Bundle Quality, Safety & Experience Committee 20 June 2023

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26 QS23/60 Exclusion of Press and Public
Resolution to Exclude the Press and Public – "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 20 January 2023
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Cheryl Carlisle	Independent Member – from 10:00
Jacqueline Hughes	Independent Member
John Gallanders	Independent Member
Hugh Evans	Independent Member

In Attendance:

Peter Bohan	Associate Director of Occupational Health Safety and Security
Gareth Evans	Acting Executive Director of Therapies & Health Science
Matthew Joyes	Associate Director of Quality
Phil Meakin	Associate Director of Governance
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Angela Wood	Executive Director of Nursing and Midwifery
Nick Lyons	Executive Medical Director
Molly Marcu	Interim Board Secretary
Mike Smith	Project Lead Mental Health
Gaynor Thomason	Programme Director for Clinical Safety Improvement (for part)
Paul Lumsdon	Interim Director of Nursing Mental Health
Rod Taylor	Director of Estates (for part)
Ben Thomas	Consultant Nephrologist
Karren Mottart	IHC Medical Director (for Part)
Barbara Cummings	Interim Director of Performance
Fflur Jones	Audit Wales
Jackie Allen	CHC

Agenda Item	Action
OPENING ADMINISTRATION	
QS23.01 - Welcome, Introductions and Apologies for Absence **QS23.01.1** Apologies were received from Chris Stockport, Executive Director of Transformation and Planning, Sue Green, Executive Director of Workforce and Organisational Development, Dave Harries, Internal Audit and Iain Wilkie, Interim Director of Mental Health.	
QS23.02 - Declarations of Interest on current agenda **QS23.02** There were no declarations of interest noted.	
QS23.03 - Minutes of Previous Meeting Held in Public for Accuracy	

QS23.03.1 It was resolved that the minutes were approved as an accurate record of the meeting held on 1 November 2022	
QS23.04 - Matters Arising and Table of Actions **QS23.04.1** The Action log was reviewed in detail and where appropriate actions were removed. It was noted that actions should be completed before the next meeting and if this were not possible an update in the action log noted as to why. **QS23.04.2** The Committee reviewed the action log and closed actions where appropriate.	
QS23.05 - Patient Story **QS23.05.1** The Committee viewed a video on a patent who shared her experience through diagnosis and treatment of Pulmonary Embolisms (PE) in Ysbyty Glan Clwyd. The Associate Director of Quality thanked Catrin for sharing her story and highlighted the leaning identified in the paper. **QS23.05.2** The Executive Medical Director advised that improvement work needs to be undertaken in this area and advised that he would work outside the meeting to confirm that the patient was receiving the correct medication and support psychologically. **QS23.05.3** A discussion took place around different experiences of care with regards to PE experienced across the Health Board and the Executive Director of Nursing and Midwifery advised that training, information and communication would be replicated across the Health Board to ensure consistency but that the management of PE varies across the UK. **QS23.05.4** It was agreed that actions from the patient stories would be reviewed at the new Oversight and Assurance Group and report back into QSE through the Executive Director of Nursing and Midwifery's Chair's Assurance Report. **QS23.05.5** It was agreed that there would be a year-end report received at QSE on Patient Stories. **QS23.05.6 It was resolved that** the Committee receive and reflect upon the story	NL AW AW
QS23.06 - Corporate Risk Register [Director of Estates joined the meeting] **QS23.06.1** Attendees discussed the Health and Safety risks in depth around Estates discussing in detail the risk around the likelihood of a legionella outbreak. It was noted that there are controls and mechanisms in place to reduce the exposure but that there was an inherent challenge with water quality, management and usage but that the likelihood was low but the impact would be great. Questions were raised in relation to the score of the risk and it was noted that this risk rating had been identified by Corporate Health and Safety but that it would be reviewed to see if the scoring could be reduced through evidence. The Board Secretary queried the methodology applied, that there was a lack of tangible justification for the risk rating. The Director of Estates agreed to review the risk rating. **QS23.06.2** Attendees discussed the fire safety risk noting that the issue with this risk was the level of consistency across all sites and ownership on each site. The Board	RT

Secretary clarified the identification of a risk exposure due to certain things not taking place, noting that there had not been any reportable incidents, she queried what was within the gift to implement and that there was a need to do something differently. It was acknowledged that a lot of the issues were in relation to capital funding. It was agreed that the Board Secretary and the Director of Estates would meet to identify what risks were in relation to capital funding and report back to the committee. An Independent Member declared an interest as a Health and Safety Representative.	MM/RT
QS23.06.3 Attendees noted that the Risk Management Group was stood down in December due to Industrial Action and that papers had been circulated by email but that they had not been scrutinised in a meeting. It was agreed that the role of the Risk Management Group was to challenge the score and that what was not being identified was site ownership of risk management.	
QS23.06.4 Attendees discussed the de-escalation of two vascular risks and that due to the Risk Management Group being stood down these had not been considered in detail despite recommendations being received by members of the Risk Management Group and then the HBLT. The Associate Director of Governance advised that it was his proposal to look at the risks in detail at these groups.	
QS23.06.5 The Executive Medical Director clarified the reasoning behind the de-escalation of the Vascular Risks advising that following consultation with colleagues, in his opinion it was correct that they be reduced. It was noted that there should however be a new risk that the Vascular Steering Group have raised which relates to the wider sustainability of the Vascular Service.	
QS23.06.5 Attendees discussed due process and that evidence was required and submitted to the QSE Committee should any risk being proposed for downgraded. The Board Secretary endorsed the process, that it was the Committees responsibility to challenge and hold the ring on de-escalation and that when this was being considered timing is identified. It was agreed that there was a need to ensure that there was a consistent approach. The Board Secretary suggested that a template was produced to alleviate the requirement of going toing and froing between meetings and that the challenge was with the Risk Management Group to ensure evidence was clear when risks are changing status.	PM
QS23.06.5 It was agreed that at the next QSE Committee there would be a deep dive on the Vascular Risks.	PM
QS23.06.X It was resolved that the Committee reviewed and discussed the report and agreed that Vascular risks should not be downgraded and reinstated at its previous level until it had been through due process.	
QS23.07 Polices for Approval [Consultant Nephrologist joined the meeting] **QS23.07.1** The Consultant Nephrologist presented the policy advising that he had been the National Lead for Consent. It was noted that the narrative on the coversheet supported how the policy would be implemented. Clarification around the data was shared with regarding compliance around peer auditing. The Consultant Nephrologist advised attendees that the concerning statistic was the 75% of the time that the patient leaflets had not been provided. The Executive Medical Director thanked those who had been involved in producing the policy noting that due to the national leadership role the Health Board was ahead of the curve.	

QS23.07.2 Attendees noted that the track changes were showing in the document to show that comments had been included in the most up to date version. It was discussed that a policy is only as good as it's usage and that it was a very long policy but clear that was the reason an executive summary had been produced. **QS23. 07.3 It was resolved** that the Committee approved the Consent to examine or treatment Policy	
QUALITY SAFETY AND IMPROVEMENT	
QS23.08 - Mental Health Outcomes and Improvement **QS23.08.1** The Executive Nurse Director shared that she thought the paper was very informative but questioned the data source on page four and the length of time that the work identified on page six was going to take. The Interim Nurse Director agreed to review page 4 of the report where it said "data source" rather than the dates and review the HCA numbers and amend the report for the next Committee. It was noted that with reference to the work being undertaken on page 6, that the timing of 10 months to triangulate was too long. **QS23.08.2** It was noted that the outstanding actions are the focus and that a risk assessment would be completed on the actions and notify the Committee if there are any concerns that deadlines would not be met. **QS23.08.3** The Committee were informed that by the end of February all band 5 staff will be given training on risk assessment and suicide training and that this would be documented. **QS23.08.4** The work on auditing risk assessments is ongoing and a weekly meeting takes place to understand how improvements can be made. It was noted that some beds which were identified as anti-ligature are now not and that to mitigate the capacity around health and safety this is now being bought in. **QS23.08.5** A discussion took place around staffing and training, noting that the 100% figure for staff being trained in risk assessment and suicide was for those in post. The Executive Director of Nursing advised that clinical ownership was essential and the Project Lead Mental Health confirmed that the Ward Managers, Matrons and Heads of Nursing were doing the spot checks. It was noted that a lot of hooks had been put on walls given the increase in corridor nursing and that these should be included in risk assessments. **QS23.08.6** It was requested that with regards to the outstanding actions for the Notice of Contravention outcomes were required and the Project Lead for Mental Health agreed to review the digital patient record system to ensure that all those who needed access to the system would be able to access it. **QS23.08.7 It was resolved** that Committee reviewed the proposed update on the development of the MH&LD Divisional Improvement Plan.	PL PL MS
QS23.09 - YGC Improvement Plan **QS23.09.1** Attendees received the YGC Improvement plan noting that it had been scrutinised in a lot of detail at Cabinet. Patient bounce back is a measure that is being	

recorded and this was being done over a 72-hour period without concerns currently being raised. What was being identified as the main concern was the closure of nursing homes and staffing. It was noted that what was once best practice is now no longer supported but the Health Board is looking at home support and maximising Community Hospitals. Clarity was given in relation to rehabilitation, care homes and hone setting discharge. Concern was raised in relation to Local Authority budgets **QS23.09.2** An Independent Member queried whether there was an improvement in documentation being seen, and if cancer patients in crisis were being able to be seen at the cancer centre. The Programme Director for Clinical Safety Improvement advised that the IHC's were doing documentation audits and improvement has been seen but there is further work to be done. **QS23.09.3** The Executive Medical Director advised that there was a requirement to look at multidisciplinary team notes on cancer and though improvements were being seen further work was being done, specifically around weekend and bank holidays and that the information was being reviewed at the forthcoming Cancer Partnership Board. **QS23.09.4** An Independent Member queried consultants and recruitment in terms of overall safety and assurance and how often the Health Board was running below capacity and what impact that was having on patients. The Executive Medical Director advised that there was some ongoing debate as to whether the traditional staffing model is effective, however, it was noted that the Health Board is below RCEM Standards and that it was mitigate through a high volume of agency staff, which introduced its own risk and problems, however, if the Health Board were to benchmark it was in a better place than others. **QS23.09.5** The Programme Director for Clinical Safety Improvement advised that there is work ongoing to look to appoint consultant nurses and are consultant physiotherapists. **QS23.09.6** An Independent member questioned medical oversite on the Emergency Department at YGC and Paediatrics, given that it was now common practice to see patients waiting outside of the waiting room. The Executive Director of Nursing and Midwifery advised that from a nursing perspective, there is a Nurse in place and Health Care Support Workers are there providing refreshments. Audits are taking place to ensure that this is taking place and nurses are speaking to patients outside. It was acknowledged that the workforce is under extreme pressure. **QS23.09.7 It was resolved** that the Committee noted the progress made to date on the YGC Improvement Plan.	
QS23.10 - Vascular Improvement Plan **QS23.10.1** The Committee received the Vascular Improvement Plan an Independent Member highlighted that it was documented that there were still some issues with regards to record keeping and that he had heard that some patients were moving from a vascular route to an orthopaedic route. Clarification was sought on the proposed reduction of the staffing risk down to a tier 2 and if this identified that there were now enough consultants recruited. Finally, clarification was sought on the timing of the HIW report. **QS23.10.2** The Executive Medical Director advised that there had not been a change in policy with regards to the treatment of patients. With regards to the workforce, the consultant workforce is at establishment but with locum reliance. Attendees noted that a middle grade rota was now in place. Further recruitment around nursing, phycology etc	

has been paused at the current time due to funding. Finally, the Executive Medical Director advised that it was anticipated that the HIW report would be received in March. **QS23.10.3** The Executive Medical Director advised that the report received was a little sparse due to a number of meetings being stepped down due to industrial action and that a fuller report would be received at the Vascular Steering Group and then onto the March QSE meeting. **QS23.10.4** An Independent Member advised that he would email the Executive Medical Director his operational queries outside of the meeting. **QS23.10.5** The Executive Director of Nursing and Midwifery updated on the conversations taking place with Welsh Government noting that what the Health Board is experiencing with regards to vascular is the same as other Health Boards. **QS23.10.6** A discussion took place with regards to the pathways matching the improvement plan, it was noted that a meeting had been scheduled to review what has been achieved with regards to the pathways and what is still yet to do [The Programme Director for Clinical Safety Improvement left the meeting] **QS23.10.7 It was resolved** that the Committee noted the summary of actions taken since the last update.	JG
QS23.11 - Urology Improvement Plan [The IHC Medical Director joined the meeting] **QS23.11.1** The IHC Medical Director presented the report. An Independent Member raised concerns around harm and waiting lists. It was noted that optimising pathways and centres of excellence would be utilised to reduce patient harm, an example of how this is being undertaken with the prostrate cancer pathway was shared. **QS23.11.2** The IHC Medical Director advised that with regards to streamlining waiting lists this was in relation to reducing steps that do not add value, for example following GP referral a patient should be able to go straight to diagnostics rather than via a consultant. **QS23.11.3** The Executive Medical Director advised that since the production of the paper two issues have been identified and that a response was being drafted to HIW around urology cancer wait lists. **QS23.11.4** Attendees discussed the robotic surgery, consultant training and the choice of robot purchased. It was noted that further conversations around procurement and the Urology HIW response would be taken outside of the meeting.	NL
QS23.12 Patient Safety Report This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.13 - Patient and Carer Experience Report	

This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.14 - HIW Update This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.15 - Quality/Safety Awards and Achievements This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.16 - Health and Safety Report including HSE Update **QS23.16.1** The Committee received the Health and Safety Report an Independent Member queried if there was any way to highlight racially motivated incidents, it was noted that this was done and submitted to the equities group. **QS23.16.2** Attendees discussed walk abouts and inspections, it was noted that a range of areas ae reviewed and that a detailed plan could be brought back to QSE Committee with clarity around Primary Care. **QS23.16.3** The Board Secretary highlighted the Health and Safety gap analysis plan and noted that given this was the basis on which work was prioritised it needed to be seen. The Associate Director of Occupational Health Safety and Security advised that the gap analysis was used to develop the three year strategy which had been shared at QSE in the past. **QS23.16.4** The Committee noted that further work was ongoing around falls given the data was not showing sufficient improvement. The Executive Director of Nursing and Midwifery advised that her senior team were looking at how to take this forward.	
QS23.17 - Nurse Staffing Act This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
REPORTS	
QS23.18 - Chair's Assurance Reports This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.19 - Infection Prevention Report This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	
QS23.20 – Quality & Performance Report This item was taken as a consent item due to timing, any questions should be forwarded and appended to the minutes with responses.	

CLOSING BUSINESS	
QS23.23 - Issues Discussed in Previous Private Session **QS23.21** The Committee noted that the items that were discussed in the private session on 1 November 2022 were: • Update on Mental Health Investigations presented by the Executive Director of Public Health • Incident Report presented by the Executive Director of Nursing and Midwifery • Health & Safety Executive Compliance Update presented by the Executive Director of Workforce and Organisational Development	
QS23.22 - Date of next meeting **QS22.255.1** It was noted that the next QSE Meeting would be held on 7 March 2023.	
QS23.23 Exclusion of Press and Public **QS23.23.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 19 May 2023 Via Teams

Present	
Name	**Title**
Rhian Watcyn Jones	Independent Member, Chair
Prof Mike Larvin	Independent Member
In attendance	
Richard Coxon	Interim Head of Corporate Affairs (minutes)
Alison Griffiths	Director of Nursing
David Jenkins	Independent Advisor (observing)
Mandy Jones	Deputy Executive Director of Nursing
Matt Joyes	Associate Director of Quality
Dr Nick Lyons	Executive Medical Director
Phil Meakin	Interim Board Secretary
Susan Morgan	Head Of Health, Safety and Security
Marty Mcauley	Interim Deputy Board Secretary
Tracey Radcliffe	Head of Patient Safety
Angela Wood	Executive Director of Nursing & Midwifery
Rachel Wright	Patient and Carer Experience Lead

Agenda item	**Action**
OPENING BUSINESS	
QS23.24 Welcome introductions and apologies QS23.24.1 Rhian Watcyn Jones, Independent Member and new Chair (Chair) of the Quality, Safety & Experience (QSE) Committee welcomed everyone. She stated that the meeting was not intended to be a comprehensive look at all matters QSE; rather a start-up meeting to be followed by a second meeting in June. QS23.24.2 The Chair reported that Prof Mike Larvin, Independent Member had to leave at 4pm so the agenda would be moved around to ensure quoracy. For the Committee to be quorate, two Independent Members and two Executive Directors had to be present. QS23.24.3 Apologies were received from: Alan Brace, Independent Advisor Chris Lynes, Deputy Director of Nursing and Midwifery James Risley, Deputy Medical Director	

QS23.25 Declarations of interest on current agenda QS23.25.1 There were no declarations of interest noted.	
QS23.26 Minutes of the last meeting and action log QS23.26.1 It was agreed that the minutes of the meeting would be carried over for approval at the next meeting.	
QS23.27 Patient Story QS23.27.1 The patient story circulated prior to the meeting was not reviewed as it is also on the agenda for the board meeting on the 25 May 2023.	
QS23.28 Patient Safety Report QS23.28.1 Tracey Radcliffe (TR), Head of Patient Safety introduced the Patient Safety report which covered the previous three-month period which was taken as read. QS23.28.2 TR highlighted the following points from the report: • It was reported that from February to April 2023, 28 National Reportable Incidents (NRIs) had occurred and 64 notifications were submitted. The difference in the numbers related to incidents which occurred in prior months that have been awaiting outcomes from harms meetings. The total number of NRI investigations that are overdue is 34 of the 57 that are open. • The NRIs reported during this period were themed as follows: Grade 3 or above Health Acquired Pressure Ulcer (5); Falls resulting in harm (12); Assessing and recognising patient/service user deterioration (2); Delays in clinical assessment or treatment (5); Infection prevention (2); Injury of unknown origin (1) and Death of patient known to Mental Health services (1). • It was noted that there were weekly meetings focussed on reviewing open investigations and that a Quality Strategy was being developed. QS23.28.3 Prof Mike Larvin (ML), Independent Member commented that it was a good detailed report and was pleased that work was on an upward trajectory. The Chair suggested that a timeline for the development of the Quality Strategy would be helpful. QS23.28.4 The Committee received the report.	
QS23.29 Patient and Carer Experience Report	

QS23.29.1 Rachel Wright (RW), Patient and Carer Experience Lead presented the Patient and Carer Experience Report which covered the period from December 2022 to March 2023. During this period the Health Board had received 756 complaints, 585 being complaints managed under the Putting Things Right Regulations (PTR). Of the 756 complaints received 171 were initially classified as Early Resolutions. Of these, 11 cases were upgraded to 'managed under PTR' due to the service involved not managing resolution within two working days.

QS23.29.2 It was noted that the majority of the complaints related to Secondary Care Services and the top themes related to: clinical treatment and assessment, poor communication, appointments and medication. There is ongoing pro-active work by the Patient Advice and Liaison Service (PALS) to coordinate with services, addressing recurring themes. Attitude and behaviour issues are common themes across all services.

QS23.29.3 It was reported that performance remained below the All-Wales target of 75% for complaints closed within 30 working days. The number of complaints closed within the timeframe was 30% during the months of December 2022 to March 2023. This performance level is a slight improvement in comparison with previous reporting months. To support the achievement of the key performance indicators, each Integrated Health Community (IHC) had adopted weekly meetings to manage the progress of complaints received. In addition, a new weekly scrutiny meeting to manage the overdue complaints backlog had been established chaired by the Deputy Executive Director of Nursing.

QS23.29.4 There were 290 overdue complaints at the end of March 2023. This is a significant reduction in overdue complaints achieved through staff working overtime and considerable efforts by both the Complaints Team and the services involved to investigate complaints and complete reports within PTR timescales.

QS23.29.5 In answer to a question from the Chair, it was noted that patient and carers could give feedback without using electronic devices. These included Care and Share Interviews or over the phone, depending on service.

QS23.29.6 In response to a question raised by the Chair, it was confirmed that carers could also leave feedback and they were supported through Carers Champions.

The Chair noted the improvement in meeting targets. She felt that as well as meeting targets it was essential to investigate the root causes of complaints and deal with underlying issues.

QS23.29.7 The report was received by the Committee.

QS23.30 Clinical Effectiveness Update Report

QS23.30.1 Nick Lyons (NL), Executive Medical Director introduced the Clinical Effectiveness Update Report and apologised to the Committee as he had been on leave when the report was issued. He believed that the report did not give assurance only partial or no assurance. For this reason, he provided a brief commentary with a view to producing a more comprehensive report in future.

QS23.30.2 NL highlighted the following points from the report:

- BCU Hospital Transfusion Committee - Transfusion survey feedback had identified that medical staff had not undertaken any transfusion related training. It was noted that currently there is no formal programme available for transfusion training for medical staff (apart from F1s) and support is required from clinical specialities to be able to link in with clinical governance days in order to deliver this training.

- Major Haemorrhage Procedure (MHP) training - No formal clinical training regarding MHP currently in place. Recommendation is that Transfusion training should be mandatory for all staff involved in the transfusion process.

QS23.30.3 NL reported that there was a lack of suitable accommodation to provide training. However, options were being look at to provide training with Bangor University and reviewing dates where there is capacity.

QS23.30.4 ML confirmed that there were available training rooms at Bangor University outside of term time.

QS23.30.5 The report was received by the Committee on the understanding that clinical effectiveness matters would be considered more fully in the future.

QS23.31 Regulatory Assurance Report

QS23.31.1 Matt Joyes (MJ) Associate Director of Quality presented the Regulatory Assurance Report which provided the Committee with an updated position in relation to quality related regulatory activity for the period January 2023 to April 2023 which was taken as read.

QS23.31.2 MJ highlighted the following points from the report:

- Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. It inspects NHS services, and regulates independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement. Following inspections of BCUHB HIW identified two services that required improvement - Services Requiring Significant

Improvement (SRSI): • Emergency Department at Glan Clwyd Hospital – HIW inspected on three occasions (08-10 March 2022; 03-05 May 2022; 28-30 November 2022) and made 71 recommendations and 304 service improvement actions. Significant work has been undertaken by staff to address actions and the following week would be meeting specifically to review collected evidence in depth. • Vascular Services - The Royal College of Surgeons Clinical Record Review Report, published 20 January 2022, identified a number of concerns that indicated a risk to patients using the vascular service. HIW undertook a review and conducted onsite field work across all sites in November 2022 with follow up remote evaluation of data and information. • The HIW inspected Foelas Mental Health Unit, Learning Disabilities, Bryn y Neuadd Hospital on 22 March 2023. The draft report had not yet been received but no immediate concerns were raised. • It was noted during January to April 2023, there were 148 new inquests or requests for information from the coroner's office. During the same period the previous year, 128 new inquests or requests for information were received from the coroner's office in North Wales. QS23.31.3 In a discussion around sufficient resource to improve services, it was noted that dedicated staff had been allocated to collate information and evidence for HIW actions. It was acknowledged that staff working in the emergency department work very hard and are overstretched. QS23.31.4 In response to a question, MJ confirmed that were HIW to visit tomorrow they would see improvements since their visit in March 2022. It was noted that the actions had been maintained and supported by staff who 'owned it' though it was acknowledged that cultural changes took longer to embed. QS23.31.5 The Committee received the report.	
QS23.32 Health and Safety Report QS23.32.1 Susan Morgan (SM), Head of Health, Safety and Security presented the Health and Safety Report which was taken as read. QS23.32.2 SM highlighted the following points from the report: • The Health and Safety Executive (HSE) sent a letter of notification of contravention which was received 9 May 2022, to detail material breaches identified following the investigation of the death of a patient by ligature in the Hergest Unit.	

- The HSE is actively investigating 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. Further reports are being submitted to the HSE following patient falls where an inadequate falls assessment was completed or identified controls not implemented. 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 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) – it was noted that since the 1 January 2023 there have been 15 reports submitted under RIDDOR. This includes eight staff 'over 7 days' related injuries with three falls, two assaults, one head injury and two musculoskeletal injuries. There were seven patient related specified injuries following falls.

- It was noted that the main area of concern was manual handling training where 5,000 staff (53%) have yet to update their training which is on an annual basis.

QS23.32.3 The report was received by the Committee. The Chair asked for BCUHB actions to address H & S issues to be identified in future reports.

Prof Mike Larvin, Independent Member left the meeting at 16.02.

QS23.33 Nurse Staffing Act

QS23.33.1 Alison Griffiths (AG) Director of Nursing introduced the Nurse Staffing Act report which was taken as read and provided a summary of key health and safety team activities and areas for escalation since the 1 January 2023.

QS23.33.2 It was noted that Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards.

QS23.33.3 The Act has two key requirements:
1). A duty to calculate and take steps to maintain nurse staffing levels
2). Apply triangulated methodology to nurse staffing level calculations i.e., Professional Judgement /Patient Acuity / Quality Indicators. In line with the Act, nurse staffing calculations were approved by a designated person authorised to undertake this calculation on behalf of the Chief Executive Officer which is the Executive Director of Nursing.

QS23.33.4 There was some discussion as to how safe staffing levels were triangulated and calculated with Angela Wood (AW), Executive Director of Nursing & Midwifery, explaining how she approves based on complex needs of patients.

