Health Board receives an annual notification of the National Clinical Audit and Outcome Review Plan (NCAORP) from Welsh Government (WG), which describes priority areas for completion by all Health Boards regarding mandatory audits; these form our Tier 1 activity. Relevant Tier 1 (National audits) are incorporated within relevant Divisional/Directorate annual clinical plans, progress on which is then reported by the Clinical Effectiveness Department on a quarterly basis.

2.0 Risks reported to the Clinical Effectiveness Team

The current risks reported to Clinical Effectiveness on the Risk Register in Quarter 4 are:

Audit	Audit level	Risk ID	Risk Tier	Risk level	Nature of Risk
Stroke (SSNAP)	Tier 1	4022	**Tier 2**	**High**	Delay in Stroke assessment/treatment compromising patient care/outcomes
2222 (Emergency call out)	Tier 2	3731	**Tier 1**	**Extreme**	Delivery of safe and effective resuscitation may be compromised due to training capacity issues
2222 (Emergency call out)	Tier 3	3082	**Tier 2**	**High**	BCUHB cannot report accurate cardiac arrest or outcome data.
DNACPR	Tier 2	2124	**Tier 3**	Moderate	Communication issues and lack of defined pathway may lead to inappropriate resuscitation and potential clinical negligence claims/concerns.

3.0 Tier 1 Overview of Quarter 4 - Clinical Audit Activity 2022-2023

The tables below show the position on 31/03/2023 (end of Quarter 4).

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2023-2024
Estimated publications due	9	8	12	4	5
Actual publications	13	8	7	4	-
Part A due	3	16	2	*	
Part A received	3	11	0		
Part A overdue	0	5	2		
Part B due	0	3	17	10	8
Part B received	0	3	12	6	-
Part B overdue	0	0	5	4	-

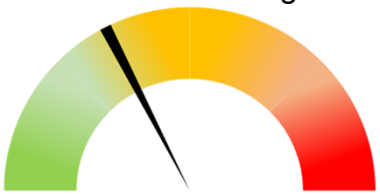
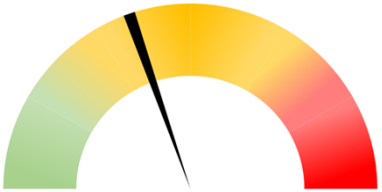
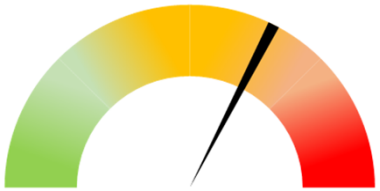
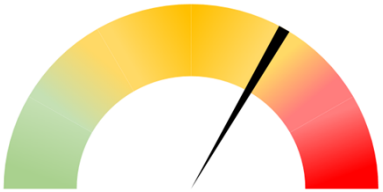
* November 2022 - change in assurance process to a single stage response, which removed the “Part A” element.

3.1 BCUHB Assurance returns

3.1.1 List of completed Service Assessment returns

Six of the **10** service assessment returns due were received – please see table below.

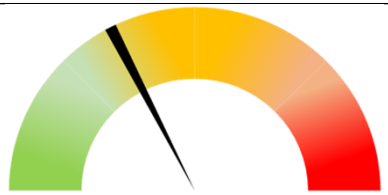
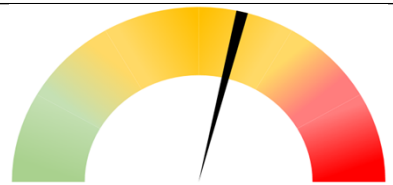
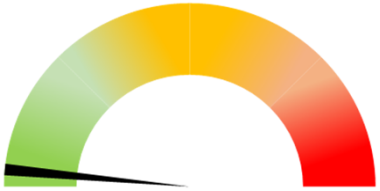
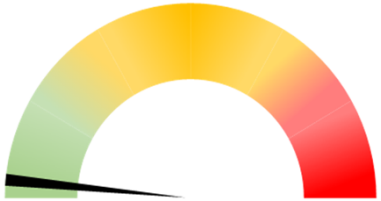
National Audit publication	Lessons/Actions

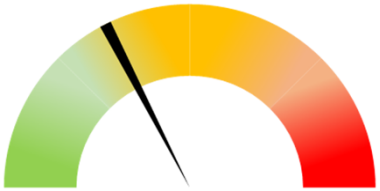
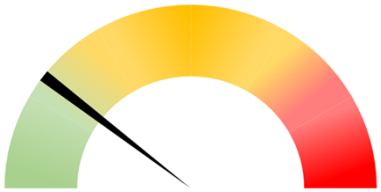
<table>
<tr><td rowspan="2">National Vascular Registry Audit (NVR) – 2022 Annual Report (2019-21 audit period)</td><td>Assurance Level: Significant
 
The service is in the process of examining the reasons for the open aneurysm mortality rate, treatment delays and specialist amputee therapy support.</td><td>Clinical risk level: Minor
 
All of the issues are work in progress to reduce the potential risk to patients and outlined in the action plan.</td></tr>
<tr><td colspan="2">BCUHB Action plan received outlining the following actions:
Effective pre-operative patient work up – work to increase specific pre-operative diagnostic investigations, which includes Cardio respiratory stress assessment as part of abdominal aortic aneurysm (AAA). Access in a timely manner is a challenge given the nature of the urgent surgery (Quarter 3 2023/24)
Pre-Operative Assessment Clinic (POAC) support - A business case has been put forward for increased POAC support to the health board in 2022 through the surgical directorate at Glan Clwyd. This is not specific to Vascular but it will support vascular .The decision is awaited. (Quarter 3 2023/24)
Increase theatre capacity - There is an organisational programme to improve theatre capacity as part of the “Journey to Excellence” and work will commence for vascular in February 2023. (Quarter 4 2022/23)
Specialist amputee therapy - There is a recognition that a definitive rehabilitation service to support vascular amputees does not exist. A desktop exercise is being undertaken on February 2nd 2023 to review previous patients post amputee pathway. This will identify some of the gaps in the service before a larger multi-agency transformation programme commences in March/April 2023 (Quarter 4 2023/24)</td></tr>
<tr><td>Stroke Audit (SSNAP) – 9th Annual Report (2021/22 Audit period)</td><td>Assurance level: Limited
  </td><td>Clinical risk level: Moderate to Major
  </td></tr>
</table>

	The demands of the 3 acute hospital sites, in particular delays in ambulance responses, the Emergency Department (ED) and high acuity of Stroke patients presents challenges to patient flow. The COVID-19 pandemic has also impacted upon all areas of performance, particularly therapies performance due to the inability to proceed with group sessions.	There is a risk that patients' assessments, diagnostic test, therapeutic intervention and therapy will be delayed. This could lead to harm, deterioration in condition, which would lead to increased level of intervention required, longer length of hospital stay, long-term impact on quality of life following a stroke and irreversible health effects
	BCUHB Action plan received outlining the following actions: • **Direct to Acute Stoke Unit (ASU) within 4 hours -** establish a Stroke assessment bay on ASU to enable immediate transfer of patient from the Emergency Department to the specialist unit. (Quarter 1 2023/24). • **Computerised Tomography (CT) scan within 1 hour -** establishment of Stroke assessment bay will support implementation of straight to CT scan pathway. (Quarter 1 2023/24) • **Increased service hours of Stroke coordinators/specialist nurses -** The extended service of an additional 3 hours per site will support improvement of compliance against key performance indicators and subsequent patient outcomes. (Quarter 1 2023/24) • **Support increased therapies performance and facilitate patient flow -** Stroke specialist rehabilitation unit to support increased therapies performance and facilitate patient flow to create bed capacity on the acute hospital site to improve direct to ASU target attainment. (Quarter 1 2023/24) • **Support optimise patient therapies time and rehabilitation -** The Early Supported Discharge service will support and optimise patient therapies time and rehabilitation, it will also facilitate patient flow to create bed capacity on the acute hospital site to improve direct to ASU target attainment. (Quarter 1 2023/24)	

National Neonatal Audit Programme (NNAP) – 2021 Summary Report	**West**		**Central**		**East**	
	Assurance: Limited	**Risk:** Moderate	**Assurance:** Significant	**Risk:** Low	**Assurance:** Limited	**Risk:** Low
						

	East were formally identified with an outlier status for two year follow up and limited assurance is reported because of this however the audit lead reports that premature babies receive four other enhanced developmental follow ups in the first 18 months so he considers the clinical risk is low. West are struggling to provide the recommended eye test for premature babies because they are sharing the Ophthalmologist from Central. **It has been stated that support from the Board for the Business Case would help these vulnerable babies.**	
	• **West, East and Central signed off Locally** • **Not yet signed off by OMD** **Action plan received outlining the following actions:** • Audit to be carried out in to investigate the cause of the **low provision of two year follow up** by 01/01/2024. Staffing gaps to be investigated and clinician to be identified to undertake follow up in Central. • Our maternity and neonatal services joined Perinatal Excellence to Reduce Injury in Premature Birth (PERIprem Cymru) in 2023. PERIprem is a bundle of perinatal activities aimed at optimal start in life for premature babies. The bundle includes timely administration of **antenatal steroids, magnesium Suphate** and will have a positive impact on the incidence of **bronchopulmonary dysplasia** (BPD). • **Breastfeeding on discharge** improved in 2022 as a result of completed actions in East. In West and Central Stage 2 Baby Friendly Initiative (BFI) Accreditation training is ongoing via UNICEF Nivea Project in or to improve breastfeeding levels. • Dr M Joishy (Consultant Paediatrician) in West is the handler for the risk associated with the **Retinopathy of Prematurity (ROP) service**. Interim management has been evolving e.g. Consultants from Liverpool and Wrexham have supported the service but currently babies have been taken to YGC for ROP. A business case is being submitted to find a long term arrangement for ROP screening for both YG and YGC. Discussion around nurses conducting the ROP test. Due 31/12/2023 • Data monitoring and feedback to be carried out to improve the picture in the next report for the percentage of **parents seen within 24 hours by senior staff**. Outcome due in June 2023 • In West **parents presence during consultant ward round** is the subject of a quality improvement project. Results are due July 2023.	
National Audit of Cardiac Rehab (NACR)	**Assurance level: Significant**	**Clinical risk level: Moderate**

<table>
<tr><td rowspan="2">- Quality and Outcomes Report 2022</td><td> 
Green certification status granted across all 3 BCU sites (40% of programmes across the UK are green certified)</td><td> 
Across BCU the services are unable to offer cardiac rehab to all cardiology patients and this is currently under review by the Strategic Lead and the pathway team. Staffing remains a challenge and this has been escalated through the Directorates and the North Wales Cardiac Steering Group.</td></tr>
<tr><td colspan="2">Action plan received outlining the following actions:
• BCUHB plans to recruit to vacancies by May 2023 and train new staff to meet the recommendation to reduce known inequalities in service provision.
• Several members of staff will undergo Rehabilitation Enablement in Chronic Heart Failure (REACH-HF) training by June 2023 in order to ensure that service complies with British Association for Cardiovascular Prevention and Rehabilitation (BACPR) standards
• Psychology input to be mapped and developed as part of the new Pathway for Cardiac Rehab to be developed by September 2023.
• Ensure adequate staffing levels at all times, with up-to-date Immediate Life support (ILS) training to reduce excess risk associated with exercise training. Continue to risk stratify all patients to ensure appropriate numbers and staffing are available. Completed action.
• Ca-rdiac Rehab are working with the pathways team to review the service with the aim to safely provide all components of CR to all eligible groups. Pathway due September 2023.</td></tr>
<tr><td>National Prostate Cancer Audit (NPCA) – 2022 Annual Report</td><td>Assurance level: Full
  </td><td>Clinical risk level: None
  </td></tr>
</table>

	BCUHB has maintained its' standards when compared to the last BCUHB report and national benchmark	There is no deficit in compliance against the audit standards
	• No Action Plan developed as compliant with all audit standards. BCUHB has improved on certain parameters (percentage of low risk patients referred for radical treatment) such that it now falls in the 'green' (0%) which is much better than the national average	
National Bowel Cancer Audit (NBoCA) – 2022 Annual Report (2020/21 Audit Period)	**Assurance level:** Significant  Service compliant with over 75% of audit measures. No significant outliers	**Clinical risk level:** Low  Service compliant with over 75% of audit measures. No significant outliers
	BCUHB Action plan received outlining the following: • **Major resection rate in potentially curative patents** – Audit of Ysbyty Glan Clwyd cases (Quarter 1 2023/24) • **Attempted laparoscopic surgery** – Audit of Ysbyty Glan Clwyd cases (Quarter 1 2023/24) • **Urgent/emergency surgery** – Audit of Ysbyty Gwynedd cases (Quarter 1 2023/24) • **Abdomino-perineal excision of the rectum (APER) rate in rectal cancer patients -** Audit of Ysbyty Gwynedd (Quarter 1 2023/24) The above audits will be a deep dive to identify local issues directly related to performance below the recommended standards/All Wales score. Findings from these will be reviewed by lead clinicians and recommendations implemented shortly thereafter.	

In addition to the service assessments above, action plans were received during quarter 4 for projects that were delayed from Quarter 3.

National Audit publication	Lessons/Actions

National Diabetes Audit (NDA) - Report 1: Care Processes and Treatment Targets 2020/21	**BCUHB Action plan received outlining the following:** • **Complete ALL care processes at annual diabetic reviews** - review & monitor performance against the NDA at the BCUHB Diabetes Planning and Delivery Group (DPDG) meeting (Quarter 1 2023/24) • **Access (clinical space) for planned eye screening for People living with diabetes (PLWD) in North Wales** - Liaise with Diabetes Eye Screening Service (DESW) for update report for participating screening sites in BCUHB settings. To identify areas of good provision / high uptake, and where improvements are required. (Quarter 1 2023/24) • **Assess improvement options for specialist services to participate in future NDA** - Engagement with BCUHB Informatics in place to review diabetes management platforms that could assist specialist diabetes teams in BCUHB to participate in future NDA's (depending on system compatibility). BCUHB Informatics & DHCW in place to review solutions to this via WISDM patient management system for diabetes in conjunction with clinicians from secondary care diabetes team (Quarter 2 2023/24) • **Utilise the Clinical Effectiveness Education sessions to raise awareness of the NDA recommendations** - Plan content for diabetes education with Clinical Effectiveness lead pharmacist (Quarter 1 2023/24)

3.1.2 List of delayed & outstanding Service Assessment returns

National Audit publication	Reason for non-response & escalation
National Paediatric Diabetes Audit (NPDA) - Parent and Patient Reported Experience Measure (PREMs) 2021	**Action plan not received from East (received for Central & West area)**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings and discussed with BCUHB Diabetic lead who will support progress with outstanding diabetic responses.
In-patient Falls Audit (Falls & Fragility Fractures Audit Programme) - Working together to improve inpatient falls prevention (2021 clinical & 2022 facilities audit data)	**Action plan not received for all three areas**. Lack of engagement to requests for a response to the publication escalated to area through local Clinical Effectiveness Meetings
National Early Inflammatory Arthritis Audit (NEIAA) - Year 4 Annual Report (2021/22)	**Final Action plan not received for all three areas**. Project Lead has drafted an action plan during Quarter 4, awaiting details of SMART actions.
Renal Registry - 24th Annual Report	This audit reports as a BCU wide service. Clinical Lead finalising detail of SMART Action Plan in Quarter 4.

3.2 Benchmarking

When a National Audit report includes Health Board specific data we benchmark BCU against the National outcomes and against BCU data in previous reports.

Key	***Comparison with National Benchmark*:**	***Comparison with Last BCUHB Report*:**
R	Where BCUHB reported performance is at or above the benchmark in less than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

Four National Audit reports have been published in Quarter 4, of which all included BCU identifiable data.

The table below outlines the benchmarking information:

Tier 1 **Project reference**	**Title**	***Performance against***		***Progress / Completed Actions***	***Outstanding issues - by whom by when***
		National Benchmark	***Last BCU report***		
Acute					
NCAORP/2022/45	National Emergency Laparotomy Audit (NELA) – Year 8 report	A	A	• Data for this audit year (2020-21) affected by the pandemic.	• Action plan due to be completed in Quarter 1 (2023/2024)

Tier 1 Project reference	Title	*Performance against*		*Progress / Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Cancer					
NCAORP/2022/31	National Prostate Cancer Audit (NPCA) – 2022 Annual Report (2020/21 audit period)	G	G	• Maintained compliance when compared to the last report and national benchmark	• Action plan completed in Quarter 4
NCAORP/2022/32a	National Oesophago-Gastric Cancer Audit (NogCA) – 2022 Annual Report (2019/21 audit period)	G	G	• Maintained compliance in line with last update	• Action plan due to be completed in Quarter 1 (2023/24)
NCAORP/2022/32b	National Bowel Cancer Audit (NBoCA) – 2022 Annual Report (2020/21 audit period)	G	G	• Service compliant with over 75% of audit measures	• Action plan completed in Quarter 4

3.3 Assurance response timetable for reports published in Quarter 4 - as of 31st March 2022

Project Reference	Title of National Audit	Name of report	Date of publication	Assurance response due in Quarter Report
NCAORP/2022/45	National Emergency Laparotomy Audit (NELA)	Year 8 Report*	13-Mar-23	Quarter 1 (2023/24)
NCAORP/2022/31	National Prostate Cancer Audit (NPCA)	2022 Annual Report (2020/21 audit period)	12-Jan-23	Quarter 4
NCAORP/2022/32a	National Oesophago-Gastric Cancer Audit (NogCA)	2022 Annual Report (2019/21 audit period)	08-Feb-23	Quarter 1 (2023/24)
NCAORP/2022/32b	National Bowel Cancer Audit (NBoCA)	2022 Annual Report (2020/21 audit period)	12-Jan-23	Quarter 4

* Information required from host for benchmarking NELA not available at the date of publication – service assessment of compliance could not be requested until end April and will therefore be reported in Quarter 1 (2023/24).

Key	**Red**	Response overdue
	Amber	Response not received but within deadline
	Green	Response received

4.0 Tier 2 Audit Program

The Tier 2 program is a suite of audits mandated across the Health Board (which are not reported nationally) related to high-risk activity and corporately agreed service improvement priorities. It is likely that the number of these audits will increase in line with evidence from Harms Reviews, Concerns Recommendations, Prevention of Future Death Notices, and Ombudsman Reports. The Clinical Effectiveness team is working closely with the Quality Department to ensure that the correct Tier 2 audit program is in place to provide assurance across the risks that the Health Board holds.

Tier 2 reports below have been submitted in Q4 (as per the reporting schedule).

Project title	Report due	Objectives
Antibiotic Review Kit (ARK)/Start Smart then Focus audit	**Continuous** (month by month)	Continuous online audit via Public Health Wales tool, undertaken by prescribers in secondary care. Still poor compliance with audit across BCU. Agreed at BCU Strategic Antimicrobial Stewardship Group (ASG) to form a short-term working group to look at audit and make recommendations to Wales AMRDB (Antimicrobial Resistance Delivery Board). The AMRDB group leads the AMR agenda for Wales as the operational delivery group with all HBs in Wales. Recommendations will be made to WG on the audits to be completed around Antimicrobial Resistance (AMR) and Antimicrobial Stewardship (AMS). Audit revised to improve compliance and results. Review conducted in West with recommendations and findings agreed. IPC team to support whole hospital data collection once a quarter - starting this quarter.
Sepsis Audit	Q4	Sepsis – SHIELD group noting fall-off in compliance with sepsis bundles over the last few months. **Action:** new sepsis tool being implemented across BCU/All Wales
Peer Review of Consent to Examination and Treatment Processes	Q1 2023/24	Continuous audit reported annually. Ensure compliance with the consent to examination or treatment processes. Previous audit identified improvement required to evidence quality of patient information provided and use of EiDO information leaflets, and compliance with the Welsh Language Regulations. Data collected via AMaT. Extenstion of the data collection period has impacted on the expected date of reporting, now expected to report end of quarter 1 (previously end of quarter 4).

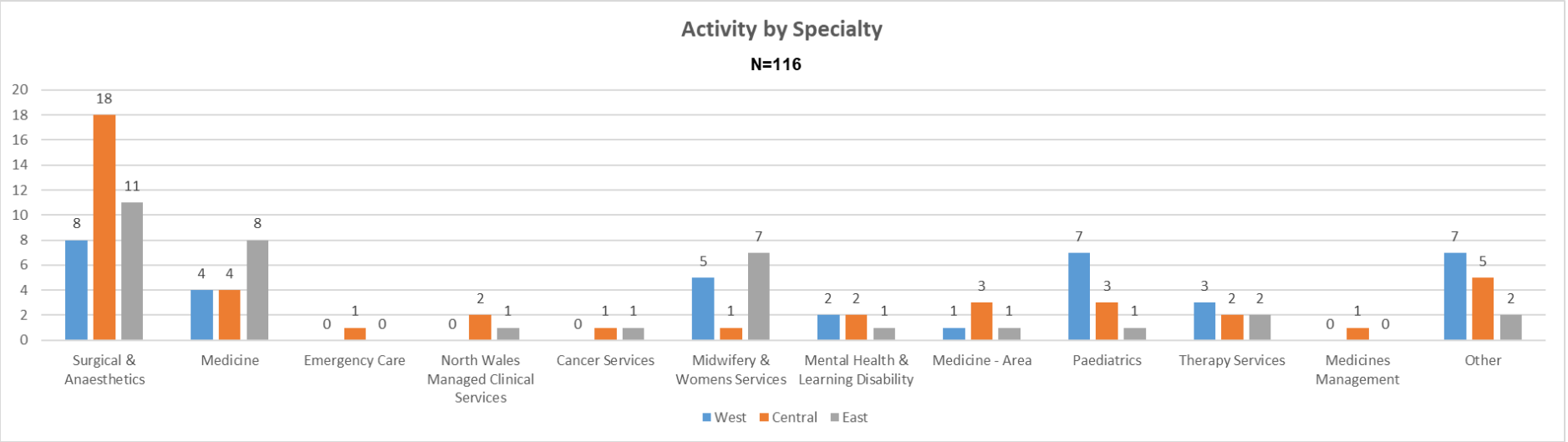
Project title	Report due	Objectives
Discharge Notification Audit	Q4	A recent Regulation 28 regarding discharge notification to primary care colleagues has resulted in the development and inclusion of this audit. It is currently in its first cycle of audit and results will inform both HB and local improvement plans.
Ward Manager Weekly and Monthly Audit	Q4	This complements the ward accreditation framework, monitoring standards across the following areas: patient safety, harm-free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care. The output from the audits is reported on IRIS. The metrics questions are currently under review. Ownership is locally by the ward manager and site nursing hierarchy. This very broad audit reports to IPSG, Safeguarding, PQSG (Quality EDG) and ultimately QSE depending on the subject. Weekly audit to be discontinued in 23/24 as digital data is available. Monthly ward audit covers 114 wards and provides data for visits and discussions. Part of Quality management. To be updated again in the annual report.
Record Keeping	Q4	Continuous audit using AMaT, which enables clinical teams to track progress locally and implement a cycle of improvement - themes linked to poor MDT records, limited evidence of discussions with patient and/or families etc. Initially launched in Quarter 1 using the STAR audit tool for Surgical specialties, with the intention of rolling out to all non-surgical specialties including Paediatrics, Womens and Mental Health. Activity at the end of Q2 and Q3 indicated a low response level across BCU, although a number of specialties have submitted data which is currently being reviewed in detail to inform a roll out of this audit in 2023-24.
2222 Audit	Q4	Patient data collection is running with Switchboards Central & West using the online form to record all 2222 calls. Patient data collection is now underway in Central and West but is hampered by staffing issues. I.T. support remains a challenge with insufficient capacity in I.T. to provide support in all but urgent instances. Development of reporting and dashboards remains outstanding.While this is a Tier 2 risk, there is also a separate ongoing Tier 1 risk (Score 20) within the service around staffing levels / training facilities and training capacity. The time investment the Tier 1 risk is taking up means that this Tier 2 risk is having to be placed on hold until that risk is resolved.

Project title	Report due	Objectives
Root Cause Analysis Hospital Acquired Thrombosis (HAT)	Q4	**NICE guideline NG89, MM79 and the All-Wales Thromboprophylaxis Policy** RCA HAT is clinically managed by Thromboprophylaxis Nurse Specialists on the three acute sites using an assessment tool designed to provide assurance to BCUHB/Welsh Risk Pool in relation to the number of potentially preventable HATs, as well as gathering lessons learned, with collected data validated by Digital, Data & Technology (DDaT). An e-form for RCA for HAT is now in use and work to provide up-to-date, real-time feedback of RCA results and lessons learned to HMT and governance leads continues through the development of a HAT dashboard. Learning can be shared across BCUHB to increase patient safety and identify any areas requiring further improvement. A recent example of improved practice is the VTE risk assessment for lower limb injuries, which was updated to incorporate the Trip cast score.
Antimicrobial Point Prevalence Audit (Inpatients)	Q4	All-Wales Antimicrobial Point Prevalence Survey - the prescription chart of every patient in a ward or hospital on a set day is checked to see if an antimicrobial has been prescribed and the reasons for the prescription are recorded. This is local information about which antimicrobials are used and why it can be used to target interventions etc. The data collection is currently in paper format - future potential for electronic capture - which is then transferred onto an excel spreadsheet. Public Health Wales HARP report March 2023 reported a slight fall in the Wales antimicrobial prescribing rate in 2022, with BCUHB below the Wales average.
DNACPR	Q4	Audit of DNACPR forms to continue. **Actions for mitigation against risks identified are as follows**: All Wales DNACPR policy and forms adopted by the Health Board and implemented. Awareness raising ongoing. Advance care planning being promoted together with Treatment Escalation Plans which prompt for the use of DNACPR forms. Memos to staff reminding them of the requirement to consult and how to complete the forms. Audit. Discussion taking place regarding methods of ensuring that the DNACPR form is communicated between BCUHB and Primary care. Executive ownership still being debated. Ongoing as Executive portfolios being clarified. ther action to enable progress - Needs agreement on Executive Lead now. Remains the same as executive responsibilities being clarified.

5.0 Tier 3 Audit Activity

This activity relates to those audits that should be agreed by the service/specialty and included within their local annual clinical audit forward plan. Activity is captured through our self-registration database; project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During Quarter 4, 116 projects were registered across the Health Board and there was a total of 25 projects completed during the quarter. The largest proportion of tier 3 audit topics were linked to Service evaluation (29.3%) and against NICE Guidelines (14.7%). Of the remainder: 11.2% were re-audits, 8.6% in response to National guidelines and 6% in response to National clinical audit findings.



Clinical Audit Annual Report

2022/23

(April 1st' 2022 to March 31st'2023)

Information following March 31st will be submitted to the next Quarterly Report

Report Author: Joanne Shillingford: Head of Clinical Effectiveness

Executive Lead: Dr Nick Lyons, Executive Medical Director

Contents*:*

Welcome to the Annual Report

Executive Summary

This report provides an overview of clinical audit activity carried out across Betsi Cadwaladr University Health Board from 1st April 2022 to the 31st March 2023.

The Clinical Audit Team within the Clinical Effectiveness Department is primarily concerned with facilitating the development of SMART action plans for improvement in response to the recommendations from clinical audit reports. The Department focusses on the projects identified in the NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP), Tier 1 Audits and the Betsi Cadwaladr University Health Board (BCUHB) list of prioritised audits at Tier 2. The effect of recent challenges including the COVID19 pandemic are still felt acutely within the organisation and clinical teams have identified a resulting shortage of time to respond to audit findings. However, there are a number of points to celebrate in this report.
BCUHB Clinical Audit Policy has been reviewed and updated to promote, maintain and support a culture of best practice in the management and delivery of Clinical Audit within the Health Board. The policy clarifies the roles and responsibilities of all staff engaged in Clinical Audit activities. It is expected to be approved early in 2023/24.

A new BCUHB Service Assessment of Compliance proforma has been developed to secure and track quality assurance, capturing details from National Audit findings, recommendations and local continuous quality improvement, whilst also identifying levels of assurance and any clinical risk. The form has been piloted since early November 2022, with an improvement in the quality of the updates seen since the pilot began with helpful feedback for further changes to the proforma received. The Clinical Effectiveness Department is now able to extract more detail from specialities on what has happened as a result of an audit, and what evidence can be provided for sharing learning with others.

Eight registered risks associated with the findings of the National Clinical audits have been reported to the Clinical Effectiveness Team, which are in the body of the report.

BCUHB has engaged fully with 32 out of 37 NCAORP projects that are relevant to the organisation. Where non-participation is identified, they are escalated via the Assurance Report to local Clinical Effectiveness Groups (CEG) to discuss and resolve locally. They may then escalate further to Strategic CEG and the Quality, Safety and Experience (QSE) committee.

Monitoring continues of the Tier 1 and Tier 2 audit plans and the completion of SMART actions in response to findings within specified timescales.

Clinical Audit is promoted via the BetsiNet webpage. This includes the promotion of free “Learn at Lunch” sessions from the Healthcare Quality Improvement Partnership (HQIP) and the Clinical Audit Support Centre (CASC). Following the success of the CASC Clinical Audit Training there is a plan in the future to offer “Learn at Lunch” sessions to BCUHB staff from within the department.

The pilot of the audit management and tracking database AMaT is progressing, with Tier 1 actions being monitored through AMaT, as well as agreed Tier 2 audits and a roll out of NICE guidance in specific specialties. Through this, we are engaging clinical and corporate stakeholders to deliver increased visibility of audit activity and strengthened real-time reporting. We continue building relationships with colleagues in other Welsh Health Boards through an AMaT forum group and the All-Wales Clinical Audit and Effectiveness Network Group.

We continue to work towards 100% participation in the full programme of National Clinical Audits and Clinical Outcome Reviews and agreed Tier 2 audits, noting improvements made in quality and safety of patient care, sharing outcomes and experience and lessons learnt and identifying which actions have been followed.

Introduction

Clinical Audit is defined as:

“A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change” (Principles of Best Practice in Clinical Audit NICE 2002)

In Wales, Health Boards are required as part of their Quality Strategy to have an annual Clinical Audit Forward Plan in place to fully participate in all national clinical audits and outcome reviews listed in the annual National Clinical Audit & Outcome Review Annual Plan.

These audits come under the category Tier 1 within BCUHB and it is essential that they are treated as priorities and that appropriate resources are provided to support them.

Participation in the National Clinical Audit and Outcome Review Programme (NCAORP) is entirely in line with the principles of prudent healthcare. It clearly demonstrates the commitment to make the most effective use of all skills and resources and to reduce inappropriate variation using evidence-based practices consistently and transparently.

This report provides an overview of clinical audit activity carried out across Betsi Cadwaladr University Health Board from 1st April 2022 to the 31st March 2023.

Risks reported to the Clinical Effectiveness Team

Following the publication of National (Tier 1) Audit reports, Clinical Effectiveness works with the relevant Clinical Service to develop an assessment of performance against the national standard. In November 2022, the assessment document was revised to include confirmation of any level of service risk, the details of which now form part of the Clinical Audit quarterly update. Any service risks relating to Corporate (Tier 2) Audits are individually confirmed with each service and are included in quarterly updates throughout the audit year. To date, the primary themes for identified risks have related to resource capacity, staffing and training needs.

Risks identified within BCUHB are registered by a member of staff ('risk handler') who is then responsible for regularly reviewing the tier and level of that risk, together with updating the Risk Register with any improvement made or additional mitigations put into place. The Executive Board requires each BCUHB Clinical Service to provide assurance regarding any risk which it holds and to assess the potential impact on patient care. The organisational oversight and reporting of this process is the responsibility of the Risk Management Team.

The current risks which have been reported to Clinical Effectiveness on the Risk Register 2022/23 are:

Audit	Audit level	Risk ID	Nature of Risk
Stroke (SSNAP)	Tier 1	4022	Delay in Stroke assessment/treatment compromising patient care/outcomes
2222 (Emergency call out)	Tier 2	3731	Delivery of safe and effective resuscitation may be compromised due to training capacity issues

2222 (Emergency call out)	Tier 3	3082	BCUHB cannot report accurate cardiac arrest or outcome data
Heart Failure (NHFA)	Tier 1	4431	Reduced Heart failure service for inpatients and clinician support
Cardiology (NACRM, MINAP, NHFA)	Tier1	3937	East IHC patients are unable to access cardiology outpatients.
Cardiology (NACRM, MINAP, NHFA, NAPCI)	Tier 1	2951	Cardio-respiratory workforce requires investment to prevent risks to patients across BCUHB
Cardiology (NACRM, MINAP, NHFA)	Tier 1	2304	West IHC patients are unable to access cardiology outpatients.
DNACPR	Tier 2	2124	Communication issues and lack of defined pathway may lead to inappropriate resuscitation and potential clinical negligence claims/concerns

Clinical Audit Policy

The Clinical Audit Policy was submitted to the Executive Delivery Group (EDG) for Quality meeting where it was approved on 17th April 2023; this is to be finally ratified at the next QSE which is held bi-monthly.

Clinical Audit Activity:

TIER 1 AUDIT: NHS Wales National Clinical Audit and Outcome Review Plan (NCAORP)

Each year, the Health Board receives notification of the NCAORP which describes priority areas for completion by all Health Boards. The BCUHB audit plan describes these required audits.

The Tier 1 audit process
All Nationally mandated projects are expected to complete an assurance pro-forma that summarises their improvement plans and progress between data collection and reporting. Reflecting the requirements of Welsh Government previously this was managed through a 2-stage process (part A & B) that was to be completed within a total of 16 weeks of publication and reported to Welsh Government.

At the end of 2021/22 the Welsh Government considered that as the audit process had matured, audit results should feed into a range of networks within each Health Board; it determined that policy development proformas to be an additional layer, which were no longer required to be reported directly on a regular basis (although this is still externally monitored periodically).

During 2022/23 the Clinical Effectiveness Department redeveloped the process and redesigned the assurance pro-forma to a single-stage form to better understand and capture additional information from the clinicians on assurance and risk, including where learning from audit findings is shared with a focus on SMART action plans to improve patient care.

Tier 1 Participation
For 2022/23 BCUHB identified 37 clinical audit projects relevant to the Health Board. Some of these require continuous data collection across years; other types of audits collect data within specific timeframes. NCAORP projects are described as Tier 1 projects.

We did not achieve full participation by all services in 2022/23. We participated in 32 (86%) of Tier 1 audits across BCUHB services. The audits which achieved partial or no participation are described below:

Partial Participation:
There was partial participation in four Tier 1 audits. The following audits were not completed on all required sites with actions in each of the relevant Quarterly reports:

1. **NACAP - Adult Asthma**: Wrexham Maelor (WXM) have never submitted data except for the Organisational element. Ysbyty Glan Clwyd (YGC) have not submitted data since Nov 2019. All sites have identified insufficient staff resource for data collection to be a risk to future delivery.
2. **NACAP - COPD:** Chronic Obstructive Pulmonary Disease, Wrexham Maelor (WXM) have never submitted data except for the Organisational element. All sites have identified insufficient staff resource for data collection to be a risk to future delivery.

3. **NACAP - Children & Young People Asthma:** These are continuous audits requiring clinicians to collect the data. Ysbyty Gwynedd (YG) has been unable to identify resource to participate since December 2019.
4. **National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12), East:** Challenges with submitting data have been reported due to the lack of clinical time. However, an action plan has been written for this project in response to national recommendations.

No Participation:
There was no participation in one Tier 1 audit:

1. **The Fracture Liaison Service**. This service is undertaken from Llandudno (YGC). The service has not participated in this audit since it began in January 2016. Insufficient clinical and administrative capacity is identified by the service as prohibiting required participation.

   Previously, no participation has been reported to the Service Lead, and reported to the local CEG and in future, IHC Lead, after failed follow up.

What do the Tier 1 audit results tell us?
Of the 37 audits on the NCAORP audit programme, 33 published their findings across 36 different reports during 2022/23; this included multiple publications for the Stroke Audit, National Diabetes Audits, and a combined report for the COPD & Adult Asthma Organisation audit.

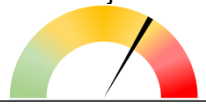
Assurance responses were requested for a total of 32 reports, this excluded three audits (National Joint Registry, Change Mix Programme and Major Trauma Audit) who published their findings but due to the method and nature of the data reporting an assurance response was not requested. In addition, the Fracture Liaison Service audit was published but BCUHB are not registered to take part in this audit and therefore an assurance response was not requested.

The table below summarises how:

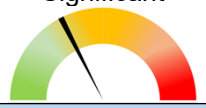
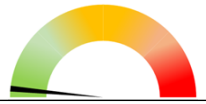
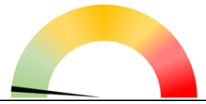
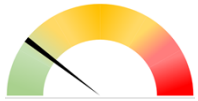
I. Tier 1 performance benchmarks against All Wales or where relevant our UK peers
II. Comparison of audit results with the previous BCUHB audit cycle (where available)
III. Assurance and risk level (for publications after the introduction of the new assurance pro-forma in November 2022)

IV. Action planning progress as of 31/03/2023 (National Audits are only classified as completed once actions for improvement have been identified)

National Audit	Report publication period	Speciality	Performance RAG status		Assurance Level	Risk Level	Action Planning
			against National benchmark	Last BCU report			
Acute							
National Joint Registry (NJR)	Q2	Trauma & Orthopaedics	This report does not provide the level of data which the HB can measure against				
National Emergency Laparotomy Audit (NELA)	Q4	Surgery / Anaesthetics	Amber	Amber	tbc	tbc	Action plan due Q1 2023/24
Case Mix Programme (CMP) ICNARC		Anaesthetics	❖	❖	❖	❖	❖
Major Trauma Audit (TARN)		Emergency Medicine	❖	❖	❖	❖	❖
Long Term Conditions							
National Diabetes Foot Care Audit (NDFA)	Q1	Podiatry / Diabetes	Specific Health Board data not included in the report		*	*	Draft action plan received
National Diabetes Inpatient Safety Audit (NDISA)	Q2	Diabetes / General Medicine	No comparative data provided		*	*	Action plan not received +
National Pregnancy in Diabetes Audit (NPDA)	N/A	Obs & Gynae / Diabetes	Not reported in 2022/23				
National Core Diabetes Audit (NDA)	Q2	Diabetes	Green	Red	*	*	Complete – Improvements ongoing
NDA: Adolescent & Young Adult	Q1		Specific Health Board data not included in the report		*	*	Action plan not received +
NDA: Type 1 diabetes	Q1		Green	Red	*	*	Action plan not received from East & West +
National Paediatric Diabetes Audit (NPDA)	Q1	Paediatrics	Green	Green	*	*	Complete – Improvements ongoing

National Audit	Report publication period	Speciality	Performance RAG status		Assurance Level	Risk Level	Action Planning
			against National benchmark	Last BCU report			
	Q2 (PREM report)		Amber	Green	*	*	Action plan not received from East IHC +
National Asthma & COPD Audit Programme (NACAP): COPD Secondary Care	Q1	Respiratory medicine	Organisational report, no comparable data provided *(Joint publication with Adult Asthma)*		*	*	Action plan not received +
NACAP: Adult Asthma	Q1	Respiratory medicine	Organisational report, no comparable data provided *(Joint publication with COPD)*		*	*	Action plan not received +
NACAP: Paediatric Asthma Secondary Care	Q1	Paediatrics	Organisational report no comparable data provided		*	*	Complete – Improvements ongoing
NACAP: Pulmonary Rehabilitation	Q2	Therapies	Organisational report no comparable data provided		*	*	Complete – Improvements ongoing
Renal Registry	Q3	Renal medicine	Amber	Amber	-	-	Draft action plan received
National Early Inflammatory Arthritis Audit (NEIAA)	Q3	Rheumatology	Red	Green	tbc	tbc	Draft action plan received
All Wales Audiology Audit	N/A	Audiology	Not reported in 2022/23				
Older People							
Sentinel Stroke National Audit Programme (SSNAP)	Q1	Stroke	Acute Organisational report. Specific BCUHB data not included.		*	*	Complete – Improvements ongoing
	Q3		Amber	Amber			Complete – Improvements ongoing

National Audit	Report publication period	Speciality	Performance RAG status		Assurance Level	Risk Level	Action Planning
			against National benchmark	Last BCU report			
Falls & Fragility Fractures Audit Programme (FFFAP): National Hip Fracture database	Q2	Trauma & Orthopaedics	Amber	Amber	*	*	Action plan not received from East +
FFFAP: In-patient Falls Audit	Q3	General Medicine	Red	Amber	tbc	tbc	Action plan not received +
FFFAP: Fracture Liaison Service	-	General Medicine	Not registered to participate in this audit				
National Dementia Audit	N/A	Mental Health	Not reported in 2022/23				
National Audit of Breast Cancer in Older People (NABCOP)	Q1	Breast Surgery / Cancer	Green	Data not comparable with previously report data	*	*	Complete – Improvements ongoing
End of Life							
National Audit for Care at the End of Life (NACEL)	Q2	Palliative Care / Medicine	Amber	Amber	*	*	Complete – Improvements ongoing
Heart							
National Cardiac Audit Programme (NCAP): National Heart Failure Audit	Q1	Cardiology	Amber	Amber	*	*	Complete – Improvements ongoing
NCAP: National Audit of Cardiac Rhythm Management	Q1	Cardiology	Amber	Amber	*	*	Complete – Improvements ongoing
NCAP: National Audit for Percutaneous	Q1	Cardiology	Amber	Amber	*	*	Complete – Improvements ongoing

National Audit	Report publication period	Speciality	Performance RAG status		Assurance Level	Risk Level	Action Planning
			against National benchmark	Last BCU report			
Coronary Intervention (PCI)							
NCAP: Myocardial Ischaemia National Audit Project (MINAP)	Q1	Cardiology	Amber	Amber	*	*	Complete – Improvements ongoing
National Vascular Registry Audit (NVR)	Q3	Vascular	Amber	Green	Significant 	Minor 	Complete – Improvements ongoing
National Audit of Cardiac Rehabilitation (NACR)	Q3	Cardiology	Green	Data not comparable with previous reported data	Significant 	Moderate 	Complete – Improvements ongoing
Cancer							
National Lung Cancer Audit (NLCA)	N/A	Respiratory medicine / Cancer	Not reported in 2022/23				
National Prostate Cancer Audit (NPCA)	Q4	Urology / Cancer	Green	Green	Full 	None 	Complete
National Gastrointestinal Cancer Audit Programme: - Oesophago-Gastric Cancer Audit (NOgCA)	Q4	General Surgery / Cancer	Green	Green	tbc	tbc	Action plan due Q1 2023/24
National Gastrointestinal Cancer Audit Programme: – Bowel Cancer Audit (NBoCA)	Q4	General Surgery / Cancer	Green	Green	Significant 	Low 	Complete – Improvements ongoing

National Audit	Report publication period	Speciality	Performance RAG status		Assurance Level	Risk Level	Action Planning
			against National benchmark	Last BCU report			
Women's and Children's Health							
National Neonatal Audit Programme Audit	Q3	Paediatrics	Amber	Amber	tbc	tbc	Complete – Improvements ongoing
National Maternity and Perinatal Audit	Q1	Obstetrics / Midwifery	Amber	Amber	*	*	Complete – Improvements ongoing
Other							
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy12)	Q2	Paediatrics	Insufficient data submitted to audit to provide comparison		*	*	Complete – Improvements ongoing
National Clinical Audit of Psychosis	Q2	Mental Health	Red	Red	*	*	Complete – Improvements ongoing

* Not reported - Risk and Assurance levels only captured on reports published after the introduction of the new assurance pro-forma in November 2022.

❖ ICNARC and TARN are continuous National Audits for which quarterly site reports are issued by the host to the acute clinical teams; work is ongoing to incorporate their reporting cycle into CEG quarterly reporting.

\+ Outstanding action plans have been reported to the Service Lead and reported to the local CEG and in future, IHC Lead, after failed follow up.

Learning from National Audits

Audit results are disseminated through a variety of local service meetings, including but not limited to Clinical Governance meetings and Improvement Groups. The findings, recommendations and lessons learnt are discussed and used to inform the development of improvement action plans. The Clinical Effectiveness team monitors progress against these actions.

Summary of the action plans produced in response to national audit findings highlighted improvement work being undertaken by the local specialties including but not limited to:

- Implementation of new strategies, pathways & services
- Staff recruitment and staff training

- Improved informatics and support to assist in participation in National audits
- Local deep dive audits to identify local issues directly related to performance below the recommended standard

Challenges of Tier 1 audits

1. Ensuring participation across all Tier 1 audit projects.
2. Reduction in the number of non-responses to the findings of Tier 1 audits.
3. Identification of the speciality learning from the national audit findings.
4. Identification of the speciality risks when not fully compliant.
5. Improved SMART action planning.
6. Monitoring and reporting of outcomes and impact of action plans.

Proposals

- Escalation of gaps in participation & responses to IHC/Divisions to influence participation and address the local resources needed to meet the requirements of national audits.
- Better understanding of speciality learning from the national audit findings. Further development of the assurance pro-forma to capture this information following each audit publication.
- Continue with the robust review of the SMART actions and clinical data that was introduced during 2022/23
- Continued roll out of the Audit Monitoring & Tracking (AMaT) software to assist with the monitoring and reporting against the Tier 1 action plans, with a focus on understanding the outcomes and impacts of these on patient care.

TIER 2 AUDIT: Corporate Clinical Audits

Executives and Divisional Management Teams identify local priority audits that become part of the Annual Audit Plan, referred to as Tier 2 audits. These projects are risk assessed against organisational objectives. In 2022/23, 12 audits were identified to be started within the year, of which 5 are considered continuous ongoing as they relate to continued accreditation.

Clinical Audit & Effectiveness Facilitators monitor and engage with the leads to ensure that outcomes are reviewed, and assurance is provided for the Health Board

The objectives for the Tier 2 audits were captured in our quarterly reports and are available on the Clinical Audit BetsiNet webpage.

Project title	Report due	Update
Ward Manager Audit	Continuously analysed and reported	All wards across the Health Board (114 areas) complete the Ward Accreditation metrics/audit continuously via IRIS. Ward managers, Matrons, and Heads of Nursing are expected to review their metrics to identify trends and themes to celebrate, or opportunities for improvement. The metrics are used as part of the routine accountability meetings and unannounced visits from the Director of Nursing. Metrics are viewed and improvements discussed. Any required improvement plan must be written within 10 days of the visit.
DNACPR	Annually	Audit cycle for 2022/23 completed. Aim is to repeat audit cycle annually if enough junior doctors available to complete data collection on each of the 3 sites. Presented key findings to various groups in the form of PowerPoint slides and posters. Posters also circulated to all Juniors and Consultants via email. Recommendations: Addition of DNACPR checkbox to EPOC discharge summaries. Communication workshop on ceilings of treatment conversation for Foundation doctors in Wrexham. Discussion with primary care coordinators regarding onwards communication of completed DNACPR forms – ongoing.
Audit of upper GI bleeding	Spring 2023	Data collection closed (Aug 2022) and now awaiting analysis and report from British Society of Gastroenterology, originally due Spring 2023 but now delayed until Summer 2023.
Peer Review of Consent to Examination and Treatment Processes	Q4	Data collection started in June 2022; extension of the data collection period due to challenges with participation at speciality level has impacted on the expected date of reporting. Data collection completed in quarter 4 and now expected to report end of quarter 1 2023/24 (previously report was expected end of quarter 4).
Health Records Keeping	Q4* (*reporting adjusted to 2023-24)	Continuous data collection initiated within the surgical specialities during 2022. Although a number of specialities have participated, the overall response level has been less than anticipated, therefore the submitted data is currently being reviewed in detail to inform progress of the audit which is now anticipated to report during 2023-24.

Antimicrobial Point Prevalence Audit (Inpatients)	Q4	Data collected in November and submitted to Public Health Wales. Public Health Wales Healthcare Associated Infection & Antimicrobial Resistance Programme (HARP) report was published March 2023 reported a slight fall in the Wales antimicrobial prescribing rate in 2022, with BCUHB below the Wales average. Will be updated in Q1/23
Antibiotic Review Kit (ARK)/Start Smart then Focus audit	Quarterly	Data collected and sent to clinical teams in West, email also shared with IHCs in Central and East. Data is collected quarterly and provided to clinical teams for them to develop an improvement plan for any areas that are not >85%. A comprehensive plan has been provided to CEG, with improvement plans to be presented to local Antimicrobial Stewardship Group (ASG) and then fed to Health Board ASG – planned for starting with June's meeting.
2222 Audit	Q4* (*reporting adjusted to 2023-24)	Continuous data collection initiated 2022 on two acute sites, however progress with this audit has been hampered by low staffing levels, training capacity, training facilities and insufficient IT capacity to fully support its completion. Reporting is now anticipated during 2023-24.
Compliance with relevant LocSSIPs	Q4	Data collection started in June 2022, but limited data collected for this audit across BCUHB during 2022/23. Deputy Executive Medical Director met with Site leads in December 2022 to review audit approach and plan to adjust methodology and relaunch in 2023/2024.
Sepsis Audit	tbc	Previously known as 'Audit of Sepsis Six reporting' but has been in transition to 'Sepsis Audit' during 22/23. A recent statement by the Academy of Medical Royal Colleges has resulted in agreement that the risk assessment needs to be updated. Action plan: new sepsis tool to be implemented across BCU/All Wales when available.
Discharge Notification Audit	tbc	This is a new Tier 2 audit which has been in development during 22/23. A recent Regulation 28 regarding discharge notification to primary care colleagues has resulted in the development and inclusion of this audit. It is currently Q4 22/23 in its first cycle of audit and results will inform both HB and local improvement plans. Data is collected continuously via IRIS

Root Cause Analysis Hospital Acquired Thrombosis (HAT)	Q4* (*reporting adjusted to 2023-24)	Continuous data collection throughout 2022-23. Data is being validated at the end of Q4 prior to reporting.

Challenges of completing Tier 2 audits:

1. Availability of Clinical and Nursing Staff to collect the data
2. Participation at specialty level for some of the Tier 2 audits
3. Staffing levels, training capacity, training facilities and insufficient IT capacity to fully support completion
4. Delays in reporting

Proposals

1. Clinical staff availability to improve current participation and completion
2. 2023/24 going forward changes made to a fluid rather than fixed plan will enable the need for local audit priorities to be added in year
3. Involve IHC Leads with problem areas for accountability

TIER 3 AUDITS: Locally initiated projects

Locally initiated audits are undertaken within specialties and departments by local agreement. A corporate database holds this audit activity. Project leads self-register their audits and upload completed audit reports. The audit is considered closed when the audit report has been uploaded.

During this year, 415 projects were registered of which 87 (21%) were completed (as of 31/03/2022). This is similar in performance compared with last year where 22% (n=90) of Tier 3 audits (total n=402) were completed (as of 31/03/2021).

Information on this activity is made available on the Clinical Effectiveness BetsiNet webpage, where summary graphs and the details of the registered audits can be reviewed and monitored by the relevant speciality.

There are a range of different audits within Tier 3, these include but are not limited to:

- audits which check quality or safety issues (in specialities)
- audit of Tier 1 actions to ensure they have been completed
- audit in response to localised risk or assurance issue such as compliance with national guidance

Full details of individual registered projects and their completed reports can be found on the clinical audit e-registration database.

Summary of the findings and action plans from the completed projects highlight the need to raise awareness of process and standards through educational training and improved documentation. 4 of the completed audits (4.6%) showed that they were meeting the required standards.

Registration of Tier 3
During 2022/23 the self-registration tool was developed to identify if the local audits were risk based (and on a risk register), if they were undertaken across BCUHB, and details on when and where the results would be presented. This information will be captured for 2023/24 activity and reported in our quarterly and annual reports going forward.

Future development of the Tier 3 audits will include capturing a description of the assurance gained and risks identified resulting from the findings of each audit project. It will also collect information on the key successes/concerns and information on where the learning from the project is disseminated.

Challenges of Tier 3 audits

1. Ensuring activity is aligned to priorities and agreed by the specialty
2. Increasing the number of projects that complete
3. Increasing details of outcomes
4. Removal of abandoned/withdrawn audits which local areas do not close

Proposals

- Changes made to the self-registration database for 2023/24 will help identify audits that are risk based, however, further scrutiny of this activity is required at a speciality level to ensure that registered activity is aligned to their priorities

- There is a need to develop a process of monitoring the completion of Tier 3 audits, including better understanding of the actions and outcomes, assurance gained, and risks identified from the audit. This would have to be a manual process whilst the further development of the self-registration tool is ongoing
- Ongoing two-way engagement with specialities and divisions to improve current participation and completion

Recommendations and Key Priorities for Clinical Effectiveness Department:

1. Awaiting approval on the updated Clinical Audit Policy – the Clinical Effectiveness Department will then promote, maintain and support a culture of best practice in the management and delivery of Clinical Audit within the Health Board. The policy will clarify the roles and responsibilities of all staff engaged in Clinical Audit activities.
2. Monitor the implementation plan for Tier 1 and Tier 2 audits, to ensure that completion of set actions in line with specified timelines are achieved. These actions need to be escalated to local Clinical Effectiveness Groups if dates are not met, to discuss and solve locally.
3. Following the redesign of the Service Assessment Form by the Clinical Effectiveness Department, we have seen improvement with more detail being extracted from specialities on what has happened as a result of the audit, and what evidence can be provided for sharing learning to others. This will continue to be rolled out and monitored and improved if necessary.
4. Clinical Effectiveness Department to continue the ongoing development of the clinical audit exception report escalation (as noted above) for presentation at the Clinical Effectiveness Group meetings, providing timely information to address delivery risks and to maximise the positive impact of audit on quality and safety. Further escalation if not resolved would be to BCUHB Strategic Clinical Effectiveness Group (CEG), the Executive Delivery Group (EDG) for Quality, and ultimately the Quality, Safety and Experience (QSE) committee.
5. Continued development of risk identification with clinicians to better understand what partial or non-compliance with audit means, and how compliance can reduce risk.
6. Promotion of clinical audit through training via links on the BetsiNet webpage, which may include “Learn at Lunch” sessions with such teams as the Clinical Audit Support Centre (CASC). The team will also develop useful presentations on clinical audit that they will share on the BetsiNet webpage and drop-in sessions can be arranged for areas on request for other support and guidance as needed. Continued development is in progress.
7. Developing the audit management and tracking database (AMaT) within the new structure of BCUHB. To continue with monitoring of Tier 1 audits and actions being uploaded, also uploading and using AMaT on a number of agreed Tier 2 audits to promote the system and to help areas engage with the benefits of information sharing and reports that they can access.

8. Develop closer partnership working with Clinical Audit Leads/Hospital Medical Directors through the department attending local Clinical Effectiveness Groups, to improve knowledge and understanding of national and local audit/review activities, and provide guidance and support, as needed.
9. Continue building relationships with colleagues in other Welsh Health Boards through the AMaT forum group and general networking groups.
10. Commitment to 100% participation in the full programme of National Clinical Audits and Clinical Outcome Reviews and agreed Tier 2 audits, noting all improvements made in quality and safety of patient care, sharing outcomes and lessons learnt, and identifying what actions have been followed. These will be shared through quarterly and annual reports, with papers submitted to relevant BCUHB corporate groups.
11. Continued development of the Clinical Effectiveness BetsiNet webpage, promoting via BCUHB bulletins, in meetings, link noted on agendas and link on department emails. Feedback invited to help improve the contents of the webpage and include up to date information. Uploading of regular updates on Tier 1, 2 and 3 audits to share learning and support target dates being met with clear and contemporaneous information.

Teitl adroddiad: ***Report title:***	Performance Report - Month 3 2023/24			
Adrodd i: ***Report to:***	Quality, Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 22 August 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This Report relates to the Month 2, 2023/24 This paper provides Committee members with an update of performance against the Board's Key Performance metrics, the key measures contained within the 2023/24 National Performance Framework and Welsh Government Ministerial Priority Measures under the Quadruple Aims set out in "A Healthier Wales". Final documents published 20 June 2023. Key areas of improvement are identified with actions and mitigations being taken by operational teams detailed in the 'Exception Reports' contained within Appendix 1 (IQPR Report) of this paper.			
Argymhellion: ***Recommendations:***	The Committee is asked to: Review the contents of the report and confirm agreement to any actions proposed, or identify any additional assurance work or actions it would recommend Executive colleagues to undertake.			
Arweinydd Gweithredol: ***Executive Lead:***	Russell Caldicott, Executive Director of Finance and Performance			
Awdur yr Adroddiad: ***Report Author:***	Barbara Cummings, Interim Director of Performance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:				

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2023-24.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Performance, Finance and Information Governance Committee
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N The Report has not been Equality Impact Assessed as it is reporting on actual performance.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The pandemic has produced a number of risks to the delivery of care across the healthcare system
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within the annual plan will have direct and indirect impact on the financial recovery plan of the Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on our current and future workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed in parts (narratives) by senior leads across the Health Board and relevant Directors. And the full report has been reviewed by the report author.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	This QP report provides an opportunity for areas of under-performance to be identified and subsequent actions developed to make sustained improvement.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable

Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** Continued focus on any areas of under-performance where assurance isn't of sufficient quality to believe performance is or will improve as described.
Rhestr o Atodiadau: Dim ***List of Appendices:*** *Quality & Performance Report*

Guidance:

CYFARFOD CYHOEDDUS BWRDD Y CYFARWYDDWYR
RHOWCH Y DYDDIAD
TEITL YR ADRODDIAD

BOARD OF DIRECTORS MEETING IN PUBLIC
INSERT DATE
REPORT TITLE

1. **Cyflwyniad / Cefndir**
   Y cyd-destun sy'n esbonio pam fod yr adroddiad yn cael ei gyflwyno i'r Bwrdd/Pwyllgor, unrhyw gamau ymgynghori blaenorol, a'r pwrpas o'i gyflwyno i'r Bwrdd

   Introduction/Background
   Set the scene on why the report is submitted to the Board/committee, where it has been previously in terms of consultation, and the aim for its submission to Board

2. **Corff yr adroddiad /** ***Body of report***

3. **Goblygiadau Cyllidebol / Ariannol /** ***Budgetary / Financial Implications***
   3.1 Nid oes goblygiadau cyllidebol yn deillio o'r papur hwn. Mae'r adnoddau ar gyfer cynnal cydymffurfiaeth yn cael eu goruchwylio gan ...
   There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by …
   3.2 NEU Mae'r goblygiadau cyllidebol yn cael eu lliniaru'n llawn/rhannol drwy ...
   OR Budgetary implications are and fully/partially mitigated via….

4. **Rheoli Risg / Risk Management**

   Mae un risg ar Datix sy'n gysylltiedig â'r maes hwn, sef risg ID xxxx. Mae hon yn risg rannol

   There is one risk on Datix linked to this area which is risk ID xxxx. This risk is partially

5. **Goblygiadau Cydraddoldeb ac Amrywiaeth /** ***Equality and Diversity Implications***

   5.1 Os yw'r adroddiad hwn yn ymwneud â 'phenderfyniad strategol', h.y. bydd y canlyniad yn effeithio ar sut mae'r Bwrdd Iechyd yn cyflawni ei bwrpas statudol dros gyfnod sylweddol o amser ac ni ystyrir iddo fod yn benderfyniad 'o ddydd i ddydd', mae'n rhaid i chi gynnwys Dyletswydd Economaidd-gymdeithasol (SED), Asesiad o Effaith Cydraddoldeb (SEIA) yn ogystal ag asesiad Effaith Cydraddoldeb (EqIA) fel atodiad.

   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 a Socio-economic Duty (SED) Impact Assessment (SEIA) as well as a completed Equality Impact (EqIA) as an appendix.

   5.2 Mae angen cydymffurfiaeth EqIA yn unol â Gweithdrefn WP7 er mwyn sicrhau bod cydraddoldeb a hawliau dynol yn cael eu hymgorffori i brosesau penderfynu a datblygu polisi'r sefydliad.
   EqIA compliance is required in accordance to Procedure WP7 to ensure equality and human rights are embedded into organisational decision-making and policy development processes.

Quality and Performance Report

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

Performance to June 30th 2023
(Where published)

Presented on 22nd August 2023

Quality, Safety and Experience

Table of Contents

Section 1

BCU Performance

Delivery Framework KPI Summary

(published early June 2023 by WG)

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

BCU Delivery Framework KPI Summary (published position June 2023)

	No. measures where target has been achieved or the actions required are back on track	No. measures where the majority of actions required are on track but there is scope to improve	No. measures where the target has not been achieved or the actions required are not back on track and improvements are required	Target/ Compliance not currently available
Quadruple Aim 1: People in Wales have improved health and well being with better prevention and self management	1	0	6	3
Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	10	0	15	0
Quadruple Aim 3: The health and social care	3	0	1	0
	5	0	8	1
Summary	19	0	30	4

Section 2

NHS Wales Performance Framework Metrics

Quadruple Aims 1-4

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

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

	Committee	Target		Sep-23	Oct-23	Nov-23	Dec-23	Compliance			Rank
Percentage uptake of the influenza vaccination amongst adults aged 65 years and over	QSE		Actual								
			Trajectory								

Note: Data reflects the last week of each month. Applicable during: 01.09.2023 - 31.03.2024. Age range to be confirmed.

	Committee	Target			Apr-23	May-23	Jun-23	Compliance			Rank
Percentage uptake of the COVID-19 vaccination for those eligible - spring booster	QSE		Actual		14.3%	50.5%	68.9%				3rd out of 7 health boards
			Trajectory								

Note: Data reflects the last week of each month. Applicable during: 01.04.2023 - 30.06.2023. Includes: aged 75 years & over; residents in care home for older adults and; immunosuppressed aged 5 years & over.

	Committee	Target		Sep-23	Oct-23	Nov-23	Dec-23	Compliance			Rank
Percentage uptake of the COVID-19 vaccination for those eligible - autumn booster	QSE		Actual								
			Trajectory								

Note: Data reflects the last week of each month. Applicable during: 01.09.2023 - 31.03.2024. Age range to be confirmed.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
Percentage of patients offered an index colonoscopy procedure within 4 weeks of booking their Specialist Screening Practitioner assessment appointment	QSE		Actual	19.4%	22.8%						1st out of 7 health boards
			Trajectory								

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
Percentage of well babies entering the new-born hearing screening programme who complete screening within 4 weeks	QSE		Actual	97.1%	96.8%						5th out of 7 health boards
			Trajectory								

	Committee	Target		Apr-23	May-23	May-23	Jun-23	Compliance	12 month trend		Rank
Percentage of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	QSE		Actual	97.2%	94.2%						3rd out of 7 health boards
			Trajectory								

	Committee	Target	5%	Q4 21/22	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Compliance	12mth Trend - Comparison with Same Period Previous Year	Rank
Percentage of adult smokers who make a quit attempt via smoking cessation services	QSE		Actual	4.43%	4.29%						4th out of 7 health boards
			Trajectory								

	Committee	Target		Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Compliance	12mth Trend	Rank
Percentage of people who have been referred to health board services who have completed treatment for substance misuse (drugs or alcohol)	QSE		Actual	68.2%	64.9%	65.6%	67.4%	61.2%			5th out of 7 health boards
			Trajectory								

	Committee	Target	95%	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Compliance	12mth Trend	Rank
Percentage of children who are up to date with the scheduled vaccinations by age 5 ('4 in 1' preschool booster, the Hib/MenC booster and the second MMR dose)	QSE		Actual	92.2%	92.0%	90.7%	91.2%	90.9%			1st out of 7 health boards
			Trajectory								

	Committee	Target	95%	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Compliance		Rank
Percentage of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15	QSE		Actual								
			Trajectory								

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

Percentage of the primary care dental services (GDS) contract value delivered (for courses of treatment for new, new urgent and historic patients)	Committee	Target	TBA					Compliance	12 month trend		Rank
	PFIG		Actual								
			Trajectory								

Note: New measure - data will be included in the next few months.

Number of patients referred from primary care (optometry and General Medical Practitioners) into secondary care Ophthalmology services	Committee	Target	TBA	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	1,875	1,498	1,802					7th out of 7 health boards
			Trajectory								

Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)	Committee	Target	Increase	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	1,212	1,104						1st out of 7 health boards
			Trajectory								

Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people age under 18 years	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	61.6%	80.2%	67.0%					5th out of 7 health boards
			Trajectory								

Note: AB unable to submit since Aug-22, therefore Jul-22 data rolled over

Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people age under 18 years	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	35.1%	54.4%	42.3%					4th out of 7 health boards
			Trajectory								

Note: AB unable to submit since Aug-22, therefore Jul-22 data rolled over. C&V are currently experiencing data quality issue

Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults age 18 years and over	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	74.9%	70.2%	77.5%					5th out of 7 health boards
			Trajectory								

Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults age 18 years and over	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	85.3%	86.3%	82.6%					5th out of 7 health boards
			Trajectory								

Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Committee	Target	65%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	44.3%	54.9%	56.5%	51.6%				4th out of 7 health boards
			Trajectory								

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Median emergency response time to amber calls	PFIG	Reduce	Actual	00:52:41	00:07:11	00:52:42				7th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Median time from arrival at an emergency department to triage by a clinician	PFIG	Reduce	Actual	30	26	25	24			4th out of 6 health boards
			Trajectory							

Note: Data relates to major A&Es only

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Median time from arrival at an emergency department to assessment by a senior clinical decision maker	PFIG	Reduce	Actual	137	140	134	147			5th out of 6 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	PFIG	Improve	Actual	66.9%	66.0%	68.7%	70.4%			6th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival until admission, transfer or discharge	PFIG	Reduce	Actual	2,865	2,812	2,994	2,685			7th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)	PFIG	75%	Actual	63.1%	62.5%	60.1%	59.7%			3rd out of 6 health boards
			Trajectory							

Note: all Wales target compliance is based on the 12 month trend

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Number of patients waiting more than 8 weeks for a specified diagnostic	PFIG	0	Actual	8,119	8,686	9,099	9,097			6th out of 7 health boards
			Trajectory							

Note: Currently still awaiting a diagnostic profile from AB, therefore target compliance will show as red until received.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	PFIG	95%	Actual	92.7%	94.4%	92.7%				1st out of 6 health boards
			Trajectory							

Note: Includes: Art therapy; podiatry; dietetics; occupational therapy, physio therapy and; speech and language therapy.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Number of patients waiting more than 14 weeks for a specified therapy (including audiology)	PFIG	0	Actual	2,192	1,791	1,704	1,551			6th out of 7 health boards
			Trajectory							

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

Number of patients waiting over 52 weeks for a new outpatient appointment	Committee	Target	0	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	12,090	11,503	12,001	11,772				6th out of 7 health boards
			Trajectory								
Number of patients waiting more than 36 weeks for a new outpatient appointment	Committee	Target	0	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	22,635	23,096	23,658	24,095				7th out of 7 health boards
			Trajectory								
Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Committee	Target	0	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	80,322	82,887	86,586	81,426				7th out of 7 health boards
			Trajectory								
Number of patients waiting more than 104 weeks for referral to treatment	Committee	Target	0	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	9,515	9,188	8,953	8,808				7th out of 7 health boards
			Trajectory								
Number of patients waiting more than 52 weeks for referral to treatment	Committee	Target	0	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	35,394	34,871	35,289	35,596				7th out of 7 health boards
			Trajectory								
Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	87.5%	33.3%	50.0%					6th out of 6 health boards
			Trajectory								

Note: CTM provides sCAMHS services for the residents of SB up until March 2023. AB unable to submit since Aug-22, therefore Jul-22 data rolled over. BCU submitted a nil return for Aug-22 and Dec-22. SB operate a single point of access

Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	38.2%	37.0%	38.2%					2nd out of 7 health boards
			Trajectory								
Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	Committee	Target	80%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend		Rank
	PFIG		Actual	92.1%	91.9%	93.8%					1st out of 7 health boards
			Trajectory								

Percentage of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS	Committee	Target		2019/20	2020/21	2021/22	2022/23	2023/24	Compliance	12mth Trend	4 Period Trend	Rank
	PFIG		Actual	41.2%	59.8%	77.1%						7th out of 7 health boards
			Trajectory									

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

Percentage of sickness absence rate of staff	Committee	Target	5%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12mth Trend		Rank
	PFIG		Actual	6.33%	6.24%	6.23%					6th out of 12 organisations
			Trajectory								

Note: Data is for a rolling 12 months.

Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Committee	Target	7.18%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12mth Trend		Rank
	PFIG		Actual	9.1%	9.1%	8.8%	8.9%				3rd out of 11 organisations
			Trajectory								

Note: Data is for a rolling 12 months and excludes employees who retire and return to NHS Wales and organisational 'churn'. A full methodology is available on request. In a number of cases, large turnover figures are due to a small workforce where any leavers will inflate the rate significantly. This data is experimental - there are some organisation specific anomalies which

Agency spend as a percentage of total pay bill	Committee	Target	TBA	Mar-23	Apr-23	May-23	Jun-23	Compliance	12mth Trend		Rank
	PFIG		Actual	7.7%	7.1%	7.0%					9th out of 12 organisations
			Trajectory								

Percentage of headcount who have had a Personal Appraisal and Development Review (PADR) / medical appraisal in the previous 12 months (excluding doctors and dentists in training)	Committee	Target	85%	Mar-23	Apr-23	May-23	Jun-23	Compliance	12mth Trend		Rank
	PFIG		Actual	76.4%	76.7%	77.2%					1st out of 12 organisations
			Trajectory								

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of episodes clinically coded within one reporting month post episode discharge end date	PFIG	95%	Actual	70.5%	63.4%					7th out of 8 organisations
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of all classifications' coding errors corrected by the next monthly reporting submission following identification	PFIG	90%	Actual							
			Trajectory							

Note: New measure - data will be included in the next few months.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of calls ended following WAST telephone assessment (Hear and Treat)	PFIG	17%	Actual	13.3%	13.5%	12.3%				5th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Compliance	12 month trend	Rank
Number of Pathways of Care delayed discharges	PFIG	Reduce	Actual							8th out of 8 organisations
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	PFIG	90%	Actual	93.2%	93.6%	88.7%				5th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	PFIG	90%	Actual	85.1%	83.8%	85.0%				4th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Number of patient experience surveys completed and recorded on CIVICA	QSE	Improve	Actual							
			Trajectory							

Note: Number of surveys completed and recorded varies between organisations due to the number of different surveys undertaken by each and the different survey methods e.g. SMS, QR code etc. New measure - data will be included in the next few months.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Compliance	12 month trend	Rank
Cumulative number of laboratory confirmed bacteraemia cases - Klebsiella sp	QSE	103	Actual	144	6	16	32			1st out of 6 health boards
			Trajectory							

Note: 12 month trend is based on the monthly number of cases. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

NHS Wales Performance Framework Metrics

(Latest data published June 2023)

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

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Compliance	12 month trend	Rank
Cumulative number of laboratory confirmed bacteraemia cases - Aeruginosa	QSE	27	Actual	38	3	8	10			6th out of 6 health boards
			Trajectory							

Note: 12 month trend is based on the monthly number of cases. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Compliance	12 month trend	Rank
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population - E-coli	QSE	67	Actual	73	61	66	71			2nd out of 6 health boards
			Trajectory							

Note: 12 month trend is based on the monthly cases per 100,000 of the population. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Compliance	12 month trend	Rank
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population - S.aureus bacteraemia	QSE	20	Actual	26.02	22.18	22.12	25.09			3rd out of 6 health boards
			Trajectory							

Note: 12 month trend is based on the monthly cases per 100,000 of the population. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-24	Apr-24	May-23	Jun-23	Compliance	12 month trend	Rank
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population - C.difficile	QSE	25	Actual	41.63	41.80	41.69	39.92			5th out of 6 health boards
			Trajectory							

Note: 12 month trend is based on the monthly cases per 100,000 of the population. Data is provisional. Target is for achievement for Mar-24. Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset (>14 days after admission)	QSE	Reduce	Actual	36.6%	38.0%					3rd out of 6 health boards
			Trajectory							

Note: Measure not applicable to Powys as HB has no acute hospitals.

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Percentage of ophthalmology R1 appointments attended which were within their clinical target date or within 25% beyond their clinical target date	PFIG	95%	Actual	56.2%	59.6%	56.1%				7th out of 7 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Number of ambulance patient handovers over 1 hour	PFIG	Reduce	Actual	2,192	2,048	2,025	1,883			6th out of 6 health boards
			Trajectory							

	Committee	Target		Mar-23	Apr-23	May-23	Jun-23	Compliance	12 month trend	Rank
Number of National Reportable incidents that remain open 90 days or more	QSE	Reduce	Actual	47	48	44	41			8th out of 11 organisations
			Trajectory							

Note: If an organisation has a blank it means that there was no reportable incidents for that period due to be closed within the 90 day period. The number achieving target is currently out of 10 as HEIW has no reportable incidents for the reporting period and DHCW only had a reportable incident from Feb-23

Further Information

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

NHS Welsh Government Delivery Framework Metrics (Latest data published July 2023)

Quadruple Aim 1

Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management							
Measure	Target	Current Data		Measure	Target	Current Data	
		Period	Value			Period	Value
% of adult smokers who make a quit attempt via smoking cessation services	5% annual target	2022/23	4.29%	% uptake of the COVID-19 vaccination for those eligible - Spring Booster (Mar-23 to Jun-23)	75%	Jun-23	68.9%
% people referred to HB services who have completed treatment for substance misuse (drugs or alcohol)	4 quarter improvement trend	Q4 22/23	61.2%	% uptake of the COVID-19 vaccination for those eligible - Autumn Booster (Sep-23 to Mar-24)	75%	Sep-23	
% children up to date with vaccinations by age 5 ('4 in 1' preschool booster, Hib/MenC booster, 2nd MMR)	95%	Q4 22/23	90.9%	% patients offered index colonoscopy within 4 wks of booking Specialist Screening Practitioner appt	90%	Apr-23	22.8%
% of girls receiving the Human Papillomavirus (HPV) vaccination by the age of 15 (Q1 & Q4 23/24)	90%	Q1 23/24		% well babies entering new-born hearing screening programme who complete screening within 4 wks	90%	Apr-23	96.8%
% uptake of the influenza vaccination amongst adults aged 65 years and over (Sep-23 to Mar-24)	75%	Sep-23		% of eligible new-born babies who have a conclusive bloodspot screening result by day 17 of life	95%	May-23	94.2%

Quadruple Aim 2

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement									
Measure		Target	Current Data		Measure	Target	Current Data	
			Period	Value			Period	Value
% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS		100%	2021/22	77.1%	Number patients spent 12 hrs or more in emergency care from arrival to admit, transfer or discharge	Imp trajectory towards 0 by Mar-24	May-23	3,012
% primary care dental services (GDS) contract value delivered (new, new urgent and historic patients)		Month on month inc 30% Sep-23,100% Mar-24	new measure - data will be inc. in the next few months		% of patients starting first definitive cancer treatment within 62 days from point of suspicion	Imp trajectory towards 80% by Mar-26	May-23	60.1%
Num of patients referred from primary care (optometry & GP) into secondary care Ophthalmology services		Imp trajectory towards reduction by Mar-24	May-23	1,802	Number of patients waiting more than 8 weeks for a specified diagnostic	Imp trajectory towards 0 by Mar-24	May-23	9,099
Number of consultations delivered through the Pharmacist Independent Prescribing Service (PIPS)		Increase compared to same month prev year	Apr-23	1,104	% of children (aged under 18 years) waiting 14 weeks or less for a specified Allied Health Professional	12 month improvement trend		92.7%
% LPMHSS assessments within 28 days from referral	Under 18 years	80%	May-23	67.0%	Number of patients waiting more than 14 weeks for a specified therapy (inc. audiology)	Imp trajectory towards 0 by Mar-24		1,704
	18 years and over			42.3%	Number of patients waiting over 52 weeks for a new outpatient appointment	Imp trajectory towards 0	May-23	11,772
% theraputic interventions started within 28 days following LPMHSS assessment	Under 18 years			77.5%	Number of patients waiting more than 36 weeks for a new outpatient appointment			23,210
	18 years and over			82.6%	Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%	Imp trajectory towards 0	May-23	80,792
% of emergency responses to red calls arriving within (up to and including) 8 minutes		65%	Jun-23	51.6%	Number of patients waiting more than 104 weeks for referral to treatment	Imp trajectory towards 0	May-23	8,953
Median emergency response time to amber calls		12 month improvement trend	May-23	00:52:42	Number of patients waiting more than 52 weeks for referral to treatment			35,289
Median time from arrival at an emergency department to triage by a clinician		12 month reduction trend	May-23	25	% of patients waiting less than 28 days for a first appointment for sCAMHS	80%	May-23	50.0%
Median time from arrival at an emergency department to assessment by a senior clinical decision maker				136	% of children/young people waiting <26 weeks to start an ADHD/ASD neurodevelopment assessment		May-23	38.2%
% of patients spend less than 4 hrs in emergency care from arrival until admit, transfer or discharge		Imp compared to same month prev year or 95%	May-23	68.7%	% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health		May-23	93.8%

Quadruple Aim(s) 3 and 4

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable							
Measure	Target	Current Data		Measure	Target	Current Data	
		Period	Value			Period	Value
% of sickness absence rate of staff	12 month reduction trend	Apr-23	6.24%	Agency spend as a percentage of the total pay bill	12 month reduction trend	Apr-23	7.1%
Turnover rate for nurse and midwifery registered staff leaving NHS Wales	Roll 12 mnth reduction against 19/20 baseline	Mar-23	7.02%	% headcount by organisation who have had a PADR/medical appraisal in the previous 12 months	85%	Apr-23	76.7%

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes								
Measure		Target	Current Data		Measure		Target	Current Data	
			Period	Value				Period	Value
% of episodes clinically coded within one reporting month post episode discharge end date		Maintain 95% or 12 month imp trend	Apr-23	63.4%	Cumulative number of laboratory confirmed bacteraemia cases:	Klebsiella sp	103	Apr-23 to May-23	16
% of all classifications' coding errors corrected by the next monthly reporting submission following		90%	new measure - data will be inc. in the next few months			Aeruginosa	27		8
% of calls ended following WAST telephone assessment (Hear and Treat)		17%	May-23	12.3%	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population:	E-coli	67.00		65.68
Number of Pathways of Care delayed discharges		12 month reduction trend	May-23	290		S.aureus bacteraemias (MRSA and MSSA)	20.00		22.18
% HB residents who have a valid care & treatment plan	Under 18 years	90%	May-23	88.7%		C.difficile	25.00		41.80
	18 years and over			85.0%	% RT ophthalmology appointments attended within target date or within 25% beyond of clinical target date		95%	May-23	56.1%
Number of patient experience surveys completed and recorded on CIVICA		Month on month improvement	new measure - data will be inc. in the next few months		Number of ambulance handovers over 1 hour		Imp trajectory towards 0 by Mar-24	Jun-23	1,883
% of confirmed COVID cases within hospital which had a definite hospital onset of COVID		Reduction compared to same month 22/23	Apr-23	38.0%	Number of National Reportable incidents that remain open 90 days or more		12 month reduction trend	Jun-23	41

Report as at: 11 Jul 23

Target delivered:

Target not delivered:

Blank cell: no data currently available

Trend / target compliance not currently available:

Performance has improved over the last 12 mths:

Performance has deteriorated over the last 12 mths:

Performance has remained static over last 12 mths:

Quality & Performance Report
Betsi Cadwaladr University Health Board

Further information is available from the office of the Director of Performance for further details regarding this report. And further information on our performance can be found online at:

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

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

follow @bcuhb

http://www.facebook.com/bcuhealthboard

Teitl adroddiad: ***Report title:***	Patient and Carer Experience Report		
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)		
Dyddiad y Cyfarfod: ***Date of Meeting:***	22 August 2023		
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with information and analysis on significant patient and care experience feedback arising during the time period under review, alongside longer-term trend data, and information on the improvements underway.		
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.		
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery		
Awdur yr Adroddiad: ***Report Author:***	Mandy Jones, Deputy Executive Director of Nursing Leon Marsh – Head of Patient and Carer Experience Rachel Wright, Patient and Carer Experience Lead Manager Kim Warrington-Davies, Complaints Lead Manager		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Patient Experience and Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Considerations in this report cover compliance with the Putting Things Right Regulations and Ombudsman requirements.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A

Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	N/A
Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Next Steps: N/A	
List of Appendices: Patient and Carer Experience Report April 2023 - June 2023	

Patient and Carer Experience Report
April 2023 – June 2023

1. INTRODUCTION

1.1 This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient and carer experience activity arising during the period under review. The aim is to provide the committee with assurance on the Health Board's work to improve patient experience.

2. COMPLAINTS - PERFORMANCE

2.1 During April 2023 to June 2023 the Health Board received 573 complaints, 47 of these were managed under Putting Things Right, and an additional 98 were resolved as Early Resolutions.

2.2 The majority of the complaints related to Secondary Care Services. The top themes relate to: clinical treatment and assessment, poor communication, appointments and medication. Pro-active work is ongoing with the Patient Advice and Liaison Service (PALS) to coordinate with services, addressing recurring themes. Attitude and behaviour issues are common themes across all services.

2.3 To support the achievement of the key performance indicators, each Integrated Health Community (IHC) has adopted weekly Putting Thing Right Meetings to manage the progress of complaints received. In addition, a weekly scrutiny meeting to manage the overdue complaints backlog is well established and chaired by the Deputy Executive Director of Nursing, this ensures that all directors of nursing are sighted on their overdue complaints, and are tracking the progress in providing a timely resolution.

2.4 There were 265 overdue complaints at the end of June 2023. This is a significant reduction in overdue complaints since October 2022, this has being achieved by the considerable efforts of staff from both the Complaints Team and the services involved to investigate their complaints and complete their reports within PTR timescales.

2.5 The Complaints Team are currently working to trajectories to reduce the overdue complaint number by 20 complaints per month from the overall Health Board overdue numbers. It has been identified that the numbers aren't reducing to the volume expected due to a high number 'tipping over' to become overdue over the week. The Complaints Team have adopted a targeted approach to ensure that these complaints are closed within the 30 working day timeframe, streamlining the approvals process, ensuring that those due to becoming overdue are prioritised to ensure that we are meeting deadlines. In addition we are including a selection of the complaints due to becoming overdue in the weekly scrutiny meetings to ensure traction and to hasten the responses.

2.6 A weekly meeting is in place with the Executive Director of Nursing to review grade 1's and 2 complaints received for the previous week, this supports early resolution to low level concerns, these includes complaints where appointment waiting times, staff attitude and communication issues were raised, personalised letters are produced and submitted to the complainant as a form of resolution.

2.7 The current position as of the 8th of August 2023 is as follows:

- Number of complaints overdue (this includes Grade 4 and 5 Complaints over 180 days+) = 249 Complaints overdue, of these overdue numbers 48 are Grade 4 and 5).
- The total number of open Complaints are 444.

The Complaints Team are currently managing several complex complaint cases where the unreasonable Behaviour Policy may have been adopted to support the management of these complaints, this ensures that a designated point of contact is implemented to ensure that the Health Board captures and investigates all concerns raised.

3 PATIENT AND CARER EXPERIENCE

3.1 Patient feedback and listening to the voices of patients, carers and service users is key to ensure effective service improvement. During April 2023 to June 2023, the Patient Advice and Liaison Service supported the resolution of 1677 enquiries. Below are the top three enquiry themes:

- Delay in appointment (negative)
- Clinical treatment and assessment (negative)
- Communication (negative)

3.2 To help promote positive communication and to raise awareness of PALS and how they can support services in the early resolution of enquiries, the Patient and Carer Experience Team have delivered 14 training sessions within the reporting period. Training was delivered to staff at GP Managed Practices, Site Speciality Managers and Ward Managers across Integrated Health Communities.

3.3 During April 2023 to June 2023, 6150 patient feedback surveys were completed on the Civica All Wales real time feedback system. In June 2023, 83.82% of patients who completed the survey felt always listened to and 83.17% of patients always felt involved in decisions about their care (80% always target).

3.4 CIVICA All Wales real time feedback system is one method used to provide assurances that the Health Board is listening and learning from patient and carer feedback. On the 19th June 2023, the Patient and Carer Experience Team launched SMS feedback surveys where text messages are now sent to all patients attending outpatient appointments. In June 2023, BCUHB received 3,099 feedback surveys completed by patients and family members in comparison to 1560 in May 2023. There has been a significant increase in the number of feedback returns since increasing

accessibility for patients and their families to provide feedback on their recent hospital experience through SMS. A priority for the Patient and Carer Experience Team is to working with services to empower them to use feedback data to help inform learning and service improvement.

3.5 BCUHB is working with Small Business Research Initiative (SBRI) funded by Welsh Government to explore innovative digital solutions to improve communication between relatives when their loved one is in hospital. Three wards in Ysbyty Glan Clwyd have been identified; Ward 1, 5 and 9 to take part in piloting this technology from September – December 2023. As part of the pilot un-paid carers/families will receive daily messages on a digital platform updating them on the care of their loved one. The Patient and Carer Experience Team are leading on the engagement of this project, involving staff, patients and families through a series of focus groups, surveys and interviews to capture experiences to inform the development of the digital solution.

3.6 To celebrate National Carers Week from the 5th – 11th June the Patient and Carer Experience Team worked with NEWCIS and Carers Outreach to organise 13 events at community and acute hospital sites across North Wales. The aim of the pop up events were to raise awareness of the role of an unpaid carer. The events gave unpaid carers and the public an opportunity to access information, advice and support to un-paid carers. The Patient and Carer Experience Team have been developing relationships with Carers Leads and carers networks continue across Local Authorities in North Wales.

3.7 PALS Officers have been working with West Mental Health and Learning Disability Service to explore how they can best support them to improve patient and carer experience. On a bi-weekly basis PALS Officers are attending the Hergest Unit for "Feedback Fridays". This is an initiative developed where PALS Officers meet with patients and carers over a cup of tea to capture their feedback and to help facilitate the resolution of enquiries. A manager from Hergest Unit are also available at this time to discuss enquiries raised by patients, carers and relatives.

3.8 PALS Officers continue to engage with community hospitals across North Wales. Within this reporting period staff have visited Ysbyty Cefni, Llandudno General Hospital, Deeside Hospital and Dolegllau Hospital to explain to staff the different methods available to patients, relatives and carers to provide feedback. As part of the engagement visit PALS Officers provide advice on how to create patient and carer friendly ward notice boards, whilst also promoting accessible health care ensuring the hospital has access to easy read feedback surveys and providing them with iPads to capturing feedback through the CIVICA All Wales real time feedback system.

4. CONCLUSION

4.1 This report provides the Quality, Safety and Experience Committee with information and analysis on patient and carer experience. It highlights a range of positive areas of practice as well as some challenges such as complaints performance.

4.2 Services need to become increasingly pro-active in complaints management supported by the Complaints Team and their service managers. A targeted plan, developed in collaboration with the Directors of Nursing, is under development and will be implemented over the remainder of the year.

4.3 Significant patient experience improvement activity is underway as detailed in the report.

4.4 The QSE Committee is requested to note the report.

Teitl adroddiad: ***Report title:***	**Infection Prevention and Control Annual Report 2022-23**
Adrodd i: ***Report to:***	Quality Safety Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 22 August 2023
Crynodeb Gweithredol: ***Executive Summary:***	This is the Infection Prevention and Control (IPC) Annual Report relating to the period April 2022 to March 2023. It seeks to provide assurance that the organisation is meeting its statutory requirements in relation to the management of IPC in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections (HCAI) 2014. This report outlines our key achievements and challenges and provides an assessment of performance against national targets in relation to HCAIs and antimicrobial prescribing for the year. The Board is asked to note that IPC is a high priority for BCUHB with a strong commitment to preventing all HCAIs. **Key Achievements 2022/23:** • Compared to other Health Boards, and using 'age-standardised' data, BCUHB were performance ranked 1st for *Klebsiella Blood Stream infections (*BSI), 2nd for *E. coli* and *P. aeruginosa* BSIs, 3rd for MRSA and MSSA BSIs and 4th for *C.difficile.* • In March 2023, Dr Deepannita Bhattacharjee, Consultant Microbiologist was appointed as the pan-BCU Infection Prevention (IP) Doctor with 4 sessions allocated per week. • Excellent progress has been made to review and update all IP policies and protocols. Significant work has also been undertaken to develop and expand the existing IP web pages. • COVID-19 outbreaks continued to occur during 2022/23 but were identified and contained quickly. BCUHB continues to adhere to the National Wales Framework Guidance to provide a consistent approach for NHS Wales's organisations to identify, review and report patient safety incidents following nosocomial transmission of COVID-19 in compliance with NHS (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right. • IP worked with Public Health Wales and Informatics to establish a detailed database of blood culture information enabling staff to identify types, numbers and locations of all blood cultures taken. The contamination rate has reduced from 3-5% for April-Sept 22 to 1-2% in Nov–Jan which is less than the national average of 2-3%. • The IP Team held a number of campaigns and awareness events in 2022/23 focussing appropriate glove use, *C.difficile*, Antibiotic Awareness and Standard IP Precautions. • There are now over 390 trained IP Champions within BCUHB to help drive forward IP improvements and key messages. • Following annual audit, both water and ventilation services showed an improved position in 2022/23 compared to the previous year. • The reintroduction of clear bags for general/recyclable waste and correct segregation has reduced the number of clinical waste bags used, reduced clinical waste storage and the associated costs. • The Operational Estates Department received £500,000 discretionary capital funding in 2022/2023 to improve the hospital environment and a number of projects were completed.

	• Six monthly decontamination audits were conducted within BCUHB in 2022/23 by the Decontamination Adviser and Nurse. In addition, a total of 24 audits were completed in Community Dental Services. • BCUHB continues to achieve the 2.5% year-on-year antibiotic use reduction required. The Commonwealth Partnerships for Antimicrobial Stewardship project was successfully completed and has secured a further grant of £96,000 to continue this work over the next two years. • The terms of reference and ways of working of the IP group were revised in line with the Health Boards new reporting structures and all areas now present in-depth quarterly reports, rather than short monthly reports, to provide a greater level of assurance. **Key Challenges:** • COVID-associated issues continued to dominate the workload of the IP Team during 2022/23; there were 3,961 admissions of COVID-19 positive patients in 2022/23; just under half of these admissions were defined as healthcare-associated infections. • Focusing resources that primarily mitigate COVID-19 spread has inadvertently reduced attention to traditional IP programs in terms of lack of surveillance efforts, targeted process measures and containment strategies. IP resources have been pressurised and primarily diverted to outbreak management. 2022/23 also saw significant numbers of Influenza and Norovirus infections and outbreaks, all competing for the limited number of siderooms and adding additional pressure to clinical and IP teams. This led to a service that has been mainly acting reactively, as opposed to proactively, for much of the year. • In 2022/23 BCUHB saw a significant rise in infection rates for *C.difficile, E.coli* and MRSA blood stream infections (BSI) compared to the previous year. • Gram-negative bacteria resistance, in particular E.*coli* resistance to the main group of antibiotics used to treat these infections, continues to be an issue in BCUHB. Wrexham in particular has high resistance rates compared to the rest of Wales which is causing concern; the reasons for this are not yet clear. • Seasonal variation means there is usually an increase in *C.difficile* cases reported during summer months, but BCUHB rates were further exacerbated by a level two outbreak in YG in February 2023 effecting 26 patients and a small number of wards. • During 2022/23, there were 451 laboratory confirmed cases of Norovirus over the winter months (compared to just 186 in 2020/21) and 37 outbreaks in hospitals across BCUHB. • During the 2022/23 Influenza season, there were 1,432 laboratory confirmed cases of Influenza across BCHUB in inpatients compared to just 99 cases the previous year. There was a sharp peak at the end of the calendar year leading to 16 outbreaks across BCUHB, however, numbers subsided in January. • Staff Influenza Vaccination levels were low this year with just 43.7% of BCUHB staff vaccinated this year. • There is an ongoing lack of appropriate decant facilities within BCUHB and limited resources within deep cleaning teams to deliver a programme of cleaning with high level disinfection within inpatient bays to reduce the environmental bioburden.

	• Provision of adequate IP Nurse Team staffing has been further challenged by both short and long-term sickness. IP Nurse Team staffing remains on the risk register. • Cases of Monkeypox infection began to occur in the UK in May 2022 with an outbreak that lasted until November. A BCUHB Monkeypox Operational Planning Group meeting was quickly established with the IP Team as an integral part. Wales reported 48 cases of which 13 occurred within BCUHB. • Both scarlet fever and invasive Group A Streptococcal infections increased in late 2022; the most significant impact was seen in primary care and in paediatrics. • There was 1 level one Vancomycin Resistant Enterococci (VRE) outbreak in critical care in YGC involving 11 patient starting February 2023 which was quickly contained. • The Safe Clean Care Harm Free programme ended in March 2023. The three Project Managers that were supporting this and other IP projects have been reallocated to work in other areas. The IP Team now has no Project Management support allocated to it. • In 2022/23, compliance with mandatory training for level 1 IP was 83.4%, below the target of 85% and just 78.2% for staff requiring level 2 training; rates are significantly lower amongst medical staff. • A comprehensive Strategic Review of Decontamination of Medical Devices was undertaken by NHS Wales Shared Services Partnership – Specialist Estates Services in August 2022. The review highlighted many areas that needed to be addressed including flexible Endoscopy Decontamination Units, Sterile Services Departments (SSD) and Community Dental Services. Following the report an external decontamination consultant was employed for 6 months (3 days per week) to support implementation of the recommendations. A Decontamination Strategy has been approved by the IP Group, a new management structure proposed and support given to the successful implementation of a new compliant SSD track and trace system. Further work and significant resource will be required to support Decontamination projects in the years ahead including updating and centralising endoscopy reprocessing departments at YGC and WM. Decontamination of reusable medical devices remains on the risk register. • At WHM and YGC SSDs there were three occasions where decontamination contingency plans had to be implemented and the work transferred to another SSD. There were some delays in processing, however, this did not significantly impact patient procedures. All sites require significant investment moving forwards, and as a result, the decontamination contingency plan is not robust.		
Argymhellion: ***Recommendations:***	The Board is asked to receive the Infection Prevention and Control Annual Report for 2021/22 for assurance and approve for publication.		
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery		
Awdur yr Adroddiad: ***Report Author:***	Rebecca Gerrard Director of Nursing Infection Prevention and Decontamination		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Further work is required to meet the overall aim of zero tolerance approach to all avoidable infections.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This report underpins the Board's strategic direction around delivery of services.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	BCUHB has statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention Control Report, consisting of an overview and progress report on the Infection Prevention and Control arrangements together with other Infection Prevention and Control activities and initiatives. Trajectories for reducing healthcare associated infections for 2022/23 were issued in March 2022 via Welsh Health Circular 014 titled 'Antimicrobial Resistance (AMR) and Healthcare Associated Infection Improvement Goals for 2021-23'. It set out nine improvement goals for Health Boards to optimise the use of antimicrobials and lower the burden of infection. Details on BCUHB's compliance with each of these improvement goals is included within this Annual Report. There were no COVID-19 related RIDDOR reports made to the Health and Safety Executive in 2022/23.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	*N* Not required
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	*N* Not required

In accordance with WP68, has an SEIA identified as necessary been undertaken?	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	Key Infection Prevention risks on the Risk Register: 1. Potential that medical devices are not decontaminated effectively so patients may be harmed. This matter was logged on the Tier 1 Risk Register with a score of 16 in 2022/23. Current score now 12. 2. Inability to deliver timely Infection Prevention & Control services due to limited capacity. This matter was logged on the Tier 1 Risk Register with a score of 15 in 2022/23. Current score now 12. 3. Reduction in Public Health Wales Consultant Microbiologists. This matter is currently logged on the Tier 2 Risk Register with a score of 9.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	NA
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	NA
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report was compiled with information supplied by a number of senior managers in BCUHB who attend the Strategic Infection Prevention Group. It was presented to the group on 27 June 2023. No further changes were requested.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	In 2022/23 there were two risks on CRR as above. These have been reviewed and are now Tier 2 risks with a score of 12 each.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** A workplan for the Strategic IP Group and for the IP team have been drawn up for 2023/24. Each area/IHC also has its own IP Plan-on-a-page to deliver.	
Rhestr o Atodiadau: ***List of Appendices:*** Infection Prevention and Control Annual Report 2022-23	

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

Infection Prevention and Control Annual Report 2022-23

Infection Prevention and Control Annual Report 2022-23

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1.0 Executive Summary

This annual report relates to the period April 2022 to March 2023 and seeks to provide the Board with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections, 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention and Control Report consisting of an overview and progress on the infection prevention and control arrangements together with other activities and initiatives.

Prevention and control of infection is a high priority for BCUHB, with a commitment to preventing all healthcare associated infections (HCAI) by adopting a zero tolerance approach to all avoidable infections. However, the COVID-19 pandemic has continued to impact on the routine delivery of the work programme for infection prevention with priorities requiring adjustment according to competing workload pressures.

1.1 Key Achievements and Challenges

Key Achievements 2022/23

- In March 2023, Dr Deepannita Bhattacharjee, Consultant Microbiologist was appointed as the pan-BCU Infection Prevention (IP) Doctor with 4 sessions allocated per week to provide expert Microbiology advice and strategic overview of infection prevention and control.
- Excellent progress has been made to review and update all IP policies and protocols and there are currently no existing IP written control documents that exceed their review dates. Significant work has also been undertaken by the IP Team to develop and expand the existing IP web pages.
- COVID-19:
    - BCUHB continues to adhere to the National Wales Framework Guidance to provide a consistent approach for NHS Wales's organisations to identify, review and report patient safety incidents following nosocomial transmission of Covid-19 in compliance with the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.
    - COVID-19 outbreaks continued to occur during 2022/23 but were identified and contained quickly.
    - There were no COVID-19 related RIDDOR reports made to the Health and Safety Executive in 2022/23.
- IP have worked with Public Health Wales and Informatics in 2022 to establish a detailed database of blood culture information enabling staff to identify types, numbers and locations of all blood cultures taken. The contamination rate has reduced from 3-5% for April-Sept 22 to 1-2% in the period Nov–Jan which is less than or equal to the national average (2-3%).
- The IP Team held a number of IP Campaigns and Awareness events in 2022/23 focussing on IP measures including appropriate glove use, C.difficile, World Antibiotic Awareness Week and Standard IP Precautions.
- There are now over 390 trained IP Champions within BCUHB to help drive forward IP improvements and key messages with fortnightly drop-in sessions held with IP Leads taking place to support them.
- Both water and ventilation services showed an improved position in 2022/23 compared to the previous year according to the annual audits carried out by Authorising Engineers from NHS Wales Shared Services Partnership.
- The reintroduction of clear bags for general/recyclable waste and correct segregation has reduced the number of clinical waste bags used, reduced clinical waste storage and the costs associated with clinical waste.

- The Operational Estates Department within BCUHB received £500,000 discretionary capital funding within 2022/2023 to improve the hospital environment and a number of projects were completed in each area.
- To provide necessary assurance of compliance with decontamination processes, six monthly decontamination audits were conducted within BCUHB in 2022/23 by the Decontamination Adviser and Nurse. In addition, a total of 24 audits were completed in Community Dental Services.
- Antimicrobial Resistance (AMR) and Prescribing Programme:
    - BCUHB continues to achieve the 2.5% year-on-year reduction required to achieve the minimum 25% reduction rate (TARGET - Items/1000 STAR-PU) by 2023/24. Currently, BCUHB has met the 25% reduction rate for primary care, with one year left of the target.
    - AMR International Work: The Commonwealth Partnerships for Antimicrobial Stewardship 1.5 (CwPAMS) project was completed; the partnership with Malawi was very successful in achieving al the aims of this short 9 month long project and has been successful in securing a further grant of £96,000 to continue this work over the next two years. The partnership were also highly commended in the Hub Cymru Africa partnership awards.
- The terms of reference and ways of working of the IPSG have been revised in line with the Health Boards new reporting structures and all areas present in-depth quarterly reports, rather than short monthly reports, to provide a greater level of assurance.

Key Challenges

- COVID:-19:
    - It has been over three years since the WHO declared a global COVID-19 pandemic but COVID-associated issues have continued to dominate the workload of the IP Team during 2022/23.
    - There were 3,961 admissions of COVID-19 positive patients between 01/04/22 – 31/03/23; just under half of these admissions were defined as healthcare-associated infections.
    - Focusing resources that primarily mitigate COVID-19 spread has inadvertently reduced attention to traditional IP programs in terms of lack of surveillance efforts, targeted process measures and containment strategies. IP resources have been pressurised and primarily diverted to outbreak management. 2022/23 has also seen significant numbers of Influenza and Norovirus infections and outbreaks, all competing for the limited number of siderooms and adding additional pressure to clinical and IP teams. This led to a service that has been mainly acting reactively, as opposed to proactively, for much of the year.
- In 2022/23 BCUHB has seen a significant rise in infection rates last year for C.difficile, E.coli and MRSA blood stream infections (BSI) compared to the previous year.
- Compared to other Health Boards, and using 'age-standardised' data BCUHB are performance ranked 4th for *C.difficile,* 3rd for MRSA and MSSA BSIs, 2nd for *E.coli BSIs*, 1st for *Klebsiella* BSIs and 2nd for *P. aeruginosa BSIs.*
- Gram-negative bacteria resistance in particular E.*coli* resistance to the main group of antibiotics used to treat these infections continues to be an issue in BCUHB. Wrexham in particular has high resistance rates compared to the rest of Wales which is causing concern; the reasons for this are not yet clear.
- Seasonal variation means there is usually an increase in C.difficile cases reported during summer months, but BCUHB rates were further exacerbated by a level two outbreak in YG in Feb/March 2023 effecting 26 patients and a small number of wards.
- During 2022/23, there were 451 laboratory confirmed cases of Norovirus over the winter months (compared to just 186 in 2020/21) and 37 outbreaks in hospitals across BCUHB.

- During the 2022/23 Influenza season, there were 1,432 laboratory confirmed cases of Influenza across BCHUB in inpatients compared to just 99 cases the previous year. There was a sharp peak at the end of the calendar year leading to 16 outbreaks across BCUHB, however, numbers subsided in January.
- Staff Influenza Vaccination levels were low this year with just 43.7% of BCUHB staff vaccinated this year.
- There is an ongoing lack of appropriate decant facilities within BCUHB and limited resources within deep cleaning teams to deliver a programme of cleaning with high level disinfection within inpatient bays to reduce the environmental bioburden.
- Provision of adequate IP Nurse Team staffing has been further challenged by both short and long-term sickness. IP Nurse Team staffing remains on the risk register with a score of 15.
- Cases of Monkeypox infection began to occur in the UK in May 2022 with an outbreak that lasted until November. A BCUHB Monkeypox Operational Planning Group meeting was quickly established with the IP Team as an integral part. Wales reported 48 cases of which 13 occurred within BCUHB.
- Both scarlet fever and invasive group A streptococcal infections increased in late 2022; the most significant impact was seen in primary care and in paediatrics.
- There was 1 level one Vancomycin Resistant Enterococci (VRE) outbreak in critical care in YGC involving 11 patient starting February 2023 which was quickly contained.
- The Safe Clean Care Harm Free programme ended at the end of March 2023. The three Project Managers that were supporting this and other IP projects have been reallocated to work in other areas. The IP Team now has no Project Management support allocated to it.
- In 2022/23, compliance with mandatory training for level 1 IP was 83.4%, below the target of 85% and just 78.2% for staff requiring level 2 training; rates are significantly lower amongst medical staff.
- A comprehensive Strategic Review of Decontamination of Medical Devices was undertaken by NHS Wales Shared Services Partnership – Specialist Estates Services in August 2022. The review highlighted many areas that needed to be addressed including flexible Endoscopy Decontamination Units, Sterile Services Departments (SSD) and Community Dental Services. Following the report an external decontamination consultant was employed for 6 months (3 days per week) to support implementation of the recommendations. A Decontamination Strategy has been drafted, a new management structure proposed and support given to the successful implementation of a new compliant SSD track and trace system. Further work and significant resource will be required to support Decontamination projects in the years ahead including updating and centralising endoscopy reprocessing departments at YGC and WM. Decontamination of reusable medical devices remains on the risk register with a score of 16.
- At WHM and YGC SSDs there were three occasions where decontamination contingency plans had to be implemented and the work transferred to another SSD. There were some delays in processing, however, this did not significantly impact patient procedures. All sites require significant investment moving forwards, and as a result, the decontamination contingency plan is not robust.

2.0 Infection Prevention and Control Governance and Delivery Frameworks

2.1 The Infection Prevention Sub Group (IPSG) was authorised by the Quality, Safety and Experience Committee and the Board to support safety throughout BCUHB by monitoring, directing and ensuring assurance of effective IP arrangements throughout the Health Board; and the assurance of compliance with external standards for healthcare providers. It reported through the Group Chair, the Executive Director of Nursing and Midwifery, to the Quality, Safety Group and Experience Committee and onwards to the Executive Board. IPSG met

monthly, however, formal meetings did not take place in August and January and meetings in December and February addressed issues for escalation only due to other competing work pressures including strike action. An organogram of the full accountability arrangements can be found within Appendix 1. The IPSG terms of reference and programme of work underwent review and the group was renamed as the Strategic Infection Prevention Group in March 2023 in line with the new Health Board meetings structure.

2.2 Local Infection Prevention Groups (LIPGs) are established within each community (Central, East, and West) and are accountable to the IP Sub Group.

2.3 Groups reporting in to the Infection Prevention Sub Group

- The Decontamination Management Group
- The Antimicrobial Stewardship Group
- The Corporate-Led Healthcare Associated Infection (HCAI) Review Group
- The Water Safety Group (WSG)
- The Ventilation Safety Group
- HCAI Corporate Review Group
- Safe Clean Care – Harm Free (SCC-HF) Project

2.4 Safe Clean Care – Project Summary

Safe Clean Care Harm Free (SCC-HF) was an improvement and mobilisation programme designed to support the implementation of a culture of zero-tolerance approach to Health Care Associated Infections (HCAIs). The formal programme ended in March 2023 with initiatives to be managed as 'business as usual' and a final annual update report has been produced. Over the two years the programme evolved and developed supporting behavioural change around pride of our place, making space safe, rapid learning and safe action saves lives.

The final year ran campaigns around;

- Clearing and cleaning our environments
- Improved IPC guidance and implementation
- Reiteration of basic infection prevention practices that are easily forgotten e.g. frequent basic hand hygiene, physical distancing, clean environments, invasive devices insertion and care, and rapid isolation of suspected infections
- IPC champions to lead locally the improvements and working practices assurance.

Other supportive key pieces of work included:

- Development of 'one stop shops' to support staff access to resources and material; to ensure it can all be easily found, understood, and used.
- New ways of collecting and analysing information to ensure data could be clearly measured and reviewed.
- Innovative partnerships seeking new approaches and learning around IP with Public Health Wales Behavioural Change Unit, Knowlex and Staffordshire University.
- An Autumnal Celebration Event which brought people together to share, learn, and network. The photographs below were taken at this event.

The full SCC Annual Report for 2022/23 is available as a separate document on Betsinet.
The three Project Managers that were supporting Safe Clean Care and Infection Prevention projects have been reallocated to work in other areas. IP currently has no Project Management support allocated to it.

3.0 The Infection Prevention and Control Team

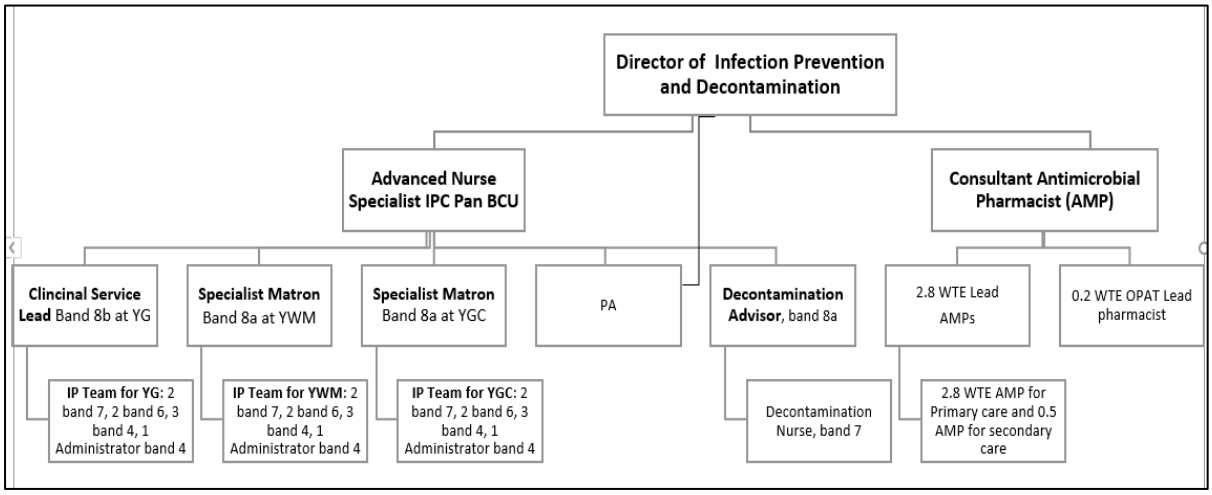
The Executive Director of Nursing is the appointment lead with Board responsibility for Infection Prevention. The main operational team is led by the Director of Nursing for Infection Prevention and Decontamination.
Despite ongoing recruitment measures, the provision of adequate staffing within the infection prevention nursing team has remained challenging in 2022/23 and there continues to be a national shortage of qualified infection prevention nurses. There have been internal promotions within the IP Team at BCUHB with additional support and education provided by Senior IP Nurses, and appointment to more junior positions has been less challenging.
The Senior IP Nurse employed via an agency in February 2022, now works just one day per week within the team, effectively backfilling for the 8b IP Nurse who is supporting the Nosocomial COVID-19 HCAI Programme one day per week.

Provision of adequate team staffing has been further challenged by both short-term and long-term sickness with 1,185 sickness days reported during 2022/23 (compared to 1,084 in 21/22) equating to an average sickness rate over 10%. The highest sickness related category related to gastrointestinal issues with a rate of 5.8%. Sickness is managed in accordance with WP11 Managing Attendance at Work Policy and referrals are made to the Occupational Health Department as appropriate.

Within the Infection Prevention Team there are 2.0WTE Decontamination staff who are specifically designated for the provision of decontamination advice across BCUHB; namely the Decontamination Advisor supported by the Decontamination Nurse.

A Consultant Antimicrobial Pharmacist reports to the Director of Infection Prevention and Decontamination. 6.3WTE Antimicrobial Pharmacists are assigned to support the antimicrobial stewardship programme reporting officially through the Pharmacy Team, although some of these posts have also been vacant this year due to secondment and inability to recruit.

The IP Nursing Team is further supported by a part time Information Technology Analyst who sits within the Informatics Team and a Healthcare Associated Infection (HCAI) Epidemiologist employed by Public Health Wales, however, this resource is limited.
The current structure of the Infection Prevention and Decontamination Team is illustrated below:



The IP Nurses provide routine service during week days 8:30-17:00 and an on call service at weekends and bank holidays from 09:00-17:00, with the on call Public Health Wales Microbiologists providing cover outside of these hours.
The whole IP Team had a productive and enjoyable away day in September enabling a review of how to improve current ways of working and outputs, both in local teams and collaboratively as a pan-BCU team. An IP Team Development Plan has been written to support the existing team members with their personal and professional development and succession planning.

4.0 Public Health Wales Consultant Microbiologists

The microbiologists working within BCUHB are employed by Public Health Wales of which just 1.5 WTE were directly employed in 2022/23; with the others working as agency or bank employees due to longstanding difficulties in recruitment. Physician Associates and Senior Biomedical Scientists support the work programme. Recruitment to current vacancies within the team continues but with limited success and work is ongoing towards developing a microbiologist trainee programme in North Wales to attract others. There is a risk assessment relating to the low numbers of Consultant Microbiologists supporting BCUHB currently scoring 9 (see Appendix 2). In March 2023, Dr Deepannita Bhattacharjee, Consultant Microbiologist was appointed as the Pan BCUHB Infection Prevention Doctor with four sessions allocated per week to provide expert microbiology advice and strategic overview of Infection Prevention and Control.

5.0 Infection Prevention and Control Policies and Guidance

A comprehensive suite of pan-BCUHB infection prevention written control documents, e.g. policies, protocols, standard operating procedures (SOPs) and guidelines are available on the Health Board's intranet site. Infection prevention written control documents reflect relevant current legislation, Welsh and UK guidance, Welsh Health Circulars, published professional guidance and best practice.

Excellent progress has been made in the review of draft or out of date policies, protocols and standard operating procedures and there are currently no existing infection prevention written control documents that exceed their review dates. COVID-19 related SOPs contained with the 'COVID-19 Toolkit' have been promptly reviewed, approved and disseminated on receipt of

updated guidance. Furthermore, a number of new protocols and standard operating procedures have been developed according to Health Board need.

A gap analysis of infection prevention written control documents recommended within the Welsh Government 'Code of Practice for the Prevention and Control of Healthcare Associated Infection' has been completed and a structured, priority focused plan of their development will be overseen by the Strategic Infection Prevention and Control Group moving forwards.

Infection Prevention Webpage Development
Significant work has been undertaken by the IP team to develop and expand the existing IP web pages. Outdated information has been removed and additional resources uploaded to the site e.g. disease specific resources, education tools, posters and fact sheets to enable staff to access accurate information easily. The web pages have become much more of a 'real-time' and 'live' resource in addition to a forum to communicate improvement campaigns, the celebration of achievements and good practice initiatives. Pages on the IP site have had over 40,000 views in this calendar year.

6.0 Mandatory Reporting of Health Care Associated Infections

6.1 The Six Key Performance Indicators

Welsh Government trajectories remained unchanged for 2022/23 (Welsh Health Circular 2022/014). A summary of performance for BCUHB against the relevant HCAI Improvement Goals and the All Wales rates are illustrated in the tables below. Rates are given as 'crude' as previously reported, but also as 'age-standardised' taking into account the age structure of the health boards, to make data more comparative.

Improvement Goal	Target	All Wales performance 2022/23	BCUHB 'crude' performance rate 2022/23	BCUHB 'age standardised' rate 2022/23	BCU performance 2021/22
C.difficile: Reduce the annual incidence to 25 cases per 100,000 or below.	n~175 Rate: 25	Rate: 36.8	n~301 Rate: 42.8	Rate: 39.4	n~215 Rate: 30.6
MRSA: Zero tolerance of preventable MRSA blood stream infections.	n~0	Rate: 2.24	n~17 Rate: 2.42	Rate: 2.24	n~10 Rate: 1.42
MSSA: Reduce the annual incidence to 20 cases per 100,000 or below.	n~140 Rate: 20	Rate: 25.5	N~171 Rate: 24.3	Rate: 22.5	n~169 Rate: 25
E.coli: Reduce the annual incidence of *E. coli* bacteraemia to below 67 cases per 100,000.	n~471 Rate: 67	Rate: 66.9	n~511 Rate: 72.6	Rate: 66.7	n~436 Rate: 62
Klebsiella: Reduce the annual incidence of by 10% against 2017-18 figures (n~115).	n~103	Rate: 22.3	n~144 Rate: 20.4	Rate: 18.9	n~138 Rate: 19.6
Pseudomonas: Reduce the annual incidence by 10% against 2017-18 figures (n~31).	n~27	Rate: 6.15	n~38 Rate: 5.4	Rate: 5.0	n~37 Rate: 5.2

In 2022/23, BCUHB's reported cases were over trajectory for all mandatory organisms, however, rates were lower than the All Wales average rates for MSSA, Klebsiella and Pseudomonas. It is suggested that the timeframe for achieving the targets has now been extended to the end of March 2024, however the new Welsh Health Circular confirming this has not yet been published.

The table below illustrates the trajectories for all Health Boards in Wales (crude data):

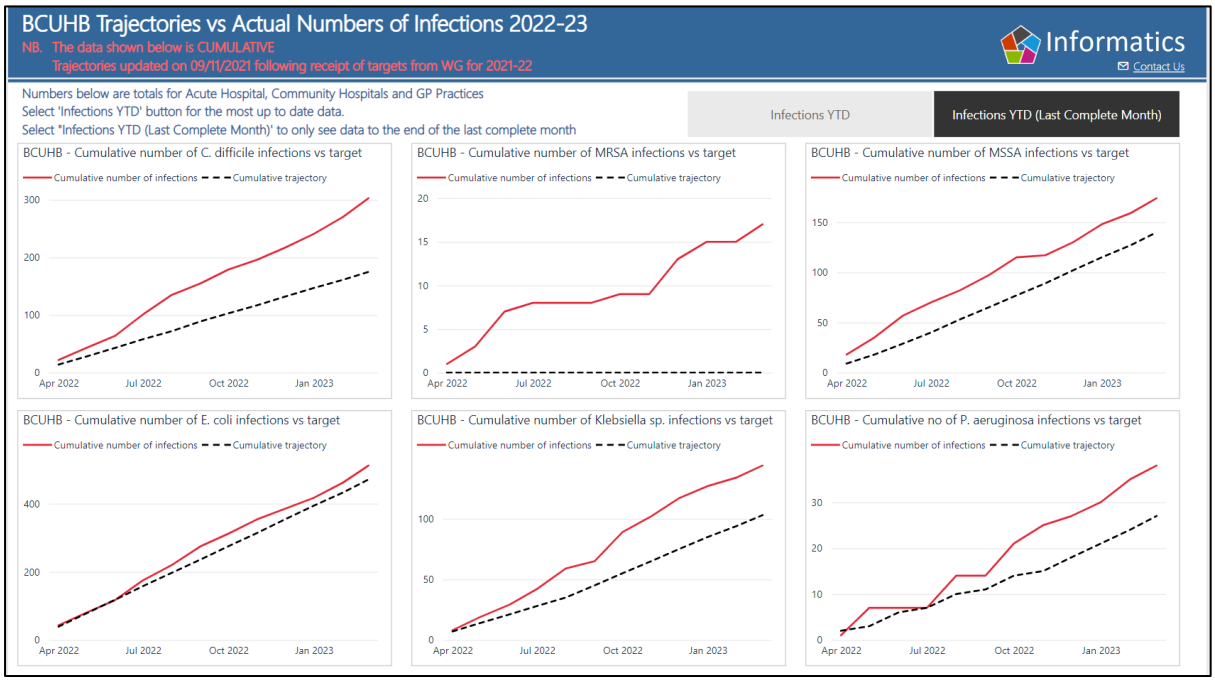
Wales 2022/23 HCAI mandatory surveillance summary, Apr 22 - Mar 23

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

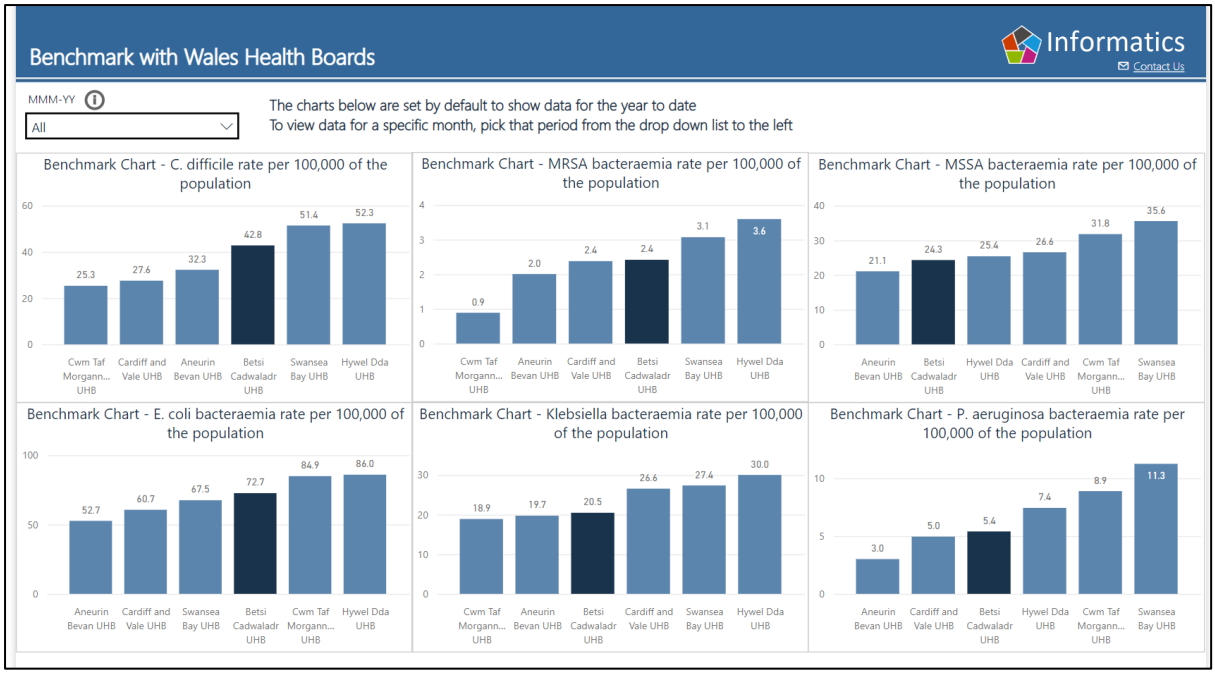
Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	193	32.26	12	2.01	126	21.06	138	23.07	315	52.66	118	19.73	18	3.01	451	75.39
Betsi Cadwaladr UHB	301	42.79	17	2.42	171	24.31	187	26.59	511	72.65	144	20.47	38	5.40	693	98.53
Cardiff and Vale UHB	139	27.55	12	2.38	134	26.56	144	28.54	306	60.65	134	26.56	25	4.96	465	92.17
Cwm Taf Morgannwg UHB	114	25.34	4	0.89	143	31.79	147	32.68	382	84.92	85	18.90	40	8.89	507	112.71
Hywel Dda UHB	204	52.35	14	3.59	99	25.40	113	29.00	335	85.96	117	30.02	29	7.44	481	123.42
Powys THB	12	9.02	0	0.00	0	0.00	0	0.00	1	0.75	1	0.75	1	0.75	3	2.26
Swansea Bay UHB	201	51.41	12	3.07	135	34.53	147	37.60	260	66.50	107	27.37	44	11.25	411	105.13
Velindre NHST	3		0	0.00	2		2		11		1		0		12	
Wales	1,167	36.82	71	2.24	810	25.56	878	27.70	2,121	66.92	707	22.31	195	6.15	3,023	95.38

The graphs below illustrates BCU trajectories versus actual numbers of infections in 2022/23:

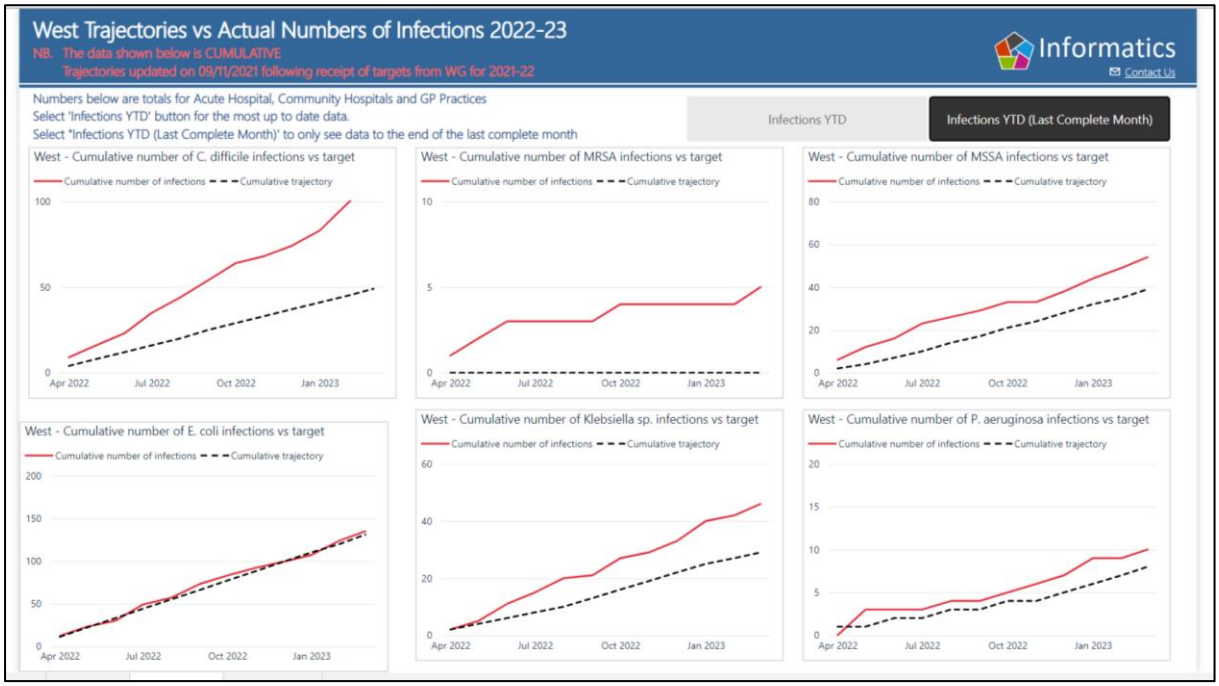


Using 'crude' data, in comparison with other Welsh Health Boards, BCUHB's performance ranked 4th for *C.difficile* and MRSA, 2nd for MSSA, 4th for *E.coli* and 3rd for *Klebsiella* and *P. aeruginosa*.



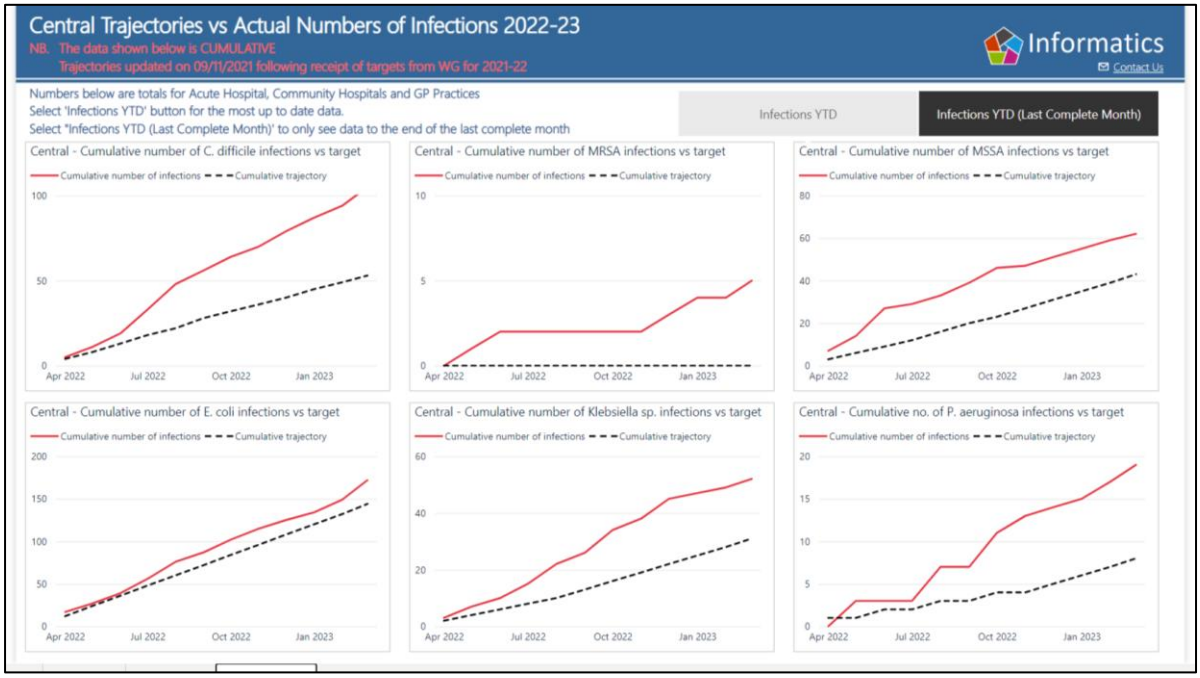
Compliance with trajectories in each of the three healthcare communities is illustrated below.

Data for West



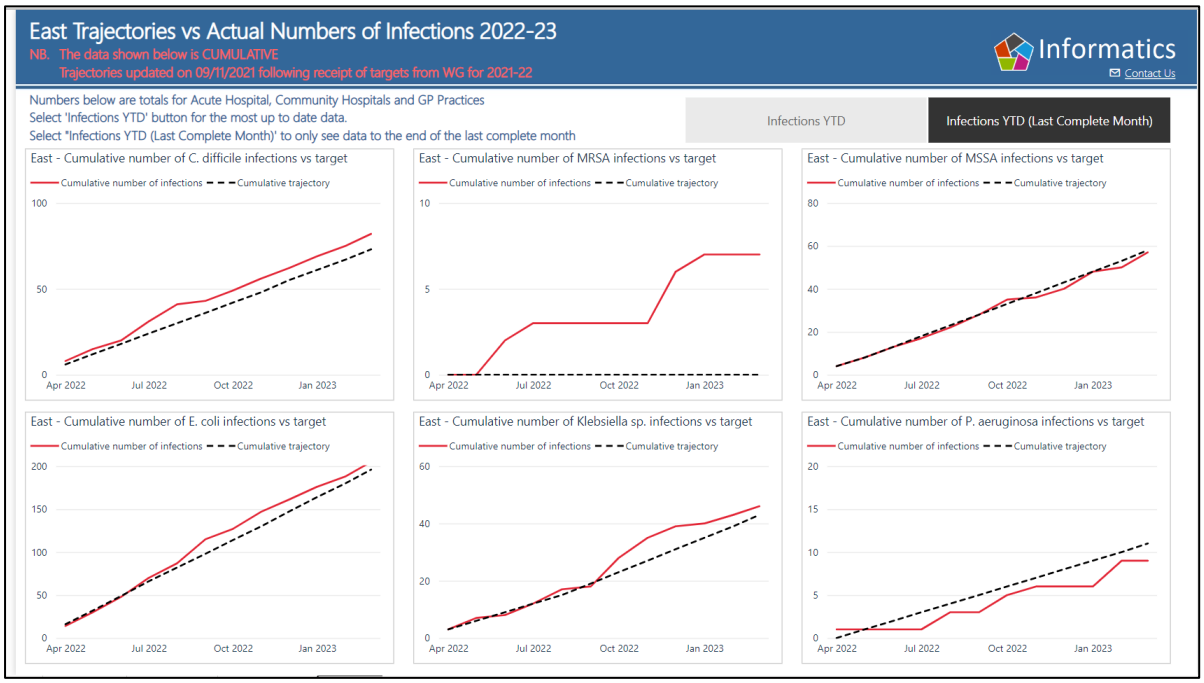
West were very close to trajectory for *E.coli* infections but over for all other infections.

Data for Centre



Centre were over trajectory for all six infections.

Data for East



East ended the year within trajectory for MSSA infections and *P. aeruginosa* and very close to trajectory for *C.difficile*, *E.coli* and *Klebsiella* infections.

Infection rates have increased in the last few years for all organisms. The COVID-19 pandemic continues to have significant impact on healthcare systems with the recognition that focusing resources that primarily mitigate COVID-19 spread has inadvertently reduced attention to traditional infection prevention programs in terms of surveillance efforts, targeted process measures and containment strategies. IP resources have been pressurised and regularly diverted to outbreak management. 2022/23 has also seen significant numbers of Influenza and Norovirus infections and outbreaks, all competing for the limited number of siderooms and

adding additional pressure to clinical and IP teams. This led to a service that was mainly acting reactively as opposed to proactively for much of the year to reduce infections. There is also an ongoing lack of any decant facilities within BCUHB and limited resources within deep cleaning teams to enable a programme of cleaning with high level disinfection within inpatient bays to take place to reduce the environmental load and reduce *C.difficile* spores.
A renewed focus and additional resource will be required to reduce infections moving forwards. A 'plan on a page' for 2023/24 has been developed which sets out the priorities for the forthcoming year and has been approved by IPSG and can be found within Appendix 3.

6.2 Patient Incident Reviews

All NHS organisations are required to complete a Patient Incident Review (PIR) for key healthcare associated infections. Within BCUHB, the target is to convene a multi-disciplinary team meeting within 72 hours of the reported result to undertake an initial review of the case and determine if it was unavoidable or avoidable, however, medical engagement is often poor and requires continued reinforcement. Action plan development addresses any required recommendations to prevent reoccurrence and enhance clinical practice and learning is shared across the organisation. The Datix system is utilised by Ward Managers to upload the completed PIR document.
Each of the three healthcare communities selects two cases to present to the monthly Corporate HCAI Review meetings for wider learning across the organisation.

6.3 Clostridiodes (formerly Clostridium) difficile Infection (*C.diff*)

In 2022/23, BCUHB reported 301 cases (rate of 42) compared to 215 (rate of 30) in 2021/22. The overall rate for Wales also increased in 2022/23 from 34 to 37 with Hywel Dda also seeing a significant rise in numbers.

Betsi Cadwaladr UHB C. difficile monthly update, Apr 10 to Mar 23

Select health board: Betsi Cadwaladr UHB | Select organism: C. difficile

301 C. difficile have been reported by Betsi Cadwaladr UHB for Apr 22 - Mar 23. This is approximately 40% more than the equivalent period in 2021/22. The provisional rate of C. difficile in Betsi Cadwaladr UHB for Apr 22 - Mar 23 is 42.79 per 100,000 population.

Betsi Cadwaladr UHB numbers and rates of C. difficile per 1,000 hospital admissions and 100,000 population, Apr 10 to Mar 23

	Number of specimens	Number of inpatient specimens	Number of non-inpatient specimens	Rate/1,000 admissions	Rate/100,000 population
2022/23	301	171	130	3.25	42.79
Mar	33	16	17	4.43	55.24
Feb	29	19	10	3.89	53.75
Jan	23	13	10	2.95	38.50
Dec	20	15	5	2.46	33.48
Nov	18	10	8	2.11	31.14
Oct	25	14	11	3.08	41.85
Sept	20	8	12	2.69	34.60
Aug	34	16	18	4.47	56.92
Jul	36	22	14	4.72	60.26
Jun	21	13	8	2.79	36.33
May	20	16	4	2.53	33.48
Apr	22	9	13	3.18	38.06
2021/22	215	121	94	2.47	30.57
Mar	13	6	7	1.74	21.76
Feb	15	7	8	2.26	27.80
Jan	5	1	4	0.73	8.37
Dec	10	4	6	1.47	16.74
Nov	19	9	10	2.54	32.87
Oct	29	13	16	3.93	48.55
Sept	31	18	13	4.43	53.62
Aug	23	14	9	3.16	38.50
Jul	23	15	8	2.97	38.50
Jun	25	16	9	3.19	43.24
May	14	10	4	1.86	23.44
Apr	8	8	0	1.14	13.84
2020/21	212	103	109	2.81	30.14
2019/20	176	99	77	1.76	25.16
2018/19	171	90	81	1.71	24.49
2017/18	277	173	104	2.88	39.78
2016/17	268	168	100	2.84	38.52
2015/16	355	221	134	3.70	51.12
2014/15	395	262	133	4.11	56.91
2013/14	447	300	147	4.74	64.60
2012/13	637	473	164	7.05	92.26
2011/12	597	476	121	6.53	86.72
2010/11	805	664	141	8.73	117.36

Chart1. Betsi Cadwaladr UHB monthly numbers of C. difficile by location type, Apr 10 to Mar 23

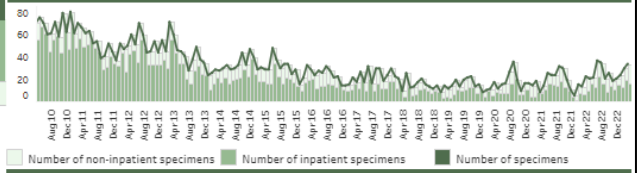


Chart 2. Betsi Cadwaladr UHB monthly rates of C. difficile per 1,000 hospital admissions, Apr 10 to Mar 23

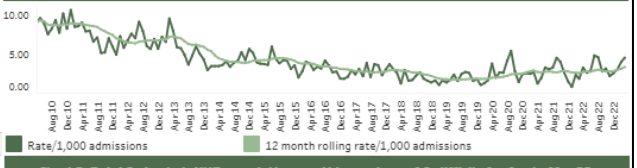


Chart 3. Betsi Cadwaladr UHB cumulative monthly numbers of C. difficile for Apr to Mar 23 compared to the equivalent period in 2021/22

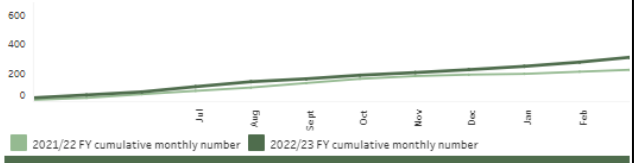
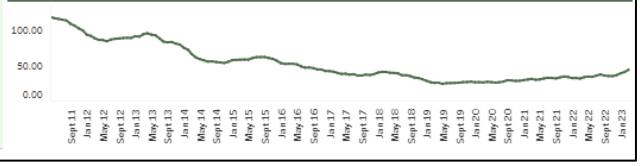


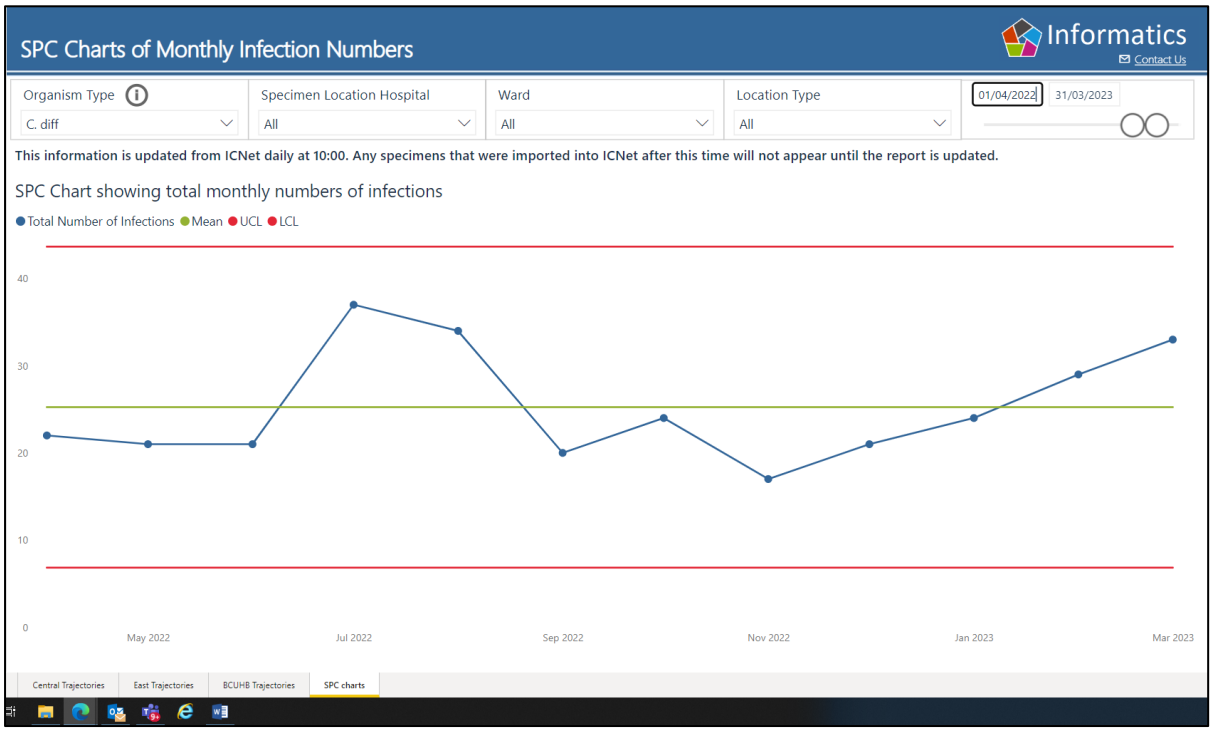
Chart 4. Betsi Cadwaladr UHB monthly rolling 12 month rates C. difficile per 100,000 population, Apr 10 to Mar 23



It was also noted that BCUHB appeared to be seeing a higher number of reinfections of *C.diff* cases and a review was carried out. Key findings included:

- Data suggest that recurring infections do occur, with patients often having more than one additional episode.
- Those patients who test toxin negative and later go on to test toxin positive represent about 11% of repeat infections.
- Recent outbreaks have involved both toxin negative and toxin positive patients. Some of these have been indistinguishable at genomic sequencing profiles.
- Recent outbreaks suggest that toxin negative cases are linked to positive cases and further investigations should be undertaken to elucidate possible pathways; the IP team now consider both toxin negative and positive cases in PIRs.
- The Antimicrobial Pharmacist reviewed 16 randomly selected recent reoccurrences and reviewed first and second line antibiotics. Key learning from this was shared with prescribers, including GPs and ward pharmacists.
- A national study is now taking place looking at the role of toxin negatives in reoccurrence.

Seasonal variation means there is usually an increase in *C.diff* cases reported during summer months (as illustrated below) but BCUHB rates were further exacerbated by a level two outbreak in YG in Feb/March 2023 effecting a small number of wards (see the section below on the 'West Outbreak' for further details).



In addition to the *C.diff* outbreak in West, six other 'Periods of Increased Incidence' (PII) were also detected and managed in 2022/23 across BCUHB; three in YGC and three in WM, however all six were confined to just one ward each time.

Along with the PIRs that are carried out on each of the mandatory infections, additional information should be entered by the IP team into a 'Deep Dive' database on ICNet (BCUHBs clinical surveillance software system) to enable summary data to be obtained. The following questions are answered within this:

- Was the infection avoidable or unavoidable?
- Was the infection hospital or community onset?

- Is the infection healthcare associated?

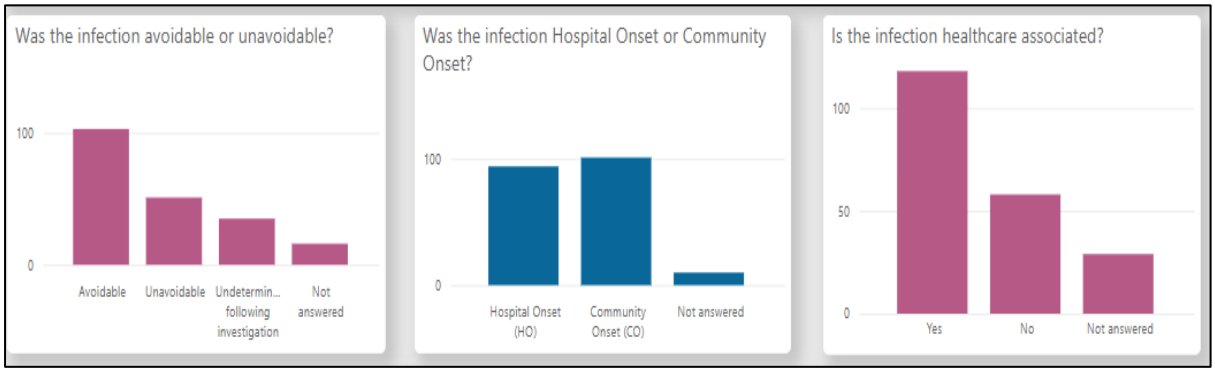
Due to IP nurse staffing resource issues and lack of data analyst resource, this data was not consistently completed for all cases in 2022/23, however, it does continue to provide some useful information as outlined below. The IP Team have now timetabled this to be updated regularly for all future cases and new categories will be added to include the source of infection, to enable more targeted interventions in the future. Current Data Analyst resource is limited at present within the team but there are plans to recruit a part time band 5 in 2023 to support this work.

The data below represents the 68% of *C.diff* cases that have been added to the Deep Dive database.

Percentage of Deep Dives Carried Out by Area

Area	Number of Deep Dives Carried Out	Total Number of Infections During Month	Percentage Deep Dives Completed
West	96	113	85%
Central	47	105	45%
East	62	82	76%
Total	205	300	68%

Central had significantly less IP nurse staff in the early part of 2022/23 which impacted completion of the Deep Dive data for the early part of the year, however, this has much improved as IP nurse staffing levels have increased.
Approximately 50% of *C.difficile* cases were hospital onset / healthcare associated / avoidable, indicating more work is required to reduce these infections.



C.difficile	
Was the infection avoidable or unavoidable?	
Avoidable	103 (50%)
Unavoidable	51(25%)
Undetermined	35
Not answered	16
Was the infection hospital or community onset?	
Hospital Onset	94 (46%)
Community Onset	101 (49%)
Not answered	10
Was this a Healthcare Associated Infection (HCAI)?	

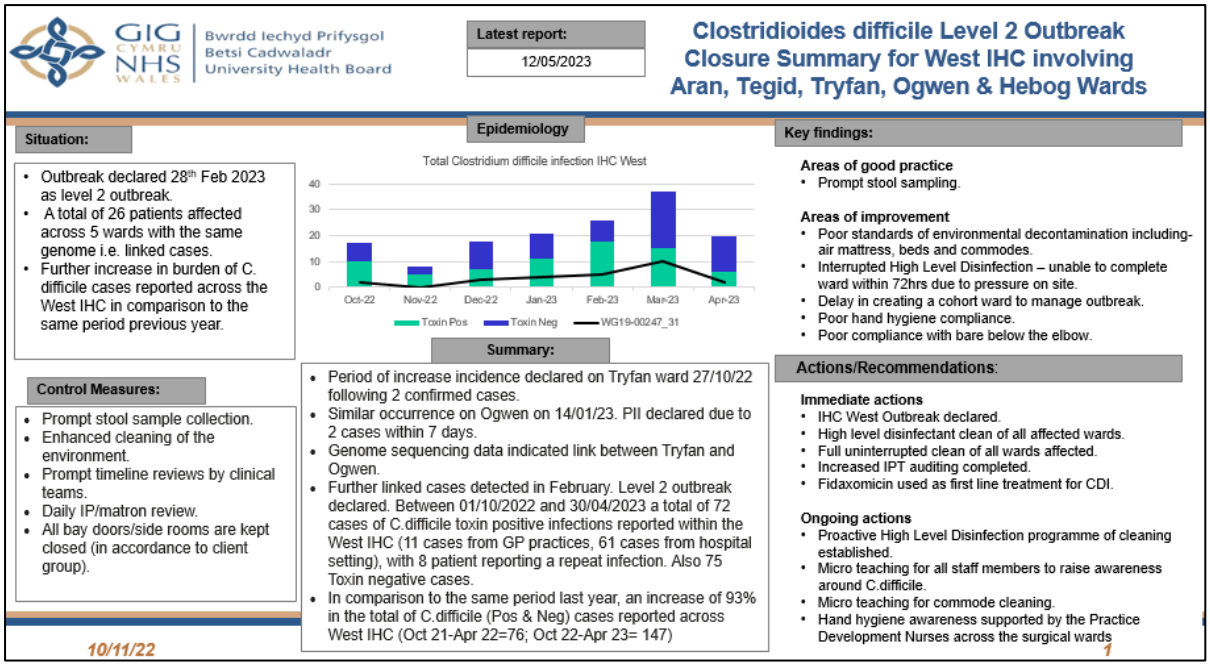
HCAI	118 (58%)
Not HCAI	58 (28%)
Not answered	29

A BCUHB *C.difficile* Task and Finish group was established in August 2022 to review *C.diff* pathways, treatments and identify further areas requiring action, with the aim of reducing rates at BCUHB. The group has continued to meet regularly and the following actions have been taken:

- The PIR tool was reviewed and refined to ensure there was a focus on prevention measures, not just control.
- A new Faecal Transplant Procedure was written based on the latest NICE guidance and shared with colleagues across BCUHB to encourage uptake at all sites.
- Further training has taken place with junior members of the IP team to ensure that they have a good understanding of *C.diff* and are competent to deliver training to clinical staff.
- The mattress audit tool has been refined and relaunched with the IP team carrying out random checks during ward visits.
- The local PHW Research Scientist and the Healthcare Epidemiologist attend the C.difficile Task and Finish group and feed into national *C.difficile* groups. They carried out an 18 month study of *C.difficile* in oncology and haematology patients, having previously noted an over representation of this patient group within C.difficile case numbers, and a detailed report was produced in January. The report was shared with clinical staff who have drawn up an action plan to address the recommendations. The Microguide in relation to Fidaxomicin has also been strengthened to ensure it is clear that this should be the first line treatment for these patients.
- The Management of Diarrhoea Flow Chart was revised and circulated, forms part of the teaching package for clinical staff and is available within the *C.difficile* toolkit pages on the Health Board's intranet (Betsinet).
- Throughout February, a multifaceted BCUHB-wide *C.difficile* improvement campaign led by the IP Team was delivered (see later section on Education for more detail).
- The IP webpages were reviewed with the support of the Communications Team to ensure key messages could be effectively shared and disseminated, with total views during the *C.difficile* campaign reaching 1,880.
- Progress with Deep Clean programmes on the acute sites is now monitored by IPSG.
- The 'Period of Increased Incidence' protocol was strengthened to request that Deep Cleans were completed for the complete ward/all bays, and not just the bay affected.
- A small number of senior doctors have been identified *C.difficile* Champions for their profession and help 'sell' the key messages to their colleagues.
- Weekly microbiologist led C.difficile ward rounds have been reinstated at all three acute sites; due to a lack of consultant microbiologists last year these were not always taking place.

West Outbreak

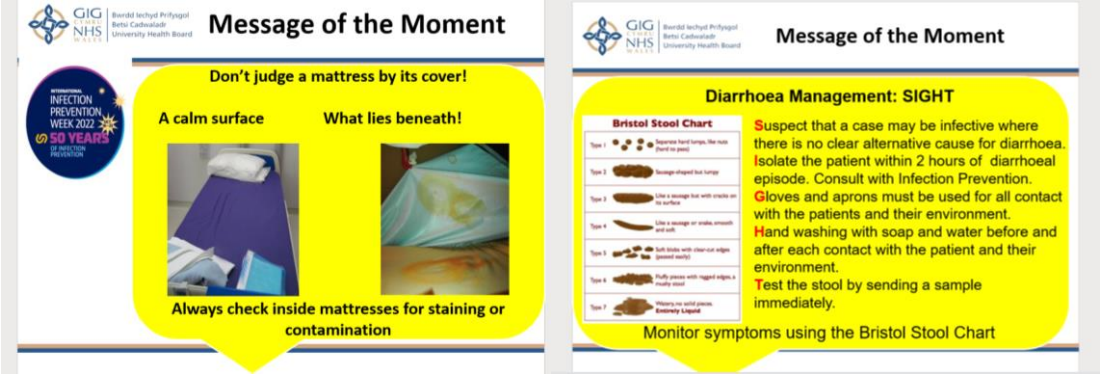
In February 2023 a level 2 outbreak of *C.difficile* was identified in West IHC involving 26 patients (who had the same genome) across five wards. Regular meetings took place and a number of actions instigated. The outbreak was declared over in April 2023 when patient numbers reduced, actions were completed and the group were confident that preventative IP measures were in place. The outbreak summary slide can be found below.



Themes arising from PIRs of patients acquiring *C.difficile* in 2022/23 across BCUHB included:

- Delayed sampling and isolation of patients
- Gaps in completing Bristol Stool Chart records
- Delay in starting appropriate treatment
- Reoccurrences not being referred for faecal transplant in timely manner
- Inappropriate use of antibiotics
- Medical teams not reviewing PPIs/laxatives
- Microbiology advice not sought
- Commodes and mattresses not being inspected and cleaned properly
- No assurance around patient hand hygiene and audits not being performed
- Patients becoming re-infected due to their single room not being disinfected on completion of treatment and symptoms settling
- Limited assurance around cleaning regimes and enhanced and deep cleans not always carried out when required
- Proactive programmes of deep cleaning with High Level Disinfection not in place
- Mandatory training compliance requiring improvement
- Concerns re Emergency Department being an environmental reservoir with an inability to perform high level disinfection, lack of isolation, number of toilets, overcrowding, long length of stay; this is being escalated though LIPGs.
- Currently there is no recorded tracking of a patients journey to know what bed space/rooms patients have been in.
- Lack of siderooms in East and West, PODs are used for 'isolating' patients with diarrhoea, however these are not effective for isolation purposes (only segregation) and do not have any ensuite facilities nor hand hygiene sinks in many cases.

Key learning is been collated and shared at IPSG, LIPGs, Safe Clean Care meetings and added to 'Message of the Moment' slides sent to clinical staff. Examples can be found below.

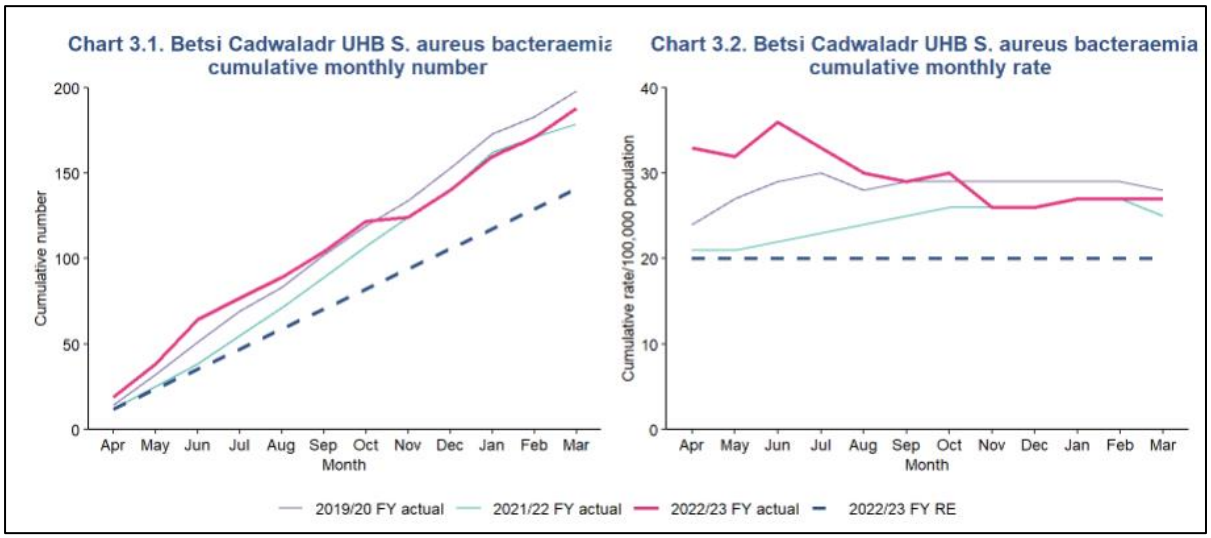


Areas requiring ongoing/further focus

- Prompt identification, testing, isolation and treatment of patients with symptoms. Inclusion of stool charts on the Welsh Nursing Care Record has helped support this as there is now a daily prompt for completion. However, they are less visibile / accessible for medical staff and they are often only completed once per day, rather than each occasion a patients has their bowels opened.
- Prompt faecal transplant is required for patients with *C.difficile* reinfections at all acute sites – the consultant specialist in YG can support but clinical leads are being sought for WM and YGC.
- Review of cleaning protocols within Emergency Departments.
- Cleaning and checking of all mattresses between patients, inside and out, with regular audit to provide assurance.
- Active and ongoing engagement with clinicians in relation to antibiotic use including input from the Antimicrobial Pharmacists.
- Ensuring that the pro-active and reactive High-level disinfection programmes take place.

6.4 Staphylococcus aureus Blood Stream Infections (BSI)

In 2022/23, the cumulative monthly rate for *S.aureus* BSIs in BCUHB started high but fell as the year progressed, as illustrated below:



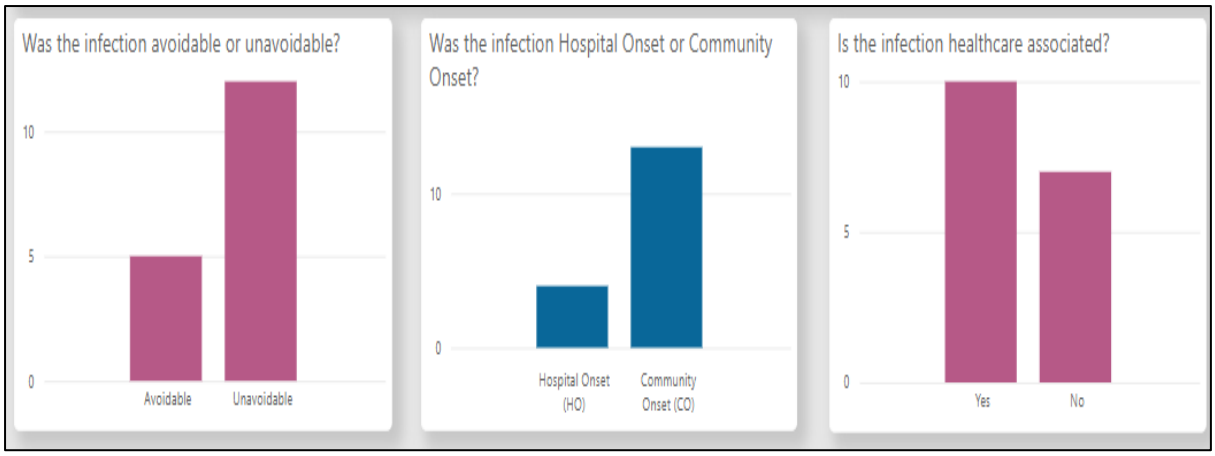
The IP Team have worked with Public Health Wales and Informatics during 2022 to establish a detailed database of blood culture information enabling staff to identify types, numbers and locations of all blood cultures taken. The database has been presented at IPSG and used to

highlight departments that have a higher rate of contaminated blood cultures, enabling more targeted education and training in those areas.
The blood culture contamination rate has reduced from 3-5% for April-Sept 22 to 1-2% in the period Nov–Jan which is less than or equal to the national average (2-3%). It is now monitored quarterly through the IPSG.

Methicillin Resistant *Staphylococcus Aureus* (MRSA) Blood Stream Infections

BCUHB reported 17 cases in 2022/23 with a rate of 2.42 compared to the All Wales rate of 2.24.

A Deep Dive was carried out on all 17 cases as shown below:



Five of the 17 cases (29%) were deemed avoidable, the majority (n~13, 76%) were community onset and 10 (59%) where classed as a healthcare associated infection (HCAI). Of the 10 HCAI cases, five were related to urinary catheters, four related to skin conditions and one classed as a contaminant. Further work is required to reduce these infections.

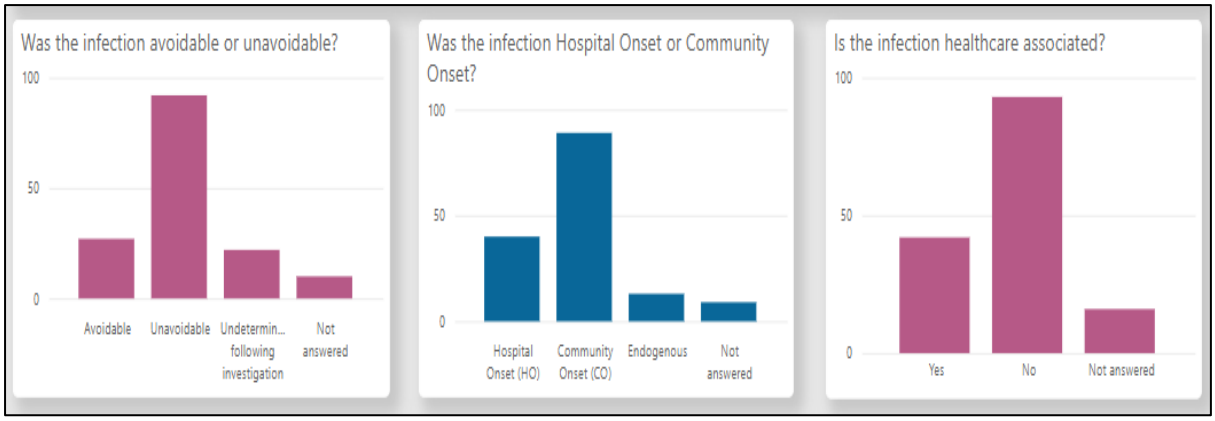
MRSA	
Was the infection avoidable or unavoidable?	
Avoidable	5 (29%)
Unavoidable	12 (71%)
Was the infection hospital or community onset?	
Hospital Onset	4 (24%)
Community Onset	13 (76%)
Was this a Healthcare Associated Infection (HCAI)?	
HCAI	10 (59%)
Not HCAI	7 (41%)

Methicillin Sensitive *Staphylococcus Aureus* (MSSA) Blood Stream Infections (BSI)
BCUHB reported 171 cases in 2022/23 with a rate of 24.3 compared to the All Wales rate of 25.5.