QS23.33.5 It was noted that Quality Indicators are linked to care provided by nurses such as pressure ulcers; medicine administration errors; patient falls and complaints. QS23.33.6 There was some discussion around workforce and multi-disciplinary support and the challenges surrounding recruitment to posts. It was noted that that new job roles were being developed to ensuring that the appropriate staff were available to provide the right care for patients. There is a consultation being undertaken with the Welsh Government currently about staffing levels and are hoping for more flexibility. QS23.33.7 The Committee noted the report.	
QS23.34 Reflections on meeting QS23.34.1 The Committee agreed that there had been good interaction amongst attendees with short and concise reports which had been useful. It was agreed that an agenda setting meeting would be held for the next QSE meeting which was scheduled for the 20 June 2023. QS23.34.2 It was agreed that this felt like an inclusive meeting and a safe space to discuss issues and concerns. The Chair stated that the Independent Members were here to both challenge and support the Executive and operational teams.	
QS23.35 New Risks QS23.35.1 No new risks were identified in the meeting.	
QS23.36 Date of next meeting QS23.36. The next meeting will be held on the 20 June 2023.	

Teitl adroddiad: ***Report title:***	National Institute for Health and Care Excellence (NICE) Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with a position status regarding NICE guidance compliance.			
Argymhellion: ***Recommendations:***	The committee is asked to receive 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: ***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:*** *NICE guidance is disseminated in a timely manner, with updated processes to align with the new IHC structure. A new IT system Audit Management and Tracking (AMaT) has been purchased by Clinical Effectiveness and we are working with the Quality Department to ensure effective implementation. Once this is completed, training can be rolled out across the Health Board to use the software.*				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The benefits of successfully implementing NICE guidance are in the delivery of better health and social care outcomes with the help of evidence-based advice.			

Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	When making a decision about how to treat a patient, ignoring and failing to adhere to the NICE guidelines is likely to lead to legal consequences.
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/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)***	N/A
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)*	N/A
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 processes are in place with regards ensuring compliance with NICE guidance across BCUHB.*	
List of Appendices: *None*	

1. INTRODUCTION

Betsi Cadwaladr University Health Board (BCUHB) has a statutory responsibility to disseminate, implement and monitor our compliance with NICE guidance.

IHCs and the Specialised Clinical Services/Mental Health/Womens Health Divisions are responsible for assessing and incorporating NICE and National Guidance into their practice.

The NICE Guidance Implementation and Assurance Protocol (approved August 2022) is available to view on the Clinical Effectiveness webpage on Betsinet: NICE Guidance Implementation and Assurance (sharepoint.com)

2. PROCESS

2.1 NICE guidance is identified from www.nice.org.uk, which is reviewed weekly to identify any newly published guidance or updates by the Clinical Project Lead and NICE Senior Administrator.

2.2 This guidance is then circulated to an identified NICE clinical lead within the speciality to which it relates, along with a NICE Compliance form and information explaining what is then required; 'compliance' in this context means that our policies and procedures are aligned with the guidance as set out by NICE. The form should be returned within 8 weeks of receipt with a compliance status as outlined below; if returning a 'partial' or 'not achieved' status then a SMART Action plan is expected giving an outline of the work to be carried out in order to achieve the 'fully achieved' status. If a response is not received within the allotted timescale the compliance status will be recorded as 'Not Achieved', and escalated as per 2.4 below.

- **Fully Achieved**: NICE consider greater than 80% to be fully compliant.
- **Partially Achieved – Acceptable**: Although compliance less than 80% no significant patient risk is identified.
- **Partially Achieved – Improvement Needed**: Compliance less than 80% and patient risk identified. Action plan expected and risk register reference number.
- **Not Achieved**: Details expected including improvement plan and risk register reference number.

This data is kept up to date on an in-house spreadsheet, with plans in place to use the Audit Management and Tracking (AMaT) database, which is currently being piloted in Womens Services. Training is also being developed to support roll out across BCUHB.

2.3 Each nominated NICE clinical lead is responsible for reviewing the guidance and submitting a response within agreed timescales and for providing timely updates. The initial response must identify any gaps, and the rationale or assurance underpinning the actions required for compliance via the NICE Compliance form.

2.4 Significant issues of clinical risk or 'no response' are escalated to the local Clinical Effectiveness Groups in the first instance, with further escalation to the Strategic Clinical Effectiveness Group (CEG) as indicated

2.5 Only when all services have responded can we confirm the overall Health Board position with regards guidance compliance; we therefore cannot be 'fully achieved' on a guidance unless all specialties/sites have responded.

3. POSITION

The total number of guidelines published or updated during the last financial year April 22 – March 23 was 236. The overall percentage of Fully, Partial and Not Achieved for April 22 - March 23 is as below:

Fully Achieved	55	16.5%
Partially Achieved	94	28.1%
Not Achieved / No response	185	55.4%
Total responses expected	334	100%

4. SUMMARY

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 compliance form is expected from Clinical Leads for ALL NICE guidelines relevant to the Health Board. An Action plan should be completed for all partial or not achieved status. Including decisions not to implement.	NICE Spreadsheet / database being rolled out 2023-2024	NICE Senior Administrator will coordinate with Clinical Specialty. With roll out of AMaT in conjunction with IHC/ Division leads	Continuously reviewed and updated		Areas that do not complete an Action Plan within the timeframe stipulated after the first chase from NICE Senior Administrator will be reported as not achieved. The outstanding NICE guidance is reported with the NICE monitoring report to Local CEGs and 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 that action up.
	NICE monitoring report Local Clinical Effectiveness Meetings receive Monthly Report (NICE Monitoring section)		Monthly	Local CEGs Strategic CEG Quality Delivery Group (QDG) Quality Safety Experience Committee (QSE)	
	Weekly catch up with Clinical Project Lead		Weekly	Clinical Effectiveness Departmental meeting	
Dissemination, monitoring and implementation of NICE guidance	NICE spreadsheet will record compliance and exceptions. Compliance reporting to all IHC and Divisions monthly, local CEGs and weekly catch ups arranged		Continuous monitoring. Monthly reporting.	Local CEG Strategic CEG Quality Delivery Group (QDG) Clinical Audit & Effectiveness Monthly meeting	

Teitl adroddiad: ***Report title:***	Infection Prevention			
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with a summary of the Infection Prevention and Control arrangements in BCUHB, highlights current performance with improvement goals, key challenges and the initiatives being taken to reduce infection rates. There is also an update on progress with the decontamination of reusable devices and Antimicrobial Stewardship initiatives which also sit within the IP framework.			
Argymhellion: ***Recommendations:***	The Board is asked to note this report and the actions being taken to achieve the improvement goals.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Rebecca Gerrard, Director of 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:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health & Social Care Act - Code of Practice for the Prevention & Control of HCAIs			
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?***	NA			
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?***	NA			

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)***	There are two associated Tier 1 risks on the risk register: • Decontamination risk (CRR22-19) 'Potential that reusable medical devices are not decontaminated effectively so patients may be harmed' scoring 16 • IP nursing team risk (CRR22-18) 'Inability to deliver timely IP services due to limited capacity' scoring 15.
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***	NA
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See above
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: Gweithredu argymhellion ***Next Steps*: *Implementation of recommendations***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Appendix 1: Key Mandatory Organisms Appendix 2: SIPG Plan on a Page for 2023/24	

1. Introduction/Background

Infection prevention and control (IP) 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. The IP team provide a service to all services in BCUHB including 3 Acute Sites, 74 community facilities, 1 prison, 16 community and local hospitals, 137 GP Practices and 8 Mental Health and Learning Disabilities inpatient facilities.

1.1 Staffing and governance arrangements

- The IP nursing team at BCUHB is divided into 3 with a small team based at each of the acute sites. Teams are operationally led by an Assistant Director of Nursing Infection Prevention who reports to the strategic Director of Nursing for Infection Prevention and Decontamination. There is also 2 decontamination staff (an adviser and a nurse) and a Consultant Antimicrobial Pharmacist in the team.
- PHW provide laboratory and microbiology support. In March 2023, Dr Deepannita Bhattacharjee, Consultant Microbiologist with Public Health Wales (PHW) was appointed as the pan-BCU IP Doctor with 4 sessions allocated per week to provide expert Microbiology advice and strategic overview. There had been no-one in this post for several years before this.
- The Strategic Infection Prevention Group (SIPG) meets monthly and is authorised by QSE to support safety by monitoring, directing and ensuring assurance of effective IP arrangements throughout the health board.

2. Compliance with Welsh Improvement Goals

There is mandatory reporting to PHW for six key infections which include *C.difficile* and 5 blood stream infections: Methicillin Resistant *Staphylococcus aureus* (MRSA), Methicillin Sensitive *Staphylococcus aureus* (MSSA) and 3 gram negative infections (*E.coli, Pseudomonas* and *Klebsiella*). See Appendix 1 for further information on these infections.

Improvement goals for lowering the burden of infection in health boards are set by the Welsh Government via Welsh Health Circulars (WHC). The WHC for 2023/24 has not yet been published but it is thought the goals will remain unchanged.

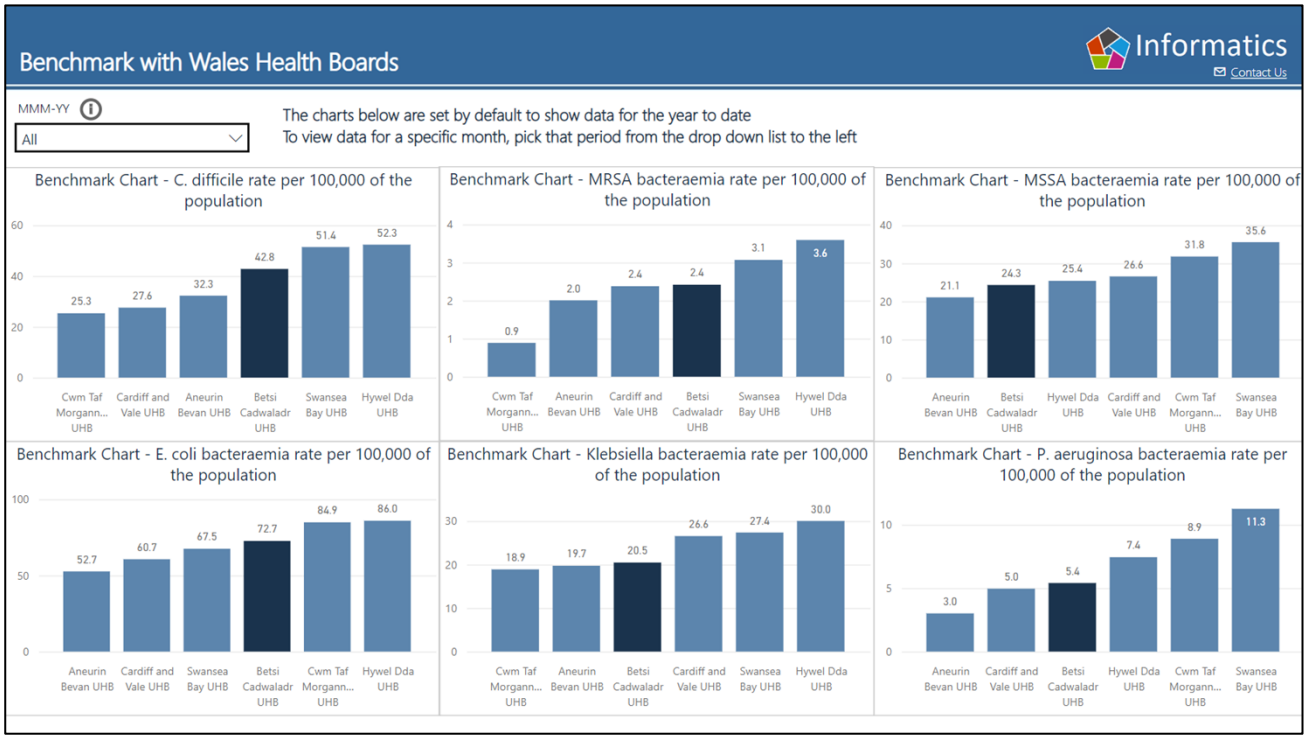
Data is not yet available for this new financial year but a summary of performance for BCUHB against the Improvement Goals and the All Wales average rates for 2022/23 are presented in the table below. Rates are given as 'crude' and 'age-standardised', taking into account the age structure of the health board.

BCUHB's reported cases were over trajectory for all mandatory organisms, however, they were lower than the All Wales average rates for MSSA, *Klebsiella* and *Pseudomonas*.

WHC Improvement Goal	Target	All Wales 'crude' performance rate in 2022/23	BCUHB 'crude' performance rate in 2022/23	BCUHB 'age standardised' rate in 2022/23	BCU 'crude' performance in 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 saw a significant rise in infection rates for *C.difficile, E.coli* and MRSA blood stream infections compared to the previous year.
Seasonal variation means there is usually an increase in *C.difficile* cases reported during summer months, but BCU rates were further exacerbated by a level two outbreak in YG in Feb/March 2023 affecting 26 patients and 5 wards and there is now an outbreak at YGC involving 3 patients across 2 wards to date.
At the end of March 2023, BCUHB were 4th for *C.difficile,* 3rd for MRSA and MSSA, 2nd for *E.coli*, 1st for *Klebsiella* and 2nd for *P. aeruginosa* compared to other health boards (using 'age-standardised' data) as illustrated below.



Comparative data for England is not available but PHW have been asked to obtain this where possible.

3. Current Key Challenges

- Infection rates are rising and organisms are becoming more resistant. The population is ageing, patient acuity is rising and there are challenges recruiting and retaining staff. Much of the estate in BCUHB is old and there is lack of siderooms and en-suites, poor ventilation, a lack of sinks, patients are too close together in bays and there are some bays without doors.
- Despite the appointment of a Consultant Microbiologist as the IP Doctor, PHW Microbiology support is lacking with just 1.5 WTE directly employed in 2022/23; with the others working as either 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.

- In 2022/23 the COVID-19 pandemic continued to impact on the routine delivery of the work programme for IP with priorities requiring adjustment according to competing workload pressures. 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.
- 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. IP now has no Project Management support allocated to it.

4. Key Improvement Initiatives being taken to reduce infection rates in 2023/24

4.1 Generic

- **Annual plan**: The SIPG has developed a 'Plan on a Page' outlining the key themes for focus in 2023/24 and a quarterly 'deep dive' is being undertaken on each of the accountable areas to monitor their progress and gain assurance. See Appendix 2 for the Plan on a Page.
- **Conference:** The IP team are holding a conference on 4th October called 'Back to the Future' highlighting the fundamentals of IP on 'back to the basics' whilst looking forward to the future for all clinical staff at BCUHB.
- **Patient reviews:** IP are ensuring that a detailed multi-disciplinary Patient Incident Review (PIR) is completed for all key HCAIs, with action plans for any required recommendations to prevent reoccurrence, enhance clinical practice and ensure learning is shared across the organisation.
- **Ward cleaning:** IP are delivering a Spring Clean Campaign including the launch of the new 'Which Clean do I Mean?' tool and a standardised nurses cleaning checklist.
- **Blood culture contamination rates**: a detailed database of blood culture information enabling identification of types, numbers and locations of all blood cultures taken has been developed to help identify departments that have a higher rate of contaminated blood cultures, enabling more targeted education and training in those areas.
- **IT tools**: IP are working with IT to further develop electronic audit tools and reporting formats.
- **Air purification**: IP are working with Estates to review the use of air purifiers in clinical areas where there is poor ventilation and make recommendations to SIPG.

4.2 Organism specific

- ***C.difficile***: A BCUHB *C.difficile* Task and Finish group was established late 2022 to review pathways and treatments and identify further areas requiring action, with the aim of reducing rates at BCUHB. The group meets regularly and a number of actions have been taken including development of a new Faecal Transplant Procedure for reinfections, launch of a new mattress audit tool, support from a number of *C.difficile* Medical Champions to act as ambassadors and delivery of a multifaceted improvement campaign launched in February which received over 1880 views online. IHCs are now required to have reactive and proactive Deep Clean programmes with High level Disinfection on the acute sites and progress is being monitored by SIPG. Weekly microbiologist-led *C.difficile* ward rounds have also been reinstated at all 3 acute sites. Each of the IHCs are holding a '*C.difficile* summit' to educate staff on the issues and what part they can play to reduce rates. *C.difficile* numbers Jan-March averaged 29 per month; there were 24 in April and 25 in May and it is hoped these numbers will continue to fall.
- ***E.coli*:** The majority of E.coli blood stream infections are related to urinary catheters. A pan BCU catheter audit took place in April to gain a better understanding of the key issues and this will reported back to SIPG in June and an action plan developed. A project to reduce gram negative infections is also one of the initiatives being taken forward via the Safe Care Collaborative; BCU should see a reduction in E.coli infection rates this year.
- **MRSA:** A more detailed analysis of cases in 2022/23 has been undertaken; 71% were deemed unavoidable and the majority (76%) were community-onset. The most common

cause was related to urinary catheters, therefore, the initiatives outlined above should also support a reduction in MRSA blood stream infections in 2023/24.

5. Decontamination of reusable medical devices

- The 2 members of the Decontamination team provide advice, support and carry out twice yearly audits in a number of decontamination services including 3 Sterile Service Departments (SSDs), 8 departments undertaking endoscope decontamination and our Community Dental services.
- A comprehensive Strategic Review of Decontamination of Medical Devices was undertaken by NHS Wales Shared Services Partnership Specialist Estates Services in August 2022 which 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 has been employed for 6 months (3 days per week) to help take the recommendations forward and a new Decontamination Strategy has been drafted. A new management structure has been proposed and support given to the successful implementation of a new compliant SSD track and trace system. Progress is being monitored via the Decontamination Group but further work and 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.

6. Antimicrobial Stewardship

- The Consultant Antimicrobial Pharmacist drives forward BCUHB's Antimicrobial Stewardship programme with support from others in the pharmacy division.
- Improvement goals are set by Welsh Government via WHCs; BCUHB continues to achieve the 2.5% year-on-year reduction required by BCUHB to achieve the minimum 25% reduction rate by 2023/24. However, there is still evidence of inappropriate prescribing of antibiotics and compliance with Start Smart then Focus Audits is poor.
- BCUHB, in particular Wrexham, has the highest levels of antibiotic resistance in Wales as outlined in a recent report from PH Wales. There has been no secondary care antibiotic usage data sent from PHW since September 2021, but from an in-house database we know that East do not use greater amounts of antibiotics than the other regions in BCUHB. Antibiotic usage in primary care was on a downward trend in line with trajectory but did increase in winter due to the high rate of group A strep infections and Wrexham is in line with this. PHW have pulled together a group to collate and triangulate further data from PHW, pharmacy and IP to carry out a descriptive Epi Study looking at demographics etc.

7. *Budgetary / Financial Implications*

There are no budgetary implications associated with this paper.

Appendix 1: Key Mandatory Organisms

Staphylococcus aureus is a bacterium that's a common coloniser of human skin and mucosa. It can cause disease, particularly if there's an opportunity for the bacteria to enter the body. Illnesses that may develop include skin infections, wound infections, urinary tract infections, pneumonia and bacteraemia. After this, blood stream infection may then develop.
Most strains of this bacterium are sensitive to many antibiotics, and infections can be effectively treated. Some *S. aureus* bacteria are resistant to the antibiotic methicillin, they're called methicillin-resistant *Staphylococcus aureus* (MRSA).
Bacteraemia occurs when bacteria get into the blood stream. Blood stream infection is also sometimes called septicaemia, which implies greater severity and clinical significance. A wide variety of bacteria can cause bacteraemia, one of the most common being *Staphylococcus aureus*.

C.difficile is short for *Clostridioides* (previously *Clostridium*) *difficile* infection (CDI). It is the leading cause of healthcare associated infection (HCAI) diarrhoeal illness and leads to considerable morbidity and, too often, mortality, as well as health care economic burden. In 2017, CDI was calculated to increase patient length of hospital stay by, on average, 7-12 days with an additional cost of approximately £4700 per patient, compared to those without CDI.
Antibiotic and healthcare exposure, along with advanced age, are the main risk factors for colonisation and infection. Disruption to the gut microbiome, allows *C. difficile* to proliferate and cause mild to life-threatening bowel inflammation, precipitating the disease pathology.
The bacterium can be spread directly, or indirectly, between patients from healthcare workers and family members, the environment, or via food and animals when skin, surfaces and fomites are contaminated and not sufficiently cleaned prior to contact. It can persist in the environment, on surfaces, people, animals, food and fabrics, in the form of spores, for extended periods (months to years) and can lead to prolonged transmission events and outbreaks.
Poor hand hygiene, contaminated surfaces and other fomites, like medical devices, are often implicated in transmission, allowing patients to ingest spores that can colonise or infect. In the community, *C. difficile* is associated with farming and animals, contaminated food, and can be isolated from soil. There is also evidence of spread between individuals in domiciliary settings, including care homes.

Gram-negative bacteria: There are many different types of Gram-negative bacteria; some live in the intestine harmlessly, while others may cause a variety of diseases. Bacteria that are normally harmless in their normal environment can cause problems if they grow in other parts of the body and can cause a range of infections with differing severity and associated mortality. One of the most serious infections Gram-negatives can cause bloodstream infections.
Gram-negative bacteria such as *Escherichia coli, Klebsiella* spp. and *Pseudomonas aeruginosa* are the leading causes of healthcare associated bloodstream infections. Gram-negative bacteria can be resistant to antibiotics and in some cases will be multi-resistant rendering most available antibiotics useless.

Appendix 2: SIPG Plan on a Page for 2023/24

Teitl adroddiad: ***Report title:***	Corporate Safeguarding Report			
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee [QSE]			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with a high level position relating to Corporate Safeguarding and its regulated activity			
Argymhellion: ***Recommendations:***	The Committee is asked to receive this report for assurance			
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 Vulnerability & Exploitation Board Community Safety Partnerships Safeguarding Maturity Matrix			
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) (Wales) Act 2019 and Children Act 1989 and			

	2004.VAWDASV Act 2015, 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* An EQIA (Equality Impact Assessment) is not required for this report
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 provides Assurance to the Board; therefore, SEIA is 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)***	The following risks are monitored in line with the Safeguarding and Reporting Framework following the Organisational Reporting cycle of business.. CRR21-14 There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients Current Risk Rating = 20 [to be agreed at the next RMG meeting as a reduced score of 16] CRR21-15 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 Current Risk Rating = 16
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***	A thorough informative report demonstrating increased activity, organisational and national challenges with ongoing intervention and implementation of legislations, guidance, policies, and procedures to safeguard the service users, staff, and the Health Board.
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: Dim ***List of Appendices:*** *None*

1. Introduction.

This report provides the Quality, Safety and Experience Committee with updated assurance regarding compliance with key statutory legislation.

2. Health Inspectorate Wales / Care Inspectorate Wales

In February 2023, a Joint Inspection Review of Child Protection Arrangements [JICPA] took place within BCUHB. This was the first review of its kind nationally.

This is an extremely positive report, an Assurance and Implementation Plan is under development to support the findings and recommendations.

3. Liberty Protection Safeguards (LPS), the Mental Capacity Act (MCA), and the Deprivation of Liberty Safeguards (DoLS)

The Deputy Minister for Mental Health and Wellbeing issued a Written Statement in April 2023 with 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.

BCUHB have been allocated WG non-recurring funding for 2023-24 to support the DoLS activity, Mental Capacity Training, Education and Awareness; provide geographical leadership on the implementation of a regional and stronger Independent Mental Capacity Advocate [IMCA] service.

4. ISO Accreditation - Sexual Assault Referral Centre (SARC)

The Forensic Science Regulator has published supporting Guidance and Codes of Practice and Conduct (March 2023) to support the attainment of International Standards for Anticontamination of Sexual Assault Referral Centres and Assessment, Collection and Recording of Forensic Science related evidence. This accreditation must be implemented across all SARCs by October 2023.

A position paper was presented at the Health Board Leadership Team [HBLT] by the Central IHC, as they have accountability for the SARC. Corporate Safeguarding have taken the Lead role for the delivery of the Accreditation since February 2022.

5. Child at Risk [CAR]

In 2022-23, the Corporate Safeguarding Team received 4130 Child at Risk reports. This is a 13.4% increase, when compared to 2021-22. Since 2019 to 2023, there has been a 44% increase of reports across BCUHB.

6. Adult at Risk [AAR]

During 2022-23, the Corporate Safeguarding Team have received 1716 Adult at Risk Reports from across BCUHB (this includes commissioned patients by BCUHB but receive care out of county). This is a 22% increase for the same period in 2021/22.

7. Domestic Homicide Reviews [DHR] /Child Practice Review [CPR] / Adult Practice Review [APR]

There are currently 9 DHR's, 8 CPRs and 2 APRs. This is an increase for this reporting period.

This increase in demand significantly impacts' upon the resources of the Corporate Safeguarding Team, and other panel members from across BCUHB, in relation to clinical expertise, administration and panel attendance. Corporate Safeguarding both Chair's and are Reviewers.

8. Single Unified Assessment 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 will to inform professional practice on a national platform via the Wales Safeguarding Repository. The go live date is expected sometime in June 2023.

9. Digital Engagement /Activity

CITO - The Corporate Safeguarding Team are currently engaging with the BCUHB CITO team in the development of an e-Form which will allow BCUHB staff to submit an electronic Safeguarding report for Children and Adults at Risk. This project aims to enable a more streamlined submission of reports and improve the data quality.

Once for Wales Concerns Management System (Datix Cymru) - Corporate Safeguarding are in early discussions regarding the new Safeguarding Module that will be available on Datix Cymru. The module is piloted in Aneurin Bevan Health Board and captures safeguarding case records. The Datix team are also reviewing the functionality for recording and managing DoLS cases within the system.

10. Training Compliance

Safeguarding Training compliance is reviewed monthly and is analysed, disseminated and enables targeted intervention at both micro and macro level across the Health Board.

The Home Office 'Prevent' (Anti-terrorism) E – Learning Training package was considered at the Mandatory Training Group on the 15.5.23 and was agreed to be a three-year refresher mandatory training package.