87% 0f MSSA BSIs have been subject to a Deep Dive investigation:

Percentage of Deep Dives Carried Out by Area

Area	Number of Deep Dives Carried Out	Total Number of Infections During Month	Percentage Deep Dives Completed
West	49	54	91%
Central	48	62	77%
East	54	57	95%
Total	151	173	87%



The majority were unavoidable (61%), community onset (59%) and not healthcare associated (62%), however further work is required to reduce these infections.

MSSA	
Was the infection avoidable or unavoidable?	
Avoidable	27 (18%)
Unavoidable	92 (61%)
Undetermined	22
Not answered	10
Was the infection hospital or community onset?	
Hospital Onset	40 (26%)
Community Onset	89 (59%)
Exogenous	13
Not answered	9
Was this a Healthcare Associated Infection (HCAI)?	
HCAI	42 (28%)
Not HCAI	93 (62%)
Not answered	16

Of the cases deemed healthcare associated, many are device related with peripheral cannula being the most common source.
Common themes from MRSA/MSSA PIRs include:

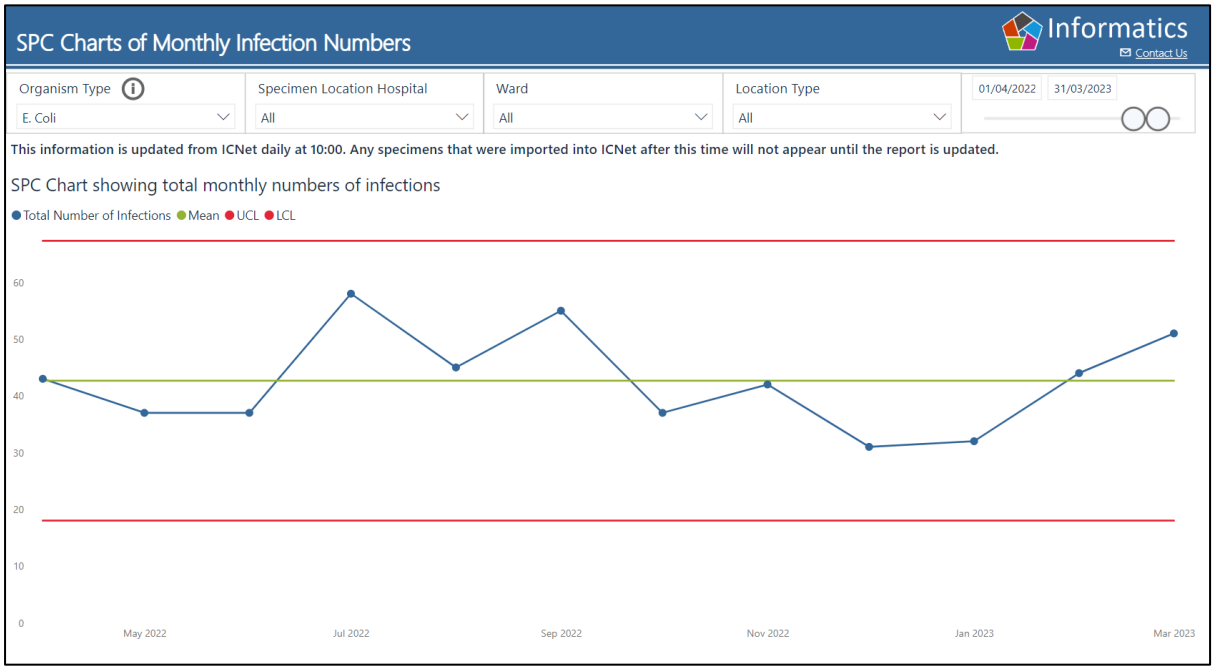
- Missed screening opportunities, on admission and of wounds
- Delayed decolonisation treatment
- Limited evidence regarding using sterile techniques (ANTT) for blood culture collection and / or no evidence of blood culture packs being used
- Documentation not completed properly
- Intravenous line placements e.g. renal not being performed in a controlled area due to lack of appropriate facilities i.e. are performed in the ward at the patient's bedside
- Use of femoral intravenous lines , and other options not being considered
- Incorrect duration of antibiotics
- Delayed identification and management of other positive inpatients
- Failure to isolate MRSA patients with chronic skin conditions
- Urinary catheter passports not always used
- Wound mapping/body charts not always completed

6.5 Gram negative blood stream infections
There was a mixed picture for these infections during 2022/23, but there was an increase in *E.coli* infections. Rates for *Pseudomonas* and *Klebsiella* are relatively unchanged.

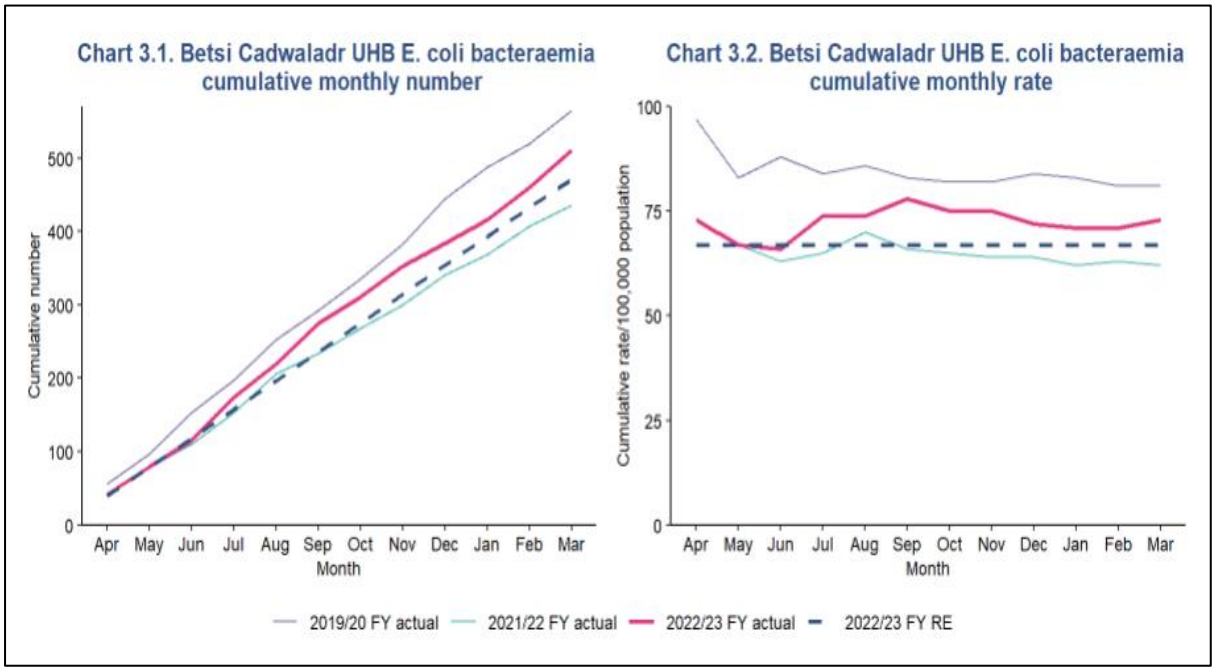
Escherichia coli Blood Stream Infections

In 2022/23 E.coli BSIs increased to 72.6 per 100,000, an increase from 62 in 2021/22 but lower than the rate seen in 2020/21.

The chart below illustrates the total number of cases per month for the last year. There was a commonly seen seasonal increase in the summer months but also a further rise in infections during March 2023 which is being investigated.



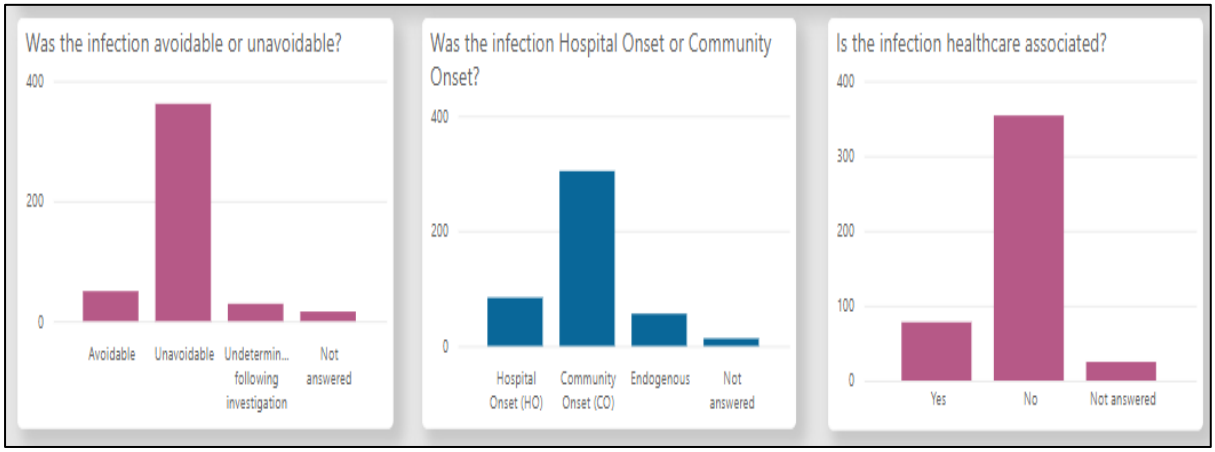
The chart below illustrates the *E.coli* BSI rate over the last three years and the target rate (dotted line).



A Deep Dive was carried out on 89% of cases as shown below:

Percentage of Deep Dives Carried Out by Area

Area	Number of Deep Dives Carried Out	Total Number of Infections During Month	Percentage Deep Dives Completed
West	128	135	95%
Central	136	172	79%
East	193	205	94%
Total	457	512	89%



The majority of *E. coli* blood stream infections were from samples collected in the Emergency Department, deemed community onset with many endogenous (originating from the individual) in nature and, therefore, unavoidable.

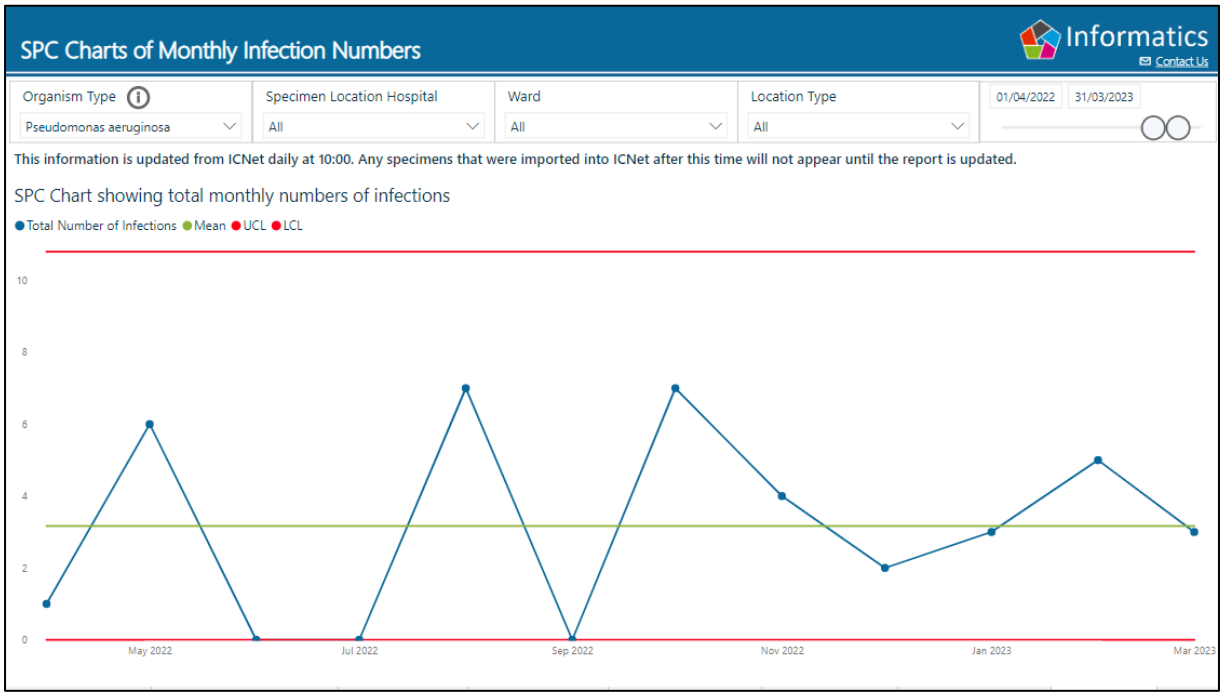
E.coli	
Was the infection avoidable or unavoidable?	
Avoidable	50 (11%)
Unavoidable	362 (79%)
Undetermined	29
Not answered	16
Was the infection hospital or community onset?	
Hospital Onset	84 (18%)
Community Onset	304 (67%)
Exogenous	56
Not answered	13
Was this a Healthcare Associated Infection (HCAI)?	
HCAI	78 (17%)
Not HCAI	354 (77%)
Not answered	25

Patient reviews found avoidable *E.coli* BSIs to be largely associated with urinary catheters and catheter associated urinary tract infection (CAUTI). A refocus is planned during 2023/2024 to ensure practices associated with urinary catheters are optimal in order to prevent CAUTI and subsequently reduce bloodstream infections that can occur as a result.
A CAUTI prevalence audit performed across all inpatient areas within the acute and community hospitals at the start of the 2023/24 will provide a baseline rate and will inform

clinical areas where improvement in catheter associated practices are required. The implementation and/or re-launch of the Catheter Passport, HOUDINI (an evidence- based approach to empower staff to remove catheters at the earliest opportunity), trial without catheter protocol and blocked catheter flowchart will all assist to achieve such improvements. Success will be measured following a repeat audit performed later on in the year. The CAUTI Project is also one of many projects being delivered through the Safe Care Collaborative led by Improvement Cymru and the Institute for Healthcare Improvement.

***Pseudomonas aeruginosa* Blood Stream Infections**

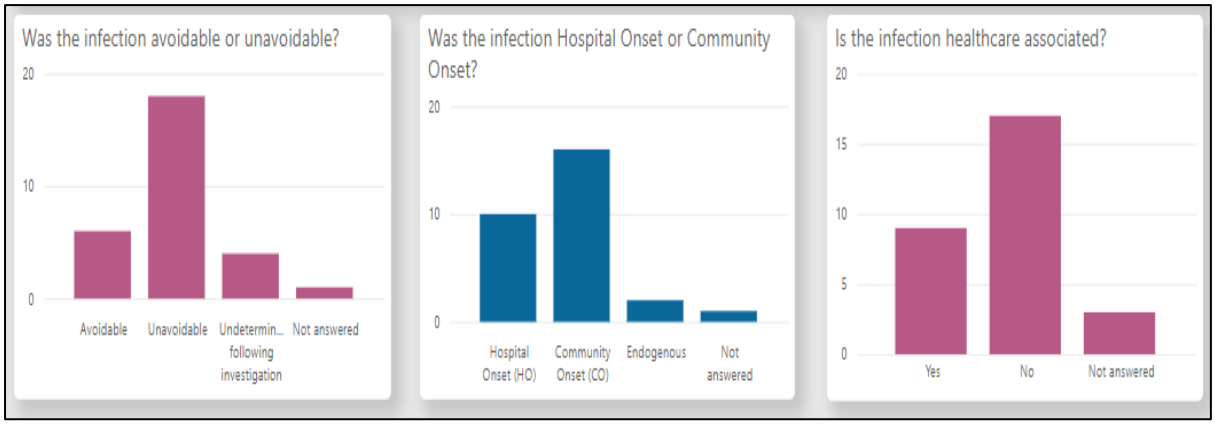
In 2022/23 the *Pseudomonas* BSI rate was 5.4 100,000, slight increase from 5.2 in 2021/22 but lower than the All Wales average of 6.15.
The chart below illustrates the total number of cases per month for the last year.



A Deep Dive investigation has been carried out on 76% of cases as shown below:

Percentage of Deep Dives Carried Out by Area

Area	Number of Deep Dives Carried Out	Total Number of Infections During Month	Percentage Deep Dives Completed
West	9	10	90%
Central	13	19	68%
East	7	9	78%
Total	29	38	76%

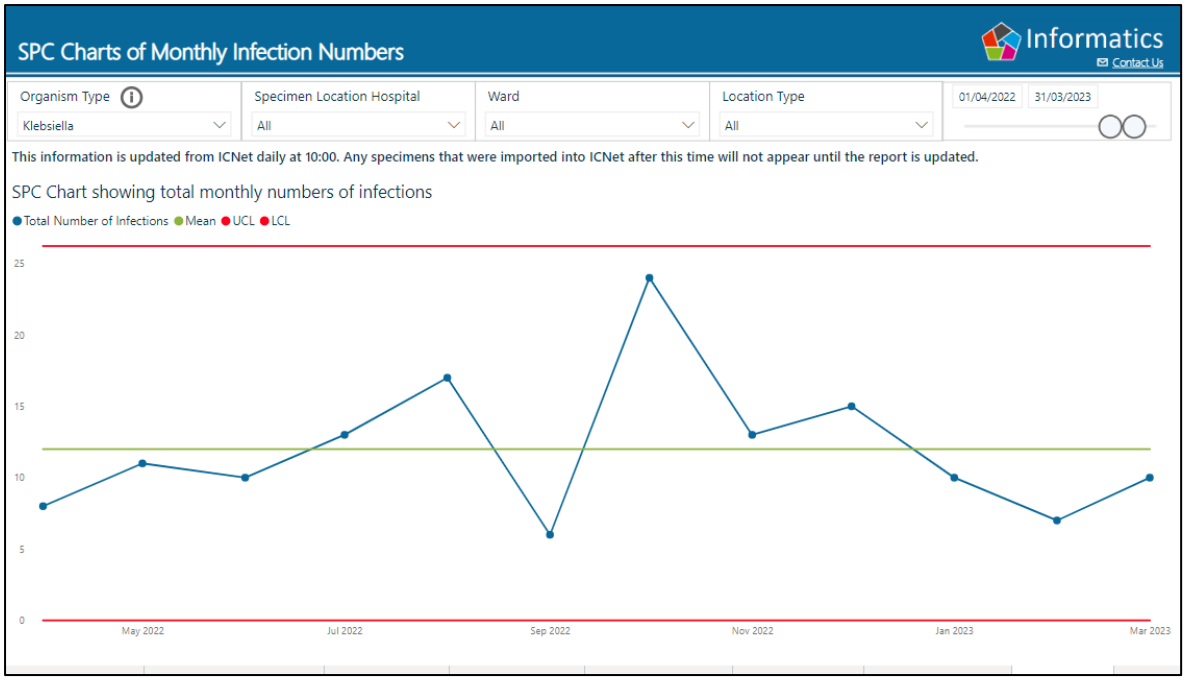


The majority were unavoidable, community onset and not healthcare associated but further work is required to reduce these infections.

Pseudomonas aeruginosa	
Was the infection avoidable or unavoidable?	
Avoidable	6 (21%)
Unavoidable	18 (62%)
Undetermined	4
Not answered	1
Was the infection hospital or community onset?	
Hospital Onset	10 (34%)
Community Onset	16 (55%)
Exogenous	2
Not answered	1
Was this a Healthcare Associated Infection (HCAI)?	
HCAI	9 (31%)
Not HCAI	17 (59%)
Not answered	3

Klebsiella **Blood Stream Infections (BSI)**

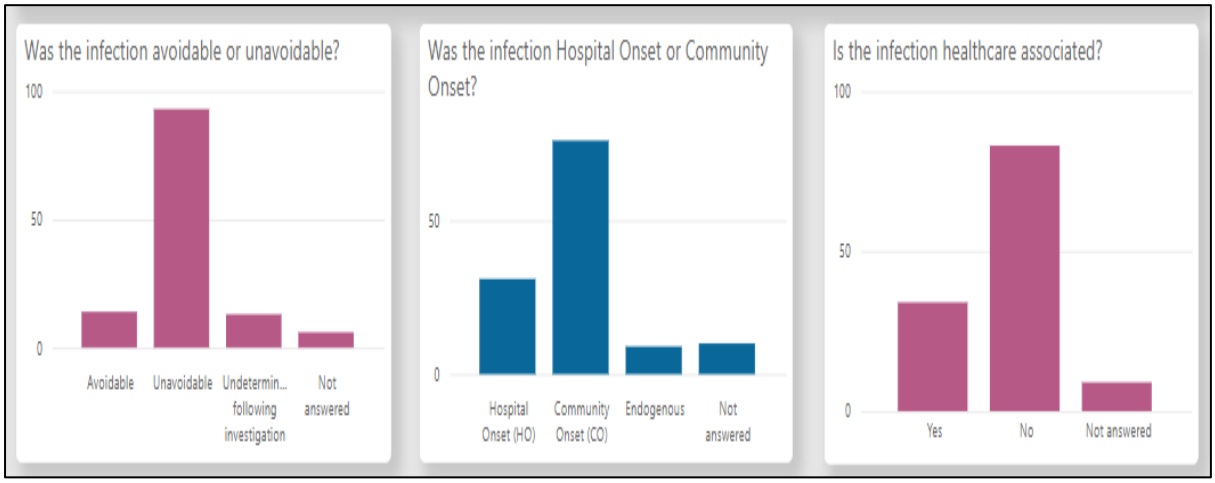
In 2022/23 the *Klebsiella* BSI rate was 20.4 100,000, up slightly from 19.6 in 2021/22 but lower than the Wales average of 22.3.
The chart below illustrates the total number of cases per month for the last year.



A Deep Dive investigation has been carried out on 88% of cases as shown below:

Percentage of Deep Dives Carried Out by Area

Area	Number of Deep Dives Carried Out	Total Number of Infections During Month	Percentage Deep Dives Completed
West	44	46	96%
Central	40	52	77%
East	42	46	91%
Total	**126**	**144**	**88%**



The majority were unavoidable, community onset and not healthcare associated.

Klebsiella species	
Was the infection avoidable or unavoidable?	
Avoidable	14 (11%)
Unavoidable	93 (78%)
Undetermined	13
Not answered	6
Was the infection hospital or community onset?	
Hospital Onset	31 (25%)
Community Onset	76 (60%)
Exogenous	9
Not answered	10
Was this a Healthcare Associated Infection (HCAI)?	
HCAI	34 (27%)
Not HCAI	83 (66%)
Not answered	9

Of the gram negative BSI healthcare associated cases deemed to be avoidable, lessons learned from the PIRs include:

- Absence or gaps in insertion and maintenance bundles/VIP scores for urinary catheter and vascular devices
- Lack of documented evidence of Aseptic Non-Touch Technique (ANTT) in blood culture collection and urinary catheter insertion
- Junior doctors not had ANTT trained supervision or assessment
- No evidence that the recommended blood culture packs were used
- Bladder scans not always performed pre catheterisation
- Repeat catheter changes with no clinical indication
- Delays in catheter changes when required
- Failure to consider or perform Trial without catheter (TWOC)
- Inappropriate antibiotics prescribed
- Antibiotic treatment prescribed based on 'dipstick' of urine
- Catheter specimens not collected when requested
- Urine samples sent in incorrect sample containers so not processed in lab, delaying identification and appropriate treatment
- Delayed review of sample results or no documentation of review of results
- Poor documentation by medical teams on treatment changes, resulting in multiple changes in prescribing
- Catheter passports not always being issued
- Non-compliant patients – catheter management, traumatic catheter removals
- Prophylaxis not given for catheter insertion following traumatic removal

7.0 COVID-19

It has been over three years since the global pandemic was declared, however, COVID-19 issues continued to dominate the work of the IP Team during 2022/23. National and Welsh guidance was regularly updated over the year with the following key events:

- April 22: COVID-19 testing facilities closed, there was no longer a requirement for people to self isolate, patient visiting restrictions were relaxed and isolation of asymptomatic contacts of in-hospital cases of COVID-19 was no longer required. A risk assessment for waiting areas was approved by IPSG.
- May 22: Mask wearing was no longer compulsory for all areas.
- June 22: Social distancing restrictions were relaxed, the approach to managing staff sickness returned to pre-pandemic normal practice but masks were reintroduced as COVID-19 cases rose again.

- July 22: Introduced LFT testing for patients at day 5 and 6 to support early de-isolation of patients where possible.
- Aug 22: Welsh Government ceased the provision of LFT tests to members of the public, LFTs were used to test health and social care staff that were a household contact of a positive case to enable staff to return to work earlier, PPE guidance during CPR was updated, masks were removed from most areas and visiting guidance relaxed again.
- Sept 22: Routine asymptomatic testing was paused across hospitals and care homes.
- Oct 22: Further changes to testing guidance.
- Nov 22: Mask wearing was reintroduced as numbers of COVID-19 and flu patients rose but PCR testing of staff was discontinued in outbreaks.
- Dec 23: Updated guidance from Welsh Government requested a risk based approach to the management of patients be used to manage the large number of COVID-19 and Influenza patients being seen. Using this guidance a new risk assessment for BCUHB was written and approved on cohorting patients, or contacts of those with confirmed respiratory infections.
- Jan 23: CMO letter issued re identifying patients who have travelled to China in the last 14 days and ensure specimens are sent for typing. The BCUHB risk assessment was updated for the control measures to minimise the transmission of all seasonal respiratory viral infections.
  Also in January 2023, 27 PCR test results were inaccurately reported by PHW. The error was quickly identified and rectified, however, the IP Team were not initially informed and some wards acted on the incorrect result, patients were wrongly isolated and some commenced on treatment (Tamiflu). No harm occurred to any patient and the incident was reported on Datix and at IPSG. The issue was escalated to PHW leads to investigate to ensure the error is not repeated.
- Feb 23 – BCUHB stepped down mask wearing again.

7.1 COVID-19 Admission Data

There were 3,961 admissions of COVID-19 positive patients between 01/04/22 – 31/03/23 with an average length of stay of 31 days. Following similar trends previously reported for 2020/21, approximately half (2096 patients; 53%) of these admissions were associated with community-associated infection.

Definitions from the Welsh Government:

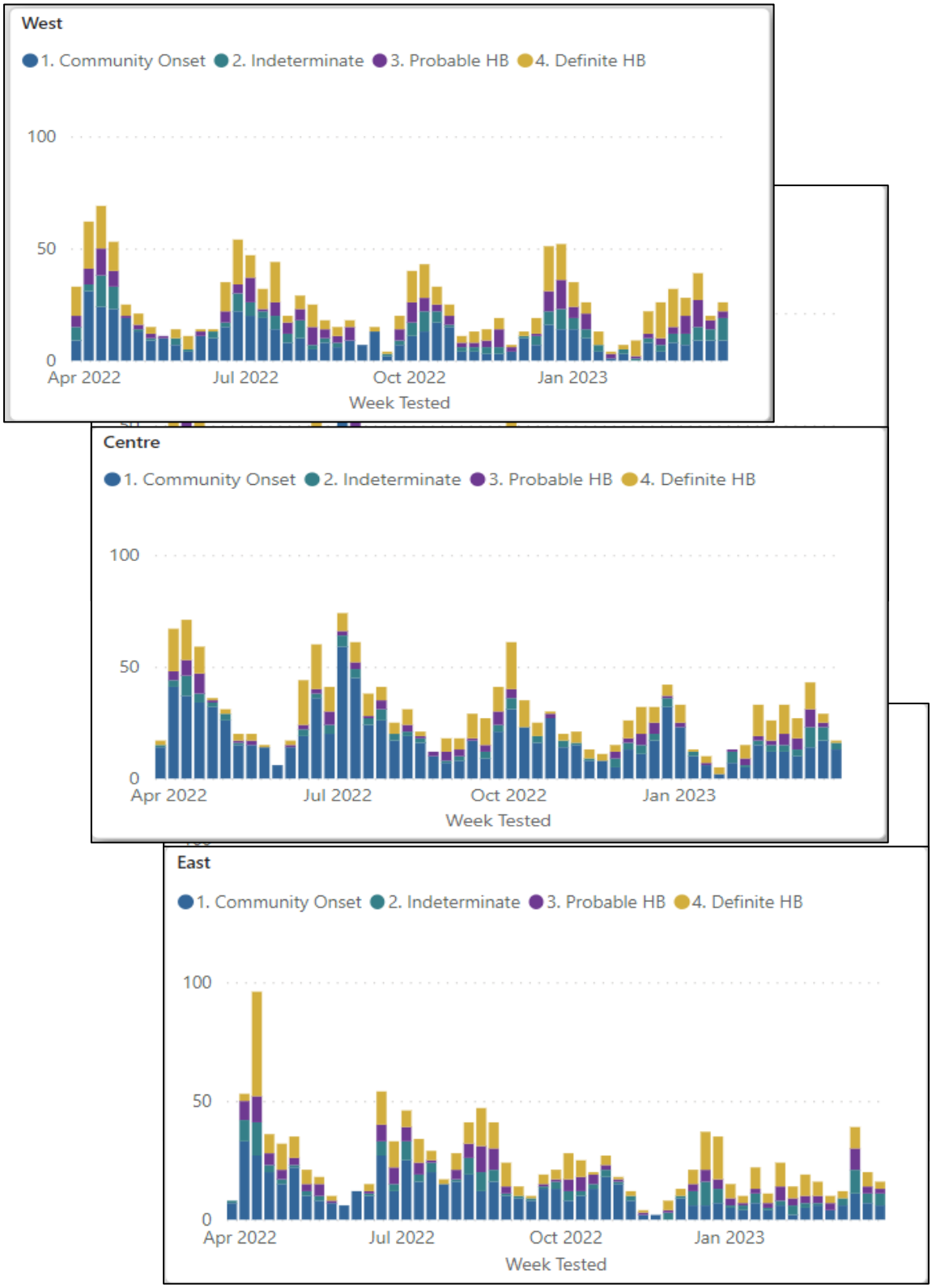
- **Community-associated COVID-19:** Symptoms present on admission or with onset on day 1 or 2 after admission. (Symptom onset on days 3-7 and a strong suspicion of community transmission).
- **Indeterminate association:** Symptom onset on day 3-7 after admission, with insufficient information on the source of infection to assign to another category.
- **Probable healthcare-associated COVID-19:** Symptoms onset on day 8-14 after admission (Symptom onset on day 3-7 and a strong suspicion of healthcare transmission).
- **Definite healthcare-associated COVID-19:** Symptom onset on >14 days after admission

Cases by age band are shown below and display that most were in those 80 years and above:

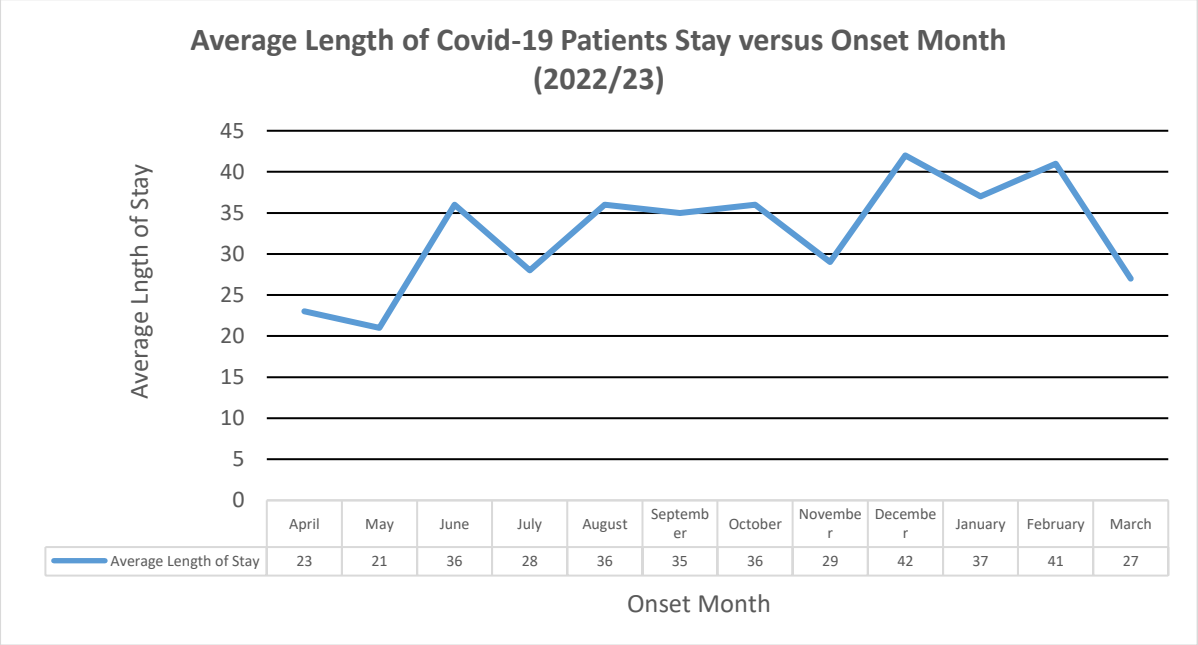
Age Bracket	Cases
Under 50 years old	746
50-54 years old	117
55-59 years old	181
60-64 years old	202

65-69 years old	284
70-74 years old	364
75-79 years old	558
80 and over	1509

Admissions by healthcare acquired infection status are shown below for each area:



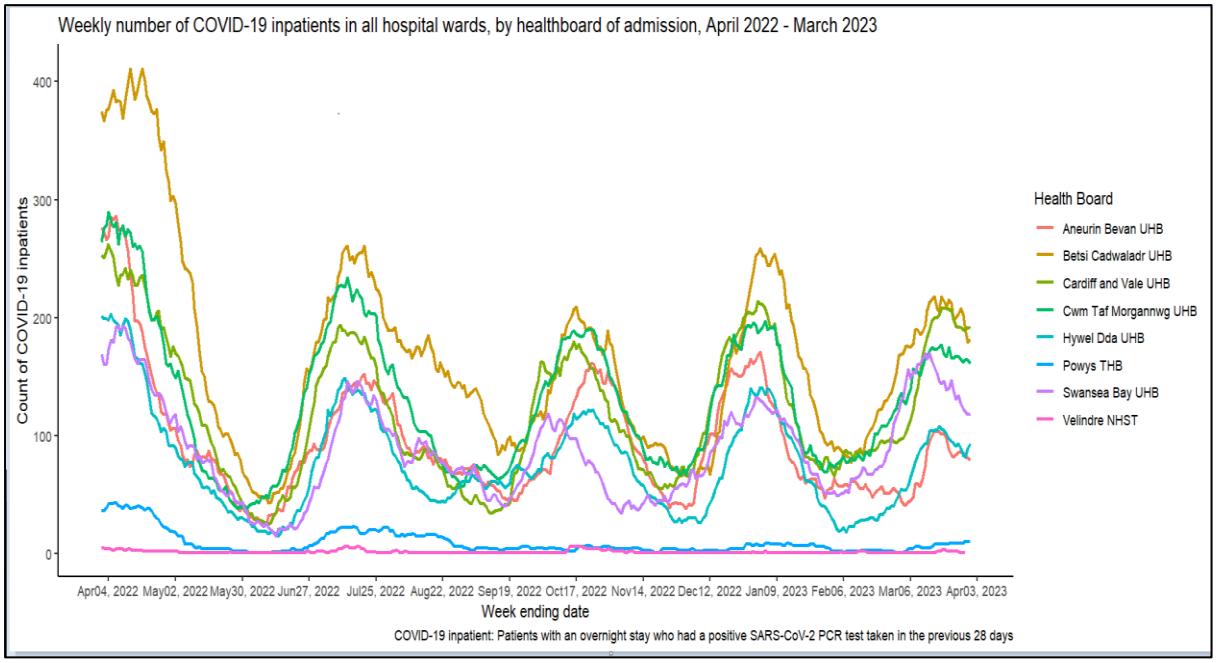
7.2 Average Length of Stay is shown below for each month. This was highest in December and February.



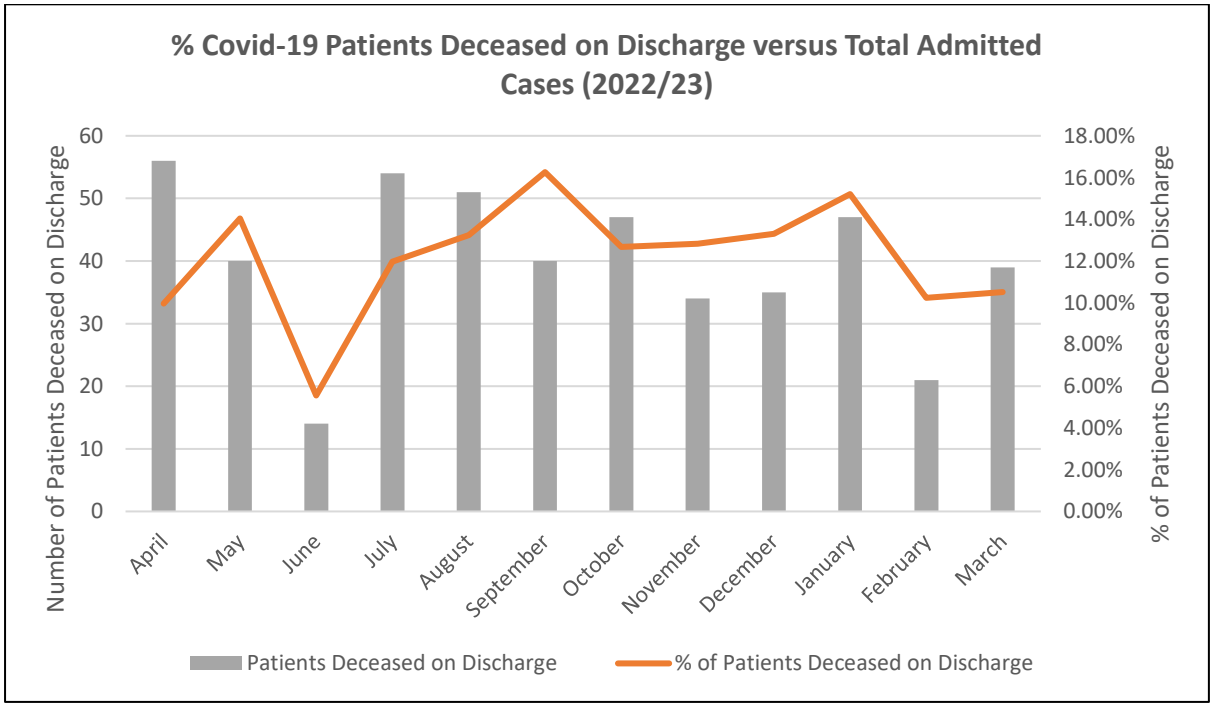
Data Definitions:
Inpatient activity is calculated based on health board spells. An individual is counted once where they were transferred between sites within a 12 hour period; transfers outside this window will be counted as a separate admission/readmission.
Admissions exclude the following specialty groups: Women's Services, Paediatrics, and Mental Health.
COVID-19 status is defined by a positive test result following admission or in the two days prior. Please note, test status is confounded by changes in testing policy during the pandemic. This methodology will also include patients who are not admitted for COVID-19 treatment but have a positive test result.
Healthcare acquired infection status is reported based on the day's difference between admission and test dates – this may vary from the outcome following post infection review.
Critical care bed day analysis was based on ward specific data therefore excludes surge beds outside these areas.

All hospital onset cases defined as probably or definitely healthcare associated were subject to a PIR and learning collated and shared at LIPGs and IPSG for onward cascade.

7.3 Comparison with other Health Boards:
The graph below outlines the weekly number of inpatient cases in all hospital wards by Health Board, highlighting the cyclical waves seen.



7.4 Deceased on discharge data is shown below for each month with highest rates seen in September and January.



7.5 COVID-19 Outbreaks

COVID outbreaks continued to occur during 2022/23 but were identified and contained quickly in most cases. For each indeterminate, probable and definite onset case, a DATIX, PIR and if required, an improvement plan, is completed. Learning then discussed at safety huddles and at other forums including LIPGs.

7.6 Care Homes

The North Wales response to preventing, containing and managing the spread of infectious diseases/COVID-19 in care homes and other closed care settings continues to be, multi-

agency and multi-disciplinary. The care home Multi-Agency Oversight Group (MAOG) was established during the COVID-19 pandemic and now meets weekly.
During the active COVID-19 pandemic period the Quality Development team took a very reactive approach when supporting care homes across North wales with IPC advice and support. Moving forward our approach is now a more proactive education, training and support provision for our care homes.

Key Achievements with care homes:

- Launch of a catheter passport (CAUTI) to help improve urinary catheter care for care homes which is measured through the IHCs and also audited via our Continence Clinical quality support tool by a practice development nurse.
- Clinical Quality Support tools and resource packs for both proactive and reactive control and management are now in place for all nursing homes across North Wales with both on site and virtual visits in place by Practice Development Nurses.
- The COVID-19 vaccination programme completed its first phase working with vaccination teams to offer an in-house service for both staff and residents within the health and social care sector accessing vaccinations for staff and residents in care homes; uptake was much improved with good uptake and minimal delays experienced.
- The flu campaign programme was completed and the quality development team worked closely with the community pharmacy teams to engage staff to increase accessibility and increase flu vaccine uptake within care homes.
- Flu Campaign Webinars for all nursing and residential care homes and domiciliary care were held promoting the importance of having vaccines. More webinars have been set for 2024.
- IP webinars are held for all care homes across North Wales on an annual basis working alongside Public Heath Wales and IP teams.
- The development of a regular 'Provider Briefing' for care homes across North Wales included information updated testing guidance for staff/service users, Welsh Government updates, the Test Trace Protect COVID-19 service, information on PPE, access to testing over Bank holiday periods, contact tracing updates and Preventing Infection Workbooks to support the care homes.

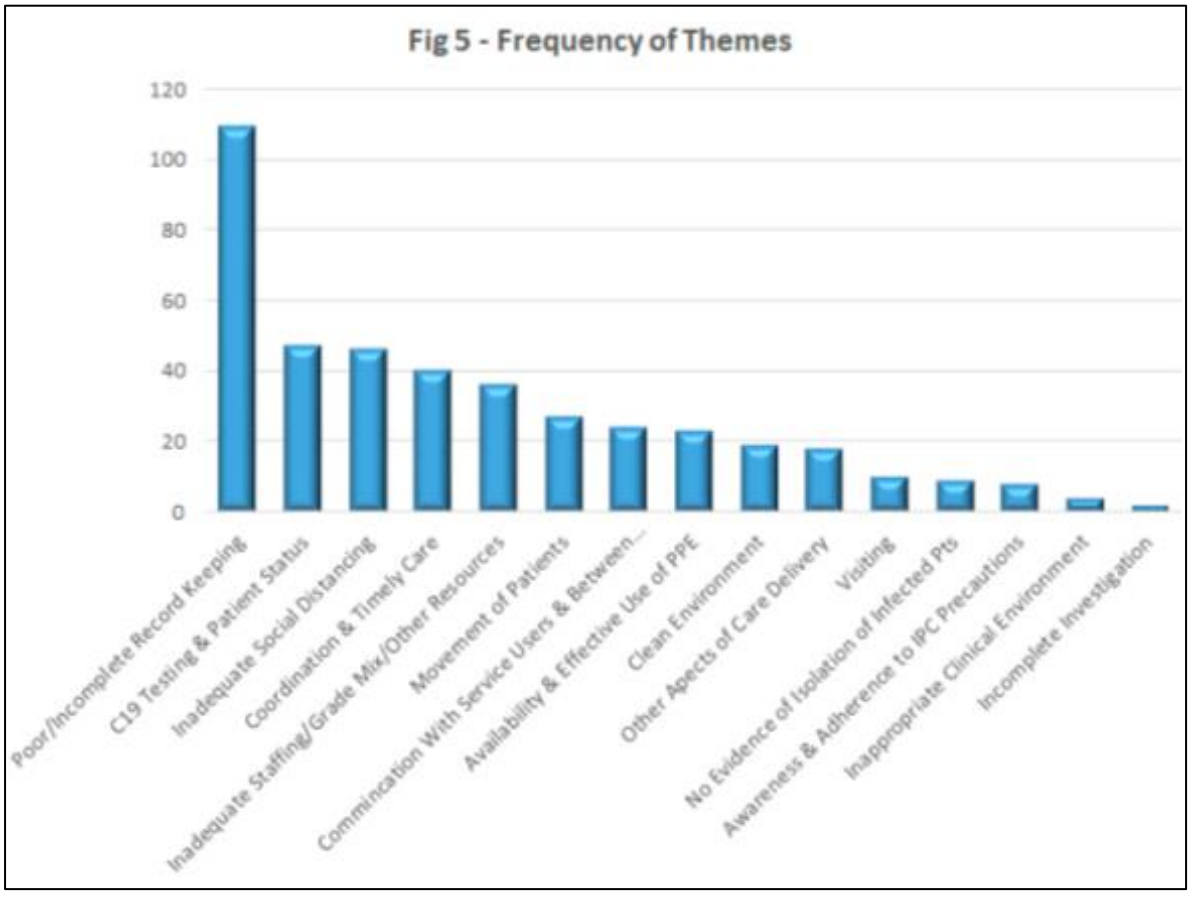
Future planned activities with care homes includes:

- Further work is required with our partners to support them with IP education programmes to implement the Safe Clean Care campaign in care homes.
- Develop IP champions in care homes to act as ambassadors of good practice.
- The Health Protection Service have appointed two new Protect Practitioner posts (with two more to be recruited) to work with Residential Care Homes as part of their role. They sit within the Health Protection Service (Public Health) and will support Care Homes (as well as other settings and sectors) across North Wales to interpret, implement and evaluate relevant national and local guidance in the surveillance, prevention and management of infectious diseases. The Protect Practitioner role will form an effective link by utilising their knowledge, relevant field experience and effective leadership skills, whilst also working closely with the BCU Quality Development Team to ensure continuity of service support. The role will include supporting care settings with the transition to business as usual over the next 12 months as we come out of the pandemic and with the introduction of new Guidance from Welsh Government.

7.7 Investigation into Nosocomial Transmission of COVID-19

BCUHB continues to adhere to the National Wales Framework Guidance to provide a consistent approach for NHS Wales's organisations to identify, review and report patient safety incidents following nosocomial transmission of COVID-19 in compliance with the National

Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.
BCUHB are in continuous contact with the Delivery Unit NHS Wales National Nosocomial Covid-19 Programme (NNCP), working closely with Health Boards and organisations across Wales. BCUHB was one of the first organisations to adopt a proactive approach to engage with the families of those affected with the nosocomial transmission of COVID-19 to include them as part of the proportionate investigations.
A Lead Project Manager was appointed in October 2022 to provide clear direction on the project, building working relationships and communication with the Delivery Unit and relevant stakeholders.
A Scrutiny panel has been meeting since November on a weekly basis to review each case. An experienced member of the IP team is seconded for one day per week to provide specialist IP input to the project.
138 cases have been reviewed all of which demonstrated no breach of duty.
BCUHB have introduced a Learning Plan that is in line with the Delivery Unit plan along with mechanisms in place to capture themes as illustrated below:



Examples of good practice included:

- Movement of patients to side wards with evident symptoms
- Transferring patients with COVID-19 to cohort ward or side rooms
- Screening others as part of outbreaks.

The table below demonstrated the current position that has been issued to the Delivery Unit with investigations for Wave 1 to 4; the dataset demonstrated progress to date (as of 11/04/2023).

Activity Summary - Investigation Review Status							
	<= 1st Wave	Wave 1	Wave 2	Wave 3	Wave 4	Live	Grand Total
Completed	17	334	258	93	55	5	762
In-Progress		9	14	6	30		59
Not Started	39	429	537	374	834	568	2781
Grand Total	56	772	809	473	919	573	3602

On average since January 2023, the team have been completing 77 cases per month providing assurance of completing the investigations within the timescales set.

8.0 Other Significant Infections and Incidents

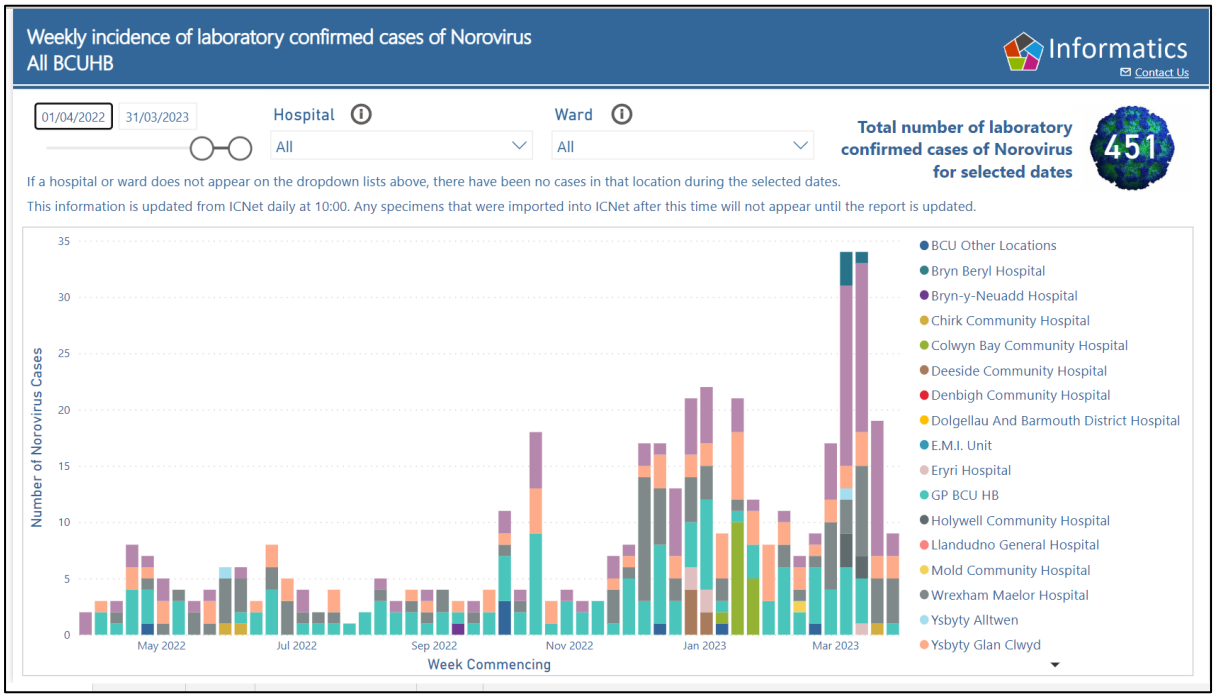
8.1 CPE (Carbapenemase-producing Enterobacterales)

In 2022/23 in BCUHB there was one case where CPE was thought to be acquired in hospital from another. This was in critical care in YG in February 23. Both patients were quickly isolated, all patient contacts followed up and screened as per protocol and enhanced cleaning instigated followed by a full deep clean with high level disinfection. No further associated cases have been identified since.

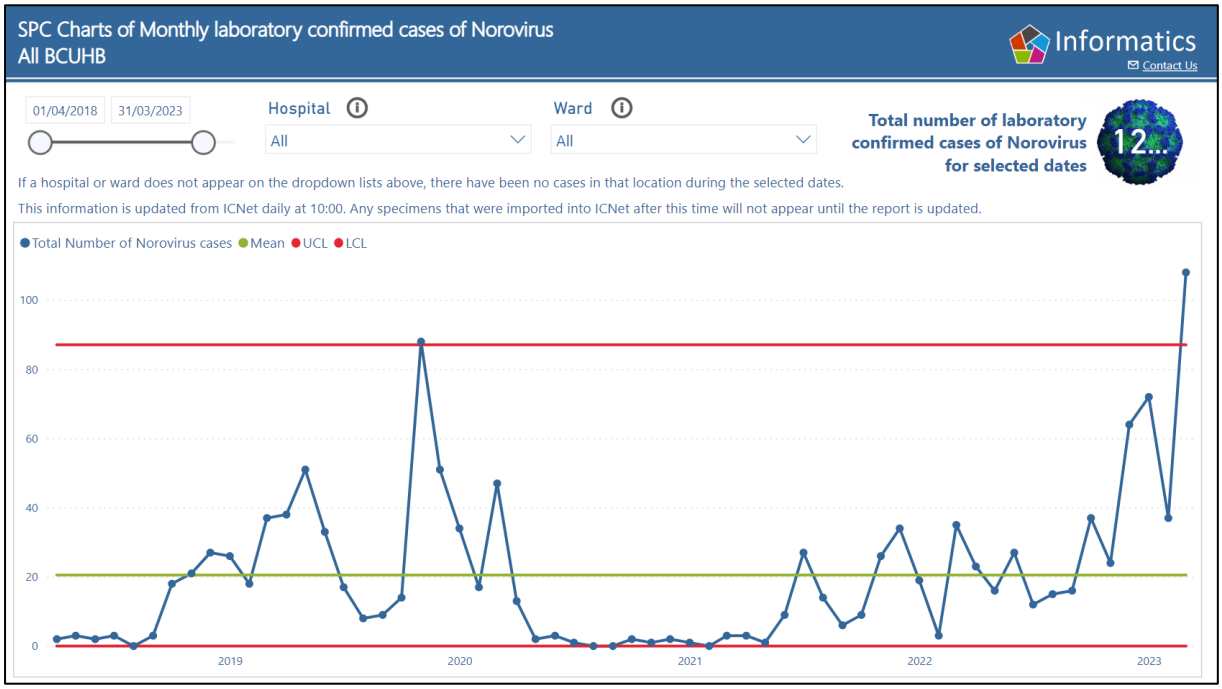
8.2 Norovirus

During 2022/23, there were 451 laboratory confirmed cases of Norovirus over the winter months (compared to just 186 in 2020/21) and 37 outbreaks in hospitals across BCUHB creating additional pressure on siderooms and patient flow.

The total number of laboratory confirmed cases of Norovirus during 2022/23 is illustrated in the chart below:



Numbers in 2022/23 were higher than they have been since 2018. The graph below shows cases from 1/4/2018 – 31/3/2023 .

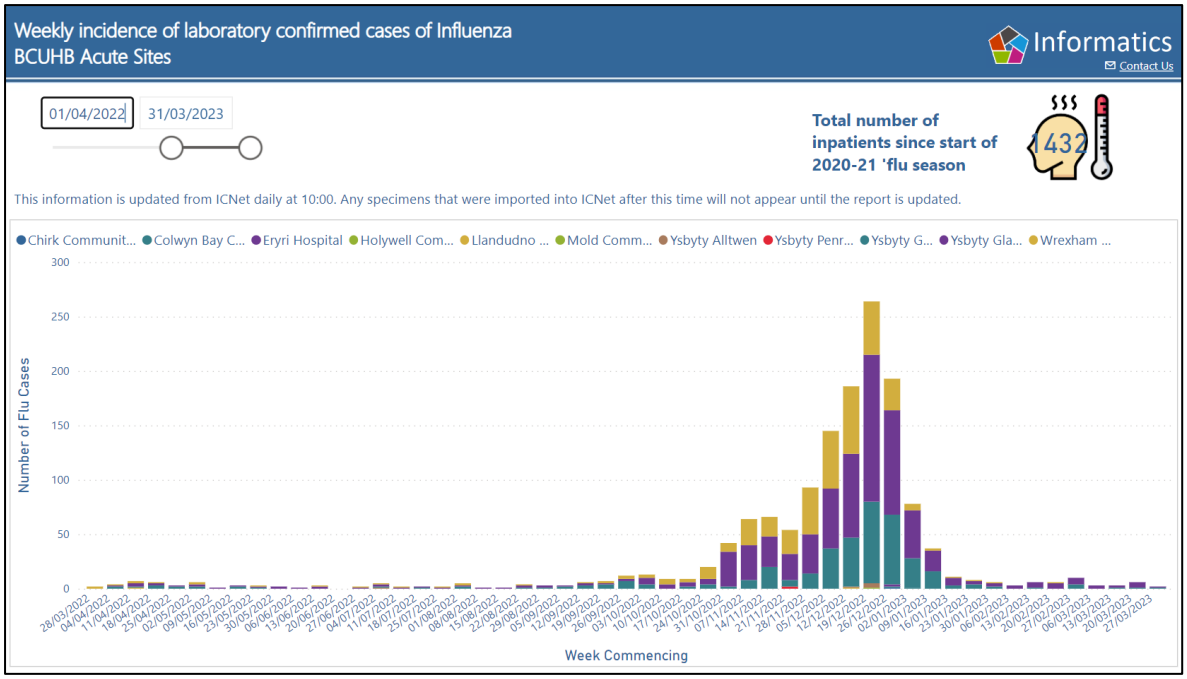


Of the 318 Norovirus cases seen in hospital, 203 (64%) were hospital onset i.e. samples collected 48 hours after admission.

Location	Hospital Onset	Community onset	Total
Central	71 (72%)	27	98
East	64 (63%)	37	101
West	68 (58%)	51	119
Total	203 (64%)	115	318

8.3 Influenza

During the 2022/23 influenza season, there were 1,432 laboratory confirmed cases of Influenza across BCHUB in inpatients compared to just 99 cases the previous year. There was a sharp peak right at the end of the calendar year as shown below, leading to 16 outbreaks across BCUHB, but numbers quickly subsided in January 2023.

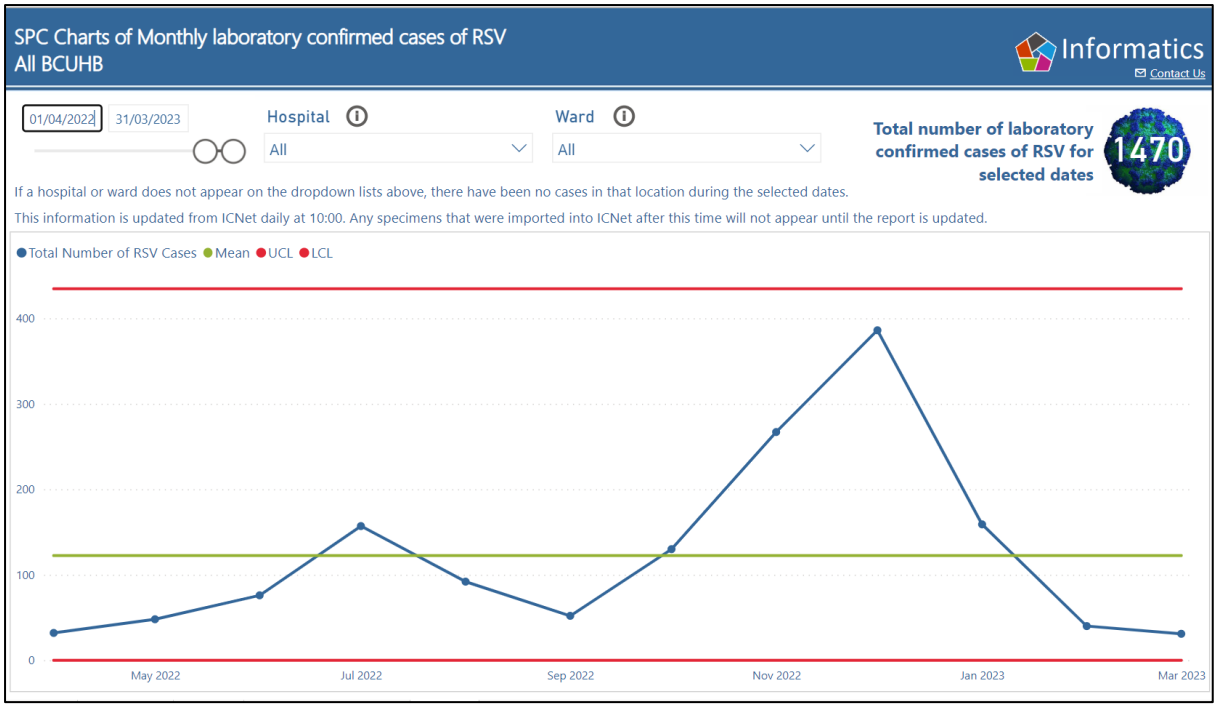


Of the 1,432 cases, 1,249 (87%) were reported in adults (>16 years of age).
YWM reported 365 cases, YGC reported 675 cases and YG reported 376 cases.
An average of 9% were classed as Hospital Onset i.e. samples collected 48 hours after admission, but this varied across the 3 acute sites.

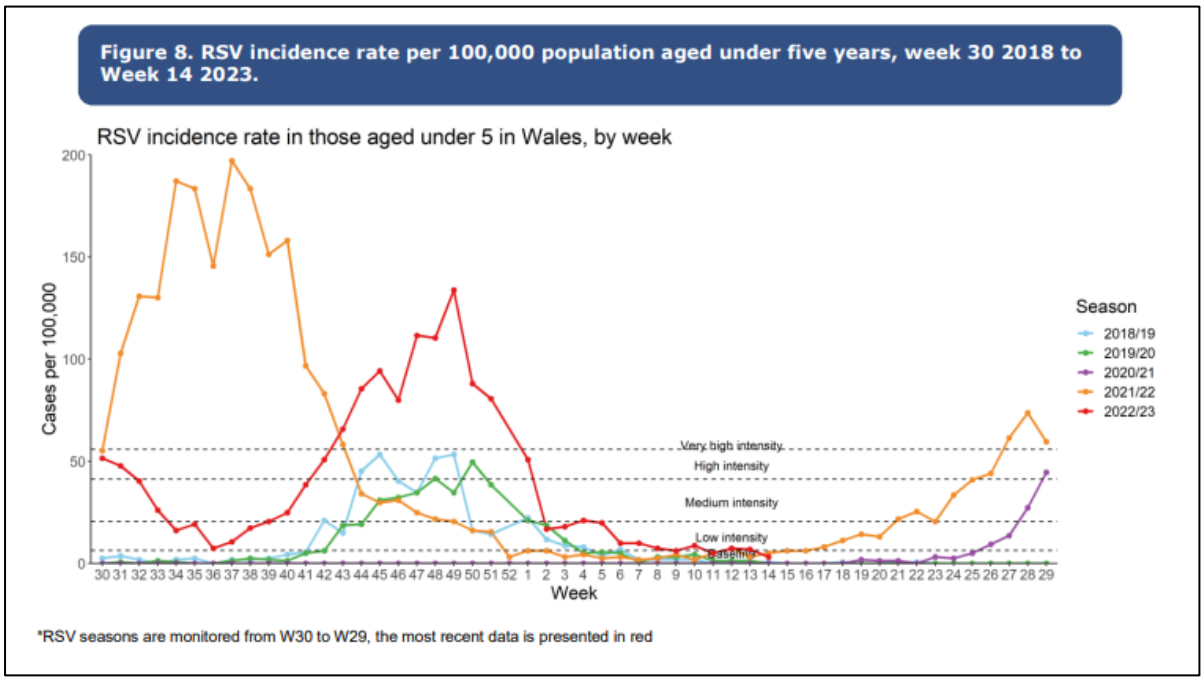
Location	Hospital Onset	Community Onset	Total
Central	33 (5%)	635	668
East	35 (10%)	296 (inc HMP)	331
West	57 (17%)	269	326
Total	125 (9%)	1200	1325

8.4 RSV

There were 1,470 laboratory confirmed cases of Respiratory Syncytial Virus (RSV) in BCUHB during 2022/23 with a peak in December, compared to 1,969 in 2021/22 where there was a peak in September.
There were no RSV outbreaks identified.



This picture was reflected across Wales in the under 5 age group as illustrated below:



8.5 Monkeypox

Cases of Monkeypox infection began to occur in the UK in May 2022 with an outbreak that lasted until November. A Monkeypox Operational Planning Group meeting was quickly established in BCUHB with the IP Team as an integral part, and continued to meet regularly until it was stood down in November.

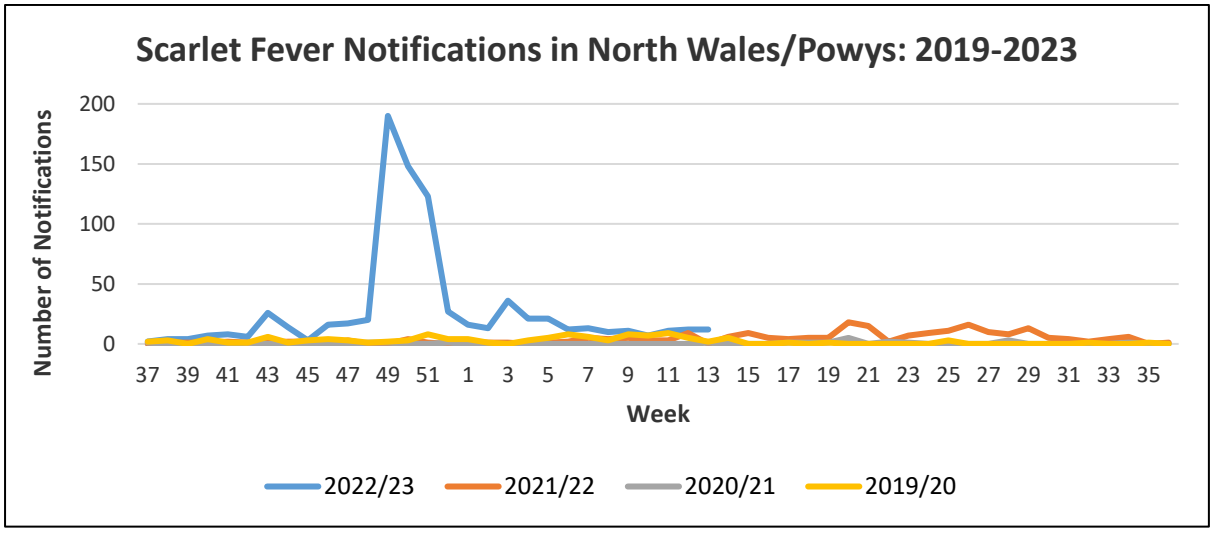
Wales had 48 cases of which 13 were in BCUHB.

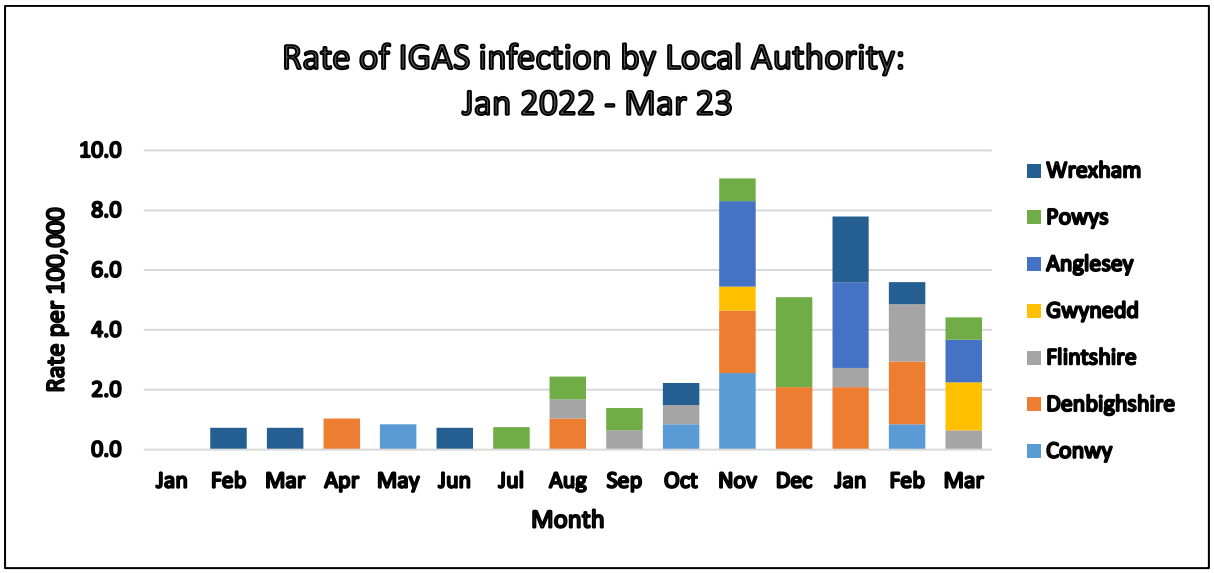
There was just one inpatient in YGC in June 2022 that was admitted with non-classical symptoms and Monkeypox was not diagnosed until several days post admission. Contact tracing and vaccination was carried out in line with national guidance and there was no identified cross-infection to other patients, visitors or staff.

Monkeypox was classed as a High Consequence Infectious Disease (HCID) requiring high level IP precautions not usually in use in Wales, but the Advisory Committee on Dangerous Pathogens (ACDP) in June 2022 recommended that the strain of Monkeypox virus currently in community transmission within the UK (Clade IIb, B.1 lineage) should no longer be classified as an HCID.
The IP Team worked throughout the summer months with BCUHB and PHW colleagues translating national and regional advice into local protocols and supported clinical teams to develop risk assessments and pathways for identification, testing and management of suspected and confirmed cases. A toolkit of information including clinical features, management of cases, IP measures, cleaning, linen and waste precautions, patient risk assessments letters for contacts is available as part of the Monkeypox toolkit within Betsinet should further cases occur in the future.

8.6 Group A *Streptococcus*

Both scarlet fever and invasive group A streptococcal infections increased in late 2022. Up to week 48, there were 1542 reports of scarlet fever in children aged under 15 years old, compared to 886 during the same period in 2019 (395 and 121 respectively in 2020 and 2021). In the same period and age group there have been 16 cases of iGAS in Wales, compared to 11 in 2019 (2 and 0 respectively in 2020 and 2021).

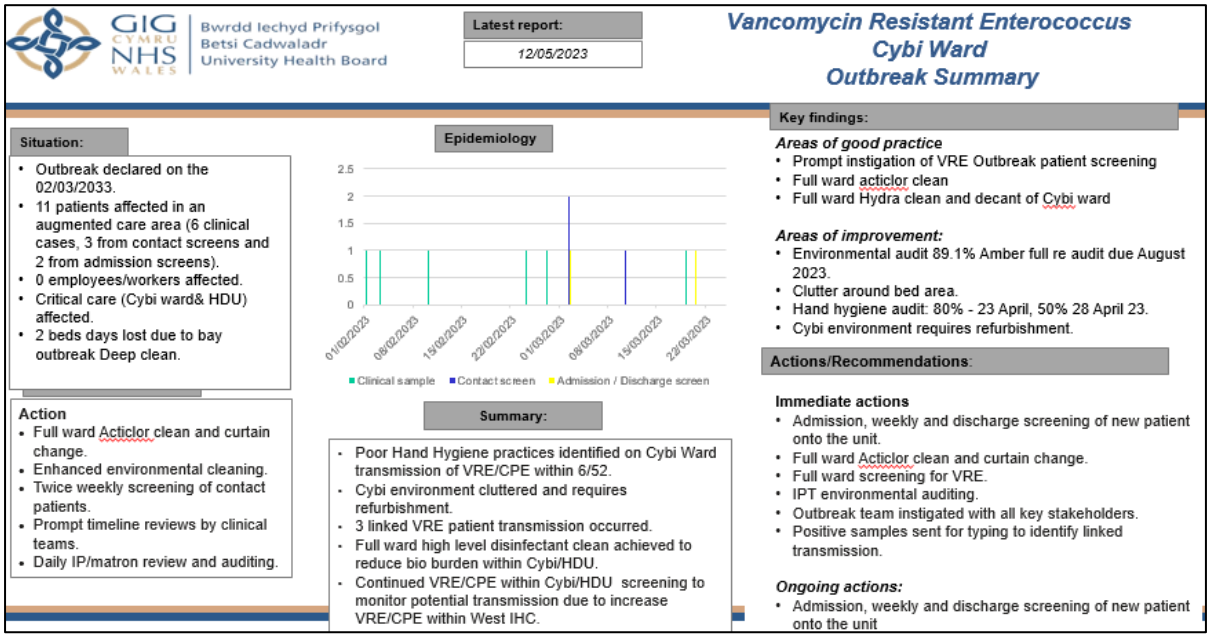




Public Health Wales issued a briefing in early December 2022 providing guidance for primary and secondary care including signs and symptoms to be alert for and action to be taken. The Antimicrobial Stewardship team also revised their guidelines in the BCUHB Microguide in line with PHW recommendations.
The causes for this increase were not clear, but it is thought that changes in circulating respiratory infections following the pandemic played a role. Co-infections with respiratory viruses were found in some cases, although testing had increased following the pandemic. The most significant impact of these infections was seen in primary care and paediatrics.

8.7 VRE

Vancomycin Resistant *Enterococci* (VRE) are bacteria that usually live harmlessly in your gut. This is called colonisation (a person is said to be a 'carrier'). However, these bacteria can sometimes develop resistance to common antibiotics. If these resistant bacteria then move to a normally sterile part of the body, such as the bloodstream, they can cause an infection.
There was one level 1 outbreak in critical care in YGC involving 11 patients in critical care starting in February 2023 but it was quickly contained and closed. The outbreak was reviewed at one of the Corporate HCAI Review group meetings and key learning shared across BCU. A summary of the outbreak can be found below.



8.8 Contaminated Blood Cultures

Blood cultures are an important investigation to help tailor effective management for patients with severe sepsis. Samples that are contaminated when obtained (i.e. grow a microorganism but the infection is not clinically significant), increase laboratory workload and can delay or cause incorrect changes to patient management. This can prolong patient hospitalisation, increase the risk of harm and increase cost to health boards. Current guidelines indicate that hospitals generally see an average contamination rate of 2–3%.
Prior to 2022 BCUHB had no accurate data on its blood culture contamination rate but the IP Team have worked with PHW and IT to establish a database that can now be interrogated for this information and it is updated monthly. Data was first presented to the IPSG in September 2023 and is now issued quarterly as part of the cycle of business. Q4 showed an overall contamination rate of 1% which is below the national average. However, there are variations in practice, for example, WM Emergency Department take more blood cultures than those in YG and YGC and YG Critical care take more blood cultures than other Critical care areas.

8.9 Asylum seekers and Refugees

In April 2022 IP advice and support was required to help manage the health care requirements of the Ukrainian refugees, particularly with respect to isolation and screening requirements if they were to be admitted to hospital. Also for staff to be alerted to antimicrobial resistance and ensure the lab was alerted.

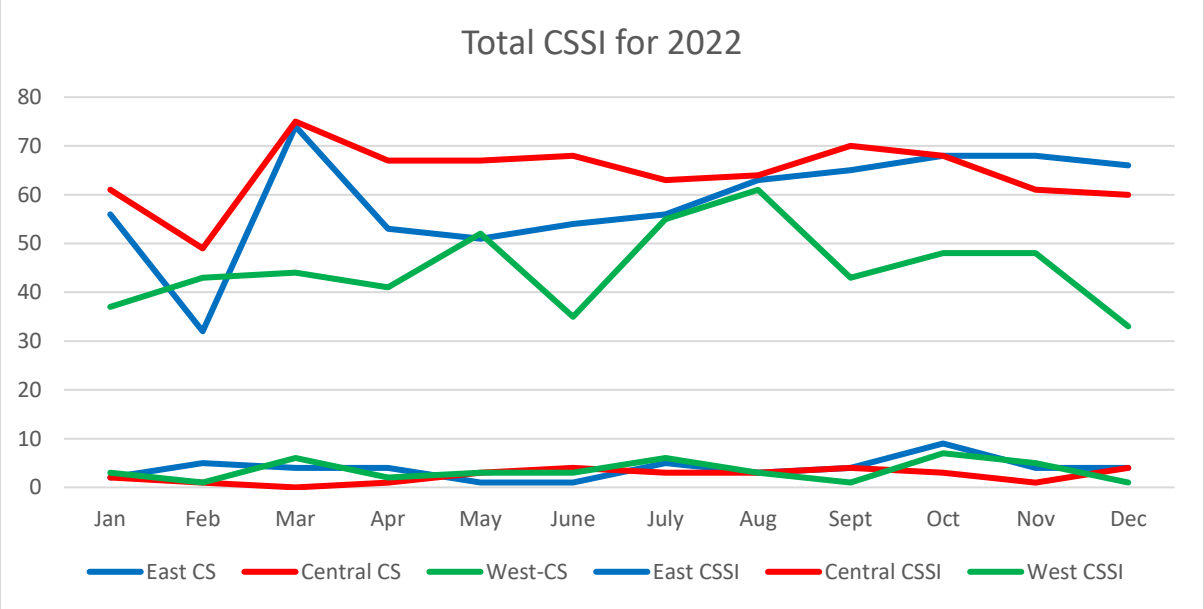
Along similar lines, in November 2022 IP advice and support was required to help manage the healthcare requirements of the refugees that were accommodated in Delgarrog. One individual was admitted to the paediatric ward at YGC and IP provided support on screening and the IP measures required.

9.0 Surgical Site Infection Surveillance

9.1 Caesarean section Surgical Site Infection (CSSI) Surveillance

During 2022 BCUHB has seen the re-introduction of regular HARP reports on caesarean section SSIs. These confirm the improvements made in data collection up from 70% in 2021 to 87% for Q1 of 2022.

The most recently published HARP report evidences an increase in the rate of CSSI from 2.9% to 3.8% across BCU. This is being investigated but it is felt to reflect the improved accuracy of the data collected.



Inpatient rates of CSSI remain low and are associated with women who have systemic infection. We continue to see consistency of reporting of infection in women in the community after day 10 and this remains the focus for improvement.

Continued focus on prevention of outpatient infections in planned for 2023. Wound care training has been provided, however, this has been mostly for inpatient staff and efforts will be continuing to roll this out to community.

The introduction of Leukomed dressings is currently being evaluated as an improvement method. A cost saving was associated with its introduction which will also form part of the analysis. ACSSI action plan has been developed to keep track of improvements in order to monitor and evaluate their effects.

9.2 Orthopaedic Surgical Site Surveillance

Data was received from PHW in October 2022 reporting some of the orthopaedic procedures undertaken in BCUHB between 2022 and 2023. However, it is not thought to be complete, and there was just one infection noted at YWM. The HARP team have been contacted to support understanding of future reporting arrangements.

10. Vaccination programmes delivered in BCUHB 2022-2023

10.1 COVID-19 Vaccination

The COVID-19 vaccination programme in North Wales launched a Spring Booster Vaccination Campaign from April 2022–July 2022 and a further campaign in autumn running from September 2022 – March 2023. In conjunction, an evergreen campaign ran with the above programmes offering 1st and 2nd primary doses and initial booster doses for priority cohorts 1-10, including children aged 5-17 year olds and those who were immunosuppressed. Programme delivery was as per the Joint Committee on Vaccination and Immunisation (JCVI) National Guidance and overseen by the NHS Executive.

The programme continues to be delivered simultaneously via vaccination centres, and 'Hub and Spoke' models, GP Primary Care providers and community settings. BCUHB teams continue to focus on the most vulnerable, delivery to care homes, the identified cohort for each campaign, citizens within HMP Berwyn and those who are identified as house-bound. Regular reviews of the hard to reach and low uptake areas continues to be undertaken, in an ongoing effort to 'leave no person behind' and tackle potential inequalities.

Health Board uptake rates for 2022-2023 are illustrated in the table below, these high rates could not have been possible without the support and assistance of key stakeholders including:

- Conwy, Gwynedd and Flintshire Local Authorities
- Glyndwr University whose facility at Catrin Finch has been the base for our Wrexham Vaccination Centre and continues to do so.
- Primary care contractors.
- North Wales General Practitioners and Community Pharmacies.
- Various services within BCU such as School Nursing and District / Community Nurses.