Health & Safety and Corporate Safeguarding are engaged and are in the process of developing an Implementation Strategy.

Table 1: highlights the trajectory in compliance March 2022 to March 2023.

	Mar22	Mar23	Trajectory
MCA – Level 1	76.5%	80.9%	↑
MCA – Level 2	77.0%	81.8%	↑
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	73.7%	77.1%	↑
VAWDASV	65.5%	70.2%	↑

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 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 4th April 2023 and the Extraordinary Risk management Group meeting on the 5th May 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 4th April 2023 and an Extraordinary Risk Management Group meeting on the 5th May 2023 and further updates to the risks have been incorporated. 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 15th June 2023, therefore an updated position of the risks will be presented during the Quality, Safety and Experience Committee on the 22nd August 2023.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Full Corporate Risk Register Report. Appendix 2 - Newly Escalated Risks. 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
20th June 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 needs 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 4th April 2023 and during an Extraordinary Risk Management Group meeting on the 5th May 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 15th June 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 2nd August 2022, it was noted that risk CRR20-05 'Timely access to Care Homes' originally related to the pandemic but that the landscape has now changed and the controls no longer meet the description, gaps. The risk is no longer effective in its current form and collaborative work with the risk team, finance, and operational leads has taken place to split and rewrite as two separate risks, resulting in development of the two new Corporate Risks CRR23-40 (Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding.) and CRR23-41 (The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow.). As a result CRR20-05 has been closed and removed from the risk register.

2.4 During the Risk Management Group meeting on the 4th October 2022 the Ophthalmology service proposed to disaggregate risk CRR20-08 'Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients' by the clinical conditions which will enable the risks to reflect impact on patient safety/care by the clinical conditions. Work has since taken place to review and re-write the risk, with 5 new risks approved to replace the current CRR20-08. This has resulted in 2 new additional risks included on to the Corporate Risk Register CRR23-42 (Age related Macular Degeneration (AMD) and Intra Vitreal Injection Service (IVT), and CRR23-43 (Risk of Irreversible Sight-Loss from Delayed Care for "New" and "Follow-Up" Glaucoma Patients), with 3 additional risks being managed at Tier 2 level.

2.5 The following Public Health Risks have been revised and amendments to the risk which provides further clarify of the risks:

- CRR22-20 - Residents in North Wales are unable to achieve a healthy weight due to the obesogenic environment in North Wales.
- CRR22-21 - There is a risk that adults who are overweight or obese will not achieve a healthy weight due to engagement & capacity factors.

2.6 During the risk review process, and following inclusion in the Risk Management Group papers, Corporate Risks CRR22-25 (Risk of failure to provide full vascular services due to lack of available consultant workforce), and CRR22-26 (Risk of significant patient harm as a consequence of sustainability of the acute vascular service) there is a proposal from the service to de-escalate the risks from the current score of 20 (consequence 5 x Likelihood 4) to a score of 12 (Consequence 4 x Likelihood 3) and the risks to be managed at a Tier 2 level. Since the escalation of the risk where the workforce was diminished due to sickness and annual leave, the service is now running at full capacity with 6 permanent consultants in post and 3 locum consultants in addition, the middle grade tier has been established to cover 9am to 5pm, across the sites 7 days a week. For YGC from Monday the 14th November 2022 there will be 24/7 cover of middle grades.

2.7 The following risks have been incorporated onto the Health Board's risk register and following Executive approval and presentation at the Risk Management Group have been included onto the Corporate Risk Register (Appendix 2).

- CRR23-44 – Pathology Laboratory Information Management System (LINC).
- CRR23-45 – Risk to patient and staff safety due to Industrial Action.
- CRR23-46 – Duplicate Hospital Numbers
- CRR23-57 – Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.
- CRR23-58 – Temporary Suspension of Home Birth Service due to WAST provision

2.8 During the Extraordinary Risk Management Group meeting held on the 5th May 2023 as a result of a decision to hold the meeting to the April 2023 Risk Management Group meeting, the following risks have been incorporated onto the Health Board's

Corporate Risk Register following presentation of the risks to the group by the relevant risk leads (Appendix 2):

- 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
- CRR23-48 – There is a risk to patient safety within MHLD inpatient units presented by access to low height and other ligature anchor points
- CRR23-49 – Risk of the cost of planned care recovery exceeding the £27.1m funded from WG which is included in the budget
- CRR23-50 – Financial outturn for 2022/23
- 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
- CRR23-52 – WG cash funding for 2023/24
- CRR23-53 – Loss of beds due to the number of Medically fit for discharge patients (MFFD) across BCUHB.
- CRR23-54 – Flow out from the Emergency Units resulting in length of stay in EU being > 12 hours.
- CRR23-55 – Inability to manage ambulance demand in a safe timely fashion.
- CRR23-56 – Inability to deliver safe timely care in Emergency Units.

2.9 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.

2.10 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)	48	0	20	2
Tier 2 (9-12)	308	81	36	90
Tier 3 (1-8)	200	38	20	77

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.

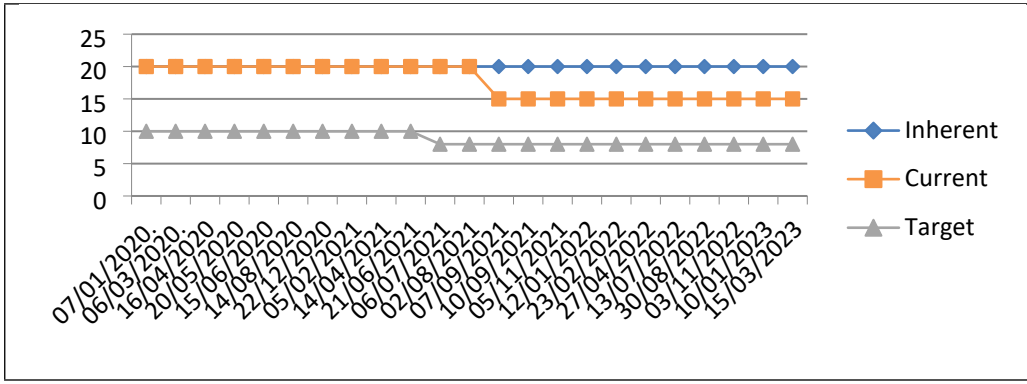
5. Equality and Diversity Implications

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:** 15 March 2023
	Risk: Asbestos Management and Control	**Date of Committee Review:** 20 January 2023
		Target Risk Date: 30 June 2023
There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, Health and Safety Executive enforcement action including fines, prosecution and reputation damage to BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 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.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group.

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.	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 86% for Asbestos awareness training and 92% for local operations managers. The target of 95% is still anticipated to be achieved by end of qtr 1 2023.

Progress since last submission
1. Controls in place reviewed to reflect current position. 2. Gaps in controls reviewed to reflect current position. 3. Proposal to extend the Target Risk Due date from the 31/03/2023 to the 30/06/2023 to allow for the full implementation of the MiCad system within the Health Board. 4. Proposal to reduce the current risk score from the current score of 15 (Consequence =5, Likelihood = 3) to a current risk score of 10 (Consequence =5, Likelihood = 2), following review at the Asbestos Management Group on the 10th April 2023 to gain assurance that the processes are in place and the robustness of the process and the reporting. Resulting in the de-escalation of the risk from a Tier 1 Corporate Risk to be managed at a Tier 2 level.

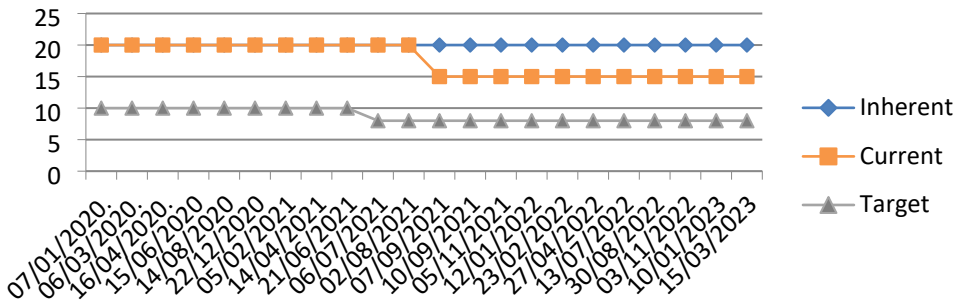
5. Action ID 12243 - Proposed extension to the action due date to the 30/06/2023 to allow full implementation of the Asbestos Module of the MiCad system.

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

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2023	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. March 2023 progress update - Proposed extension to the action due date to the 30/06/2023 to allow full implementation of the Asbestos Module of the MiCad system.	On track

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 March 2023
	Risk: Contractor Management and Control	**Date of Committee Review:** 20 January 2023
		Target Risk Date: 30 June 2023

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



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 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. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

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 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. 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. 4. Proposal to extend the Target Risk due date from the 31/03/2023 to the 30/06/2023 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. 3. Action ID 12252 – Action delayed, Operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems. 4. Action ID 12256 – Action closed as the current system for signing in/out has been identified as the SHE software being implemented within Operation Estates, the project team has been set up to oversee the mobilisation. 5. Action ID 12257 – Action delayed, Currently a paper exercise, which present a risk of failure to follow due process within the SOP.

Once the SHE system is in place this will transform over to a digital relationship which will mitigate single point of failure. Senior Estates Officers/Estates Officers currently carry out the local inductions based on the Operational Estates Control of Contractors procedures guidance (SOP). This forms part of the project work that the BCUHB/Evotics workshop will pick up and drive forwards. 6. 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.

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).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH)	Delay

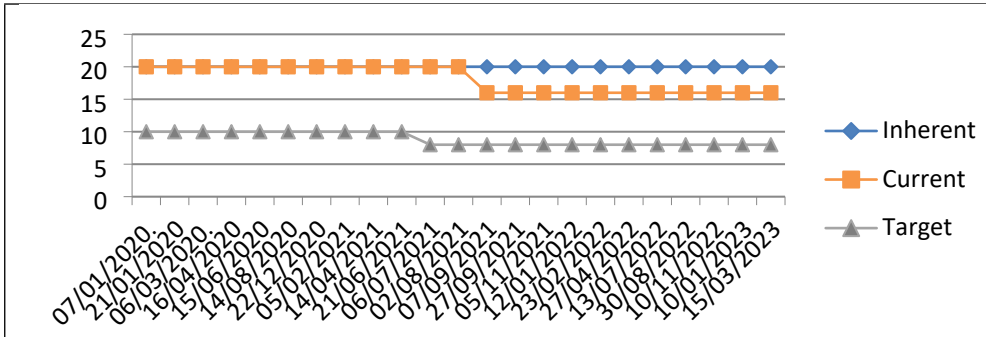
					and Inspection process to ensure compliance. March 2023 progress update - Operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems.	
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE software.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of (SHE) - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor appointment criteria across the Health Board. March 2023 progress update - Action closed as the current system for signing in/out has been identified as the SHE software being implemented within Operation Estates, the project team has been set up to oversee the mobilisation.	Completed
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of the SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.	Delay

					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. March 2023 progress update - Currently a paper exercise, which present a risk of failure to follow due process within the SOP. Once the SHE system is in place this will transform over to a digital relationship which will mitigate single point of failure. Senior Estates Officers/Estates Officers currently carry out the local inductions based on the Operational Estates Control of Contractors procedures guidance (SOP). This forms part of the project work that the BCUHB/Evotics	

					workshop will pick up and drive forwards.	
	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.).	Mr Rod Taylor, Director of Estates & Facilities	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. March 2023 progress update - Operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems.	Delay

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 March 2023
	Risk: Legionella Management and Control.	**Date of Committee Review:** 20 January 2023
		Target Risk Date: 30 April 2023

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 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. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonas.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Strategic Infection Prevention Group. 4. Quality, Safety and Patient Experience Committee.

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.	

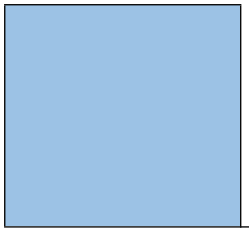
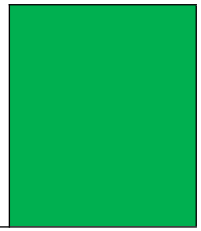
Gaps in Controls/mitigations
1. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case has been approved as part of the IMTP with funding agreed recurrently from April 2023, which will provide supported additional 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. Controls in place review 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 31/03/2023 to the 30/04/2023 to allow the risk to be discussed and agreed to the Water Safety Group on the 11th April 2023. 4. Proposal to de-escalate the risk by the 30/04/2023 following Authorising Engineers audit which will be presented at the Water Safety Group meeting on the 11th April 2023, proposal to reduce the current risk score of 16 Consequence =4, Likelihood =4), to 8 (Consequence =4, Likelihood = 2), and for the risk to be managed at Tier 2 level. 5. Director of Capital and Estates queried the consequence risk score of 4, and it's felt that the consequence of such risk should be scored as a 5 due to the risk to life.

6. Action ID 24081 – Action closed due to the audit being received by the Health Board which will be presented at the Water Safety Group on the 11th April 2023.
7. Action ID 19015 – Action delayed, Funding secured, delay due to departure of the previous Director of Estates.

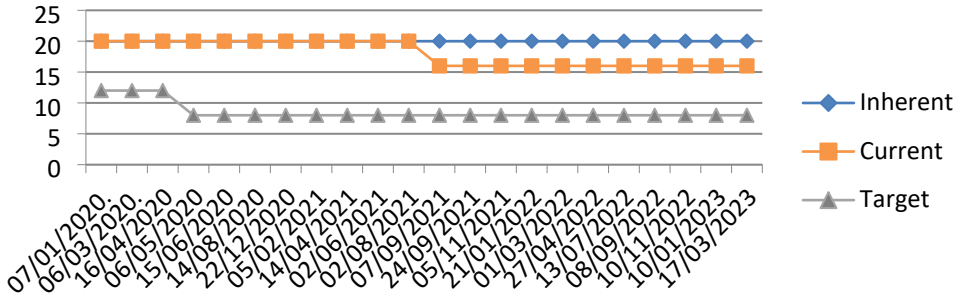
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

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.	Mr Rod Taylor, Director of Estates & Facilities	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. March 2023 progress update - Funding secured, delay due to departure of the previous Director of Estates.	Delay
	24081	Audit response following the Shared Services Authorised Engineer for Water Audit	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	Address any shortfalls identified as a result of the audit which will be required to be implemented.	Completed

					March 2023 progress update - Action closed due to the audit being received by the Health Board which will be presented at the Water Safety Group on the 11th April 2023.	

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 17 March 2023
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 20 January 2023
		Target Risk Date: 31 March 2025

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 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. 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Annual Compliance returns submitted to Welsh Government.

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).	

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. 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. Corporate Health and Safety audit undertaken and a number of recommendations made which are being acted upon over the forthcoming months. 4. 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. 5. 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.

6. Action ID 15036 - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of September 2023.
7. Action ID 24142 – Action delayed, business case to be presented to the SOHSG via the FSMG due to be held end of March.
8. Action ID 24397 – Action delayed, policy to be taken to the next SOHSG for implementation.

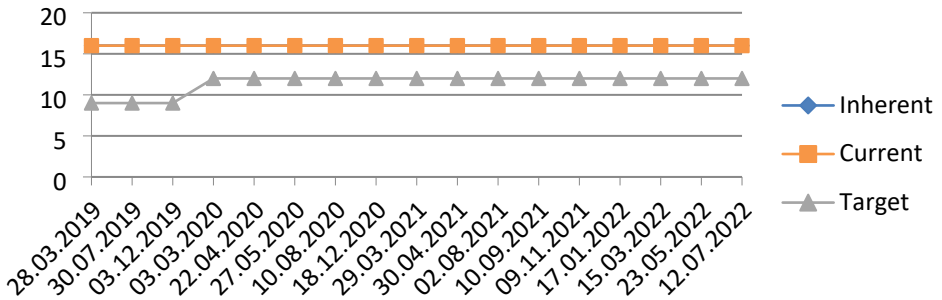
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

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	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	To be included in site specific manual and training developed with Manual Handling Team. March 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.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order. March 2023 progress update - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of September 2023.	Delay
	24142	Develop a Management structure to ensure adequate capacity to deliver Fire Safety requirements within the Health Board.	Mr Rod Taylor, Director of Estates & Facilities	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. March 2023 progress update – business case to be presented to the SOHSG via the FSMG due to be held end of March.	Delay
	24397	Implement recommendations following the Corporate Health and Safety audit	Mr Rod Taylor, Director of Estates & Facilities	31/12/2022	Ensure recommendations from the Corporate Health and Safety audit are implemented which will strengthen current policies and procedures. March 2023 progress update – policy to be taken to the next SOHSG for implementation.	Delay

CRR20-06 – Proposed changes to this risk (links into 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:** 12 July 2022
		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.	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. 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.	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. 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

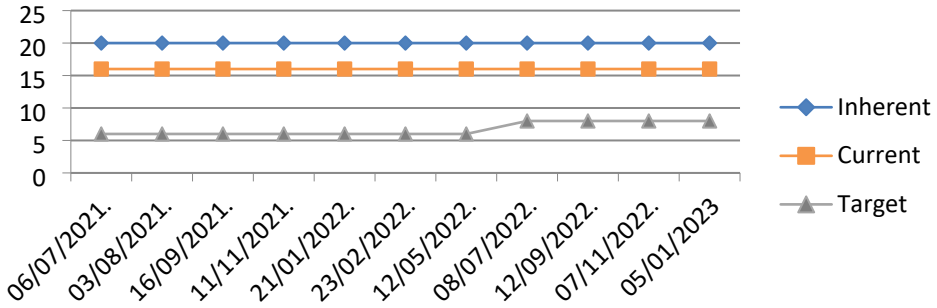
		future of 'fit for purpose' file libraries for legacy paper records.	Records and Digital Integration		Government (5 case business cases) – break ground circa 2023, we will not be able to start the work to explore if the Ablett can be retained and redesigned for health records until the business cases 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

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 05 January 2023
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 20 January 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.



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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. 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 in place to monitor and develop forward look recruitment and retention initiatives to mitigate 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. Full representation and active participation in national policy and decisions making forums such as All Wales Nurse Staffing Group, All Wales Recruitment and Retention Group and the All Wales Temporary Staffing Group.	

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. 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 newly appointed Nurse Staffing Programme Lead will oversee the implementation and associated training requirements relating to the SafeCare System. 3. Not all Nursing staff groups are on electronic rotas and plans will need to be developed by the respective Integrated Health Community Teams. Recoginising personnel changes there is an ongoing schedule of roster and Safecare training. 4. Whilst the People Strategy and associated plans are in place, there is a requirement to develop a specific Nurse recuitment and retention 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
1. Risk Description updated to reflect current position of the risk. 2. Controls reviewed to ensure relevance with current risk position. 3. Gaps in controls reviewed to ensure relevance with current risk position. 4. The Autumn nurse staffing reviews are complete and were presented to Board in November 2022 and agreed, further discussion is ongoing with regards to the workforce and financial outcomes of the reviews. 5. The overseas nurse recruitment business case is in the final stages of approval, having been noted at Executive Delivery Group, with minor amendments required prior to final approval, final approval is still awaited due to cancellations of the Executive Delivery Group as a result of ongoing operational pressures. 6. Action ID 17509 – Action delayed, awaiting direction from Welsh Government Nursing officer, chaser e-mail to be sent. 7. Action ID 18834 – Action delayed, dashboard developed in October 2022 but currently being refresher and will be re-launched to nursing seniors, service pressures has delayed implementation. 8. Action ID 18835 – Action delayed, Band 4 roles are being successfully recruited into fastrack nurse training, however, the progression of band 2/3 nursing roles into band 4 roles is behind schedule. There are currently 48 additional places available (100 in total)for Health Care Assistants within the Health Board to apply for level 4 training that would allow them to progress into band 4 roles. 9. Action ID 20039 – Action delayed, recognised in the Intermediate Medium Term Plan (IMTP) and work is ongoing to implement the programme. 10. Action ID 22121 – Action delayed, Paediatrics are in the process of being implemented, 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 nurse stafffing programme lead will work with the East Integrated Health Community Team to consider resource requirements and timelines for implementation into the Community Hospitals. 11. Action ID 22122 – Action delayed, Gap analysis to be undertaken of current activities by Director of Nursing for Workforce. Individual Integrated Health Community workforce plans have been submitted to the Executive Director of Nursing. These plans will form the basis to develop the overall plan. Current system pressures have further delayed to progress on this action. 12. Action ID 24185 - Action Closed. A successful three pronged approach that saw the recruitment of 42 whole time equivalent Health Care Assistants into positions across the Health Board. 13. Identification of new action ID 24577 for all Clinical Nursing staff to be added to the Electronic Rostering system.

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 subsequently aspirant programmes.	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 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.	On Track

					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.	
	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	Delay

					This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development January 2023 progress update - Awaiting direction from Welsh Government Nursing officer, chaser e-mail to be sent.	
	18834	Introduce targeted monitoring across rosters, through Key Performance Indicators management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Workforce Optimisation Advisor	30/06/2022	Effective utilisation of substantive staff. January 2023 progress update - Dashboard developed in October 2022 but currently being refresher and will be re-launched to nursing seniors, service pressures has delayed implementation.	Delay
	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. January 2023 progress update - Band 4 roles are being successfully recruited into	Delay

					fastrack nurse training, however, the progression of band 2/3 nursing roles into band 4 roles is behind schedule. There are currently 48 additional places available (100 in total)for Health Care Assistants within the Health Board to apply for level 4 training that would allow them to progress into band 4 roles.	
	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. January 2023 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is ongoing to implement the programme.	Delay
	22121	Implement Allocate Safecare system to all clinical areas and associated training requirements.	Mrs Alison Griffiths, Director of Nursing Workforce	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	Delay

					mitigation at a local level. January 2023 progress update - Paediatrics are in the process of being implemented, 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 nurse stafffing programme lead will work with the East Integrated Health Community Team to consider resource requirements and timelines for implementation into the Community Hospitals.	
	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. January 2023 progress update - Gap analysis to be undertaken of current activities by Director of Nursing for Workforce. Individual Integrated Health Community workforce plans have been	Delay

					submitted to the Executive Director of Nursing. These plans will form the basis to develop the overall plan. Current system pressures have further delayed to progress on this action.	
	24185	Corporate recruitment of Health Care Support workers to close the vacancy gaps and provide a stable and resilient workforce ahead of anticipated winter pressures.	Mrs Alison Griffiths, Director of Nursing Workforce	31/12/2022	Provide a stable and resilient workforce ahead of anticipated winter pressures, and associated increased activity and patient acuity. 3 phased approach will be taken phase 1 will recruit from the existing bank of staff, phase 2 will recruit from an identified number of individuals that have recently applied for a post within the Health Board, and phase 3 will involve a well-publicised recruitment campaign targeted at the public, this is provisionally booked for mid November 2022 with checks and offers being made on the day. January 2023 progress update - Action Closed. A successful three pronged approach that	Completed

					saw the recruitment of 42 whole time equivalent Health Care Assistants into positions across the Health Board.	
	24359	Monitor prioritisation of the Nurse Workforce and staffing resource requirements as part of the IMTP planning process to ensure sufficient resources are made available to support nurse recruitment on a recurrent basis.	Mrs Alison Griffiths, Director of Nursing Workforce	31/03/2023	Provide sufficient resource to support nurse recruitment and retention in areas such as overseas nurse recruitment and student nurses.	On track
	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

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:** 10 March 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

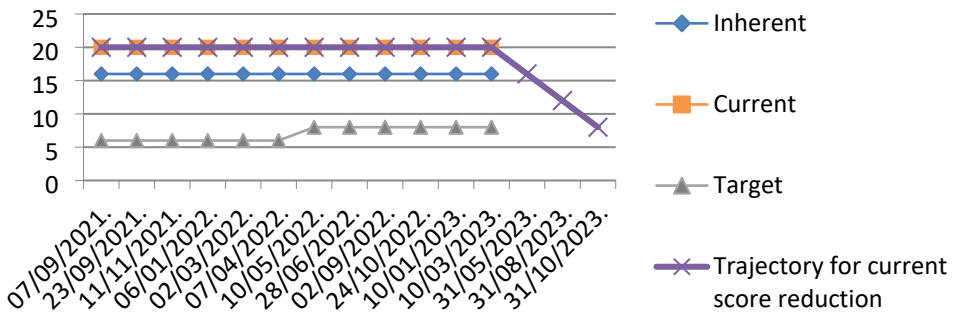
There is a risk that the increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

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 Safeguads (LPS) requires engagement at a National, Regional and Local level which has resulted in the divertion of resources.

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	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 January 2023	Unchanged		

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. 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.	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. 6. Mental Capacity Act training compliance and DoLS backlog is

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 Safeguardings 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.	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 to wards 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.