COVID-19 Vaccination Position from April 1st 2022 – March 31st 2023

Cumulative Total Vaccinations	Spring Booster 2022	Autumn Booster 2022	Ever-green	5-11 Year Olds	12-15 Year Olds	16-17 Year Olds	Immuno-suppressed 0.1, 0.2 & 0.3	Spring Booster April 23 - Present
397,749	98,979	283,207	48,483	16,345	8,484	4,537	38,425	27,662

Data Correct as of 10.05.23

During the Spring Booster programme 2022, the programme commenced with the Pfizer vaccine whereby the 15minute wait (post vaccine) was removed, adding further flexibility to the programme. This enabled a smoother vaccination process to deliver to care homes and house bound citizens. BCUHB met the Welsh Government target of 75% uptake and exceeded by completing the programme with 92% uptake.

The Autumn Booster Programme 2022 saw the introduction of new bi-valent vaccines named Moderna Spikevax, which was licensed to those aged 18+ and a Pfizer Comirnaty BioNTech bi-valent vaccine, which became available from September and licensed for those aged 12+. The campaign delivered to citizens aged 50+, care homes, health and social care staff, housebound citizens and those who were immunosuppressed. The Autumn 2022 programme was offered from September 2022 focusing first on those in care homes and over 75's, allowing a minimum of three months from the previous dose. The aim was to complete the campaign before December 2022, to provide additional protection in time for the expected winter peak of other seasonal viruses and enable the opportunity for mop-up's in January 2023. BCUHB met Welsh Government target of 75% uptake and exceeded by completing the programme with 81.2% uptake.

The Spring Booster campaign 2023 introduced a further vaccine called Sanofi Pasteur

VidPrevtyn Beta. This was to be delivered to those in the eligible cohorts of care homes, house bound citizens and those citizens aged 75+. The campaign commenced April 2023 with a plan to finish on 30th June 2023. The current uptake to date can be seen in the above table.

Wider BCUHB Immunisation Framework Planning
BCUHB are now strategically planning following the publication of the National Immunisation Framework (NIF), which marks a move into the implementation phase of vaccination transformation, with a process of transition to the new arrangements expected during 2023 and 2024. The framework provides an aim with regards to equity of access to all immunisations offered through BCUHB by introducing a one programme approach and following the below principles;

- Provision for identifying groups with low vaccination uptake
- Provision for determining barriers to uptake
- Partnership working and meaningful engagement with community champions, trusted voices and third sector organisations
- Co-production of tailored interventions
- Evaluation of actions and interventions

Implementation will be overseen by the NHS Executive, with Welsh Government moving into an oversight role while retaining the lead on key workstreams that enable transformation. Welsh Government ambition is to establishment a National Immunisation Framework for Wales to deliver world-leading outcomes in vaccine preventable disease from 2023.

Measles: Now that the COVID-19 restrictions have been relaxed there is a concern that measles cases will start to occur. For many years BCUHB has been proactive in maximising uptake of this vaccine to reduce the risk of a measles outbreak occurring and this work has paid off as a report setting out the uptake for the measles, mumps and rubella (MMR) vaccine per school year is very favourable for BCUHB in every age category compared to other health boards in Wales. BCUHB is one of three Health Boards to reach 95% in every age group for the 1st MMR which is a significant achievement.

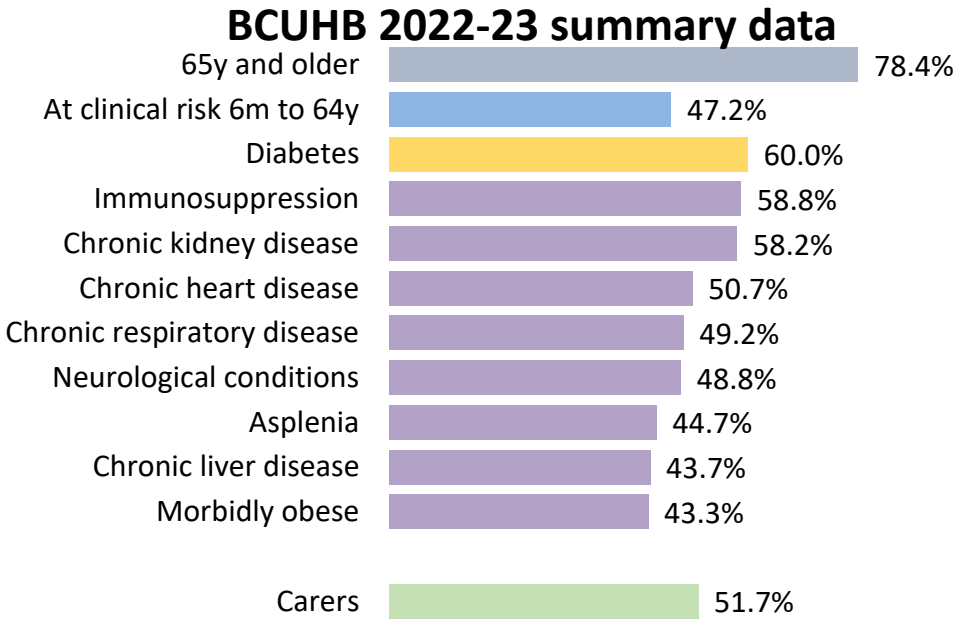
10.2 Seasonal Influenza Vaccination Programme
The achievements listed below would not have been possible without the collaborative efforts of many dedicated staff in Primary Care and within the Health Board.
In Wales in 2022/23, the seasonal influenza vaccination was offered to a large number of individuals including:

- all those aged over 50 years
- all those aged between 6 months and 49 years under in a clinical risk group
- all pregnant women
- all children aged two years and over, including all children in school.
- Care Home and Healthcare Workers

In addition to the above groups, residents of long-stay care homes and those who were the main carer for an elderly or disabled person whose welfare may be at risk if the carer fell ill were offered vaccination. Vaccination of staff working in adult care home settings is an important step to protecting the residents of care homes from the virus, and also ensuring resilience and business continuity in the care home sector, further protecting residents from the impacts of an outbreak of influenza.
The Health Board has worked closely with care homes regarding the availability of vaccines for their staff and encouraged community pharmacies to work with care homes to support access either at the pharmacy or at the care home premises as part of an improved access scheme which was nominated for the national Vaccination Saves Lives Award in 2023.
Welsh Government steered health boards to co-administer the flu and COVID-19 vaccines which was facilitated when possible.

Due to the severe pressures in the NHS over late November and December and that the uptake was not as high as they would like, the Welsh Government issued a Welsh Health Circular (WHC 2022 035) instructing health boards to provide support to the Flu campaign and requested 'mop up' sessions were provided at vaccination centres.
BCUHB purchased a Flu vaccine contingency stock which was accessed 26 times quite early on in the campaign due to an increased demand in some areas.
Overall, it was a very positive year as BCUHB exceeded the required 75% target for those people aged 65 years and over at 78.4% and should be considered as an outstanding achievement. This represents the highest uptake of vaccines given by all Health Boards in Wales and for those in an at risk group the uptake was 47.2%, the 3rd highest uptake in Wales. The final data for 2022-23 including a more detailed breakdown of the uptake for at risk conditions and also those aged 50-64 years is yet to be published so the data shown below may be subject to change.

Chart showing uptake of seasonal influenza vaccine in BCUHB per eligible group:
Those with diabetes are highlighted in yellow in the chart below, as this is the highest uptake of the clinical risk groups.



Data provided by Public Health Wales 21.4.2023

BCUHB Influenza Strategy for 2023/24
The BCUHB Influenza plan for 2023/24 is now in development following a series of Flu debrief sessions. Guidance within the Annual Influenza Strategy correspondence has not yet been published by Welsh Government, however, a Welsh Health Circular on influenza WHC 2022 (031) has been published and will aid planning, as it includes information on which influenza vaccines will be issued and which groups are eligible for vaccination. The only announcement we are waiting for is if those aged 50-64 years are to be included this year, if they are then the Welsh Government will supply those vaccines for that element of the vaccination campaign. The health board is implementing the NICE guideline Flu Vaccination: Increasing Uptake. This winter, BCUHB needs to prepare for uncertainty relating to influenza activity and the consequences for next year could be much higher or unseasonal activity may be observed. In 2023/24, achieving a high vaccination uptake will be an important priority to reduce morbidity and mortality associated with influenza and to reduce hospitalisations during a time when the NHS and social care may again be managing the impact of COVID-19 outbreaks.

Ensuring eligible individuals are vaccinated before the influenza virus circulates widely will be a key priority for the BCUHB Influenza campaign. Clusters play a major role in devising plans for their local communities to maximise uptake. All existing strategies implemented during 2022/23 will be implemented again next year, with a renewed focus on supporting clusters to further develop their plans to address the inequalities in uptake and to increase accessibility to the vaccine. There will be opportunities to co-administer with the COVID-19 vaccine should vaccine supply allow.
The majority of the vaccinations will be administered by GPs and school immunisation teams with the support of community pharmacies, district nurses and Covid vaccination teams, with the bulk of the work completed between September and December 2023. BCUHB has purchased a contingency stock of vaccine to support delivery of the programme to meet the demand if there is an increase in requests for vaccination for next year.

10.3 Staff Influenza Vaccination
8,456 influenza vaccinations were given to staff in 2022/23 which equates to an update rate of just 43.7% compared to almost 60% the previous year. 'Vaccination fatigue' is thought to be one of the causes for this drop in compliance.

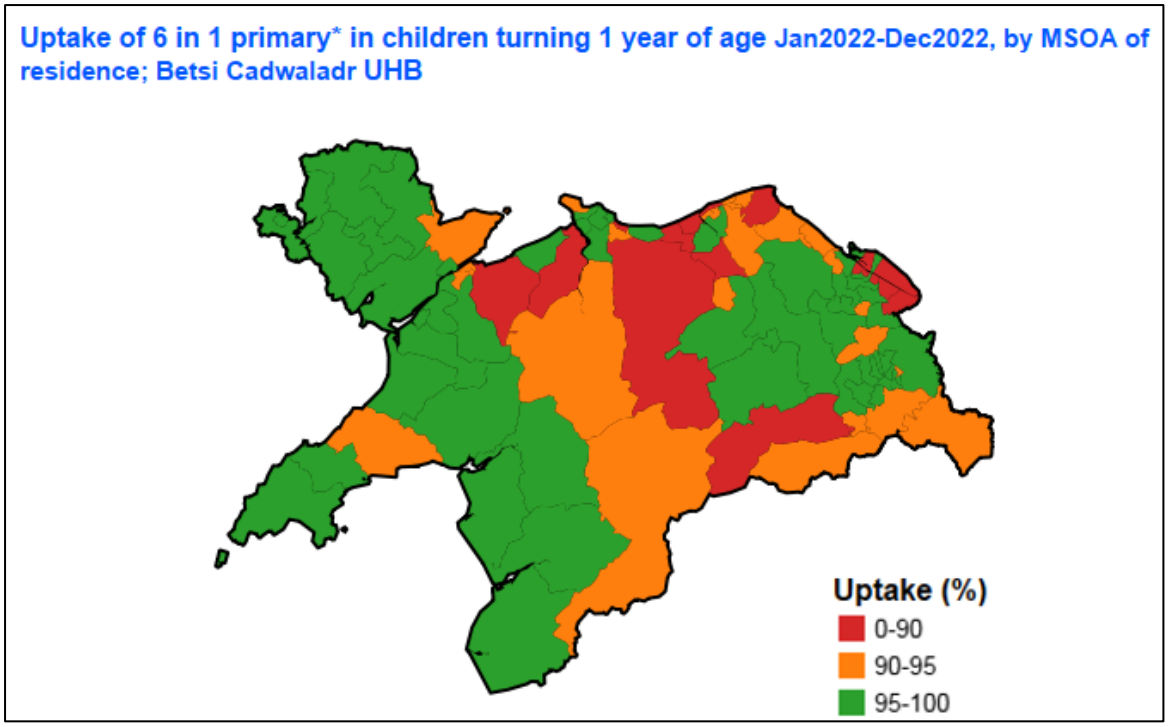
10.4 Childhood Vaccination Programme
Childhood vaccinations were one of the essential services that GP practices had to continue to provide during the Pandemic. Since 2020 Public Health Wales has published a monthly report "The effect of COVID-19 on the timeliness of childhood vaccines" which shows that the vaccines were given later than normal during the initial pandemic. Slowly this situation is improving across Wales and more children are being vaccinated on time.
Overall performance against the targets for routine childhood immunisation programme, in comparison to Wales is good, with the Health Board achieving some of the highest uptake rates in Wales for all categories. It is acknowledged that not all uptake targets have been met and there is work to do to reduce inequalities in uptake across all age ranges. Below is provisional data for BCUHB, whilst we wait for the publication of the full Annual COVER report for the financial year 2022-23.

- Uptake of 6in1[1] at 1 year: 94.6%
- Uptake of MMR1 at 2 years: 93.4%
- Uptake of MMR2 at 5 years: 91.7%

[1] *Uptake of pertussis used as proxy.*
Data for this report was provided by NHS Wales Informatics Service from Children and Young Persons Integrated System (CYPrIS). The data was sourced from Community Child Health databases maintained by local Child Health Office staff in Trusts throughout Wales based on regular returns from doctors and nurses who immunise or advise on immunisation. Uptake data are for LHB resident population, not for LHB GP practice populations.

These annual results for 2022/23 are for one-year cohorts of children living in Wales as at 31/03/2023 and reaching their first, second, and fifth birthdays between 01/04/2022 and 31/03/2023.

The chart below using the Middle Super Output Area (MSOA) mapping, shows where we should focus efforts to increase the uptake of the 6 in 1 vaccine.



10.5 Immunisation and Blood Tests carried out by Occupation Health are illustrated in the table below:

	Qtr1 2022	Qtr2 2022	Qtr3 2022	Qtr4 2023	Total 2022/2023
Immunisations & blood tests BCU	2573	3068	2937	4183	12761
Immunisation & blood tests Non BCU	588	886	1037	934	3445
Total Immunisation & Bloods	**3161**	**3954**	**3974**	**5117**	**16206**

11.0 Needle stick/sharps/body fluid contamination incidents
The table below shows the numbers of incidents each quarter; none of them were RIDDOR reportable. The recent increase in numbers has been highlighted and is being reviewed at LIPGs and IPSG.

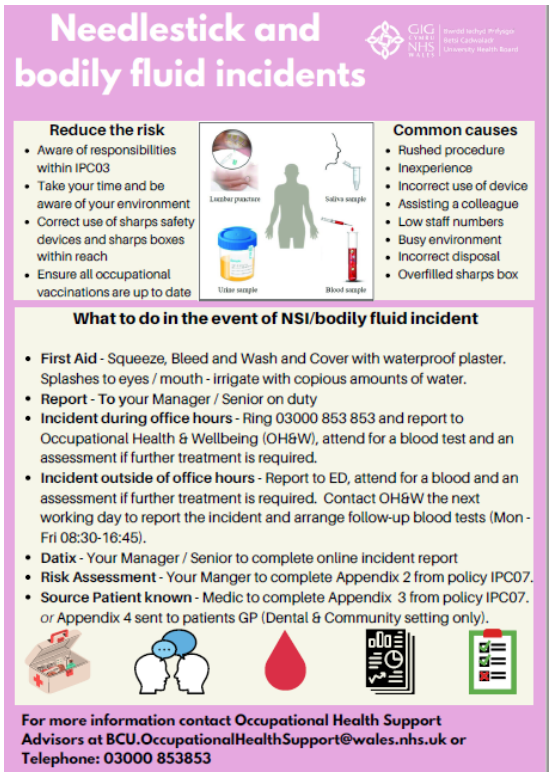
	Qtr 1 2022	Qtr 2 2022	Qtr 3 2022	Qtr 4 2023	Totals
Number of incidents	78	72	82	93	325
Average per month	26	24	27	31	108

The table below provides more detail of the procedure being undertaken when the incident occurred.

Activity	Number
Assisting colleague with procedure	15
Blood lancet sampling	9
Cannulation	7
Cleaning instruments	1
Dental procedure	8

Disposing of waste	42
General cleaning	5
General Tidying	2
Giving injection	42
Immunisation	1
Insulin needle [patient]	12
Insulin syringe & needle [non patient]	1
Other	56
Scalpel use	3
Spit incident	1
Surgical procedure	31
Suturing	12
Venepuncture	61
(blank)	7
Grand Total	**316**

The following poster has been produced and widely circulated and IHCs have been asked to raise awareness at their meetings and through clinical teams.



12.0 Education and Training in Infection Prevention and Control

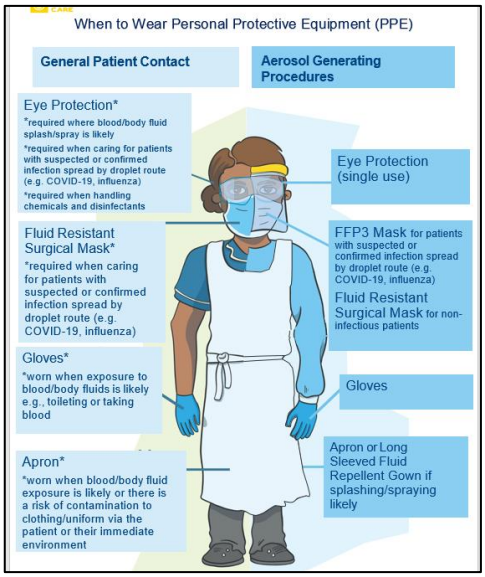
12.1 Infection Prevention Campaigns and Awareness Events

Glove Awareness Week May 2022

As part of RCN's Glove Awareness Week 2022, the IP team asked staff to be more glove aware highlighting when gloves are needed and just as importantly, when they are not, along with how to prevent skin problems related to glove use. BCUHB staff made pledges to 'Change One Thing' about unnecessary glove use and these were featured on BetsiNet.

SCC-HF Standard Precautions September 2022

The IP Team launched the updated Standard Precautions Protocol and linked this with World Sepsis Day on 13th September to promote correct PPE use and standard precautions. A PPE survey was conducted to establish perceptions of practice, PPE microteaching sessions were delivered and 'Message of the Moment', 'When the Wear PPE' and 'Key Principles of PPE' posters. The IP Team visited clinical areas using trolley dashes, providing ward/department education on the history of PPE, using 'Side room Sally' to help staff identify areas of poor practice and asking staff to sign up to making one change to improve their own PPE practice. A comprehensive communications strategy and the IP webpage were also used to disseminate the key messages.



International Infection Prevention Week 16-22 October

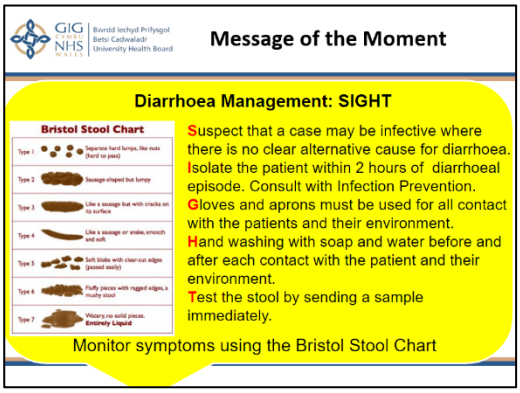
During International Infection Prevention Week the IP Team marked the occasion by promoting ways to prevent healthcare associated infections by 'making the bed-space safe'. A new bed cleaning protocol, mattress audit tool, Message of the Moment and other resources were launched to support best practice in cleaning bed spaces.

Innovative technologies were also launched, including ATP monitoring to identify organic material within the environment and CiFi Torch (forensics technology). This work was promoted using support from the communications team, the IP webpage and was showcased at the Health Boards SCC-HF Celebration event at Oriel House in St Asaph on 26th October.

Making a Difference – our commitment to tackling *C.diff* February 2023

Throughout February, a multifaceted improvement campaign led by the IPTteam was delivered BCUHB wide to help improve *C.difficile* performance. The Director of Infection Prevention and Decontamination launched the event, introducing topics of focus, which included the development and circulation of key documents and resources (such as a *C.difficile* Factsheet, Isolation Matrix, Bristol Stool Chart and Management of Diarrhoea Pathway), delivery of *C.difficile* microteaching sessions, development of a Faecal Microbiota Transplantation (FMT) promotional video and identification and support of C.difficile Medical Staff Champions to act as ambassadors of *C.difficile* prevention within their Hospitals.

Excellent antimicrobial stewardship was further promoted as part of World Antibiotic Week in November with continuing efforts to focus work on 'IV to oral switch' with designated ward rounds, implement the use of Community Pharmacist checklists to guide discussions with patients about taking antibiotics appropriately and use of social media, websites and other media forums to share key messages.



12.2 Compliance with Mandatory Infection Prevention Training

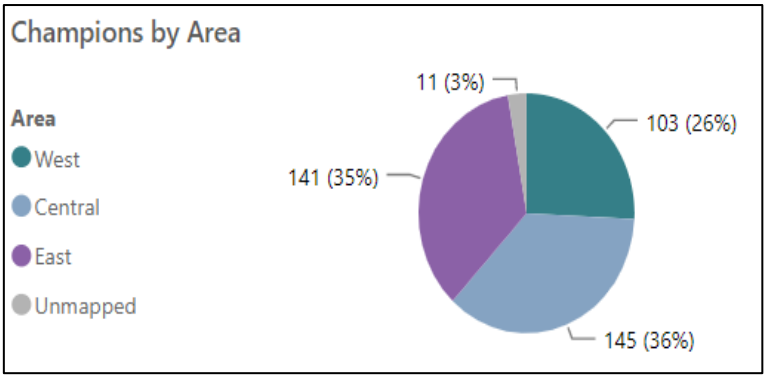
In 2022/23, BCUHB-wide compliance with mandatory training at level 1 was 83.4%, below the 85% target, with compliance for staff requiring level 2 training at just 78.2%, as illustrated in the table below.

Level	Competency Name	Compliant	Non-Compliant	Compliance %
Level 1	Infection Prevention and Control - Level 1 - 3 Yearly	17131	3411	83.39%
Level 2	Infection Prevention and Control - Level 2 - Annual	11395	3167	78.25%
Other	Aseptic Non Touch Technique - 3 Yearly	10874	1733	86.25%
Total		**39400**	**8311**	**82.58%**

Donning and doffing of PPE is now included as part of the IP mandatory training and not reported separately.
Training levels amongst medical staff is currently particularly low but it was agreed in February 2023 that IPC level 2 and ANTT training should be mandatory for doctors and this is being promoted.
The IP Team deliver quarterly ANTT 'Train the trainer' sessions in each area and support practical sessions with the education team on a monthly basis.
To support record keeping a practical competency assessment tool for ANTT was launched on ESR in July 2022. Electronic booking and recording of ANTT will provide accurate data to monitor ANTT compliance within BCUHB. A new All Wales ANTT Policy is expected in April 2023; BCUHB IP Team will carry out a gap analysis against it with an action plan to address any shortfall.

12.3 Infection Prevention Champions

A new heat map database was established in June 2022 to show the IP Champions trained to date and where they work. There are now over 390 IP Champions trained in BCUHB promoting IP messages:



An IP Champion Padlet has been set up and fortnightly drop-in sessions held on Teams with IP team members enabling them to ask questions and seek further support.

12.4 Infection Prevention Massive Open Online Course (MOOC)

This provides enhanced infection prevention knowledge, understanding and application, and is aimed at registered practitioners and senior level staff in supervisory roles who are responsible for ensuring compliance with good IP practice e.g. ward and departmental clinical managers. The online programme is run by Bangor University over eight weeks.
After a gap due to staffing issues at Bangor University this programme restarted in January 2023 and staff have been encouraged to attend. We are unable to get an accurate list of attendees from BCU but all junior IP Nurses are given time to complete this programme.

12.5 Ad hoc Infection Prevention Training sessions

During 2022/23, the local IP teams have delivered a range teaching sessions between them including:

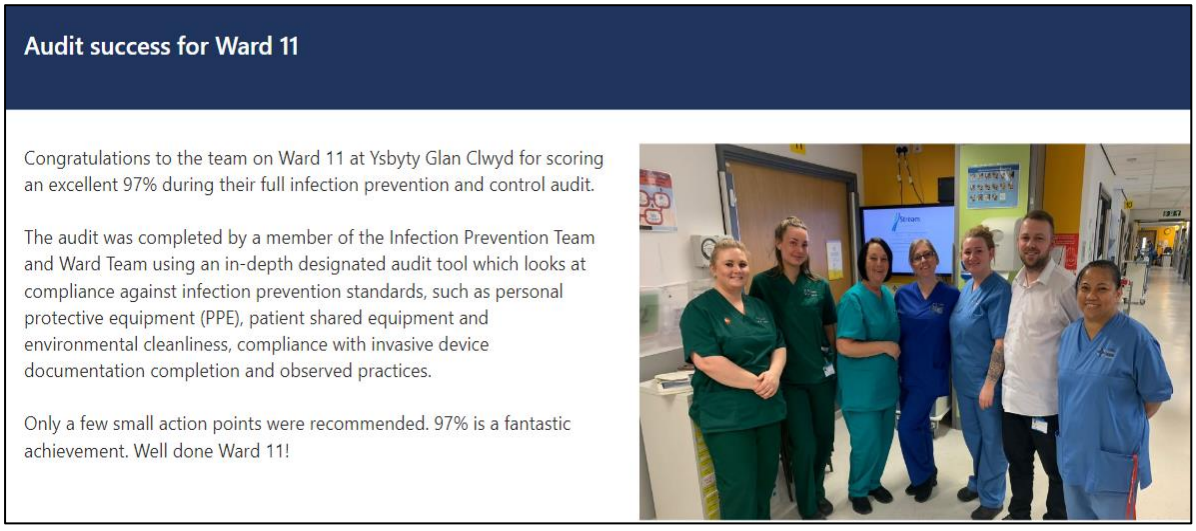
- On an ad hoc basis:
  - Hand Hygiene
  - Personal Protective Equipment
  - Donning and doffing of PPE
  - MRSA screening and management
  - Management of *C.difficile* (including a *C.difficile* summit in Central and West with East following to follow in April 2023)
  - The single room risk assessment process
  - The diarrhoea management tool
  - Management of Norovirus
  - Practical commode cleaning
  - Trolley/mattress/bed-space cleaning
  - The IRIS audits system
- Learning from Post Infection Reviews has been delivered at meetings/forums and via GP training sessions
- General infection prevention sessions have also been delivered to student nurses on induction and on Harm Free Day in the East
- ANTT Train the Trainers sessions
- Presentations at Ground Rounds on *C.difficile* and antimicrobial prescribing Start Smart and Focus audits in West

13.0 Infection Prevention and Control Team Audits

Up until June 2022, the IP Team continued to perform unannounced observational audits across the Acute and Community Hospitals. During the summer of 2022, and with increased resource in the team, it was possible to reinstate the full ward IP audits across assessment areas, inpatient areas and some of the high-risk units such as theatres, endoscopy, renal dialysis and cancer.

During 2022/23:

- Central IP Team completed 18 full ward/departmental IP audits with nine wards receiving green status, seven receiving amber and two receiving red. Thirteen of the areas audited were in the acute hospital wards to include the cancer day wards with three community hospital wards also audited. A high score of 97% for Ward 11 was highlighted and celebrated on BetsiNet.



- East IP Team completed 27 full ward IP/departmental audits with 19 areas receiving green status, four receiving amber and four receiving red. 19 of the areas were in the acute hospital and included the cancer day unit, Theatre A, Endoscopy and the renal dialysis unit. Six community hospital wards and two Mental Health and Learning Disabilities areas were also audited.
- West IP Team completed 17 full ward/departmental audits with two areas receiving green, nine receiving red and six receiving amber. 10 of the areas audited were in the acute hospital, two community hospital wards and five Mental Health and Learning Disability areas.

There is an expectation that during 2023/24 all inpatient areas in the acute and community hospitals will receive a full ward IP Team audit with all high risk areas such as Theatres and Endoscopy also audited during the forthcoming year.

The IP Team have worked closely with IT to develop new electronic audit tools for hand hygiene, mattress and commode audits and these are now available on IRIS to allow ward staff and the IP Team to input data. Staff with access to IRIS can now review performance relating to each of these audits to understand where improvement is required.
There is a plan in 2023/24 to enhance the availability of electronic audits on IRIS.

14.0 Estates
14.1 Water
BCUHB uses in excess of 500,000m³ (figure based on consumption 2022-2023) of water during the course of a normal year, which is provided for by Local Water Authorities' (Welsh Water and Harfen Dyfrdwy).
The water system and functions on site range from the provision of potable water supplies, tank fed water supplies and specialist 'treated' water supplies providing for process plant and medical equipment.
The management arrangements for Water Safety Systems within BCUHB are contained within ES02 Policy for the management of Safe Water Systems which is published on BetsiNet.
Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 04-01) and HSG274.

During 2022-2023 the Water Safety Group developed a number of key documents to support the safe use of water systems at department level, the below documents were published:
- Standard Operating Procedure (SOP) for Management of Little Used Outlets
- Standard Operating Procedure (SOP) for Management of Pseudomonas (Operational Estates)

NHS Wales Shared Services, Special Estates Services Authorising Engineer (Water) Annual Report
The Authorising Engineer is appointed by the Deputy Duty Holder (Director of Capital and Estates) and is a named representative of the NHS Wales Shared Services Partnership, Specialist Estates Services Team. They conduct an annual review/audit of operational procedures and compliance and submit a report to the Water Safety Group. The report for 2022-2023 reported a compliance rating of Green, which shows an improved position since 22021-2022 as illustrated below.

2021	2022
	
Water safety Compliance Contractor Appointed **WSG held frequently and improved attendance from core members.** **RPs/DRPs appointments completed for all areas except East** **Many Risk Assessments have been renewed**	**Performance of Water safety Compliance Contractor has improved.** **WSG meetings held regularly and good attendance from members.** **2 Site Audits completed.** **5 RP/ DRP Assessments completed.**
Yellow	**Green**

14.2 Ventilation

BCUHB acknowledges its responsibilities under the Health and Safety at Work Act 1974 and supporting legislation relevant to this discipline, (including The Control of Substances Hazardous to Health (COSHH) Regulations 2000 and subsequent approved codes of practice such as L8 and published guidance documentation such as Health Technical Memorandum (HTM) 03-01 Specialised Ventilation Systems for Healthcare Premises and HTM 04-01, The Control of Legionella), to ensure that it meets the criteria and standards for Ventilation Systems within its control.

The Policy for the Management of Ventilation Systems ES05 was developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all ventilation systems in use within the organisation. The policy is published on BetsiNet.

During 2022-23, the Ventilation Safety Group has supported redevelopment projects and reviewed information on verification of critical ventilation systems, examples of such support are listed below:

- Support the design principles for Minor Operation Procedure Rooms.
- Trial the benefits of installing Air Purifiers within poorly ventilated areas.
- Review Isolation Rooms within the Health Board and agree a principle of negative pressure

To improve ventilation in existing Healthcare premises, short-term actions that can be taken are limited and include:

- Leaving windows open whenever possible, and opening and closing windows for typically 5 to 10 minutes every hour throughout the day during cold weather, to improve natural ventilation and purge airborne contaminants.

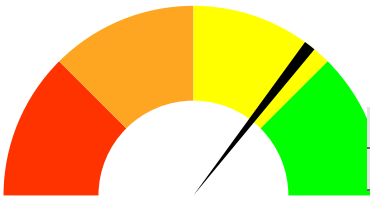
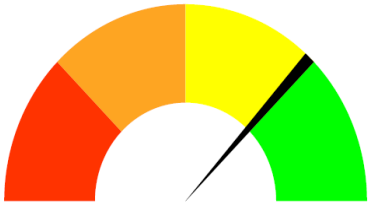
Longer-term options to improve ventilation include the following:

- All new mechanical ventilation systems to be designed in accordance with the guidance given in the new version of HTM 03-01 Part A (2021).
- Install additional negative pressure isolation suites in accordance with WHC 033 (2018).

Next Steps for 2023-2024: Review the findings of the Air Purifiers trials in Hebog Ward at Ysbyty Gwynedd and confirm if the results provide assurance to the Health Board.

NHS Wales Shared Services, Special Estates Services – Authorising Engineer (Ventilation) Annual Report

The Authorising Engineer, Ventilation is appointed by the Deputy Duty Holder (Director of Estates and Facilities) and is a named representative of the NHS Wales Shared Services Partnership, Specialist Estates Services team. They conduct an annual review/audit of operational procedures and compliance and submit a report to the Health Board. The report for 2022 - 2023 reported a compliance rating of Yellow.

2021	2022
	
Additional APs appointed but more APs are required. **No CPs appointed** **Governance largely in place** **Procedures are being implemented** **Risks identified** **Action plans pending funding, with progress where possible**	**Additional APs appointed but more APs are required.** **Some CPs appointed** **Governance largely in place** **Procedures are being implemented** **Risks identified** **Action plans pending funding, with progress where possible**
Yellow **(Reasonable assurance)**	**Yellow** **(Reasonable assurance)**

14.3 Waste Management

Since COVID–19, the high volumes of clinical waste has reduced on all sites across BCUHB; no clinical waste has been stored on site.

The reintroduction of clear bags for general/recyclable waste for correct segregation of waste has reduced the number of clinical waste bags, reduced having to store waste and reduced the cost of clinical waste. 85-90% of all sites have clear bag segregation in place. The remaining areas are entrances and exits due to the reintroduction of masks, red areas that change.

Over the last 12 months all BCUHB sites have returned waste back to' business as usual' and reintroduced the clear bag for general/recyclable waste. This has reduced the amount of clinical waste being produced and disposed of.

BCUHB's principle recycling & general waste contractor has also enabled us to reduce the volume of waste sent to landfill.

The Health Board's 'de-clutter' campaigns continue to be a great success, encouraging wards and departments to clear clutter and unused items, improving tidiness and easing the cleaning of their areas and supporting our efforts to maintain a safe, clean environment.

Wrexham Maelor Hospital is undertaking a reusable sharps bin trial for three months within theatres, maternity unit and two wards. The reusable containers can be used up to 500 times which is a huge contrast to our single use containers which are incinerated. It is estimated that if Wrexham Maelor did a full site roll-out, it would eliminate 22 tonnes of single use plastic per year. The trial is receiving positive feedback.

Environmental Legislation – Consultation on the Separate Collection of Waste Materials for Recycling: A Code of Practice for Wales – BCUHB consultation response has been consulted upon. Welsh Government have responded to the consultation, by the Autumn the Code of Practice will be placed before the Senedd to become legislation once agreed non hospital sites will require compliance to the legislation by 1st April 2024 hospitals by 1st April 2026.

Pre Acceptance Waste Audits Carried out:

West Area	Tywyn Hospital	07 June 2022
	Bethesda Medical Centre/Isgraig clinical/Penygroes clinic/Bala HC.	26 October 2022 (undertaken by Stericylcle)
	Ysbyty Gwynedd	30 + 31 January 2023 & 3, 16 + 24 February 2023
	Llanfair PG health centre	30 January 2023
	Bryn Y Neuadd Hospital	17 February & 5 May 2023
	Dolgellau Hospital	21 March 2023
	Alltwen Hospital	23 March 2023
	Canolfan Goffa Ffestiniog	23 March 20223
	Bryn Beryl Hospital	27 March 2023
	Cefni Hospital	18 April 2023
	Penrhos Stanley Hospital	21 April 2023
Central Area	Abergele Hospital	30 January 2023
	Bryn Hesketh Unit	21 November 2022
	Colwyn Bay Hospital	18 November 2022
	Corwen Clinic	23 June 2022
	Denbigh Hospital	21 June 2022
	Hafod	24 June 2022
	Llandudno Hospital	31 January 2023
	Pathology YGC	30 January 2023
	Ruthin Hospital	19 May 2022
	Ty Nant	21 February 2023
	Ysbyty Glan Clwyd	14 October & 1 November 2022
East Area	Broughton Clinic	15 December 2022
	Catherine Gladstone	15 December 2022
	Cefni Mawr	9 December 2022
	Chirk Hospital	5 July 2022
	Coedpoeth Clinic	9 December 2022
	Deeside Hospital	11 October 2022
	Glyn Ceiriog	9 December 2022
	Grove Road Clinic	27 June 2023
	Holywell Hospital	6 March 2023
	Llay Clinic	6 March 2023
	Mold Hospital	16 and 21 December 2022
	Plas Madoc Clinic	17 October 2022
	Ruabon Clinic	6 May 2022
	Saltney Clinic	15 December 2022
	Wrexham Maelor	Various dates October/December 2022

Training
Current compliance with e-learning mandatory training – Environment, Waste & Energy was 84.2% in March 2023. Agency staff, Bank Staff, GP practices and Locum doctors do not undertake the mandatory training but they do have access to the training through learning.nhs.wales.

ISO14001:2015 Audits Completed 2022-2023

- Ysbyty Glan Clwyd
- Ruthin Hospital and Denbigh Hospital
- Chirk and Deeside Hospital
- Grove Road Clinic
- Llanfair PG Clinic & Maes Derw Clinic
- Bala health Centre & Corwen Clinic
- Grove Road Clinic

There were areas for improvement raised during 2022 audits relating to Legionella and Fire. The auditor also raised two minor NC's; firstly discrepancies with COSHH risk assessments in Facilities. It is requested that Domestic Services managers review and update. The second NC related to Fire Risk Assessments not been actioned by the nominated relevant person. Gareth Griffiths Fire Officer to review.

14.4 Environmental Improvement Works – Safe Clean Care
The Operational Estates Department within BCUHB received £500,000 discretionary capital funding within 2022/2023 to improve the hospital environment. The projects were presented to each LIPG for approval. Four different work stream were developed based on geographical responsibility within Operational Estates (East, Central and West) and MHLD.

Operational Estates Department – West

YG - Front Reception
YG - Aran Ward - Room Upgrade
YG - Stairwell - Phase 1 of 2
YG - Theatre 8&9
YG - Eye Clinic
Ysbyty Penrhos Stanley - Upgrade bathroom Cybi Ward
Hypoclorus Misting M/C
Eryri Peblic Kitchen

Operational Estates Department - East

WMH - Theatre
WMH - Shooting Star - Flooring
WMH - Erddig Wet Room
Capital - AMU
Catering Toilets
Hypoclorus Misting M/C

Operational Estates Department – Central

CBCH Flooring
YGC ED Doors
YGC Corridor E
CBCH - handrail wards 1 & 2

Gastro Storage / Flooring
CBCH WHB and Radiator Covers wards 1 & 2
DCH Handrail replacement
Hypoclorus Misting M/C

MHLD

Tim Dyffryn Clwyd
Ty Llewelyn - Flooring
Ablett - Flooring
Cefni - Flooring
Foelas - Upgrade Rooms
Hafod - Flooring
Nant Y Glyn - Upgrade Room

Examples of some of the improvements are illustrated below:

14.5 Risk Register

A number of infection prevention related risks are part of the Operational Estates Risk Register; they are reviewed regularly. Specific elements included are ventilation and control of contractors.

ID	Ref	If Pan BCU 'Yes' who is the Host Region?	Specialty	Unit	Handler	Title	Risk Rating (Initial)	Risk Rating (current)	Risk Rating (Target)	Risk Type
4618	Op E QSAM		Estates Operational - Environmental	Ysbyty Abergele Hospital	Hughes, Mr Arwel	Abergele Hospital - Environmental Infrastructure and Patient Safety Risk	12	12	6	Tier 2 - (Current Score 9-12)
3020	CRR20-02	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Engineering		Taylor, Mr Rod	Contractor Management and Control	20	15	8	Tier 1 - Corporate Risk (Current
2446	Ventilation Safety Group	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Engineering	Wrexham Maelor Hospital Acute	Hughes, Mr Arwel	Critical Ventilation - Estates Operational - Engineering	15	12	6	Tier 2 - (Current Score 9-12)
2194			Estates Operational - Building	Ysbyty Abergele Hospital	Hughes, Mr Arwel	current vulnerability of the Abergele estate	16	12	6	Tier 2 - (Current Score 9-12)
1671	Op E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Environmental		Taylor, Mr Rod	Divisional Health and Safety Management Arrangements	16	12	6	Tier 2 - (Current Score 9-12)
2434	CRR23-35		Estates Operational - Engineering	Wrexham Maelor Hospital Acute	Taylor, Mr Rod	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site	20	16	6	Tier 1 - Corporate Risk (Current Score 15-25)
2451	Electrical Safety Group		Estates Operational - Engineering		Hughes, Mr Arwel	Electrical Infrastructure Community Hospitals - Estates Operational Engineering	12	9	6	Tier 2 - (Current Score 9-12)
3022	Electrical Safety Group	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Engineering		Hughes, Mr Arwel	Electrocution at Work	20	10	6	Tier 2 - (Current Score 9-12)
1664	OP E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Building		Taylor, Mr Rod	Estates and Facilities Backlog Maintenance / Infrastructure Modernisation	16	12	9	Tier 2 - (Current Score 9-12)
4255	Op E QSAM		Estates Operational - Building	Bryn y Neuadd Hospital	Taylor, Mr Rod	Facilities Department - Structural Risk	20	12	5	Tier 2 - (Current Score 9-12)
4356	Decommissio ning GP		Estates Operational - Building	Field Hospital	Welham, Dale	Field Hospital - Security Incursions to Vacant Site	12	1	1	Tier 2 - (Current Score 9-12)
3618	Decommissio ning Group		Estates Operational - Building		Welham, Dale	Field Hospital Decommissioning - Timeline	20	1	1	Tier 2 - (Current Score 9-12)
4283	Op E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Engineering		Taylor, Mr Rod	Health & Safety and Statutory Compliance Resources Business Case	16	12	6	Tier 2 - (Current Score 9-12)
1666	Op E QSAM	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Environmental		Hughes, Mr Arwel	Infection Prevention and Control	16	9	6	Tier 2 - (Current Score 9-12)
3023	CRR20-03	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Environmental		Taylor, Mr Rod	Legionella Management and Control.	20	16	8	Tier 1 - Corporate Risk (Current Score 15-25)
4275	Ventilation Safety Group	Other (Pan BCU Corporate Offices e.g. Finance, Estates, MHI&LDS, etc.)	Estates Operational - Engineering		Taylor, Mr Rod	Non-Critical Ventilation	12	12	6	Tier 2 - (Current Score 9-12)
1318	IP Estates Priorities		Estates Operational - Environmental		Hughes, Mr Arwel	Risk of infection due to delays in Infection Prevention Urgent Estates Work Priorities	16	6	6	Tier 2 - (Current Score 9-12)
1667			Estates Operational - Engineering		Taylor, Mr Rod	Staff Resources and Capability	16	12	8	Tier 2 - (Current Score 9-12)

15.0 Facilities

Changes to Operational Facilities Structures.

2022/23 saw significant changes to the structure for Operational Facilities as a whole; the health board introduced an initiative called Stronger Together which directed that Operational Facilities be separated from Operational Estates to be realigned under the 3 Integrated Health Communities (East, Centre and West).

Following the retirement of the Head of Facilities in early 2023 the Facilities oversight team have been realigned to the line management of the Chief of Operations.

15.1 Environmental Cleaning Services 2022-23

The cleanliness of any healthcare environment is important for the prevention of the spread of infection and patient safety and well-being. Furthermore, the cleanliness of an environment can contribute to the overall quality of a patients experience. All Health Board staff have a responsibility for the cleaning and maintenance of their workplace and have a role to play in providing continuous improvement in environmental cleanliness. The National Standards of Cleaning, Wales (2009) set out the cleanliness requirements for all Health Boards in Wales.

As part of the response to COVID-19, an addition to the present National Standards of Cleaning (Wales) has been issued in late 2020 under the title COVID-19 Addendum, Key Standards for Environmental Cleanliness; this relates to all staff who undertake cleaning within

a healthcare facility. During December 2021 this was superseded by All Wales Key Standards for Environmental Cleanliness

Management Arrangements
Operational Facilities service provide Domestic Services across the HB, they provide a quality service and strive to improve the cleaning agenda wherever possible.
The Domestic Services Departments work closely with the Integrated Health Communities, have daily representations at the hospital huddle meetings and are in regular contact with the Infection Prevention Team.

Cleaning Responsibilities Framework
The BCUHB cleaning responsibilities framework document for Secondary Care and Community Hospitals was reviewed as part of the Safe Clean Care Programme, however it was agreed that a revised framework could not be fully instigated until Domestic Services recruitment was complete. The ongoing recruitment status means that this has not yet been instigated.
The framework was introduced to provide clear guidance on which staff group had responsibility for cleaning items of equipment; in cases where enhanced or specialist cleaning is required this is undertaken by the Domestic Services Deep Clean Teams. The framework is reviewed on a regular basis, with discussions taking place during 2022/23 regarding rebalancing framework activities from Nursing to Domestics to align cleaning processes that are undertaken by both staff groups.

Service Continuity/Improvement
During 2022/23 the domestic services management team continued to review cleaning processes and procedures, and Head of Facilities IHC East is representing the Health Board and participating in the ongoing development of the updated All Wales National Standards of Cleaning document, along with senior leaders from the Infection Prevention Team.

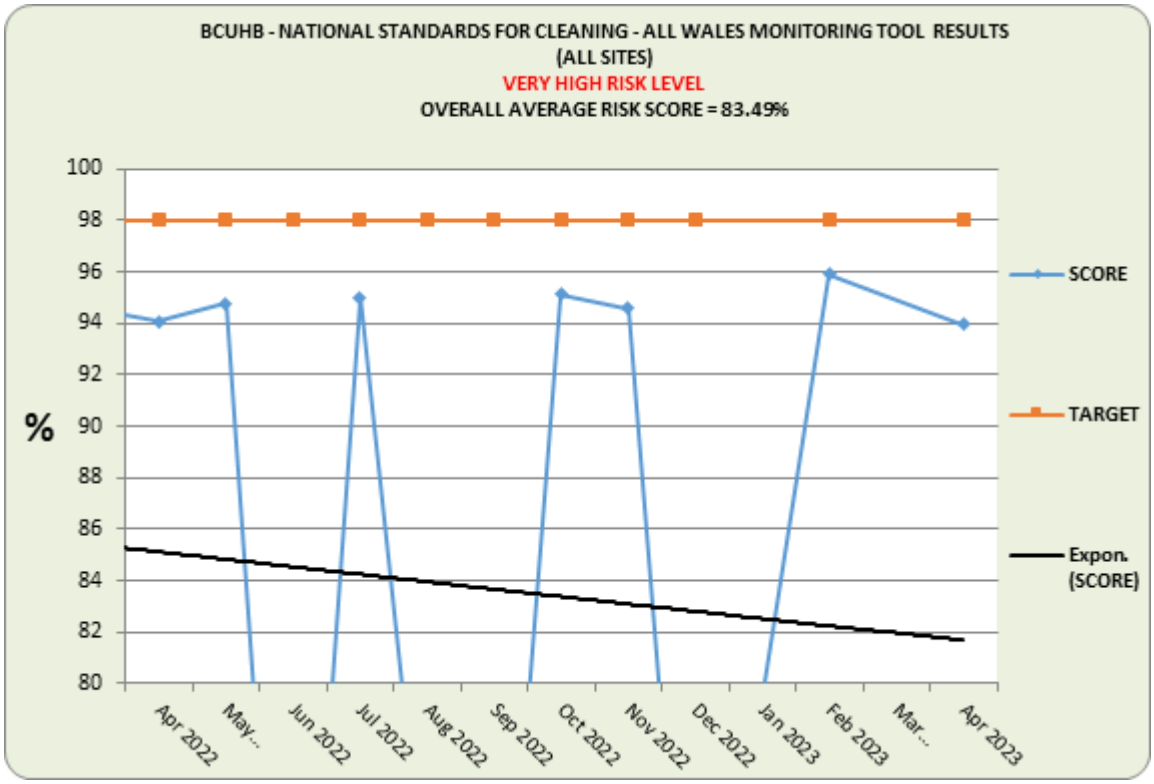
Enhanced and new cleaning processes
Since the last report, as part of the Domestic Services high-level disinfection process, the use of hydrogen peroxide vapour (HPV) has been replaced in favour of Hypochlorous Acid Misting Units as part of the enhanced cleaning process, in conjunction with Ultra Violet Light (UVC) decontamination where appropriate. This innovation was adopted following extensive trials conducted as part of the Safe Clean Care Improvement Programme which informed our improvement methodology for 2022/2023.

Monitoring
The National Standards for Cleaning, Wales (2009) stipulate that continuous monitoring of environmental cleanliness is undertaken. The Domestic Supervisors facilitate the audit process with support from nursing and estates colleagues. Senior Nursing, Ward Matrons/Departmental Heads and Operational Estates management are provided with the cleaning results following audit for their own areas.
Although Credits for Cleaning (C4C) has been the preferred auditing tool for use by the Health Board over recent years, the COVID-19 outbreak highlighted capability gaps in the C4C software as well as a recognition that it no longer accurately reflects the physical estate as so much development had taken place, therefore the Head of Facilities instigated a switch from C4C to MICAD Audit, the switch requires a significant amount of work to data cleanse and rebuild audit schedules, the scheduled completion date for the project is 30th September 2023.

Due to COVID-19, the frequency of audits has been intermittent due to restricted access to clinical areas and departments, as well as our auditor resources being affected by sickness, an active decision was taken at the height of the pandemic to prioritise cleaning duties over auditing duties when staff sickness levels made it necessary, which is reflected in the graphs reported below.

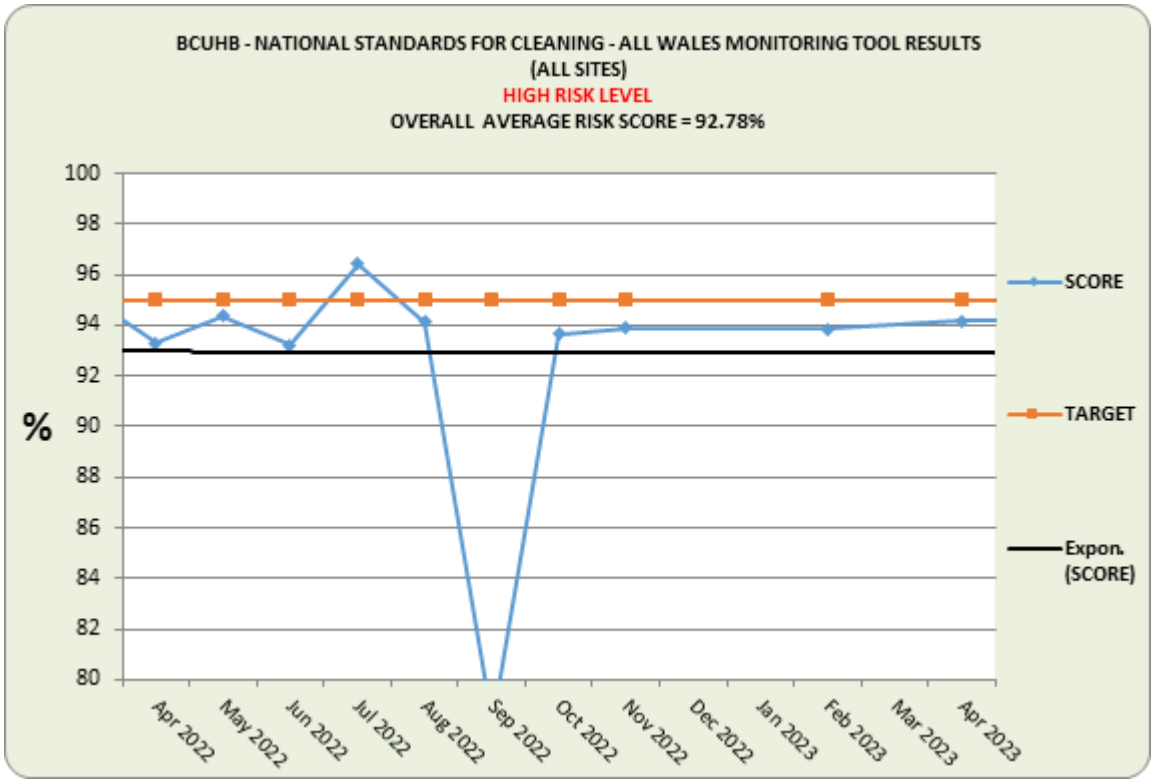



Average results for all sites for Very High Risk and High Risk Areas for 2022/23 are shown below:



Very high risk functional areas include operating theatres, ICUs, SCBUs, accident and emergency (A&E) departments, and other departments where invasive procedures are performed or where immuno-compromised patients are receiving care.

High-risk functional areas include general wards (acute, non-acute and mental health), sterile supplies, public thoroughfares and public toilets.



Systems to test the efficacy of cleaning (Adenosine Trisphosphate- ATP and CiFi torch technology) were implemented during 2022/23 and further work during 2023/24 will be undertaken to embed appropriate usage and further roll out.

ATP (Adenosine triphosphate) testing is used to measure levels of ATP on a surface. Testing is done after a surface has been cleaned and indicates the efficiency and effectiveness of the cleaning being done, and therefore the cleanliness of the environment.

The CiFi torch is an instrument that can locate human biological traces, bacteria and organic matter that cannot be seen with the naked eye, and therefore supports cleaning and facility management staff to achieve forensic standard results

The Trial of these tools led to the Health Board instigating a Memorandum of Understanding with the Centre for Crime, Justice and Security of Staffordshire University on the 8th December 2022 which aims to:

“Create a forum for the enhancement of knowledge and knowledge transfer of academic and clinical excellence. In part, this will explore the application of forensic science methods to the operational application of clinical cleanliness assessments and a review of procedures used for managing infection control.”

This work has already resulted in several trials at Chirk Hospital and has borne early fruit in presentations being presented by Dr Sarah Ferguson at the National Infection Prevention Conference on the 26th of April 2023.

Resource Establishment

Focus has also been placed on the recruitment of new Domestic Assistants to support the COVID-19 Addendum guidance supported by workforce and recruitment colleagues. It was envisaged that the full establishment would be achieved by the end of the March 2023, but due to the present employment market and a large amount of out of area applicants, recruitment is still ongoing.

15.2 NWSSP Linen Services

The North Wales Laundry is located on the Glan Clwyd acute site and run as part of the All Wales Laundry Service (NHS Wales Shared Services Partnership). The Laundry provides linen services for all Health Board sites and Wales Ambulance NHS Trust sites in North Wales. The service is used by all clinical wards and departments within the Health Board. The Laundry produces over six million individual pieces of linen per year.

The below table details the breakdown of linen items processed in 2022/23:

Site	April	May	June	July	August	September	October	November	December	January	February	March	
Central Area													
Glan Clwyd Hospital	108549	131241	104878	99971	130362	100641	110800	138097	105658	134288	107470	104660	1376615
Glan Clwyd Mortuary	432	540	604	645	647	560	627	678	600	630	560	560	7083
Glan Clwyd Residences	1198	1427	1190	1150	1648	1149	1200	1472	1072	1386	1339	1057	15288
Glan Clwyd Ablett Unit	3282	4584	2883	2427	3718	2662	3009	4421	2975	3760	2916	2655	39292
YGC Ty Nerys Unit	300	308	260	225	253	362	250	380	235	175	230	225	3203
Abergele Hospital	4227	5585	3525	5047	4368	4455	4396	4771	3122	4732	5977	4499	54704
Bryn Hesketh Unit	1688	1832	1824	1933	2098	1480	1394	1799	1703	1552	1672	1897	20872
Colwyn Bay Hospital	3881	5240	3658	3460	4519	4075	3370	4417	3742	4755	3217	3803	48137
Denbigh Hospital Ward	2891	3736	2026	2610	3542	2948	3108	3685	2960	3504	2943	3064	37017
Llandudno Hospital	11589	14118	10737	11373	14607	11826	11832	14610	10715	13830	10414	10621	146272
Ruthin Hospital	2412	3294	3094	1557	3110	2451	2616	3409	2533	3945	3038	2865	34324
Tan Y Castell	450	559	275	297	484	369	302	486	428	557	588	478	5273
NWAS	244	210	115	124	153	148	205	284	317	303	198	227	2528
Hafod Unit Rhyl	18	0	42	0	24	0	24	30	0	28	18	0	184
Royal Alex Hospital	118	354	263	275	310	262	85	185	340	275	240	190	2897
East Area													
Wrexham Maelor Hospital	64809	86903	71820	74576	90759	71802	75992	99580	77721	97196	78815	78672	968645
Wrexham Renal Unit	800	695	765	905	920	980	900	1480	1440	1240	1360	1660	13145
Wrexham Residences	816	350	814	700	796	400	764	882	635	1236	1115	780	9288
Wrexham Surgical Unit	8928	12582	9444	9742	10922	9562	8625	10922	7639	10595	8098	17752	124811
Wrexham Top Floor Unit	19090	26037	21047	21750	25422	21589	22422	27575	19470	27547	21885	21455	275289
Croes Newydd Wrexham	1950	2540	2249	1993	2647	2259	2155	2522	1921	2134	1954	1896	26220
Heddfan Unit Wrexham	3173	4602	3277	3259	4422	3729	3379	3789	2995	3193	2106	2800	40724
Chirk Hospital	2090	2532	2149	2070	2639	2286	2198	2696	2180	2828	2042	2018	27728
Coed Celyn Hospital	136	122	266	229	303	201	191	195	128	130	145	121	2167
Deeside Hospital	5032	6130	4589	4353	5669	4754	4935	5859	4380	6412	4945	5379	62437
Holywell Hospital	4359	5786	4231	4250	5526	4716	4100	5278	4126	5736	4309	4700	57117
Mold Hospital	4479	5522	4385	4472	5644	4730	4708	6112	5181	6403	4917	5122	61675
Penley Hospital	597	731	687	430	480	356	661	558	470	628	439	616	6653
West Area													
Bangor Hospital	93578	115950	90286	91348	113073	89460	99627	122409	95461	121,845	93708	97280	1224025
Bangor Residences	910	1110	895	908	1287	888	909	830	760	858	870	525	10750
Bangor Renal	430	687	650	575	560	555	695	760	565	1153	660	655	7945
Alltwen Hospital	2970	3404	2423	2432	3001	2361	2404	3695	2926	2644	2710	2755	33725
Bryn Beryl Hospital	1974	2481	2123	1952	2543	2111	2149	2758	2198	2382	2091	1973	26735
Bryn Y Neuadd Hospital	2320	2850	1225	1810	1805	2430	2158	1810	2645	2511	1346	1901	24811
Cefni Hospital	1758	2614	1790	1911	2383	1993	2086	2548	2158	2995	2350	1931	26517
Dolgellau Hospital	1970	1948	1293	1314	1643	1748	1629	2120	1561	1505	1691	1328	19750
Eryri Hospital	3484	4293	3515	3388	4060	3633	4047	5169	3711	4727	3417	3292	46736
Penrhos Stanley Hospital	3371	4293	3046	3785	4718	3590	3661	4881	4274	4886	3854	3407	47766
Tywyn Hospital	1652	1729	1331	1152	1537	1498	1639	1992	1488	1721	1526	1732	18997
Total across all areas													**4957345**

The following additional items have also been processed in 2022/23 as part of the NWSSP Laundry cleaning:

- Pan BCU - 1,102, 818 Microfibre Mops & Cloths
- Pan BCU – 439,914 Vileda or String Mops
- Pan BCU – 1288 Air Mattresses



North Wales Linen Services transferred from BCUHB to NWSSP on the 1st April 2021. The factory will remain on the YGC site until further notice.

15.3 Food Safety

The Health Board introduced a BCUHB Primary Authority Scheme (PAS) agreement between Wrexham County Council (WCC) and the Health Board in 2016 originally on a three year agreement which was retendered in 2020 for a further three years with WCC, prior to this food safety was monitored by the six different Local Authority, Environmental Health Teams across North Wales. This did not allow standardisation for BCUHB in relation to food safety policy and process. BCUHB Facilities Management Services have developed over the last three years in partnership with their Primary Authority Scheme provider a robust food safety system which merged 21 food safety policies and associated documentation into one.

The objectives which formed the agreement of activity to be undertaken in partnership between the primary authority and the Health Board are:

- To provide expert advice with the updating of the BCUHB Catering Strategy in relation to the Food Safety Act and associated regulations and guidelines. The PAS advises on the strategic direction for both Acute and Community Hospitals which may require different methods of food delivery dependant on the type of patient. The advice will also include satellite ward/department and retail catering.
- To support the maintenance of the BCUHB Food Safety Management System to cover both primary and satellite catering facilities to achieve the performance indicator set by the organisation to have all catering outlets at a Food Safety Score of level 5.
- To provide expert advice on new/changes in food safety legislation and regulations e.g. Allergens, labelling.
- The training of Nursing, Catering and Non Clinical staff on the BCUHB Food Safety Management System and Food Hygiene to a level which matches their job description and employment personal specification in relation to food service.
- To provide expert advice with the prioritising of catering equipment and kitchen infrastructure to support the writing of business justification cases for the modernisation and replacement of equipment and premises in line with the BCUHB catering strategy. The business justification cases will form the case of need for requesting capital funding.
- To conduct a programme of audits and associated compliance checks on Health Board catering premises to support continuous improvement in relation to the BCUHB Food Safety Management System.
- Undertake other activities which sit within the scope of the primary authority scheme agreement has requested by the Health Board.

Food Safety Scores at time of writing are given below:

Location	Rating	Date	Status
Anglesey & Gwynedd (West IHC)			
Ysbyty Gwynedd	5	07/02/23	→
Ysbyty Bryn Beryl	4	10/02/23	↓
Ysbyty Dolgellau	5	21/03/22	→
Ysbyty Tywyn	5	18/03/22	→
Ysbyty Alltwen	5	03/11/22	↑
Ysbyty Cefni	5	12/05/23	→
Eryri Hospital	4	25/01/23	→
Penrhos Stanley Hospital	5	11/01/22	→
Bryn y Neuadd	5	21/04/23	→
Conwy & Denbighshire (Centre IHC)			
Ysbyty Glan Clwyd	5	06/01/23	→
Child Adolescent Unit Catering, Abergele Hospital	5	07/02/23	→
Denbigh Infirmary	5	13/01/23	→
Llandudno Hospital	5	09/02/23	→
Colwyn Bay Hospital	5	07/09/22	→
Ruthin Hospital	5	08/02/23	→
Wrexham & Flintshire (East IHC)			
Wrexham Maelor	5	20/03/23	↑
Deeside Community Hospital	5	16/08/22	→
Mold Community Hospital	5	05/08/22	→
Chirk Community Hospital	5	03/05/23	→
Holywell Community Hospital	5	28/03/22	→
Penley Hospital	5	24/02/22	→

Key	
No Change	→
Increase	↑
Decrease	↓

NB – All Health Board food hygiene ratings are available on the BCUHB intranet here or the Food Standards Agency (FSA) Web-link http://ratings.food.gov.uk

Food Safety Training
Our commitment to ensure that all our Catering staff receive the highest quality Food Safety training through the Primary Authority, which means that our trained capability often exceeds Food Safety Legislation which helps our Catering Teams to provide the best levels of Food Safety

Ward Kitchens
The responsibility for the management of Ward kitchens sits with Nursing Leadership. Regular ward kitchen audits are carried out by ward staff with support from the Health Boards Catering

Departments who continue to undertake ad-hoc audits to ensure compliance in line with the Food Safety Act.
The Infection Prevention team have taken a number of interventions to ensure compliance, which has supported best practice and improvement in the management of ward fridges. Recent Environmental Health Officer, Food Safety enforcement visits have recognised this in the corrective action reports following the visits.

15.4 Facilities Risk Management.
Of the Risks currently on the Facilities Risk Register those with an Infection Prevention aspect are as follows:

Risk 4695 – NWSSP Laundry – This risk is being managed by way of BCUHB executive partnering with NWSSP via the Shared Services Committee and by the Facilities Oversight team facilitating reviews of operational solutions along with a medium term review of the Service Level Agreement and Memorandum of Temporary Occupation. Updates will be reported in the SIPG.
Risk 4463 – Central IHC – Domestic Services 7 day service pressure – This risk is being managed by the Central Area IHC with unfunded service support demands being reported via the LIPIG.
Risk 4462 – Central IHC - Domestic Services – Enhance Cleaning Requests - This risk is being managed by the Central Area IHC with unfunded service support demands being reported via the LIPIG.
Risk 4465 – West IHC - Domestic Services – Recruitment - This risk is being managed by the West Area IHC with service support shortfalls being reported via the LIPIG.
Risk 4456 – East IHC - Domestic Services – Enhanced Cleaning Requests - This risk is being managed by the East Area IHC with unfunded service support demands being reported via the LIPIG.
Risk 4466 – West IHC – Domestic Services 7 day service pressure - This risk is being managed by the West Area IHC with unfunded service support demands being reported via the LIPIG.

16.0 Decontamination of Medical Devices
Decontamination involves pre-cleaning, leak testing (where applicable), cleaning, disinfection, removal of residue chemical, inspection and assembly, sterilisation, transport and storage of reusable medical devices. The Spaulding classification identifies the level of decontamination of medical devices required and is used to identify the appropriate process, this may include a combination of manual and automated processes. For decontamination to be effective, each stage of the process must be undertaken by trained and competent staff and processing equipment must meet national standards which will include controls and monitoring of the process.
The definition of a medical device is broad and includes ‘all products except medicines, used in healthcare for the diagnosis, prevention, monitoring and treatment of illness or disability’. Therefore, the majority of patients treated within BCUHB will be in contact with a medical device that has been decontaminated and dependent on the procedure it will range from relatively low risk to extremely high-risk devices.
Medical devices that are used on more than one patient have the potential to transmit infection between patients. This can occur if all the stages of decontamination are not completed, untrained staff undertake the decontamination process incorrectly and if any residue contamination is remaining on the device after the decontamination process. International (ISOs), National guidance (WHTMs) manufacturer’s instructions for use (IFUs) must be followed to ensure patient safety. The IP Team also provide professional advice to clinical and estates teams to ensure patient and staff safety.
The Welsh Health Circular (WHC/2015/050) presented the Decontamination Improvement Plan for organisations across Wales in order to ensure that reusable medical devices are safe for use on a patient and for staff to handle without presenting an infection risk.

16.1 Audit

To provide necessary assurance of compliance with decontamination processes, six monthly decontamination audits were conducted in BCU in 2022/23 by the Decontamination Adviser and Nurse. Several infrastructure/resource challenges have been identified including out of date/aged automatic washer disinfectors, autoclaves, and the environment including air handling units which pose a significant risk if they fail, as they are either at end of life or obsolete and will require significant capital and would interrupt service continuity. This has been logged on the Tier 1 risk register with a score of 16.

16.2 Strategic Review

A comprehensive Strategic Review of Decontamination of Medical Devices was undertaken by NHS Wales Shared Services Partnership – Specialist Estates Services (NWSSP-SES) in August 2022 which highlighted areas that needed to be addressed including flexible Endoscopy Decontamination Units (EDUs), Sterile Services Departments (SSDs) and Community Dental Services (CDSs) across BCUHB.

Positive findings from report included:

- The Health Board has an existing structure to ensure there are governance systems in place compliant with WHTM 01-01 part A. It is pro-active with ensuring that there is a process of continual improvement with decontamination of medical devices.
- BCUHB has committed to enter the national agreement, in development for the All-Wales systems within sterile services. It is envisaged this will be implemented across endoscopy areas in the future. Infrastructure redevelopments should take into consideration the consequences of such agreements when finalising long term plans.

Challenges identified from report:

- All three Sterile Service Department (SSD) engineering services are near or at the end of life and will require replacement over the next ten years, with the Wrexham Maelor unit being the priority.
- Concerns raised with the current infrastructure, equipment and built environment for Endoscope decontamination at YGC and WM (including endoscopy, urology, and ENT).
- BCUHB need to investigate the purchase of a compatible sterilisation system for scopes that enter sterile cavities i.e. choledochoscopes.
- Local decontamination facilities supporting community dental premises are generally in poor condition, with units often lacking appropriate environmental controls. Recommendations include exploring the transfer of decontamination activities to SSD.
- A need for a collaboration on a Health Board wide management strategy as currently each Decontamination unit operates to different standards/systems.
- Non-lumened scopes used in ENT should be decontaminated using automated methods; WM currently use manual. YGC use disposable. Decontamination procedures should be reviewed and changed to reflect the updated guidelines.
- The strategic review concludes that i**f** BCUHB are committed to a modernisation strategy, an in-depth formal review of its decontamination service should be carried out to incorporate both the internal needs of the organisation, along with the wider needs of the NHS in Wales. Significant investment is required to develop and upgrade the necessary infrastructure for decontamination services.

Following the report an external decontamination consultant was employed for six months (three days per week) and work carried out as detailed below:

- A BCUHB decontamination strategy 2023-2030 was developed to meet existing and expected guidance.
- An option appraisal on the configuration of decontamination services including SSDs was completed.

- The decontamination management structure pan-BCUHB has been reviewed and developed. The recommended changes include the appointment to a new post and a change in the reporting lines for decontamination services. This will support centralisation of services and recognise decontamination as a healthcare science profession. The structure will drive forward the decontamination strategy to ensure compliance to national guidance and best practice in BCUHB.
- Managed the project team to the successful implementation of a new compliant SSD track and trace system to mitigate the risk of loss of data as required by WHTM 01-01-Part A. This was completed April 2023
- Decontamination risks on Datix were reviewed for accuracy, appropriateness and new risks identified to be added to register. This ensures a reflection of the decontamination services across BCUHB.
- Reviewed the current IP decontamination audit process and implemented changes to the method and developed robust audit documentation.
- Implemented monthly meeting with SSD Managers to review standardisation across the three units and to encourage proactive sharing of best practice.
- Provided support and technical advice to centralisation of the decontamination of flexible endoscope projects. This is an essential area that needs to be progressed on YGC and WMH sites as NWSSP-SES has advised that this work must be completed by 2024 at the latest.
- Completed a SBAR on decontamination of TOE probes and concluded the move to compliance can be addressed as part of the flexible endoscopy projects to install appropriate sterilisation system.
- Attended and advised at the Medical Device Capital Group to assist with the compliance of equipment. There is still a requirement for significant spend on decontamination processing equipment in next two years to reduce the risk of failure.

The conclusion of the work was for management of all decontamination services to be consolidated and move from the current silo approach to a BCUHB overview to ensure that the service provision is compliant, safe and cost effective.

16.3 Sterile Services Departments

There are three SSDs in BCUHB, one on each acute site, they are all registered with the Medicines and Healthcare Products Regulatory Agency (MHRA); this is a Welsh Assembly Government mandatory requirement. To enable this registration, ISO 13485 accreditation is required and compliance to the Medical Devices Directive/Regulations. Each site was audited by the external Notified Body during 2022, corrective action reports raised have been addressed and accreditation has been retained. The NWSSP-SES report clearly identifies significant risks in regard to the environment, fabric, ventilation systems, services and equipment in the SSDs and all need significant investment to ensure this accreditation and level of service provided can be maintained.

The existing SSDs information system (Track and Trace) was at end of support by the company at the end of 2022. It did not meet the current NHS Digital requirements and therefore a new system was purchased that is compliant to NHS Digital and WHTM guidance and was implemented during March/ April 2023.

SSD failures: At WHM and YGC there has been three occasions where contingency plan has been implemented and the work transferred to another SSD. The contingency plan worked and although there were some delays in processing, patients' procedures were not significantly affected. As all sites need investment the contingency plan is not robust.

All departments are also experiencing unplanned downtime due to services failure for up to half a day and have been managed successfully and not led to contingency plans being implemented.

16.4 Endoscopy

The NWSSP-SES report recommended the following: *By implementing The All-Wales strategies and sharing resources prevents duplication, and links with the "Once for Wales" policy put forward by Welsh Government. NWSSP-SES recommends the use of a dedicated central resource for endoscope decontamination as this leads to better process outcomes and subsequently enhanced standards of patient safety.*

YG has centralised the decontamination processing of flexible endoscopes and does meet the standards for the Joint Advisory Group (JAG) for accreditation to undertake the bowel screening programme. A decontamination audit was completed by NWSSP-SES and was shown to be acceptable, however a full JAG audit has not been undertaken, so the department is not yet accredited. The remaining issue at YG is that it does not have the capacity to process the ENT flexible endoscopes in the centralised unit but a bid for an additional EWD will provide the capacity and has been funded for 2023/4.

YGC and WMH have not centralised the decontamination processing of flexible endoscopes and therefore, processing is undertaken in four departments. The environment and equipment do not meet the current guidance (WHTM01-06) for processing flexible endoscopes. In addition, there are 5 local units where high level disinfection of endoscopes is being undertaken using a manual process within these acute sites.

Plans are being progressed at WMH to move to a centralised service, an area that can meet current standards has been identified and capital monies identified for 2023/4, however to ensure this becomes a full centralisation of flexible endoscopes, it needs the commitment from all MDT so that all existing automated processing areas (two) and local high-level disinfection (2) on the site will be closed and all flexible endoscopes processed in this purpose built compliant unit with a dedicated team of decontamination technicians.

The plan for centralisation at YGC is not as developed but is being worked up to achieve the 2024 date advised by NWSSP-SES for compliance. This will require significant investment which has not yet been identified.

16.5 Other scopes and probes

Choledochoscopes: there has been no change and they are currently still just disinfected. Best practice requires sterilisation of these devices to be compliant to WHTM 01-06. Due to materials used in the manufacture of these devices current sterilisation processes available are not suitable and therefore, a low temperature sterilisation system needs to be purchased and should be part of the centralisation of flexible endoscopy project.

Trans-oesophageal echocardiogram (TOE) probes: these are being processed through an EWD at YG compliant to best practice (WHTM) 01-06. YGC and WMH decontaminate their TOE probes using a semi-automated system which although is identified in the WHTM 01-06 guidance, is not best practice. On completion of the centralisation of the flexible endoscopy process the TOE probe decontamination should move to this facility.

ENT Nasoendoscope: on all sites are manually high level disinfected which is not best practice. The need to move to best practice of being processed in an EWD as part of the centralisation of flexible endoscopy. In some instances, sterile disposable nasoendoscope are being used.

16.6 Ophthalmology:

Decontamination standards related to laser contact lens is variable across the 3 sites YG, Abergele and WMH and engagement from clinical leads is required to take this forward and standardise according to national guidance.

16.7 Ultrasound equipment

There have been a few IP issues relating to the decontamination of ultrasound equipment during 2022/3. The main concern has been the change in the manufacturer's instructions

regarding the decontamination of trans-vaginal and trans-rectal probes by the supplier. This presented as a Wales and UK-wide issue and after constructive conversations, the existing method of decontamination was agreed could be continued. The areas where these probes are decontaminated, using a combination of manual clean and automated high-level disinfection, is audited by the IP decontamination team. New national guidance is being developed to assist with this area of decontamination.

16.8 Community Dental Services (CDS)

In 2022/3 a total of 24 audits were completed by the IP decontamination team in CDS. There are two left to complete. This has been to provide a base line for decontamination services and was carried out in conjunction with the senior dental nurse/decontamination lead (CDS) and deputy Director of community dentals. There were many issues raised and in one case the department was closed on the same day as the audit. Three sites currently closed need considerable upgrades before re-opening. One site currently meets gold standard at HMP Berwyn. All actions identified remain the responsibility of the CDS personnel to resolve. The plan going forward for 2023/24 will be to provide specialist decontamination advice for new builds/ refurbishment and in response to action plans in place.

In addition to the audit findings the following were identified:

- There is no Authorised Person Decontamination (AP(D)) for CDS, this will affect the decontamination equipment input required to meet the WHTM 01-05 guidance.
- There is a fleet of Mobile Dental Units, which are currently not in use and it has been recommended that these are not reinstated.
- The risks are on the BCUHB risk register.

16.9 The Decontamination Group

The Decontamination Group meets on a regular basis and is proactive in ensuring a process of continual improvement with decontamination of medical devices. AAA reports are submitted for all acute and community sites carrying out decontamination. The Decontamination Team follow up non-attenders. Risk assessments are reviewed and updated. The group ensures training issues are being addressed.

16.10 Other issues managed by the Decontamination team in 2022/23:

- Sleep Angel mattresses: these mattresses do not have a zip cover that can be opened allowing the inside to be inspected for ingress of fluids. A significant number of these mattresses purchased for the Rainbow hospitals during the early part of the pandemic have had to be either moved to beds in Mental Health where risk assessment allows their use or replaced.
- Spirometry equipment and premises: following a query raised at the All Wales Sterilisation and Decontamination Group a review was undertaken at all 3 sites to ensure equipment was being decontaminated or disposed of as appropriate.
- Decontamination of Incubators: Following new guidance the decontamination nurses worked with SCBU to update the SOP.

17.0 Antimicrobial Resistance and Prescribing Programme

17.1 Welsh Health Circular AMR Improvement Goals

BCUHB continues to achieve the 2.5% year-on-year reduction required by BCUHB to achieve the minimum 25% reduction rate (TARGET - Items/1000 STAR-PU) by 2023/24.

The 2013/14 baseline rate for BCUHB was 1,408.4 items/1000 STAR-PU, and the rate achieved at the end of the 2021/22 financial year was 971.5 items/1000 STAR-PU: This represents a 31.0% reduction in total antimicrobial volume by the HB against the baseline. Currently, BCUHB has met the 25% reduction rate for primary care, with one year left of the target.

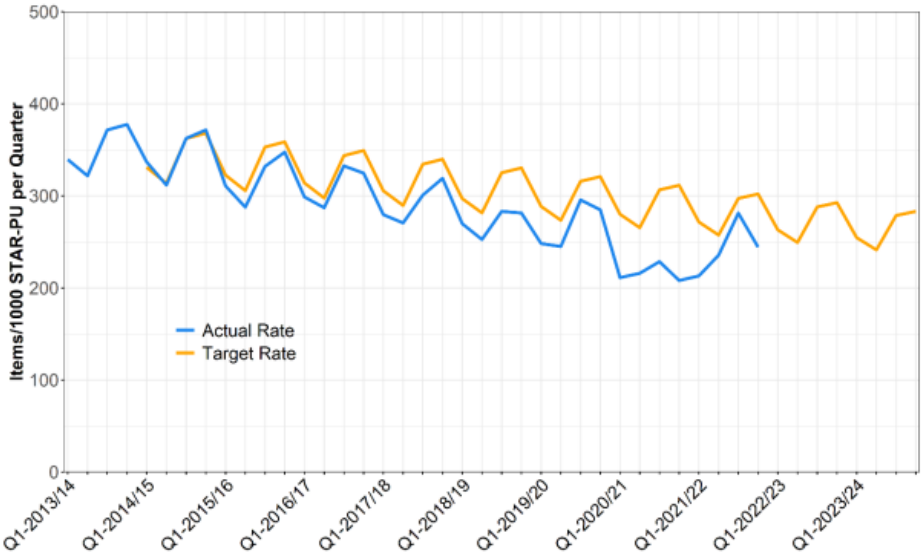
PHW has failed to provide any data for the whole year for secondary care, therefore we cannot report on our progress against the targets.

17.2 Primary care

Despite positive overall results in primary care prescribing, the iGAS issues prior to Christmas have shown a significant increase in antibiotic use, as a AMS team will continue to monitor this work and work on decreasing the rates to continue to meet our target and ensure patient safety. The overall picture is of decreases with an overall decrease to meet the improvement goal as seen above.

Primary care AMS staffing has been a significant issue this year as all three primary care antimicrobial pharmacists were either on secondment or promoted. This left vacancies in these roles for the majority of the year, therefore interventions and new work was limited.

The figure below shows antimicrobial trajectory by quarter and usage for BCUHB for the period ending March 2022.



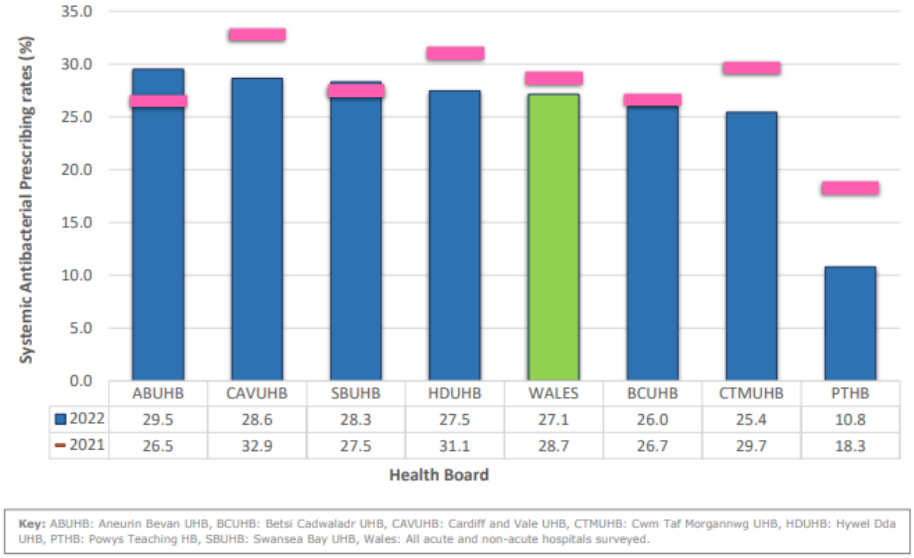
Information & data for Betsi Cadwaladr UHB to support WHC prescribing improvement goals 2021/22 for primary care period ending 31st march 2022, Public Health Wales.

17.3 Secondary Care

The lack of secondary care data has made work difficult and understanding whether interventions implemented have had an impact. The poor compliance with the Start Smart then Focus audit has also affected the HBs understanding of AMS impact. A review of the audit carried out on the Ysbyty Gwynedd site and the recommendations for changes are being implemented across the three acute sites to ensure quality data to support AMS activity.

The 2022 Point Prevalence Study showed good results in BCUHB, with the HB prescribing rates below the Welsh average at 30.7% and the systemic prescribing rates also below the Welsh average at 26.0%.

The figure below shows Systemic antibacterial prescribing rates for Health Boards 2021 and 2022 from 2022 Point Prevalence Study.



Antimicrobial Resistance & Prescribing Programme Point Prevalence Survey of Antimicrobial Prescribing in Hospitals in Wales 2022, Public Health Wales, Version 1 Issued: 18/04/2023.

17.4 Dental

BCUHB is the first in Wales to have implemented a dental Antimicrobial Stewardship (AMS) programme. The AMS and dental teams have produced an empirical antibiotic guideline for dentists to use, available on Microguide®. They are currently implementing a programme of audit with the dental services and HEIW to ensure a quality audit programme.

17.5 Antibiotic Resistance and Monitoring

Gram-negative bacteria resistance in particular *E.coli* resistance to the main group of antibiotics used to treat these infections continues to be an issue in BCUHB. Some areas in BCUHB have very high resistance rates compared to the rest of Wales. This is causing concern.

BCUHB has established a resistance working group to look at rates, review, and make recommendations on guidance changes. However there are issues with our PHW colleagues and their access to our data and dashboards; this is delaying this critical and crucial work.

The lack of certain antibiotic blood level monitoring being available in BCUHB is also a major issue given resistance rates and therefore, limits guideline change and safe use of certain antibiotics in BCUHB.

17.6 World Antibiotic Awareness (WAAW) week 18-24 November 2022

This year's WAAW took place in November with activities across the Health Board. In the acute sites there were stands with information run by the trainee pharmacists. In central, the MDT clinical conference was on the theme of AMR and AMS and introduced the IV to oral switch poster. Each of the sites also ran MDT IV to oral antibiotic switch ward rounds, identifying and intervening patients who could have their antibiotics changed from IV to oral. In primary care, the antibiotic checklist for community pharmacies used again to engage patients in discussions about their antibiotics. Resources were also distributed to GP practices on when to use antibiotics along with patient information.

17.7 AMR International Work

The Commonwealth Partnerships for Antimicrobial Stewardship 1.5 (CwPAMS) project was completed. The partnership was very successful in achieving al the aims of this short 9 month long project. We developed good working relationships with two hospitals in Malawi: Kamuzu Central Hospital in Lilongwe and Mzuzu Central Hospital and the Antimicrobial Stewardship committees.

- Completed a Global Point Prevalence Survey (Global-PPS) of antimicrobial usage in the hospitals, identifying areas where antimicrobial stewardship could be improved: for example, reduced usage or oral administration.
- Developed and supported implementation of a toolkit to guide these improvements, including tools for ongoing audit.
- Developed and delivered training on antimicrobial stewardship and resistance, infection prevention and control, and use of the toolkit. 120 staff across the two hospitals have been trained – some as trainers themselves – and the training is now being adopted as the AMS training tool in the hospitals.
- Completed a second Global-PPS, which is currently being analysed to evaluate impact.
- Engaged with national pharmacy groups and lead, including within the Ministry of Health in Malawi, to ensure the partnership's work aligns to national plans and is embedded as standard practice.

The partnership will be publishing the results of the first project. The partnership has been successful in securing a CwPAMS 2.0 grant of £96,000 to further this work over the next 2 years. The partnership also where highly commended in the Hub Cymru Africa partnership awards.

18.0 Health and Safety

18.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

There were no COVID-19 related RIDDOR reports were made to the Health and Safety Executive in 2022/23. From the 72hour reviews, there were either no workplace failure in precautions noted, or there was an identifiable home life positive contact or the affected person believed they caught it outside of work.

18.2 Mask Fit testing

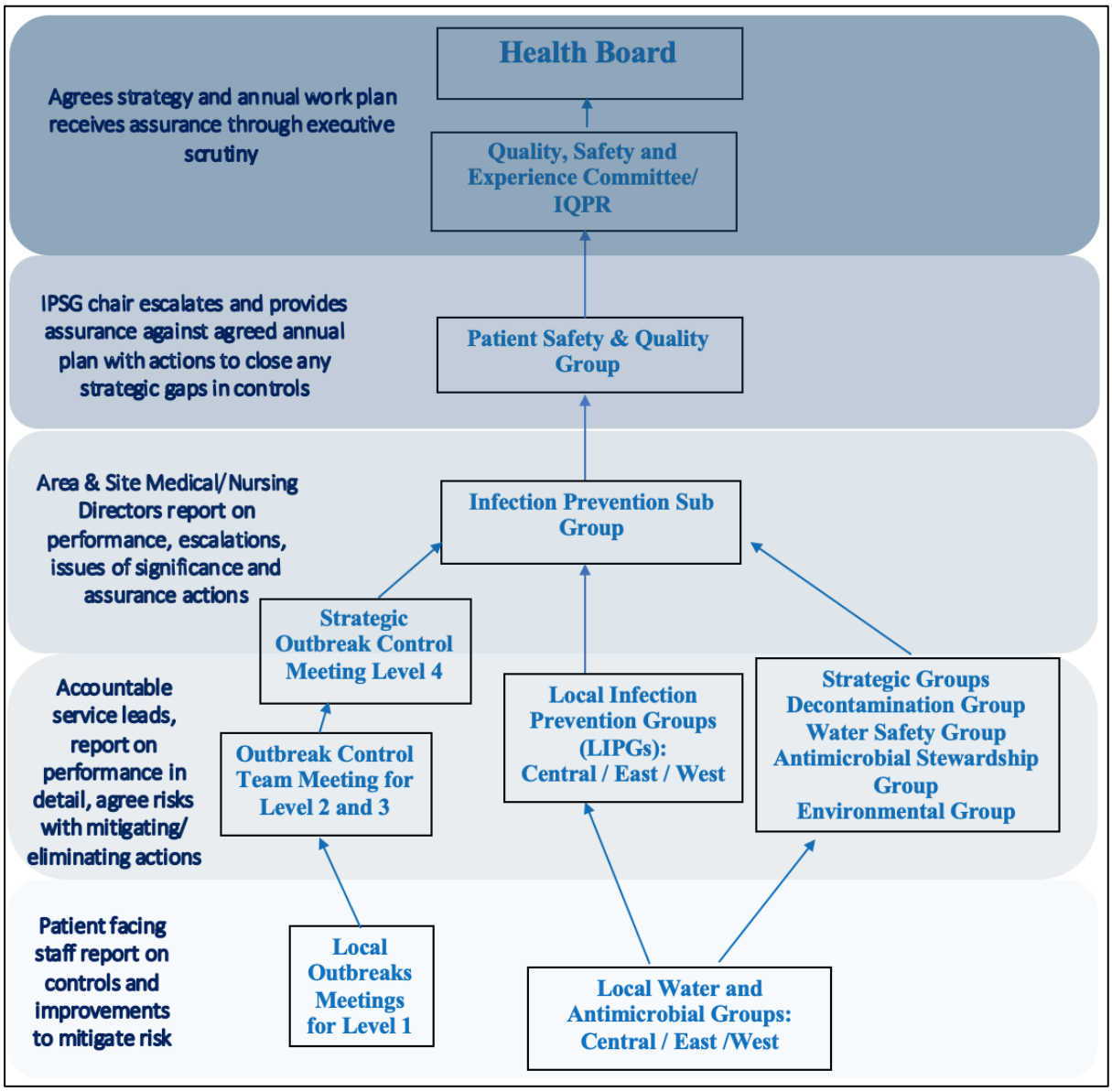
In 2022/23, 5394 FFP fit tests were undertaken on healthcare workers across BCUHB compared to the 6325 in 2021/22. From June 2022 to March 2023 (previous reporting was not audited) there were a total of 856 DNA's from across the three sites. A full local reporting database is still operational of all staff within their wards and departments who require fit testing. This is sent every 3-6 months to managers for updating any staff changes.

Once fit testing has been completed, the staff member is provided with a certificate giving full details of the mask type, model, size and expiry date where applicable. They are also provided with an ID card stating the manufacturer, model and size of the mask/respirator they were tested on, as well as the date of test. Audit checks are undertaken monthly in different areas. Staff can now update their own fit testing competency on ESR with approval by their manager.

BCUHB have 24 Porta Count Qualitative Testing machines and all fit testers have been trained by Fit2Fit Accredited Trainers. Training sessions are held monthly where the need is greatest.

19.0 Appendices

Appendix 1: An organogram of the accountability arrangements of the Infection Prevention Sub Group



Appendix 2: Key Infection Prevention and Control Risks scoring 15+

ID	Title	Date Opened	Current Score	Last Reviewed
4325	Potential that medical devices are not decontaminated effectively so patients may be harmed	21/02/2022	16	7/3/23 (monthly)
4241	Inability to deliver timely Infection Prevention & Control services due to limited capacity	10/12/2021	15	7/3/23 (monthly)

OUR VISION
Zero healthcare associated infections (HCAIs)

Infection Prevention Sub-Group – Plan on a Page 2023-24

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

OUR PRIORITIES FOR 2023-2024

Lower the burden of infection	Reduce IP risk from medical devices	Optimise antimicrobial use	Improve education & training in IP	Lower the environmental burden

A COLLABORATIVE APPROACH TO DELIVERING OUR PRIORITIES: ZERO AVOIDABLE HCAIs

Staff engagement & ownership across all staff groups. Standard precautions for all. Patient & outbreak reviews (PIRs). Audit & surveillance programmes. Vaccination campaigns. Policies & protocols. Data & epidemiology. Optimised use of siderooms. Local SMART action plans to reduce HCAIs. Effective outbreak control meetings.	Risk management. Datix for incidents. Improvement plans and workplans. Capital investment. Policies and protocols. Audit and surveillance. Education and training. Sharps management. Management of beds and mattresses. IPSG subgroups e.g. Decontamination	Engagement with all healthcare professionals. Prudent prescribing. Antibiotic resistance data. Audit and surveillance. Policies and protocols. Antimicrobial ward rounds. Education and training including primary care. Multi-disciplinary PIRs. Antimicrobial pharmacists.	IP in every job description. All Staff qualified in IP for their role. IP improvement initiatives. Sharing lessons learnt & good practice. IP Champions and MOOC Programmes. IP mandatory training. Patient/carer/visitor education. Policies and protocols. Up to date Betsinet with all IP info.	Credits for cleaning (C4C)/Micad audits. Cleaning checklists and protocols. Proactive/reactive HLD programmes. Ventilation maximised. Safe Water, incl water sampling & little-used sinks/outlets. Improvements to the estate. ATP testing. Risk management. IP Environmental audits. National Cleaning Standards. Food safety. Cleaning Responsibilities Framework.

DELIVERABLES / SUCCESS LOOKS LIKE

1. Approved local IP Improvement Plan to achieve Welsh Government Improvement Goals/trajectories, learning identified from PIRs and current IP Priorities - regular review, trends & progress to be demonstrated.
2. Audit programme including hand hygiene, PPE, Mattresses, Pillows, Commodes, Water flushing, CAUTI, MRSA and CPE screening, completion of Blood culture, catheter and cannula care bundles, Bristol stool chart, cleaning schedules etc.
3. Capital programme in place and being achieved to drive improvements on identified priorities.
4. Comprehensive risk register related to Infection Prevention and Decontamination with an appropriate/effective governance approval and review structure. Summary of Tier 1 risks and mitigations to be highlighted to IPSG.

In lower ¼ for 'surgical site infection' rates. >85% compliance with audits & audit scores. **PIRs**: 85% PIRs completed within 10 days. A multi-disciplinary team, including Drs present at all PIRs & HCAI Executive reviews where 2 are presented each month. Prompt investigation of all other key HCAIs e.g. CPE with summary report to IPSG. Audit programmes – highlight compliance, action being taken to improve and progress. Faecal transplant programme at each site. Outbreak closure slides completed for all outbreaks and submitted to IPSG. All wards complete daily sideroom reviews. Improved compliance with screening e.g. MRSA and CPE. Evidence that patients with MRSA are decolonised promptly & appropriately as per SOP. Improved vaccination rates.	Improved compliance with audits. CAUTI rates reduced. Gram negative blood stream infection rate reducing (E.coli target <67 per 100,000). Blood culture & vascular bundles completed. Evidence ANTT documented in all cases. Blood culture contamination rates <3%. Zero tolerance to MRSA bacteraemias. All patients with long-term catheter have a passport. MSSA bacteraemia rate reducing (target <20 cases per 100,000). Sharps injuries reduced. **Decontamination:** Capital investment / Continuous improvement programme for decontamination facilities. No decontamination incidents. Reduction in sharps incidents. Proactive management of Datix incidents.	Achieve Antimicrobial Workplan goals – quarterly reporting to IPSG. Reduce antibiotic resistance rates. Microguide is kept up to date. SStF audits completed. Implement mandatory ARK training and for compliance to be >85%. Improved compliance with audit programmes and improved scoring. Specimens sent as requested and results followed up and acted upon. Complete yearly Point Prevalence Study. Improve primary/secondary care information exchange. No vacant positions in Antimicrobial Pharmacy team. Well attended, regular ASGs. Promote/encourage nurse stewardship.	ESR training compliance rates >85%. IP Champion on every shift. Programme for Clinical supervisors to attend IP MOOC. Improved compliance with fit testing. Patients informed and aware of how they can contribute to IP/self-care. ANTT assessors in every ward/dept. Monitored programme of improvement initiatives based on infection rates/key themes from PIRs. Processes for sharing lessons learnt with audit data to show learning has been achieved and sustained. All IP and Decontamination related policies and protocols up to date. Junior doctors training sessions. Process to cascade information/new protocols etc to clinical staff.	Facilities cleaning audit scores and trends. Proactive and re-active HLD programme in place and achieved. Improved water and ventilation scores. Improved compliance with audits & tests. 5 star food ratings achieved across BCU. Patients with diarrhoea isolated within 2 hours. Respiratory patients isolated within 6 hours. Ward fridge audits completed daily. Full IP clinical/environmental audit scores >85%. ATP swab scores <50. Bristol Stool Chart completed at least daily for all patients with loose stools. Proactive Environmental cleanliness group. Improved waste segregation scores. Monthly mattress checks completed in full. De-clutter campaigns. Cleaning schedules completed in full.

Teitl adroddiad: ***Report title:***	Corporate Safeguarding Annual Report 2022-2023 Adroddiad Blynyddol Diogelu Corfforaethol 2022-2023
Adrodd i: ***Report to:***	Health Board Meeting Cyfarfod y Bwrdd Iechyd
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 22 August 2023
Crynodeb Gweithredol: ***Executive Summary:***	The Safeguarding and Public Protection Annual Report 2022-2023 provides assurance against performance and compliance in respect of statutory safeguarding legislation and best practice, regarding to Safeguarding Adults and Children and Young People who are at risk of harm, Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV), Mental Capacity and Deprivation Liberty Safeguards and the wider Public Protection and Harm agenda. The safeguarding agenda is underpinned by legislation, policy and procedure. The role of the Safeguarding and Public Protection Team is to provide expert guidance and statutory direction to ensure the Health Board executes its responsibilities and complies with safeguarding legislation, providing assurance that strategic measures are implemented. The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of monitoring and collating NHS performance, enabling benchmarking, organisational assurance, shared practice and a drive for improvements. Public Health Wales in consultation with all Health Boards in Wales have developed a new and updated tool for 2022-23 reporting. Scoring has been removed with an emphasis placed upon assurance, the implementation of actions, and current safeguarding activity. With the introduction of new legislation and an increase in training compliance the service has experienced a significant rise in the level of and case work, This is inclusive of case complexity based upon the adaptation of new legislation into practice, this has been experienced throughout the Health Board and by our partner agencies. This reflects the National picture and demonstrates the importance of safeguarding which includes the wider harms agenda such as VAWDASV, Modern Slavery and DoLS. The report highlights performance and activity data from the period of 01.04.2022 to 31.03.2023. This includes key achievements and assurance, and identifies areas where a targeted approach is required to ensure improvements to safeguard service users and their families.
Argymhellion: ***Recommendations:***	The Board is asked to note the Annual Report for the period of 2022-2023.
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery

Awdur yr Adroddiad: ***Report Author:***	Michelle Denwood, Director of Safeguarding and Public Protection			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☒ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	North Wales Safeguarding Adult Board North Wales Safeguarding Children Board			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Social Services and Wellbeing (Wales) Act 2014; Crime and Disorder Act (2014); The Human Rights Act 1998; Mental Capacity Act 2005; Mental Capacity (Amendment) Act (Wales) Act 2019; Children Act 1989 and 2004; and the Domestic Abuse Act (2021)			
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *N* This Report is provided for assurance relating to the Board, it is not in relation to a decision. Darperir yr Adroddiad hwn i sicrwydd yn ymwneud â'r Bwrdd, nid yw mewn perthynas â phenderfyniad.			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* This Report it is not in relation to a decision. Yr Adroddiad hwn nid yw'n ymwneud â phenderfyniad.			
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Not applicable			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*	Not applicable			

Financial implications as a result of implementing the recommendations	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Clear report, evidences continued intervention, organisational challenges and the increase in activity.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR21-14 CRR21-15
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps:*** Implementation of recommendations	
Rhestr o Atodiadau: ***List of Appendices:***	

BOARD OF DIRECTORS MEETING IN PUBLIC
Tuesday, 22 August 2023
Corporate Safeguarding Annual Report 2022-2023

1. Introduction

The Social Services and Wellbeing (Wales) Act 2014 (Part 7) is the legislation governing the Safeguarding and Public Protection Agenda. Specific legislation drives the key subject areas and the wider harm agenda relating to Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV), Human Trafficking and Modern Day Slavery, Child Sexual Exploitation. The Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) Code of Practice is fundamental in the overarching and targeted agenda.

The Annual Report 2022-2023 outlines the continued progress and the activities relating to Safeguarding Adults, Safeguarding Children and Young People and the wider safeguarding agenda which is driven by legislation, and best practice guidance.

The impact of the COVID-19 pandemic saw an increase in reporting across all areas evidencing an upward trend. BCUHB reported a 400% increase in the reported activities relating to Domestic Abuse (DA) incidents in 2021-22 and this has been replicated during 2022-23. The national position is similar with increased reporting recorded. However, the numbers alone do not reflect the demand on our services or front line services due to the complexity, severity and the recognised risk to life relating to each incident.

As a result of the unprecedented increase in all aspects of the safeguarding agenda the team submitted a Business Case to support the strengthening of the service. This is in-line with HASCAS recommendation 6 which states although a significant resource was committed to developing sound foundations for the safeguarding structure, as an organisation such as BUCHB a very significant amount of work still needs to be done. This requires continued Board scrutiny and oversight but must be reported to Welsh Government if for any reason progress in the future falters or slows down. The Business Case is central to the development of the team but has not been approved and no formal update has been received to date.

In addition, the Public Protection agenda has seen a meteoric rise in activity legislated by the Crime and Disorder Act 2015. Public Protection activity relating to Modern Day Slavery, Human Trafficking, County Lines, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), and Terrorism has required an increase in operational and multi-agency activities over the last 12 months. DoLS activity has also increased for the 6th year running. Improved training and education processes, with the production and dissemination of materials (funded by non-recurring Welsh Government monies) across the Health Board and partner agencies to include Local Authorities and Public Health Wales have strengthened the MCA and DoLS agenda.

To provide assurance and compliance the annual report provides evidence of strategic activity and safe care and practice. Safeguarding is everyone's business and the Health Board has a legal duty to fully engage, comply and report the organisation's position to the Welsh Government.

2. Key Performance Activities

The Safeguarding and Public Protection Team have continued to embed National and Regional Strategic Plans into practice to identify, reduce and safeguard service users, their families and BCUHB employees, with a particular emphasis upon high risk and targeted services across the organisation. Performance is benchmarked against local, regional and national safeguarding and public protection performance indicators. This evidence supports targeted intervention to improve standards and increased safety.

2.1 Quality and Governance Framework

The National NHS Safeguarding Maturity Matrix is a quality framework which supports our evidence against our compliance with legislation, best practice and innovative preventative work and enables BCUHB to benchmark against other NHS organisations in Wales. The Safeguarding Maturity Matrix self-assessment of Safeguarding arrangements was undertaken by all NHS organisations in Wales. A Governance and Rights-Based Approach, Safe Care, Adverse Childhood Experiences (ACE) Informed, Learning Culture, and Multi Agency Partnership Working are the five (5) standards evaluated. The highest possible score for each criterion is five (5), for a total score of twenty-five (25). In 2022-23 reporting on the SMM has been amended and updated. Scoring has been removed with a Red, Amber, Green, Grey (RAGG) rating system in place to better monitor actions.

2.2 Safeguarding Maturity Matrix Score

BCUHB achieved a score of 25:25 (2021-22) as shown in Table 1 below. The SMM for 2022-23 is due to be submitted in August 2023 to PHW. This will be reported within the Q1 and Q2 2023-24 Report.

Table 1

Dates	Score	Trend
2019 - 2020	23	↑
2020 - 2021	25	↔
2021 - 2022	25	↔

2.3 Reporting Data

Safeguarding continue to record a year on year increase in activity and complexity relating to the identification and reporting of abuse and harm. This is in line with the National NHS picture and for our partner agencies. The key areas evidenced are;

2.3.1 Adult at Risk Reporting Data

In 2022-2023, the Corporate Safeguarding Team received 1716 Adult at Risk Reports from across BCUHB services. This is a 22% increase against the 2021-2022 position and double the increase seen in 2021-22.

Table 2

Year	Reports	
2021-2022	1407	
2022-2023	1716	

Table 3

Year	West	Central	East	Out of Area	Total
2021-2022	402	435	517	53	1407
2021-2022	614	512	559	32	1716
% Change	↑ 52.7%	↑ 17.7%	↑ 7.9%	↓ 39.6%	↑ 22%

The increase in safeguarding support, responsive supervision and training for staff is believed to have contributed to the improved identification of risk and harm. The additional of safeguarding materials such as pens, booklets, and key cards has also seen a positive increase in Adult at Risk reporting.

The continued implementation of the Wales Safeguarding Procedures (2019), and the introduction of the new statutory role of the Designated Safeguarding Person (DSP) and Enquiries Lead (EL), and the implementation of further Safeguarding Ambassadors have contribute to a greater informed workforce. It should also be noted that although there is an increase in reporting this does not suggest and increase in neglect or abuse. The purpose of the Adult at Risk process is to protect individuals from the risk of harm through early reporting and the identification of the potential risk to the individual. Increase reporting is seen as a proactive and protective measure.

2.3.2 Child at Risk Reporting Data

During 2021-2022 the Corporate Safeguarding Team received 4,130 Child at Risk Reports. This is a significant increase of 13.4% when compared to 2021-2022.

Table 4

Year	Reports	
2021-2022	3642	
2022-2023	4130	

Table 5

Year	West	Central	East	Out of Area	Total
2021-2022	596	1059	1928	59	3642
2022-2023	745	1334	1967	84	4130
% Change	↑ 25%	↑ 26%	↑ 2%	↑ 42%	↑ 13.4%

It is difficult to decipher with any degree of certainty the reason as to why Child at Risk reporting rates have increased, however, themes captured within the reports include; Domestic Abuse and particularly the impact of COVID19 upon children and young people's mental health.

Symptoms of depression and Post Traumatic Stress Disorder (PTSD) have significantly increased in children and young people between the ages of 7.5 and 12 years old, when compared to pre Covid-19 rates (Bignardi et al 2020, Wright et al 2021).

Young Minds, a leading charity championing children and young people's mental health have undertaken four (4) surveys relating to the impact of Covid-19. The latest survey was undertaken during the January 2021 national lockdown. Their report concludes that the pandemic has had a devastating impact on children leading to increased anxiety and self-harming behaviours, 67% of those surveyed believed that Covid-19 would have long-term negative effects on their mental health (Young Minds 2021).

It is also important to acknowledge the national 'cost of living crisis' which has contributed adversely towards the lived experience of children, young people and their families. The Welsh Government stated over a third of children and young people in Wales are living in poverty, the highest proportion of any UK nation (WG 2021-2022). A Barnardo's Cymru report (May 2023) state '*living in poverty can mean a child is living in a cold home, going hungry, or without everyday essentials'. Wales now has the worst child poverty rate of all the UK nations at 31% (Welsh NHS Confederation 2022).*

2.4 Joint Inspection Child Protection Arrangements

In February 2023, a Joint Inspection Review of Child Protection Arrangements [JICPA] took place within BCUHB. This was the first review of its kind in North Wales. The report has recently been published, please see the links below;

https://www.careinspectorate.wales/230518-we-have-published-our-joint-review-child-protection-arrangements-jicpa-denbighshire

https://www.careinspectorate.wales/joint-inspectorate-review-child-protection-arrangements-jicpa-denbighshire-2023

There will now be an Assurance and Implementation Plan developed to support recommendations and learning which will be an agenda item at the Executive Delivery Group Quality, which will be monitored through our Safeguarding, Governance and Performance Group.

2.5 BCUHB require a Child Sexual Abuse (CSA) Action Plan in response to the WG Second Iteration 3 year plan 2023-2026

The Action Plan is a legal requirement and requires targeted intervention and management. BCUHB CSA Action Plan will be aligned to the WG Action Plan based on the Independent Inquiry into Child Sexual Abuse (IICSA 2022) recommendations.

A Task & Finish Group has been established and are working on the first draft of the second iteration Action Plan.

Corporate Safeguarding continue to attend and engage with the Welsh Children's Commissioners CSA Roundtable Forum to ensure full engagement with the CSA.

2.6 Domestic Homicide Reviews (DHR), Adult Practice Reviews (APR), and Child Practice Reviews (CPR)

The criteria for the multiagency reviews are laid down in the Safeguarding Boards Functions and Procedures (Wales) Regulations 2015.

The purpose is to promote a positive culture of multiagency learning, for which Safeguarding Boards and Partner agencies hold statutory responsibility.

Our current position evidencing our participation and engagement regarding Adult Practice Reviews (APR's), Child Practice Reviews (CPR's), Domestic Homicide Reviews (DHR's) and Multi Agency Professional Forums (MAPF's) are shown in Table 6 below;

Table 6

Review Type	Current up to 31.3.2023			New			Total
	East	West	Central	East	West	Central	
Adult Practice Reviews	1	0	0	0	1	1	3
Child Practice Reviews	3	0	4	0	0	1	8
Domestic Homicide Reviews	3	5	1	0	0	0	9
Multi Agency Professional Forums	0	0	2	0	0	1	3

During this period, a national review of the governance and reporting of future reviews is taking place. The objective is to have National data, improved learning and the identification of themes and trends using a National data tool to inform national and local learning and ultimately improve safeguards. The new process will be known as the Single Unified Assessment Review (see SUSR below).

This reporting period has seen an increase in the number of DHR's with 4 victims completing suicide. This has raised challenges around the inconsistencies in the DHR process across the region, consent issues and the sharing of information. In response to this a DHR Standard Operating Procedure is being developed to strengthen the governance process.

Other key themes for North Wales are identified as self-neglect and the lack of an identified Care Coordinator for patients. Communication internally and with partner agencies and documentation are also a consistent findings.

All recommendations and learning relating to the Health Board are implemented and monitored in line with the Safeguarding Governance and Reporting Framework, with oversight from the North Wales Safeguarding Boards, Welsh Government and the Home Office.

2.7 Single Unified Safeguarding Review (SUSR)

The purpose of the SUSR was to create a single review process where a multi-agency approach is required, incorporating the following review processes Adult Practice Review; Child Practice Review; Domestic Homicide Review; Mental health Homicide Review; Offensive Weapon Homicide Review. The final report is then used to inform professional practice via the Wales Safeguarding Repository.

Following the Welsh Government (WG) consultation process on the final proposal for SUSR all responses will be analysed, and relevant changes will be made to the statutory guidance as a result. The SUSR Co-ordination Hub will be developing a dashboard which will hold live documents such as the Approved Chairs and Reviewers List, the Action Plan and recommendation monitor and the list of all ongoing reviews in Wales.

The Wales Safeguarding Repository (WSR) team presented a demonstration of the repository at the launch of the Security, Crime and Intelligence Innovation Institute in Cardiff University. The demonstration was attended by stakeholders from a wide range of agencies and organisations.

BCUHB have been fully engaged in the development of the SUSR process and the consultation focus groups and sessions that have been delivered to many different groups and boards across Wales. The initial timeframe dictates that the SUSR process will go live sometime in June 2023 (now delayed, awaiting WG confirmation). Training will run in tandem with the launch of the process. It is expected that agencies will provide skilled staff to undertake the SUSR, however it has been acknowledged that this will result in an increase in workload and costs. WG have taken this into account and we await their response.

The SUSR will process will be managed by Safeguarding Boards. Previously Domestic Homicide Reviews were managed by Community Safety Partnerships who held accountability for the governance, commissioning and completion, to include the actions and recommendations. This change will again have an impact on resources and finances.

2.8 Mental Capacity 'Amendment' Act 2019 and the Liberty Protection Safeguards

The Deputy Minister for Mental Health and Wellbeing issued a Written Statement in April 2023 providing an update on the implementation of the LPS. This followed recent confirmation from the UK Government that they are not progressing the implementation of the Mental Capacity (Amendment) Act 2019 and the LPS within this Parliament.

A significant amount of work has been taken forward to date to support planning and preparedness for the implementation of the Liberty Protection Safeguards [LPS]. WG are also very conscious of the need to consider the existing Deprivation of Liberty Safeguards [DoLS] with the view to strengthening current arrangements, and improving ongoing monitoring and reporting, and support for the workforce. WG will continue to provide funding at a comparable level to 2022-2023 levels and as a result the Health Board are to consider next steps, which will include membership of the LPS National Steering Group and subgroups.

Mental Capacity Act training compliance has seen an improvement over the last 12 months. Table 7 below demonstrates a clear improvement in training compliance across the organisation with further work in place during 2023-24 to promote awareness.

Table 7

	Mar22	Mar23	Trajectory
MCA – Level 1	76.5%	80.9%	↑
MCA – Level 2	77.0%	81.8%	↑

2.8.1 Deprivation of Liberty Safeguards (DoLS)

NHS organisations have reported a significant increase in DoLS applications, legal challenges and Court of Protection activity. The increase does not evidence the required resource and commitment to fulfill this legal requirement, which is fundamental to patient safety and experience.

Welsh Government have recognised this increase in activity and they have acknowledged the postponement of the revised guidance has been challenging for all organisations.

To support the recognised challenges relating to Deprivation of Liberty Safeguards and the required organisational preparation for the new legislation, interim and non-recurring monies have been made available through funding streams.

We have continued to meet and fully engage with the Welsh Government funding process and monies are available to support interim arrangements.

BCUHB have been allocated non-recurring funding for 2023-24 to support Mental Capacity Training, Education and Awareness; provide geographical leadership on the implementation of a stronger IMCA service; reduce and manage the DoLS Backlog; review the current DoLS system; support a more robust process for the assessment of 16 and 17 years olds; develop a process for escalation to the Court of Protection for Community/CHC based DoLS; and engage in local, regional and national workgroups to support MCA/DoLS activity.

The injection of additional funding is currently reporting and evidencing an improved training compliance with Mental Capacity Act training and Deprivation of Liberty Safeguards activity. This position will be reported to the Mental Health Capacity and Compliance Committee (MHCCC) in line with the reporting cycle for 2023-2024.

2.9 ISO Standard for Sexual Assault Referral Centres / Forensic Science Regulator Guidance

The Forensic Science Regulator has published supporting Guidance and Codes of Practice and Conduct to support the attainment of International Standards for Anticontamination of Sexual Assault Referral Centres and Assessment, Collection and Recording of Forensic Science related evidence.

Completion of the ISO Standards is required by October 2023. Failure to achieve the ISO accreditation will mean that North Wales will no longer have a forensic service. Victim of sexual abuse will have to travel to an accredited SARC in England or South Wales in order to have samples taken that can be used in a criminal investigation. This risk of failure to deliver the accreditation of services is currently on the risk register ID 4121.

The Safeguarding team are leading on this activity with support from the Central IHC.

2.10 Identification and Referral to Improve Safety (IRIS)

The IRIS Project supports the training of GPs in domestic abuse encouraging referrals to specialist services. This activity supports some of the recommendations from a recent Domestic Homicide Reviews, relating to Primary Care, in respect to Routine Enquiry Domestic Abuse.

A business case was developed in December 2022,to request further funding by BCUHB of the IRiS Project, as the funding from the Office of the Police and Crime Commissioner was due to end in March 2023. Corporate Safeguarding agreed to fund Q1&2 2023-2024 with negotiations to be held with Primary Care for continuous funding. These negotiations have proved to be unsuccessful resulting in the project ceasing in September 2023.

2.11 New legislation

2.11.1 Serious Violence Duty (2023)

In December 2022, the Home Office published the Serious Violence Duty (2023). Preventing and reducing serious violence Statutory Guidance for responsible authorities is a priority across England and Wales 2022.

The Duty requires BCUHB, as a specified authority, to collaborate and plan to prevent and reduce serious violence. The Corporate Safeguarding and Public Protection Team and Public Health Wales (PHW) are fully engaged in the Task and Finish Group and other relevant work-streams. During 2023-24 the team will ensure that BCUHB are fully compliant with the legislation and all accompanying documentation.

2.11.2 Online Safety Bill (2023)

The Online Safety Bill seeks to establish a regulatory framework for certain online service providers. It will also create several new offences of false communications, threatening communications, sending or showing flashing images electronically, ('epilepsy trolling') and sending photographs or films of genitals ('Cyberflashing'). The government has said it will bring forward several amendments to the Bill in the House of Lords including new offences relating to intimate images and promoting self-harm, criminal sanctions for senior managers of non-compliant providers, and promotion of small boat crossings.

The Bill was passed in January 2023 and is currently undergoing detailed scrutiny in the House of Lords, with a wide range of issues being debated. The Bill is expected to receive Royal Assent during the summer of 2023. There is a planned strategic approach to ensure the organisation are fully aware of the Bill which includes n implementation and assurance programme.

It is likely that we will observe an increase in safeguarding activity as a result of this Bill and this is recognised by all NHS organisations.

2.12 Training and Development

Mandatory, targeted intervention and bespoke training packages are in place to increase awareness to support the prevention and identification of abuse and harm.

There is a continuing trend upwards of the levels of compliance across the organisation in relation to safeguarding training. There has been a significant emphasis from the team to promote engagement with training across all IHC's and services. We continue to monitor compliance levels via area and target intervention to support areas to maintain compliance trends with the goal of 85% compliance.

Training data and the analysis of compliance is reported and escalated by the Safeguarding Reporting Framework and areas target to support improvement and compliance.

We continue to have areas and departments in which we are targeting to support and improve the training compliance and the application of learning.

Table 8 BCUHB Safeguarding Training Compliance

Safeguarding Module	Mar22	Mar23	Trajectory
Safeguarding Adults – Level 1	78.8%	82.3%	↑
Safeguarding Adults – Level 2	75.7%	80.9%	↑
Safeguarding Children – Level 1	77.4%	79.8%	↑
Safeguarding Children – Level 2	75.7%	80.9%	↑
VAWDASV	65.5%	70.2%	↑

We fully engage and respond to new legislation, learning from reviews, investigations and both National and Regional enquiries. To ensure quality and enhanced safeguards are in place we always benchmark against our current practice and findings are implemented and audited to provide assurance.

2.13 Evidence of improved safeguards

Patient B is a 19-year-old service user who was diagnosed with a moderate to severe Learning Disability. Patient B was an inpatient on a General Hospital Ward, however to meet their clinical care requirements they were transferred to a Mental Health Hospital for a further period of clinical assessment. Due to the immediate assessment of the person's Mental Capacity, the patient's care and treatment was to be provided under the DoLS Legal Framework.

The General Hospital Ward (Managing Authority) applied for an Urgent DoLS Application on the day of admission (the earliest opportunity). The Urgent Application covered an initial period of seven days, with the option to extend the authorisation by the Supervisory Body (BCUHB) to fourteen days. This ensured that Patient B was supported with the immediate and necessary safeguards and legal framework. It also provided Patient B with a route of appeal their Deprivation of Liberty to the Court of Protection in accordance with *AJ v A Local Authority* [2015] EWCOP.

Utilising Welsh Government monies a Best Interest Assessor (BIA) and a Section 12(2) Doctor were appointed and completed the necessary assessments out of normal working hours to ensure the Standard DoLS authorisation was completed within the required fourteen days.

2.14 Case Learning

Patient B was lawfully deprived of their liberty. This provided Patient B with a legal framework for the deprivation and a route of appeal to the Court of Protection if required. A capacity assessment, specific to DoLS, was completed and recorded in the patient notes on the day of admission. As part of the DoLS assessment, the BIA reviewed the level of deprivation on the ward to ensure any restrictions and/or restraints were the least restrictive.

By ensuring the DoLS application was completed timely and accurately, it reflected positively upon BCUHB as the Supervisory Body and the Ward as the Managing Authority. More importantly, the patient's needs were met and they were legally protected by the actions taken.

Although there was no legal challenge, or further directions by the Court of Protection, by acting immediately and in-line with legislation this reduced any legal costs and any distress experienced by the patient or the family.

2.14.1 Assessment and Analysis

- Improved awareness due to an increase in training compliance.
- Improved recognition by front line staff of the Mental Capacity Act (MCA).
- The delay in Deprivation of Liberty Safeguards authorisation is a national issue.

2.14.2 Actions Taken

- A targeted approach has been implemented, supported by enhanced administration funded by non-recurring Welsh Government (WG) monies. This includes daily telephone calls to each ward where a Deprivation of Liberty Safeguards application was in place, to challenge the position and support any change.
- Amendment to working practice and the delivery of services, from five (5) days to seven (7) days a week was implemented for a period of 6 months funded by non-recurring WG monies.
- Bespoke training events and additional Mental Capacity Act Training packages are being delivered.
- Welsh Government recognise the challenges for NHS organisations, which has resulted in the availability of time limited funding.
- We have reported a significantly improved position with a reduced 'backlog' of Deprivation of Liberty Safeguards applications. From a reported position of one hundred fourteen (114) applications, to a reported position of thirty-six (36) applications by March 31st 2023.
- WG monies has funded MCA educational materials such as pens, booklets, and key cards. These include easy read guides for patients and their families.

2.15 Once for Wales Concerns Management System (OfWCMS)

The OfWCMS will change in the way we report Adults and Children at Risk and will also change the way we submit DoLS applications (and potentially LPS pending UK Government changes to legislation). In addition, a comprehensive training programme will be needed to ensure that all staff are fully aware of the system and how to report concerns.

The Safeguarding and Public Protection Team have engaged in Local and National meetings to provided comments that were shared with Public Health Wales in relation to the Adult/Child at Risk reporting framework as currently the system would not meet statutory or regional requirements under the Wales Safeguarding Procedures.

Escalation of the proposed new system have bas been made to the North Wales Safeguarding with Welsh Government and PHW having met with key stakeholders across North Wales, to include all 6 LA's, with the view to the LA's adopting the OfWCMS system into practice or to ensure that IT Systems are able to link up and send/receive necessary information.

There is continued engagement with PHW to support ongoing consultation in relation to the potential implementation and impact of the new system. Communications and engagement with partner agencies to ensure that they are fully aware of any changes is ongoing and a review of all training packages is pending to ensure compliance.

2.16 Conclusion

The detailed report evidences the substantial and progressive activities taken to provide assurance of compliance with legislation and the wider safeguarding strategic agenda.

The safeguarding strategy ensures a person centered, rights based approach with targeted intervention and prevention, which is lawful and consistent and will result in increased patient safety and experience, and a reduction in harm and financial and/or reputational damage. There is clear and continuous evidence of learning and improvement, with targeted activities to improve our safeguards.

The strategic priorities for 2022-2023 demonstrate our dedication to improvement on a continuous basis to safeguard our service users and families, employees, and the Health Board.

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. A Safeguarding and Public Protection Business Case has been submitted to the Executive Board for consideration during 2022-23.

4. Risk Management

4.1 CRR21-14 - **Risk: -** There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients.

The number and complexity of cases engaged in the Court of Protection arena remains on the increase. Legal challenge has resulted in intensive Court of Protection activity and as a result, external legal services are commissioned in some cases, to support the Court process.

4.2 CRR21-15 – **Risk: -** There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Wellbeing (Wales) Act 2014.

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 and 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.

5. Equality and Diversity Implications

All Policies, Procedures, documentation, and safeguarding activity that impacts upon patients, staff or the organisation are in line with a supporting Equality Impact Assessment (EqIA). Consultation and engagement takes place with both internal and where appropriate, external services.

Teitl adroddiad: ***Report title:***	East IHC Quality and Safety progress update			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 22 August 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Health Board with information and analysis on the progress of the East IHC in improving quality,patient safety and experience			
Argymhellion: ***Recommendations:***	The Committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Michelle Greene East IHC Director			
Awdur yr Adroddiad: ***Report Author:***	Andrea Hughes East IHC Director of Nursing			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
There is confidence in the data provided in the report, however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.			
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	N/A			

Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:***	

INTRODUCTION

Quality in healthcare means safe, timely, effective, efficient, equitable and person centred health care which is embedded within a culture of continuous learning and improvement. (Health and social care Wales Act 2023)

This report aims to provide assurance to the Quality, Safety and Experience Committee with information on the progress of East IHC in improving quality, patient safety and experience over the last 12 months since the inception of the IHC's..

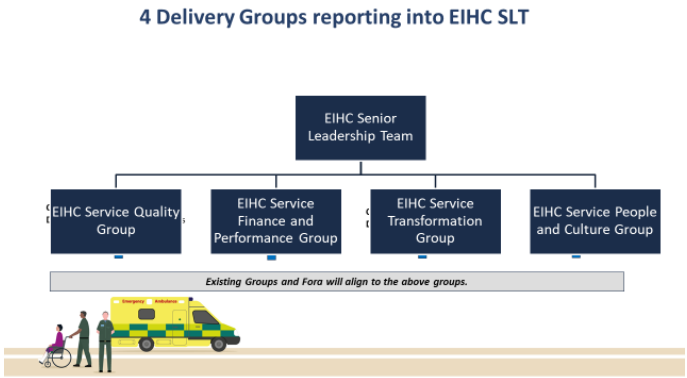
BACKGROUND

Following the 2021/2022 people and organisational development programme Stronger Together, the new operating model outlined how BCUHB organised itself to deliver healthcare across North Wales. As a result of the operating model 3 integrated Health Communities were formed on the 1st August 2022 from the previous 3 Area Divisions and 1 secondary care division, with 3 District General Hospitals.

East IHC directorates include Wrexham Maleor Hosptial , Healthcare at HMP Berwyn, Childrens services, Community services (including end of life and palliative care service across N Wales), Primary Care (including out of hours across N wales)

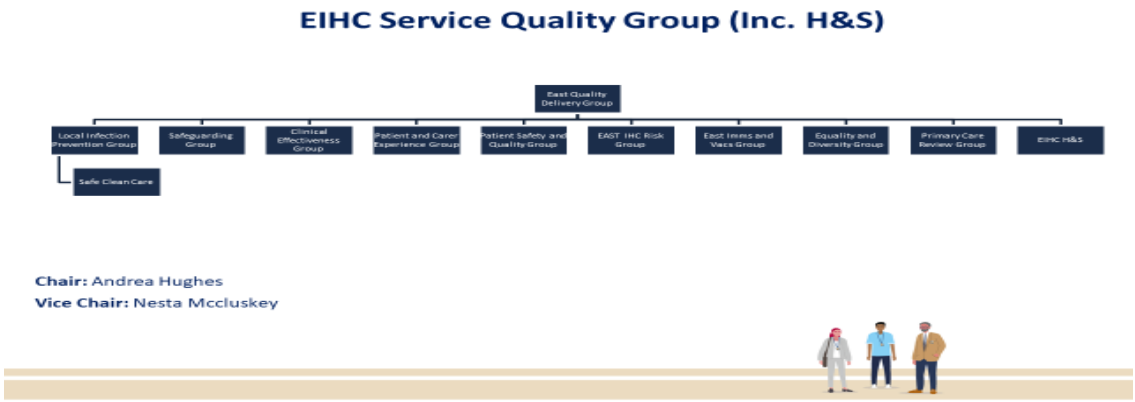
DEVELOPING THE ARCHITECTURE

Bringing together the pre-existing governance structures into one clearly defined reporting framework has been a major achievement, some key roles were not recruited to until February of 2023, however the EIHC now has the framework below fully operational.



Underpinning the EIHC Service quality group are sub groups as outlined below. The East already had joint LIPIG, Safeguarding and Imms and Vacs meetings so had joint working (across area and secondary care) foundation principles in place. The Structure shown provides the assurance process by which the QSG is able to report into the Executive Delivery Group for Quality.

Below the sub groups identified each directorate has as integrated governance structure in which patient safety, experience and quality is scrutinised to provide assurance to the QSG and the SLT



The SLT has also instigated 360 Service reviews with the SLT. Whilst the details of these are in development they include quality & assurance, for services to present all critical issues and issues for escalation for example GIRFTT Action Plans/Safe Care Collaborative/6 Goals

Objective for 2023/24 is to develop an IHC Assurance Framework which brings the principles of BAF into the IHC and a reporting structure which aligns to the IHC risks, and provides a recorded level of assurance from services based on the 4 levels of assurance (no assurance, limited assurance, reasonable assurance and substantial assurance)

A PERFECT MONTH

The waiting times for patients across all specialities is of significant concern. It is widely recognised that any delay to patient care brings with it, the risk of harm. Continued pressures from unscheduled and emergency care continue to impact on surgical inpatient bed capacity, in particular for our patients requiring Orthopaedic intervention. As a solution to support the Orthopaedic Recovery Plan – the Senior IHC Leaders requested the Surgical Directorate operate 'A Perfect Month'. This programme of work ran from ~ w/c Monday 19th June 2023 – for a period of 4 weeks.

- Current status PTL: 5141 patents waiting
- Stage 1- 155 weeks, stage 2 – 4 waiting up to 229 weeks

As part of the perfect month a new minor procedure room for hand surgery was opened in the Maelor Hospital, this enables a higher volume of patients who spend much less time in the hospital, free up theatre time and significantly reduce waiting times and improve the patient experience.
Patient experience during the perfect month was monitored though feedback and outcomes from this will provide additional information to inform future services.

One of the other areas of performance monitored was the staff experience, overall morale is reported to be much improved and job satisfaction and a reduction in staff sickness.

The 1. table below identifies the improvements made in theatre utilisation during each week of the perfect month against baseline data.

KPI's & Metrics – Perfect Month End Point Theatre Data

Week	Number of Inpatient Procedures	Number of Daycase Procedures	Number of Minor Op Procedures	Average Bed Occupancy U5 – 21 Inpt bed base (%) exc. Daycase beds	Average Length of Stay (LOS) Days
1	17	34	0	25%	2.2
2	26	11	2	40%	2.6
3	23	9	0	61% -reduced to 17 beds. 4 bedded bay escalated into by site	2.7
4	17	11	0	48%	2.6

- Average stage 4 activity is **88** procedures a month. During the Perfect Month **147** procedures were undertaken
- Low bed occupancy is a result of supported sex segregation

Baseline Data January – March 2023

Month	Number of Inpatient Procedures	Number of Daycase Procedures	Number of Minor Op Procedures	Average Bed Occupancy Samaritan – 13 bed base (%)*	Average Length of Stay (LOS) Days
January	12 -activity lost due to site pressures until 25.01.23*	68	0	50%	2
February	64	56	0	54%	3.3
March	59	56	0	61%	3.6

*Due to the inpatient bed occupancy being at 13, lists had to be reduced to accommodate all of the consultants to have equal operating capacity. The average LOS was between 3-5 days per Primary arthroplasty and 5-7 days per revision

Table 2 . is a summary of the performance against Key performance indicators

Summary KPI's & Metrics – Perfect Month End Point Theatre Data

Number of Theatre/Minor Op Sessions Planned **70**	Number of Theatre/Minor Op Sessions Delivered **70**	Number of Patients Planned **155**	Number of Patients Delivered **147**	Number of Standby Patients Planned **20**
Number of Short Notice Cancellations – within 24hrs of TCI **8**	Number of Short Notice Cancellations Backfilled **2**	Number of DNA's **1**	Overall % short notice cancellations (target ≤ 5%) **7%**	Average In Session Utilisation (target 85%) **95%**
% Late Starts (target ≤10%) **28.3%**	% Early Finishes (target ≤10%) **9.6%**	Average Number of Patients Per Session (target 2) **2.5**	Average Length of Stay (target ≤2.5 days) **2.5**	Daycase patients from other specialties operated on as a result of Orthopaedics not using Pasteur Ward **25**

- 2 short notice cancellations were not backfilled during the 1st 2 weeks due to the cancellations occurring too late in the day. An emergency patient was operated on and a Bilateral Joint Replacement procedure carried out which had only been listed for one side.
- 2 patients were cancelled on the day in week 3 due to infection risks with open wounds – not backfilled
- 2 patients cancelled on the day in week 4 due to no HDU bed available & patient not fit to proceed – Fast AF – not backfilled

Trauma Activity:
- Week 1 – 24 cases
- Week 2 – 26 cases
- Week 3 – 20 cases
- Week 4 – 20 cases

Key:
- Improvement to baseline
- Improvement to baseline , below target
- No improvement to baseline, below target

Objectives 2023/24
Continue to mainstream and embed the benefits and lessons learned in delivering the perfect month within other specialities and across the IHC's
Develop a plan to sustain the improvements and meet the challenges of having ring-fenced elective beds available within a pressurised system
Establish the financial impact

PRIMARY CARE MANAGED PRACTICES

East IHC has a high proportion of managed practices service almost 1/3 of our population. These practices represented a high percentage of complaints from patients, councillors, MPs and MS' predominantly about access. Additionally other care issues such as; the backlog from covid continues to cause issues with chronic disease management .Heavy reliance on agency staffing. The SLT recognised the need for an improvement programme which was launched in November 2022 focusing on three key projects

1. Access
2. Communication
3. Recruitment and retention

Achievements
Access – new websites for all practices. Improved access to telephony data. Review of clinical hours and staffing modelling, scoping of the "hub" reviewing how services can be shared and maximising the economies of scale.

Communication and engagement – Primary care staff newsletter launched, staff survey at beginning of programme will be repeated in Nov 2023 - building relationships with the research facility , engagement programme underway with local MP's , MS' and Councillors

Recruitment and Retention – successfully recruited 13 salaried GP's - 3 new ANPs , nursing and administrative teams more robust and cross working.

Outcomes
A HIW instpection at Hillcrest medical Centre reported

- *We found that Hillcrest Medical Centre was aiming to provide a high quality experience to their patient population'*
- *'We observed staff greeting patients in a polite and friendly manner both in person and on the telephone.'*
- *'We found there were systems and processes in place to ensure patients were being treated with dignity and professionalism.'*
- *'We found a staff team who were very patient centred and committed to delivering a high quality service to their patients.'*

A noticeable reduction in the number of complaints and concerns and a reduction in overdue responses.

Objectives 2023/24
Continue to focus on the 3 Key projects within the programme initiatives include:

- Focus on Chronic Disease management continuing improvement to include Weekend surgeries,– use to full potential Implantation of a rota system for practices
- Setting up Patient Participation Groups, development of patient newsletter
- Increase salaried GP cohort, develop closer links with the Academy Increase ANP, AHP and other senior clinicians with skillset to see patients with on the day ailments
- Review and enhance the Primary Care Dashboard

OTHER NOTIBLE ACHIEVEMENTS

Stroke Rehab
The Stroke rehab beds in Deeside community hospital are now established and being led by a consultant therapist Nia Williams. In parallel the newly formed Early Supported Discharge (ESD) team are actively taking patients home earlier from both the acute stroke ward and the rehab wards.
Both teams are multidisciplinary, clinically led services which although in their infancy are gaining positive feedback from service users.

Long Covid Service
Long covid services have now been established based in East IHC and stretching across the whole of BCU. Jointly headed by Therapy and Psychology the team are offering a multi disciplinary approach to individuals struggling with the impact of their diagnosis. A multi award winning team, the future is to incorporate the work into a Community Complex Conditions service involving similar diagnoses and funded recurrently with Welsh Government Adferiad monies.

Safety on Site
The third Safety on Site Conference has been successfully completed at Wrexham Maelor Hospital. These are held quarterly and have been planned and developed by the local Practice Development Nurses. The aim is to understand and share data in relation to incidents and harms and, with the assistance from the experts in various fields, share learning and quality improvements as to how we can work together to improve care and experience for our patients and reduce the risk of repeat harms. The event is now an IHC wide approach, enabling a wider wealth of learning and experience.

There have been challenges is the release of staff to attend, given the ongoing service pressures but this has been mitigated by focused planning, continuous communication and support for the senior teams to enable to release of staff,

The next conference is planned for September and the invitation to attend will be made available to all across the Health Board. This is an 'in person' event as evaluation shows that this supports the most enhanced participant experience. For the first time there will also be a poster competition, enabling staff to showcase their quality improvement initiatives.

Harms poster 1.pdf

CONCLUSION

This report provides the QSE with information on the progress of East IHC in improving quality, patient safety and experience over the last 12 months since the inception of the IHC's.

As the IHC continues to mature it will continue to develop its systems, processes and behaviours to achieve improvements in its understanding of the requirements to support safety and quality.

The key points of note are:

- The progress in embedding the architecture to support assurance to the IHC of the quality, safety and patient experience.
- The action taken by the IHC to respond to the orthopaedic waiting list risk and the need to understand the challenges regarding sustainability.
- The action taken by the IHC to respond to the managed practices concerns regarding access

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 22 August 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to highlight and to note the progress on the management of the Corporate Risk Register and the new escalated risks, and discussions which took place during the Risk Management Group meeting on the 15th June 2023 and the 8th August 2023.			
Argymhellion: ***Recommendations:***	The Committee is asked to: Review and discuss the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Phil Meakin, Associate Director of Governance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	See the individual risks for details of the related links to Strategic Objectives.			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	No
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	See the individual risks for details of the related links to the Board Assurance Framework.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	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.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Risk Management Group met on the 15th June 2023 and the 8th August 2023. Please see the individual progress notes on each risk.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)	Not applicable

Reason for submission of report to confidential board (where relevant)	
Camau Nesaf: ***Next Steps:*** The Risk Management Group will be meeting on the 3rd October 2023, therefore an updated position of the risks will be presented during the Quality, Safety and Experience Committee on the 31st October 2023.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Full Corporate Risk Register Report Appendix 2 – Risks for De-escalation. Appendix 3 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score. Appendix 4 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels.	

Quality, Safety and Experience Committee
22nd August 2023
Corporate Risk Register Report

1. Introduction/Background

1.1 The continued 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 aims to reflect 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.

2. Body of report

2.1 The Risk Management Group met on the 15th June 2023 and on the 8th August 2023 to review the Corporate Risk Register

Meetings will be arranged with the risk leads to update the risks in line with the next Risk Management Group meeting which is scheduled for the 3rd October 2023.

2.2 Following discussion and support at the Risk Management Group during 2nd August 2022, risk CRR20-06 'Management of Patient Records' is now being split into 3 separate risks. Revised risk for 'Retention and Storage of Patient Records' (CRR22-32) has been developed, and was approved for inclusion on the Corporate Risk Register at the 4th October 2022 Risk Management Group. A second of the three proposed revised risks has further been developed and included on the Corporate Risk Register following the approval from the Health Board Leadership Team 'Risk of Lack of access to clinical and other patient data' (CRR23-33). Work remains ongoing to develop the 3rd revised risk 'Risk of poor clinical recording of patient information', which will include the transfer over of open actions from the current CRR20-06 and result in the closure and archiving of the current Corporate Risk CRR20-06 'Management of Patient Records'.

2.3 During the Risk Management Group meeting on the 15th June 2023 a deep dive was undertaken for Corporate Risk CRR21-17 'The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours'. The risk was being presented with the proposal for de-escalation to Tier 2. During the Risk Management Group it was agreed that the risk should be de-escalated from the Corporate Risk Register to Tier 2 level with 3 separate risks developed within each individual IHC and managed regionally.

2.4 The following risks have been approved by the relevant Executive Directors for de-escalation from Tier 1 Corporate Risks, and were presented to the Risk Management Group on the 8th August for discussion and de-escalation:

- CRR21-13 – 'Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)'. Risk proposed for de-escalation and management at Tier 2 level and to create one overarching Corporate Risk in relation to staffing as a workforce wide risk, it will detail these particular groups as high risk. The Deputy Director of Workforce agreed for one Corporate staffing risk to be managed under the Executive Director of Workforce.
- CRR22-18 – 'Inability to deliver timely Infection Prevention & Control services due to limited capacity'. Risk proposed for de-escalation and management at Tier 2 level and to create one overarching Corporate Risk in relation to staffing as a workforce wide risk, it will detail these particular groups as high risk. The Deputy Director of Workforce agreed for one Corporate staffing risk to be managed under the Executive Director of Workforce.
- CRR22-19 – 'Potential that medical devices are not decontaminated effectively so patients may be harmed'. Risk proposed for de-escalation and management at Tier 2 as scoring was reduced from major to moderate and actions being controlled and progressed.
- CRR22-27 – 'Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services'. Reduction in current risk score, audits will however continue to ensure safe standards.
- CRR23-45 – 'Risk to patient and staff safety due to Industrial Action'. No further planned industrial actions and scoring reduced from major to moderate and actions being controlled and progressed.

2.5 The following risks have been incorporated onto the Health Board's risk register and following Executive approval, work continues to further develop the risk descriptors, mitigating factors and action plans to include the risks onto the Corporate Risk Register.

- CRR22-28 – Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- CRR22-29 - Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model,
- CRR22-30 - Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns
- CRR22-31 - Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model.
- CRR23-36 - Cost of Living Impact on Staff and Patients.
- CRR23-37 - Targeted Intervention.
- CRR23-38 - Workforce.
- CRR23-39 - Patient Flow - Impact on Access and Quality of Care.

2.6 During the review of the Corporate Risk Register, a gap analysis was undertaken and will also form a more prominent role of the risk management team going forward and become business as usual.
Anticipated Corporate Risks under development:

- Planned care, three risks are currently under development.
- Quality, three risks are currently under development. (incl. Falls, learning from inquests)
- Special Measures – Risk of not making planned improvements
- Primary care-Sustainability

2.10 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting the breadth and categories of risks recorded in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	51	0	20	2
Tier 2 (9-12)	290	109	29	114
Tier 3 (1-8)	201	31	22	86

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

4. Risk Management

4.1 See the full details of individual risks in Appendix 1 and 2.

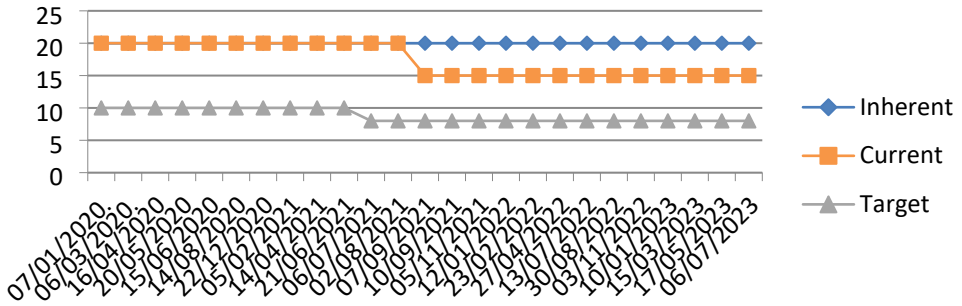
5. Equality and Diversity Implications

5.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

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

Appendix 1 – Full Corporate Risk register - Public

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2023
	Risk: Asbestos Management and Control	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 August 2023
There is a risk that staff, patient's visitors and contractors are exposed to asbestos, causing mesothelima, a condition which leads to death. Areas across all sites have asbestos in the building with areas like walls being at higher risk of damage, ceilings being rarely likely to be damaged. Contractors not approved by Estates do not consult with the asbestos register before carrying out work, this further increases CRR20-02. BCUHB is non-compliant with the Asbestos at Work Regulations 2012, as there are actions outstanding in some areas from surveys. This non-complaince could result in significant finacial claims/prosecution and Health and Safety Executive enforcement action as well as reputational 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 May 2023	unchanged		

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 internal asbestos management system completed by an independent UCAS accredited body. 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. 9. 5 year programme for the removal of high risk asbestos with monitoring at the Asbestos Group is in place with oversight at the Strategic Health and Safety Group. 10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework. 11. Senior Estates Officer/Asbestos Management appointed and in place. Review of systems and procedures in line with the Asbestos management policy.	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. 5. Self assessment completed and submitted to Welsh Government which use specialist services to review the returns for consistence and compliance.

Gaps in Controls/mitigations
Not achieving 95% target for compliance with training, it is felt that due to absences 100% compliance is not achievable. Significant progress has been made in terms of training and compliance with further work ongoing, continued to increased compliance is due to long term absences. Current compliance level is 96.58% for Asbestos awareness training and 94.3% for local operations managers. The target of 95% is still anticipated to be achieved by end of qtr 2 2023/24.

Progress since last submission

1. Controls in place reviewed to reflect current position.
2. Gaps in controls reviewed to reflect current position.
3. Asbestos re-inspection surveys have taken place and have identified required actions as a result. Which will putting together a removal programme for this financial year which mitigate the risk.
4. Audit from Sentinel Environmental has taken place in August 2022, which resulted in 5 are of non-conformance, with 3 remaining open to date, training, leased buildings and data management. Agreed with Sentinel that an annual audit will be undertaken.
5. Compliance with duty to manage training is now at 96.58% and asbestos awareness compliance has increased to 94.3%.
6. Action ID 25111 – Action closed, Agreed with Sentinel that the audits will be undertaken annually, with last audit undertaken during August 2022 and planned next audit August 2023, with budget set annually for the audits.
7. Identification of new action ID 25122 - Identify all current lease buildings and plans in place to review and ongoing monitoring.

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

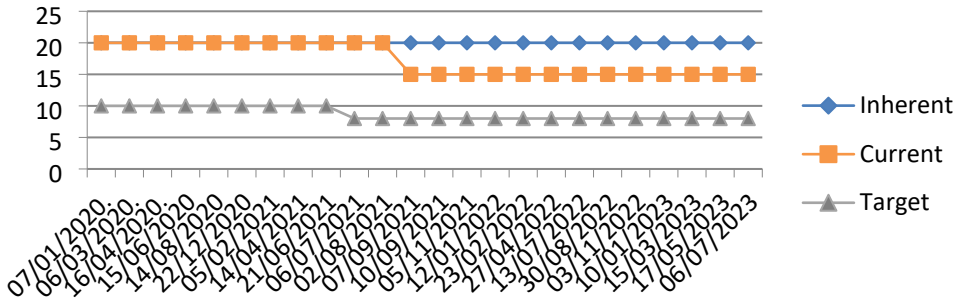
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Arwel Hughes, Head Of Operational Estates	30/08/2023	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. July 2023 progress update – MiCad system has been purchased and working with	On track

					Micad to populate the information and undertake training on the system. Upload the server with reports currently in place as a PDF document in order for the information to be available to all. Once this is in place, Sentinel to use the portal to carry out survey reports which will bespoke to BCU.	
	25111	Commissioning of an independent audit to confirm current level of compliance and provide assurance on current risk mitigation plan	Arwel Hughes, Head Of Operational Estates	30/08/2023	confirm current level of compliance and provide assurance on current risk mitigation plan July 2023 progress update – Action closed - Agreed with Sentinel that the audits will be undertaken annually, with last audit undertaken during August 2022 and planned next audit August 2023, with budget set annually for the audits.	Completed
	25122	Identify all current lease buildings and plans in place to review and ongoing monitoring.	Arwel Hughes, Head Of Operational Estates	30/0802023	Working with Property team to identify which properties require ongoing asbestos monitoring as per lease agreements.	On track

					A number of buildings have already been identified (approx. 70%) with new management surveys to be undertaken this financial year.	

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2023
	Risk: Contractor Management and Control	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 July 2023

There is a risk to physical harm to staff, patients and visitors and disruption to clinical service due to contractors being on site and undertaking works that are non-complaint with basic health and safety. BCUHB is currently failing to achieve compliance with H&S legislation due to the fact that contractors are being invited on site without the required control and documentation necessary to ensure safe working practices are undertaken. This increase risk to all site users and could result in injury/loss of life, disruption of clinical services, prosecution and reputational harm.



	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 May 2023	Unchanged		

Controls in place	Assurances
1. Control of Contractors Procedure in place, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 2. Induction process being delivered to new contractors, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place. 5. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation. 7. Integral evaluation process in place to monitor performance of Health Board contractors with oversight at the Occupational Health and Safety Strategic Group. 8. Approved Contractors Framework for minor works across the Health Board in place, monitored quarterly as part of the Contract Performance Review	

Gaps in Controls/mitigations
Staff resources gap due to demand versus capacity. 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. Reduction and declining of current list of requests and prioritisation of works to align with Health & Safety obligations in terms of the management and control of contractors. Additional to current funding has been allocated from 23/24 for additional resources.

Progress since last submission
1. Risk Description reviewed and updated to provide clarity on the risk. 1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gap in control has been reviewed to ensure relevance with current risk position. 3. Project group set up for the mobilisation of the SHE software, meeting held on a weekly basis. 4. Proposal to extend the Target Risk due date from the 31/03/2023 to the 31/07/2023 due to the requirements to liaise with Health Boards nominated contractors as their information is required to be inputted onto the system which would result in an approved contractors list moving forwards. 5. Action ID 12252 – Action delayed, Meeting to be set up with IHC leads to formulate a plan with their requirement and identification of leads, meetings to be set up by the 16/06/2023. 6. Action ID 12257 – Action delayed, The Authorized Person is developing new fit for purpose induction material to be implemented with the new Control of Contractors software, anticipated completion by end July 2023.

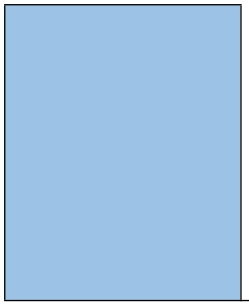
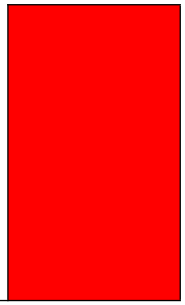
7. Action ID 12258 – Action delayed, Operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems. Meeting to be set up with IHC leads to formulate a plan with their requirement and identification of leads, meetings to be set up by the 16/06/2023.

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 Health & Safety Management within Health & Safety Policy).	Richard Daniel, Interim Director Of Capital & Estates	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 Control of Substances Hazardous to Health (COSHH) and Inspection process to	Delay

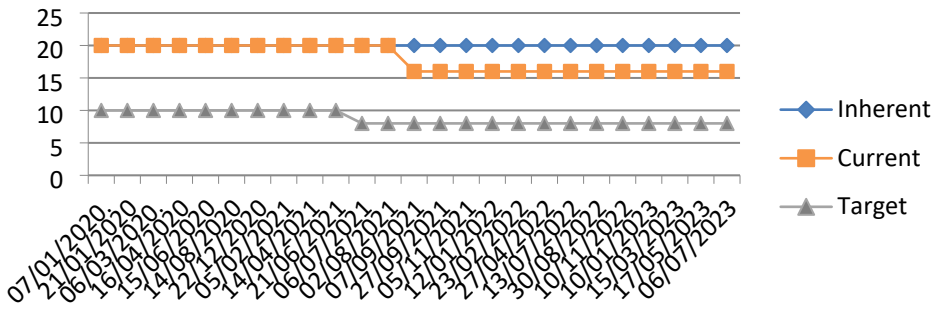
					ensure compliance. May 2023 progress update – Meeting to be set up with IHC leads to formulate a plan with their requirement and identification of leads, meetings to be set up by the 16/06/2023.	
	12257	Identify level of Local Induction and who carry it out and to what standard.	Richard Daniel, Interim Director Of Capital & Estates	30/09/2022	Implementation of the SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes. May 2023 progress update - The Authorized Person is	Delay

					developing new fit for purpose induction material to be implemented with the new Control of Contractors software, anticipated completion by end July 2023.	
	12258	Identify responsible person to review Risk Assessments and signs off the Method Statements (RAMS). Skills, knowledge and understanding required to be competent to assess documents (Pathology, Radiology, IT etc.).	Richard Daniel, Interim Director Of Capital & Estates	31/03/2022	Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes. May 2023 progress update - Operating model agreed, this action will need to be aligned with each IHC's Governance	Delay

					and Health and Safety Management systems. Meeting to be set up with IHC leads to formulate a plan with their requirement and identification of leads, meetings to be set up by the 16/06/2023	

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2023
	Risk: Legionella Management and Control.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 December 2023

There is a risk that staff, patients and visitors are exposed to legionella due to positive samples of the presence of legionella within water systems. BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). Some Departments that manage operational and service practices in the estate, fail to inform Estates of changes that impact the safe management of legionella, particular risk with the older buildings, and are unaware of their obligations in the control of legionella. Instances of this are where they fail to declare that they are no longer using a water outlet and the rooms have been repurposed. There is a lack of training, awareness and understanding of legionella and reaffirming responsibilities and required actions.



	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 May 2023	Unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place, reported to and signed off by the Water Safety Group, which is reported to Infection Prevention Sub-Group and Quality and Safety Committee. 2. Risk assessment undertaken by clear water, with action and issues reported to the water Safety Group. 3. High risk engineering work completed in line with Clearwater risk assessment.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Strategic Infection Prevention Group.

4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonas. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety 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. 10. Alterations to water systems are now signed off by responsible person for water safety. 11. Local Infection Prevention Groups in place with oversight of water safety. 12. Standard Operating Procedure for the management of little used outlets implemented and in place. 13. Standard Operating Procedure for the management of Pseudomonas implemented and in place.	4. Quality, Safety and Patient Experience Committee.

Gaps in Controls/mitigations
1. Lack of assurance for the management of water systems at ward/departmental levels, Estates need to agree a management strategy with the Health Board that assures that local areas managers are undertaking Statutory duties. 2. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case has been approved as part of the IMTP with funding agreed recurrently from April 2023, which will provide supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety. Included in the Integrated Medium Term Plan, supported by risk ID 4283.

Progress since last submission
1. Risk Description reviewed and updated to provide clarity on the risk. 2. Controls in place review to ensure relevance with current risk position. 3. Gaps in controls reviewed to ensure relevance with current risk position.

4. Proposal to extend the Target Risk Due date from the 31/03/2023 to the 31/12/2023.The Water Safety Group has concerns that the risk is not being managed at a local level, to provide this assurance Estates need to agree a management strategy with the Health Board that assures that local areas managers are undertaking Statutory duties. 5. Audit by the Authorizing engineer for Water to be reviewed within the 3 localities by 21/06/2023, resulting in a new action being identified, ID 25112. 6. Action ID 19015 – Action delayed, Assurance awaited from the Authorizing Engineer for Water.

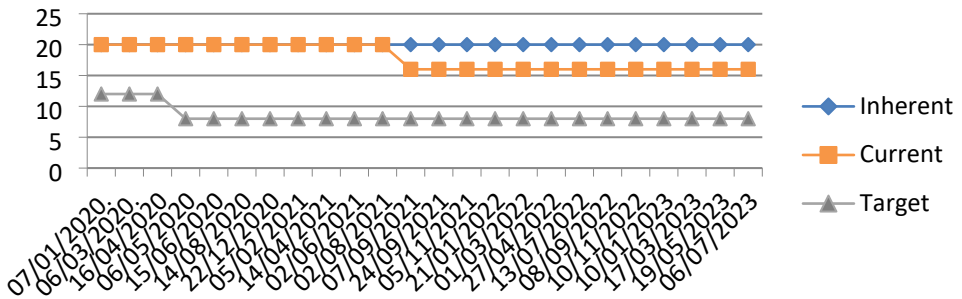
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

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	19015	Secure funding and appointment of 3x band 7 Senior Estates Officers for water safety.	Richard Daniel, Interim Director Of Capital & Estates	31/03/2022	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. May 2023 progress update – Assurance awaited from the Authorizing Engineer for Water.	Delay
	25112	Audit by the Authorizing engineer for Water to be	Arwel Hughes, Head	21/06/2023	Identification of further actions required.	Delay

		reviewed within the 3 localities	of Operational Estates			

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 06 July 2023
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 March 2025

There is a risk of fire across sites across BCUHB. The Health Board is currently non-complaint in regards to Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005)). This is due to a historic lack of control of maintenance activities. There are breaches in compartmentation that mean a fire would not be contained or managed, and risks are exhaserbated by inefficeint hospital plans in that the most vulnerable being located in the most difficult areas to evacute.There also continues to be unresolved damage to fire doors throughout and aged fire detection systems that are in urgent need of replacement.



	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 May 2023	Unchanged		

Controls in place	**Assurances**
1. Fire Safety Policy established and implemented, annual report reported to Board and supported by Welsh Government. 2. Fire risk assessments in place. 3. Fire Engineer regularly monitors Fire Safety Systems.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken. 6. Escape routes identified and evacuation drills undertaken, established and implemented. 7. Fire Safety Mandatory Training and Awareness sessions regularly delivered to BCUHB Staff. 8. Fire Warden Mandatory Training established and being delivered to Nominated Fire Wardens. 9. Appointed Authorising Engineer for fire safety in place through NHS shared services (specialist estates services).	4. Annual Compliance returns submitted to Welsh Government.

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance. Prioritisation of maintenance regimes in place by the use of risk based assessments. 2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure. Two applications to Welsh Government for Programme Business Case (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals. Ysbyty Gwynedd - Programme BC submitted to WG currently in discussion to secure capital for professional fees to develop a priority list of fire safety measures in advance of the site wide re-development. Wrexham Maelor Hospital - £54m requested to the site which includes fire safety for active and passive fire safety measures.

Progress since last submission
1. Risk description reviewed and updated to provide clarity on the risk. 2. Controls in place reviewed to ensure relevance with current risk position 3. Gaps in controls reviewed and updated to ensure relevance with current risk position. 4. Corporate Health and Safety audit undertaken and a number of recommendations made which are being acted upon over the forthcoming months. 5. The Health Board has secured for 2023/24 additional £1.716 million capital funding through EFABS/2 (Welsh Government) to address fire safety issues across the Health Board.

6. Department have lost one member of staff since last update and are in the process of recruiting to the post, interviews early August 2023.
7. Action ID 12276 - Action delayed due to awaiting the all wales guidance document or inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. Each IHC are reviewing their protocols for dealing with the movement of bariatric patients through SOHSG following the interest shown by the HSE due to the numbers of patient falls experienced within BCUHB.
8. Action ID 15036 - Action delayed due to staffing, department have lost one member of staff since last update and are in the process of recruiting to the post, interviews early August 2023.
9. Action ID 24142 – Delay in progress due to change in Director structure within Capital and Estates. Business case to be developed and presented to Director of Estates by end of September 2023.
10. Action ID 24397 – Policy not ratified at SOHSG are group was not quorate, Policy will now be presented at next SOHSG at the end of August 2023, and action plan developed to address the recommendations within the audit with appropriate target dates.