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. Welsh Government monies identified to strengthen training and implementation of LPS for 16/17 year olds.
4. 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.
5. 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.
6. 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).
7. Action ID 18117 – Action delayed, BCUHB are awaiting formal notification from WG of receipt of non-recurring WG funding for the period 2023-2024.
8. Action ID 20957 – Action delayed, WG have not yet disseminated the Code of Practice. It has been reported that it is unlikely that the Liberty Protection Safeguards will be implemented prioir to 2024-25. The request is made that this action and target date is amended in line with UK and WG timelines. The proposed date is 30.04. 2024.
9. Action ID 21213 – Action delayed, 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.
10. Action ID 23505 – Action Closed, BCUHB have supported an increase in the IMCA service accorss North Wales. Welsh Government funding (availbale for 3 years) has been utilised to ensure that advocacy across North Wales is available to individuals.
11. Action ID 23506 – Action delayed, 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.
12. Action ID 24304 – Action delayed, Internal conversations have taken place and the development of a Standard Operational Procedure is underway. However, due to the limited resources as highlighted within the Safeguarding Buiness Case, this action will not meet the target date for completion. There has also been a delay in WG non-recurring funding being issued. This has been recognised and reported by WG.
13. Action ID 24578 – Action delayed, 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.
14. Action ID 24579 – Action Closed, Using WG non-recurring funding has supported 7 day working during some 2022-23. Further funding has not yet been issued by WG but it is recognised a 7 day service is a key target and supports compliance .
15. Action ID24580 – Action Closed, Audit outcomes are reported through the MHCC Committee. Intervention is monitored via the MHCCC.
16. Action ID 24590 – Action Closed, Escalation completed. The Safeguarding Business Case has been completed and identifies the need for additional financial resources.
17. Identification of new action ID's 24806, 24807 and 24808.

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. March 2023 – BCUHB are awaiting formal notification from WG of receipt of non-recurring WG funding for the period 2023-2024 BCUHB recurring monies - 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	Delay

					response and a date for formal submission.	
	20957	Evidence an imporved 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. March 2023 – WG have not yet disseminated the Code of Practice. It has been reported that it is unlikely that the Liberty Protection Safeguards will be implemented prioir to 2024-25. The request is made that this action and target date is amended in line with UK and WG timelines. The proposed date is 30.04. 2024	Delay
	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	Delay

					activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. March 2023 - 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.	
	23505	Establish commissioning and governance arrangements for IMCAS as directed by the LPS code of practice	Michelle Denwood, Director of Safeguarding	31/03/2023	The appointment of Independent Mental Capacity Advocates and delegated resource will ensure patients voice and choice will be	Completed

			and Public Protection		heard and will be part of the legal considerations given to a patients Deprivation of Liberty. Additional IMCA's will support the LPS process and provide patients with an independent voice under the legal framework. Working with the six LA's provides assurance that all interested agencies are aware and engaged in the process. March 2023 progress update- BCUHB have supported an increase in the IMCA service accorss North Wales. Welsh Government funding (availbale for 3 years) has been utilised to ensure that advocacy across North Wales is available to individuals.	
	23506	Establishment of operational groups to support the implementation of LPS	Michelle Denwood, Director of Safeguarding	31/03/2023	To ensure that the service and function is embedded in front line practice.	Delay

		within clinical and operational service delivery.	and Public Protection		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.	
	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. March 2023 – Internal conversations have taken place and the development of a Standard Operational Procedure is underway. However, due to the limited resources as highlighted within the Safeguarding Buiness Case, this action will not meet the target date for completion. There has also been a delay in WG non-recurring funding being issued. This has been	Delay

					recognised and reported by WG.	
	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 manadatory 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
	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 and Commissioned Service Providers National NHS Health Board benchmarking has taken place. Engagement has taken	Delay

					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.	
	24579	Develop, implement and trial a 7 Day Out of Hours MCA and DoLS advisory service utilising WG funding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Utilise WG funding to ensure out of hours MCA and DoLS compliance amongst frontline services. Undertake audits of applications and BIA activity/performance within the trial period. Review the trial 7 day service to determine the long term requirements of services. March 2023 – Using WG non-recurring funding has	Completed

					supported 7 day working during some 2022-23. Further funding has not yet been issued by WG but it is recognised a 7 day service is a key target and supports compliance .	
	24580	Embed regular documentation audits into practice to provide assurance that there is no delay in the quality or completion of DoLS applications.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Updating current audit activity will ensure that the submitted DoLS and MCA documentation meets the requirements of the legal framework in line with the Deprivation of Liberty Safeguards legislation. An improvement in the documentation submitted will reduce the time taken to process applications, reduce the time taken by front line staff having to amend or revisit documentation, and ultimately speed up the process of authorisation which will ensure compliance with the legal framework. March 2023 – Audit outcomes are reported through the MHCC Committee. Intervention is monitored via the MHCCC.	Completed

	24590	Escalation of the increased costs for Section 12(2) doctors assessment	Michelle Denwood, Director of Safeguarding and Public Protection	10/02/2023	To consider the development of a business case to support additional funding following the IMTP process. The MHCC Committee to review the section 12(2) report written by MHLD in conjunction with the DoLS report to determine next steps as they are the commissioning Committee. March 2023 – Escalation completed. The Safeguarding Business Case has been completed and identifies the need for additional financial resources. The action is complete.	Completed
	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	On Track
	24807	Agree 2023-24 commissioning arrangements within the	Chirs Walker, Head of Safeguarding Adults / MHLD	31/03/2024	March 2023 – WG providing 2023-24 funding to support strengthening of current IMCA services. Work	On Track

		organisation and across North Wales Lcoal Authorities to implements a stronger Independent Mental Capacity Advocacte (IMCA) service in line wth WG recommendations			undertaken with BCUHB procurement and finance teams to support application of WG guidelines. Meetings held with Local Authorities to ensure engagement and agreement. Further work planned to support IMCA provision growth. This will include an Audit of activity.	
	24808	Evidence improved quality and standard of clinical records realting to MCA Assessments and DoLS Applications	Chirs Walker, Head of Safeguarding Adults / MHLD	30/09/2023	March 2023 - BCUHB performance Data and National Reports recognise omissions in the 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	On Track

CRR21-15	**Director Lead:** Executive Director of Nursing and Midwifery.	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 March 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 January 2023
		Target Risk Date: 31 October 2023

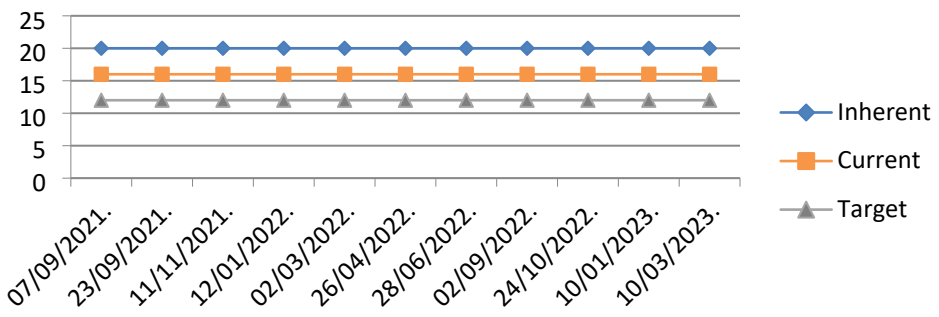
There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Well-being (Wales) Act 2014 (SSWWA).

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 January 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 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. The BCUHB Children's Division have appointed the named Doctor for Safeguarding Children. A period of supervision and support is taking place due to the identified learning needs of the appointee. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor. 7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act 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 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.

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). 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.	6. Mental Capacity Act training compliance and DoLS backlog is 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. 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. A number of senior and operational posts remain vacant following recruitment, risk assessment are in place focusing upon service delivery and the identification of activities to ensure compliance and engagement. Recruitment has taken place during January 2023 to both Operational and Senior posts and both are following the recruitment process, anticipated start date for the posts will be March / April 2023. 7. IHC Safeguarding Forums are 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. There is a lack of engagement at the Safeguarding Governance and Performance Group from the existing membership as a result of the new BCUHB Operating Model. Contact made with IHC Leads/Directors and Corporate Leads to ensure engagement in the revised Terms of Reference and Reporting Framework. A meeting has taken place with IHC Directors who are in support of the proposed Governance framework which is compliant with Operational Models Governance Framework and overview and assurance relating to attendance will be at the Safeguarding Governance and Performance Group (SGPG), next meeting scheduled for the end of April 2023.
9. 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.
10. 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.
11. 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.
12 Audit data has shown there is 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.
13. 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.
14. 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.

15. 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.
16. 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.
17. 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 and working additional hours to cover for AL, and complex activity.
18. 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 is taking place. Reporting and Governance is strengthened, discussions are taking place at CEO and Executive level to agree the revised governance and management arrangements going forward.

Progress since last submission

1. Controls in place updated to reflect current risk position.
2. Gaps in controls updated to reflect current risk position.
3. Risk description reviewed and updated to reflect current risk position.
4. Assurances reviewed and updated to reflect current risk position.
5. 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.
6. The Interim post holder for Safeguarding Quality and Governance will become vacant at the end of January 2023, action has commenced to recruit to the vacancy.
7 Health Inspectorate Wales and other regulators are undertaking a joint review of Safeguarding practice relating to the Denbighshire Local Authority area. Interviews with key individuals and field work is to take place during February 2023.

8. 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.
9. 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 is to take place on the 18th January 2023 with the Executive Director of Nursing to obtain clarity regarding timescales and the transfer of funding and staff.
10. Recruitment has taken place during January 2023 to both Operational and Senior posts and both are following the recruitment process, anticipated start date for the posts will be March 2023.
10. Action ID 18113 – Action delayed, Professional Allegations (Section 5) North Wales Safeguarding Board are requesting an update position from WG Project Board and this action is one of the key priorities for 2023- 2024.
11. Action ID 18120 – Action delayed, The SUSR consultation is now live as of the 6th March 2023. The formal consultation period will be 14-weeks, finishing on the 9th June 2023. BCUHB providing a response and are fully engaged in the North Wales Focus Group, held on the 19th April 2023.
12. Action ID 21216 – Action delayed, Business Case has now progressed to the next stage. We are waiting for formal feedback regarding next steps.
13. Action ID 23507 – Action delayed, the need for additional financial resource via the MHLD Division has been included within the Safeguarding Business Case. As referenced in ID(21216).
14. Action ID 24085 – Action Closed, the Terms of Reference for the IHC Safeguarding Forums have followed process for review and consultation and will be ratified at the next SGPG 2023.
15. Action ID 24086 – Action Closed, there has been an improvement and Forums are taking place. The revised ToR and reporting will be reviewed in line with the Safeguarding and Governance Reporting Framework.
16. Action ID 24306 – Action Closed, the Revised Safeguarding Reporting Framework was ratified – January 2023.
17. Action ID 24595 – Action Closed, a framework and process has been implemented in MHLD. A review of attendance for MAPPA 3 has been completed by Corporate Safeguarding. MHLD Divisions has been fully engaged to ensure attended at all MAPPA 3 meetings. Ratification of this framework and an update to provide assurance will be an action at SGPG 2023.
18. Identification of new action ID's 24801, 24802, 24803, 24804 and 24805.

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	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. March 2023 progress update - Professional Allegations (Section 5) North Wales Safeguarding Board are requesting an update position from WG Project Board and this action is one of the key priorities for 2023-2024 Corporate Safeguarding and Workforce are meeting on the 29.03.2023 to develop the Terms of Reference for the BCUHB Workplace Professional Allegation meeting. This meeting will	Delay

					support robust Risk Assessments and action planning which will protect; Victims, alleged perpetrators and the organisation.	
	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. March 2023 - progress update - The SUSR consultation is now live as of the 6th March 2023. The formal consultation period will be 14-weeks, finishing on the 9th June 2023. BCUHB providing a response and are fully engaged in the North Wales Focus Group, held on the 19th April 2023.	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 Integrated Medium Term Plan. The delayed LPS Code of Practice has impacted upon the development and revised proposed Safeguarding Structure and Business Case. March 2023 - the Business Case has now progressed to the next stage. We are waiting for formal feedback regarding next steps.	Delay
	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	Delay

					implementation of safeguarding practice and training. This action has again been discussed with the interim Director of Nursing MHLD March 2023 - The need for additional financial resource via the MHLD Division has been included within the Safeguarding Business Case. As referenced in ID(21216)	
	24085	Review IHC/MHLD/Womens Safeguarding Forums Terms of Reference and the Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that reporting and governance is in line with the organisations revised structure ensuring operational and strategic safeguarding activity is aligned to the organisations performance and risk management activities ensuring compliance with safeguarding legislation relating specifically to the NHS. March 2023 - The Terms of Reference for the IHC	Completed

					Safeguarding Forums have followed process for review and consultation and will be ratified at the next SGPG 2023.	
	24086	Monitor and review that Safeguarding Forums are convened in line with the Safeguarding Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that the Safeguarding agenda is embedded and key areas of risk escalated within the identified Health Economies and Mental Health and Learning Disabilities. March 2023 - there has been an improvement and Forums are taking place. The revised ToR and reporting will be reviewed in line with the Safeguarding and Governance Reporting Framework	Completed
	24306	Update and review Safeguarding Governance and Performance Group [SGPG] Terms of Reference and the Safeguarding Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding Governance and Reporting activity will be in line with BCU's governance framework. This will ensure direct line of accountability remains with the Chief Executive and Safeguarding remains everyone's business. This will ensure risks are reduced	Completed

					and key activities obtain support and engagement. March 2023 – The Revised Safeguarding Reporting Framework was ratified – January 2023 The Terms of Reference was reviewed and updated and will be ratified at the April 23 SGPG meeting	
	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	On track

					Reviewers for complex multi-agency death reviews. March 2023 - Due to the vacancy of a number of senior positions and the level of activity this activity is delayed. The NWSB Business Meeting agreed a North Wales approach regarding training and performance will also be a priority – giving consideration to the Single Unified Safeguarding Review (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	March 2023 - Discussions are taking place with the Assistant Director of Quality to ensure an identified pathway of reporting and governance includes Corporate Safeguarding.	On track
	24583	Improve and embedded processes agreed with HMP Berwyn relating to the access by the prison clientel of NHS services, to strengthen the management	Michelle Denwood, Director Of Safeguarding And Public Protection	30/06/2023	Engagement has commenced and dates agreed to progress with this work. Immediate safeguards are in place for HMP to	On track

		of risk, governance and communication.			notify where appropriate safeguarding. March 2023 - East Director of Nursing for Secondary Care is supporting Corporate Safeguarding in the development of the BCUHB Implementation and Assurance Action Plan and will feedback to the April 23 SGPG meeting	
	24584	Ensure and improve the statutory participation at MAPPA 2 and MAPPA 3 (Very High Risk Individuals) meetings by Corporate Safeguarding, and MHLD as required by the Crime and Disorder Act 2014.	Michelle Denwood, Director Of Safeguarding And Public Protection	30/05/2023	Immediate controls have been put in place and the development of a Standard Operating Procedure and a notification agreement with the MAPPA Co-ordinator. Awareness training has commenced. March 2023 - Agreement with the Probation Service has been reached to ensure attendance by BCUHB staff at MAPPA meetings. The MAPPA SOP is under review to reflect the necessary changes.	On track

					The governance framework will be Ratified at the SGPG April 2023	
	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. March 2023 – this position is currently vacant and we are waiting for confirmation of the Safeguarding Business Case to fund this post on a substantive basis.	On track
	24595	Mental Health and Learning Disabilities to implement a framework to support attendance at Multi Agency Public Protection Arrangements (MAPPA) 3.	Mr Chris Walker, Head of Safeguarding Adults	31/03/2023	An improved communication pathway will ensure forensic Psychiatrists are in attendance at MAPPA3's March 2023 progress update - A framework and process has been implemented in MHLD. A review of attendance for MAPPA 3 has been completed by Corporate Safeguarding. MHLD	Completed

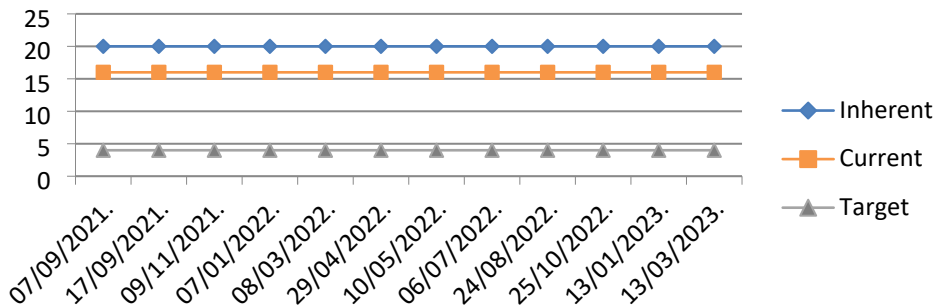
					Divisions has been fully engaged to ensure attended at all MAPPA 3 meetings. Ratification of this framework and an update to provide assurance will be an action at SGPG 2023	
	24801	JICPA – Development implementation of the “Implementation and Assurance Plan”.	Lynda Collier, Head of Safeguarding Children	30/06/23	March 2023 –informal feedback received from the JICPA Inspectors on the 9.2.23. Formal feedback and draft report will be received at the end of March / beginning of April 23. Current position in response to the informal feedback is that Corporate Safeguarding are in the process of developing an Implementation and Assurance Plan	On Track
	24802	Corporate Safeguarding will allocate representation / membership to key groups to support implementation and compliance against the	Chris Weaver, Head of Safeguarding Children	30/04/23	March 2023 – Stephen Hughes from the OPCC will be making contact with the Director of Safeguarding and Public Protection (BCUHBs SRO) to inform next steps	On Track

		new Serious Violence Duty: Preventing and Reducing Serious Violence Statutory Guidance for Responsible Authorities [2022],			This will be in line with the implementation timescale. Corporate Safeguarding Team are currently considering relevant interventions	
	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	March 2023 - Corporate Safeguarding and the Health and Safety Team, Emergency Planning are engaged in the early discussions and attending the Preparedness Forum which is a subgroup of the NW Contest Regional Board.	On Track
	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	March 2023 – 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 with the Suicide and	On Track

					Self Harm Forum to ensure future engagement and reporting is in line with the Revised Safeguarding Reporting Framework.	
	24805	NW Sexual Assault Referral Centre (SARC) to meet the National Service ISO Specifications	Chris Weaver, Head of Safeguarding Children	31/10/23	March 2023 - Corporate Safeguarding continue to support the ISO programme (Feb 2022) This is a joint programme of work with NWP with oversight of WG and IPCC. This activity was the responsibility of the Childrens Division prior to the New Operating Model. Currently the Central IHC manages the activities within SARC, and recruitment to the Vacant Managers post is taking place. Reporting and Governance is strengthened, discussions are taking place at CEO and Executive level to agree the revised governance and management arrangements going forward.	On Track

CRR21-16	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 13 March 2023
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 20 January 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. 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.	1. Regular oversight and review by the Occupational Health & Safety Team. 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. Although the training programme is in place there is currently a national shortage of manual handling trainers. Re-advertisement for posts is continuing. 2. Low compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance, however with the lack of trainers in place improvement in compliance rates is challenging. 3. Lack of integrated booking system for Orientation training with the ESR system and ESR is not easy to use. Manual bookings currently in place. 4. 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. 5. 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 54.05% as of the 08/03/2023. 6. 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, with one currently in post and one to commence on the 20/03/2023. 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. Action ID 17979 – Action delayed, Manual Handling Manager commenced in post on the 1st March 2023. Band 6 Manual Handling advisor in post in West from the 20th March 2023 having completed a 4 week trial period as a re-deployed member of staff. Band 4 posts for the West Region have commenced in post on the 1st March with the second post from Monday the 13th March 2023. 6. Action ID 18859 – Action delayed, Manual Handling policy has been reviewed by the Manual Handling Manager, to be sent for consultation prior to presentation at the Strategic Occupational Health and Safety Group for approval on the 20th April 2023. 7. Action ID 23660 - Action closed. The external trainer has not continued to provide training following the trial in August 2022 since March 2023 due to the contract reaching the procurement limit. Champions Manual Handling courses have re-commenced since February 2023 which provides the opportunity for staff members to have their competency approved on the ward as an alternative to classroom sessions, limiting the need to attend classroom training sessions. 8. Action ID 24050 – Action delayed, first meeting to be held in May 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
	17979	Additional trainers sought, to be clinically trained as	Mrs Susan Morgan,	30/11/2021	Additional trainers to provide training to the standard set	Delay

Actions being implemented to achieve target risk score		per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Head of Health and Safety		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. March 2023 progress update - Manual Handling Manager commenced in post on the 1st March 2023. Band 6 Manual Handling advisor in post in West from the 20th March 2023 having completed a 4 week trial period as a re-deployed member of staff. Band 4 posts for the West Region have commenced in post on the 1st March with the second post from Monday the 13th March 2023.	
	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	Mrs Susan Morgan, Head of Health and Safety	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	On track

		data to show high-risk areas to target for training.			and patients if those who handle patients more-often have the appropriate training. March 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 Skeletal Group, with the first meeting planned for May 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 and Safety	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. March 2023 progress update - Manual Handling policy has been reviewed by the Manual Handling Manager, to be sent for consultation prior to presentation at the Strategic Occupational Health and Safety Group for approval on the 20th April 2023.	Delay

	23660	Consideration of alternative methods of Manual Handling training.	Mrs Susan Morgan, Head of Health and Safety	30/09/2022	Looking at alternative training delivery will improve capacity to increase compliance rates to support the prevention of staff and patient injury. March 2023 progress update - Action closed. The external trainer has not continued to provide training following the trial in August 2022 since March 2023 due to the contract reaching the procurement limit. Champions Manual Handling courses have re-commenced since February 2023 which provides the opportunity for staff members to have their competency approved on the ward as an alternative to classroom sessions, limiting the need to attend classroom training sessions.	Completed
	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 and Safety	31/12/2022	Identify hot spot areas and to target those areas for intervention. March 2023 progress update - First meeting to be held in May 2023.	Delay

<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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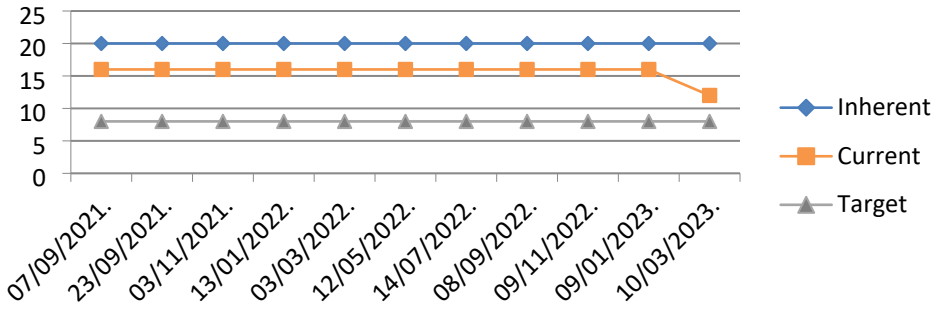


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in January 2023	decreased		

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 Risk to support the Health Board when a young person has a Depravation of Liberty Safeguards in place via court of protection.	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.

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 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. 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.

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.

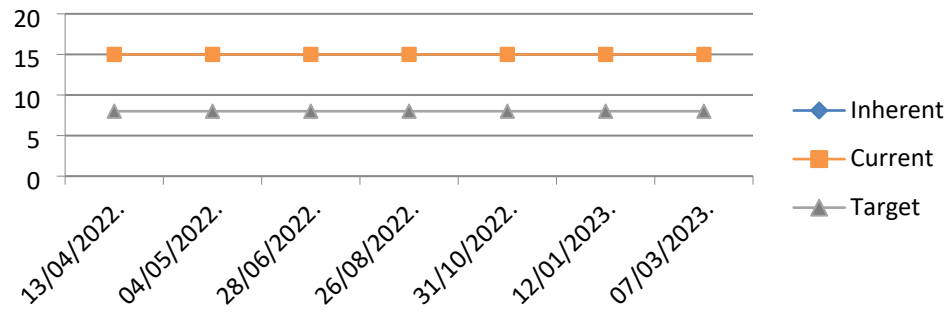
Links to	
Strategic Priorities	**Principal Risks**
Improved USC (Unscheduled Care) pathways Integration and improvement of MH (Mental Health) Services	BAF21-01 BAF21-08

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 - MW to provide update	Delay
	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 -	Delay

					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.	
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital. March 2023 progress update - Ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing.	Delay
	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:** 07 March 2023
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** 20 January 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	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 January 2023	unchanged		

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
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. Infection Prevention Team are currently experiencing significant staff sickness at a senior level, some of which is long term and 2 senior staff are on maternity leave, which is impacting the workload of the team. Even though the vacancy situation has improved within the team, there remains challenges to provide an effective service.

4. Action ID 20659 – Action delayed, 17/03/2023 Meeting re-arranged with Finance following initial cancellation due to Industrial Action and Winter pressures. 5. Action ID 21696 – Action delayed, appointing at lower grade and providing training to staff members is in place and remains ongoing. 6. Action ID 22927 - Action Closed, Course is in progress since 23rd January 2023.

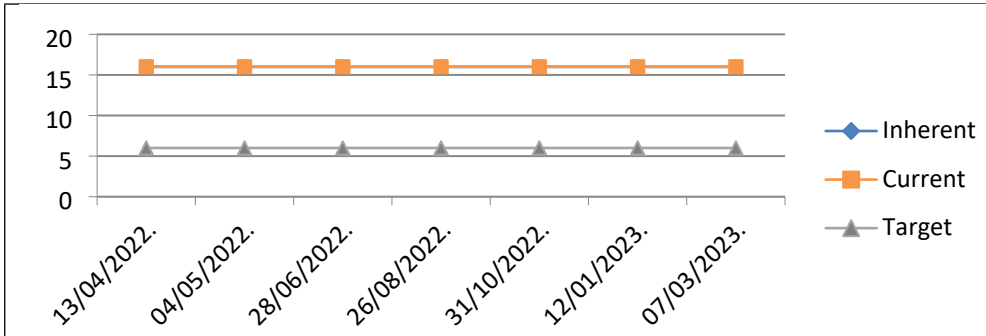
Links to	
Strategic Priorities	**Principal Risks**
Transformation fro Improvement (key enabler)	BAF21-09

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	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 March 2023 progress update - 17/03/2023 Meeting re-arranged with Finance following initial cancellation due to Industrial Action and Winter pressures.	Delay
	21696	Recruit to current vacant Infection Prevention posts	Mrs Andrea Ledgerton,	30/09/2022	Fill current vacant posts March 2023 progress	Delay

			Specialist Matron IP		update - Appointing at lower grade and providing trainnig to staff members is in place and remains ongoing.	
	22927	Promote Infection Prevention Massive Open Online Course education programme	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/01/2023	To improve knowledge, practice and compliance with IP in wards and departments. March 2023 progress update – Action Closed, Course is in progress since 23rd January 2023.	Completed

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:** 07 March 2023
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** 20 January 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	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**
1. Decontamination audits have been increased to twice yearly. 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. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning. 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. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership.	3. Decontamination audits by Authorised engineers. 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. 3. There are not many risks on Datix related to Decontamination and there is inconsistency in scoring e.g. one site has a risk related to track and trace in Sterile Services and Disinfection Units scoring 10, another scores it 4. Review of all risks relating to Decontamination completed and work ongoing to further improve with relevant departments. The Decontamination Group have oversight of all the Decontamination Risks on a bi-monthly basis. 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
1. Control in place review to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Action ID 22147 - Action delayed, progress made with updates from all the areas provided during January 2023, another meeting planned for the 23rd March 2023 to confirm that all Policies and SoP's are up to date. 4. Action ID 23024 – Action delayed, submission has been submitted with the assessment due to take place on the 17th May 2023. 5. Action ID 22148 – Action delayed, capital bid has been approved, awaiting purchase date for the equipment. 6. Action ID 22152 – Action delayed, group has reformed and is in the process of developing plans to address the funding required.

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	Delay

					for review by the end of 2022. March 2023 progress update - Progress made with updates from all the areas provided during January 2023, another meeting planned for the 23rd March 2023 to confirm that all Policies and SoP's are up to date.	
	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 March 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. March 2023 progress update - Group has reformed and is in the process of developing plans to address the funding	Delay

					required.	
	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. March 2023 progress update - Submission has been submitted with the assessment due to take place on the 17th May 2023.	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. March 2023 progress - Draft Options appraisal submitted to the Executive Director of Nursing during March 2023.	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. March 2023 progress update - Draft to be	On track

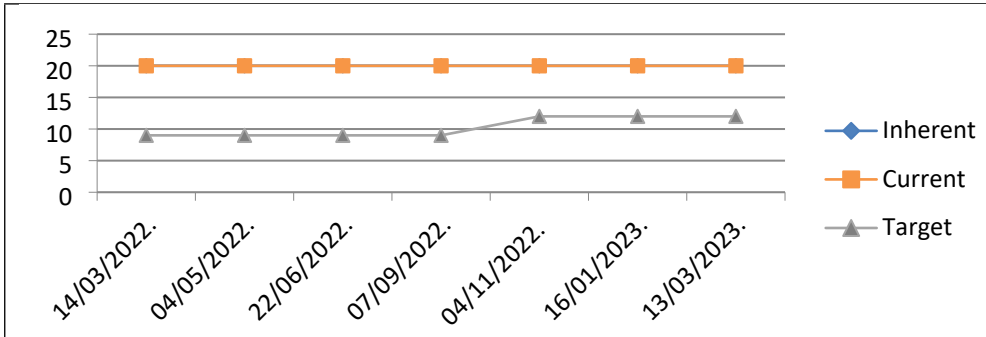
					submitted to the Executive Director of Nursing during March 2023.	

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:** 13 March 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: 30 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.



	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 January 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 Healthy 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. Developing North Wales planned approaches and accessing intelligence regarding access and uptake via the Elemental software. Progress will be reported via the Population Health	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

Group, Primary Care groups and via the Well North Wales Programme (including Partner organisations). 10. Lobby for long term investment in North Wales approach.	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.

Progress since last submission
1. Risk Title amended to reflect obesogenic environment. 2. 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. Business cases for weight services submitted as part of IMTP process. 6. Progress report to Welsh Government submitted reflecting use of prevention and early years weight funding. This will inform allocation for 2023/24. 7. Confirmed funding received from Welsh Government for 23/24 and 24/25. 8. Action ID 22377 – Action Closed, continue to offer the services, tier 3 children's obesity service with tier 2 adult's in place and looking expand the service. Range of ongoing projects within tier 1 funded through National funding streams as part of healthy weight, health Wales and prevention and early years programme, and have contributed to the development of the Public Health communications plan. 9. Identification of new action ID 24809 - Improve access to healthy and affordable food

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	22372	Together with regional partners and stakeholders implement a 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	On track

target risk score					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 providers etc. March 2023 progress update - Continue to work to programme plan	
	22373	Work with organisations and employers to promote 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	On track

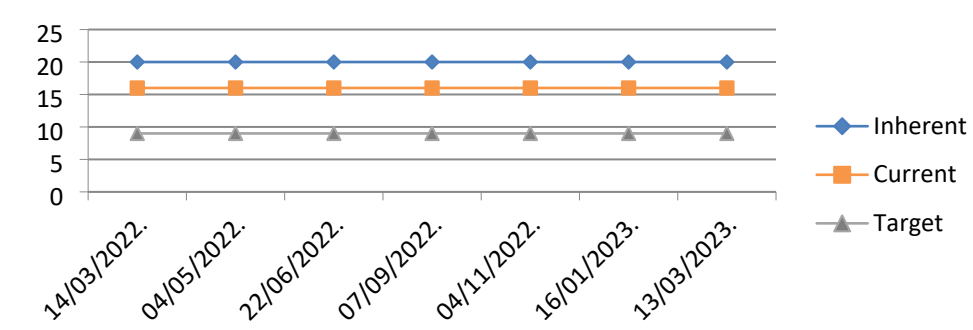
					away from work to prepare and eat a healthy meal. It is also crucial that the workplace supports their staff to remain active while at work as both diet and physical activity are crucial to achieving a healthy weight. March 2023 progress update - Continue to progress delivery as per plan	
	22375	Working with our local and national partners, optimise access to the natural environment and opportunities to be active	Ceriann Tunnah, Consultant in Public Health	16/01/2024	Increasing physical activity levels is crucial in supporting people to achieve and maintain a healthy weight. One way that we can 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	On track

					way of doing this is to optimise access through social prescribing. March 2023 progress update - Working with Actif Wales to promote activity. Social prescribing session with partners to look to develop a set of consistent measures across North Wales.	
	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	On track

					seek support to achieve and maintain a healthy weight.	
	22377	Weight management services	Ceriann Tunnah, Consultant in Public Health	31/03/2023	By ensuring those residents in North Wales who are overweight or obese can effectively access and engage with specialist weight management services working alongside the remaining whole system approach we will start to reduce the overall prevalence of overweight and obesity in North Wales. March 2023 progress update – Action closed, Continue to offer the services, tier 3 children's obesity service with tier 2 adult's in place and looking expand the service. Range of ongoing projects within tier 1 funded through National funding streams as part of healthy weight, health Wales and prevention and early years programme, and have contributed to the development of the Public	Completed

					Health communications plan.	
	24809	Improve access to healthy and affordable food	Ceriann Tunnah, Consultant in Public Health	31/3/2024	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. March 2023 progress update - Investment from Prevention and Early Years funds to provide mobile access to healthy affordable food.	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:** 13 March 2023
	Risk: There is a risk that those patients (children and adults) who are already overweight and obese will remain so, due to a lack of services and capacity within the specialist weight management treatment services delivered by BCUHB.	**Date of Committee Review:** 17 January 2023
		Target Risk Date: 31 December 2025
There is a risk that adults who are overweight or obese will not achieve a healthy weight. 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 January 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.	1. Risk is regularly reviewed at the Public Health Senior Management team meetings and at their local governance meeting.

3. A Level 2 adult weight management service offering a range of 12 week weight managemnt 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+ 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 managemnt 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 Manangement 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.. Business cases have been prioritised by the Population Health Executive Delivery Group, awaiting response from the Health Board in line with budget allocations. 6. Risk is reviewed and monitored at the Population Health Executive Delivery Group. 7. Draft plan for use of Prevention and Early Years funding targeted at weight services for 23/24 developed.

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	NEW	Implement the Adult and Children, Young People and Families All Wales Weight Management Pathways	Ceriann Tunnah, Consultant in Public Health	31/12/2025	Implementation of the weight management pathways will ensure that we have the different types of weight management services and the	On track

target risk score					required service capacity to meet the needs of those residents who are overweight or obese and want to access specialist support to help them achieve a healthy weight.	
	22357	Carry out a programme of Insight work	Ceriann Tunnah, Consultant in Public Health	31/03/2024	Insight work will enable us to improve outcomes for patients who were identified as overweight or obese. 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 i.e. patients achieving a healthy weight and adopting healthy behaviours	On track
	22358	Establish the 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.	On track

	22359	Together with informatics create a performance management dashboard for weight services	Ceriann Tunnah, Consultant in Public Health	31/03/2024	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 March 2023 progress update - Difficulty in obtaining data from all systems in use but working through this with IM&T.	On track
	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.	On track
	NEW	Identify sustainable revenue streams	Ceriann Tunnah, Consultant in Public Health	31/03/2025	Business cases Link in to IHC and service planning Lobby for national investment	On track

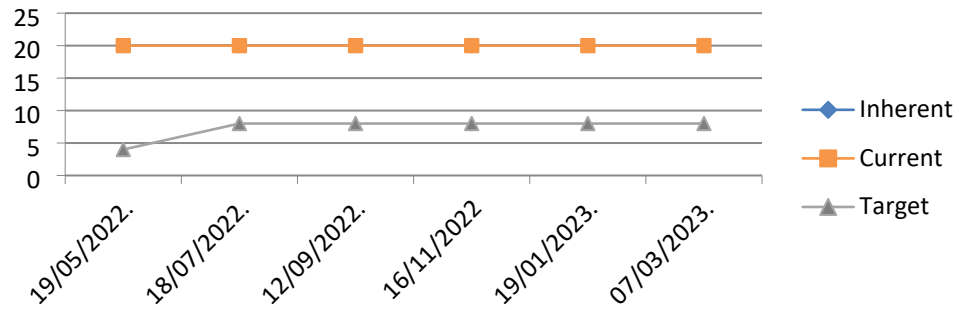
					March 2023 progress update - Continue to work to secure sustainable revenue however the indication for HB funds 23/24 is that there will be minimal if any investment – to be confirmed.	

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 March 2023
	Risk: Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** 20 January 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 January 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. 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.	The risk is reviewed monthly by the Resuscitation Services senior management team, and is presented to the Resuscitation committee on a quarterly basis. 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. 2. There is no dedicated training accommodation on the Central locality. This lack of 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 resuscition 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

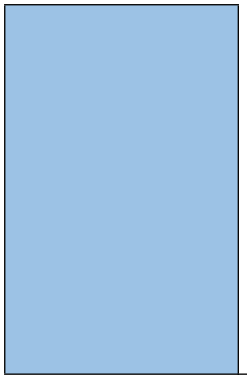
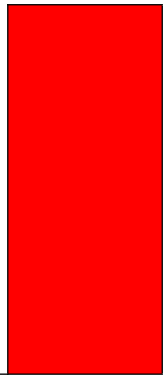
1. Controls in place reviewed to reflect current risk position.
2. Gaps in controls reviewed to reflect current risk position.
3. It is anticipated that following the resolution to the accommodation issues in the Central Region, the risk score will be reduced from current score of 20 to a score of 12, resulting in the risk being de-escalated from the Corporate Risk Register and managed at Tier 2 level.
4. 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.
5. Reporting to the Executive Medical Director on the progress of the risk response and training trajectory information continues.
6. Meeting took place with Integrated Health Community Central Team (IHC) with the Resuscitation Service to discuss proposals and IHC support in relation to accommodation on the Central site. The proposal is supported by the Executive Medical Director. Outcome of the meeting was that the IHC supportive in principle, however IHC felt this was something they would support Central HMT to deliver.
7. Meeting was held on the 22 February 2023 between representatives from Resus services, Planning team, and Director of operations HMT Central, Deputy Executive Medical Director to formalize the move and HMT agreement to move to the Laing o'Rourke site. HMT's preferred option is to locate Resus services and Vascular secretaries into the building, second preferred option for Resus services and the Track Trace Protect team to occupy the space. Senior Project Manager for Planning has identified potential slippage funding but this is time critical and requires written approval from HMT before the funding will be lost. Actions from the meeting were;

a. Deputy Executive Medical Director to discuss the continuation of CTU within the building with the Executive Director of Public Health and re-visit previous risk assessments. Action has now been completed.
b. Director of Operations HMT Central to confirm whether Vascular secretaries or CTU will occupy the space alongside Resus Services.
c. Director of Operations HMT Central to request written confirmation from IHC Director to support the additional capital spend required, without which planning cannot continue and slippage monies will be lost.
8. Action ID 19313 – Action delayed, quotation received awaiting funding from either IMTP or the IHC. Meeting planned with the Resuscitation Team and the Central site Integrated Health Community team to discuss allocation of funding and occupancy on site. No confirmation of the meeting in place.
9. Action ID 23208 – Action delayed, Approval from Integrated Health Community regarding the additional spend still awaited to allow the Estates works to take place.
10. Identification of new action ID 24769 - Decision on Co-occupancy services, 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.

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." March 2023 progress update - Quotation received awaiting funding from either IMTP or the IHC. Meeting planned with the Resuscitation Team and the Central site IHC team to discuss allocation of funding and occupancy on site. Slippage monies identified	Delay

					however, delays in decision to approve the spend will mean the loss of the slippage funding.	
	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. March 2023 progress update - Plans and costings received and shared, awaiting funding allocation. February 2023 progress update - Approval from IHC regarding the additional spend still awaited to allow the Estates 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.	On track
	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	Delay

					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.	

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:** 08 March 2023
	Risk: Inability to deliver safe, timely and effective care - Wrexham Emergency Department.	**Date of Committee Review:** 20 January 2023
		Target Risk Date: 09 January 2024

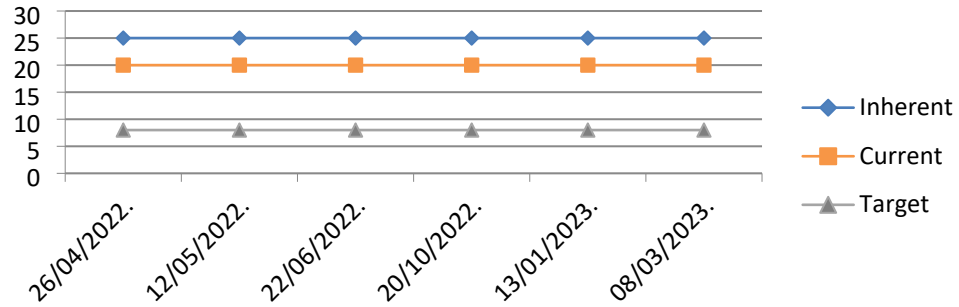
There is a risk that patients attending Emergency Department (ED) would not be able to receive timely, safe and effective care. This is caused by overcrowding and reduced physical capacity due to delayes to transfer of patients awaiting specialty beds. This could lead to:

• 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 January 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.	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 of occurred due to overcrowding.

Gaps in Controls/mitigations
1. Insufficient Capacity/physical environment to mitigate overcrowding, outpatients areas currently used for patients in the waiting room when minors are 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 model being developed that will re-direct patients to the relevant specialties upon presentation to the ED, expected to be operational by the end of April 2023. 6. Additional training for the Reception staff to support with highlighting red flag patients has been completed. 7. Action ID 20605 – Action delayed, Business case for additional Health Care Support Workers to be developed. 8. Action ID 21360 – Action delayed, additional capacity in place in relation to the Urgent Treatment Centre, however, consistent staffing not available to fully utilise the area, in use but not to full capacity. Daily reviews of availability to use the area based on available staffing, recruiting to Nurse vacancies that will support more consistent use of the area 9. Action ID 23002 - Action remains delayed due to the need to remove the pods from AMU assessment which will increase the patient co-hort that can be directed to this area. Due to site pressures the surgical SDEC becomes bedded therefore restricting the ability to direct patients to the area. Pods are being removed from AMU Assessment week commencing 6th March 2023, following the work to remove pods elsewhere on site this will allow the ring fencing of 2 trollies to increase the number of GP referred patients directed to AMU, expected to be in place by the end of March 2023.

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. March 2023 progress update - Business case for additional Health Care Support Workers to be developed.	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. March 2023 - additional capacity in place in relation to the Urgent Treatment Centre, however, consistent staffing not available to fully utilise the area, in use but not to full capacity. Daily reviews of availability to use the area based on available staffing, recruiting to Nurse vacancies that will support more consistent use of the area.	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 March 2023 progress update - Pods are being removed from AMU Assessment week commencing 6th March 2023, following the work to remove pods elsewhere on site this will allow the ring fencing of 2 trollies to increase the number of GP referred patients directed to AMU, expected to be in place by the end of March 2023. Streaming to support improved direct referrals of patients to the specialities is expected to be in place by the end of April 2023.	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.	On track

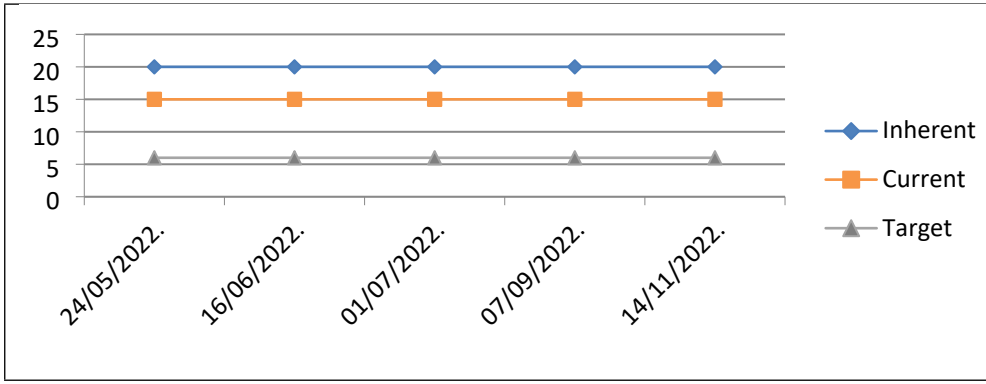
					March 2023 progress update - Unscheduled care Improvement Group has been established that includes Community and Local Authority representatives which reviews the unscheduled care patient pathway and the group is focused on improvements to reduce demand at the front door and supporting improved discharge.	

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:** 08 November 2022
		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 July 2022	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**	Completed

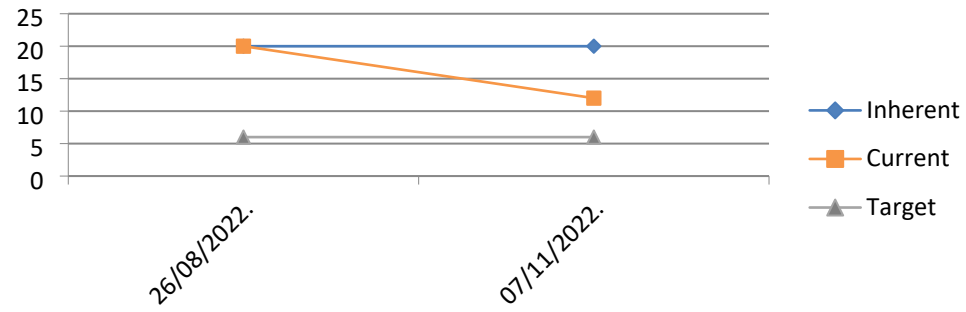
					All substantive posts holders have been appointmented. Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	
	23334	Set-up internal selection process for Senior Nursing posts (format, panel representation).	Lesley Hall, Assistant 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	Completed

					November 2022 progress update Selection and appointment process now complete.	
	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	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**	Delay

		posts (format, panel representation) (If required).			Suitable candidate not identified. Post to renamed Chief Operating Officer and re-advertised.	

CRR22-25	**Director Lead:** Executive Medical Director	**Date Opened:** 20 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of failure to provide full vascular services due to lack of available consultant workforce	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023

There is a risk that there will be delays in the delivery of emergency, urgent and routine care for vascular patients.
This is caused by to lack of consultant workforce which has impacted on services recently and meant only emergency and urgent services can be provided for a short period of time. Business Continuity plans are not adequate to mitigate and patients may need to be transferred NHS England for the the provision of urgent and emergnecy services.



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	4	3	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 - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1. There are business continuity meetings occurring (between 3 and 5 times weekly) with all relevant operational teams 2. Action plans and decision logs are being maintained and reported to Exec Team daily. 3. Consultant Workforce Rotas are monitored on a daily basis forecasting risks and mitigations put in place	1. Regular review through the 3-5 times weekly vascular operational planning meetings (which feed directly to the Executive Medical

4 records of cancelled procedures are being kept and the risk of patient harm due to those cancellation being monitored. 5. External communication to Community and Primary Care outlining management and referral of routine, urgent and emergent patients 6. Further contingencies are being planned for potential additional complications which may lead to diversion of services to NHSE, including the number of emergency and urgent patients 7 Daily Monitoring of gaps in rota. (Consultant rota as normal from 01/08/2022) from 01/08/2022 Agency Locum commencing to support 1 x long term sickness, restricted practice and dual operating. 8. Further contingency to be agreed with Executive Medical Director in relation to diversion of potential aortic emergency to another Organisation.	Director and be reviewed via Quality, Safety and Experience Committee.

Gaps in Controls/mitigations
1. There is diminished resource across operational, governance, network and clinical teams in order to maintain any traction on day to day service running, planned improvements, action plans, and transformational change in addition to this work.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Proposal to extend the target risk date from the 31/10/2022 to the 31/03/2023 to allow sufficient time for building a contingency plan with NHS England to support the provision of Vascular Services. 3. Proposal to de-escalate the risk from the current score of 20 (consequence 5 x Likelihood 4) to a score of 12 (Consequence 4 x Likelihood 3) and the risk to be managed at a Tier 2 level. Since the escalation of the risk where the workforce was diminished due to sickness and annual leave, the service is now running at full capacity with 6 permanent consultants in post and 3 locum consultants in addition, the middle grade tier has been established to cover 9am to 5pm, across the sites 7 days a week. For YGC from Monday the 14th November 2022 there will be 24/7 cover of middle grades. 4. Action ID 23819 - Action closed, business continuity meetings have been running with gold command structure to ensure safe provision of service. These will be stepped down with Executive approval in November 2022.

5. Action ID 23999 - Action closed, this is managed as business as usual through surgical operation team processes.
6. Action ID 24000 - Action closed, dual on call for AAA continues in the event that Vascular service cannot provide dual on call, patients who require urgent or emergency AAA surgery would be transferred to Stoke Hospital. Complex surgery continues to be provided by Liverpool Vascular Services.
7. Action ID 24001 – Action delayed, The service is now able to provide a full Vascular service with 9 doctors working at Consultant level, work continues in building a contingency plan with NHS England to support the provision of Vascular Services and to build partnerships with larger Vascular service in England to ensure a more sustainable future service. Anticipated to have an agreed support through NHSE by 31/03/2023.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	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	23819	Develop local business continuity plans with Hub and Spoke Site Directorate Managers	Mrs Elaine Hodgson, Deputy Directorate General Manager	26/07/2022	Action closed 07/11/2022 Provide appropriate escalation and plans to mitigate risks Work is in progress, all three General Managers across each site are currently working on the business continuity plan. October 2022 progress update - Action closed. Business continuity meetings have been running with gold command	Completed

					structure to ensure safe provision of service. These will be stepped down with Executive approval in November 2022.	
	23999	Daily review of all overdue patients to ensure urgent patients are recognised and discussed with clinicians to ensure no harm due to delay in treatment	Ms Jenny Farley, Vascular Network Director	31/08/2022	Action closed 07/11/2022 Ongoing daily reviews to ensure no harm due to delay in treatment October 2022 progress update - Action closed. This is managed as business as usual through surgical operation team processes.	Completed
	24000	Chief Medical Officers Meetings with HB Executive Medical Director to discuss where support can be offered from in the event of inability to provide emergency and time critical care.	Ms Jenny Farley, Vascular Network Director	31/08/2022	Action closed 07/11/2022 Agreement with Liverpool (LiVES) Vascular services to support MDT decision making to ensure patients are prioritised Work in progress with Stoke Hospital to receive Urgent and Emergency Patients if required. October 2022 progress update - Action closed. Dual on call for AAA continues in the event that Vascular service cannot	Completed

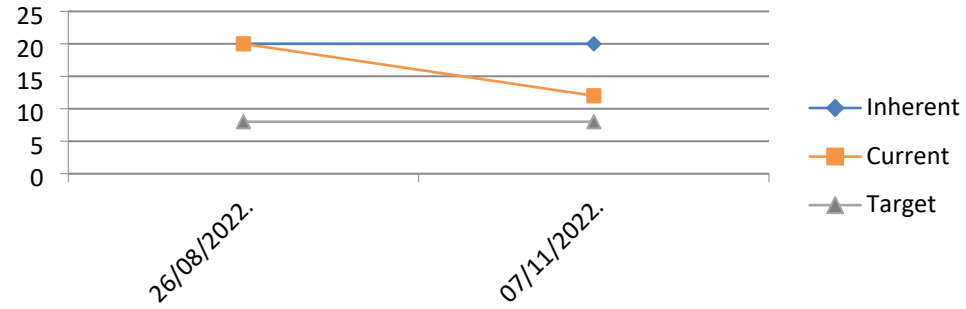
					provide dual on call, patients who require urgent or emergency AAA surgery would be transferred to Stoke Hospital. Complex surgery continues to be provided by Liverpool Vascular Services.	
	24001	Identifying all vascular patients on the waiting lists and prioritising in the event of all day-case and outpatient services need to be transferred out to England	Jenny Farley Vascular Netwrok Director	31/08/2022	The service is now able to provide a full Vascular service with 9 doctors working at Consultant level. 3 x weekly meetings with each site to report any urgent or time critical patients that require escalation for clinical intervention. October 2022 progress update. Exec approved data has been provided to NHSE and work continues in building a contingency plan with NHS England to support the provision of Vascular Services and to build partnerships with larger Vascular service in England to ensure a more sustainable future service. Anticipated to have an agreed support through NHSE by 31/03/2023.	Delay

CRR22-26	**Director Lead:** Executive Medical Director	**Date Opened:** 29 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of significant patient harm as a consequence of sustainability of the acute vascular service	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 December 2022

There is a risk that the acute vascular service may not be sustained.