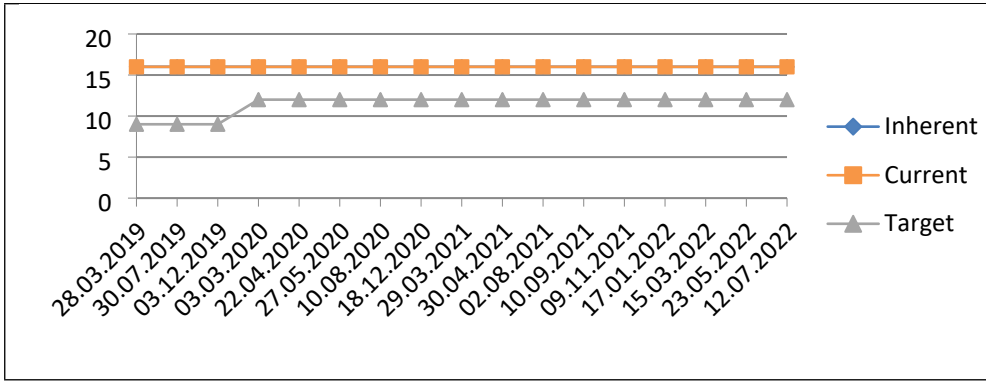
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

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
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Richard Daniel, Interim Director Of Capital & Estates	30/09/2022	To be included in site specific manual and training developed with Manual Handling Team. July 2023 progress update - Action delayed due to awaiting the all wales guidance document or inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. Each IHC are reviewing their protocols for dealing with the movement of bariatric patients through SOHSG following the interest shown by the HSE due to the numbers of patient falls experienced within BCUHB.	Delay
	15036	Fire Risk Assessments in place Pan BCUHB.	Richard Daniel, Interim Director Of Capital & Estates	30/09/2022	Improve safety and compliance with the Order. July 2023 progress update – Action delayed due to staffing, department have lost one member of staff since last update and are in the process of recruiting to the post, interviews early August 2023.	Delay
	24142	Develop a Management structure to ensure adequate capacity to deliver Fire Safety	Richard Daniel, Interim Director Of Capital & Estates	31/03/2023	Ensure compliance with Fire Safety Legislation. Business case to be developed to secure funding to align with the new Fire Management structure.	Delay

		requirements within the Health Board.			July 2023 – Delay in progress due to change in Director structure within Capital and Estates. Business case to be developed and presented to Director of Estates by end of September 2023.	
	24397	Implement recommendations following the Corporate Health and Safety audit	Richard Daniel, Interim Director Of Capital & Estates	31/12/2022	Ensure recommendations from the Corporate Health and Safety audit are implemented which will strengthen current policies and procedures. July 2023 – Policy not ratified at SOHSG are group was not quorate, Policy will now be presented at next SOHSG at the end of August 2023, and action plan developed to address the recommendations within the audit with appropriate target dates.	Delay

CRR20-06 – Links to CRR22-32 and CRR23-33

CRR20-06	**Director Lead:** Chief Digital and Information Officer	**Date Opened:** 28 March 2019
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 12 July 2022
	Risk: Informatics - Patient Records pan BCUHB	**Date of Committee Review:** 17 January 2023
		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 2022	Unchanged		

Controls in place	**Assurances**
1. Informatics Strategy in place, with regular reporting to, Partnership, People and Population Health Committee. 2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB, monitored by the Patient Records Group. 3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance

4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Centralised Team to manage 'Subject Access Requests' for Patient Records pan-BCUHB established, monitoring compliance with the legislation, monitoring compliance with legislation and supporting the rectification of commingling within patients clinical notes. 6. 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. 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.	and Information Governance Committee. 3. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Delayed implementation and recruitment, to be able to digitalise all specialties within 4 years. Improved relationship with supplier and recruitment to take place with a phased approach for digital implementation. 2. Fit for purpose on site estate to hold physical records with the lack of current plans to scan records. The estate to hold physical records requires upkeep, current off site storage in place. 3. Lack of attendance at the Patient Records Group. Not all records custodians in attendance, monitoring and contacting leads within areas to implement change. 4. Lack of central oversight of records sent out by other departments. Urgent meeting to support standardisation and consistency of processes. Reporting of compliance to Patient Records Group to be implemented. 5. Compliance check for information sent out not robust. Band 4 staff currently quality checking information sent. 6. Local site improvement plans being developed in a silo manner without standardised approach across the Health Board. Health Records representation on improvement boards to be established.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Action ID 12429 – Action remains on hold until the Mental Health Business Case is progressed with the Welsh Government. 4. Identification of new action ID 23746 to establish a new all encompassing Patient Records Programme that pulls all streams of work under one overall governance arrangement. 5. Identification of new action ID 23747 for the identification of recruitment for a Programme Manager to bring all strands of the patient records programme together. 6. Identification of new action ID 23748 for the Acting Executive Director of Therapies and Health Sciences to become the Senior Responsible Officer for the Clinical Records Standards element and The Chief Digital and Information Officer the Senior Responsible Officer for the Paper Records Management and CITO Electronic Document Record Management System elements. 7. Identification of new action ID 23749 to ensure that the DHR Programme is re-scoped into an Electronic Document Record Management System. 8. Identification of new action ID 23750 for the immediate review of the patient record policies, standard operating procedures and the associated delivery of training and awareness, to improve integrity and quality of information in clinical records as they are now in paper form.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

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	12423	Development of a local Digital Health Records system.	Aspinall, Mrs Nia, Head of Patient Records and	30/09/2024	July 2022 progress update – An SBAR will be presented to the Executive Board during August, requesting a re-scope	On track

target risk score			Digital Integration		of the project. However the early adopter work is still ongoing with both vascular and rheumatology. Full update and agreed recommendations to be provided after the Executive Board.	
	12425	Digitise the clinic letters for outpatients.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	31/12/2022	July 2022 progress update - Action remains delayed due to a delay in the start of the Medical Transcribing Electronic Discharge project, resources now in place.	On track
	12426	Digitise nursing documentation through engaging in the Welsh Nursing Care Record.	Brady, Mrs Jane, Senior Lead Nursing Informatics Specialist	30/09/2024	July 2022 progress update - Business case approved February 2022. Welsh Nursing Care Record now live across East community hospitals and all East medical and surgical wards in secondary care. This concludes the Welsh Nursing Care Record rollout in East. Planning for Central implementation has commenced with a proposed go live of mid-September 2022, starting in Ysbyty Glan Clwyd.	On track
	12429	Engage with the Estates Rationalisation Programme to secure the	Aspinall, Mrs Nia, Head of Patient	31/01/2023	ON HOLD until the Mental Health Business Case is progressed with the Welsh	On Hold

		future of 'fit for purpose' file libraries for legacy paper records.	Records and Digital Integration		Government (5 case business cases) – 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 Full Business Case is September 2022.	
	23746	A new all encompassing Patient Records Programme is established that pulls all streams of work under one overall governance arrangement.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	A programme in place that will support the mitigation of the risk with the central management and oversight of the individual elements.	On track
	23747	The identification or recruitment of a Programme Manager established for the overall programme and management to ensure all three elements are scoped and re-costed.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	The action will provide support in the mitigation of the risk with the central management and oversight of the individual elements.	On track
	23748	The Acting Executive Director of Therapies and Health Science become the Senior Responsible Officer for the Clinical Records Standards element and the Chief Digital and Information	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	These programmes require their scopes clearly being defined so that all are clear what they aspire to deliver and how to support the reduction in the risk score and reduce the volume of incidents, complaints	On track

		Officer the Senior Responsible Officer for the Paper Records Management and CITO Electronic Document Record Management System (EDRMS) elements.			and claims regarding inappropriate record keeping.	
	23749	The Digital Health Record Programme is re-scoped into an Electronic Document Records Management System.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	To focus on addressing the more immediate patient records management challenges facing the Health Board utilising the proven capabilities of the CITO product.	On track
	23750	Immediate review of the patient record policies, standard operating procedures and the associated delivery of training and awareness and to improve integrity and quality of information in clinical records as they are now in paper form.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	Part of this work is currently underway as part of the Ysbyty Glan Clwyd improvement plan and when fully implemented will support the reduction in the risk score.	On track

CRR21-14	**Director Lead:** Executive Director of Nursing and Midwifery.	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 19 July 2023
	Risk: There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients.	**Date of Committee Review:** 04 November 2022
		Target Risk Date: 31 October 2023

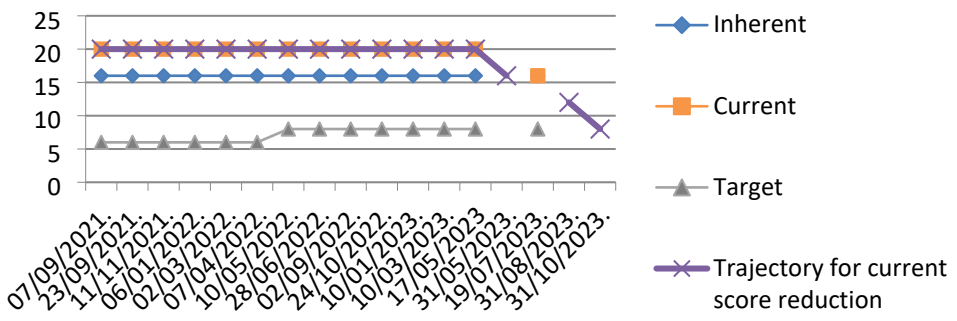
There is a risk that patients may be unlawfully detained due to the increased level of Deprivation of Liberty Safeguards (DoLS) activity.

This may be caused by the increased number of patients who are refusing admission or who have a mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meets the legal framework).

This is due to 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.

The amendments to the Mental Capacity Act, resulting in new legislation and the required preparation by the Welsh Government for the implementation of the Liberty Protection Safeguards (LPS) requires engagement at a National, Regional and Local level which has resulted in the divertion of resources. The implementation of LPS has been delayed by the UK and Welsh Government, BCUHB were awarded with non-recurring fudning via a bidding process to support the criteria set out by WG to reduce the DoLS Backlog and support additional MCA and DoLS activty. The Backlog is a national term utlised to describe the number of patient/individuals who are currently not supported by a legal framework whilst in a hospital setting. Prior to the issue of non-recurring funding BCUHB had 144 (average) patients who were admitted and treated outside of the DoLS legal framework. This has been reduced to 29 (average) patients due to the additional work undertaken by the team folowing the successful bidding process and issuing of non-recurring WG funding for 2023-24.

This could lead to harm to patients from unlawful detention, increase in Court of Protection Activity (COP), which may result in greater operational pressures, and an increase in financial cost, poor patient experience and reputational damage for BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
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 May 2023	Decreased		

Controls in place	Assurances
1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health Capacity and Compliance Committee (MHCCC), Executive Delivery Group – Quality Group [EDGQ]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 Adult at Risk training Levels 2 and 3 are in place for Mental Health and Learning Disabilities (MHLD) and key departments. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a]. 5. Deprivation of Liberty Safeguards (DoLS) COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act [MCA] training in primary and community settings.	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 Board Workshop. 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.

7. Welsh Government non-recurring monies has been utilised to increase physical capacity in and out of hours to support the process of identifying patients on wards that could potentially be unlawfully detained to prevent harm to patients. 8. Liberty Protection Safeguards (LPS) Implementation group is in place to inform the organisation of LPS and to commence the preparation for the receipt of COP and future implementation of LPS across the organisation reporting to the Mental Health Capacity and Compliance Committee [MHCCC] Committee. 9. Welsh Government non-recurring monies are identified to strengthen training and implementation of LPS for 16/17 year olds. 10. Heads of Safeguarding's Strategic Objectives are cross referenced and include actions from the identified Safeguarding Risks ensuring triangulation and governance. These risks are monitored following the Safeguarding Governance Framework. 11. Welsh Government non-recurring monies have supported the development of training materials for MCA, and the appreciation and understanding of capacity, which has included the reiteration of the safeguarding Team and the contact details.	6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government. 7. A Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the safeguarding team, which is reported to the MHCCC (Mental Health Capacity Compliance Committee). 8. The MCA awareness materials were disseminated from 14th November – Safeguarding Week.

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 within BCUHB control. Training and guidance for 16/17 year olds has been developed until the statutory guidance is published. 2. New legislation and statutory guidance driven by the Central and Welsh Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. In addition, the increase in activity and complexity is also not in BCUHB's control. Preparation and the implementation of LPS and activity to support DoLS is dependent upon capacity, resource and expertise and the awaited revised Code of Practice. A BCUHB Corporate Safeguarding Business Case has been approved as part of the Integrated Medium Term Plan (IMTP) 2022-23. The business case has been delayed presentation to the Board Workshop due to organisational challenges which are outside of the Corporate Safeguarding Teams responsibility. The BCUHB Safeguarding Business Case has received support from both Finance and the Planning Department to ensure it meets the requirements to enable formal agreement by the Executive Team. We continue to have a delay in a formal response by the Planning Department. To ensure this activity is expedited further, e mail communication has been initiated requesting a response and a date for formal submission. WG monies, which are non-recurring are currently used to support the implementations of key activities in line with

WG direction on the Mental Capacity Act and DoLS Backlog. The possibilities of more money will be considered and allocated from April 2023 – 2024.3. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. The increase in data reporting and supporting activity has supported the identification of risk and intervention.

4. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. Some multi-agency guidance and intervention has been developed as a result of new Legislation and national guidance, which is being overseen by the North Wales Safeguarding Boards and supports collaboration with partner agencies.

5. There is a lack of consistent training compliance rates across the Health Board. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the Deprivation of Liberty Safeguards Co-ordinator towards noting the timescales and legal duties. In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training.

6. New Liberty Protection Safeguards Code of Practice is proposing that the commissioning arrangements of Independent Mental Capacity Advocates will be the responsibility of Health Boards on behalf of both health and local authorities. At present there is a lack of commissioned service in place and new arrangements require establishments in terms of governance arrangements and quality monitoring. Confirmed with WG and meeting arranged with the 6 local authorities.

7. Sudden rise in the number of DoLS assessment resulting in a backlog. We a currently using non-recurring Welsh Government monies to support current post holders to work additional hours, weekends and evenings (we are unable to recruit to specialist posts).

8. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting, this was identified in a Court of Protection DoLS case and it is noted that this is not unique to BCUHB. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance. Immediate safeguards are in place and work is taking place alongside the Risk Team who has developed a SoP.

9. There are local and national staffing challenges with regard to the recruitment of MCA and DoLS (BIA) specialist staff. This has been recognised by Welsh Government. There are currently no Best Interest Assessor courses available to train staff as a result of the delayed authorisation of the Legal Framework. We are supporting flexible working arrangements, the immediate recruitment to vacancies and current post holders (BIAs) are working enhanced hours to deliver out of hours support. From November/December a 7 day MCA and DoLS advisory service using WG non-recurring monies will be in place.

10. During Q2 2022-23 there has been an increase in the number of DoLS applications submitted by the Managing Authority 74% of all applications required amendments to the application prior to authorisation. A rolling audit activity with immediate escalation is in place.

11. The team and service is experiencing a combined sickness and vacancy position of 30%. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.
12. The development and ratification of strategic activities are delayed and some are outside of the original timescales. Risk assessments against each activity are in place to identify the risk and priority of the activity. Specific activities are highlighted to reporting Committees/Groups to obtain agreement if timescales require amendment or escalation.
13. Potential lack of funding as a result of a review of section 12 (2) doctors activities which has resulted in an increase in costs. Escalation report completed, benchmarking of costs have taken place on a National basis and escalation to the executive Director of Nursing and Executive Director of Public Health (lead for Mental Health and Learning Disabilities).
14. The identified DoLS Authorisers within each IHC are unable to complete the identified task as part of the statutory framework to obtain a legal deprivation. Corporate Safeguarding has scrutinised the current authorisers list, identified gaps and reiterated and escalated the importance of the role with each IHC / Department.

15. The Ockenden Review (2018) Recommendation 6 recorded that the then Executive Director of Nursing had committed significant resources into developing sound foundations for the safeguarding structure. However, it is recorded for an organisation such as BCUHB a significant amount of work was still needed to be done and that this work would need continued Board scrutiny and oversight to ensure progress in the development of the service continues and if necessary reporting to Welsh Government if progress falters or slows down.

16. To ensure that following the appointment of new Independent Members that they are afforded training, awareness and understanding of the Safeguarding and Public Protection (which is inclusive of DoLS and the MCA).

Progress since last submission

1. Risk Description reviewed and updated to reflect current risk position
2. Controls in place reviewed to ensure relevance with current risk position.
3. Gaps in Controls reviewed to ensure relevance with current risk position.
4. Proposal to reduce the current risk scoring from **20** (Impact = 4, Likelihood = 5) to **16** (Impact = 4, Likelihood = 4), due to the reduction in the backlog of patients from 144 to 29 patients (average), this is as a result of the interim and non-recurring WG monies. In addition, on the 8th April 2023 BCU was informed that progress on the implementation of LPS (by the UK and Welsh Government) has been postponed until after the next General Election.

5. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance in relation to identified community settings. First meeting of the group was held during December 2022. SoP under development to support the services following the postponement of LPS.
6. Recently informed, due to the Health Board financial position all IMTP applications and business cases are to be reviewed with the possibility that funding will not be allocated. Revised IMTP submission for funding to be allocated over a 2 year period with clear priorities identified for 2023/24. Still awaiting BCU Board update.
7. Potential lack of funding as a result of a review of section 12 (2) doctors activities which has resulted in an increase in costs. Escalation report completed, benchmarking of costs have taken place on a National basis and escalation to the executive Director of Nursing and Executive Director of Public Health (lead for Mental Health and Learning Disabilities). Current agreement with section 12 (2) doctors to continue with agreed costs, awaiting National guidance and agreement.
8. Action ID 18117 – Action closed, Due to the delay in implementation as directed by UK and Welsh Government no further action can be taken with regard to this action. The request is made to close this action and review when UK and Welsh Government announce updates. This is believed to be in 2026-2027.
8. Action ID 20957 – Action closed, Due to the delay in implementation as directed by UK and Welsh Government no further action can be taken with regard to this action. The request is made to close this action and review when UK and Welsh Government announce updates. This is believed to be in 2026-2027.
9. Action ID 21213 – Action delayed, No further update has been received. This has been escalated through SGPG.
10. Action ID 23506 – Action closed, Due to the delay in implementation as directed by UK and Welsh Government no further action can be taken with regard to this action. The request is made to close this action and review when UK and Welsh Government announce updates. This is believed to be in 2026-2027.
11. Action ID 24304 – Action delayed, An application to WG has been completed to utilise non-recurring WG funding to support this action.
12. Action ID 24578 – Action delayed, An application to WG has been completed to utilise non-recurring WG funding to support this action.
13. Action ID 24806 – Action closed, The review of the number of authorisers has been completed with training days set to complete additional training.
14. Identification of 4 new actions.

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	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	Additional resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. WG have issued non-recurring funding letters to support the wider MCA, DoLS and IMCA activates. July 2023 progress update – Due to the delay in implementation as directed by UK and Welsh Government no further action can be taken with regard to this action. The request is made to close this action and review when UK and Welsh	Complete

					Government announce updates. This is believed to be in 2026-2027.	
	20957	Evidence an improved position regarding MCA training compliance and application and DoLS Backlog to prepare for the implementation and identified plans in readiness for the receipt of the Mental Capacity Act – Liberty Protection Safeguards Code of Practice.	Michelle Denwood, Director of Safeguarding and Public Protection	31/05/2022	This will enable the organisation to be prepared for the receipt and implementation of the Liberty Protection Safeguards Code of Practice in the absence of a UK Government timeframe. LPS has been delayed by UK and Welsh Government but there remains an emphasis on improved compliance with MCA legislation. The action to ensure an improved position in relation to MCA and the DoLS Backlog is ongoing, with evidence of progress provided to the MHCC Committee. July 2023 progress update – Due to the delay in	Complete

					implementation as directed by UK and Welsh Government no further action can be taken with regard to this action. The request is made to close this action and review when UK and Welsh Government announce updates. This is believed to be in 2026-2027.	
	21213	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. July 2023 progress update – No further update has been received. This has been escalated through SGPG.	Delay
	23506	Establishment of operational groups to support the	Michelle Denwood,	31/03/2023	To ensure that the service and function is embedded	Complete

		implementation of LPS within clinical and operational service delivery.	Director of Safeguarding and Public Protection		in front line practice. This will reduce unlawful detention and comply with the Code of Practice. March 2023 – There have been no further updates from WG. It is likely that due to a delay outside of BCUHB's control that a new completion date is required. The action requires the Code of Practice to progress. No further work is to be undertaken by organisations until notified by the Government. July 2023 progress update – Due to the delay in implementation as directed by UK and Welsh Government no further action can be taken with regard to this action. The request is made to close this action and review when UK and Welsh Government announce	

					updates. This is believed to be in 2026-2027.	
	24304	Implementation of a task and finish group for Court of Protection DoLS within key community settings to ensure internal engagement to establish clear lines of accountabilities, escalation and governance.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	This will reduce the likelihood of unlawful detention and non-compliance relating to the directions of the court. July 2023 progress update – An application to WG has been completed to utilise non-recurring WG funding to support this action.	Delay
	24305	Improve the implementation and understanding of the Mental Capacity Act (MCA) and improve MCA Mandatory training compliance.	Michelle Denwood, Director of Safeguarding and Public Protection	30/10/2023	Improve understanding and unlawful detention of service users. March 2023 – MCA mandatory training compliance has improved but there remains areas of concern that require bespoke intervention. These have been identified with the service/division and actions agreed to progress compliance.	On track

					May 2023 progress update – A further improvement in MCA training compliance has been recorded. WG have issued funding letters to support further activity. July 2023 progress update – WG non-recurring funding has been received to support the action. Activity to improve MCA compliance is underway via bespoke training, additional resources and materials, and Legal and Risk supported learning.	
	24578	Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding to engage in the development of a SoP to support to manage the complex process of Community DoLS and for the identification of patients who may be eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Co-ordinators, Health Visitors	Delay

					and Commissioned Service Providers National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with Commissioning Services has commenced. March 2023 – Due to pressures within the service and the lack of resources identified within the Safeguarding Business Case this action is delayed. However, work is ongoing to develop a working SOP with colleagues to ensure compliance with legislation. May 2023 progress update – Work remains ongoing, delay due to lack of identified resources.	

					July 2023 progress update – An application to WG has been completed to utilise non-recurring WG funding to support this action.	
	24806	Improve engagement and increase the number of DoLS Authorisers within each IHC.	Chris Walker, Head of Safeguarding Adults / MHLD	30/06/23	March 2023 – notification and engagement has been made with each IHC. A further implementation and Improvement plan will be developed July 2023 progress update – The review of the number of authorisers has been completed with training days set to complete additional training.	Completed
	24807	Agree 2023-24 commissioning arrangements within the organisation and across North Wales Local Authorities to implements a stronger Independent Mental Capacity Advocate (IMCA) service in line with WG recommendations	Chris Walker, Head of Safeguarding Adults / MHLD	31/03/2024	March 2023 – WG providing 2023-24 funding to support strengthening of current IMCA services. Work undertaken with BCUHB procurement and finance teams to support application of WG guidelines. Meetings held with Local Authorities to	On Track

					ensure engagement and agreement. Further work planned to support IMCA provision growth. This will include an Audit of activity. May 2023 progress update – WG delay in issuing funding letters and subsequent funding. Agreement in place to support current IMCA service. Tendering process will be commenced to address further strengthening of the IMCA service. July 2023 progress update – BCUHB have agreed to support the national commissioning of IMCA services. Work is ongoing in relation to additional WG monies and the tender process.	
	24808	Evidence improved quality and standard of clinical records	Chris Walker, Head of Safeguarding	30/09/2023	March 2023 - BCUHB performance Data and National Reports recognise omissions in the	On Track

		relating to MCA Assessments and DoLS Applications	Adults / MHLD		quality of clinical records which can result in unlawful detention. Completion of the Audit application is under review and a planned audit schedule and review is in draft. The audit and findings will be monitored by the MHCC Committee May 2023 progress update – Audit of documentation is underway and will be shared with the MHCC Committee. July 2023 progress update – No change. MHCC Committee has not been reconvened, however the report once completed will be shared at the SGPG for assurance and any additional actions.	
	New action	To access Best Interest Assessor [BIA] Training from Manchester University	Chris Walker, Head of Safeguarding	31/12/2023	May 2023 progress update – Manchester University have confirmed that they	Completed

		Identify and agree a refresher and new training programme for BIAs and new BIAs utilising WG funding	Adults / MHLD		run 2 courses in 2023. We have looked to secure up to 5 places on each course but we are awaiting agreement from Manchester. Additional 'refresher' training via Manchester is also in development. July 2023 progress update – BIA training has been secured at Manchester University. Once the course is completed BCUHB staff will be able to support the work to reduce the DoLS Backlog utilising WG non-recurring funding.	
	New action	Temporary uplifts have been put in place since WG monies were received to support additional activities and funded enhanced administrative/clinical/strategic posts to address outstanding and additional activities.	Chris Walker, Head of Safeguarding Adults / MHLD	31/10/2023	May 2023 progress update – Regional Business Team temporary uplift from a Band 3 to a Band 4. Data Analysist temporary uplift from a Band 6 to a Band 7	On Track

					July 2023 progress update – further secondment opportunities have been commissioned utilising WG non-recurring monies and in line with the criteria set out by WG.	
	New Action	The Ockenden Review (2018) Recommendation 6 recorded that the then Executive Director of Nursing had committed significant resources into developing sound foundations for the safeguarding structure. However, it is recorded for an organisation such as BCUHB a significant amount of work was still needed to be done and that this work would need continued Board scrutiny and oversight to ensure progress in the development of the service continues and if necessary reporting to Welsh Government if progress falters or slows down. The Safeguarding and Public Protection IMTP completed to support the request for further resources within the service. It	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2024	July 2023 progress update – Since the publication of the Recommendation the Safeguarding and Public Protection team have strengthened areas that were needed to secure the service and provide BCUHB with the necessary assurance and governance with regard to the Safeguarding agenda. The Safeguarding agenda expanded prior, during and following the COVID pandemic. In particular areas such as VAWDASV, Modern Slavery, Child at Risk, Adult at Risk, MAPPA and DoLS have seen an increase in activity of up to 400%.	On track

		was submitted in December 2021-22 and placed on the reserve list for approved funding pending the submission of the full Business Case in 2022-23. The full Business Case was completed and submitted as requested in 2022-23 but no formal feedback has been received to indicate support for the proposed strengthening of the service.			The current service relies on the good will of staff to support the increased activity and is not sustainable. Following submission of the Business Case there has been no indication in relation to supporting the proposed improvements to the service. Additional funding would ensure that BCUHB is able to meet the requirements of the Safeguarding and Public Protection Agenda and support a reduction in the risk currently posed. Additional staffing, and the introduction of a 42 hour safeguarding service could significantly reduce the financial and reputational risk to the organisation through a failure to adhere to national legislation and process.	
	New Action	New Independent Members (IM's) have been appointed to	Michelle Denwood,	30/09/2023	July 2023 progress update – The Safeguarding and	On Track

		support Board activity, scrutiny, governance and assurance. Work to be undertaken to ensure that all new IM's are aware of the Safeguarding and Public Protection Agenda which is inclusive of DoLS and the MCA.	Director of Safeguarding and Public Protection		Public Protection team to request IM details to support their awareness and understanding of the Safeguarding Agenda which include DoLS and the MCA. To provide mandatory/bespoke training where appropriate or necessary.	

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:** 19 July 2023
	Risk: There is a risk that patients and service users may be harmed due to non-compliance with the Social Services and Well-Being (Wales) Act 2014	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 July 2024

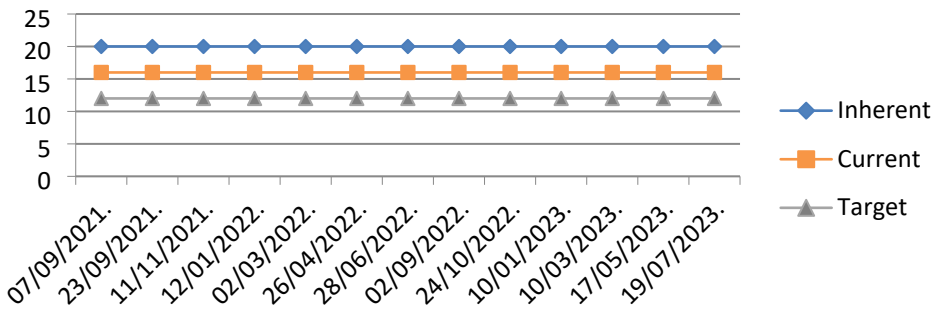
There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Well-being (Wales) Act 2014 (SSWWA).

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 ,the Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] in addition to 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 legislation and statutory 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.

There is a risk that the Health Board may not be able to discharge its statutory duties in line with the new Serious Violence Duty: Preventing and Reducing Serious Violence Statutory Guidance for Responsible Authorities [2022]. This legislation will place an increase in statutory engagement and multi-agency accountability to ensure that relevant services work together to share information to allow them to target interventions, where possible through existing partnership structures, collaborate and plan to prevent and reduce serious violence within local communities.



	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 May 2023	Unchanged		

Controls in place	**Assurances**
1. All Wales and North Wales Safeguarding procedures approved and in place. 2. BCUHB local work programmes is in place and aligned to the National strategies which are regularly reported to Welsh Government. 3. 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 (SGPG) and Safeguarding Forums agendas. 4. A standardised data report on key areas including Adult at Risk, Child at Risk and Deprivation of Liberty Safeguards (DoLS) is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [Wales] Act 2014 and Wales Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms. 6. 7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 8. Welsh Government interim monies has been utilised to increase physical capacity out of hours. 9. Sexual Abuse Referral Centre (SARC) lead has been identified for the Health Board to support the implementation and compliance against the SARC accreditation. SARC remains the accountability of the Central Integrated Health Community (IHC).	1. This risk is regularly monitored and reviewed at the SDPG. 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 / Children's Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is

10. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews. 11. Monies secured and implemented for the role of Independent Domestic Violence Advocate in YG and YGC and WMH. 12. Health Board Leading on Emergency Department Safeguarding Action plans to support the Health Inspectorate Wales [HIW] findings, recommendations and overarching HIW action plans reporting and monitored at the relevant Safeguarding Forums and to the Safeguarding Governance and Performance Group 13. Undertaking bespoke supervision/peer support activities within high risk and low compliance areas/departments via Hospital Management Team's, reporting to the Safeguarding Governance and Performance Group. 14. Targeted intervention for key areas ie. the 3 Emergency Departments and a number of identified wards and areas within Mental Health and Learning Disabilities is in place, with escalation taking place accordingly. 15. The Safeguarding Reporting Framework and the Safeguarding Governance and Performance Group ToR were updated to reflect and support the new BCUHB Operational Model. 16. In line with the new Serious Violence Duty: Preventing and Reducing Serious Violence Statutory Guidance for Responsible Authorities [2022], BCUHB have identified the Director of Safeguarding and Public Protection as the Senior Responsible Officer [SRO] which is in line with Chapter Four: Sector Specific Guidance;260.	monitored by the Safeguarding Governance and Performance group, MHACCC and is reported into the Welsh Government. 7. BCUHB are fully engaged in National and Regional Forums to provide assurance of the implementation of the Serious Violence Duty: Preventing and Reducing Serious Violence Statutory Guidance for Responsible Authorities [2022]

Gaps in Controls/mitigations
1. The increase in safeguarding activity, with enhanced complexity as a result of COVID and the impact of the lockdown period which resulted in Children and Young People and Vulnerable Adults not being seen by professionals to identify abuse and harm. The increase in victims recognised as a result of Domestic Abuse and Sexual Violence, Refugees, Modern Day Slavery/Human Trafficking, Prevent and County Lines, has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. This has resulted in the prioritisation of elements of service delivery aligned to the identified risk, being put in place and the development of a Safeguarding Business Case. 2. The 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 a comprehensive digital clinical patient record reduces the identification of individual patient risks which results in the delay of information, communication and is time consuming. Safeguarding mandatory fields are in place within the Symphony system into Emergency Departments relating to non-accidental injuries for children under the age of 2 years, with alternative platforms in place when they have limited digital patient records. BCUHB Corporate Safeguarding is supporting the National Team to develop the Safeguarding Datix to capture the data collected by BCUHB.
4. Lack of consistent approach by the six 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. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible.
5. Compliance rates of training does not provide assurance against the knowledge and application of the training into clinical practice. Measuring understanding and application of training materials using desktop reviews, audit and utilising a survey monkey is to be developed and monitored by implementation plans. Targeted activity for low compliance and high risk areas. Dissemination of Learning materials took place during Safeguarding week and remains an ongoing activity (Mugs, pens, keyrings relating to Consent and Capacity and Mental Capacity Act (MCA).
6. One senior and operational posts/hours remain vacant due to retirement or reduction in hours actioned under flexible working. Recruitment has taken place, risk assessment are in place focusing upon service delivery and the identification of activities to ensure compliance and engagement. The Survey Monkey regarding the delivery of services will support the agreed future delivery and anticipation of activity.
7. IHC Central Safeguarding Forum is not consistently taking place, there is proactive engagement taking place with the chairs to review membership and the agenda including the cycle of business to ensure full engagement and escalation. This will be supported by the review of the terms of reference and reporting framework relating to the Safeguarding Governance and Performance Group (SGPG).
8. The number of Child Practice Reviews/Adult Practice Reviews/Domestic Homicide Reviews have increased considerably, this places increased pressure upon the Team to allocate statutory membership and statutory participation. The Safeguarding Boards for both Children and Adults is to discuss and consider revised training engagement and governance activities relating to participation of organisations in the complex area of work. Corporate Safeguarding as a result of the outcome will review the Safeguarding Standard Operating Procedure (SoP) to strengthen and streamline governance and reporting and the identification of Trends. Processes are in place to ensure engagement and participation following National and Local procedures.
9. There is a lack of standardised engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team and the Safeguarding Team. The newly appointed Head of Safeguarding Business, Quality and Governance is agreeing a

pathway and developing a Standard Operating Procedure (SoP) to ensure consistency, engagement and collaboration, this activity has commenced.
10. There is reduced engagement and embedded process agreed with HMP Berwyn regarding access by the prison clientel for NHS services and the management of risk and governance. Head of Safeguarding Adults is finalising a pathway and SoP to ensure consistency, engagement and collaboration with the prison service to ensure a framework is in place and is effective. Discussions have taken place to inform safeguarding of any current required engagement.
11. Audit data has shown there was a reduction in Statutory participation at MAPPA 2 and MAPPA 3 (Very High Risk Individuals) meetings by Corporate Safeguarding (Crime and Disorder Act 2014). This had resulted in immediate interim controls to be put in place but a review of the Safeguarding Standard Operating Procedure and awareness Training has commenced.
12. The allocation of resettlement of refugees within the six Local Authority areas has significantly increased, this is outside of the control of BCUHB. However, full engagement and participation in multi-agency activity is required. Corporate Safeguarding remain engaged as part of the statutory membership at each of the three Safeguarding Delivery Boards which remains the responsibility in line with the Social Services and Well-Being (Wales) Act 2014.
13. The Joint Inspection Child Protection Arrangements [JICPA], identified a number of areas requiring development. The areas identified related to front line activity, IT and Training compliance and documentation. Corporate Safeguarding have identified an Implementation and Assurance Plan which evidences targeted intervention with ownership and accountability in line with the Safeguarding Reporting Framework.
14. In line with the new Serious Violence Duty: Preventing and Reducing Serious Violence Statutory Guidance for Responsible Authorities [2022]. Legal duties are identified for NHS organisations and full engagement and participation is required. BCUHB have identified the Director of Safeguarding and Public Protection as the Senior Responsible Officer [SRO] which is in line with Chapter Four: Sector Specific Guidance;260. Discussions are taking place to support the identification of key activities, risk and engagement.
15. Martyn's Law – Protect Duty Legislation will be coming into force as a result of the Manchester terrorist attacks. Corporate Safeguarding and the Health and Safety Team, Emergency Planning are engaged in the discussions and attending the Preparedness Forums which are a subgroup of the Contest Regional Board. The Home Office Prevent Training was agreed on 15/5/23 to be a BCUHB mandatory training package by the Mandatory Training Group.
16. The Head of Safeguarding Adults/Adult at Risk remains vacant. The interview has taken place, position has been appointed to, employment checks are taking place, with an expected start date of June 2023. The Senior Team has utilised carrying over Annual Leave which has been authorised, interim cover arrangements are in place. A survey monkey is taking place for feedback from the team to obtain feedback of the interim service delivery arrangements. The senior team have been flexible and working outside of working hours/weekends and working additional hours to cover for AL, and complex activity.

17. Corporate Safeguarding are leading and supporting compliance of the ISO Sexual Assault Referral Centre (SARC) which was the responsibility of the Childrens Division prior to the New Operating Model. Currently the Central IHC manages the activities within SARC, recruitment to the Vacant Manager post has taken place – awaiting the start date. Reporting and Governance is strengthened, discussions are taking place at CEO and Executive level to agree the revised final governance and management arrangements going forward.
18. The North Wales Safeguarding Board expressed a concern that there are few applications for consideration for an Adult Practice Review (APR) to learn lessons. BCUHB are engaged in a task and Finsh Group to develop a Governance Framework to discuss Unexpected Deaths in Adults, which include suicide, following the same principles of the PRUDiC for children.
19. The BCUHB Safeguarding Training data cannot be recorded by Level 2 and Level 3. The data is presented in key forums, with targeted intervention and oversight by the Safeguarding Governance and Reporting Group and IHCs.
20. Named Doctor for Safeguarding Children is in post and holds a strategic portfolio. This post holder is currently on long term sick leave and availability for cover arrangements remain a challenge. The Clinical Director for Paediatrics has oversight on a regional footprint and in consultation with the Head of Safeguarding Children key priorities are given immediate consideration.

Progress since last submission

1. Risk Description reviewed and amended to reflect the current position of the risk.
2. Controls in place updated to reflect current risk position.
3. Gaps in controls updated to reflect current risk position.
4. Proposal to extend the Target risk due date from the 31/10/2023 to the 31/07/2024, due to the challenge the Health Board has is the increase in demand is not within the Health Board's control and the financial challenges of the organisation may again stop the business case.
5. The Ockenden Review (2018) Recommendation 6 recorded that the then Executive Director of Nursing had committed significant resources into developing sound foundations for the safeguarding structure. However, it is recorded for an organisation such as BCUHB a significant amount of work was still needed to be done and that this work would need continued Board scrutiny and oversight to ensure progress in the development of the service continues and if necessary reporting to Welsh Government if progress falters or slows down.
6 As a result of high level of sickness and vacancies a review of the Safeguarding operational governance structure has taken place, resulting in a regional footprint relating to management and escalation for clinical specialists for both Children and Adults.
7 The Interim post holder for Safeguarding Quality and Governance became vacant at the end of January 2023, action has commenced to recruit to the vacancy. 6. Due to the Organisations Financial position, a review of the Intermediate Medium Term Plan (IMTP) has been submitted to the Executive Team with recognition that funding may not be supported.

8. As a result of the Operating Model, Sexual Abuse Referral Centre (SARC) is to transfer into the Safeguarding portfolio with regards to accountability and responsibility. A meeting took place on the 18th January 2023 with the Executive Director of Nursing to obtain clarity regarding timescales and the transfer of funding and staff. A decision was made to keep the management and responsibility of the SARC in the Central IHC, until a review is completed as part of the ISO Accreditation work.
9. Recruitment has taken place during January 2023 to both Operational and Senior posts and both are following the recruitment process, Senior Manager post commenced during March 2023, with the Head of Safeguarding adults post commenced 10.07.2023
10. Action ID 18113 – Action delayed, The First draft of the Standard Operating Procedure is completed and is now in the second phase of consultation. Which will include learning from retrospective desktop reviews.
11. Action ID 18120 – Action delayed, The consultation is closed and we await next steps.
12. Action ID 21216 – Action delayed, awaiting formal feedback with regard to the Safeguarding and Public Protection Business case.
13. Action ID 23507 – Action delayed, awaiting formal feedback with regard to the Safeguarding and Public Protection Business case.
14. Action ID 24582 – Action delayed, As a result of the JICPA an Improvement and Assurance Plan is under development and includes this recommendation. This will be ratified at the SGPG in October 2023. (ID 24801)
15. Action ID 24583 – Action delayed, Appointed to the Head of Safeguarding Adult post 10.07.2023. The vacancy has resulted in a delay but this action will progress as a key objective.
16. Action ID 24594 – Action delayed, No further update, continue to await formal feedback re business case.
15. Action ID 24801 – Action delayed, JICPA Improvement & Assurance Action Plan for BCUHB is complete. A multi-agency action plan has been requested by the WG. This will be monitored by the Safeguarding Children's Board. Ratification SGPG October 2023.
17. Action ID 24802 – Action Closed, Corporate Safeguarding have allocated key representation and the Director of Safeguarding & Public Protection is the statutory single point of contact.
18. Action ID 24803 – Action complete. Martyn's Law and the Protect Duty Legislation is a recognised agenda item at the SGPG. There is an agreed escalation for the threat/risk within BCUHB and agreement to identify a SPOC.
19. Action ID 24804 – Action delayed. A Senior Leads consultation event has been arranged.
20. Identification of a new action to develop and agree the BCUHB Training and Implementation Strategy for the Home Office mandatory Prevent Training
21. The BCUHB Leadership Group and the WoD Director agreed to support the implementation of BCUHB Safeguarding Training data to be recorded by Level 2 and Level 3 instead of a combined compliance. (Linked to WoDs Risk Register)

22. A clinical lead has been appointed for 3 days per week and will be working with the North Wales Police and key stakeholders to develop the clinical SOPs which will be in place from October 2023.

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

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**
	18113	Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014].	Michelle Denwood, Director of Safeguarding and Public Protection	20/12/2021	The process and the development of Key Performance Indicators' can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings.	Delay

					June/July 2023 progress update: The First draft of the Standard Operating Procedure is completed and is now in the second phase of consultation. Which will include learning from retrospective desktop reviews.	
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Director of Safeguarding and Public Protection	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. June/July 2023 progress update: The consultation is closed and we await next steps.	Delay
	21216	Utilise the agreed BCUHB IMTP funding application to support the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-Being [Wales] Act 2014to support the increased activity. This is dependent on the approval and governance process as part of the	Delay

					Integrated Medium Term Plan. The delayed LPS Code of Practice has impacted upon the development and revised proposed Safeguarding Structure and Business Case. June/July 2023 progress update - Action delayed, awaiting formal feedback with regard to the Safeguarding and Public Protection Business case.	
	23507	Mental Health & Learning Disability to include the identification of resource to support a Safeguarding physical presence within the Mental Health Units.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	A single point of contact and physical presence will support the front line clinician to identify and to safeguard service users who may be at risk of harm. Will support the implementation of safeguarding practice and training. This action has again been discussed with the interim Director of Nursing MHLD	Delay

					June/July 2023 progress update - Action delayed, awaiting formal feedback with regard to the Safeguarding and Public Protection Business case.	
	24581	Ensure panel members, Chairs and Reviewers of Multi-agency Child and Adult Death Reviews have the necessary skills and expertise to engage and to ensure monitoring arrangements are embedded into the role and responsibilities.	Michelle Denwood, Director Of Safeguarding And Public Protection	31/09/2023	The newly appointed Head of Safeguarding Business, Quality and Governance is reviewing the Safeguarding Standard Operating Procedure (SoP) to strengthen and streamline governance and reporting and improve the identification of themes and trends. The Practice Development Lead is developing specialist Training to support panel members and to increase the availability of BCUHB safeguarding specialist as the designated Chairs and Reviewers for complex multi-agency death reviews. The NWSB Business Meeting agreed a North Wales approach regarding training and performance will also be a priority – giving	On track

					consideration to the Single Unified Safeguarding Review (SUSR) July 2023 – We are awaiting the national position on the implementation and training schedule of the new SUSR.	
	24582	Improve the consistency of escalation and engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team with the Safeguarding Team	Michelle Denwood, Director Of Safeguarding And Public Protection	31/07/2023	July 2023 progress update – As a result of the JICPA an Improvement and Assurance Plan is under development and includes this recommendation. This will be ratified at the SGPG in October 2023	Delay
	24583	Improve and embedded processes agreed with HMP Berwyn relating to the access by the prison clientel of NHS services, to strengthen the management of risk, governance and communication.	Chris Walker, Head of Safeguarding Adults/MHLD	30/06/2023	Engagement has commenced and dates agreed to progress with this work. Immediate safeguards are in place for HMP to notify where appropriate safeguarding. July 2023 progress update – Appointed to the Head of Safeguarding Adult post 10.07.2023. The vacancy has resulted in a delay but	Delay

					this action will progress as a key objective.	
	24594	Recruit to the position of Head of Safeguarding, Quality Governance and Risk	Michelle Denwood, Director Of Safeguarding And Public Protection	30/04/2023	The portfolio ensures assurance and quality measures are in place to ensure the Organisation is compliant with the legal requirements of the Social Services Wellbeing (Wales) Act and supporting legislation. June/July 2023 progress update – No further update, continue to await formal feedback re business case.	Delay
	24801	Joint Inspection Child Protection Arrangements (JICPA) – Development of the “Improvement and Assurance Action Plan”.	Lynda Collier, Head of Safeguarding Children	30/06/23	June/July 2023 progress update – JICPA Improvement & Assurance Action Plan for BCUHB is complete. A multi-agency action plan has been requested by the WG. This will be monitored by the Safeguarding Children’s Board. Ratification SGPG October 2023.	Delay
	24802	Corporate Safeguarding will allocate representation /	Chris Weaver, Head of	30/04/23	June/July 2023 progress update – Action Closed, Corporate Safeguarding	Complete

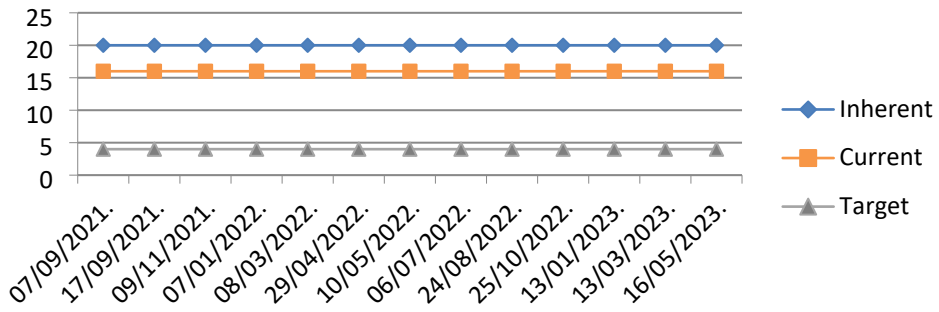
		membership to key groups to support implementation and compliance against the new Serious Violence Duty: Preventing and Reducing Serious Violence Statutory Guidance for Responsible Authorities [2022],	Safeguarding Children		have allocated key representation and the Director of Safeguarding & Public Protection is the statutory single point of contact.	
	24803	Martyn's Law – Protect Duty Legislation to be an agenda item at key BCUHB and Safeguarding Groups/Forums, with assurance regarding engagement, participation and escalation to provide assurance and evidence that monitoring arrangements are in place in line with NHS legal duties.	Chris Walker, Head of Safeguarding Adults	31/10/23	June/July 2023 progress update – Action Closed, Martyn's Law and the Protect Duty Legislation is a recognised agenda item at the SGPG. There is an agreed escalation for the threat/risk within BCUHB and agreement to identify a SPOC.	Complete
	24804	Review and implement the Safeguarding Service Delivery Model across BCUHB in line with the new Operating Model, Safeguarding Reporting Framework, demand, operational challenges and LA priorities (Lead Agency).	Lynda Collier, Head of Safeguarding Children	30/07/23	An interim service delivery model is in place. A Survey Monkey has been developed to obtain feedback from Safeguarding Team Members. Engagement and discussion is planned to engage with the Regional LAC Forums and	Delay

					with the Suicide and Self Harm Forum to ensure future engagement and reporting is in line with the Revised Safeguarding Reporting Framework. June/July 2023 progress update – A Senior Leads consultation event has been arranged.	
	24805	NW Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications	Chris Weaver, Head of Safeguarding Children	31/10/23	June/July 2023 progress update – ISO activity remains active an in place. ISO Accreditation - Building work is underway with a plan for an open day in August. A clinical lead has been appointed for 3 days per week and will be working with the North Wales Police and key stakeholders to develop the clinical SOPs which will be in place from October 2023	On Track
	New action	Develop and agree the BCUHB Training and Implementation Strategy for	Practice Development Leads Yvonne	31.10.23	May 2023 progress update - Agreed the Prevent Training is to be Mandatory. Paper	On Track

		the Home Office mandatory Prevent Training	Hughes and Angela Roberts		presented at both the Mandatory Training Group and the Health and Security Group June/July 2023 Update - The PREVENT Training was discussed and agreed as a recommendation to be mandatory in the BCU Training Group and the Health & Safety Group with a proposal to be presented at the Board for formal agreement.	

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:** 16 May 2023
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 20 June 2023
		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, Health and Safety Executive enforcement action (recent related Improvement Notices for Patient Falls, Patient Handling and Portering Load Handling risk assessments) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, 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. There is an increased risk due to mass recruitment of HCA's, Nurses leading to failure to deliver compliance.



	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 January 2023	unchanged		

Controls in place	Assurances
1. Health & Safety Strategy has been approved which includes Manual Handling. 2. Training plan is in place specifically in relation to Manual Handling, training compliance is monitored by the Mandatory training group.	1. Regular oversight and review by the Occupational Health & Safety Team.

3. Recruitment programme has been approved and is in place as part of the Health & Safety business case. 4. Risk assessments in place to provide safe training environment. 5. A full review of the training was completed in August 2021 to ensure the training provided was in line with the All Wales Manual Handling training passport scheme. 6. Suite of fully functional training rooms secured. 7. Datix system is monitored daily by the Health and Safety team to review incidents and follow up on lessons learnt. 8. Multi-disciplinary team including Manual Handling representative set up and currently auditing compliance with patient handling risk assessments. 9. Manual Handling Manager commenced in post on the 01/03/2023.	2. Reviewed at the Strategic Occupational Health and Safety Group. 3. Risk Management Group oversight. 4. Local Partnership Forum. 5. Health and Safety Executive inspections.

Gaps in Controls/mitigations
1. Low compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance, however with the larger recruitment drives requiring additional 2 days foundation training courses to be provided this is impacting on the Patient Handling Refresher Programme compliance rates is challenging. 2. Lack of integrated booking system for Orientation training with the ESR system and ESR is not easy to use. Manual bookings currently in place. 3. Did Not Attend (DNA) at training sessions. A review of the rate of DNAs and evaluation of causes of none attendance remains a gap in the system. This will be undertaken by the new band 6 roles, when in post. This will strengthen the review of DNA's as part of the work programme. 4. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the Manual Handling Passport Scheme. The business case has been agreed and is being implemented, but this remains a gap in the controls until recruitment has been successful. Current compliance for Patient Handling refresher is now at 53% as of April 2023. 5. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments, action plan developed to comply with HSE improvement notice and Multi-Disciplinary Team set up to audit internal compliance.

Progress since last submission

1. Controls in place reviewed to reflect current position.
2. Gaps in Controls reviewed and updated to reflect current position.
3. Recruitment of 3 Manual Handling trainers has taken place, however, this is to replace current vacancies. Further 2 additional posts have also been recruited and commenced. Trainers are being trained and will become independent trainers by the end of June 2023.
4. Administration support for the Manual Handling team to monitor DNA's at training has since left the post, the post was recruited through bank staff, funding for a replacement post is not available.
5. Contract for the external training rooms in Commodore House Abergele ends in December 2023, plans in place to move to training room 1 in Abergele Hospital, however the residents building has been ear marked for rationalisation and therefore this may not be a long term solution.
6. Contract for the external training rooms in Parc Menai in Bangor ends in February 2024, potential for use of a training room in Bryn Y Neuadd currently being explored as a alternative, however this will only allow one training room which may not be sufficient, however, the team are providing training in the Community Hospitals in the West.
7. Contract for the training rooms in Redwither Tower in Wrexham ends February 2024, IHC Director aware, and considering space in Plas Gorau in Wrexham.
8. SBAR to be completed to be presented to Executive Team with an update on current position by the 31/05/2023.
9. 3x vacant band 6 advisor posts to go back out to advert, led by the new Manual Handling Team Manager by the 31/05/2023.
10. Action ID 17979 – Action Closed, All trainers are now in place and recruited.
11. Action ID17980 – Action delayed, In depth checks using the ESR system to identify staff sickness trends and high risk areas. This will form part of the work of the Muscular Skeletal Group, with the first meeting planned for June 2023. Training Needs Analysis will be drafted in preparation for the meeting.
12. Action ID 18859 - Delayed action, Manual Handling Manager is currently reviewing the Policy, to be presented at the next Health and Safety Leads Team Meeting during June 2023.
13. Action ID24050 – Action delayed, First meeting to be held in June 2023.

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	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.	Mrs Susan Morgan, Head of Health, Safety and Security	30/11/2021	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. May 2023 progress update - Action Closed, All trainers are now in place and recruited.	Completed
	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.	Mrs Susan Morgan, Head of Health, Safety and Security	01/04/2023	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. May 2023 progress update - In depth checks using the ESR system to identify staff sickness trends and high risk areas. This will form part of the work of the Muscular	Delay

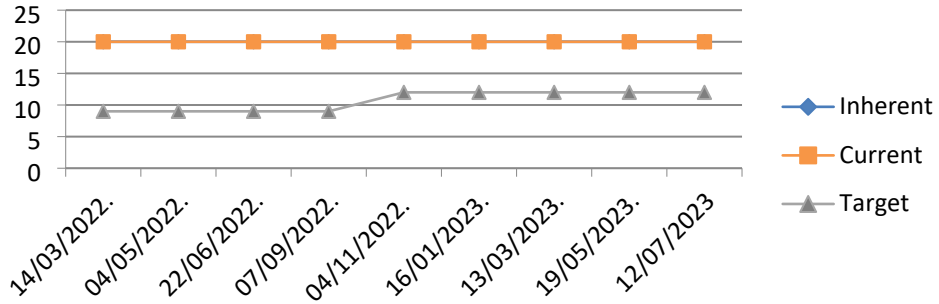
					Skeletal Group, with the first meeting planned for June 2023. Training Needs Analysis will be drafted in preparation for the meeting.	
	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mrs Susan Morgan, Head of Health, Safety and Security	31/12/2021	Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the likelihood of injury to both patients and staff. May 2023 progress update - Delayed action, Manual Handling Manager is currently reviewing the Policy, to be presented at the next Health and Safety Leads Team Meeting during June 2023.	Delay
	24050	Muscular-skeletal disorder group to be re-instated to review trends in incidents and follow up improvement actions.	Mrs Susan Morgan, Head of Health, Safety and Security	31/12/2022	Identify hot spot areas and to target those areas for intervention. May 2023 progress update - First meeting to be held in June 2023.	Delay

CRR22-20	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 12 July 2023
	Risk; Residents in north Wales are unable to achieve a healthy weight due to multifactorial and complex system wide factors that promote overweight and obesity	**Date of Committee Review:** 17 January 2023
		Target Risk Date: 31 December 2025

There is a risk that residents in North Wales may be unable to achieve a healthy weight and may become overweight and obese.

This may be caused by behaviours involving food intake, current circumstances, lack of physical activities, the living environment, food production and consumption, socio-economic factors and a lack of engagement with health professionals.

This may have an impact on or lead to unhealthy weight and obesity and place them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression, which could lead to potentially avoidable deaths.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	Assurances
1. Continue to take a life course approach to implementing prevention based healthy weight initiatives which will report progress via a number of routes including the Healthy Weight Healthy Wales National Group, the BCU Population Health Group, and the Regional Partnership Group. 2. The continuation and further targeted development of 'Healthy Start' which provides vouchers for pregnant women and eligible families to buy milk, fruit, vegetables and pulses in local shops. 3. Continuation and further development of Maternity and Health Visiting Services supporting breastfeeding and weaning to support the Infant feeding Strategy, monitored via the North Wales Strategic Infant Feeding Group. 4. Community Dietetics Services will work with childcare provision embedding 'Tiny Tums' programme across all Early Years settings to encourage healthy, nutritious eating habits from early years. 5. Further supporting schools to take a 'whole schools' approach to health and wellbeing with a particular focus on diet through initiatives such as Come and Cook with your child and considerations regarding developing healthy eating habits and increased physical activity. 6. Actif North Wales - a strategic partnership supporting residents of north Wales to be more active 7. Continue to support the workforce to make healthy choices such as a balanced diet, active travel and moving more often through targeted campaigns and supportive services/infrastructure. Working with catering, dieticians, estates and occupational health colleagues to contribute to planning which considers these factors. 8. Further develop the whole system partnership approach to tackle risk factors through influencing priorities such as environmental planning and design, access to healthy food and active travel. 9. Further develop the links and access to Social Prescribing that encourages physical activity through partnership working with Primary Care, Local Authorities and Third Sector. 10. Lobby for long term investment in North Wales approach.	1. Risk is regularly reviewed at the Public Health Senior Management team meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. The Population Health Executive Delivery Group reviews Tier 1 risks. 4. The risk is linked to Corporate Risk register entry CRR22-21 in respect of wider determinants 5. National funding for 22/23, 23/24 through Prevention and Early Years allocations and has been confirmed for 23/24 and 24/25. 6. Progress reports are submitted and reviewed with challenge by Welsh Government Leads. 7. Progress is reported to Regional Partnership Board and PPPH Committee. 8. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (23/24-25). 9. There is senior Public Health representation by the Health Board at Public Service Boards, Partner

	Boards, Regional Partnership Board and National forums. 10. The risk is linked to Corporate Risk register entry CRR22-21 in respect of weight services.

Gaps in Controls/mitigations
1. In order to implement a system wide approach it is necessary for commitment from partners wider than the Health Board to prioritise the implementation of evidence informed practices and proposals. 2. The North Wales region is not operating at the pace or scale required to meet the current and forecast needs of the population. Resources and current pressures for all partners and the Health Board presents significant challenge to increase the activates required. 3. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success. 4. There is no secured long term funding to support implementation and growth of the whole system approach across North Wales at scale. 5. The current cost of living crisis will adversely affect those most at risk from factors which increase overweight or obesity 6. The current financial position of the Health Board and its partners will negatively impact on new investment into key business cases which support this work. 7. The current position of the Health Board within escalatory measures and short term focus on meeting ministerial and special measures priority actions may reduce focus on longer term priority work. 8. There is a shortfall in non-pay budget available from the grand fund due to increased pay costs as a result of the pay award. There is no additional funding allocation as part of the grant fund to support this.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Performance & Risk Management Group meet monthly as part of Public Health's governance and communications structure. 4. Performance and Risk Management Group report to the Population Health Executive delivery group. 5. The Whole system approach delivery plan has been launched. 6. The governance structure has been agreed for Whole System approach. 7. Progress reports have been submitted to HBLG, PHEDG and the Public health senior leadership team. 8. Strategic Partnership Group established in line with Whole System Governance structure.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

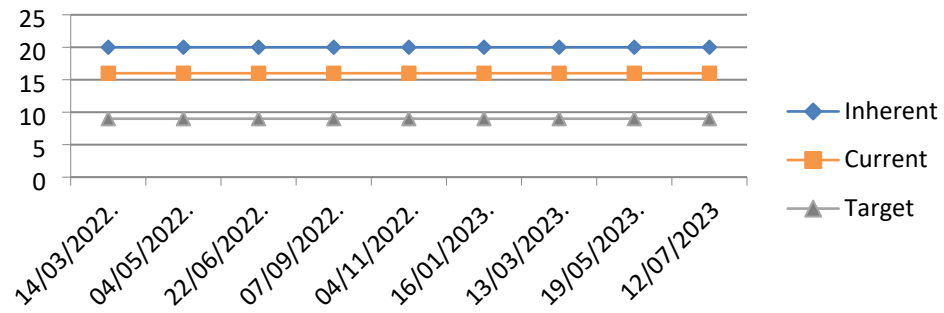
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	22372	Whole system approach to healthy weight	Ceriann Tunnah, Consultant in Public Health	31/03/2025	Taking a whole system approach to healthy weight will ensure that all partners are prioritising the issue of healthy weight and considering the impact of their decision-making on the population's ability to achieve a healthy weight. Obesity is a complex multi-factorial problem that requires a whole system approach. Key partners that are crucial to this work include spatial planners, transport providers, education providers, food providers, leisure	On track

					providers etc. July 2023 progress update - Strategy launched with partners and governance structure in place.	
	22373	Healthy Choices in the workplace	Ceriann Tunnah, Consultant in Public Health	31/05/2023	The working age adult population spend a significant amount of their time in the workplace. As a result it is crucial that we support workplaces to be health promoting. This means ensuring staff have access to healthy food choices, equipment to make healthy meals, enough time away from work to prepare and eat a healthy meal. It is also crucial that the workplace supports their staff to remain active while at work as both diet and physical activity are crucial to achieving a healthy weight. July 2023 progress update - This action will close on approval of the BCUHB food environment policy. Currently with the established group. Policy will be ready by September for BCU to review.	On track
	22375	Social prescribing	Ceriann Tunnah, Consultant in Public Health	31/03/2024	Increasing physical activity levels is crucial in supporting people to achieve and maintain a healthy weight. One way that we can	On track

					support people to do this for free is by promoting access to the natural environment. By doing this will also improve people's mental health as well as their physical health. This approach will also develop people's appreciation for nature and the need to protect it. One way of doing this is to optimise access through social prescribing. July 2023 progress update - this action will close on re-tendering of Social Prescribing Services in 23/24 as it will form part of the contracting requirements.	
	22376	Pre-diabetes programme	Ceriann Tunnah, Consultant in Public Health	31/03/2025	By identifying patients who are at risk of developing diabetes and supporting them to access specialist weight management services we are taking a teachable moment opportunity and ensuring the patient is supported to improve their health and wellbeing. Primary care brief interventions are crucial in motivating people to change by implementing this programme across North Wales it is hoped more of the population who are overweight or obese will seek support to achieve and maintain a healthy weight.	On track

					July 2023 progress update - pilot work is currently underway within the West Region.	
	24809	Improve access to healthy and affordable food	Ceriann Tunnah, Consultant in Public Health	31/03/2024	Access to healthy and affordable food has been identified as a key priority to supporting people to achieve a healthy weight through the system mapping process. Enabling this makes the healthy choice the easy choice for our residents. July 2023 progress update - we have piloted a mobile shop facility across each local authority and are in the process of writing up findings.	On track

CRR22-21	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 12 July 2023
	Risk: Lack of Specialist Weight Management Services (Children and Adults)	**Date of Committee Review:** 17 January 2023
		Target Risk Date: 31 December 2025
There is a risk that those patients (children and adults) who are already overweight and obese will remain so, due to a lack of Specialist Weight Management Services. This could be caused by non-engagement with specialist weight management services or demand for services exceeding capacity. This could impact on the health outcomes for these individuals by placing them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression		



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	**Assurances**
1. Healthy Weight Healthy Wales funding to support with the implementation of the All Wales Weight Management Pathways for children and adults. 3. A Level 2 adult weight management service offering a range of 12 week weight management services (Kind Eating, Slimming World and Second Nature) for adults with a BMI of 30+ 4. A Level 3 adult weight management service for adults with a BMI of 45+	1. Risk is regularly reviewed at the Public Health Senior Management team meetings and at their local governance meeting.

5. A Level 3 children, young people and families weight management service for children above the 99th centile. 6. The establishment of a BCU Healthy Weight Healthy weight management pathway group to oversee the delivery of specialist weight management services. 7. A Level 2 children, young people and families pilot delivered in Wrexham	2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. The Population Health Executive Delivery Group reviews Tier 1 risks. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants 5. National funding for 22/23, 23/24, 24/25through Prevention and Early Years and Healthy Weight Healthy Wales allocations. 6. Progress reports are submitted and reviewed with challenge by Welsh Government and Public Health Wales Leads. 7. Progress is reported to Regional Partnership Board. 8. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (23/24-25).

Gaps in Controls/mitigations
1. The current Health Board provision does not meet the scale required to address current or forecast North Wales population requirements and as informed by the All Wales Weight Management Pathway and NICE guidance 2. The lack of capacity within the Level 3 Adult service has resulted in significant waiting lists and waiting times for patients 3. There is currently no Level 2 Children, Young People and Families weight management service in north Wales 4. There is no identified long term funding for some aspects of the weight management pathway which are currently supported via annual national allocations.

5. Recruitment pressures - lack of weight management workforce available - both ability to attract and numbers.
6. Some of the current systems for data collection are not compatible with producing the weight management service dashboard resulting in the health board being unable to report on outcomes against the NHS performance framework obesity targets and All Wales Weight Management Pathway minimum dataset
7. The cost of living crisis could undermine the current effectiveness of the workplan and the capability of the patients to engage with programmes and adopt a healthy eating regime.
8. The current financial position of the Health Board will negatively impact on new investment into key business cases which support this work.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to reflect current position. 3. Actions reviewed and progress provided against the actions. 4. The Public Health team PIDs for 23/24 associated with Healthy Weight are approved 5. The plan for use of Prevention and Early Years grant funding in 23/24 has been submitted to Welsh Government 6. Agreement to recruit grant funded staff into permanent positions (increasing opportunity to recruit within weight services) 7. Inclusion of Healthy Weight plan and delivery within the BCUHB 23/24 Annual plan.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

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	22357	Insight work	Ceriann Tunnah, Consultant in Public Health	31/03/2023	Insight work will enable us to improve outcomes for patients who were identified as overweight or obese.	Delay

target risk score					Factors that will be considered will include how patients access services, the intervention they receive and the factors that led to then disengaging. This information will allow us to design our weight management services to meet the needs of patients achieve better outcomes e.i patients achieving a healthy weight and adopting healthy behaviours July 2023 progress update- staff sickness has delayed the progress against this work however member of team will now progress this as part of their portfolio during 23/24. Final report by March 2024.	
	22358	pregnancy weight management service	Ceriann Tunnah, Consultant in Public Health	31/12/2023	Providing a weight management service during pregnancy will ensure that women are able to achieve a healthy weight during and after pregnancy and maintain their healthy behaviour postnatally. July 2023 progress update -	On track

					staff to provide service are currently out for recruitment. Recruitment continues.	
	22359	performance management dashboard	Ceriann Tunnah, Consultant in Public Health	31/03/2023	Developing a performance management dashboard will ensure that we are able to monitor the uptake of the service by population groups that are at increased risk of adverse outcomes from obesity. The dashboard will enable us to monitor both uptakes and outcomes by ethnicity, gender and deprivation decile July 2023 progress update - funding has been secured for an analyst post to progress this in 23/24. In discussion with Public Health Wales and National teams regarding potential duplication of work regarding developing the data sets and intel to support dashboard development, funding agreed but awaiting National steer.	Delay

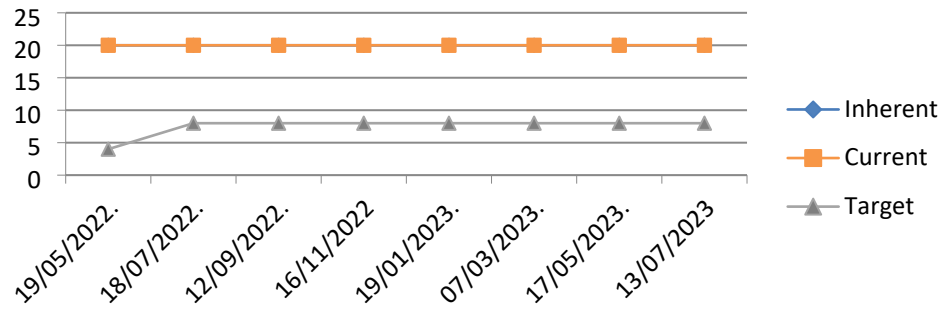
	22943	Implement Healthy Weight Healthy Wales Programme Plan	Ceriann Tunnah, Consultant in Public Health	31/03/2024	Funded activity targeted at improving healthy eating habits and tackling obesity. July 2023 progress update - ongoing work in line with programme plan	On track

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 13 July 2023
	Risk: Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 December 2023

There is a risk that BCUHB staff cannot access their mandatory resuscitation training.

This is due to several factors including:
A lack of 'fit for purpose' training accommodation and equipment across the sites; Insufficient numbers of Resuscitation Officers/Trainers.

This could lead to failure to deliver effective patient care resulting in preventable harm or death from impaired or unsuccessful resuscitation. Additional risk of financial claims against BCUHB resulting from preventable harm/deaths.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	**Assurances**
1. Resuscitation Policy and Guidance is in place for the Health Board with compliance overseen by the Resuscitation Committee. 2. Training plan in place governed by the UK core skills framework. 3. Resuscitation training is a mandatory training programme across the Health Board.	The risk is reviewed monthly by the Resuscitation Services senior management team, and is presented to the Resuscitation committee on a quarterly basis.

4. Delivery of the training has been re-designed to increase capacity, this has resulted in the reduction of clinical staff's time away from clinical duties. 5. Systems and processes are in place to manage attendance at training sessions. 6. Additional temporary training footprint sourced within the Central region. 7. Assurance that all resuscitation attempts by the emergency response teams are led by staff who hold the current Advanced Life Support qualification for the respective teams. The assurance of this is being supported by the reinstatement of the daily test bleeps for the teams in Central, and with a log of the current advanced resuscitation qualification status recorded each day as team members respond to the test bleep. Where an 'expected team leader' does not hold the required qualification, then the team leadership role is deferred to another team member who does hold the required qualification. 8. Advanced courses have been picked up within West and East sites for the Central region depending on availability of rooms.	Training figures and capacity are regularly reviewed on a quarterly basis at the Resuscitation Committee via site reports. The risk has been presented to PSQ (Performance Safety & Quality), and Clinical Effectiveness groups (13th October 2021)

Gaps in Controls/mitigations
1. Despite controls above, there remains a deficit of approximately 2000 training places per year for resuscitation training at UKCSTF Level 3 on the Central locality. Work ongoing with Finance to move budget to enable an increase in establishment of resus staffing within BCU. 2. There is no dedicated training accommodation on the Central locality. This lack of fit for purpose accommodation is in breach of the national standards as set by the Resuscitation Council UK. Continued breach could result in loss of course centre license on the Central locality which would cease all level 3 training from the site. The identified potential accommodation requires investment (quotations have been provided to Central Integrated Health Care (IHC) teams) to make safe and fit for purpose and there is currently no identified funding source. Identification of this funding source has been asked for from Central Site Management with support from Estates / Planning / Finance teams. 3. With particular relevance to the Ockenden report is the Newborn Life Support (NLS) provision which is running on limited capacity both East and West, and is at 0% capacity in central with no NLS training at all due to the lack of availability of suitable training accommodation. 4. The Audio-Visual system required for these courses is failing on the East site. In May 2022 two of the systems failed during the delivery of an Advanced Trauma Life Support course, which required those rooms to run without these resources for the remainder of the course. This impeded the course delivery and will feature in the course report from the course director to the Royal college of Surgeons. The failure of the AV system will impact on every course run in the East venue and requires replacement.

5. There is currently no functional and reliable cardiac arrest audit within BCUHB. Therefore rates (other than raw switchboard data), outcome data, and improvement opportunities cannot be reliably established. Actions are in place to develop a functional audit of 2222 calls.
6. There is an identified deficit of Whole Time Equivalent resuscitation officers against National standards across the Health Board. At present bank staff are used to cover and increase training capacity where possible, request for staffing to meet National Standards is included within the IMTP submission.

Progress since last submission

1. Controls in place reviewed to reflect current risk position.
2. Gaps in controls reviewed to reflect current risk position.
3. It is anticipated that following the resolution to the accommodation issues in the Central Region, the risk score will be reduced from current score of 20 to a score of 12, resulting in the risk being de-escalated from the Corporate Risk Register and managed at Tier 2 level.
4. Policy awaiting sign off by Executive but has been ratified at sub-groups.
5. Work planned to commence on the 17th July to create temporary teaching rooms within the Laing O'Rourke building on the YGC site which will enable an increase in the training capacity within the Central region.
6. Plans drawn and quotations received for the required Estates works to provide dedicated training facilities for the Central Region. These plans have been provided to Central IHC with a request that funding is identified. Simultaneously Integrated Medium Term Plan submission has been progressed by the Resuscitation Services, but is awaiting an approval decision.
7. Meeting on the 14th July between Resus services and IHC reps to finalise planned works and address any outstanding issues in relation to services required within the training areas. Also to determine which teams the resus services will share the accommodation with.
8. Action ID 19313 – Action delayed, Work planned to commence on the 17th July to create temporary teaching rooms within the Laing O'Rourke building on the YGC site which will enable an increase in the training capacity within the Central region.
9. Action ID 23208 – Action delayed, Resus services are now funding the temporary Estates work up to £5000, which enables the temporary training accommodation works to take place.
10. Action ID 24769 – Action delayed, Meeting on the 14th July between Resus services and IHC reps to finalise planned works and address any outstanding issues in relation to services required within the training areas. Also to determine which teams the resus services will share the accommodation with.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Strengthen our wellbeing focus Primary and community care Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-04 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	19313	Provision of permanent and fit for purpose training and office accommodation on the YGC site	Mrs Sarah Holloway, Resuscitation Services Manager	30/09/2022	"While it will not mitigate the clinical absence of Resuscitation Officers from the acute site, or loss of other non-training activity; the identification of a suitable commercial venue in which we can provide all levels of resuscitation training, along with F&P funding approval will lower the score in relation to training from 20 to 4 in the short term (lease period). This will mitigate the risk until a permanent venue within the YGC footprint is developed." July 2023 - Work planned to commence on the 17th July to create temporary teaching	Delay

					rooms within the Laing O'Rourke building on the YGC site which will enable an increase in the training capacity within the Central region.	
	23208	To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues.	Paul Andrew, Director of Operations	30/06/2022	This action will enable a building to be secured for delivering training on the Centre Site thereby helping mitigate and manage this risk in the long-term. July 2023 – Resus services are now funding the temporary Estates work up to £5000, which enables the temporary training accommodation works to take place.	Delay
	24628	Recruitment of additional staff to meet with National staffing standards	Mrs Sarah Holloway, Resuscitation Services Manager	31/12/2023	Ensure that the Health Board has sufficient resuscitation training capacity to meet its obligations and provide safe and effective care to the population of North Wales. July 2023 – Meeting with Finance has taken place to agree movement of budget	On track

					allocation to pay to increase establishment.	
	24769	Decision on Co-occupancy services.	Paul Andrew, Director of Operations	01/03/2023	This will speed up the process of moving Resus Services into the building with Estates work provided to enable teaching to escalate. This should bring the risk score down from the current score of 20 to a risk score of 12, which will allow the risk to be managed at Tier 2 level and de-escalation from a current Tier 1 Corporate Risk. July 2023 - Meeting on the 14th July between Resus services and IHC reps to finalise planned works and address any outstanding issues in relation to services required within the training areas. Also to determine which teams the resus services will share the accommodation with.	Delay

CRR22-23	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 02 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 13 July 2023
	Risk: Inability to deliver safe, timely and effective care - Wrexham Emergency Department.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 09 January 2024

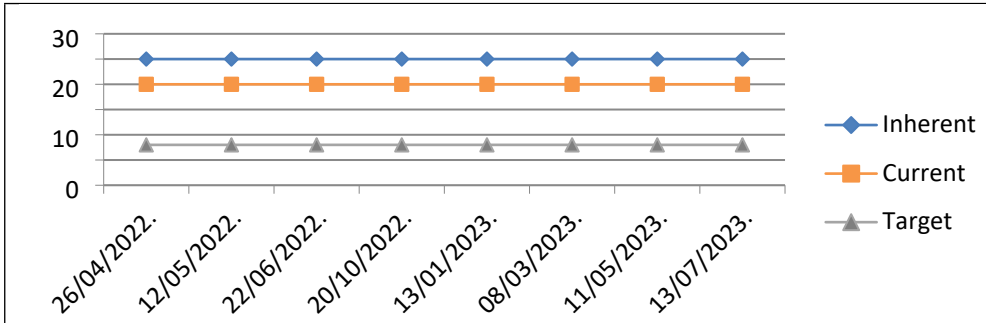
There is a risk that patients attending Emergency Department (ED) would not be able to receive timely, safe and effective care. This is caused by overcrowding and reduced physical capacity due to delayes to transfer of patients awaiting specialty beds. This could lead to:

• Delay/inability to triage new attendants within 15 minutes of arrival as per national key performance indicators in line with Emergency Department Quality and Delivery Framework/Welsh Government Targets, deterioration in health/condition and increase level of harm including increased length of stay, level of intervention required and potential increase in mortality, breach of infection prevention measures and standards, which would increase spread of infection and/or potential outbreak.

•I nability to bring patients into the department from ambulances, detrimental impact to the community in terms of redeployment/response of ambulances, inability to meet privacy and dignity needs of patients, breach of performance measures as set out and monitored by Welsh Government, and pressure on the workforce, i.e. increase in workload due absences, difficulty in recruitment and retention of staff.

• Negative feedback / patient experience that is reflected via Health Inspectorate Wales and Community Health Council national reviews.

• On going risk of patients leaving without being seen further impacting on Welsh Ambulance SService Trust demand and patients deteriorating in the community after leaving without being seen.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	Unchanged		

Controls in place	Assurances
1. Site escalation policy in place. 2. Emergency department escalation policy in place. 3. Infection prevention policy in place. 4. Welsh Government guidelines in place. 5. Standard Operating Procedure (SOP) for the management of patients held in ambulances outside ED. 6. Standard Operating procedure in place for triage of patients in relation to escalation of patients. 7. Matrons audit in place to identify areas i.e. welfare checks. 8. Additional health care support workers shifts generated to increase ability to perform welfare checks throughout the department with the increase volume of patients. 9. Screening process in place at point of entry to identify those at risk / suspected COVID with appropriate action taken. 10. Reception staff highlight red flag patients to the Triage nurse for appropriate escalation. 11. The Urgent Treatment Centre is in place that supports managing the risk held in the waiting room.	1. Risk is reviewed at Emergency Care meeting and escalated to site Quality and Safety and Health and safety meeting. 2. Triage waits Key Performance Indicator data reported monthly through the Integrated Health Community (IHC) accountability meetings. 3. Report to Clinical Effectiveness Group. 4. Performance is monitored through harms, incidents, complaints and handovers. 5. Fortnightly reviews with Welsh Ambulance Service Trust of any harm/delays that may have occurred due to overcrowding.

12. Streaming by Senior Clinician is now in place that will re-direct patients to the relevant specialties upon presentation to the ED, that supports managing the risk held in the waiting room.	

Gaps in Controls/mitigations
1. Insufficient Capacity/physical environment to mitigate overcrowding, alternative areas currently used for patients in the waiting room when the department is at capacity and all spaces blocked with patients waiting for beds. The Urgent Treatment Centre is now operational and co-located with urgent Primary Care Centre, this is unlikely to reduce the ability to admit patients delayed on ambulances or allocate a cubicle to high risk patients in the waiting room during busy periods.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. The department continues to identify incidents linked to the risk and link the incidents to the risk on the Datix system. 4. Expansion of the ED footprint to include the Urgent Treatment Centre, which will reduce the risk of patients leaving the department without being seen as there is more space to see patients in a more timely manner. 5. Streaming by Senior Clinician is now in place that will re-direct patients to the relevant specialties upon presentation to the ED. 6. Action ID 20605 – Action delayed, SBAR submitted to Chief Finance Officer for review with IHC Senior Leadership Team. 7. Action ID 21360 – Action delayed, all rooms now available to use (4 in total). Area regularly staffed with an ENP and a clinician although there are occasions where this is not possible due to overall staffing levels and availability of nursing staff to support with treatments. 8. Action ID 23002 - Pods have been removed from half of the podded are within AMU, work across the site is yet to be completed to remove the remaining pods, which will support ring fencing for 2 trolley spaces. Streaming at the front door of ED is in place and has seen a slight increase in the number of patients referred to SDEC.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-14

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	20605	Increase establishment for additional Health Care Support Workers	Mrs Rachel Bowen, Deputy Head of Nursing EC	30/09/2022	This will increase availability of un-registered workforce to support registered workforce in providing safe and effective care to patients in ED. July 2023 progress update – SBAR submitted to Chief Finance Officer for review with IHC Senior Leadership Team.	Delay
	21360	Increasing the footprint of ED to manage overcrowding to protect the minor injury stream (WMH)	Mrs Hazel Davies, Acute Site Director	01/12/2022	It will enable relocation of the minor stream of patients in ED to an alternative area which will reduce overcrowding within the department. July 2023 progress update – all rooms now available to use (4 in total). Area regularly staffed with an ENP and a clinician although there are occasions where this is not possible due to overall staffing levels and availability of nursing staff to support with treatments.	Delay

	23002	Increase the number of ambulant patient at Ambulatory Emergency Care/ Same Day Emergency Care (SDEC)	Bloor, Mrs Lindsey Bloor, Directorate General Manager	16/09/2022	This will reduce the number of patients in ED waiting room July 2023 progress update – Pods have been removed from half of the podded are within AMU, work across the site is yet to be completed to remove the remaining pods, which will support ring fencing for 2 trolley spaces. Streaming at the front door of ED is in place and has seen a slight increase in the number of patients referred to SDEC.	Delay
	24600	To reduce the number of patients awaiting Specialty beds in the Emergency Department due to delayed admission to a ward.	Mrs Hazel Davies, Acute Site Director	31/12/2023	Ensures that there is available capacity to meet demand presenting to the Emergency Department both via the waiting room and from the Ambulance Service. It will remove high risk patients from the waiting rooms and on corridors and will also release Ambulance Crews to respond to demands in the Community. May 2023 progress update – East IHC Six Goals and USC Improvement Group has been	On track

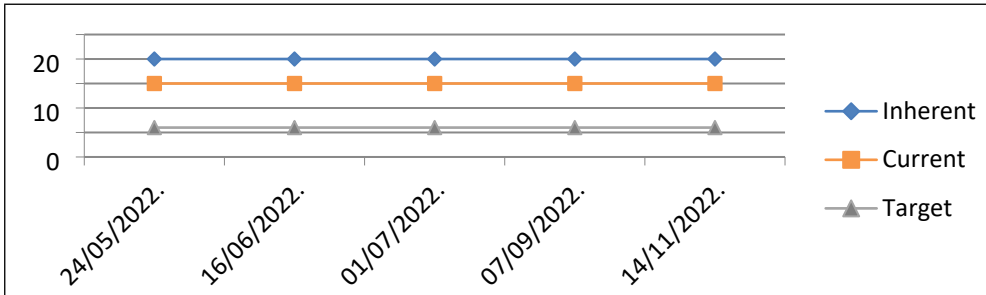
					established that includes Community and Local Authority representatives which reviews the unscheduled care patient pathway and the group is focused on improvements to reduce demand at the front door and supporting improved discharge. July 2023 progress update – challenges remain with pressures due to the number of patients awaiting a specialty bed in the ED. Work continues through the 6 Goals Programme to support improvements in this area.	

CRR22-24	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 04 April 2022
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	**Date of Committee Review:** 17 January 2023
		Target Risk Date: 31 March 2023

There is a risk of senior leadership capacity & capability gaps during the transition to the new Operating Model as people depart the organisation through the VERS process and the challenges recruiting people to new posts (internally and externally) during the transition phase when all key posts have been filled.

This has been caused by the delay to the organisational change process resulting in a divergence of parallel actions relating to those individuals leaving the organisation via VERS, the subsequent vacant posts and the recruitment to the new posts. The default position is to use the mechanism of internal backfill. Where a suitable individual cannot be identified then the posts will need to fill by external subject matter experts on an interim basis.

This may lead to a slowdown in the decision making processes as decision and action delivery defaults up to the next level in the responsibility and accountability framework.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	Unchanged		

Controls in place	Assurances
1. For the small number of posts which will become vacant the default option will be to look internally for people who can step-up on a short-term interim basis. Acting arrangements being agreed with Executives as a mitigation. Where this is not possible will look to use experienced external interims. 2. The management oversight of the transition for those and induction of new teams members is a critical role of the programme of work called: How We Organise Ourselves and the project group called the roles and the people. Arrangements have developed for these leaving the Health Board including the Operational Transition Plan and Leaving Well Handover Guide & Repository. These products along with a suite of induction and network products will support new people and emerging teams with knowledge transfer. 3. The transition of affected departments will be overseen by Executive Directors between April and March 2023. There will be additional management oversight of the How We Organise Ourselves programme, as well as the 'Roles and People' project team.	1. Risks are reviewed every 4 weeks by the Risk Management Group (Board and Director level).

Gaps in Controls/mitigations
1. Capacity of Executive Directors to respond to rapid decision making requirements. How We Organise Ourselves now has a regular weekly slot on the Executive Team agenda. Weekly Divisional Q&A sessions with Chief Executive Officer, Executive Director of Integrated Services / Deputy CEO and Executive Director of Workforce and Organisational Development provides a route for rapid escalation. 2. The management of the East, Central and West Integrated Health Community Operational Transition project plans through weekly status meetings and the connectivity to the Programme Leader Group provides a route for rapid escalation of possible gaps. 3. Demand for interim roles across the UK health sector could out-strip supply - therefore we are working closely with our agency partners to ensure we have access to the widest pool of capable individuals. 4. An early go-live date could result in vacant new posts where backfill arrangements are not appropriate as those who are acting up into existing posts will have been appointed to their new role and the interim contract period could be too short to attract interested parties - each post will be reviewed and the appropriate mitigation solution put in place.

Progress since last submission
1. Risk description reviewed to reflect current risk position. 2. Controls in place reviewed ensure relevance with current risk position. 3. Gaps in controls reviewed to ensure relevance with current risk position. 4. Action ID 23333 – Action closed as all substantive posts holders have been appointed. Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders. 5. Action ID 23334 – Action closed as selection and appointment process now complete. 6. Action ID 23335 – Action delayed, selection process taking place on 11 & 14 November 2022. 7. Action ID 23336 – Action closed, with selection and appointment process now complete. 8. Action ID 23337 – Action delayed, selection process taking place on 11 & 14 November 2022. 9. Action ID 24129 – Action closed as substantive posts holder have been appointed. An interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders. 10. Action ID 24130 – Action delayed, suitable candidate not identified. Post renamed to Chief Operating Officer and re-advertised.

Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler)	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	23333	Set-up external selection process for Integrated Health Community Director roles (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	25/07/2022	No gaps in senior leadership roles **November 2022 progress update** All substantive posts holders have been appointmented.	Completed

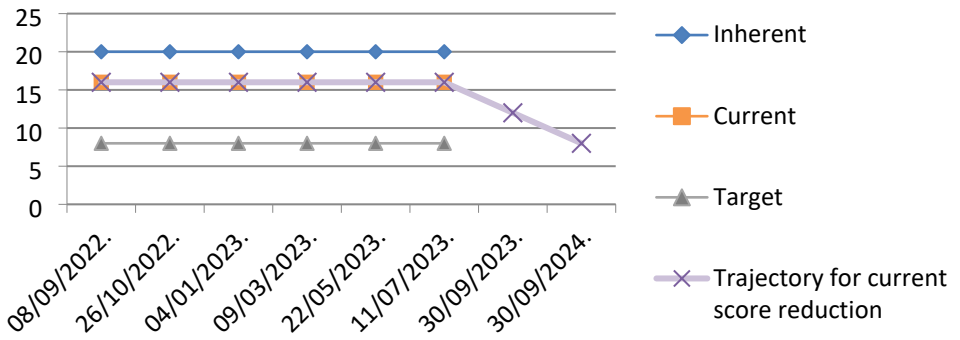
					Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	
	23334	Set-up internal selection process for Senior Nursing posts (format, panel representation).	Lesley Hall, Assistant Director – Employment Strategies & Practices	27/06/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Selection and appointment process now complete.	Completed
	23335	Set-up internal selection process for Senior Medical posts (format, panel representation).	Claire Wilkinson, Deputy Director - Operational Workforce	30/12/2022	No gaps in senior leadership roles - **November 2022 progress update** Selection process taking place on 11 & 14 November 2022	Delay
	23336	Set-up external selection process for Senior Nursing posts (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	01/08/2022	No gaps in senior leadership roles -interim/acting up arrangement in place **November 2022 progress update** Selection and appointment process now complete.	Completed

	23337	Set-up external selection process for Senior Medical posts (format, panel representation) (If required).	Claire Wilkinson, Deputy Director - Operational Workforce	30/12/2022	No gaps in senior leadership roles **November 2022 progress update** Selection process taking place on 11 & 14 November 2022	Delay
	24129	Set-up internal selection process for Deputy Director posts – Regional services and Primary Care (format, panel representation).	Lesley Hall, Assistant Director – Employment Strategies & Practices	31/10/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Substantive posts holder have been appointmented. An interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	Completed
	24130	Set-up external selection process for Deputy Director posts – Regional services and Primary Care posts (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	30/12/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Suitable candidate not identified. Post to renamed Chief Operating Officer and re-advertised.	Delay

CRR22-32	**Director Lead:** Chief Digital And Information Officer	**Date Opened:** 08 September 2022
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 11 July 2023
	Risk: Retention and Storage of Patient Records	**Date of Committee Review:** 17 January 2023
		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 lack of suitable and adequate storage space, uncertain retention periods for national inquiries and logistical challenges of sharing and maintaining standards of paper case records across the organisation.

This could lead to substandard care, patient/staff harm and inability to meet our legislative and Health and Safety responsibilities along with reputational damage and fiscal penalties.



	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 May 2023	unchanged		

Controls in place	Assurances
1. Digital, Data and Technology Strategy in place, with regular reporting to Partnerships, People and Population Health Committee. 2. Corporate and Health Records Management Policies and Procedures are in place pan-BCUHB, monitored by the Patient Records Group.	1. Chairs reports from Patient Record Group presented to Information Governance Group.

3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records. 4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Standard Operating Procedure in place pan-BCUHB and off-site storage secured. 6. Confidential destruction of records now taking place in line with the retention policy following the lift of the National Blood Inquiry Embargo. 7. New scanning and destruction provider Storetec in place, ISO 9001 accredited who are beginning to scan records directly into the CiTO records management system. 8. Standardised and consistent quality approval processes and procedures in place with Concerns Team for the sending of patient information. 9. Digital, Data and Technology Mandate Process in place for new systems and ways of working which includes Records Management, Retention and Storage requirements. This is monitored via the Digital Delivery Group.	2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee. 3. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Significant lack of fit for purpose on site estate in Central to hold physical records with no plans to back record convert all patient records. Health and Safety review ongoing to establish safe storage options, including off site storage. 2. BCUHB development of new ways of working for example Hub Based Service Delivery in a particular area to service the whole of North Wales which will require transportation of notes. Currently using internal Portering service to collect and return notes during the weekend. 3. Lack of digital systems in place, CITO programme underway to implement an electronic document patient record and integration with National systems. 4. Lack of funding to support a programme management approach to scan records before destruction can take place and eliminate the cost and need for offsite storage. Individual Services provided with the option to scan dependent on allocation of funding.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. It is anticipated that a current score of 12 will be achieved by the 30 September 2023, this will be dependent on the outcome of further discussions regarding the Ysbyty Glan Clwyd Site, and clarification with regards to the National Covid Inquiry retention requirements 4. Destruction of records underway in line with retention policy, commencing with offsite storage to support the reduction in costs. 5. All Wales Secondary Care Retention Policy Paper being presented to next All Wales Executive Medical Directors to agree standardised and implementation of national retention periods. 6. Action ID 24372 remains delayed due to progress with YGC Site and Project Leads to secure suitable storage space on the Ysbyty Glan Clwyd site. 7. Action ID 24379 – Request to close this action as Infected Blood Inquiry embargo has been lifted; any records that have met the appropriate retention period once agreed by the Patient Records Group are being confidentially destroyed. 8. Action ID 24380 – Request to close this action as all risk assessments completed with racking installed on all sites. 9. Action ID 24381, action remains delayed due to future secure storage in Ysbyty Glan Clwyd. 10. Action ID 24794 – Request to close this action as record destruction is underway. 11. Aiming to achieve target risk score within agreed timescales dependant on securely suitable fit for purpose records storage on the YGC site. Communications on going to establish Ablett Unit Project Lead to ensure health records form part of the working group for the future project plans. This will also include an impact and risk assessment for the current clinic preparation portacabins.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

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
	24372	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	31/01/2023	Formally action ID 12429 from risk CRR20-06. Mental Health Business case has been agreed, further discussion ongoing with Estates to secure current accommodation for patient records. July 2023 – No further progress. Discussions continue to be ongoing.	Delay
	24374	A new all-encompassing Patient Records Programme is established that pulls all streams of work under one overall governance arrangement.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2024	Formally action ID23746 from risk CRR20-06. A programme in place that will support the mitigation of the risk. July 2023 – work is underway with the Pre-operative Assessment Clinic (POAC) to digitise their current paper documents, starting from April 2023.	On track
	24378	Immediate review of the patient record policies, standard operating procedures and the associated delivery of training and	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2023	Formally action ID 23750 from risk CRR20-06. Ensure all policies are up to date and relevant with new processes and raising awareness amongst staff.	On track

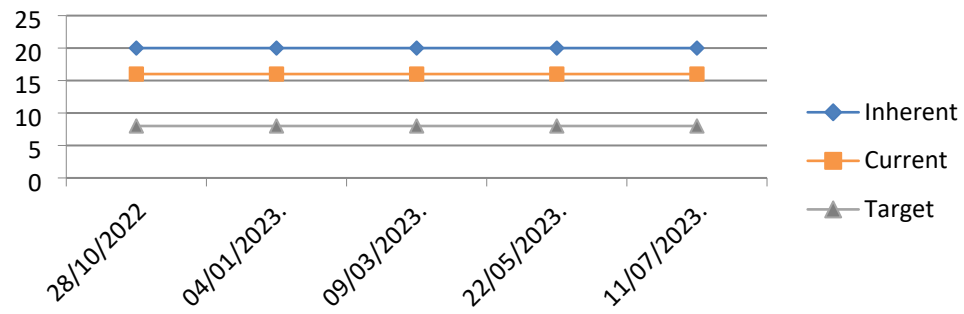
		awareness to improve integrity.			July 2023 – All policies and procedures updated, currently reviewing additional certificate and foundation level training being implemented.	
	24379	Review all files and utilise off site storage for files due for destruction.	Nia Harrison, Health Records Manager	31/03/2023	Will increase the storage capacity onsite. July 2023 – IBI embargo has been lifted, any records that have met the appropriate retention period once agreed by the Patient Records Group are or have been security destroyed. Appropriate documentation and destruction certificate are being obtained.	Complete
	24380	Risk assess all file storage locations including racking at main sites - To be undertaken by Health and Safety and Fire Safety Officers.	Nia Harrison, Health Records Manager	31/03/2023	Provide safe and secure location for patient files and staff working environment. July 2023 – Risk assessments all completed and racking installed.	Complete
	24381	Meeting to be set up with estate management to discuss current issues i.e. – Wrexham roof, YGC porta cabins and temporary locations.	Mrs Paula Butlin, Health Records Site Manager	31/12/2022	Work towards providing a safe working environment for staff and the protection of Patient records. July 2023 – Meeting with Estates booked to discuss location and when block 21 is to be demolished for the Mental Health Build. No update provided as yet. All other issues completed.	Delay
	24382	Project to be set up to look at back	Mrs Nia Aspinall,	30/09/2024	Provide digitalised copies of records and reduce facility requirements of patient	On track

		record conversion of Patient records via scanning technology.	Head of Patient Records and Digital Integration		records. Ability to meet our legislative and Health and Safety responsibilities along with reputational damage and reduce any fiscal penalties. July 2023 – Work is still ongoing with departments where possible.	
	24794	Process and Plan for the destruction of records following lifting of embargos to be developed and implemented ensuring governance and approval routes identified	Nia Harrison, Health Records Manager	01/04/2023	Ensure appropriate authorisation and governance followed with the destruction of records, to reduce storage costs and space required. July 2023 – Completed with destruction underway.	Complete

CRR23-33	**Director Lead:** Chief Digital and Information Officer	**Date Opened:** 28 October 2022
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 11 July 2023
	Risk: Lack of access to clinical and other patient data	**Date of Committee Review:** 17th January 2023
		Target Risk Date: 01 April 2025

There is a risk that Patient Information is not available when and where required, this is due to a lack of access to a single clinical data repository for patient records, unconnected separate clinical systems and local data repositories.

This could result in substandard care, patient/staff harm and inability to meet our legislative and Health and Safety responsibilities along with reputational damage and fiscal penalties.



	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 May 2023.	unchanged		

Controls in place	Assurances
1. Digital, Data and Technology Strategy in place to set the direction and vision for digital integration, with regular reporting to, Partnerships, People and Population Health Committee.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group

2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB, monitored by the Patient Records Group for the handling and management of records. 3. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group) with assurance provided to the Performance, Finance and Information Governance Committee. 4. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records. 5. Paper file identified as the Master Copy of the full record. 6. Access to current clinical systems to print clinical information ready to store in the Master File. 7. Information Governance Toolkit embedded with operational group oversight and monitoring. 8. Contract in place with third party supplier who are ISO accredited to scan directly into CiTO and destroy clinical paper records confidentially.	presented to Performance, Finance and Information Governance Committee. 3. Internal Audit Annual Information Governance Compliance Audit. 4. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Lack of oversight held outside of the central patient records function, for example Mental Health and Paediatrics. Due to the rejection of additional funding to support the programme of work to support this, this will now be undertaken on an adhoc basis by Patient Records. 2. Lack of integrated systems with a single source of truth. CiTO Programme underway to implement an electronic document management system. 3. Single Paper Record repository. Records are held across various sites as limited transportation available which leads to delays in record availability. Current weekly collections in place, but this is not sustainable for the future. 4. Adhoc changes currently happening in line with the national direction whilst there is no BCUHB wide support for a programme management approach for the single source of truth. New Mandate process implemented to prevent further disparate, silo systems.

Progress since last submission
This risk is linked to CRR22-32 – Retention and Storage of Patient Records. 1. Controls in place reviewed to ensure relevance with current status of the risk. 2. This risk is a long term risk with high level objectives / actions identified to reduce the risk score. Work has commenced in certain areas where resources have permitted, however without the additional programme management funding bringing all elements together under one umbrella, this is being undertaken on an adhoc basis within the Patient Records Team. 3. Updates to actions have been incorporated. 4. Roadmap of digital records to scope out what records can go in the local repository currently being pulled together to support the future national direction to digitise what records go where and when including the impact and change to pathways. 5. New Project set up which is being led by the Chief Technology Officer to implement an Integrated Care Record,

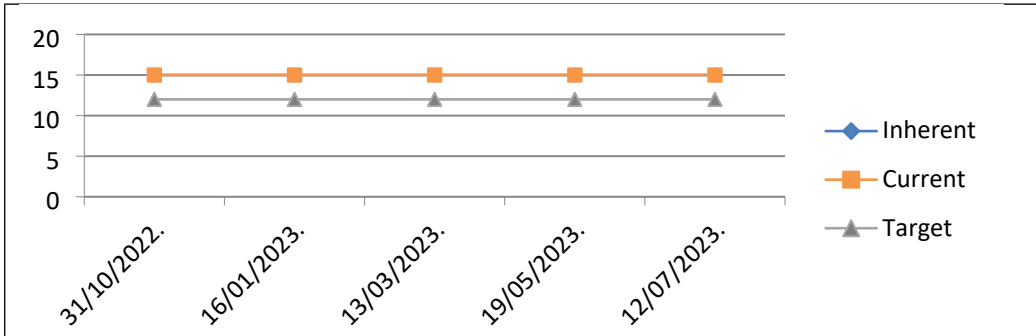
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

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	24326	Establish the cost and resources requirements to back scan all live records.	Nia Aspinall, Head of Patient Records and Digital Integration	31/10/2023	The action will support a reduction in the risk score as records will be available electronically pan BCUHB. July 2023 – Progressing on a service level basis.	On Track
	24327	Following completion of the Baseline assessment of the location of all records, a review and	Nia Aspinall, Head of Patient Records and	01/04/2024	The action will identify all locations of record storage, with the intention to provide a greater level of assurance	On Track

		recommendations will be developed and presented Partnerships, People and Population Health Committee.	Digital Integration		with standards and compliance. July 2023 – Ongoing with support from other services.	
	24328	Undertake a review of national systems to ensure these can be integrated in the Health Board's CiTO System.	Angharad Wiggin, DHR Programme Manager	01/04/2025	The action will provide single access to all patient data and support the achievement of the target risk score. July 2023 – This action is now being superseded by work being undertaken by the Chief Technology Officer. Action will be reworded to reflect this change and progress will be monitored via the new Project..	On Track

CRR23-34	**Director Lead:** Executive Director of Public Health	**Date Opened:** 28 June 2017
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 12 July 2023
	Risk: Smoking Cessation	**Date of Committee Review:** 17 January 2023
		Target Risk Date: 31 March 2024

There is a risk that residents in North Wales may be unable to quit smoking.
This may be caused by their current smoking behaviours including use of vapes and illicit tobacco, income levels, living in socio-economically deprived areas, have a mental health condition or disability, or are from ethnic backgrounds and/or from the LGBTQ+ community.
This may result in lack of confidence and/or capacity to engage with Help Me Quit Services.
This may result in premature mortality and disease including cancers, respiratory diseases and cardio vascular disease, including strokes, heart attacks and dementia.
This may impact on the Board's ability to achieve its national performance target.
This will impact on the Board's ability to comply with the Smoke Free Regulations 2020.



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	4	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	Assurances
1. Continuation of the HMQ for Baby Service with additional investment from Prevention and Early Years grant funding to support the development and pilot of an Incentivisation Scheme in one area. 2. Continuation of the HMQ in Hospital Service with additional investment from WG Prevention and Early Years funding to support the further development of this service in line with NHS Performance Framework 22-23 to support both staff and patients. 3. Investment from the WG Prevention and Early Years funding to provide support for patients with mental health conditions to support introduction of Smoke Free Regulations. 4. Pharmacy Level 3 Services supported by Prevention and Early Years funding. 6. Insight work to understand barriers identified by priority groups in accessing HMQ Services. 7. HMQ Communications Plan to include a focus on promotion of new service developments and informed by engagement with priority groups with targeted social media to encourage take up of Services. 8. Nicotine Replacement Therapy for staff insight report. 9. BCUHB's Smoke Free Regulations response to include support for staff, patient documentation, no smoking policy, signage, mental health services provision, compliance support and interface with Local Authorities. 10. Business Case for Hospital Compliance Officers (Smoke Free Environment Officers). 11. 'No Ifs No Butts' campaign with partners across the region. 12. De-normalisation actions with partners across the region. 13. Smoke Free legislation audit report	1. Risk is regularly reviewed at the Senior Manager`s meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. Escalation from Public Health Performance & Risk Management Group is to the Public Health Senior Leadership Team, with review by the Population Health Executive Delivery Group also. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants. 5. Prevention and Early Years National Programme - nationally funded. 6. Reporting progress to National teams (Public Health Wales/Welsh Government/Regional Partnership Board). 7. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25). 8. Reports on progress and risks are identified with the PPPH Committee. 9. Prevention and Early Years funding has been confirmed for 23/24 and 24/25

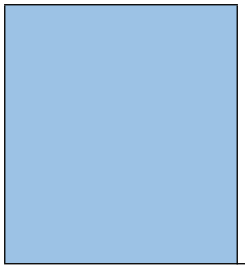
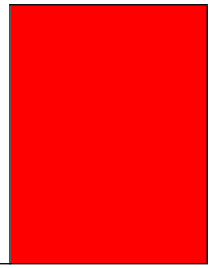
	10. Audit (March 23) reviewing compliance with Smoke Free Sites regulations. 11. Tobacco Control Management Group meet monthly to oversee the programme of work.

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements. 2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success. 3. Provision currently through National funding, with funding identified to 24/25, cost pressures for the health board if the national funding were withdrawn. 4. Services are not based onsite at all main hospitals. 5. There are difficulties attracting to vacant posts due to fixed term nature - funding is not recurrent. 6. The current financial position of the Health Board and pressures across service budgets may reduce investment in prevention activity such as smoking cessation. 7. The Health Board Smoke Free policy has not yet been approved

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to reflect current position. 3. All posts are now recruited to. 4. All accommodation onsite at main hospitals has now been sourced although YG is temporary. 5. Action ID 22823 – Action closed as all posts have been appointed to. 6. Action ID 22825 – Action closed, conversations with Ysbyty Gwynedd site have taken place and a room has been identified in the short term for HMQ staff and are awaiting current staff to be relocated which should take place in July. All accommodation now sourced. 7. Action ID 24230 – Action delayed, Service Manager advises that planning work is now underway with East managed practices, to implement the project and ensure that the project is back on track.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

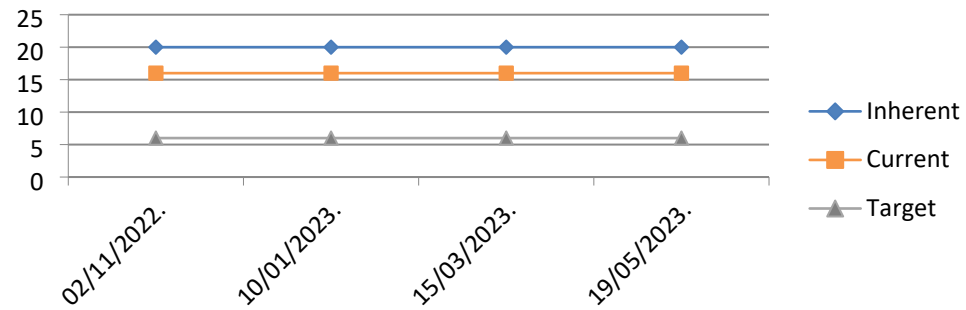
Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	22823	HMQ Services Strengthening the Service	Mrs Gwyneth Page, Public Health Assurance & Development Manager	30/12/2022	Encourage smokers to access services and quit July 2023 progress update – Action closed, all posts have been appointed to.	Completed
	22825	HMQ Services - Accommodation of staff	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/12/2022	Encourage smokers to access services and quit July 2023 progress update – Action Closed, conversations with Ysbyty Gwynedd site have taken place and a room has been identified in the short term for HMQ staff and are awaiting current staff to be relocated which should take place in July. All accommodation now sourced.	Completed
	24230	Primary Care Project (EAST Managed Practices)	Mrs Gwyneth Page, Public Health Assurance &	31/03/2023	Engaging with smokers through local GP practice to encourage interaction with service and quit attempts.	Delay

			Development Manager		July 2023 progress update – Service Manager advises that planning work is now underway with East managed practices, to implement the project and ensure that the project is back on track.	

CRR23-35	**Director Lead:** Executive Director of Finance	**Date Opened:** 19 November 2018
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19 May 2023
	Risk: Electrical and Mechanical Infrastructure on the Wrexham Maelor Site	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31March 2027

There is a risk that the engineering infrastructure on the Wrexham Maelor Site could fail, causing system failure due to age and condition.

The impact could result in an immediate and unplanned loss of clinical services.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	Low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2023	unchanged		

Controls in place	**Assurances**
In regards to the risks identified the following recovery actions are in place: 1. On Call Estates Officers and site shift staff available to attend in the case of a failure or outage. 2. Specialist Electrical and Mechanical Engineering Contractors on-call to attend site. 3. Specialist Imprest stock held in stores. 4. Bi monthly meeting of Business Continuity Team which includes representation of all stakeholders impacted by this risk.	1. Risk discussed at Estates Divisional meeting - Bi-monthly. Discussed at the East Site and IHC Risk Management Groups. 2. Authorised engineers (auditors) that assess compliance with current HTMS.

5. The BCU Planning Team (Chaired by the Hospital Director) have developed a Business Continuity Plan for essential mitigation of electrical infrastructure associated site risks and also includes those services who would be affected and need to relocate.	

Gaps in Controls/mitigations
1. The Health Board's Capital Planning team are leading on the development of a full business case (FBC) for business continuity works on the Wrexham Maelor Site, this business case is due to be supported by the Health Board in February 2023, and is then supported by Welsh Government will allow funding for improvement works as listed in the continuity programme.

Progress since last submission
1. Risk description reviewed to update to reflect current position. 2. Gaps in controls updated to reflect current position.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use resources (key enabler)	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	21571	YWM Continuity Programme Phase One	Mr Rod Taylor, Director Of Estates	31.03.2024	This will provide clarity on the deliverables, timelines and identify any un-resourced areas.	On track
	23751	YWM Redevelopment Programme	Mr Ian Donnelly, Ihcd	31.03.2024	This will provide assurance that all elements of the PBC have been implemented and associated risk	On track

			Operations East		will therefore have been effectively managed and reduced.	
	24340	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace full sections of cable between substations in their entirety therefore reducing the amount of joints and as such improving resilience. In order to mitigate the risks the following replacements are proposed with 11kv rated armoured cable:	On track
	24341	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	To provide the level of resilience security and switching control required it is proposed that a new substation is constructed which can accommodate a 6-panel distribution panel, this is also to accommodate a separate switchgear from the DNO which will controlled by the Health Board.	On track
	24342	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 3)	Mr Rod Taylor, Director Of Estates	31.03.2024	It is proposed that to provide greater resilience for this element that the substation is fitted with 2 No. ring main units and 2 No. 1,000 KVA transformers replacing the currently defective equipment.	On track
	24343	Phase 1 Continuity Scope of Works - Heating Systems in EMS Part of YWM Site	Mr Rod Taylor, Director Of Estates	31.03.2024	The risks with the heating systems will be mitigated by: Retaining pipework where there is a 2-pipe system and replacing areas served by 1 pipe systems – to increase the efficiency of the	On track

					system. Installing separate heating systems for each of the outbuildings connected to the central boiler house, such that each building is self-sufficient – removing a single point of failure to the outbuildings. Installation of injection circuit stations at the head of each department – to provide greater control and aid commissioning. Installation of above ground distribution pipework – to allow maintenance and reduce any down times. Installation of instantaneous point of use water heaters to hand basins and sinks - removing the single point of failure to the outbuildings.	
	24344	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	The installation of 9 new area valve service units and new distribution pipework at a high level both externally and within the buildings for ease of access. NIST (Non-interchangeable screw threads) Lockable Line Valves will be provided where applicable so to minimise disruption to the Hospital should any future works to the system be necessary.	On track

					The pipe run design has been sized at 35mm diameter to provide capacity for the system to work in pandemic conditions.	
	24345	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	Installation of new vacuum plant to plant rooms 1.4 and 8a with associated pipework to run in areas which allow for ease of maintenance. This also allows for N+1 resilience and an overall capacity of 6,505L/min.	On track
	24346	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 3)	Mr Rod Taylor, Director Of Estates	31.03.2024	Installation of new multiplex medical air plant complete with safety valves and integral controls. To service the increased capacity required of 6,800L/min and providing N+1 resilience.	On track
	24347	Phase 1 Continuity Scope of Works - Fire Detection Upgrade L1 and Fire Alarm Panels	Mr Rod Taylor, Director Of Estates	31.03.2024	The renewal of previously installed panels, including loop isolators which have become obsolete and the installation of a new separate network. A new network loop will be installed across the whole site excluding the residential facilities located within the north site.	On track

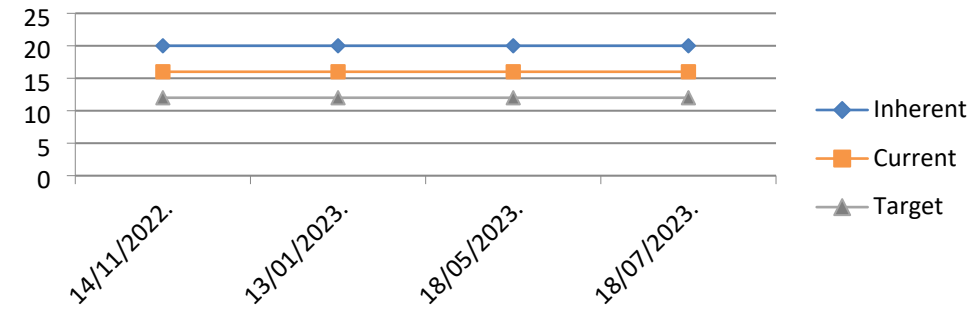
	24348	Phase 1 Continuity Scope of Works - Nurse Call including Emergency and Panic Alarms	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace the Nurse call and Panic Alarms to all wards within the YMW site.	On track
	24349	Phase 1 Continuity Scope of Works - Heating Calorifiers and Roofing Works	Mr Rod Taylor, Director Of Estates	31.03.2026	To improve obsolete systems associated with Hot Water generation and distribution by upgrading existing Hot Water Calorifiers. Roofing refurbishment will take place to EMS Flat Roof areas and valleys.	On track
	24350	Phase 1 Continuity Scope of Works - Critical Ventilation Systems	Mr Rod Taylor, Director Of Estates	31.03.2027	Critical Ventilation Systems and plant replacement for Theatres 1 to 8 including upgrading the Main Kitchen Ventilation system.	On track

CRR23-40	**Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 18th July 2023
	Risk: Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding**.**	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 November 2023

There is a risk that the current systems for commissioning placements with the independent sector has limited assurance in relation to delivering the commissioned care package which is safe, quality, improves outcomes and is providing value for money.

This is caused by insufficient resource and expertise within the CHC and contracting teams and the Wales Audit recommendation to establish a Business Support Hub

This may lead to people not receiving the correct package of care which may lead to significant harm with clinical, operational and corporate teams focusing on re-active interventions to support care home residents and care providers. This may also lead to the Health Board funding packages of care which people are not eligible for. This will impact on pathways of care delays and patients remaining in hospital for longer periods than needed, which may cause harm.



	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 May 2023	unchanged		

Controls in place	Assurances
1. Continuing Health Care Operations Group - to ensure the consistent implementation of the new CHC Framework, sharing lessons learnt from retrospective reviews and ombudsman reports. Co-ordination of the contracts including Pre-Placement Agreement and Commissioned Placement Fees is also in place. 2. Regional Commissioning Board (RCB) – joint chaired by Health & LAs and is responsible for delivery of the Wales Audit Management Plan for Commissioning Older Persons placements. 3. Fees Sub Group – reviewing current fees across health & Local Authorities. Fees methodology agreed for 2023 / 2024 (Sub-group of the RCB) in principle. Fees methodology for CHC not in place 4. Senior Management Team – Care Providers. Membership and Terms of Reference reviewed to ensure fit for purpose 5. Contract Monitoring reporting for care home providers quarterly reported to PFIG and noted in the CHC Operational Group 6. Market Stability & Population Needs Assessment group with LAs to address commissioning strategies 7. BroadCare patient information system in place allowing for consistent monitoring of placements including numbers and finance 8. Establishment of the CHC Cross Cutting Themes – April 2023 (is also a gap as resources needed to deliver)	1. Regional Commissioning Board (Sub-Group of the Regional Partnership Board) has oversight which has representatives from the Health Board, Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Independent Care Provider SMT with representatives of the 3 IHCs, MH&LD and Finance and Contracts 3. Welsh Audit Management Action Plans

Gaps in Controls/mitigations
1. No signed Pre Placement Agreement (PPA) - current gap in contracted services with a risk of providers choosing not to sign a new PPA when it is approved for release: Individual CHC commissioners and wider teams continue to support an approach of as if inferred contract basis until the new PPA can be released 2023. PPA was issued in June, CFW has challenged the release and has demanded it be withdrawn subject to their agreement. Meeting arranged with CFW and co-chairs of Regional Commissioning Group (Health & Social Care) in August to agree a way forward. Legal advice has been sought and we will now be entering into a 12 week engagement process. PPA and Individual Placement Agreement will be issued together in the Autumn in line with further legal advice.

2. The regional fees group have agreed a single recommendation to section 151 LA officers for 2023 / 24, however the picture is complicated and this is unlikely to result in a single fee in reality, rather a single methodology where variations are described. There is also a low level of assurance that the 6 LA will continue with the current agreement. This will be managed by representation from HB CHC and Contracts on the fees group and Regional Commissioning Board.
3. Delivering the Older People's Care Home Placements Audit Wales recommendation two - reviewing arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users. Workshop has been held with the LAs (September 2022) and an action plan is being developed which will need sign off by RCB
4. CHC Audit Wales recommendation 3 – CHC Team Structure (reasonable assurance). How this will be addressed will be set out in the Management Case Action plan which was submitted and agreed on 28th November 2022. Monitoring against the actions is via the Care Providers Senior Management Team.
5. CHC Audit Wales recommendation 5 – CHC Contracting and establishment of the Business Support Hub (no assurance) – There is no formal structure or governance arrangements in place for the BSH. The Management plan was signed off by Executives and submitted to Welsh Audit Office (as per point 6). This is part of a business case which will be presented to board in November 2023
6. No procurement, contractual and business support structures in the HB in addition to those to be supported by the proposed CHC Business hub for the required Direct Payments and Independent Unit Trusts in CHC required by WG. – Linked to Recommendation 5 of Audit Wales. This is part of a business case which will be presented to board in November 2023
7. CHC Audit Office Recommendation 2 –CHC Framework Training & Education, need to undertake Training Needs analysis for the organisation. CHC training attendance is challenging due to operational staffing issues. Currently exploring feedback of wider teams regarding recorded sessions with IT. The Management plan was signed off by Executives and submitted to Welsh Audit Office. This is part of a business case which will be presented to board in November 2023
8. CHC Audit Wales recommendation 1 - Weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of CHC. The Management plan was signed off by Executives and submitted to Welsh Audit Office (points 5 and 6). This is part of a business case which will be presented to board in November 2023
9. BroadCare - Finance teams are working to develop more efficient back office functions with BC functions to remove unnecessary manual processes – this has now been completed and fully operational
10. Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & Safety Corporate Risk). This is part of a business case which will be presented to board in November 2023
11. CHC improvement Group established October 2022 – this work will not progress without dedicated support. Currently trying to release funding from this year's IMPT to support critical elements of this work. This will now be an Invest to Save Business Case. This has now been replaced by the CHC cross cutting themes work.

12. As part of the National Continuing Health Care framework, there is a requirement for Health Boards to offer people who are eligible for CHC independent unit trusts (IUT), there is no process agreed across Wales for this to be administered. The Health Board is developing on a Business case proforma to agree and implement IUT's.
13. Closure of Care Homes due to business sustainability and safety and quality issues – resource from corporate CHC team, Contracting and operational teams are unable to meet the level of support required. 2 workshops held to identify what worked well and what needs to be done differently. Next steps and Actions for the HB in partnership with LAs and CIW will be agreed by end of May. Due to the increasing contractual challenges / due diligence requirements there continues to be a high risk to the stability within the market.
14. Provider Fees Issues – Due to the unprecedented number of challenges to CHC fees a weekly group has been established to ensure timely response to challenges and constant approach to responding to providers. A log of all queries and responses has been established. A monthly meeting with IHCs and MH&LD operational teams has also been established to review themes and agree tools to support management of challenges. Fees paper was presented to the Board in the private section. Uplifts have been agreed and the providers informed. This meets with some providers expectations but there remains a high level of unrest and challenge.

Progress since last submission

This risk was formally part of CRR20-05 which is now being split into 2 separate risks, 'Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding' and 'The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow.'

1. Controls in place reviewed and updated to ensure relevance with current status of the risk.
2. Gaps in controls reviewed and updated to ensure relevance with current risk position.
3. Action ID 24614 – Action delayed, Based on legal advice the HB must develop a CHC fees methodology. Engagement with providers will commence in August and conclude by December – this will inform further fee setting as part of financial annual plan
4. Action ID 24615 – Action delayed, PPA was issued in June for sign off by end September but due to the challenges made by CFW the PPA process has paused and will be part of a 12 week engagement process with partners with the aim of issuing the PPA and Individual Placement Agreement in the Autumn.

Links to	
Strategic Priorities	**Principal Risks**
Primary & Community Care Improved USC (Unscheduled Care) pathways	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	24613	To develop a regionally agreed care home commissioning strategy and associated delivery plan. Clearly setting out the elements of the HBs commissioning strategy to include Commissioning of specialist placement on a regional basis (low numbers / high cost) - (Gap / control No.4,5,13)	Kath Titchen, Commissioning Manager CHC	31/10/2023	1) Establish a Task and Finish group under the Regional commissioning Board to take this work forward July Update – this work is progressing but due date has had to be extended	On track
	24614	Agree mechanism for agreeing Fees – In year agree HBs position 2023/ 24 agree mechanism with LAs – (Gap / control No. 2 & 3)	Jane Trowman, Acting Assistant Director Care Homes Support &	31/01/2023	1) Regional Fees Group in place – agree set of principles for all partners 2) In year up-lifts, further paper to Execs (end Nov 2022) setting out the current position and options for	Delay

			CHC Commissioning		implementation including financial and flow risks July Update Based on legal advice the HB must develop a CHC fees methodology. Engagement with providers will commence in August and conclude by December – this will inform further fee setting as part of financial annual plan.	
	24615	Full implementation of the Pre-Placement Agreement (PPA) (Gap / control No. 1)	Kath Titchen, Commissioning Manager CHC	31/03/2023 Expected to have sign off by providers by end of September	3) Finalize PPA 4) Set up webinars for providers prior as part of the implementation 5) Establish a mechanism for electronic signature in line with IG 6) Agree with the LAs what the escalation process is for Homes which do not sign the PPA – will we commission placements? July 2023 – PPA was issued in June for sign off by end September but due to the challenges made by CFW the PPA process has paused and will be part of a 12 week engagement process with partners with the aim	Delay

					of issuing the PPA and Individual Placement Agreement in the Autumn	
	24616	To establish a Business Support Hub for the commissioning / procurement / brokerage (Gap / control No. 7,6,8,10,11,12)	Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	30/06/2023	Actions not sufficient to deliver against the action. 1) Establish group to write Invest to save business case for submission to Board in November 23 2) Strengthen the Contracting management process due to complexities with provider ownership and due diligence	Delay
	24617	Move from spot purchasing to commissioning / placement / block purchasing with approved providers and be able to respond strategically e.g. with clear commissioning intentions to support the outcomes of the updated population needs assessment (Gap / control No. 4, 5, 7,8,10)	Kath Titchen, Commissioning Manager CHC	30/09/2023	1) Agreed process compliant with procurement requirements. Part of the Market stabilized Service specification 2) Lessons learnt from the Block Purchasing of Additional community Capacity 3) Establish a compliant process for Block purchasing in readiness for 23/24 winter pressures 4) Review of the pathway of care delay data in relation to independent provider market and with IHCs identify schemes to support (linking with Goal 5/6 of Unscheduled care)	On track

	24618	CHC Framework – Training Needs analysis and development of key CHC role for admin and clinical staff competencies (Gap/control No. 9)	Sian Kelbrick, Head Of CHC Performance And Compliance	30/09/2023	1) Baselining the existing training programme, linking into nationally evolving CHC training requirements and support 2) Facilitate mitigation of imperfect patient journeys from the start of their care journey with CHC. 3) Through the existing regional LA HB CHC education strategic group will ensure that the key themes across the region for CHC are addressed in the lessons learnt fed back into the training programs, hot spots identified and targeted support offered and associated wider system influencing issues escalated appropriately. May 2023 progress update – no changed work progressing. Additional training requirements identified in order to improve flow including best interest assessments and management of MDTs	On track

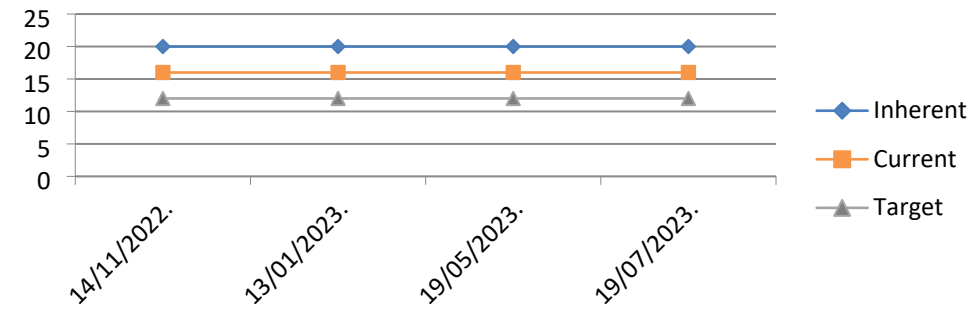
	24619	CHC framework – Individual Units/Trusts no nationally agreed process for implementation (Gap no. 14). Health Board to develop a process for handling and managing any requests	Kath Titchen, Commissioning Manager CHC	30/07/2023	Patients / family who are entitled to CHC funding under an IUT. This is currently being managed and paid for out of statutory duty by the LA. In the absence of any national guidance this development is co-developed with the family, the local authority and supported by WG CHC representation and a national IUT development working group as a vanguard case. 1. SBAR drafted and presented to the SMT for consideration by the IHCs 2. to support a vanguard/ pioneer case to move to an Independent User Trust status for CHC payments 3. Agree principles and learning for other IUT 's guidance across wales for CHC recipients and HB's	On track

CRR23-41	**Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19 July 2023
	Risk: The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 January 2024

Due to the current fagility of the independent sector there is a risk that the quality and safey of patients who need to have their care delivered by independent providers could be compromised and there is potential for harm.

This could be caused by lack of timely prevention and early intervention from across Health & Social Care due to staffing (recruitment & retention), training education.

This may lead to unnecessary admission or conveyance to hospital, long lengths of unnecessary stay in hospital, untimely discharge from hospital (Patient Flow), insufficient staff within the care placement, and staff without the appropriate training and education. Organisational reputation due to high numbers of Medically Fit for Delays and inability to respond to other system pressures (Unscheduled & Planned Care)



	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 May 2023	unchanged		

Controls in place	Assurances
1. North Wales care homes single action plan provides the framework and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). 2. Quality Assurance Framework Implementation Group – underpinned by evidenced based Clinical Quality Tools 3. Programme of support to care providers (Training & Education) via the Care Provider Quality Assurance Framework. 4. Senior Management Team for Independent Providers – currently reviewing membership and terms of reference to ensure fit for purpose	1. Regional Commissioning Board (Sub-Group of the Regional Partnership Board) has oversight which has representatives from the Health Board, Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Independent Care Provider SMT with representatives of the 3 IHCs, MH&LD and Finance and Contracts 3. CHC Improvement Group. 4. Welsh Audit Management Action Plans

Gaps in Controls/mitigations
1. There is a significant shortage in accessing appropriate placements in care homes with a worrying trend of care home closures and homes de-registering nursing beds. The Market Stability Report has now been published. Urgent demand and capacity work in progressing as part of Further Faster and the 6 Goals for Urgent and Emergency Care and winter planning 2. Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge and to avoid hospital admission but insufficient domiciliary care provision to step down to. Health Teams providing domiciliary social care due to lack of LA commissioned services. HB currently becoming registered with CIW as a domiciliary care provider. 3. Standardized approach and reporting now in place. Validated information on Pathways of Care Delays now received and shared across the Region. Action plans being developed across the 3 IHCs to focus on reducing delays – specific projects in relation to care home and dom care providers are being developed but current controls and mitigation are not sufficient to reduce the numbers. 4. Lack of resources to develop has resulted in the development of an integrated Health and Social Care Bank and Memorandum of Understanding to be escalated to the Regional Partnership Board and the Regional Workforce Board. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the HB bank would be able to

provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for HB, LA and the provider at each level of escalation to avoid further ombudsman reports of HB maladministration due to overdue reviews.
5. Overdue CHC placement annual reviews: Staffing issues, vacancies, recruitments and sick leave are affecting all areas: External support secured and additional reviews to commence in August 2023 – 10 month programme
6. CHC Audit Office Recommendation 3 – Consistent structure for CHC teams – not progressed as expected.
7. CHC Improvement Group Established – but insufficient resource to progress the work
8. Lack of Service Specification for care homes for nursing placements
9. Lack of Service specification for Domiciliary Complex care
10. Lack of Support to residential homes to prevent escalation in care needs in a timely way
11. Lack of Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & contracting risk)
12. Discharge Policy is out of date, WG currently revising Policy – including Reluctant Discharge Policy. Need to ensure consistent application of the policy and clear escalation pathways to support discharge
13. Impact on CHC teams to deliver services traditionally outside of CHC including LPS (Risk CRR21 -14) implementation, management and control of additional processes in reviews for circa 1500 complex patients annually. Implementation of interim arrangements and new emerging arrangements for Direct Payments, management of pathways outside of CHC/FNC/ and joint funded care for e.g. d2ra/ s2ra pathway.
14. Lack of and assurance framework with the independent sector to evidence that the care commissioned is being delivered and demonstrate how this is improving outcomes.

Progress since last submission

This risk was formally part of CRR20-06 which is now being split into 2 separate risks.

1. Controls in place reviewed and updated to ensure relevance with current status of the risk.
2. Gaps in controls reviewed and updated to ensure relevance with current risk position.
3. Action ID 24621 – Action delayed, Priority areas from the Care Home Workshop are progressing. ED project concluded final report in draft.

4. Action ID 24626 – Action delayed, WG has now issued the Reluctant Discharge Guidance. Full discharge policy still not issue but We are currently drafting our local policy as the current draft documents are not expected to change in the next 2 months.
5. Action ID 24627 – Action delayed, regional workforce board has been cancelled a number of times, but there is currently a review of purpose and work plan.

Links to	
Strategic Priorities	**Principal Risks**
Primary & Community Care Improved USC pathways	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	24621	Programme of support to Residential Homes (Gap Control 1)	Marianne Walmsley, Head Of Quality For Care Homes	31/03/2023	1) Quality Assurance framework includes residential home developments 2) Clinical quality Support tools developed and being promoted to all local Authorities with some implementing across residential homes 3) All Corporate Care quality team training webinars made available to residential home staff 4) Funding sourced for residential care staff to attend local training	Delay

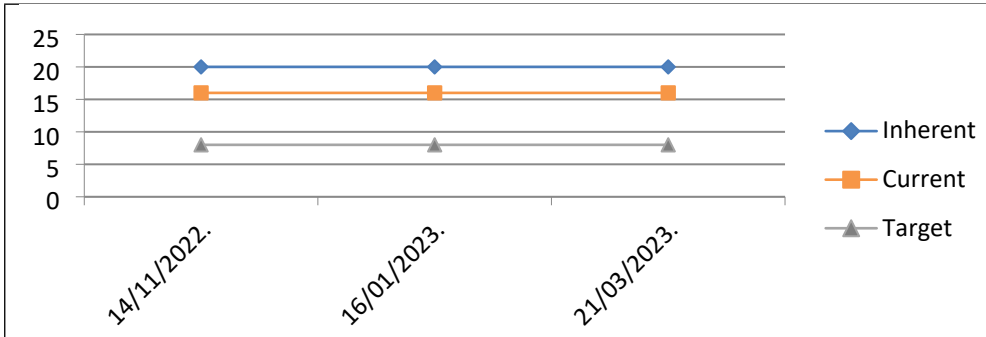
					courses in Llandrillo college 5) Monthly Provider brief to update on key issues, developments and training 6) Draft service specification for care providers 7) Emergency Department pilot looking at ambulance conveyances and emergency admissions from care home – due to report August July 2023 progress update – Priority areas from the Care Home Workshop are progressing. ED project concluded final report in draft	
	24622	Additional resource to address Backlog of reviews (Gap/control no.5)	Kath Titchen, Commissioning Manager CHC	31/01/2024	1) Options appraisal paper to HBLT to agree preferred way of addressing the backlog - approved 2) Implement programme progressing to address back log- prioritising on high risk quality categories 3) Identify quarterly trajectory 4) Develop a Communication and Engagement plan with particular focus for Local Authorities.	On track

					July – slow progress due to IG issues, all now resolved. Reviews to commence in August.	
	24623	Immedicare Programme to support Care homes including a focus on post discharge support (Gap/control No. 12)	Marianne Walmsley, Head Of Quality For Care Homes	31/12/2023	1) Funding identified from WG to pilot the project 2) Work commenced on identifying key homes with a high rate of WAST calls 3) Project group to oversee the pilot July 23 progress update - This work has been further delayed due to information sharing / IT systems not being compatible. A solution has not been finalized. This work will integrate with actions identified in 24621	On track
	24626	Review and update Health Board Discharge policy. (Gap/control No. 12)	Ms Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/3/2022	Action transferred from previous risk CRR20-05 (previous action ID 22182) This has been delayed due to the National review of the discharge policy. Draft was due to be issued November 2022. Reminders to the operational teams have been issued to	Delay

					ensure they are working to the current policy including issuing of patient leaflets re: discharge and they have no right to remain in hospital when medically optimised for discharge Develop Standard Operating Procedure for the Health Board. July 2023 progress update - WG has now issued the Reluctant Discharge Guidance. Full discharge policy still not issue but We are currently drafting our local policy as the current draft documents are not expected to change in the next 2 months.	
	24627	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers (Gap/control No. 4).	Mrs Marianne Walmsley, Head Of Quality For Care Homes	30/04/2022	Action transferred from previous risk CRR20-05 (previous action ID 18025) To ensure greater workforce resilience, training and education for Social Care staff in the care provider sector which will improve flow. Representation of care home quality team is now on the Board.	Delay

					Established a workforce improvement group as part of the Quality Assurance Framework. July 2023 progress update – regional workforce board has been cancelled a number of times, but there is currently a review of purpose and work plan.	
	24625	Implement the Audit Wales Management Action Plan for BCU – Currently limited assurance (Gap /Control No. 6)	Ms. Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/07/2023	1) Management Action Plan to be submitted to Audit by 28th November 2022. 2) Implement Actions (TBC) July 2023 progress update– system in place for monitoring. Main area of non-compliance is due to the development of the Business Support Hub. – Invest to save business case being developed for submission to Board in November.	On track

CRR23-42	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21 March 2023
	Risk: Age related Macular Degeneration (AMD) and Intra Vitreal Injection Service (IVT)	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 June 2023
There is a risk that patients could suffer irreversible sight-loss ("New" and "Follow up" patients across North Wales). This may be caused by a. delayed access to timely AMD care Pan BCU. b. Inequities in timely access to care. c. Sustainability/core delivery challenges with staffing resource and training shortfall in all 3 sites.		



	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 January 2023	unchanged		

Controls in place	**Assurances**
1. IVT services to reflect National 2 lane parallel pathway. 1. Continuous monitoring by Operational and Clinical team of North wales AMD waiting list, to ensure equity through delivery of mutual aid and/or additional clinics (as required) 2. Dashboard to inform "live" (weekly refresh) waiting time position by site and pan BCU to inform continuous monitoring for equity assurance.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care Collaborative Group and

3. Continuous modelling of AMD waiting time BCU to inform additional Super-Saturday and Twilight Clinic requirements and Pan BCU Mutual Aid.	Performance Finance Information Governance Group (PFIG).

Gaps in Controls/mitigations
1. Partial recruitment to funded posts, with East 0.5 WTE Consultant post and Central Nursing Band 3 0.3WTE interviews have taken place and final recruitment checks are in progression. Clinical Lead/Sites exploring amalgamation of Consultant vacancies Pan-BCU with to achieve 1.0 WTE post with greater feasibility of recruitment. 2. Central and West Clinical Lead posts are vacant and Pan BCU post is now vacant (Clinical Lead key to monitoring arrangements). 3. Unplanned leave (sickness) of core Ophthalmology team have impacted negatively on capacity.

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Controls in place reviewed and updated to reflect current position. 2. Gaps in Controls reviewed and updated to reflect current position. 3. All non-Consultant Transformation funded posts recruited to, with exception of Band 3 HCSW (Central). West Locum mitigation/12 month Consultant recruitment recruited. Partial additional activity commenced April 22 (Full Achievement dependent on recruitment of Consultant 0.5wte vacancy and 0.3wte Band 3 has been interviewed and is in final stage of pre-employment checks). 4. Estates challenges in West (lack of “clean’’ room facilities) entail use of Theatre for IVT—entailing loss of Theatre capacity 5. Data Challenges (see separate Datix Data Quality Risk) have impacted on Data availability for performance modelling and Once for Wales’s equity assurance. 6. Partial recruitment has enabled twilight and super Saturday sessions which have mitigated waiting times and a negative impact of core team unplanned sickness leave. Sickness has reduced the full benefit of additional staffing, performance indicated in the dashboard below: November 2022 census: 330 patients were over 100% overdue target wait (East 123/Central 191/West 16) December 2022 census: 338 patients were over 100% overdue target wait (West 31/ Central 220/East 87) January 2022 census: 313 patients were over 100% overdue target wait (West 22/Central 208/East 83)

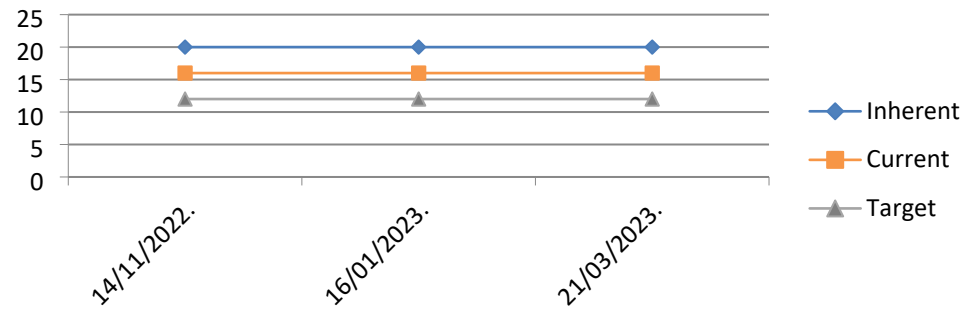
Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways Strengthen our wellbeing focus	BAF21-02 BAF21-04

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	24647	Longer-term: Explore potential of Regional Treatment Centre (RTC) potential to provide additional IVT Estates. Due to National forecast of 40% increase of AMD demand within a decade and need to plan for greater sustainability.	Jackie Forsythe, Network Manager/Roger Haslett, Clinical Lead	30/06/2023	-Provide estates to ensure 2-lane pathway delivery for patients Pan North Wales -Redress of West IVT “Clean Room” capacity gap -Redress West Theatre capacity-loss to providing estate for IVT	On track
	24648	Recruit to funded posts in the East Region and Central for Operational Management and Clinical Lead	Jackie Forsythe, Network Manager	30/06/2023	Essential to have Consultant supervision/access for non-medics who provide 2 lane IVT pathway. The pathway and outcomes in negatively impacted until these posts are recruited.	On track

CRR23-43	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21 March 2023
	Risk: Risk of Irreversible Sight-Loss from Delayed Care for “New” and “Follow-Up” Glaucoma Patients	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 June 2024

There is a risk that delayed access to timely Glaucoma care Pan BCU will lead to irreversible sight-loss for “New” and “Follow up” patients across North Wales. This is caused by sustainability challenges arising from a combination of: delayed delivery of National Digital (E-referral and electronic patient record) essential for effective Integrated delivery, staffing capacity gaps, West estate resource challenges, non-medic skills shortfall for enhanced role achievement, Ophthalmologist capacity shortfall delaying “non-medic” competency sign-off and variance in clinician appetite to progress integrated (primary Optometrist & secondary care) pathways to release capacity and reduce waiting times.

*Caveat: Data Challenges impact on “live” quantification of waiting list “by condition” numbers (See Datix Data Quality Risk)



	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 January 2023	unchanged		

Controls in place	Assurances
Maximising Non-medic led Pathways to release Secondary Care clinician & estate	1. Monthly report to Operational

capacity and reduce waiting times :- 1. Nurse led Outpatient Diagnostic Treatment Centres (ODTC) pathways are agreed core component of business as usual. These enable sites to maximise nurse led capacity to release Ophthalmologist capacity. 2. Primary Care Optometrist led ODTC pathways are agreed core component of business as usual there enable release of secondary estate and staff capacity, for reinvestment to achieve waiting time reduction. 3. National Glaucoma SOS pathway is business as usual Nationally, discharging patients safely to Primary Care. (Ocular Hypertensive Patients not currently under treatment and Glaucoma stable patients not currently under treatment). 4. BCU Inter Ocular Pressure (IOP) pathway agreed Pan BCU. With IOP patients pressures being reviewed by Primary Opticians to release secondary care nursing capacity and offer timelier waits. 5. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring: a. Agreement is in place for Nurse, Orthoptist and Optometrist skills developed through courses, placements and Ophthalmologist competency oversight: to deliver skilled workforce working to top of competence. This workforce to release Medic and/or senior nurse capacity. 6. Once for Wales Secure record sharing (National Openeyes Digital System) a. BCU plan for implementing National Digital System in place: to enable effective information sharing for Integrated pathways delivery. System is key determinant for expanding Integrated Pathways whilst mitigating capacity demand on hospital administration.	Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Nurse led ODTC's • West IHC have been challenged in securing peripheral clinics estates to deliver nurse-led ODTCs in Alltwen Hospital. Nursing Matron actively exploring alternate options. • East/West/Central have increased patients per clinical to pre COVID levels of 8 patients are challenged to meet National target of 10 patients per nurse clinic. (target 9 patients/clinic toward National target. Q3, 22)

2. Optomotrist led ODTC's East IHC paused flow of a total of 80 Glaucoma patients per month to Primary Care ODTCs from September 22.
3. Historic capacity gap in hospital placement provision and Ophthalmologist mentors for Higher qualification and competency "sign-off capacity" has negatively impacted on delivery of "enhanced-skill" Nursing and Optometrist workforce.
4. Primary Care OTDC capacity (West and East) reduced by circa 25%, due to unplanned leave. Partial mitigation achieved through "recovery" trajectory. National Contractual Reform to commence June 2023: which would expand Primary Care "workforce". Workforce predicted Nationally to offer >30% follow up capacity for Glaucoma Follow ups. In interim, current P-ODTC contract in process of expansion to offer "wider" cohort of contractors delivering current trajectory, to provide improved contingencies and patient access (Q3, 2023).

Waiting List Reduction through SOS:-
1. Variation in Clinician appetite/"Buy In" for Integrated Pathway partnership with Primary Care persists. Shared understanding supported by engagement sessions held in 2019, 2021 and 2022. Continuous improvement Networks additionally review current practice against National Pathways: with outcome of East and West SOS implementation delayed, Central clinical have yet to agree commencement of SOS.

2. East and West and Central delayed delivery of Intraocular Pressure Pathway. Central and West to commence Q4 2023. East start date to be confirmed.

Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring
1. North Wales region is a national outlier in terms of Primary-care non-medic workforce: in terms of staffing numbers and Higher level qualifications.
2. There is a Nursing enhanced role shortfall, with Ophthalmologist capacity shortfall/vacancies delaying "non-medic" competency sign-off.
Currently all sites offering Primary Care placements, within capacity. Capacity to support placement challenged by vacancies of senior clinician roles. BCU currently exploring with Welsh Government proposal to establish a Train & Treat Centre in North Wales. This would offer two years funding (Welsh Government) and additional treatment for a minimum of 1000 glaucoma, 800 AMD and 2000 acute patients per year. (On basis of full-capacity of 12 Independent Prescribing, 6 Higher glaucoma and 6 Medical Retina Higher Qualification placements)

Once for Wales Digital "Secure Folder/file Sharing

1. National programme delayed by circa 9 months, with consequence of significant increase on administration capacity, due to increased scanning/secure sharing of information with Primary Care contractors to mitigate delayed digital enabler. Interim digital solutions explored with Informatics. Glaucoma Referral refinement pathway cannot commence until system implemented: delaying achievement of 30% “false positive” Glaucoma referral waste reduction

Workforce Review to assure a sustainable, prudent workforce

1. A full service review with supporting 5 year workforce plan was recommended in 2019, within 2019 Transformation Business case that concluded *“workforce is historical and not based on population demand”*. 2021 Wales Audit report called for development of 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”*: with BCU Audit recording Workforce as Leading delivery. This will be raised as a priority to develop within Ophthalmology and Planned Care strategic meetings in Q3, 2022. A determining factor to delivery is confirmation of Contractual Reform Pathways (circaQ1, 2023)

Progress since last submission

This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks.

1. Controls in place reviewed and updated to reflect current risk position.
2. Gaps in controls reviewed and updated to reflect current risk position.
3. Pan BCU dashboard has been established that provides services with waiting lists by condition to support flow of patients to non-medic pathways.
4. All Glaucoma patients are R1 (at risk of irreversible sight-loss from delayed care.) Qtr 4, 8,921 Glaucoma patients on waiting list Pan BCU: with 5,710 breaching National KPI ≤25% over target wait.
5. Action ID 24649 - Action delayed, ongoing update requested from sites for progress.
6. Action ID 24650 – Action delayed, All sites initiated test of change of achieving 9 patients in an ODTC clinic and next step is to embed the 9 patients per clinic delivery (staged progression).
7. Action ID 24651 – Action delayed, Pre-determinant of local delivery is National programme re-assurance against Governance (information/confidentiality compliance checks within systems) this is outstanding Nationally preventing local go-live.
8. Action ID 24652 – Action closed, Highlight report in place (monthly) to support operational management delivery of ODTC targets. Action tracker established for sites to provide monthly exception reporting against delivery. East Region has re-commenced flow of patients to P-ODTC from February 2023, West Region has re-commenced consistent flow of patient to P-

ODTC's in January 2023, Central Region has re-commenced flow of patients to P-ODTC's from October 2022 and consistently maintained this.
9. Action ID 24653 – Action delayed, Conflicting Central Estate priorities have delayed confirmation of the required 4 rooms Holywell Hospital, this constitutes a significant risk to train and treat delivery.
10. Action ID 24655 – Action delayed, Primary Care Optometry scope completed. Conflicting site priorities have led to stand down of eye care network meetings delaying progression of Hospital non-medic training plan analysis.
11. Action ID 24657 - Action closed, all sites have now delivered the Integrated Pathway trajectory. However Primary care capacity to receive patients has been reduced due to unplanned leave, therefore a new action of expanding the Primary ODTC workforce is to be progressed.
12. Action ID 24658 – Action delayed, Partial delivery has commenced in Central, East delivery paused due to Admin constraints, West delivery has commenced. Where this is implemented in BCU delivery is reliant on temporary Admin funding to the end of March 2023. Network Manager and site exploring longer term solutions. Temporary extension of admin funding for 6 months has been confirmed with all sites (funded by eye care transformation fund).
13. Identification of new action ID 24815, to expand the Primary ODTC workforce team.

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

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	24649	Explore peripheral estate options for Nurse-led Ophthalmology Diagnostic and	Sandra Robinson-Clark, Ophthalmology Nursing Matron (West)	31/12/2022	-Releases estate capacity within Ysbyty Gwynedd Eye Clinic March 2023 progress update – Action delayed, ongoing update	Delay

		Treatment Centres (ODTC)			requested from sites for progress.	
	24650	Deliver increased nurse-led ODTC clinic utilisation “Test of Change”	Mannon Jones Ophthalmology Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central	31/03/2023	-Reduces Glaucoma patient waiting time March 2023 progress update – All sites initiated test of change of achieving 9 patients in an ODTC clinic and next step is to embed the 9 patients per clinic delivery (staged progression).	Delay
	24651	Deliver Interim Digital systems prior to National System “Go Live”	Dewi Edwards, BCU Regional Architect	31/12/2022	Partially reduce avoidable capacity loss*** negatively impacting on administration teams and consistent delivery of Primary ODTC pathways (***Currently unfeasible for “referral refinement” pathways) March 2023 progress update – Pre-determinant of local delivery is National programme re-assurance against Governance (information/confidentiality compliance checks within systems) this is outstanding Nationally preventing local go-live.	Delay
	24652	Review and assure consistent flow of	Paula Betts, Lead Manager	31/12/2022	-Assure maximum utilisation of contracted capacity	Completed

		patients to P-ODTCs (Primary Care Optician Diagnostic and Treatment Centres)	- Surgical (Central)		-Reduce Glaucoma patient waiting times -Redress (central) patient inequitable access to Care Closer to Home March 2023 progress update – Action closed, Highlight report in place (monthly) to support operational management delivery of ODTC targets. Action tracker established for sites to provide monthly exception reporting against delivery. East Region has re-commenced flow of patients to P-ODTC from February 2023, West Region has re-commenced consistent flow of patient to P-ODTC's in January 2023, Central Region has re-commenced flow of patients to P-ODTC's from October 2022 and consistently maintained this.	
	24653	Explore delivery of Welsh Government funded Train and Treat Centre in North Wales	Richard Price, Optometry Advisor/Jackie Forsythe, Eye Care Network Manager/Roger Haslett, Clinical Lead	31/03/2023	- Redress historic capacity gap in hospital placement provision -Reduce competency-oversight demand on Senior Nurse/Ophthalmologist's -Increase "pool/cohort" of Non-medics with Higher	Delay

					qualifications/competencies to enable extension of “Integrated Workforce” March 2023 progress update – Conflicting Central Estate priorities have delayed confirmation of the required 4 rooms Holywell Hospital, this constitutes a significant risk to train and treat delivery.	
	24654	Development of a “single medium-term workforce plan for eye care services (acute and NHS funded community services)	Nikki Foulkes, Planned Care/Roger Haslett, Clinical Lead/Richard Price, Optometry Advisor	30/06/2023	- Identify skill mix and capacity requirement of workforce to provide sustainable delivery of intended models of care	On track
	24655	Complete Non-Medic Training Needs Analysis	Richard Price, Optometry Advisor/ Mannon Jones Ophthalmology Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central	31/03/2023	-Enable delivery of an Integrated Training Plan: to best assure increased “pool/cohort” of Non-medics with Higher qualifications/competencies to enable extension of “Integrated Workforce” March 2023 progress update – Primary Care Optometry scope completed. Conflicting site priorities have led to stand down of eye care network meetings	Delay

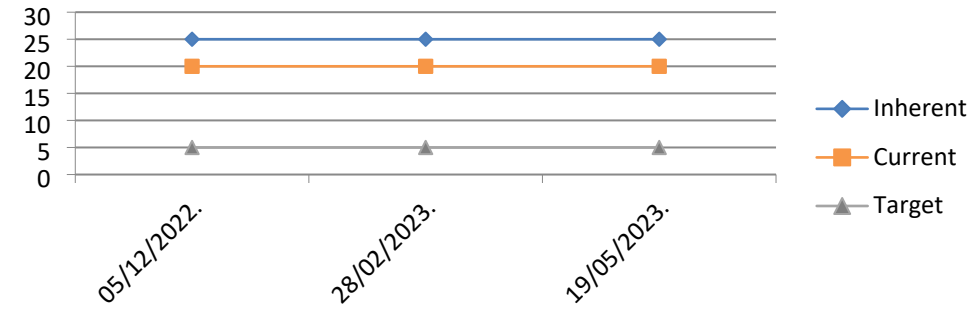
					delaying progression of Hospital non-medic training plan analysis.	
	24657	Operation sites and clinical teams to deliver agreed Integrated Pathway trajectory	Jackie Forsythe, Eye Care Co-ordinator	31/03/2023	Ensure that patient waiting times for longer waiting Glaucoma patients are reduced through integrated pathways March 2023 progress update – Action closed, all sites have now delivered the Integrated Pathway trajectory. However Primary care capacity to receive patients has been reduced due to unplanned leave, therefore a new action of expanding the Primary ODTC workforce is to be progressed.	Completed
	24658	BCU to deliver National Welsh Circular (delivery of Glaucoma SOS (see on symptom) discharge to Primary Care)	Jackie Forsythe, Eye Care Co-ordinator	31/12/2022	Reduce number of open pathways of patients waiting for Glaucoma review through safe discharge to primary care (Who will then provide ongoing review). Releases Glaucoma capacity for high risk Glaucoma patients for Secondary Care. March 2023 progress update – Partial delivery has commenced in Central, East delivery paused due to Admin constraints, West delivery has commenced. Where	Delay

					this is implemented in BCU delivery is reliant on temporary Admin funding to the end of March 2023. Network Manager and site exploring longer term solutions. Temporary extension of admin funding for 6 months has been confirmed with all sites (funded by eye care transformation fund).	
	24815	Expand the Primary ODTC workforce team.	Jackie Forsythe, Eye Care Co-ordinator	30/04/2024	Expressions of interest have been circulated to Primary Care Optometrists across North Wales, this has confirmed feasibility of expanding workforce potential. Eye care network to commence business case options to secure funding expansion. Potential partial funding may be provided by the Optometric contract reform (WECS funding to be confirmed by Welsh Government prior to April 2024).	On Track

CRR23-44	**Director Lead:** Executive Director of Therapies & Healthcare Sciences	**Date Opened:** 21 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19 May 2023
	Risk: Pathology Laboratory Information Management System (LINC)	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 01 July 2025

If the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted resulting in potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact.

Nb. The description of the risk is a nationally agreed descrpition of the risk.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	5	1	5
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the in May 2023.	unchanged		

Controls in place	**Assurances**
Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps. A provision will be added to the current legacy contract for a short-term extension until September 2025; this has been agreed in principle but not yet been formally implemented. A set of additional contract milestones to Citadel (new system supplier) will	1. Linc programme board, Senior leaders from each HB scrutinise and worked collaboratively where further work is required. 2. Briefing papers delivered to Chief Executive group.

be included in the contract change notice (CCN) for hosting; the hosting CCN has been agreed subject to Ministerial approval. The LINC programme is working with Health Boards and Trusts to review Citadel's revised delivery plan.	3. Local deployment project updated and reviewing appropriate matters. 4. Stocktake review fed back to Welsh Government 5. Rep from WG sits on the LINC programme board and is the direct contact for WG. 6. Partial assurance for Blood Transfusion, reported through Hospital transfusion committee and AAA report to PSQ.

Gaps in Controls/mitigations
LINC programme commercial position, Ref:g-2211-03b Update paper on LINC, Ref:Eg-2211-03a Gaps identified within the confidential papers above.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Pathology continuing to engage with the National Project, significant resources being assigned, close support from Digital, Data and Technology team also provided.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-16

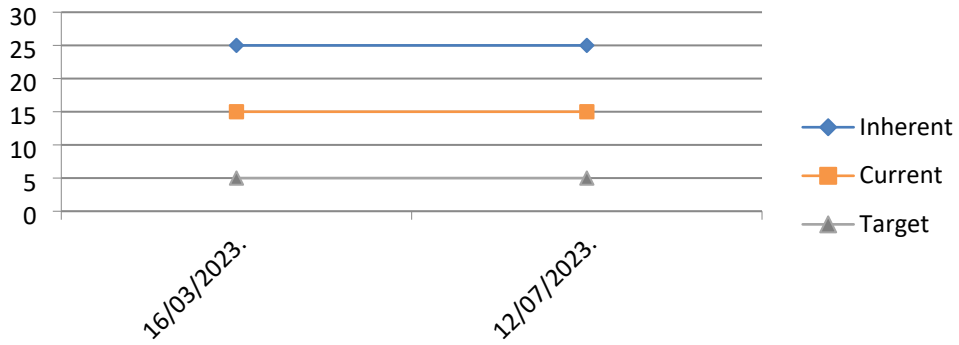
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	24498	Engage with the National process to implement a National system, and identify an agreed way forward. National Programme Board, LDP, Ad-hoc workshops in place, PHW Collaborative Executive group.	Dr David Fletcher, Directorate General Manager, NWMCS	30/09/2025	Ensure HB stakeholder are represented within the appropriate groups. Contribution to the national decision for a Once for Wales system, signed off by the Chief Executives Group. May 2023 progress update - The national project is governed by the LINC program board, which reports directly to the chief executives group, via the project Senior Reporting Officer.	On track

CRR23-46	**Director Lead:** Chief Digital and Information Officer	**Date Opened:** 16 March 2023
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 12 July 2023
	Risk: Duplicate Hospital Numbers	**Date of Committee Review:** New Risk from April 2023
		Target Risk Date: 30 June 2024

There is a risk that patient information is recorded against different hospital numbers.

This may be caused by patients having multiple hospital numbers across BCU due to historical systems requiring a different hospital number per site.

This could lead to clinical information not being readily available under one record to clinicians which could affect Patients care / patient safety, Clinical decisions making, Delays to treatment, Duplicating treatment or investigations which could lead to Increased complaints, financial penalties, claims for harm caused.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	Assurances
1. Digital Strategy implemented. 2. WPAS Policy and Procedures implemented. 3. WPAS Standard Operating Procedures, Quick Reference Guides, videos in place. 4. WPAS Training Programme implemented. 5. WPAS Communication and Awareness Programme in place. 6. Dedicated resource and process in place for the continual review of incorrect patient registrations.	1. WPAS Data Quality Groups 2. WPAS Programme Board 3. Digital Portfolio Group

Gaps in Controls/mitigations
1. There is a gap in the assurance and oversight of this risk at the Health Board Committees. New action identified to escalate the risk and raise awareness at Committee level. 2. No single hospital number within BCUHB in place. Merging of hospital numbers would provide a highly reduced clinical and patient safety risk as all information i.e. investigations, results, clinical letters etc. is available under the same record. Project Plan to be developed to traverse through the mandate process. First draft for the mandate process has been completed. 3. Patient records are impacted within a variety of systems and casenotes. Ownership of the 293 plus systems are widespread across BCU and there are many casenote custodians within the Health Board making it challenging to gain a standardisation of processes. Mitigation would be to re-establish the system owners group.

Progress since last submission
1. Risk was first presented to the Risk Management Group in April 2023 for escalation, but due to the Partnership, People and Population Health Committee being stood down, it has yet to be presented to the Committee. 2. Controls in place reviewed and updated to ensure relevance with current status of the risk. 3. Gaps in controls reviewed and updated to ensure relevance with current risk position. 4. Review of Clinical Risk Assessment also undertaken which still aligns with the current risk rating and impact. 5. New action identified to strengthen assurance process and prevent risk from materialising in the future. 6. When the single instance went live, floor walkers were available on all sites. Patient Numbering issues raised via floor walkers to raise awareness and understanding. 7. Draft paper in development to articulate proposal to support the review, reduction and integration of current system whilst awaiting the implementation of the new Asset Register.

8. Action ID 24831 – Request to close this action as it is now completed.
9. Action ID 24825 is delayed due to the need to provide clarity around the issues in other clinical systems.
10. Action ID 24832 is delayed due to Board Committee not currently meeting.
11. Action ID 24834 is delayed due to the need to implement the new Asset Register and provide training and awareness ready for the new group to start meeting.
12. Action ID 24835 is delayed with the first phase completed. Work has commenced on the next phase which will be for a new project to be established.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for Improvement (key enabler)	BAF21-13 BAF21-16

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	24825	Further Communication to go out to all clinicians to advise them to search by NHS/ Name and D.O.B in any system.	Assistant Director of Data, Intelligence and Insight	30/04/2023	Reducing risk by advising clinicians to check all possible records. July 2023 – Statement currently being drafted by Chief Clinical Information Officer. Point of clarity raised regarding impact statement could have on other systems being worked through.	Delay
	24829	Train all WPAS users on the correct process to follow (unable to	Mrs Teresa Marie Dutton, WCP	30/09/2023	Reduce risk of duplication and omitting data	On track

		comment on other systems).	Product Specialist		July 2023 – Action will be ongoing. When single instance went live, floor walkers were available on all sites. Patient Numbering issues raised via floor walkers.	
	24831	Develop automated monitoring reports to identify users registering duplicate patients.	Kathryn Lang, Assistant Director of Data, Intelligence and Insight	14/04/2023	Report will identify any users registering patients already registered within the WPAS system which would add to the complexities. July 2023 – Report in place, resource identify to contact individuals on daily basis with escalation processes in place.	Complete
	24832	Risk to be escalated to committee level.	Kathryn Lang, Assistant Director of Data, Intelligence and Insight	01/06/2023	To ensure openness, transparency and support. July 2023 – Risk escalated and approved at Risk Management Group in April, however PPPH currently not meeting.	Delay
	24834	System owners group to be re-established.	Mr John Thomas, Deputy Head of ICT	30/10/2023	To share processes and best practice to prevent re-occurrence in other systems. July 2023 – Health Board are awaiting the implementation of the new System Asset Register to re-stablish the group, provide training and awareness	Delay

					for future system management and integration technologies. There is currently a delay with the System Developers with anticipated implementation pushed from May 2023 to October 2023, which will impact on the achievement of this action timeframe.	
	24835	Develop Project Plan to progress through the business mandate process.	Kathryn Lang, Assistant Director of Data, Intelligence and Insight	31/05/2023	Reduce the impact or re-occurrence of the risk materialising. July 2023 – first draft has been completed, next phase to agree if this needs to be a project in its own right due to resource requirements.	Delay
	New Action	Develop new process to check most appropriate hospital number selected for current activity	Miranda Perkins, WPAS Manager	31/07/2023	Ability to immediately identify the use of incorrect hospital number to prevent re-occurrence and provide additional training and support.	On track

CRR23-47	**Director Lead:** Director of Mental Health	**Date Opened:** 12 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed** 21.04.2023
	Risk: There is a risk to the safety of inpatients within MHLD identifed by the Health and Safety Executive in their Notice of Contravention under Section 28(8) of the Health and Safety at Work Act 1974.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30.06.2023

There is a risk to the safety of inpatients within MHLD identifed by the Health and Safety Executive in their Notice of Contravention under Section 28(8) of the Health and Safety at Work Act 1974.

This has been caused by the three identifed breaches detailed in the notice of contravention.

This could impact/effect patient safety, reputation, finance, credibility, strategy, sustainability, together with delivery of remedial actions.