This is caused by a reduction in the consultant workforce (sickness/vacancies) and the need for dual operating which requires two consultants to be available on call 24/7.

This could impact on the safety of care for time critical patients.



	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 - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1.Reintroduction of dual consultant operating (for aortic patients only) 2.Implementation of a focussed recruitment plan 3. Enhanced MDT oversight by a specialist centre. 4.Implementation of the vascular improvement plan (following Royal College of Surgeons review) 5.Contingency planning should the staffing levels fall below acceptable levels (maximising non consultant roles to support patient care and the use of agency) 6.Ongoing risk assessment of the waiting list in line with clinical priority 7. Work in progress to out-source time critical patients including renal.	1. Additional support during the AAA operation to limit risk of complications 2. Reduces the reliance agency locums and doctors without a consultant level qualification 3. Ensures that expert skills are agreeing on the most effective procedures for patients and timely decision making, and record keeping 4. Evidences the RCS recommendations are being actioned 5. Ensures Operational Team are fully aware of the patients to prioritise for emergency or time critical transfers to other hospitals and which patient conditions can be managed safely by other vascular/renal/diabetic teams internally. 6. Ensures that patients are prioritised on their clinical need and the most urgent patients waiting time deadlines are adhered to for timely treatment 7. Prevents delays to time critical treatments.

Gaps in Controls/mitigations
1. High sickness and annual leave reduces the ability for dual operating and potentially short notice 2. Poor reputation of service makes recruiting to consultant posts challenging, plus geography of the Health Board 3. Delays in patient decision making when insufficient MDT members attend the MDT 4. 100 + actions, plus actions from the Vascular Quality Panel review, insufficient workforce to support the delivery of the actions in a timely manner

5. May happen at such short notice that immediate transfer of emergency and urgent patient is required with limited notice for NHS England providers 6. Waiting List size significant post Covid, with little capacity to manage anything other than emergency and time critical urgent patients

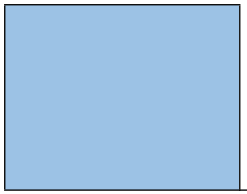
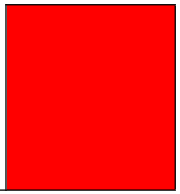
Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Proposal to de-escalate the risk from the current score of 20 (consequence 5 x Likelihood 4) to a score of 12 (Consequence 4 x Likelihood 3)and the risk to be managed at a Tier 2 level. Since the escalation of the risk where the workforce was diminished due to sickness and annual leave, the service is now running at full capacity with 6 permanent consultants in post and 3 locum consultants in addition, the middle grade tier has been established to cover 9am to 5pm, across the sites 7 days a week. For YGC from Monday the 14th November 2022 there will be 24/7 cover of middle grades. 3. Action ID 24007 – Action delay, business continuity plans contiune through the gold command structure, vascular service now fully supported by 9 consultants (6 permanent and 3 locum posts) in addition, 7 day middle grade rota in place across all 3 sites with plans form the 14th November to have 24/7 cover for the hub site. 4. Action ID 24009 – Action delay, Contract agreed with Stoke in the event that the Health Board Vascular service cannot provide time critical AAA treatment. Permanent contract negotiations are ongoing in addition to the established contract with Liverpool Vascular Service.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	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**
	24004	Additional funding requested to ensure	Ms Jenny Farley,	31/12/2022	All consultant vacancies recruited to (with the exception	On track

Actions being implemented to achieve target risk score		effective medical and therapy workforce model	Vascular Network Director		of the CD post interviews august 2022) Ensures consistently safe patient care across all three sites. Reduces the reliance on agency workforce October 2022 progress update - IMTP has approved £5.8m funding for Vascular and Diabetic services which will enhance the current workforce, recruitment has commenced.	
	24006	Vascular Improvement Plan lead in post and Vascular Network Director in post for wider transformation	Ms Jenny Farley, Vascular Network Director	31/12/2022	Supports the co-ordination of actions needed to deliver against the recommendations. Ensures regular updating of the improvement plan Longer term transformation of the services for stability October 2022 progress update - Vascular network team now includes nursing governance operational transformational interim support until the 31/03/2023, 9 vascual consultants, 7 day cover in place for middle grades across all 3 sites.	On track

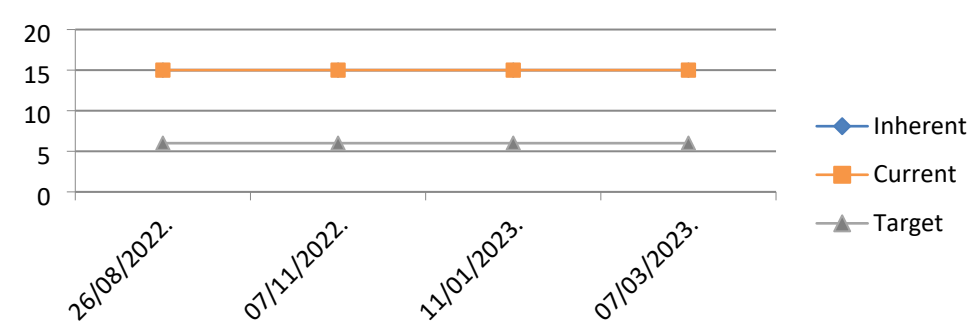
	24007	Business Continuity planning in place	Mrs Elaine Hodgson, Directorate General Manager	30/09/2022	Ensures all risks are identified and mitigated to support patient safety, enables immediate response to crisis Away Day agreed for the 16th September to complete business continuity plan . October 2022 progress update - Business continuity plans contiune through the gold command structure, vascular service now fully supported by 9 consultants (6 permanent and 3 locum posts) in addition, 7 day middle grade rota in place across all 3 sites with plans form the 14th November to have 24/7 cover for the hub site.	Delay
	24009	Working with NHSE to support the potential transfer of time critical patients to other service providers	Ms Jenny Farley, Vascular Network Director	30/09/2022	Ensures treatment of time critical patients Will help to develop a future service model to include service provision in England. October 2022 progress update - Contract agreed with Stoke in the event that the Health Board Vascular service cannot provide time critical AAA treatment.	Delay

					Permanent contract negotiations are ongoing in addition to the established contract with Liverpool Vascular Service.	

CRR22-27	**Director Lead:** Executive Medical Director	**Date Opened:** 31 January 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 March 2023
	Risk: Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services.	**Date of Committee Review:** 20 January 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	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 January 2023	unchanged		

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 desmonstrated a significant improvement in the standard of record keeping	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

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. 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.	Experience Committee, and then Board

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
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. 5. Governance Admin Assistant post funded, recruitment still pending, candidate identified awaiting funding transfer. 6. Consent training for Medical Staff planned for end of March 2023. 7. Action 22282 – Action delayed, following the Vascular quality panel and recommendations an action plan as been developed with clear actions and timeline for delivery, this will be merged with the Vascular improvement plan in line with targeted intervention and special measures. 8. Action ID 24076 – Action delayed, CITO pilot continues.

9. Action ID 24078 – Action delayed, reviewed at the end of February 2023, initial approach was not deemed suitable and requires a multi-disciplinary documentation approach to ensure holistic communication between all ward teams. 10. Action ID 24079 – Action delayed, recruitment in progress, internal candidate will likely be appointed subject to funding arrangements.

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 requirements. The RCS action plan is informed by 2 stages of RCS review, NVR report and internally identified issues.	Delay

					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. March 2023 progress update – Following the Vascular quality panel and recommendations an action plan as been developed with clear actions and timeline for delivery, this will be merged with the Vascular improvement plan in line with targeted intervention and special measures. Continue to audit clincal records and monitor each action on the vascular improvement plan on a weekly basis, by the Vascular Network Team.	
	24076	Pilot CITO as part of MDT	Mrs Zoe Taylor, Clerical	31/10/2022	To ensure legible documentation. Enhancing security and patient data	Delay

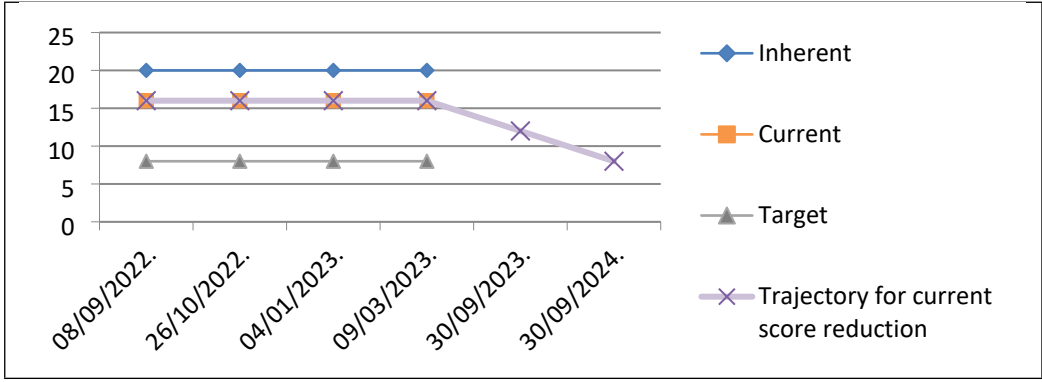
			Services Co-ordinator		storage March 2023 progress update - CITO pilot continues.	
	24078	Ward Teams working with Patient Experience teams to develop holistic communication processes for documentation and for sharing with patients	Mrs Deoborah Stones, Practice Development Nurse	31/10/2022	Will ensure holistic approach to patient care, will improve communication March 2023 progress update - Reviewed at the end of February 2023, initial approach was not deemed suitable and requires a multi-disciplinary documentation approach to ensure holistic communication between all ward teams.	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 March 2023 progress updated - recruitment in progress, internal candidate will likely be appointed subject to funding arrangements.	Delay
	24592	Appointment of an MDT admin support	Ms Caroline Sarah Elizabeth Hogbin, Site	28/04/2023	Ensure all documentation is completed nad collated form the meeting setting out actions and next steps for patient care. It releases Medical staff	On track

			Specialty manager		from admin duties to focus on patient care. and ensures timely completions of all actions following ther MDT meetings.	
	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 recruittment to start as soon as possible	On track

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: 0**9 March 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 (Infected Blood Enquiry/Covid) 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 January 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. 2. Chairs assurance report from 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 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. 6. New scanning and destruction provider Storetec in place, ISO 9001 accredited who are beginning to scan records directly into the CiTO records management system. 7. Standardised and consistent quality approval processes and procedures in place with Concerns Team for the sending of patient information. 8. 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.	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. Lack of local ability to destroy records post retention period due to national inquiry embargos. Following confirmation from the National Blood Inquiry, the destruction embargo for records has now been lifted. A destruction process and plan is in development, with the Health Records Team looking to implement from 1st April 2023, ensuring appropriate governance and authorisation is followed. 3. 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. 4. Lack of digital systems in place, CITO programme underway to implement an electronic document patient record and integration with National systems. 5. Lack of funding to support a programme management approach to scan records before destruction can take place (as permitted by the National Blood Inquiry) 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. 4. Action ID 24372 delayed due to progress with YGC Site and Project Leads to secure suitable storage space on the Ysbyty Glan Clwyd site. 5. Action ID 24378, action due date brought forward as this is now achievable. 6. Action ID 24381, action delayed, new roof in Wrexham completed, new floor laid in Ablett, only outstanding area is the future secure storage in Ysbyty Glan Clwyd. 7. Identification of new action ID 24794, Process and Plan for the destruction of records following lifting of embargos to be developed and implemented ensuring governance and approval routes identified. Currently aiming to achieve target risk score within agreed timescales dependant on securely suitable fit for purpose records storage on the YGC. Communications on going to establish Ablett Unit Project Lead to ensure health records form part of the working group for the future project plans.

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	24372	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose'	Mrs Nia Aspinall, Head of Patient Records and	31/01/2023	Formally action ID 12429 from risk CRR20-06. Mental Health Business case	Delay

		file libraries for legacy paper records.	Digital Integration		has been agreed, further discussion ongoing with Estates to secure current accommodation for patient records. March 2023 progress update – Estates confirmed contact needs to be through YGC Site Management and / Ablett Project Leads. Discussions continue to be ongoing.	
	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 March 2023 – Meeting held on the 26/10/22 with Integrated Clinical Services Leads whereby funding for a programme lead was declined. Work is continuing on an adhoc basis to pull streams of work together where possible.	On track
	24378	Immediate review of the patient record policies, standard operating procedures and the associated delivery of	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	On track

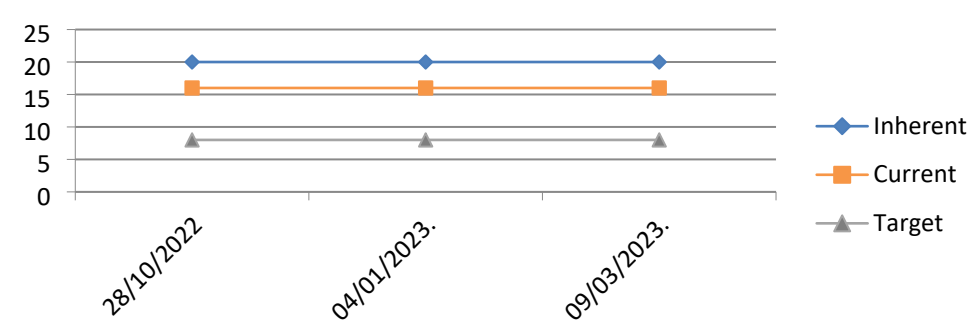
		training and awareness to improve integrity.			and raising awareness amongst staff. March 2023 – Progress update, policies and procedures updated, training and awareness programme awaiting final approval before implementation.	
	24379	Review all files and utilise off site storage for files due for destruction.	Nia Harrison, Health Records Manager	31/03/2023	Will increase the storage capacity onsite. March – Programme of work in place to move inactive records to offsite to improve the management of active records on site. This will be completed by the end of March.	On track
	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. March 2023 – progress update – work completed, with implementation of remedies underway.	On track
	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. March 2023 progress update – remaining reassessment of	Delay

					portacabins on YGC site to be completed. Reassessment of Bryn y Neuadd File library to also be undertaken.	
	24382	Project to be set up to look at back record conversion of Patient records via scanning technology.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2024	Provide digitalised copies of records and reduce facility requirements of patient records. Ability to meet our legislative and Health and Safety responsibilities along with reputational damage and reduce any fiscal penalties. March 2023 – progress update – following the rejection of the additional resource, this will now be picked up as a task and finish group action led by Patient Records.	On track
	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.	On track

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:** 09 March 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 January 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 been 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 patient records. 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. This is currently at a standstill due to the lack of funding to support a programme management approach for the single source of truth, therefore adhoc changes currently happening in line with the national direction.

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. Gaps in controls reviewed and updated to include the impact of the National Blood Inquiry and alternative solutions in development due to increasing significant cost pressures to support storage of records which could be destroyed. 3. 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. 4. Updates to actions have been incorporated. 5. 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.

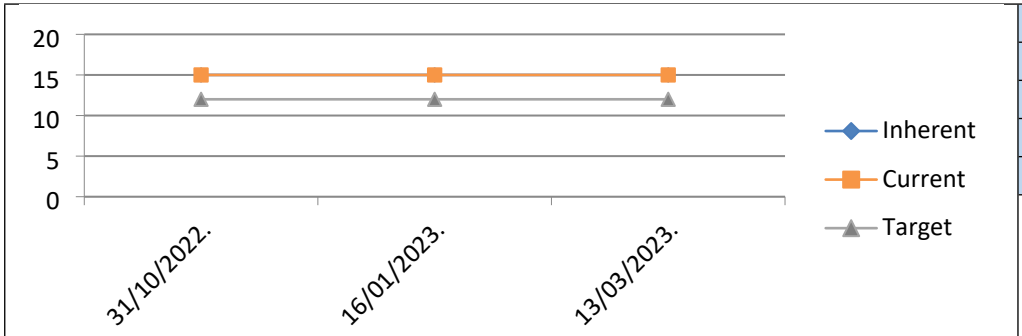
Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

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. March 2023 – progress update – currently being undertaken on an adhoc basis by Patient Records,	On Track

					also looking at the individual costs to scan certain types of records for example Covid related records.	
	24327	Following completion of the Baseline assessment of the location of all records, a review and recommendations will be developed and presented Partnerships, People and Population Health Committee.	Nia Aspinall, Head of Patient Records and Digital Integration	01/04/2024	The action will identify all locations of record storage, with the intention to provide a greater level of assurance with standards and compliance. March 2023 – progress update – currently ongoing and linked to the work undertaken with the Local Site Managers.	On Track
	24328	Undertake a review of national systems to ensure these can be integrated in the Health Board's CiTO System.	Angharad Wiggan, 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. March 2023 – progress update – CITO commencing work to link into National Systems, for example WPAS and WCP. Specifications for integration being written for WCP, currently final draft. Integration with other system specification integration in progress.	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:** 13 March 2023
	Risk: There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	**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 January 2023	unchanged		

Controls in place	Assurances
1. Continuation of the HMQ for Baby Service with additional investment from Prevention and Early Years 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.	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.

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 for 2 years, 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.

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. Work has commenced in relation to 'No ifs No Butts' and working with Trading Standards. Arts in health work with registered local landlords has identified local housing associations to work with regarding use of arts in health as a mechanism for reducing smoking by residents. Pharmacy and smoking cessation is near completion (improving communications regarding Help Me Quit). Recruitment for remaining posts continues. 4. Action ID 22820 – Action Closed, we are now commencing review of communications plan in 23/24 4. Action ID 22823 - Action delayed, Progressing recruitment plan to appoint to remaining vacant post, one post outstanding. 6. Action ID 22825 – Action delayed, Estates continue to review possible accommodation at main sites. 7. Action ID 24230 – Action delayed, Plan for 23/24 under review. Will provide full update in April 23 regarding this specific action. 8. During March 2023 an audit is taking place to review Health Board compliance with smoke free sites regulation.

10. Draft plan for use of Prevention and Early Years funding targeted at reducing smoking for 23/24 developed.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

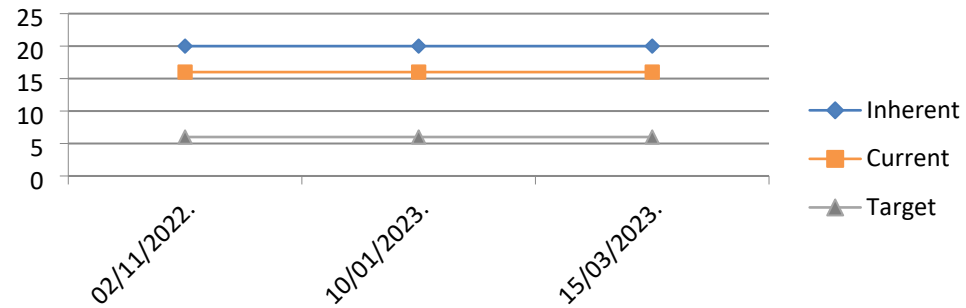
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	22820	Communication - social media HMQ	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Encourage smokers to access services and quit A communications plan has been developed for this year, and there has been on going communications activity since April regards the mental health legislation update which came into force on 1st September, this communications work with staff, patients and the public is ongoing in light of the recent changes. March 2023 progress update – Action Closed, we are now commencing review of communications plan in 23/24	Completed

	22823	HMQ Services Strengthening the Service	Mrs Gwyneth Page, Public Health Assurance & Development Manager	30/12/2022	Encourage smokers to access services and quit March 2023 progress update - Action delayed, Progressing recruitment plan to appoint to remaining vacant post, one post outstanding.	Delay
	22825	HMQ Services - Accommodation of staff	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/12/2022	Encourage smokers to access services and quit March 2023 – Estates continue to review possible accommodation at main sites	Delay
	24230	Primary Care Project (EAST Managed Practices)	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Engaging with smokers through local GP practice to encourage interaction with service and quit attempts. March 2023 progress update - Plan for 23/24 under review. Will provide full update in April 23 regarding this specific action.	Delay

CRR23-35	**Director Lead:** Executive Director of Finance	**Date Opened:** 19 November 2018
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 March 2023
	Risk: Electrical and Mechanical Infrastructure on the Wrexham Maelor Site	**Date of Committee Review:** 20 January 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 unresourced 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

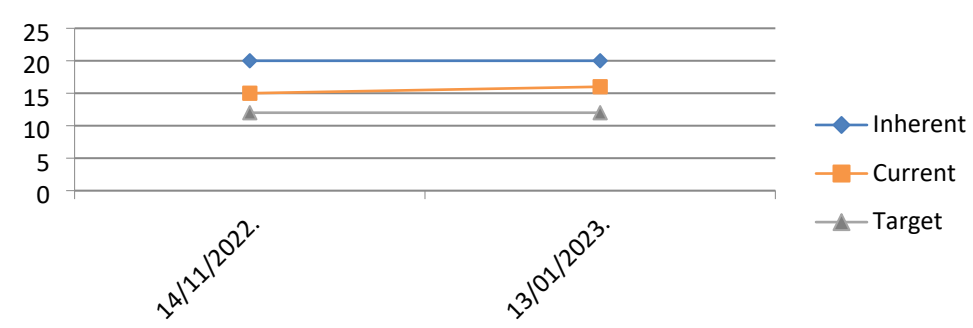
	24348	Phase 1 Continuity Scope of Works - Nurse Call including Emergency and Panic Alarms	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace the Nurse call and Panic Alarms to all wards within the YMW site.	On track
	24349	Phase 1 Continuity Scope of Works - Heating Calorifiers and Roofing Works	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:** 13 January 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 January 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 January 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 for this year do not have sufficient controls. 4. Senior Management Team – Care Providers. Membership and Terms of Reference under review 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 Improvement Group – October 2022 (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. Webinars are being arranged to provide information prior to release. This has now been further delayed due to legal challenge from Care Forum Wales (1st Feb 2023) 2. Financial overspend of £1.6m at month 5: Commissioned providers are experiencing high costs of care, which they continue to pass to commissioners on a case by case basis outside of regional fee agreements. Regional LA fees have been uplifted mid year which has eroded the CHC enhancement we have always paid. Clarity on the HBs position and the potential financial

impact to the HB is still unclear as there are ongoing challenges from both LAs, Providers and Legal challenge from Care Forum Wales. Challenges include care home fees, top ups and the inadequacy of the national agreement for Funded Nursing Care
3. 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.
4. 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
5. Delivering the Older People's Care Home Placements Audit Wales recommendation four - to develop a regionally agreed care home commissioning strategy and associated delivery plan. Workshop has been held with the LAs (September 2022) and an action plan is being developed which will need sign off by the RCB.
6. 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.
7. 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).
8. 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.
9. 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.
10. 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).
11. BroadCare - Finance teams are working to develop more efficient back office functions with BC functions to remove unnecessary manual processes.
12. Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & Safety Corporate Risk)

13. 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.
14. 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.
15. Closure of Care Homes due to business sustainability and safety and quality issues – resourse from corportate CHC team, Contracting and operational teams are unable to meet the level of support required.

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. Identification of six new actions following the revision of the risk. 4. Action ID 24614 – Action delayed, Presented to Executive Team in December with further work requested by the Executive Team, work ongoing, anticipated delay on the action due date to the end of February 2023.

Links to	
Strategic Priorities	**Principal Risks**
Primary & Community Care Improved USC (Unscheduled Care) pathways	BAF21-03

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
	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	30/06/2023	1) Establish a Task and Finish group under the Regional commissioning Board to take this work forward	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 & CHC Commissioning	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 implementation including financial and flow risks January 2023 progress update – Presented to Executive Team in December with further work requested by the Executive Team, work ongoing, anticipated delay on the action	Delay

					due date to the end of February 2023.	
	24615	Full implementation of the Pre-Placement Agreement (PPA) (Gap / control No. 1)	Kath Titchen, Commissioning Manager CHC	31/03/2023	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? Feb 2023 progress update – A series of Webinars have been arranged for care providers as part of issuing the PPA. Legal Challenge from CFW on 3 sections of the PPA which has resulted in a further delay – completion date under review	Delayed
	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	1) Draw down funding from IMPT to commence implementation including addressing CHC, Contracting, IT support 2) Via the CHC Improvement Group agree medium and longer term way forward	On track

					3) Confirm arrangements for where this sits as part of the Operating Model (Commissioning / Contracts / Finance) January 2023 progress update – Funding not released, however, continues to be pursued. Discussions on going with Executive team on where CHC sits as part of the Operating Model. Awaiting confirmation .	
	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 January 2023 progress update – Block purchasing of additional community capacity had limited	On track

					success (Commissioned 21 beds out of an anticipated 60). Process under review.	
	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. January 2023 progress update – Training programme reviewed and improvements implemented for the training programme (Point 1 above has been completed).	On track

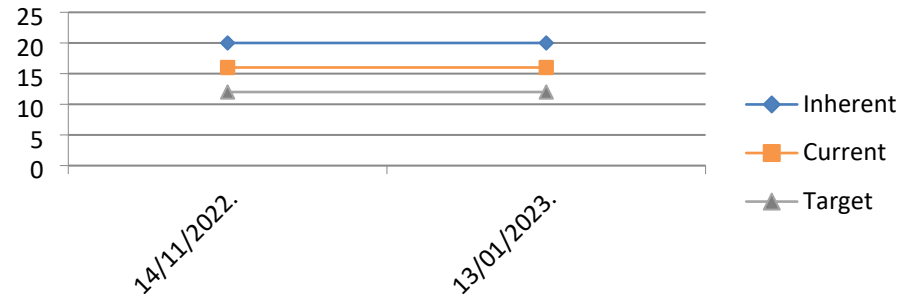
	24619	CHC framework – Individual Units/Trusts no nationally agreed process for implementation (Gap no. 14). Health Board to develop a process for handling and managing any requests	Kath Titchen, Commissioning Manager CHC	30/07/2023	Patients / family who are entitled to CHC funding under an IUT. This 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:** 13 January 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 January 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 January 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 in draft (subject to ratification by the Health Board and 6 Local Authorities by October 2022). Urgent demand and capacity work in progressed as part of the DU work on increasing community capacity to meet winter pressures (243 placements for North Wales). 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. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. Work ongoing with IT and Performance to develop digital system which is currently being piloted. This will provide a more robust system of data collection, including delays by Local Authority – this will link with national work on Pathways of Care Delays

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: A breakeven at least business recovery proposal has been submitted and approved by Health Board Leadership Team.
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 24626 – Action delayed, Guidance still not issued but is imminent. 4. Action ID 24627 – Action delayed, Regional workforce board was cancelled on the 14/11/2022, awaiting further dates. Representation of care home quality team is now on the Board. Established a workforce improvement group as part of the Quality Assurance Framework.

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	On track

					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 courses in Llandrillo college 5) Monthly Provider brief to update on key issues, developments and training 6) Draft service specification for care providers January 2023 progress update – Draft service specification for care providers is now available and engaging with Local Authority parties on the content. Additional support to residential care homes has been delivered as part of increasing community capacity and winter pressures.	
	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	On track

					2) Establish Implement programme 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. January 2023 progress update – reviews to commence during February 2023 Subject to Data Protection, Information Governance and contract agreements. Full implementation plan available.	
	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 January 2023 progress update – 15 care homes identified as part of the pilot. GP and care home engagement	On track

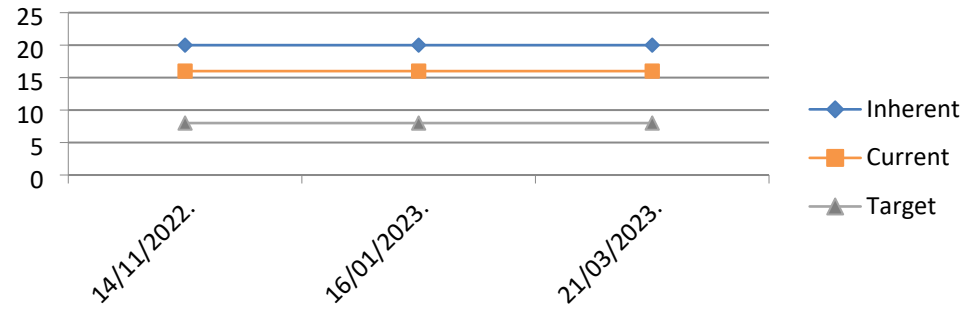
					commenced, go live by the end of February with the pilot.	
	24624	Increasing Community Placements – Winter Pressures, including improving access to Domiciliary Care (Gap/control no. 1, 8)	Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2023	1) Fortnightly meetings with DU and LAs 2) Delivery plan with monthly trajectories 3) Develop service specification for block purchasing beds in care homes to support flow 4) Develop pipeline schemes to further support winter pressures 5) Identify what works well and scale across North Wales January 2023 progress update – Block purchasing of additional beds was not successful as anticipated (21 out of 60 beds achieved). Further work ongoing to understand why care providers have not taken up this offer.	On track
	24626	Review and update Health Board Discharge policy. (Gap/control No. 12)	Ms Jane Trowman, Acting Assistant Director Care Homes	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 is due	Delay

			Support & CHC Commissioning		to be issued November 2022, and full national launch in Jan 2023. Reminders to the operational teams have been issued to 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. January 2023 progress update – Guidance still not issued but is imminent.	
	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. January 2023 progress update - Regional workforce board was cancelled on the	Delay

					14/11/2022, awaiting further dates. Representation of care home quality team is now on the Board. Established a workforce improvement group as part of the Quality Assurance Framework.	
	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) January 2023 progress update – Management action plan reviewed at monthly Senior Management Team.	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 January 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. 3. Continuous modelling of AMD waiting time BCU to inform additional Super-Saturday and Twilight Clinic requirements and Pan BCU Mutual Aid.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care Collaborative Group and 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)

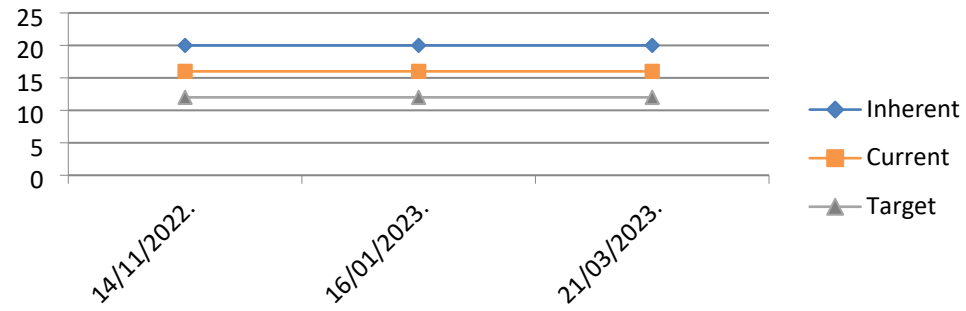
Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways Strengthen our wellbeing focus	BAF21-02 BAF21-04

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 January 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 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.	1. Monthly report to Operational 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 Treatment Centres (ODTC)	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 requested from sites for progress.	Delay
	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-	Delay

					assurance against Governance (information/confidentiality compliance checks within systems) this is outstanding Nationally preventing local go-live.	
	24652	Review and assure consistent flow of patients to P-ODTCs (Primary Care Optician Diagnostic and Treatment Centres)	Paula Betts, Lead Manager - Surgical (Central)	31/12/2022	-Assure maximum utilisation of contracted capacity -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.	Completed

	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 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.	Delay
	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	31/03/2023	-Enable delivery of an Integrated Training Plan: to best assure increased "pool/cohort" of Non-medics with Higher qualifications/competencies to	Delay

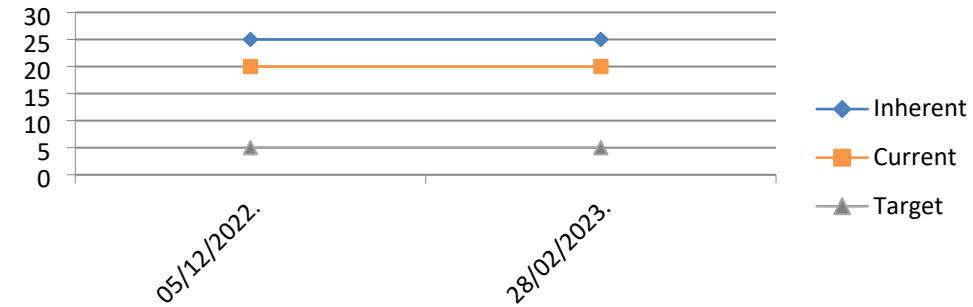
			Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central		enable extension of “Integrated Workforce” March 2023 progress update – Primary Care Optometry scope completed. Conflicting site priorities have led to stand down of eye care network meetings delaying progression of 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).	Delay

					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 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	On Track

					to be confirmed by Welsh Government prior to April 2024).	

Appendix 2 – Newly Escalated Risks

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:** 28 February 2023
	Risk: Pathology Laboratory Information Management System (LINC)	**Date of Committee Review:** 20 January 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 – New risk not presented to Board	New Risk		

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 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.	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. 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.

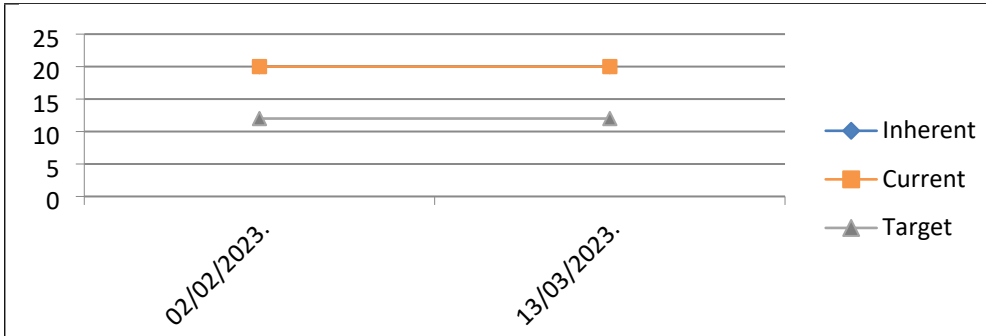
Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Pathology continuing to engage with the National Project. 4. Deployment plans shared, however, the Health Board has not yet seen the system. 5. Action ID 24498 - Action target date proposed change from the 1/2/2023 to the 30/9/2025.

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. February 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. Proposed change to the action target date from the 1/2/2023 to the 30/09/2025 due to national programme managing the project and not lead by the Health Board.	On track

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:** 13 March 2023
	Risk: Risk to patient and staff safety due to Industrial Action	**Date of Committee Review:** New risk
		Target Risk Date: 30 April 2023

There is a risk that pt and safety 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 in order to assess the impact from Workforce nursing and IHC perspectives. 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.Conducted 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. 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 an 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. 3. Business Continuity plans needs to be exercised more regularly.

Progress since last submission
1. Held a business continuity exercise on the 15th November 2022 in specific response to a loss of key staff due to industrial action. 2. Providing a series of business continuity training workshops in 2023. 3. More Senior staff engagement with business continuity process. 4. RCN ballot has not supported the WG pay and conditions offer, thefore the risk of IA continues. As a result, proposal to extend the target risk due date and actions due dates from the 31/03/2023 to the 30/04/2023.

Links to	
Strategic Priorities	**Principal Risks**
Primary and community care Making effective and sustainable use of resources (key enabler)	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
	24679	redeployment of corporate services to support operational delivery	Mrs Christine Lynes, Deputy Executive Director of Nursing	30/04/2023	The additional staff that will be released from training and corporate services will be redeployed to support the operational teams. all cancelled meetings will allow teams to support and focus on IA planning	On track
	24680	regular meetings with Trade Unions	Mrs Christine Lynes, Deputy Executive Director of Nursing	30/04/2023	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	30/04/2023	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

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:** 16 March 2023
	Risk: Duplicate Hospital Numbers	**Date of Committee Review:** New Risk
		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 - New Risk not presented to Board	New Risk		

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.	1. WPAS Data Quality Groups 2. WPAS Programme Board 3. Digital Portfolio Group

5. WPAS Communication and Awareness Programme in place.	

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. 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
New Risk

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	Kathryn Lang, Interim Head of Information	30/04/2023	Reducing risk by advising clinicians to check all possible records.	On track
	24829	Train all WPAS users on the correct process to follow (unable to comment on other systems).	Mrs Teresa Marie Dutton, WCP Product Specialist	30/09/2023	Reduce risk of duplication and omitting data	On track
	24831	Develop automated monitoring reports to identify users registering duplicate patients.	Kathryn Lang, Interim Head of Information	14/04/2023	Report will identify any users registering patients already registered within the WPAS system which would add to the complexities.	On track
	24832	Risk to be escalated to committee level.	Kathryn Lang, Interim Head of Information	01/06/2023	To ensure openness, transparency and support.	On track
	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.	On track
	24835	Develop Project Plan to progress through the business mandate process.	Kathryn Lang, Interim Head of Information	31/05/2023	Reduce the impact or re-occurrence of the risk materialising.	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:** New Risk
		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 - New Risk not presented to Board	New Risk		

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 ations 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:** 18 May 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 - New Risk not presented to Board	New Risk		

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. 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	**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 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.

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 with attendance from Health & Safety and Estates. Updates are reported to Divisional QDG, Divisional SLT and Executive Groups, Committees and MH Summits. 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 it's 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 - New Risk not presented to Board	New Risk		

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 Special Measures Oversight Group, and on to PFIG.	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

		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 - New Risk not presented to Board	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	**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		Initial reporting to WG shows a small underspend of £0.2m (draft subject to audit) – ie in line with M11 forecast. An Accountable	Steve Webster, Interim Executive	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	

target risk score		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.	Director of Finance		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 this is secure in practice already.	On track
		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 - New Risk not presented to Board	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		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	Steve Webster, Interim Executive	May 2023	Increase the focus and traction on putting in place the enablers for delivery and delivery itself.	On track

target risk score		improvement. This will report to both HBLT and the Special Measures Oversight Group, and on to PFIG.	Director of Finance			
		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 - New Risk not presented to Board	New Risk		

Controls in place	Assurances
The Health Board has established processes for notifying plans and forecasts (including cash flow 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:** New Risk
		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 transistioning 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 - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
Medically fit reviews per IHC are completed weekely. Escalation within IHC is completed when excessive delays occur.	IHC accountability reviews.

Gaps in Controls/mitigations
Accountability on MFFD / Point prevelance 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 Acopic patients. Improved front door discharge planning.	On track

CRR23-54	**Director Lead:** David Coyle	**Date Opened:** July 2022
	Assuring Committee: UEC / Six Goals for Urgent and Emergnency Care	**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:** New Risk
		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 - New Risk not presented to Board	New Risk		

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 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**
	UEC 06	Reduction in % of stays >12hrs	6 Goals Programme	October 2023	Improve flow thoughtout the EU's	On track
	UEC 07	Improvement of 4hr performance for those discharged	6 Goals Programme	October 2023	Improve flow throughtout the EU's	On track
	UEC 08	Table top review of Hospital full protocols and feedback	G Farr	June 2023	Enusre 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:** New Risk
		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 futher 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 - New Risk not presented to Board	New Risk		

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:** David Coyle	**Date Opened:** December 2021
	Assuring Committee: UEC / Six Goals for Urgent and Emergnency Care	**Date Last Reviewed:** April 2023
	Risk: Inability to deliver safe timely care in Emergency Units.	**Date of Committee Review:** New Risk
		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 - New Risk not presented to Board	New Risk		

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 transistioning 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:** 09 March 2023
	Risk: Compliance of Women's Services Clinical staff compliant with Manual Handling training has fallen below an acceptable level.	**Date of Committee Review:** New Risk
		Target Risk Date: 30 June 2023

There is a risk that Womesn Servcies and BCUH 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 beign 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
Staff completing level 1 on line have basic level of knowledge potentially reducing the inherent risk Staff able to call manual handling team for assistance All staff to be aware of how to report an injury due to a manual handling incident Issue discussed at QSE and Women's Board All areas staffed to provide minimal staffing levels which also supports manual handling requirements Current compliance for Level 1 on line – 77.3% Discussed with Head of H&S who has provided assurance of Manual Handling teams support to provision of training and clinical areas	Motoring of training performance will be completed via Women's People and Culture Group and the risk will be monitored via the Women's Risk Management Group. 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
Availability of Manual handling trainers to undertake sessions. Change in requirements requiring local staff ability to provide local training.

Progress since last submission
New Risk escalated April 2023

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler)	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
	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.	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.	On track
	24776	Lack of cascade trainers	Julie Reeve, Matron	30/06/2023	Support local training and maintain levels of compliance	On track

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:** 13 March 2023
	Risk: Temporary Suspension of Home Birth Service due to WAST provision	**Date of Committee Review:** New Risk
		Target Risk Date: 30 June 2023
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. Women's Directorate on call manager confirms with Welsh Ambulance that there is availability to respond to an emergency request form community midwife. 2. Community midwives attending community births request WAST attendance as soon as the need for transfer is identified. 3. 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.	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 4. Welsh Government reportable (All Wales issue)

4. 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. 5.Suspension of Home Birth service to be kept continually under review 6.Any woman who indicates that she wishes to continue to birth at home to be fully supported by the community midwifery teams. 7.Community midwives to continue to attend any Born Before Arrivals (BBAs) or medical assistance request from WAST for midwifery attendance. 8. Women's on call manager to be informed by Labour ward shift co-ordinator in event of any ongoing community Births. 9.WAST to be informed of any ongoing community births. 10. Should the teams have any issues over the weekend there is the option of escalating to Tactical at the Operational Delivery Unit (ODU) on 0300 123 9851.	

Gaps in Controls/mitigations
1. WAST delays - await for forecast 2. Women Choice - going against midwife clinical advice 3. Risk of clinical deterioration due to prolonged presence in a clinically inappropriate location 4. Industrial Action by WAST 5. Incidents logged of high risk transfers by partners by car

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Primary and community care	BAF21-01

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
	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.	Delay
	24195	Discussions with WG on WAST capacity	Mrs Fiona Giraud, Director Of Midwifery & Women's Services	21/09/2022	This will ensure that WG is tied into the extent of the current situation and understand it severity with the aim of assisting WAST with an improvement plan and or assistance.	Delay
	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.	Delay

Appendix 2 - 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 Awaiting Confirmation of De-escalation at 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 Awaiting Confirmation of De-escalation at 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

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.

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	20th June 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date, the deliverables associated to this Committee and a proposal on the approach for Committee reporting going forward			
Argymhellion: ***Recommendations:***	1) The Committee is asked to NOTE the progress to date. 2) The Committee is asked to APPROVE: a. The deliverables associated to this Committee for the first 90 days cycle b. The approach for Committee reporting going forward			
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:***	Paolo Tardivel, Director of Transformation and Improvement & Special Measures Programme Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Not applicable

In accordance with WP7 has an EqlA been identified as necessary and undertaken?	
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***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Appendix A – Areas of concern, independent reviews and outcomes mapping	

QUALITY, SAFETY AND EXPERIENCE COMMITTEE 20th June 2023

Special Measures update

1) Introduction

This report presents an update on Special Measures, outlining the progress to date, the deliverables associated to this Committee and a proposal on the approach for Committee reporting going forward. QSE is the first Board Committee to receive an update on Special Measures following the approval of the Organisational Response to Special Measures Escalation paper at the Health Board meeting on the 25th May 2023. This report therefore seeks to both provide an update on progress, but also to test and seek input on a proposal on the approach to future Board Committee reporting related to Special Measures. The aim is to support a consistent approach to the Special Measures governance and reporting arrangements across all Committees.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response was covered at Health Board on 25th May 2023. The paper covered the 8 areas of concerns (or 'domains') from Welsh Government and how we have agreed to take an outcome focussed approach, simplifying these into 5 key outcomes. Each of the outcomes has been broken down into a set of key deliverables and a 90 day cycle approach is being adopted to support regular planning and reviews, as well as pace of delivery.

A number of the deliverables in the first 90 days cycle are associated with supporting and enabling the 10 independent reviews that Welsh Government are supporting the organisation to conduct (noting that most though not all of these reviews will be underway or complete during the first 90 day cycle). The outcome and resultant actions of these reviews will be fed into subsequent 90 days cycles.

A summary of the 8 areas of concern, the 10 independent reviews, the 5 outcomes and how they map together can be found in Appendix A.

3) Progress to date

The update to Health Board on 25th May 2023 gave an overview of the progress made by the Executive Team with Independent Members of the Board, Independent Advisors and Welsh Government Officials in co-designing a response plan and approach that met the 8 areas of concerns set out by Welsh Government. This marked the end of the Discovery and Enabling phase, with the Stabilisation phase and its first of three 90 day cycles starting as of 1st June 2023.

Work across all areas of concern has continued throughout the process, with detailed plans held by the relevant owners across the organisation. In order to centrally monitor at an appropriate level of detail, a process of tracking progress against critical milestones for each deliverable has commenced. This is providing weekly insight into what is being achieved, any risks and associated mitigations and importantly a strong focus on the delivery confidence of each deliverable within the 90 day cycle.

A sample of recent achievements:

- Improvements made to Committee terms of reference
- It has been agreed which Committees will continue and initial work plans have been developed.
- Final draft of the Annual Plan was approved by Health Board Leadership Team and Executive Team, to be presented to Health Board on 22nd June 2023
- High level proposal developed that describes the approach we want to take to the fragmented care record and why
- Overdue National Reportable Incidents (NRI) are down to 23 from 30 the week ending 2nd June 2023, equivalent to 30% of all open NRI overdue down from 60%
- Excellence reporting (Great-ix) was launched this month

4) Assurance

A robust assurance process is being applied to ensure that special measure actions have truly delivered the intended outcome. A learning and improvement PDSA cycle approach is being taken to the detail of this process, recognising small refinements will be needed with the benefit of experience in the early weeks of the 90 day cycle.

The process has incorporated the Health Board's own experience of a maturity matrix approach as part of Targeted Intervention, as well as Cwm Taf Morgannwg's use of this approach within Special Measures.

Wherever possible progress against each deliverable is being tracked using outcomes that are meaningful and where improvement can be robustly measured and demonstrated. It should be noted that the first 90 day cycle is a little unusual in that a number of the deliverables are (understandably) about enabling later pieces of work and as such improvement in outcomes for patients and staff in these areas might not necessarily be immediately visible. For example, supporting the multiple independent reviews of different functions within the Health Board are significant deliverables in the first 90 day cycle which will not, in themselves, improve outcomes.

However they are essential to inform the improvement work required in later cycles, which is when improvements would then be visible.

Work is currently underway with Wlesh Government officials to provide maximum clarity and detail as to why each area of concern has been identified within the Special Measures framework, and to then be clear what assurances and evidence will be required to de-escalate concern in each area. This will form a set of de-escalation criteria, the first draft of which Welsh Government colleagues have indicated should be available at the end of June 2023.

5) Deliverables allocated to Committees

Each of the deliverables within the 5 outcomes have been mapped to a Board Committee for reporting and assurance purposes. The table below shows the deliverable titles against a proposed Committee, with those mapped to QSE highlighted. Appendix A holds a table with the full description of each deliverable.

Outcome 1: A well-functioning Board		Committee
1.1	Strengthen Board governance and effectiveness	Audit
1.2	IM recruitment	Audit
1.3	Board inductions	Audit
1.4	Board development	Audit
1.5	Board committees	Audit
1.6	Risk	QSE
1.7	Permanent Board recruitment	Audit

Outcome 2: A clear, deliverable plan for 2023/24		Committee
2.1	Annual Plan	PFIG
2.2	Financial Savings	PFIG
2.3	Future Financial and Value Opportunities	PFIG
2.4	Local plans	PFIG
2.5	Planning Review	PFIG
2.6	Contract procurement and management Review	PFIG
2.7	Finance team & capacity	PFIG
2.8	Financial governance	PFIG

Outcome 3: Stronger leadership and engagement		Committee
3.1	Exec Portfolios Review	Health Board
3.2	Operating Model stocktake	PPPH
3.3	Interim Finance Director recruitment	PFIG
3.4	Senior HR Cases	Health Board
3.5	Exec Team development programme	PPPH
3.6	Senior Leadership development programme	PPPH
3.7	Interims Review	PFIG
3.8	Clinical Engagement	QSE
3.9	Priority community groups engagement	PPPH
3.10	Address the fragmented care record concerns	QSE

Outcome 4: Improved access, outcomes & experience for citizens		Committee
4.1	Patient Safety Review	QSE
4.2	Planned Care	PFIG
4.3	Orthopaedics	PFIG
4.4	Vascular Review	QSE
4.5	Service improvements	QSE
4.6	MH Stocktake Review	QSE
4.7	Inpatients Safety Review	QSE
4.8	CAMHS and Neurodiversity action plan	QSE
4.9	Urgent and Emergency Care 6 goals and winter planning	PFIG

Outcome 5: A learning and self-improving organisation		Committee
5.1	Develop a 'Learning Organisation' Framework	PPPH
5.2	Learning from incidents	QSE
5.3	Clinical Governance Review	QSE
5.4	Transformation & Improvement support	PFIG
5.5	Healthcare Public Health programme	PPPH
5.6	Special Measures assurance approach	Audit
5.7	Intelligence led organisation	PFIG

6) Proposed Committee reporting approach

The proposal is to provide a report to each Committee that focusses on the deliverables that are relevant to that Committee. The intention is that this will reduce overlap and reduce the need for the same leads presenting progress to multiple Committees.

The report will outline progress of each deliverable in terms of it's:

1) Delivery of critical milestones
2) Delivery confidence associated with the overall deliverable
3) Achievement of committed outcomes / outputs
4) Associated narrative

In order to ensure alignment across the Committees, an overview of the progress against the 'assurances' for each of the 5 outcomes would also be provided.

8) Recommendations

1) The Committee is asked to **NOTE** the progress to date.