	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	Assurances
Contraventions of Health and Safety Law were identified at the time of the incident, in particular the Safety of in-patients during admission to hospital. Section 3 of the Health and Safety at Work Act 1974 requires the Health Board to ensure that such patients are not exposed to risks to their health or safety. There are three material breaches cited by HSE and the controls below list the actions taken in response the breaches: Breach 1 - Risk Assessment and Care and Treatment Plan. 1.1 Review of existing audit processes for mental health measure risk assessment to map against standard's within the clinical risk management procedure. 1.2 Audit of the Mental Health Measure risk assessment for patients against Clinical Risk Management Procedure & the Quality and Safety Audit and implement improvement plan (if required). Update 28.11.2022 - two audits have been completed. Report produced. Plan in place for next 12 months. 1.3 Arrangements have been put in place to monitor compliance with Welsh Applied Risk Research Network (WARRN) training for all registered staff 1.4 Reporting of WARRN training compliance to MHLD Quality Delivery Group 1.5 Registered nursing staff are trained in WARRN (Welsh Applied Risk Network) to 85% - progressing. 1.6 Review of MHLD AC002: Therapeutic Engagement and Observation Policy and considered amendments to reflect best practice 1.7 Ensured that staff are trained in the MHLD AC002: Therapeutic Engagement Observation Policy controls and types of observation practice. 1.8 Audited the application of MHLD AC002:Therapeutic Engagement Observation against Therapeutic Observation Procedure & implement improvement plan (if required) 1.9 Audited the Mental Health Measure Care & Treatment Plans for patients & implement improvement plan (if required) 1.10 Reviewed Acute Care Operating Framework and considered amendments in relation to frequency of updating Mental Health Measure documentation and risk assessment 1.11 Confirmed and put in place section on importance of staff understanding legal duty whilst undertaking WARRN training	HSE NoC Group – HSE Prosecution Group MHLD SLT Meeting MHLD Quality Delivery Group Strategic Occupational Health & Safety Group QSE Committee MH Summit Regulatory Oversight Group

1.13 Ensured all staff are aware of BCUHB & Health Professional regulation practice on record keeping 1.14 Reviewed MHLD Nursing MHLD CPG 002: Supervision Policy to ensure item in supervision form included for reminding nurses about policies & procedures and location on BCUHB website 1.15 Put in place nursing supervision arrangements Ward to Head of Nursing 1.16 Audited compliance with nursing supervision against MHLD CPG002: Supervision Procedure & implement improvement plan (if required) 1.17 Put in place a documentation audit with MHM and RA documentation to establish consistency of form filling compliance & implement improvement plan (if necessary) 1.18 All MHLD wards to have a Corporate H&S Review within three months and then at 6 monthly intervals & implement improvement plan (if necessary) and report to Divisional Quality Delivery Group 1.20 Put in place robust local health and safety system based on HSG65 (creation of individual ward based health & safety folders; signature lists to show staff awareness) 1.21 Provide a monthly update to MHLD Quality Delivery Group Health & Safety items of significance 1.22 Put in place local Health & Safety Group and attend West Health Economy Health & Safety Group meeting 1.23 Ensured nursing staff attend BCUHB Health & Safety training level 1 at 85% KPI 1.24 Ensured all staff are aware of MHLD Restricted Items procedure 1.25 Ensured staff trained in implementing the Restricted Items procedure 1.26 Audited compliance with the Restricted Items procedure and implement an improvement plan (if required) 1.27 Prepare a Nurse in Charge SOP to clarify roles and responsibilities for inpatient staff including handover and determine ongoing care 1.28 Implemented a Nurse in Charge SOP to clarify roles and responsibilities for inpatient staff including handover and determine ongoing care 1.29 MHLD staff 8d and above attend IOSH Leading Safely Courts 1.30 Considered different communication methods of disseminating lessons learned - 7 minute briefings, and team meetings	

1.31 Developed a lessons learned programme for all incidents and near misses to ensure lessons are implemented and tested Breach 2– Bed Safety 2.1 Ensured awareness of the Bed Allocation Decision Making Guide2.2 Audited compliance with Bed Allocation Decision Making Guide 2.3 Confirmed the cessation of mixed cohorting of patients over 70 years of age and report breaches via DATIX for review 2.4 Ensured there is an appropriate system to obtain a suitable bed and staff aware of escalation process & risk mitigation process if patient in the wrong bed type 2.5 Put in place a (calendar) system of undertaking environmental anti ligature risk reduction assessments in the West Locality 2.6 Reported anti ligature risk reduction assessments and mitigation to MHLD Quality Delivery Group 2.7 Developed and implemented training to support the risk reduction documentation to be completed by ward managers Breach 3 - Ligatures, removal of property 3.1 Reviewed and amend the MHLD Search procedure in terms of link to risk assessment and what is to be recorded when the search procedure is implemented 3.2 Designed training pack on MHLD Search procedure 3.3 Put in place training plan on how to implement the MHLD Search procedure 3.4 Audited the application of MHLD Search procedure (ensuring that appendix 2 of the restricted items Inventory of Restricted Items included) & implement improvement plan (if required) 3.5 Reviewed and amended the BCUHB Patient Property procedure in terms of link to risk assessment (as related to MHLD) 3.6 Designed & produced training slides on BCUHB Patient Property procedure 3.7 Put in place training in BCUHB Patient Property procedure	

3.8 Audited the application of the BCUHB Patient Property procedure and implement improvement plan (if required)	

Gaps in Controls/mitigations
1. The project plan actions, together with those actions listed on the Divisional 45 point action plan will require action and completion to provide assurance. 2. Building on existing audit to demonstrate sustainability of improvement's is impacted by divisional staffing vacancies, acuity on wards and a lack of dedicated divisional resource for audit. ToRs are being developed to underpin organisational internal audit these will be reviewed by the Organisational HSE Prosecution Group. 3. The target date for closure of this risk is aligned to the completion of the identified action and the completion of Court Proceedings. However, completion of this risk this may be impacted due to the timeliness of Court Proceedings. 4. The Division does not currently have a Digital Patient Record System and there is a requirement that MHLD follow the All Wales Digital solution. The All Wales System is not yet ready for roll out across the Division and Health Board.

Progress since last submission
HSE NoC response to HSE HSE NoC I&D sub-group developed Robust project plan in place to identify high risk priorities

Links to	
Strategic Priorities	**Principal Risks**
	BAF21-06

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	24333	Continue with HSE NoC meeting and associated actions	Hilary Owen, Head of Governance and Compliance MH&LD	31/03/2023 30.06.2023	Actions identified will demonstrate progress and provide assurance and evidence to the HSE to inform their decision regarding prosecution. All identified actions are intended to improve quality, safety and experience of all patients.	Delay

CRR23-48	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 11 May 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 21.04.2023
	Risk: There is a risk to patient safety within MHLD inpatient units presented by access to low height and other ligature anchor points	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30.06.2023
There is a risk to patient safety within MHLD inpatient units presented by access to low height ligature anchor points that have not been removed in prior capital programme works. This has been caused by the advice changing to organisations to remove height as an escalating factor in the appraisal of risk, which we have done. This could impact/effect patient safety catastrophically. It impacts on the estates plan, control documentation and on some of our other risk assessments, policies and procedures.		

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	1	5
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	Assurances
The consequence of this is that low to medium level height anchor and ligature points are now assessed as high risk and therefore need to be mitigated. Previous capital programmes of work have removed high level and obvious ligature points and we have seen a change in patient behaviour where hangings are more likely from low to medium level anchor points.	**1**. We have established local Ligature Risk Reduction Meetings that report to a Divisional Ligature Risk Reduction Meeting. Updates are provided to the Divisional QDG meeting with a

More recently, the All Wales Serious incident group have developed ligature risk reduction guidance based on the triangle of security outlining the principles to be followed. These are in draft at the present time however, MHLD have been advised to proceed with implementation of the recommendations. 1. Ligature Risk Reduction and Anchor Point Procedure has been reviewed and ratified with the complete removal of reference to height as the risk factor, and that all potential anchor and ligature points are highlighted as high risk and scored accordingly and therefore mitigation plans in place and escalation of unresolved issues. 2. As per policy, annual audits have been completed and subsequent risk assessments and action plans reviewed monthly by the local senior teams. 3. A library of risk reduction documents established on a shared drive for ease of reference. 4. Local ligature risk reduction meetings have been established which feed into a divisional meeting for reporting, learning and streamlining practice across the division. This meeting reports to divisional directors. 5. Some furniture has been identified to be replaced and is progressing through process 6. A forum has been established to identify additional training needs. 7. The Welsh Government Patient Safety alerts in relation to ligature risk have been circulated to all senior leadership teams and the contents discussed and actions agreed to raise awareness further in the divisional meeting. 8. When a patient is admitted onto a ward a bed allocation risk assessment is completed to ensure provision of an appropriate bed 9. A Divisional Ligature Reduction Group has been stood up 10. Environmental ligature audit of all inpatient ward areas have been undertaken by an external party 11. Ligature reduction updates and progress feeds into the Divisional Ligature Risk Reduction Group with attendance from Health & Safety and Estates. Updates are reported to Divisional QDG, Divisional SLT and Executive Groups, Committees and MH Summits.	pathway of escalation to the Divisional SLT Meeting. Updates are provided up to Executive Delivery Groups and Committees. **2**. Audits are completed annually and subsequent risk assessments and action plans are reviewed monthly.

12. The Divisional has implemented a tripartite way of working in line with guidance in that H&S and Estates colleagues are involved in ligature risk assessments and sign off of ligature works undertaken. 13. Health and Safety Training in how to undertake a ligature environmental risk assessment has been delivered with plans to progress training beyond the current number who have received training.	

Gaps in Controls/mitigations
1. Audit of controls needs to be undertaken 2. Sustainability of improvements and learning may be impacted by the ability to release staff from clinical areas to undertake training due to vacancies and acuity in the clinical environment. 3. Ensuring we remain responsive to external incidents and renewed/updated guidance 4. Consideration of environmental ligature risk assessment of clinical rooms at ED's used specifically by Psychiatric Liaison for the assessment of a patients mental health needs.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Safe, secure & healthy environment for our people	BAF21-06

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
	18799	Audit to establish effectiveness of existing controls	Smith, Mr Mike - Interim Director of Nursing	30.06.2023	Will establish robustness of current controls	On track
	24334	Undertake environmental ligature risk audit on all inpatient MHLD wards	Owen, Hilary - Head of Governance and Compliance MH&LD	31/03/2023	Existing mitigations in place with monthly ligature environmental risk assessments taking place.	Completed
	New Action aligned to Gaps in Controls	Consideration of the inclusion of environmental ligature risk assessment of clinical rooms within ED's allocated specifically to Psychiatric Liaison to undertake mental health assessments in East, Centre and West acute hospitals	Paul Lumson - Interim Director of Nursing	30.06.2023	Provision of the opportunity to extend environmental ligature risk assessment to rooms outside of the Division regularly used by mental health services.	On track

CRR23-49	**Director Lead:** Interim Executive Director of Finance	**Date Opened:** 24 April 2023
	Assuring Committee: Performance, Finance and Information Governance Committee	**Date Last Reviewed:** 24 April 2023
	Risk: Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget	**Date of Committee Review:** New Risk
		Target Risk Date:
The need to reduce the size of waiting lists to meet WG expectations and avoid harm to patients waiting, whilst the Health Board is still not able to achieve and improve on its pre-Covid core 2019-20 activity levels, could require a level of investment in insourced and outsourced activity which would cost in excess of the £27.1m funding available.		

	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	3	3	9
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	**Assurances**
Oversight from the Planned Care Board and PFIG. Performance reporting. Existing performance and accountability arrangements including IHC/other performance review meetings. The new local integrated planning process being undertaken over Q1 has a particular emphasis on planned care. After check and challenge sessions with IHCs on 18 April, IHC/SLT updated planned care plans will be reviewed at the accountability review meetings around 28 April.	Limited at present

Gaps in Controls/mitigations
Limitations on the ability of divisions and clinical teams to deliver the scale of productivity and utilisation improvements needed. Resource constraints impacting on the ability to further outsource.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**

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		A Performance Delivery Group will be set up, with clinical and other executive membership, the brief for which will include oversight of planned improvement including productivity, utilisation and waiting list management. The Planned Care Board will be a sub-group of the Performance Delivery Group. This will report to both HBLT and the	Steve Webster, Interim Executive Director of Finance	During May, but performance improvement actions already taking place as indicated above	Improved scrutiny and oversight of improved performance and associated costs	Completed

		Special Measures Oversight Group, and on to PFIG.				
		A performance and accountability framework, and IHC/other performance review meeting arrangements are already in place. But these will be strengthened through a new framework for integrated local planning and associated performance management arrangements – termed Planning, Performance and Accountability. An action plan for the implementation of this over Q1 23/24 has been agreed. Given the level of risk around planned care, there is a specific section of the plan around planned care, including a process for setting corporate expectations around productivity and other improvement, and running check and challenge meetings with IHCs.	Steve Webster, Interim Executive Director of Finance	Target completion end June, but timescales challenging	Greater clarify on and ownership of, local delivery	On track

CRR23-50	**Director Lead:** Interim Executive Director of Finance	**Date Opened:** 24 April 2023
	Assuring Committee: Performance, Finance and Information Governance Committee	**Date Last Reviewed:** 24 April 2023
	Risk: Financial outturn for 2022/23	**Date of Committee Review:** New Risk
		Target Risk Date:

At Month 11 the Health Board forecasted full-year break-even, which is key to achieving key Health Board duties, and building stakeholder confidence. There is a risk that the full-year 2022/23 outturn is different from the projected breakeven position as at Month 11, especially given uncertainties around accruals for:

- annual leave (particularly medical staff) due to sub-standard recording by on ESR;
- purchase orders, particularly because of incorrect receipting practice by system users (and correcting journals).

There is also a risk that the external auditor may find additional errors relating to last year which are material, requiring re-statement of the Health Board's 2021/22 accounts and consequential revision of the draft 2022/23 outturn.

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	5	0	0
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	New Risk		

Controls in place	Assurances
Intensive work was planned and completed during Month 12 by Corporate Finance to: • investigate and identify annual leave data available as the basis for reasonable year end estimates; • further cleanse open purchase orders that have been receipted by system users; • test manual journals at year end in conjunction with area/divisional CFOs. Internal Audit have also been sample testing the receipting of purchase orders around year end.	

Gaps in Controls/mitigations
The recording of annual leave for medical staff (as against non medical staff) is poor. There is a no reliable other source of data, and thus the accounting for annual leave for medical staff has had to be based on the ESR records in the absence of other alternatives. It is important that this system weakness is addressed in 2023/24, but this cannot mitigate the risks in accounting for 2022/23. While significant improvements have been made in cleansing of open purchase orders, and closing of several thousand old purchase orders, there is residual risk from the poor quality receipting practice. Again it is important that this system weakness is addressed in 2023/24 through training and review processes.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**

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
		Initial reporting to WG shows a small underspend of £0.2m (draft subject to audit) – ie in line with M11 forecast. An Accountable Officer letter has also been provided – highlighting a new risk that arose during March (fine arising from H&SE investigation) that could lead to further expenditure of up to £6m. If not funded by WG, this could adversely impact the full-year out-turn.	Steve Webster, Interim Executive Director of Finance	Complete	The final draft underspend is £389,000 (subject to audit). A provision has been made the fine and the cost of this is met through AME funding for WG in 2022/23, but this may be repayable in 2023/24.	Completed
		A formal response is awaited from WG to the Health Board's reporting of the initial out-turn. Informal feedback from WG is that will a clear explanation from us of the effective utilisation of funding to support the overall reported position.	Steve Webster, Interim Executive Director of Finance	May 2023	Informal explanations has been provided regarding use of performance and transformation funding. The need for any further AO letter is being clarified with WG, and this will be provided as necessary. This will increase the assurance of the Health Board retaining all funding provided in 2022/23, but	On track

					this is secure in practice already.	
		The external audit of year-end accounts is ongoing and regular engagement and communication arrangements with the team are in place to address emerging issues.	Steve Webster, Interim Executive Director of Finance	Ongoing during the audit to end July	This will enable good communication and resolution of any issues arising during the audit.	On track

CRR23-51	**Director Lead:** Interim Executive Director of Finance	**Date Opened:** 24 April 2023
	Assuring Committee: Performance, Finance and Information Governance Committee	**Date Last Reviewed:** 24 April 2023
	Risk: Risk of failure to achieve the initial financial plan for 2023/24 (£134.2m deficit), because of failure to achieve the level of financial improvement included in the plan	**Date of Committee Review:** New Risk
		Target Risk Date: 31 December 2023

The initial financial plan for 2023-24 has identified a forecast deficit of £134.2m. This includes a target for Financial Improvement of £38.7m, which is based on the following:

- Disinvestment identified £13.5m
- Savings identified £18.2m
- Savings and disinvestment stretch target £7m

Failure to deliver the target for Financial Improvement could adversely impact on the achievement of the initial financial plan and increase the deficit.

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	New Risk		

Controls in place	Assurances
Core Savings targets for IHCs, Non-IHC Directorate and Corporate functions has been agreed with senior leadership teams at HBLT. Additional cross cutting themes with Executive leadership have also been agreed to support IHC/other delivery, and a process of further review of investments by the relevant Executives. Savings delivery is reported monthly to PFIG.	None at present

Gaps in Controls/mitigations
The various measures and steps to deliver further financial improvement are not yet in place. They are need to be put in place over Q1.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**

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		A Finance Delivery Group will be set up, with both senior finance membership and clinical and other executive membership outside finance, the brief for which will include oversight of financial improvement. This will report to both HBLT and the Special Measures Oversight Group, and on to PFIG.	Steve Webster, Interim Executive Director of Finance	May 2023	Increase the focus and traction on putting in place the enablers for delivery and delivery itself.	On track

		A performance and accountability framework, and IHC/other performance review meeting arrangements are already in place. But these will be strengthened through a new framework for integrated local planning and associated performance management arrangements – termed Planning, Performance and Accountability. An action plan for the implementation of this over Q1 23/24 has been agreed.	Steve Webster, Interim Executive Director of Finance	Target completion end June 2023, but this is a challenging timescale	Increase local ownership and clarity of performance management/accountability	On track

CRR23-52	**Director Lead:** Executive Director of Finance	**Date Opened:** 24 April 2023
	Assuring Committee: Performance, Finance and Information Governance Committee	**Date Last Reviewed:** 24 April 2023
	Risk: WG cash funding for 2023/24	**Date of Committee Review:** New Risk
		Target Risk Date:

The majority of the Health Board's cash incomings are WG funding. In the context of the Health Board's scale, there are only relatively small opportunities to readily restrict cash outgoings should that be necessary. Most outgoings are workforce related (including tax and pensions), healthcare related and commercially committed. Income generation and receivables management opportunities are also relatively small.
There is a risk that Welsh Government may not cash fund the planned deficit resulting from the Health Board's operations. For 2023/24, this risk is heightened because the Health Board has submitted a significant deficit plan(£134m), which has not yet been confirmed.

	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	unchanged		

Controls in place	Assurances
The Health Board has established processes for notifying plans and forecasts (including cashflow implications), progress against them, and for drawing down cash as required in line with All-Wales requirements set by Welsh Government.	

Gaps in Controls/mitigations
The Health Board will seek to improve on the £134.2m planned deficit if possible, and will identify potential options to internally cash finance an element of it. However, this will be at the margin, and there is no realistic internal mitigation of the bulk of the £134.2m cash funding requirement.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**

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		Effective management of established cash-flow processes is ongoing, including the need to escalate actions as required.	Steve Webster, Interim Executive Director of Finance	Complete	This action will not materially impact on the risk score. It will support the Health Board in making clear to WG in a timely way the implications of	Completed

					an absence of cash funding for the deficit.	
		Reporting a cash shortfall equal to forecast deficit from the first monitoring return that includes cash reporting (Month 2) and monitoring responses to enable any appropriate and available action to be taken timely within the Health Board.	Steve Webster, Interim Executive Director of Finance	Mid June	This action will not materially impact on the risk score. It will support the Health Board in making clear to WG in a timely way the implications of an absence of cash funding for the deficit.	On track

CRR23-53	**Director Lead:** Chief Operating Officer	**Date Opened:** September 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** April 2023
	Risk: Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.	**Date of Committee Review:** 20 June 2023
		Target Risk Date:
1/3 of BCUHB bed capacity is currently occupied by stranded patients, that is impacting on all elements of UEC and planned care. The inability to get the patients discharged safely results in them deconditioning which in turns results in them transitioning back from MFFD to not medically fit		

	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 May 2023	unchanged		

Controls in place	**Assurances**
Medically fit reviews per IHC are completed weekly. Escalation within IHC is completed when excessive delays occur.	IHC accountability reviews.

Gaps in Controls/mitigations
Accountability on MFFD / Point prevalence reviews. Social care in reach within IHCs to be part of the HSSG group.

Progress since last submission
Goal 5 and Goal 6 of the Six Goal programme are leading on accurate coding with clear reporting outcomes.

Links to	
Strategic Priorities	**Principal Risks**
6 Goals for Urgent and Emergency Care	As per BAF.

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	UEC 09	Social care input on MFFD reviews/ planning	Goal 6 Lead	July 2023	Improved MFFD position	On track
	UEC 10	Utilisation of social care dashboard to support early planning.	Goal 6 Lead/ WAST	August 2023	Reduction in admissions of Atopic patients. Improved front door discharge planning.	On track

CRR23-54	**Director Lead:** Chief Operating Officer	**Date Opened:** July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** April 2023
	Risk: Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 October 2023
Emergency department gridlock continues with patients stay within the emergency departments >12hours. Evidence shows that length of stay within the Emergency Departments > Admission rates, along with > Mortality.		

	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 May 2023	unchanged		

Controls in place	**Assurances**
IHC Hospital Full protocols being instigated. ED Full protocols to be enacted in line with IHC full.	Once documents have gone through respective governance they will be shared and uploaded.

Gaps in Controls/mitigations
Bedding down of assessment units (SDEC/Acute) resulting in gridlock. Reverse boarding not formally in place nor enacted in line with acute risk. 12hr delays are an IHC risk rather than an Acute alone risk and risk stratification needs to be IHC led.

Progress since last submission
Governance around Hospital full protocols.

Links to	
Strategic Priorities	**Principal Risks**
6 Goals for Urgent and Emergency care Handbook.	

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	UEC 06	Reduction in % of stays >12hrs	6 Goals Programme	October 2023	Improve flow throughout the EU's	On track
	UEC 07	Improvement of 4hr performance for those discharged	6 Goals Programme	October 2023	Improve flow throughout the EU's	On track
	UEC 08	Table top review of Hospital full protocols and feedback	G Farr	June 2023	Ensure accurate actions with clear outcomes	On track

CRR23-55	**Director Lead:** Chief Operating Officer	**Date Opened:** March 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** April 2023
	Risk: Inability to manage ambulance demand in a safe timely fashion.	**Date of Committee Review:** 20 June 2023
		Target Risk Date:

Whilst ambulance arrivals to sites continue to reduce, we are unfortunately seeing an increase in lost hours that is causing patient harm.

This also impacts on the ability to release ambulances when Immediate release requests are requested further increasing harm in the community.

	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 May 2023	unchanged		

Controls in place	**Assurances**
Progress chasers recruited to support demand management. Access to WAST dashboards to ensure ability to see demand en-route.	Ability to support NIC with capacity. Ability to support

Gaps in Controls/mitigations
Intelligence conveyance – when instigated not always communicated with key stakeholders. Ambulance diverts – Lack of risk assessment completion to ensure all aspects are reviewed and not solely ambulances held.

Progress since last submission
Cardiff and Vale review completed with SOP's being shared to support and implemented as a matter of urgency.

Links to	
Strategic Priorities	**Principal Risks**
6 Goals for Urgent and Emergency care Handbook	As Per BAF.

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	UEC 03	Intelligence conveyance mechanism	ODU/ G Farr/NCCU	July 2023	Reduction in out of area patients attending ED'	On track
	UEC 04	Ambulance delays <4hrs	NCCU/G Farr	July 2023	Reduction in lost hours = Improvement in performance.	On track
	UEC 05	Immediate release request improvement	G Farr/S Sheldon	July 2023	Improvement in response performance along with reduction in SCIF/Appendix B	On track

CRR23-56	**Director Lead:** Chief Operating Officer	**Date Opened:** December 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** April 2023
	Risk: Inability to deliver safe timely care in Emergency Units.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: August 2023

Owing to demand v capacity across BCUHB within the Emergency units. The national KPI for 4hr performance constantly falls below the trajectory of 95%.

Bedding down of the Emergency Units is a frequent event that stops the ability to see patients in a timely fashion and commence interventions.

	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 May 2023	unchanged		

Controls in place	**Assurances**
Dashboards to support demand analysis. Regular BCUHB calls for flow.	Local IHC ownership to forecast demand and ensure effective planning. Pan BCUHB calls to support flow and ensure clear actions/ outcomes per IHC.

Gaps in Controls/mitigations
Out of hours planning ie: elements completed in short to cover the demand at time. Bedding down of Emergency departments due to lack of capacity.

Progress since last submission
All IHC have been requested to review local IHC UEC risks to confirm elements that need transitioning to a Level 1 risk. UEC Risks being discussed at 6 Goals Meeting to ensure review and action / outcomes.

Links to	
Strategic Priorities	**Principal Risks**
6 Goals for Urgent and Emergency care Handbook.	

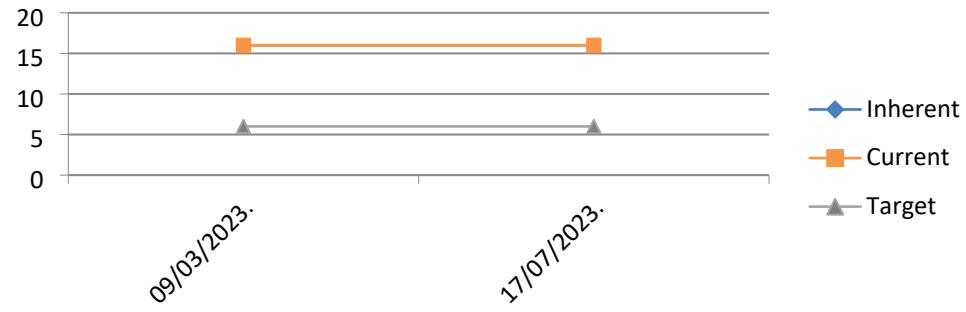
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	UEC 01	Universal Dashboard pan BCUHB	G Farr/G Charlton	June 2023	Will allow foresite for demand in turn reducing delays and improving flow and time to clinician.	On track
	UEC 02	Electronic escalation process with clear actions/ outcomes per IHC.	G Farr/ G Charlton	June 2023	Ability to support demand across North Wales to support flow.	On track

CRR23-57	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 09 March 2023
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 July 2023
	Risk: Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 29 September 2023

There is a risk that Womens Servcies and BCUHB will be in Breach of H&S Regulations (Manual Handling Operations Regulations 1992, as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002.)

This may be caused by Women's Services Clinical staff have not received up to date Manual Handling Training due to changes in how staff maintain compliance.

This could lead to Women's Services Clinical staff not being compliant with Manual Handling training as this has fallen below an acceptable level. Compliance at time or risk being raised is below 30.5% (East 44.7%, Central 18.71%, West 22.9%)



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
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. Corporate Manual Handling Policy.	1. Motoring of training performance

2. Staff completing level 1 on line have basic level of knowledge potentially reducing the inherent risk 3. Staff able to call manual handling team for assistance 4. All staff to be aware of how to report an injury due to a manual handling incident 5. Issue discussed at QSE and Women's Board 6. All areas staffed to provide minimal staffing levels which also supports manual handling requirements 7. Online Level 1 training available to staff, current compliance for Level 1 - 77.3% 8. Discussed with Head of H&S who has provided assurance of Manual Handling teams support to provision of training and clinical areas.	will be completed via Women's People and Culture Group and the risk will be monitored via the Women's Risk Management Group. 2. The Women's People and Culture Group reports up to the Women's Service Board and will highlight progress and delays in progressing actions.

Gaps in Controls/mitigations
1. Availability of Manual handling trainers to undertake sessions for Level 2 Manual Handling training. (Face to Face sessions). 2. Change in requirements for link training requires local staff to do 1.5 days every 2 years to maintain status to be able to provide training. Resulting in greater time commitment. 3. Bespoke update training which was agreed with Manual handling department in March 2023 did not take place in all 3 acute areas which would have improved staff compliance.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Proposal to extend the Target risk date from the 29/09/2023 to the 31/03/2024. 4. All staff requiring the full updates are still experiencing issues in booking a place. Recruitment to the MH team is expected to help resolve this issue. 5. Action ID 24773 – Action delayed, Staff Alert was not initially sent out, Head of Governance to re-visit issuing the alert. 6. Action ID 24775 - Ongoing action to monitor progress against risks. Discussed at Women's Risk Management Group on the 17th July 2023. Also discussed at last Women's People and Culture Group meeting on the 29th June 2023, to be discussed further at the next Women's People and Culture Group meeting. 7. Action ID 24776 – Action delayed, course in March 2023, did not take place, awaiting update from the Manual Handling team in relation to the training.

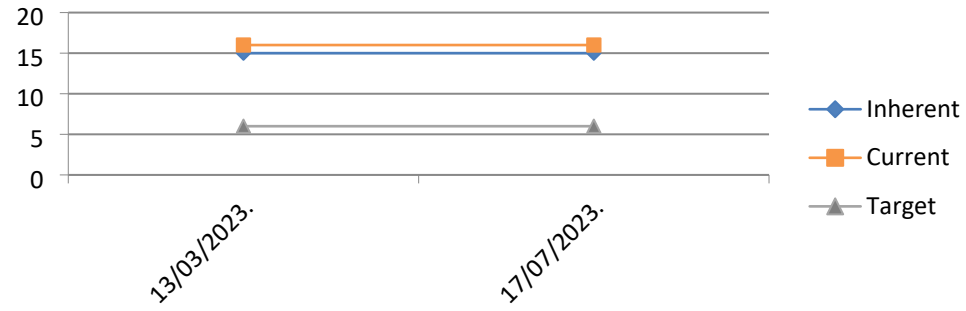
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler)	BAF21-13

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	24772	Training Plan	Julie Reeve, Matron	30/04/2023	The plan will allow for a structured prioritisation for training to be in place and monitored	Delay
	24773	Staff Alert	Mr Christopher Lube, Clinical Governance Lead	16/03/2023	Ensure staff who have not had up to date training do not undertake any Manual Handling they are not up to date with. July 2023 progress update - Staff Alert was not initially sent out, Head of Governance to re-visit issuing the alert	Delay
	24774	Review of Maternity Specific MH requirements	Julie Reeve, Matron	20/03/2023	Ensure appropriate training is provided	Delay
	24775	Monitoring of Risk and Progress	Mrs Karen Rogers, Lead Midwife MOAU/ANC	30/06/2023	Monitoring via both groups will allow for progress to be provided to Women's Service Board and escalate concerns.	Delay

					July 2023 progress update - Ongoing action to monitor progress against risks. Discussed at Women's Risk Management Group on the 17th July 2023. Also discussed at last Women's People and Culture Group meeting on the 29th June 2023, to be discussed further at the next Women's People and Culture Group meeting.	
	24776	Lack of cascade trainers	Julie Reeve, Matron	30/06/2023	Support local training and maintain levels of compliance July 2023 progress update - Course in March 2023, did not take place, awaiting update from the Manual Handling team in relation to the training.	Delay

CRR23-58	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 10 August 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 July 2023
	Risk: Temporary Suspension of Home Birth Service due to WAST provision	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 March 2024

There is a risk that mothers and/or babies may come to harm. This may be caused by delays in transfer to Acute Sites by WAST. This Could lead to (and has led to) limited birthing choice/options for mothers. This would also lead patients to make unsafe choice to receive medical attention/treatment which could result in adverse event. This would also have an impact on staff, for example increased stress for midwifery staff in trying to make safe decisions (clinical judgement) for patients, burn out.



	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	4	4	16
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. Inter Agency protocol between BCU and WAST in relation to the process of escalating a call. 2. For those Women continuing to choose to give birth at home: a. Women's Directorate on call manager confirms with Welsh Ambulance that there is availability to respond to an emergency request form community midwife.	1. WAST data - calls 3 times a day 2. Risk is discussed at Women and Maternity local Governance arrangement i.e. RMG, PSQ 3. Ongoing review of the risk assessment

b. Community midwives attending community births request WAST attendance as soon as the need for transfer is identified. c. Labour ward shift co-ordinator kept informed by community midwives Temporarily stand down the home birth service in view of the increased risks associated with Welsh Ambulance Service delays. d. All women who a planning to have a community birth to be kept fully informed of the ongoing situation around suspension of Home Birth service. e. Liaison with WAST to place a red flag on the address for any high risk home births f. Should the teams have any issues there is the option of escalating to Tactical at the Operational Delivery Unit (ODU). 3.Suspension of Home Birth service to be kept continually under review. 4.Any woman who indicates that she wishes to continue to birth at home to be fully supported by the community midwifery teams. 5.Community midwives to continue to attend any Born Before Arrivals (BBAs) or medical assistance request from WAST for midwifery attendance. 6. Women's on call manager to be informed by Labour ward shift co-ordinator in event of any ongoing community Births. 7.WAST to be informed of any ongoing community births. 8. Regular monitoring and review by the service of the Forecast received by WAST, monthly monitoring taking place, reporting to Senior Management which informs the regular review of the temporary suspension of the service, and also Incidents logged of high risk transfers by partners by car.	4. Welsh Government reportable (All Wales issue)

Gaps in Controls/mitigations
1. WAST delays - Forecast for the summer period received by WAST, monthly monitoring taking place, reporting to Senior Management which informs the regular review of the temporary suspension of the service. 2. Women Choice - going against midwife clinical advice. 3. Risk of clinical deterioration due to prolonged presence in a clinically inappropriate location and lack of available resources at the home. 4. Industrial Action by WAST 5. Incidents logged of high risk transfers by partners by car

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Proposal to extend the Target risk due date from the 31/05/2023 to the 31/03/2024 to allow sufficient time to resolve system wide pressures relating to WAST and BCUHB. 3. In line with the recommendations agreed by the Health Board Leadership Team the temporary suspension on a 6 weekly basis, with further reviews to take place on the 26th July. 4. Strengthened communication with Women around the service and risks associated with Home Births. 5. Action ID 24194 – Action delayed, ongoing action to review and monitor activity. 6. Action ID 24195 – Action delayed, National work ongoing to review methods of transportation for Women in rural settings, proposals currently out for comments as a National document. 7. Action ID 24196 – Action delayed, ongoing action to continually monitor situation and progress.

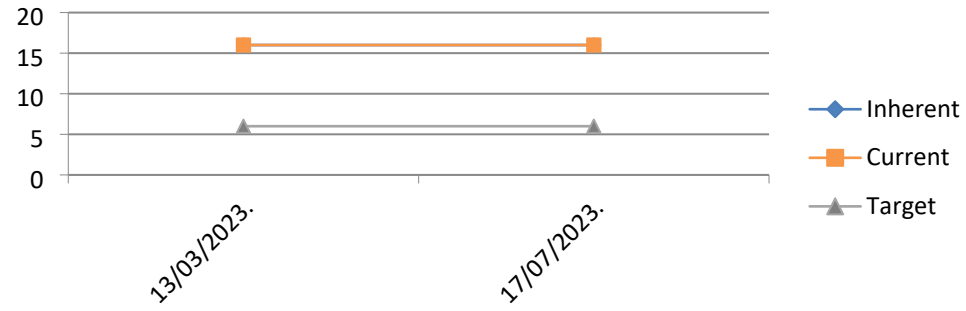
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Primary and community care	BAF21-01

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	24194	Review of incidents	Mr Christopher Lube, Clinical Governance Lead	21/09/2022	Support the HB position to WAST as to the type and impact of incidents. Will support national meeting with WAST and WG. July 2023 progress update - Ongoing action to review and monitor activity.	Delay
	24195	Discussions with WG on WAST capacity	Mrs Fiona Giraud,	21/09/2022	This will ensure that WG is tied into the extent of the current situation and	Delay

			Director Of Midwifery & Women's Services		understand it severity with the aim of assisting WAST with an improvement plan and or assistance. July 2023 progress update - National work ongoing to review methods of transportation for Women in rural settings, proposals currently out for comments as a National document.	
	24196	Ongoing Monitoring of Situation	Mrs Fiona Giraud, Director Of Midwifery & Women's Services	26/04/2023	Monitoring of the situation will allow for identification of improvement or further decline of the situation and assist in planning and communications with WG and WAST. July 2023 progress update - Ongoing action to continually monitor situation and progress.	Delay

CRR23-59	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 03 April 2023
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 July 2023
	Risk: Compliance with Birth Rate Plus	**Date of Committee Review:** New Risk
		Target Risk Date: 29 December 2023

There is a risk to patient safety as the BCUHB Woman's Service is not meeting the updated Birth Rate Plus standards for Wales. This is caused by the unfunded variance in the recommended staffing establishment of 8.9 WTE midwives Pan BCU. This leads to BCUHB Maternity services not having the recommended staffing levels to maintain a safe service to patients in North Wales.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
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. An IMTP bid has been approved by the Health Board for financial support (from the allocated NSA monies for 2023/24) to increase the Midwifery staffing establishment by an additional 8.9 wte Midwives to be Birth Rate Plus compliant as required by Welsh Government. 2. On-going engagement with Welsh Government. 3. Reported at Executive accountability meetings. 4. Agency over time or Bank staff used to cover any shortfalls.	1. Risk reviewed monthly at Womens Service Risk Management Group 2. Progress with Report from WG being published will be monitored by Womens Service People and Culture Group which reports through to

	Womens Service QSE and then to Womens Board 3. Issue part of Womens IMPT Submission to Board

Gaps in Controls/mitigations
1. Staffing levels currently do not meeting recommended levels, should be resolved by September/October 2023 with the output of the recruitment via midwifery streamlining process.

Progress since last submission
1. Risk description reviewed and updated to provide clarity on the risk. 2. Anticipated that recruitment will be completed and posts filled by the end of November 2023, proposal to bring forward the Target risk date from the 31/12/2023 to the 30/11/2023. 2. Midwifery vacancies across all sites is currently low, all recruitment being progressed, funding secured and recruitment underway. Progressing with adverts and recruitment to posts. 3. Action ID 24860 – Action Closed, funding secured and recruitment progressing to posts.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	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	24860	IMPT Support	Mrs Liz Davies, Tracing	31/07/2023	Provide clarity for future planning of service	Completed

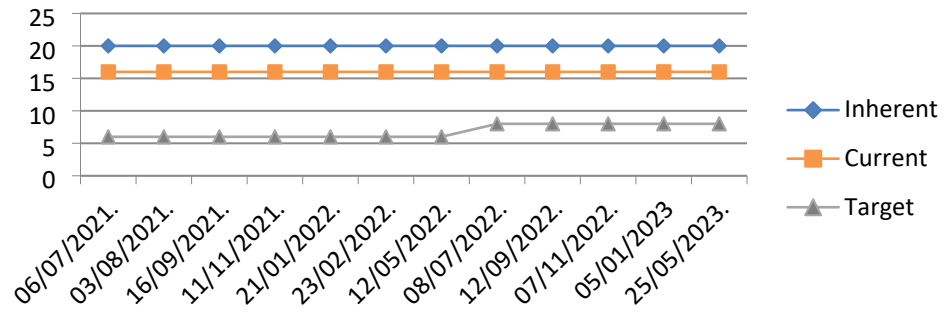
to achieve target risk score			Senior Operational Manager		July 2023 progress update - Action closed, funding secured and recruitment progressing to posts.	
	25113	Recruit to Midwifery posts	Ms Karen Roberts, Inpatient Matron	30/11/2023	Ensure that the Health Board is compliant with the Birth Rate Plus recommendations of 8.9 WTE midwifery staffing Pan BCU. July 2023 progress update - Advertisement and recruitment underway to recruit to posts.	On track

Appendix 2 – Risks for De-escalation

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:** 25 May 2023
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 30 December 2025

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 Health and Social care pressures.

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	3	12
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	Decreased		

Controls in place	Assurances
1. People Strategy (2022-2025) is in place and actively monitored through the Executive Delivery Group for People and Culture, with initiatives in place to maximise recruitment and retention across the workforce which includes Nursing. 2. Nurse Staffing Policies NU28/MHLD 0028/ outlines standards and escalation in relation to identifying and mitigating nurse staffing shortfalls across wards and departments. Nurse staffing vacancies and recruitment activity is monitored through the nursing recruitment and retention group which currently reports to the Executive Delivery Group. 3. Bi-annual Nurse Staffing reviews are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing reviews are also undertaken in other areas of the Health Board such as Community Hospitals, Mental Health, and other 24hr services. 4. The Strategic Recruitment and Retention Group terms of reference have been revised to reflect changes in the organisations operating model. The group is now called Nursing and Midwifery Workforce & Staffing Group. The group will continue to monitor and develop forward look recruitment and retention initiatives to mitigate the nursing shortfall over the next 5 years. 5. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to enable roster performance to be actively managed. Additionally allocate Safe Care compliance reports are also sent to the Directors of Nursing, to enable maximum utilisation of nursing workforce. 6. Managing Attendance at Work Policy WP11 in place with sickness, absence and wellbeing pro-actively managed to ensure the nursing workforce is optimised. 7. Utilisation of the SafeCare allocate system to provide a live/real time view of nurse staffing levels, skill mix, and patient demand. The system provides nurse managers with visibility across wards and areas enabling acuity based, safety driven decisions regarding nurse staffing and the deployment of staff. 8. BCUHB Nursing Career Framework in place and utilised to develop and train our existing nursing workforce to meet identified workforce gaps and meet succession plans across the Health Board.	1. Risk CRR21-13 is reviewed and monitored at the respective local Quality and Safety meetings. 2. Compliance with the Nurse Staffing Act and Nurse Staffing calculations are reported to the Board bi-annually (May/November) via the Quality, Safety and Experience Committee as the designated committee. 3. Monthly roster KPI reports are issued to identify areas in need of improvement and areas requiring targeted support4. Monthly SafeCare compliance reports have been developed to identify areas in need of targeted support to enable a live view of nurse staffing levels, skill mix, and patient demand. 5. Nurse Recruitment and Retention workplan aligned to organisational priorities, CNO principles and key national drivers/strategy 6. Monthly sickness absence reports produced by WOD, monitored via the workforce utilisation meetings, and managed locally by senior nursing teams.

9. Workforce planning and commissioning process in place to triangulate the requirements to develop and deliver the nursing pipeline to meet the current and future needs within the nursing workforce across BCUHB. 10. Representation and active participation in national steer groups and programmes such as All Wales Nurse Staffing Group, All Wales Recruitment and Retention Group and the All Wales Temporary Staffing Group. 11. BCUHB SOP: Nursing & Midwifery Roster Review and Approval Process & the introduction of accountability meetings to review staffing, mitigation and agency usage/spend.	

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to Key Performance Indicators e.g. Annual Leave/training. A Workforce Nursing Utilisation Dashboard is being refreshed and re-introduced to senior nursing teams to optimise nurse staffing rosters. The introduction of quarterly accountability meetings in line with the BCUHB SOP: Nursing & Midwifery Roster Review and Approval Process will enable focus and targeted support to areas of high vacancies/high temp staffing usage/poor roster compliance. 2. Whilst adult acute medical and surgical, and Area Teams Central and West have fully implemented the Safecare Allocate System, East Area is yet to implement. Paediatrics are currently in the process of implementing, and Mental Health will not be in a position to implement until an All Wales acuity tool has been agreed for this service. Although the Health Board has been using the system for some time there has been a significant change at matron and ward manager level and it is recognised that additional support is required to these areas to re-establish the discipline and compliance required to enable acuity based, safety driven decisions regarding nurse staffing. An implementation plan will oversee the roll out in outstanding areas. The All Wales SafeCare Standard Operating Procedure will further guide and strengthen the use of the system at an operational level. The Nurse Staffing Programme Lead will oversee the roster team with regards to the implementation and associated training requirements relating to the SafeCare System, and to ensure all nursing teams are on electronic rosters 4. Whilst the People Strategy and associated plans are in place, there is a requirement to develop a specific Nurse recruitment and retention plan aligned to the All Wales recruitment plan Individual initiatives are in place to inform data analysis and the revised plan will take these into account along with the wider All Wales recruitment and retention initiatives. This is being led by Director of Nursing for Workforce Staffing and Professional Standards.

Progress since last submission
Proposal to de-escalate the risk from the Corporate Risk Register and for the risk will be managed at Tier 2 level. Proposal to reduce the current risk score from 16 (Impact = 4, Likelihood = 4) to 12 (Impact = 4, Likelihood = 3). De-escalation of the risk has been approved by the Executive Director of Nursing and Midwifery: Recommendation: We will be creating a staffing risk. which staffing as a whole for BCU on one new Corporate Risk which will be managed by Workforce.

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	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and	Mrs Joy Lloyd, Senior OD Manager	31/03/2023	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce. In 2021/2022 the Health Board embarked on an ambitious three year people and organisational	Delay

		subsequently aspirant programmes.			development journey (Mewn undod mae Nerth/Stronger Together). This was and is aimed at enabling the organisation to move forward and deliver its Clinical Strategy/Plan through delivery of its People Strategy and Plan – Stronger Together. The feedback from over 2,000 staff has informed the development of 5 programmes of work, one of which is 'the Best of our Abilities', this includes the development of an integrated Leadership & Management Development Framework for all professional groups, aligned to a new Learning and Education Academy. The risk associated with the development of specific leadership offers related to specific staff groups, i.e. Head of Nursing and Ward Manager programmes will be reviewed as part of this work, with a proposal to develop a new Framework which will be inclusive of all professions and will provide a more streamlined, multi-disciplinary approach.	

					May 2023 progress update - Stronger Together Information sessions have taken place during May 2023, to share information around the work projects and gain staff feedback on proposals including the development of an integrated leadership development programme and pathway. Feedback is currently being collated and will shape this workstream going forward. The next step will be to establish a Leadership Development Working/Focus group - with representation across different professions with executive support and trade union partners, to begin to work on a programme outline, based on all feedback and reviewing past/present interventions to develop a new leadership development offering There are also early plans as part of the Special Measures framework to offer an Advanced Clinical Leadership programme for senior leaders working in partnership with HEIW, and the provision of NHS England's	

					Culture and Leadership Programme.	
	17509	Exploration of the Welsh equivalent Global Learning Programme.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	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 May 2023 progress update - Awaiting direction from Welsh Government Nursing officer, chaser e-mail to be sent.	Delay
	18834	Introduce targeted monitoring across rosters, through Key Performance Indicators management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Associate Director Workforce Optimisation	30/06/2022	Effective utilisation of substantive staff. May 2023 progress update – Launching June 2023: Vacant shift auto cascade will enable timely transfer of shifts to agencies on framework in the first instance, and to agencies off framework as a last resort. Launching June 2023:	Delay

					Wage stream will enable staff to access their salary in advance of pay day encouraging the uptake of additional duties.	
	18835	Support and progress existing band 4 roles through to fastrack nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mr Ade Evans, Vocational Education Manager	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. May 2023 progress update – Work has commenced with regards to a cadet/apprenticeship scheme that will enable a “Step into Healthcare”. We will be working collaboratively with local authorities, schools and colleges to agree timelines and launch dates.	Delay
	20039	Develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health Board's business planning cycle.	Mandy Jones, Deputy Executive Director of Nursing	30/12/2022	By embedding into the business planning cycle this will support a more integrated approach to ensure the safe staffing act is met through pathway re-design and nurse re-deployment across the Health Board. May 2023 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and	Delay

					work is ongoing to implement the programme.	
	22121	Implement Allocate Safecare system to all clinical areas and associated training requirements.	Mr Nick Graham Associate Director Workforce Optimisation	30/09/2022	Ensure that Health Board has increased visibility of the Nursing workforce to ensure efficient utilisation of nursing staff and better identify areas of risk to enable appropriate mitigation at a local level. May 2023 progress update - Paediatrics inpatient areas will go live July 1st 2023. Mental Health are currently not in a position to implement until an All Wales acuity tool has been agreed and these discussions are ongoing. The roster team will work with the East Integrated Health Community Team to consider resource requirements and timelines for implementation into the Community Hospitals.	Delay
	22122	Refresh and update the Nursing Recruitment and Retention strategy	Mrs Alison Griffiths, Director of Nursing Workforce	30/06/2022	This will allow an integrated medium term plan to be developed and implemented to ensure nurse recruitment and retention better identifies and resolves nurse staffing challenges.	Delay

					May 2023 progress update – 1st draft strategy planned for consultation October 2023.	
	24359	Resource requirements of the nursing workforce and staffing portfolio to ensure sufficient resources are made available to support nurse recruitment and retention on a recurrent basis.	Mrs Alison Griffiths, Director of Nursing Workforce	31/03/2023	Provide sufficient recurrent resource to support the strategic nurse staffing, recruitment and retention portfoilio which includes areas such as pastoral care, overseas nurse recruitment and student nurses.	Delay
	24577	All Clinical Nursing staff to be added to the Electronic Rostering system	Mr Nick Graham, Workforce Optimisation Advisor	31/12/2023	Improved oversight and visibility of the Nursing Workforce, which will support the effective deployment of Nursing resource.	On Track

<table>
<tr><td rowspan="4">CRR21-17</td><td>Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services</td><td>Date Opened: 26 July 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 10 March 2023</td></tr>
<tr><td rowspan="2">Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.</td><td>Date of Committee Review: 20 January 2023</td></tr>
<tr><td>Target Risk Date: 31 March 2024</td></tr>
<tr><td colspan="3">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 Child and Adolescent Mental Health Services (CAMHS) assessment 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 for face to face assessments is 9am-5pm over 7days a week.
• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment however are available on-call for consultation outside operational hours. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is also not available out of core hours.
• Increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
• Crisis presentations to the Emergency Departments 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.
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, longer detention in s136, delay in discharge. 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.</td></tr>
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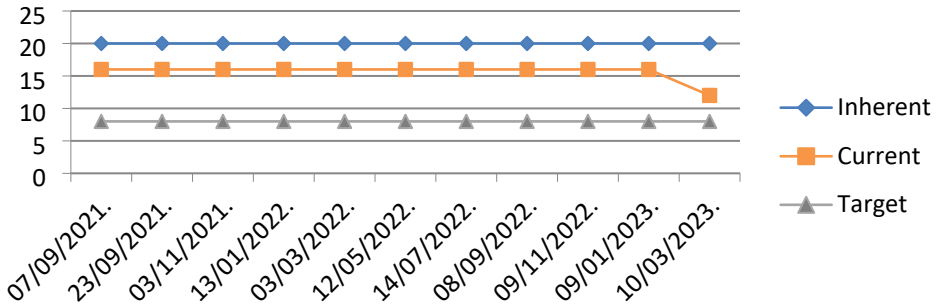


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2023	decreased		

Controls in place	Assurances
1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Integrated Health Community Team. 2. Collaborative working taking place between Mental Health Division, Emergency Departments, Paediatrics and Integrated Health Community Teams as part of the risk assessment and risk management processes. 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. 4. 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). 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and consultation out of hours telephone on-call rota. 7. CAMHS crisis teams provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting for discharge to LA placement on Paediatric wards. Access to Legal and	1. A scoping exercise or report of Child and Adolscent Mental Health Services (CAMHS) Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB 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 Welsh Government, joined with Mental Health Division on a quarterly basis.

Risk to support the Health Board when a young person has a Depravation of Liberty Safeguards in place via court of protection. 9. Safeguarding discharge Standard Operating Procedure for young people in place with escalation process. 10. Daily situation report (SITREP) reporting between Senior Clinical Managers Paediatrics and CAMHS, which includes incident notifications. 11. Analysis of intelligence from all related incidents in generating organisational learning, awareness and fostering improvements.	

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to staff shortages and availability of appropriately trained staff. Currently working with recruitment agencies to recruit to posts to extend hours of the established multi-disciplinary team already in place. 2. Lack of suitable Local Authority placements or shared safe environments within which young people can be assessed or discharged to. Looking and considering alternative safe environments/accommodation across all integrated health communities and Local Authority partners. 3. Lack of agreed consistency, threshold and standardisation for reporting related incidents across the Health Board in relation to Mental Health patients on Paediatric wards. Incidents are being reported within areas and reviews are undertaken at Child and Adolescent Mental Health Services (CAMHS) and paediatric safety meetings.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Proposal to extend the target risk due date from the 31/03/2023 to the 31/03/2024 to enable alignment with the Crisis Care Workstream within CAMHS TI programme. 4. Proposal to de-escalate the risk from the current score of 16 (consequence = 4, Likelihood = 4), to a score of 12 (consequence = 3, Likelihood = 4) and de-escalate the risk from a Tier 1 risk to be managed at Tier 2 level due to the requirement to ensure local ownership and maintenance following the implementation of the majority of actions. 5. Task and Finish Group set up to review the s136 policy specifically in relation to Children and Young people and to review the escalation processes and produce a flow chart that will be clear and easy to follow. 3 meetings have taken place with clear action

identified, due to the volume of work the tasks have been allocated to phase 1 and phase 2. Phase 1 is complete and work on phase 2 is due to commence in qtr 1 23/24.
6. Action ID 17956 – Action delayed, Mental Health Crisis Care Concordat across North Wales being re-established and will have representation appropriate for Children and young people. This re-establishment will enable the multi-agency working required and support alignment to the strategic direction of travel under the "No Wrong Door". The Crisis Care workstream under CAMHS TI will ensure the requirements are considered within service requirements.
7. Action ID 17963 - Action delayed, MH2 guidance updated and awaiting final approval following consultation. Phase 2 of the T&F group to commence with focus on updating Policy SCH03.
8. Action ID 18334 – Action delayed, ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing.
9. Action ID 21236 - Action delayed, the recommendations have been embedded into the Crisis and unscheduled care workstream within CAMHS Targeted Intervention, with the aim for completion by end of Q2 23/24.

Links to	
Strategic Priorities	**Principal Risks**
Improved USC (Unscheduled Care) pathways Integration and improvement of MH (Mental Health) Services	BAF21-01 BAF21-08

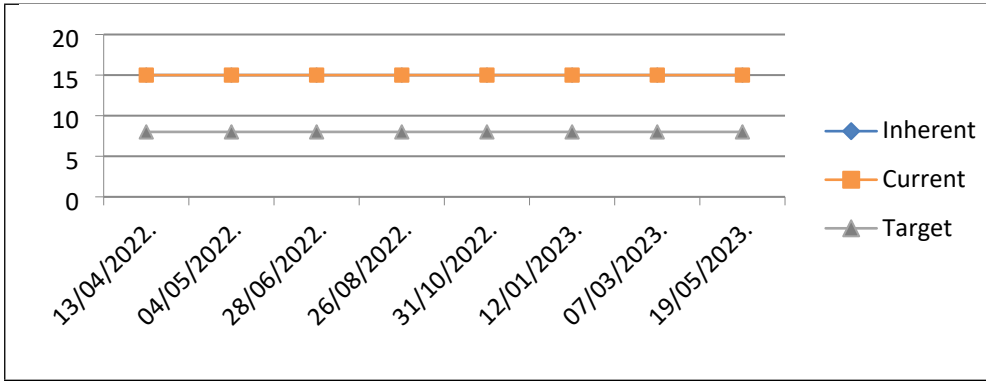
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention 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. March 2023 progress update – Mental Health Crisis Care Concordat across North Wales	Delay

					being re-established and will have representation appropriate for Children and young people. This re-establishment will enable the multi-agency working required and support alignment to the strategic direction of travel under the “No Wrong Door”. The Crisis Care workstream under CAMHS TI will ensure the requiremetns are considered within service requirements.	
	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	31/12/2022	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions. March 2023 progress update - Action delayed, MH2 guidance updated and awaiting final approval following consultation. Phase 2 of the T&F group to commence with focus on updating Policy SCH03.	Delay
	18334	Identification and development of suitable shared (non hospital) environment for	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital.	Delay

		comprehensive assessment of needs and development of a plan to address needs across agencies.			March 2023 progress update - Ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing.	
	21236	Implementation of recommendations following the Delivery Unit Crisis Care Review.	Marilyn Wells, Head of Nursing	31/10/2022	Provide further assurance following a review by an external body and the implementations of any recommendations to support the development of high quality and safe care. March 2023 progress update - Action delayed, The recommendations have been embedded into the Crisis and unscheduled care workstream within CAMHS Targeted Intervention, with the aim for completion by end of Q2 23/24.	Delay

CRR22-18	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 10 December 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19 May 2023
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 March 2024

There is a risk that Infection Prevention (IP) will not be able to provide an effective service to BCUHB.
This may be caused by the relative limitations in size of the service (taking the size of the Health Board into account) and the current significant unfilled vacancies.
This could lead to an increase in healthcare associated infections, patient harm and loss of reputation to the organisation.



	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	Decreased		

Controls in place	Assurances
1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. 2. Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 3. Reviewing and prioritising the programme of work and workloads for all staff in the team e.g. ensuring experienced Infection Prevention nurses are not doing admin tasks. 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which Infection Prevention risk is lower. 5. Reviewing and prioritising attendance at meetings and on groups etc.	1. Infection Prevention Audits reported at local groups and to the Infection Prevention Sub Group. 2. Alert organism statistics. 3. Compliance with Welsh Health Circular 2021 Number 028 reported to Infection Prevention Sub Group and to Quality Safety and Experience Committee.

6. Employed senior manager via an agency to support the team. 7. Supporting and protecting existing team with measures including weekly team meetings and reviews. 8. Plan in place on how Infection Prevention can support the Infection Prevention Champions to help promote Infection Prevention with numbers growing each month.	4. Patient incident reviews. 5. Regular review of Datix Incidents which are alerted to the team when logged on the system for learning purposes and for rectification. 6. Outbreaks are monitored, managed and reported to Infection Prevention Sub Group. 7. Regular review of Infection Control and Prevention trajectory reported at Local Infection Prevention Groups. 8 Risk regularly reviewed at Infection Prevention Sub Group.

Gaps in Controls/mitigations

1. There is a national issue recruiting into Infection Prevention and Control roles, particularly at a senior level (7s and above). Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own.
2. Experienced Infection Prevention Agency nurses only want to work remotely. Staff members working remotely are required to review policies produce reports which in turn releases non-remote working staff to undertake clinical work.
3. The 2 vacant band 8bs have been advertised but there were no suitable applicants. Post re-advertised and currently cross covering within the service with Senior members of the Infection Prevention team (IP) providing support to other areas as well as their own. Recruited internally to senior 8a level supported by other senior Infection Prevention staff.

Progress since last submission

Proposal to de-escalate the risk from the Corporate Risk Register and for the risk will be managed at Tier 2 level.
Proposal to reduce the current risk score from 15 (Impact = 5, Likelihood = 3) to 12 (Impact = 4, Likelihood = 3). De-escalation of the risk has been approved by the risk lead and the Executive Director of Nursing and Midwifery:

Recommendation:

IPC staffing- Not ‘catastrophic’ now post covid and lack of evidence however there are still risks in relation to MRSA/C.Diff. Issue is also around 10 staff not being funded and the team needing to expand. It was recommended that this is reduced to ‘major’ which removes it from CRR.

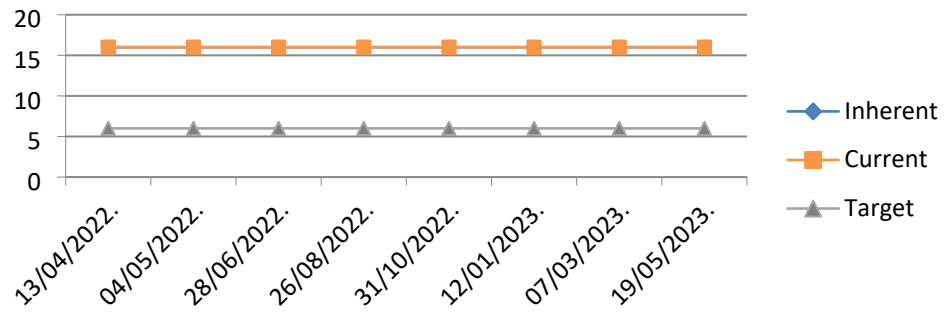
Links to	
Strategic Priorities	**Principal Risks**
Transformation for Improvement (key enabler)	BAF21-09

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**
	20659	Business case for expanding current team	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	To outline case to the Executive that more staff are required and obtain approval for funding May 2023 progress update - Finance have just confirmed that there is funding for IPC to come and this will hopefully allow us to adjust	Delay

					the budgeted staffing establishment to reflect the current structure. Once this is done we can commence working on a business case.	
	21696	Recruit to current vacant Infection Prevention posts	Mrs Andrea Ledgerton, Specialist Matron IP	30/09/2022	Fill current vacant posts May 2023 progress update - Appointing at lower grade and providing training to staff members is in place and remains ongoing.	Delay

CRR22-19	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 February 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 19 May 2023
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 31 March 2024

There is a risk that medical equipment will not be decontaminated appropriately. This is caused by a number of factors including:
1. Sterile service departments air handling units require upgrade/replacement, some equipment and the track and trace system requires replacement and at WM hospital the steam generation plant and electrical infrastructure requires an upgrade.
2. Poor, outdated facilities for decontaminating dental equipment, scopes and probes and washer disinfectors at YGC and WM are at end of life. Also they rely on a paper track and trace system.
3.There is a lack of robust approved SOPs for decontamination.
This could lead to transmission of infection, vital treatments and services having to stop, patient complaints and litigation, enforcement action, improvement notices, multiple breaches in statutory duty, critical reports and adverse media coverage.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	Decreased		

Controls in place	Assurances
1. Decontamination audits have been increased to twice yearly and the documentation strengthened to provide the assurance required. 2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units. Funding is limited and not all requested will be granted.	1. Regular review by Decontamination Group. 2. 6 monthly decontamination audits by Infection Prevention team. 3. Decontamination audits by Authorised engineers.

3. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning and now meets every 2 months. 4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board. 5. Single use scopes are being used where possible removing the requirement for decontamination. This requires significant financial resource and environmental issues. 6. Engineering support is presented from the in-house facilities team and is generally to a high standard. 7. Governance systems are managed by the Authorised Persons (Decontamination). 8. The Executive Director for Infection Prevention has been alerted and requested an overall risk assessment which has been completed. Following a paper in February 2023 the Chief Operating Officer has been requested by the Health Board Leadership Team to work with the Infection Prevention and Decontamination team to drive forward the operational recommendations. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership. 10. Decontamination Members are now asked to update on key risks at each Decontamination meeting as part of their presentation to provide ongoing assurance.	4. Sterile services departments have audits carried out by notified bodies in accordance with the Medical Device Directives/Regulations. 5. Risk register on decontamination.

Gaps in Controls/mitigations
1. The Decontamination Advisor currently on a period of extended leave. Staff member currently acting up into the position to cover this period. Exploring with Agencies whether external appointments could be made. 2. Some Consultants do not want to use single use scopes – Looking at exploring alternative methods of decontamination for the re-usable scopes. 4. Potential disruption to the safe delivery of decontamination service due to the ageing equipment and estate is being mitigated against by establishing contingency plans.

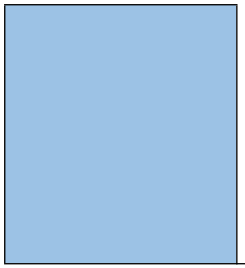
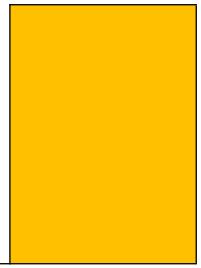
Progress since last submission
Proposal to de-escalate the risk from the Corporate Risk Register and for the risk will be managed at Tier 2 level. Proposal to reduce the current risk score from 16 (Impact = 4, Likelihood = 4) to 12 (Impact = 3, Likelihood = 4). De-escalation of the risk has been approved by the risk lead and the Executive Director of Nursing and Midwifery: Recommendation: Decontamination, not major as no impact to staff/patients which meets the major definition, reduced to moderate.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-02 BAF21-09

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	22147	Policies and Standard Operating Procedures written/revised and approved for Decontamination.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	As part of good governance and so staff are aware of their responsibilities and roles and how to decontaminate medical devices. The action will focus on policies and procedures due for review by the end of	Completed

					2022. May 2023 progress update - Action closed, members are now asked to update on Policies and SOPs at each Decontamination meeting as part of their presentation to provide ongoing assurance	
	22148	Purchase new washer disinfector for endoscopy unit at YG	Mrs Joanna Elis-Williams, Head of Secondary Care Office	31/03/2023	To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated May 2023 progress update - Capital bid has been approved, awaiting purchase date for the equipment.	Delay
	22152	Community Dental Services, Assets and Facilities group to reform and form a plan for moving forwards.	Peter Greensmith, Business Support Manager - Dental	31/03/2023	To establish formal timeframe and funding for plans. May 2023 progress update - Group has reformed and is in the process of developing plans to address the funding required.	Delay

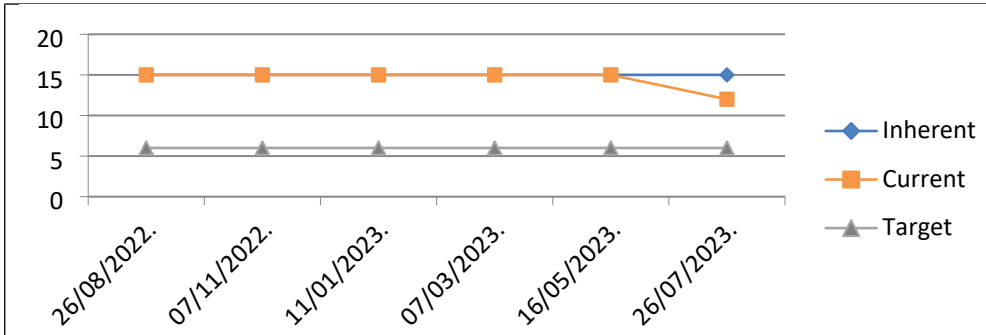
	23024	To seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To demonstrate the improvement and high standards achieved by Endoscopy at the Unit. May 2023 progress update - JAG assessment has been deferred, awaiting a new date.	Delay
	24596	Develop an options appraisal for the future of the Sterile Services Departments and obtain approval on future developments	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/05/2023	To ensure that the Sterile Services Departments can continue to provide an efficient and effective service to the Health Board. May 2023 progress update - Draft completed. Proposals to form part of a presentation being given to the HBLT in June 23 so will be delayed	On track
	24597	Develop a Decontamination Strategy to help provide a clear direction for key Decontamination services.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/05/2023	Ensure clear direction for Decontamination services and ensure that the Health Board has safe and modern decontamination facilities for the future. May 2023 progress update - Strategy written and going	On track

					to Strategic IP Group in May and to the HBLT in June – so is written within the date but won't have been formally accepted by then.	

CRR22-27	**Director Lead:** Executive Medical Director	**Date Opened:** 31 January 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 26 July 2023
	Risk: Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services.	**Date of Committee Review:** 20 June 2023
		Target Risk Date: 26 June 2023

There is a risk that the Vascular medical workfroce documentation is non-compliant with regulatory standards for recording keeping.

This could impact on patient outcomes, patient safety, reputation of the service, poor patient experience and clinical staff fitness to practice.



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	4	12
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in May 2023	Decreased		

Controls in place	Assurances
1.Weekly case note audits in YGC are undertaken to monitor standards of record keeping actions are taken when poor documentation is identified 2. During the Multi-disciplinary Team (MDT) meeting the audit results are fed back monthly. This had demonstrated a significant improvement in the standard of record keeping 3. Refresher training on consent has been provided between March and May 2022 from Health Inspectorate Wales and the General Medical Council. 4. We continue with the pilot scheme for “CITO” an electronic MDT proforma and work continues to identify if this as an effective document repository.	1. All actions relating to this risk are included on the RCS Vascular improvement plan reviewed monthly at the Vascular Steering Group which feeds into Quality, Safety, and Experience Committee, and then Board

5. MDT forms are being filed by MDT co-ordinator in the notes on the same day. 6. Handover from surgical on call night team to Vascular day team each day. 7. Weekly audits continue to be reported monthly through the Vascular steering groups, chaired by the Medical Director. 8. Appointment of a permanent Ward clerk has now taken place who will support with the filing of records.	

Gaps in Controls/mitigations
1. The pilot for Cito only covers Multi-Disciplinary Team documentation. This is a Health Board wide issues due to a lack of electronic integrated records system. 2. There is no electronic system to cover daily ward round progress notes, this is a Health Board wide issues due to a lack of electronic integrated records system. 3.Currently the surgical on call team has no electronic access to the vascular inpatient list which impacts on the ability to update the list for the vascular team (mitigated by oral handover)

Progress since last submission
3. Proposal to de-escalate the risk from the Corporate Risk Register and for the risk will be managed at Tier 2 level. Proposal to reduce the current risk score from 15 (Impact = 3, Likelihood = 5) to 12 (Impact = 3, Likelihood = 4), due to HIW satisfied with the progress of improved record keeping. Audits will however continue to ensure safe standards. 1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Discussions are ongoing to have a summary sheet to assist with the care of the patient. 4. Additional Programmed Activities have been approved for governance, workforce and training and development for medical staffing, as well as developing closer links to the University for medical teaching. Clinical lead was appointed and covering programmed activities for training and development, additional PA's have been provided for the links to the University Medical teaching, the governance PA's have not been awarded as the governance lead wishes to work part time and is therefore managing governance issues within the Special Programmed Activity. 5. Governance Admin Assistant post funded, recruitment still pending, candidate identified awaiting funding transfer. Candidate withdrew from post, post going back out to advert.

6. The outcomes of the audits are reported to the Vascular Steering Group for which the Medical Director is chair, there is a consistent improvement in record keeping.
7. Action ID 22282 – Action delayed, the Vascular Improvement plan is now integrated with the Vascular Quality Panel Improvement Plan and has become the Vascular Integrated Improvement Plan and continues to be monitored through the Vascular Steering Group.
8. Action ID 24076 – Action delayed, CITO pilot continues.
9. Action ID 24078 – Action delayed, Enlisted more of the ward clinical teams to encourage an improved patient, family and carers uptake in the patient experience surveys.
10. Action ID 24079 – Action delayed, Internal candidate withdrew interest in the post, Job Description has been modified and re-submitted for advert. Network post back out to advert closing date 27th of July 2023.
11. Action ID's 24592 and 24593 – Action delayed, Job description has been completed and the process for recruitment to start as soon as possible.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-02

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	22282	Reference to Royal College of Surgeons Vascular improvement plan	Mr Andrew Foulkes, Consultant Anaesthetist & Intensivist	31/12/2022	The actions aim to further identify issues, complete weekly audit for assurance of improvement, provide standardised documentation such as clerking and ward round documentation to prompt quality, involvement of regulatory bodies for training, 1:1 meetings with clinicians to review audits results and improvement	Delay

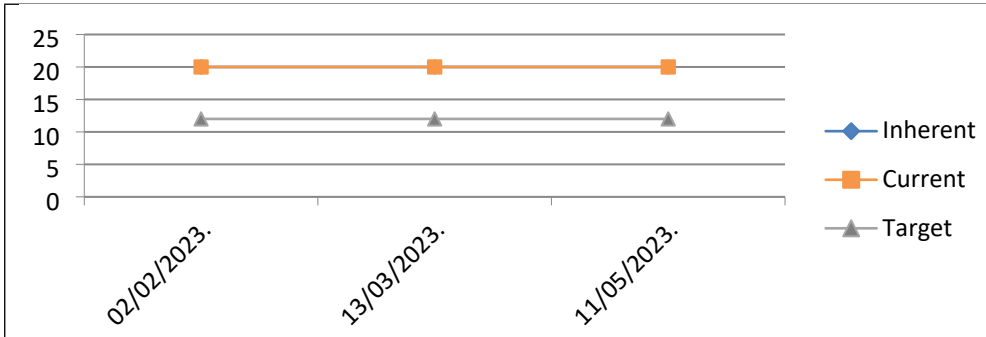
					requirements. The RCS action plan is informed by 2 stages of RCS review, NVR report and internally identified issues. There is a large number of actions assigned to improvement for documentation / consent processes which is kept up to date and reported on monthly. This is an ongoing activity. There are objective signs that the Consent process and note keeping standards have gone up. July 2023 progress update - The Vascular Improvement plan is now integrated with the Vascular Quality Panel Improvement Plan and has become the Vascular Integrated Improvement Plan and continues to be monitored through the Vascular Steering Group.	
	24076	Pilot CITO as part of MDT	Mrs Zoe Taylor, Clerical Services Co-ordinator	31/10/2022	To ensure legible documentation. Enhancing security and patient data storage July 2023 progress update - CITO pilot continues.	Delay

	24078	Ward Teams working with Patient Experience teams to develop holistic communication processes for documentation and for sharing with patients	Mrs Deborah Stones, Practice Development Nurse	31/10/2022	Will ensure holistic approach to patient care, will improve communication July 2023 progress update - Enlisted more of the ward clinical teams to encourage an improved patient, family and carers uptake in the patient experience surveys.	Delay
	24079	Administrative and governance workforce analysis undertaken, identify gaps to support governance processes	Hussein Khatib, Interim Nursing & Governance Director	31/10/2022	Identify the investment required to support effective documentation governance infrastructure July 2022 progress update - Internal candidate withdrew interest in the post, Job Description has been modified and re-submitted for advert. Network post back out to advert closing date 27th of July 2023.	Delay
	24592	Appointment of an MDT admin support	Ms Caroline Sarah Elizabeth Hogbin, Site Specialty manager	28/04/2023	Ensure all documentation is completed and collated form the meeting setting out actions and next steps for patient care. It releases Medical staff from admin duties to focus on patient care. And ensures timely completions of all actions following the MDT meetings.	Delay

	24593	Appointment of Clinical Governance Co-ordinator	Ms Caroline Sarah Elizabeth Hogbin, Site Specialty manager	28/04/2023	Support the clinical governance process for the vascular teams. Job description has been completed and the process for recruitment to start as soon as possible	Delay

CRR23-45	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 13 December 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 11 May 2023
	Risk: Risk to patient and staff safety due to Industrial Action	**Date of Committee Review:** New risk
		Target Risk Date: 31st July 2023

There is a risk that patint and staff safety will be compromised due to a number of unions taking industrial action in the form of a strike over the course of the next six months . This may be caused by Unison,RCN,RCM,GMB which is affecting WAST as well as the Health Board. This could impact and disrupt service provision due to the unavailability of a significant loss of key staff being available to provide patient care and the associated auxiliary support.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	4	20
Target Risk Score	3	4	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.Established the Industrial Action planning cell that can be stood up at any time when IA is confirmed in order to assess the impact of staff absence 2. On IA Days activating command and control arrangements both corporately and with the IHC, MHLD and Women's Services in order to monitor the staff availability and the impact on service delivery. 3. Conduct risk assessments for the services which has informed local business continuity plans.	1. Risk reviewed at the Industrial Action planning cell. 2. Risk reviewed at Gold command.

4. Provided business continuity training for business continuity leads within the services. 5. Identified services for derogation as per derogation specification as advised by Trade Unions. 6.Cancel all Training and non-essential meetings 7. Redeploy staff to areas of highest risk based on the risk assessments undertaken and clinical judgment by the IHC MHLD, Womens, and pan BCUHB services. 8. Review delivery of services and reduce activity pre IA days based on risk assessments undertaken.	

Gaps in Controls/mitigations
1. Until the day of the IA it is unknown how many staff will not attend work and support the IA. 2. Business Continuity training needs to be more in depth.

Progress since last submission
Proposal to close this risk as no further Industrial Action is planned, close of the risk approved by the Deputy Executive Director of Nursing.

Links to	
Strategic Priorities	**Principal Risks**
Primary and community care Making effective and sustainable use of resources (key enabler)	BAF21-02

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	24679	redeployment of corporate services	Mrs Christine Lynes, Deputy	30/07/2023	The additional staff that will be released from training and	On track

Actions being implemented to achieve target risk score		to support operational delivery	Executive Director of Nursing		corporate services will be redeployed to support the operational teams. all cancelled meetings will allow teams to support and focus on IA planning	
	24680	regular meetings with Trade Unions	Mrs Christine Lynes, Deputy Executive Director of Nursing	30/07/2023	This will enable BCUHB and Trade Unions to have a clear line of communication to escalate concerns and urgent issues and agree IA planning.	On track
	24681	Internal IA planning	Mrs Christine Lynes, Deputy Executive Director of Nursing /Debbie Lewis EPPR Lead	30/07/2023	This will allow the HB to have robust plans in place to mitigate as much as possible to reduce the risk to patients and staff safety and potential harm due to IA and for this to be shared with external stakeholders and partners at TCG.	On track

Appendix 3 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes – Risk entry closed and replaced by CRR23-40 and CRR23-41			
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients – Risk entry closed and desegregated into individual clinical conditions, replaced by Tier 1 risks CRR23-42 and CRR23-43			
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	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	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.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	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	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	16
CRR22-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR22-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR22-20	Residents in North Wales are unable to achieve a healthy weight due to the obesogenic environment in North Wales	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR22-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15
CRR22-25	Risk of failure to provide full vascular services due to lack of available consultant workforce.	De-escalated, risk being managed at Tier 2 Presented at June 2023 Quality, Safety and Experience Committee		
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service	De-escalated, risk being managed at Tier 2 Presented at June 2023 Quality, Safety and Experience Committee		
CRR22-27	Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.	Executive Medical Director	Quality, Safety and Experience	15
CRR22-28	Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.	Executive Director of Workforce and Organisational Development		
CRR22-29	Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-30	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-31	Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model	Executive Director of Workforce and Organisational Development		
CRR22-32 (Formally CRR20-06)	Retention and Storage of Patient Records	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-33 (Formally CRR20-06)	Risk of Lack of access to clinical and other patient data	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-34	There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	Executive Director of Public Health	Partnerships, People and Population Health	15
CRR23-35	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.	Executive Director of Finance	Quality, Safety and Experience	16
CRR23-36	Cost of Living Impact on Staff and Patients - the risk associated with the impact of the increased cost of living on Staff and Patients and how that translates to the quality of Patient Care that BCUHB delivers	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	
CRR23-37	Targeted Intervention - risk that the Targeted Intervention Programme may not meet its targets and this would lead to a negative impact on the quality of Patient Care	Deputy Chief Executive (Proposed)	Quality, Safety and Experience	

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR23-38	Workforce - The need to consolidate existing workforce risks into an appropriate described risk/risks that reflect the pan BCUHB position for the provision of services to patients. Also, to note a separate workforce risk related to statutory and regulatory requirements of being an employer	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	
CRR23-39	Patient Flow - Impact on Access and Quality of Care	Executive Director of Nursing and Midwifery (Proposed)	Quality, Safety and Experience	
CRR23-40	Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience Committee	16
CRR23-41	The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience Committee	16
CRR23-42	Age related Macular Degeneration (AMD) and Intra Vitreal Injection Service (IVT)	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	Quality, Safety and Experience Committee	16
CRR23-43	Risk of Irreversible Sight-Loss from Delayed Care for “New” and “Follow-Up” Glaucoma Patients	Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	Quality, Safety and Experience Committee	16
CRR23-44	Pathology Laboratory Information Management System (LINC)	Executive Director of Therapies & Healthcare Sciences	Quality, Safety and Experience Committee	20
CRR23-45	Risk to patient and staff safety due to Industrial Action	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	20
CRR23-46	Duplicate Hospital Numbers	Chief Digital and Information Officer	Partnerships, People and Population Health	15

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR23-47	There is a risk to the safety of inpatients within MHLD identifed by the Health and Safety Executive in their Notice of Contravention under Section 28(8) of the Health and Safety at Work Act 1974.	Director of Mental Health	Quality, Safety and Experience Committee	15
CRR23-48	There is a risk to patient safety within MHLD inpatient units presented by access to low height and other ligature anchor points	Director of Mental Health and Learning Disabilities	Quality, Safety and Experience Committee	15
CRR23-49	Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	20
CRR23-50	Financial outturn for 2022/23	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	15
CRR23-51	Risk of failure to achieve the initial financial plan for 2023/24 (£134.2m deficit), because of failure to achieve the level of financial improvement included in the plan	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	16
CRR23-52	WG cash funding for 2023/24	Interim Executive Director of Finance	Performance, Finance and Information Governance Committee	20
CRR23-53	Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-54	Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-55	Inability to manage ambulance demand in a safe timely fashion.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-56	Inability to deliver safe timely care in Emergency Units.	Chief Operating Officer	Quality, Safety and Experience Committee	16
CRR23-57	Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	16
CRR23-58	Temporary Suspension of Home Birth Service due to WAST provision	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR23-59	Compliance with Birth Rate Plus	Executive Director of Nursing and Midwifery	Quality, Safety and Experience Committee	16

Risk Key Field Guidance / Definitions of Assurance Levels V2

BAF / Risk Template Item	Please refer to the Risk Management Strategy 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 V2

	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.