2) The Committee is asked to **APPROVE**:
    a. The deliverables associated to this Committee for the first 90 days cycle
    b. The approach for Committee reporting going forward

Appendix A – Areas of concern, independent reviews and outcomes mapping

8 areas of concern (or 'domains) from Welsh Government:

1) Governance and board effectiveness
2) Workforce and organisational development
3) Financial governance and management
4) Compassionate leadership and culture
5) Clinical governance, patient experience and safety
6) Operational delivery
7) Planning and service transformation
8) Mental health

10 independent reviews:

1) Mental Health Inpatient Safety
2) Executive Portfolios
3) Use and recruitment of 'Interim' Staff
4) Planning
5) Contract procurement management
6) Patient Safety
7) Clinical Governance systems
8) Stocktake review of progress against previous Mental Health Reviews
9) Review of Office of the Board Secretary
10) Vascular review

5 Outcomes and how they map to the 8 areas of concerns and 10 independent reviews:

Outcome 1: A well-functioning Board		Area of concern	Independent reviews
1.1	**Strengthen Board governance and effectiveness**: ▪ Support and enable review of Office of Board Secretary (Governance), ▪ refresh committee terms of reference and ▪ embed special measures in all committees	1) Governance, board effectiveness and audit	9) Review of Office of the Board Secretary

1.2	**IM recruitment:** Complete recruitment to IM roles (temp)	1) Governance, board effectiveness and audit	
1.3	**Board inductions:** Implement phase 1 induction for all Board members	1) Governance, board effectiveness and audit	
1.4	**Board development:** Develop phase 1 Board development programme	1) Governance, board effectiveness and audit	
1.5	**Board committees:** Establish Board committees, complete committee induction and development of work plans	1) Governance, board effectiveness and audit	
1.6	**Risk:** Commence review and revision of risk appetite and approach	1) Governance, board effectiveness and audit	
1.7	**Permanent Board recruitment:** Commence plans for the recruitment of a permanent Board - including progressing the recruitment of the permanent Chief Executive	1) Governance, board effectiveness and audit	

Outcome 2: A clear, deliverable plan for 2023/24		**Area of concern**	**Independent Reviews**
2.1	**Annual Plan:** Produce a clear and deliverable Annual Plan for the organisation for the rest of 23/24, that delivers improvements in Ministerial priority areas	7) Planning and service transformation	
2.2	**Financial Savings:** Commence delivery of an agreed efficiency savings plan that minimises the financial deficit	3) Financial governance and management	
2.3	**Future Financial and Value Opportunities:** Commence an assessment of the potential financial opportunities for 2024/2025 and 2025/2026 and develop the contribution of value based healthcare	3) Financial governance and management	
2.4	**Local plans:** Develop and commence deployment of Divisional/Integrated Health Community integrated plans that operationalise the priorities of the Annual Plan	7) Planning and service transformation	
2.5	**Planning Review:** Support and enable a Review of planning	7) Planning and service transformation	4) Planning

2.6	**Contract procurement and management Review:** Progress implementing priorities associated with the financial control environment e.g. contract management	3) Financial governance and management	5) Contract procurement management
2.7	**Finance team & capacity:** Progress actions to stabilise the finance team and develop capacity	3) Financial governance and management	
2.8	**Financial governance:** Progress the action of the financial control environment action plan	3) Financial governance and management	

Outcome 3: Stronger leadership and engagement		**Area of concern**	**Independent Reviews**
3.1	**Exec Portfolios Review:** Support and enable a Review of Executive Portfolios (commencement date and person not yet confirmed)	2) Workforce and OD	2) Executive Portfolios
3.2	**Operating Model stocktake:** Undertake a 'stocktake' of the implementation of the Stronger Together Operating Model restructure, identifying areas to strengthen and consolidate	2) Workforce and OD	
3.3	**Interim Finance Director recruitment:** Progress recruitment of interim Finance Director	2) Workforce and OD	
3.4	**Senior HR Cases:** Resolve outstanding Respect and Resolution and similar processes related to senior leadership	2) Workforce and OD	
3.5	**Exec Team development programme:** Working with Health Education and Improvement Wales, consider options, agree and commence a Programme for Executive Team development	4) Compassionate leadership and culture	
3.6	**Senior Leadership development programme:** Working with HEIW, consider, agree and commence a Programme for organisation wide senior leadership development	4) Compassionate leadership and culture	
3.7	**Interims Review:** Support and enable the Review of Interims (report expected mid-June)	2) Workforce and OD	3) Use and recruitment of 'Interim' Staff
3.8	**Clinical Engagement:** Review mechanisms for clinical engagement, drawing up recommendations for improvement.	5) Clinical Governance,	

		patient experience and safety	
3.9	**Priority community groups engagement:** Working with the Independent Adviser (Cath Broderick), develop a structured approach to renewing engagement with specific priority community groups	5) Clinical Governance, patient experience and safety	
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.	7) Planning and service transformation	

Outcome 4: Improved access, outcomes and experience for citizens		**Area of concern**	**Independent Reviews**
4.1	**Patient Safety Review:** Support and enable the Review of Patient Safety Care	5) Clinical Governance, patient experience and safety	6) Patient Safety
4.2	**Planned Care:** Establish a revised Planned Care Programme that delivers early progress on access, outcomes and experience, whilst laying the foundations for longer term sustainability including GIRFT and other efficiency opportunities. Achieve a standard 99% of all over 156 week waits by end Q2 (booked not necessarily seen)	6) Operational Delivery	
4.3	**Orthopaedics:** As part of the Planned care Programme, refine the work programme for Orthopaedic care, to include the finalisation of the Orthopaedic expansion business case for submission to Welsh government.	6) Operational Delivery	
4.4	**Vascular Review:** Support and enable the Vascular review	5) Clinical Governance, patient experience and safety	10) Vascular review
4.5	**Service improvements:** Review, revise and implement clear improvement plans for Vascular, Urology, Ophthalmology, Oncology and Dermatology & Plastics	5) Clinical Governance, patient experience and safety	
4.6	**MH Stocktake Review:** Prepare for and support commencement of an external	8) Mental Health	8) Stocktake review of progress

	stocktake of progress against previous MH Reviews		against previous Mental Health Reviews
4.7	**Inpatients Safety Review:** Receive the report of the Mental Health Inpatient Quality and Safety Inspection and commence implementation of improvement actions.	8) Mental Health	1) Mental Health Inpatient Safety
4.8	**CAMHS and Neurodiversity action plan:** Agree and commence implementation of a CAMHS and ND action plan to improve performance in the following areas : ▪ CAMHS Mental Health Measure ▪ ND assessment waiting times	8) Mental Health	
4.9	**Urgent and Emergency Care 6 goals and winter planning:** Revise and implement urgent and emergency care plans (6 goals) and commence planning for winter preparedness for urgent and emergency care with partners	6) Operational Delivery	

Outcome 5: A learning and self-improving organisation		**Area of concern**	**Independent Reviews**
5.1	**Develop a 'Learning Organisation' Framework:** building on work already started, that identifies the culture, systems and processes to enable learning.	2) Workforce and OD	
5.2	**Learning from incidents:** Ensure there is an effective procedure for learning from incidents and preparations for inquests and HSE are clear and effective. (Linked to 5.1)	5) Clinical Governance, patient experience and safety	
5.3	**Clinical Governance Review:** Enable and support the NHS Executive to undertake a review of clinical governance	5) Clinical Governance, patient experience and safety	7) Clinical Governance systems
5.4	**Transformation & Improvement support:** Realign transformation and improvement support to enable greater focus on priority improvement areas	7) Planning and service transformation	
5.5	**Healthcare Public Health programme:** Scope an enhanced programme of Healthcare Public Health that seeks to systematically identify areas of focus for	7) Planning and service transformation	

	quality improvement, working with Public Health Wales.		
5.6	**Special Measures assurance approach:** Develop and commence implementation of an Assurance Approach for the Special measures response. Including the implementation of an organisational Maturity Matrix.	1) Governance, board effectiveness and audit	
5.7	**Intelligence led organisation:** Develop proposal to raise the organisation's maturity in using data and intelligence to improve service planning and identification of emerging service issues	7) Planning and service transformation	

Teitl adroddiad: ***Report title:***	Special Measures Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	20th June 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update on Special Measures, outlining the progress to date, the deliverables associated to this Committee and a proposal on the approach for Committee reporting going forward			
Argymhellion: ***Recommendations:***	1) The Committee is asked to NOTE the progress to date. 2) The Committee is asked to APPROVE: a. The deliverables associated to this Committee for the first 90 days cycle b. The approach for Committee reporting going forward			
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:***	Paolo Tardivel, Director of Transformation and Improvement & Special Measures Programme Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☐	

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

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	To support Special Measures
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Not applicable
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Not applicable

In accordance with WP7 has an EqIA been identified as necessary and undertaken?	
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***	
Rhestr o Atodiadau: Dim ***List of Appendices:*** Appendix A – Areas of concern, independent reviews and outcomes mapping	

QUALITY, SAFETY AND EXPERIENCE COMMITTEE 20th June 2023

Special Measures update

1) Introduction

This report presents an update on Special Measures, outlining the progress to date, the deliverables associated to this Committee and a proposal on the approach for Committee reporting going forward. QSE is the first Board Committee to receive an update on Special Measures following the approval of the Organisational Response to Special Measures Escalation paper at the Health Board meeting on the 25th May 2023. This report therefore seeks to both provide an update on progress, but also to test and seek input on a proposal on the approach to future Board Committee reporting related to Special Measures. The aim is to support a consistent approach to the Special Measures governance and reporting arrangements across all Committees.

2) Background

The background to the Health Board escalation into Special Measures and the resultant organisational response was covered at Health Board on 25th May 2023. The paper covered the 8 areas of concerns (or 'domains') from Welsh Government and how we have agreed to take an outcome focussed approach, simplifying these into 5 key outcomes. Each of the outcomes has been broken down into a set of key deliverables and a 90 day cycle approach is being adopted to support regular planning and reviews, as well as pace of delivery.

A number of the deliverables in the first 90 days cycle are associated with supporting and enabling the 10 independent reviews that Welsh Government are supporting the organisation to conduct (noting that most though not all of these reviews will be underway or complete during the first 90 day cycle). The outcome and resultant actions of these reviews will be fed into subsequent 90 days cycles.

A summary of the 8 areas of concern, the 10 independent reviews, the 5 outcomes and how they map together can be found in Appendix A.

3) Progress to date

The update to Health Board on 25th May 2023 gave an overview of the progress made by the Executive Team with Independent Members of the Board, Independent Advisors and Welsh Government Officials in co-designing a response plan and approach that met the 8 areas of concerns set out by Welsh Government. This marked the end of the Discovery and Enabling phase, with the Stabilisation phase and its first of three 90 day cycles starting as of 1st June 2023.

Work across all areas of concern has continued throughout the process, with detailed plans held by the relevant owners across the organisation. In order to centrally monitor at an appropriate level of detail, a process of tracking progress against critical milestones for each deliverable has commenced. This is providing weekly insight into what is being achieved, any risks and associated mitigations and importantly a strong focus on the delivery confidence of each deliverable within the 90 day cycle.

A sample of recent achievements:

- Improvements made to Committee terms of reference
- It has been agreed which Committees will continue and initial work plans have been developed.
- Final draft of the Annual Plan was approved by Health Board Leadership Team and Executive Team, to be presented to Health Board on 22nd June 2023
- High level proposal developed that describes the approach we want to take to the fragmented care record and why
- Overdue National Reportable Incidents (NRI) are down to 23 from 30 the week ending 2nd June 2023, equivalent to 30% of all open NRI overdue down from 60%
- Excellence reporting (Great-ix) was launched this month

4) Assurance

A robust assurance process is being applied to ensure that special measure actions have truly delivered the intended outcome. A learning and improvement PDSA cycle approach is being taken to the detail of this process, recognising small refinements will be needed with the benefit of experience in the early weeks of the 90 day cycle.

The process has incorporated the Health Board's own experience of a maturity matrix approach as part of Targeted Intervention, as well as Cwm Taf Morgannwg's use of this approach within Special Measures.

Wherever possible progress against each deliverable is being tracked using outcomes that are meaningful and where improvement can be robustly measured and demonstrated. It should be noted that the first 90 day cycle is a little unusual in that a number of the deliverables are (understandably) about enabling later pieces of work and as such improvement in outcomes for patients and staff in these areas might not necessarily be immediately visible. For example, supporting the multiple independent reviews of different functions within the Health Board are significant deliverables in the first 90 day cycle which will not, in themselves, improve outcomes.

However they are essential to inform the improvement work required in later cycles, which is when improvements would then be visible.

Work is currently underway with Wlesh Government officials to provide maximum clarity and detail as to why each area of concern has been identified within the Special Measures framework, and to then be clear what assurances and evidence will be required to de-escalate concern in each area. This will form a set of de-escalation criteria, the first draft of which Welsh Government colleagues have indicated should be available at the end of June 2023.

5) Deliverables allocated to Committees

Each of the deliverables within the 5 outcomes have been mapped to a Board Committee for reporting and assurance purposes. The table below shows the deliverable titles against a proposed Committee, with those mapped to QSE highlighted. Appendix A holds a table with the full description of each deliverable.

Outcome 1: A well-functioning Board		Committee
1.1	Strengthen Board governance and effectiveness	Audit
1.2	IM recruitment	Audit
1.3	Board inductions	Audit
1.4	Board development	Audit
1.5	Board committees	Audit
1.6	Risk	QSE
1.7	Permanent Board recruitment	Audit

Outcome 2: A clear, deliverable plan for 2023/24		Committee
2.1	Annual Plan	PFIG
2.2	Financial Savings	PFIG
2.3	Future Financial and Value Opportunities	PFIG
2.4	Local plans	PFIG
2.5	Planning Review	PFIG
2.6	Contract procurement and management Review	PFIG
2.7	Finance team & capacity	PFIG
2.8	Financial governance	PFIG

Outcome 3: Stronger leadership and engagement		Committee
3.1	Exec Portfolios Review	Health Board
3.2	Operating Model stocktake	PPPH
3.3	Interim Finance Director recruitment	PFIG
3.4	Senior HR Cases	Health Board
3.5	Exec Team development programme	PPPH
3.6	Senior Leadership development programme	PPPH
3.7	Interims Review	PFIG
3.8	Clinical Engagement	QSE
3.9	Priority community groups engagement	PPPH
3.10	Address the fragmented care record concerns	QSE

Outcome 4: Improved access, outcomes & experience for citizens		Committee
4.1	Patient Safety Review	QSE
4.2	Planned Care	PFIG
4.3	Orthopaedics	PFIG
4.4	Vascular Review	QSE
4.5	Service improvements	QSE
4.6	MH Stocktake Review	QSE
4.7	Inpatients Safety Review	QSE
4.8	CAMHS and Neurodiversity action plan	QSE
4.9	Urgent and Emergency Care 6 goals and winter planning	PFIG

Outcome 5: A learning and self-improving organisation		Committee
5.1	Develop a 'Learning Organisation' Framework	PPPH
5.2	Learning from incidents	QSE
5.3	Clinical Governance Review	QSE
5.4	Transformation & Improvement support	PFIG
5.5	Healthcare Public Health programme	PPPH
5.6	Special Measures assurance approach	Audit
5.7	Intelligence led organisation	PFIG

6) Proposed Committee reporting approach

The proposal is to provide a report to each Committee that focusses on the deliverables that are relevant to that Committee. The intention is that this will reduce overlap and reduce the need for the same leads presenting progress to multiple Committees.

The report will outline progress of each deliverable in terms of it's:

1) Delivery of critical milestones
2) Delivery confidence associated with the overall deliverable
3) Achievement of committed outcomes / outputs
4) Associated narrative

In order to ensure alignment across the Committees, an overview of the progress against the 'assurances' for each of the 5 outcomes would also be provided.

8) Recommendations

1) The Committee is asked to **NOTE** the progress to date.

2) The Committee is asked to **APPROVE**:
    a. The deliverables associated to this Committee for the first 90 days cycle
    b. The approach for Committee reporting going forward

Appendix A – Areas of concern, independent reviews and outcomes mapping

8 areas of concern (or 'domains) from Welsh Government:

1) Governance and board effectiveness
2) Workforce and organisational development
3) Financial governance and management
4) Compassionate leadership and culture
5) Clinical governance, patient experience and safety
6) Operational delivery
7) Planning and service transformation
8) Mental health

10 independent reviews:

1) Mental Health Inpatient Safety
2) Executive Portfolios
3) Use and recruitment of 'Interim' Staff
4) Planning
5) Contract procurement management
6) Patient Safety
7) Clinical Governance systems
8) Stocktake review of progress against previous Mental Health Reviews
9) Review of Office of the Board Secretary
10) Vascular review

5 Outcomes and how they map to the 8 areas of concerns and 10 independent reviews:

Outcome 1: A well-functioning Board		Area of concern	Independent reviews
1.1	**Strengthen Board governance and effectiveness**: ▪ Support and enable review of Office of Board Secretary (Governance), ▪ refresh committee terms of reference and ▪ embed special measures in all committees	1) Governance, board effectiveness and audit	9) Review of Office of the Board Secretary

1.2	**IM recruitment:** Complete recruitment to IM roles (temp)	1) Governance, board effectiveness and audit	
1.3	**Board inductions:** Implement phase 1 induction for all Board members	1) Governance, board effectiveness and audit	
1.4	**Board development:** Develop phase 1 Board development programme	1) Governance, board effectiveness and audit	
1.5	**Board committees:** Establish Board committees, complete committee induction and development of work plans	1) Governance, board effectiveness and audit	
1.6	**Risk:** Commence review and revision of risk appetite and approach	1) Governance, board effectiveness and audit	
1.7	**Permanent Board recruitment:** Commence plans for the recruitment of a permanent Board - including progressing the recruitment of the permanent Chief Executive	1) Governance, board effectiveness and audit	

Outcome 2: A clear, deliverable plan for 2023/24		**Area of concern**	**Independent Reviews**
2.1	**Annual Plan:** Produce a clear and deliverable Annual Plan for the organisation for the rest of 23/24, that delivers improvements in Ministerial priority areas	7) Planning and service transformation	
2.2	**Financial Savings:** Commence delivery of an agreed efficiency savings plan that minimises the financial deficit	3) Financial governance and management	
2.3	**Future Financial and Value Opportunities:** Commence an assessment of the potential financial opportunities for 2024/2025 and 2025/2026 and develop the contribution of value based healthcare	3) Financial governance and management	
2.4	**Local plans:** Develop and commence deployment of Divisional/Integrated Health Community integrated plans that operationalise the priorities of the Annual Plan	7) Planning and service transformation	
2.5	**Planning Review:** Support and enable a Review of planning	7) Planning and service transformation	4) Planning

2.6	**Contract procurement and management Review:** Progress implementing priorities associated with the financial control environment e.g. contract management	3) Financial governance and management	5) Contract procurement management
2.7	**Finance team & capacity:** Progress actions to stabilise the finance team and develop capacity	3) Financial governance and management	
2.8	**Financial governance:** Progress the action of the financial control environment action plan	3) Financial governance and management	

Outcome 3: Stronger leadership and engagement		**Area of concern**	**Independent Reviews**
3.1	**Exec Portfolios Review:** Support and enable a Review of Executive Portfolios (commencement date and person not yet confirmed)	2) Workforce and OD	2) Executive Portfolios
3.2	**Operating Model stocktake:** Undertake a 'stocktake' of the implementation of the Stronger Together Operating Model restructure, identifying areas to strengthen and consolidate	2) Workforce and OD	
3.3	**Interim Finance Director recruitment:** Progress recruitment of interim Finance Director	2) Workforce and OD	
3.4	**Senior HR Cases:** Resolve outstanding Respect and Resolution and similar processes related to senior leadership	2) Workforce and OD	
3.5	**Exec Team development programme:** Working with Health Education and Improvement Wales, consider options, agree and commence a Programme for Executive Team development	4) Compassionate leadership and culture	
3.6	**Senior Leadership development programme:** Working with HEIW, consider, agree and commence a Programme for organisation wide senior leadership development	4) Compassionate leadership and culture	
3.7	**Interims Review:** Support and enable the Review of Interims (report expected mid-June)	2) Workforce and OD	3) Use and recruitment of 'Interim' Staff
3.8	**Clinical Engagement:** Review mechanisms for clinical engagement, drawing up recommendations for improvement.	5) Clinical Governance,	

		patient experience and safety	
3.9	**Priority community groups engagement:** Working with the Independent Adviser (Cath Broderick), develop a structured approach to renewing engagement with specific priority community groups	5) Clinical Governance, patient experience and safety	
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.	7) Planning and service transformation	

Outcome 4: Improved access, outcomes and experience for citizens		**Area of concern**	**Independent Reviews**
4.1	**Patient Safety Review:** Support and enable the Review of Patient Safety Care	5) Clinical Governance, patient experience and safety	6) Patient Safety
4.2	**Planned Care:** Establish a revised Planned Care Programme that delivers early progress on access, outcomes and experience, whilst laying the foundations for longer term sustainability including GIRFT and other efficiency opportunities. Achieve a standard 99% of all over 156 week waits by end Q2 (booked not necessarily seen)	6) Operational Delivery	
4.3	**Orthopaedics:** As part of the Planned care Programme, refine the work programme for Orthopaedic care, to include the finalisation of the Orthopaedic expansion business case for submission to Welsh government.	6) Operational Delivery	
4.4	**Vascular Review:** Support and enable the Vascular review	5) Clinical Governance, patient experience and safety	10) Vascular review
4.5	**Service improvements:** Review, revise and implement clear improvement plans for Vascular, Urology, Ophthalmology, Oncology and Dermatology & Plastics	5) Clinical Governance, patient experience and safety	
4.6	**MH Stocktake Review:** Prepare for and support commencement of an external	8) Mental Health	8) Stocktake review of progress

	stocktake of progress against previous MH Reviews		against previous Mental Health Reviews
4.7	**Inpatients Safety Review:** Receive the report of the Mental Health Inpatient Quality and Safety Inspection and commence implementation of improvement actions.	8) Mental Health	1) Mental Health Inpatient Safety
4.8	**CAMHS and Neurodiversity action plan:** Agree and commence implementation of a CAMHS and ND action plan to improve performance in the following areas : ▪ CAMHS Mental Health Measure ▪ ND assessment waiting times	8) Mental Health	
4.9	**Urgent and Emergency Care 6 goals and winter planning:** Revise and implement urgent and emergency care plans (6 goals) and commence planning for winter preparedness for urgent and emergency care with partners	6) Operational Delivery	

Outcome 5: A learning and self-improving organisation		**Area of concern**	**Independent Reviews**
5.1	**Develop a 'Learning Organisation' Framework:** building on work already started, that identifies the culture, systems and processes to enable learning.	2) Workforce and OD	
5.2	**Learning from incidents:** Ensure there is an effective procedure for learning from incidents and preparations for inquests and HSE are clear and effective. (Linked to 5.1)	5) Clinical Governance, patient experience and safety	
5.3	**Clinical Governance Review:** Enable and support the NHS Executive to undertake a review of clinical governance	5) Clinical Governance, patient experience and safety	7) Clinical Governance systems
5.4	**Transformation & Improvement support:** Realign transformation and improvement support to enable greater focus on priority improvement areas	7) Planning and service transformation	
5.5	**Healthcare Public Health programme:** Scope an enhanced programme of Healthcare Public Health that seeks to systematically identify areas of focus for	7) Planning and service transformation	

	quality improvement, working with Public Health Wales.		
5.6	**Special Measures assurance approach:** Develop and commence implementation of an Assurance Approach for the Special measures response. Including the implementation of an organisational Maturity Matrix.	1) Governance, board effectiveness and audit	
5.7	**Intelligence led organisation:** Develop proposal to raise the organisation's maturity in using data and intelligence to improve service planning and identification of emerging service issues	7) Planning and service transformation	

Teitl adroddiad: ***Report title:***	Policy review – MD22 BCUHB Clinical Audit Policy & Procedure			
Adrodd i: ***Report to:***	Quality, Safety and Experience (QSE) Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 2023			
Crynodeb Gweithredol: ***Executive Summary:***	This paper advises the QSE Committee that in accordance with OBS1 - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, ***MD22 Clinical Audit Policy & Procedure*** has undertaken a review; following changes in the BCUHB structure and updated processes this has resulted in minor updates, amendments and improvements to the document.			
Argymhellion: ***Recommendations:***	1)The Committee is asked to: • Note that amendments / updates / improvements have been made and several links have been refreshed • Note in line with the Betsi Cadwaldr University Health Board (BCUHB) new structure and changes in processes within department for improvement, that the policy was reviewed 2) Approve the reviewed Clinical Audit Policy & Procedure MD22			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons - Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Dr James Risley - Deputy Executive Medical Director Joanne Shillingford (Head of Clinical Effectiveness)			
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*	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*

		mechanisms / objectives		

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):***	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?***	As per BCUHB Policy on Policies and WP7 Procedure for Equality Impact Assessments (EqIA), the EqIA is appended to this report.
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)***	N/A
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***	N/A
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	Reviewed policy – MD22 BCUHB Clinical Audit Policy & Procedure - noted and approved via: 1) Uploaded to the BCUHB Draft Documents for Consultation page with accompanying pan-BCUHB communications, and shared via link

	to the Clinical Effectiveness webpage 2) Update to local Clinical Effectiveness Groups and promoted through communications bulletin and via Clinical Effectiveness team
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)***	Amherthnasol Not applicable
Camau Nesaf: **Next Steps:** 1) Place the reviewed MD22 - BCUHB Clinical Audit Policy & Procedure onto the Policies, Procedures and other key documents page 2) Raise awareness of the reviewed MD22 - BCUHB Clinical Audit Policy & Procedure via the BCUHB weekly bulletin 3) Promote MD22 - BCUHB Clinical Audit Policy & Procedure to relevant local Clinical Effectiveness Groups/meetings to ensure a culture of best practice in the management and delivery of patient care, and to communicate that the purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures	
Rhestr o Atodiadau: **List of Appendices:** **1)** MD22 - BCUHB Clinical Audit Policy & Procedure onto the Policies, Procedures Policy **2)** MD22 - EQIA	

Clinical Audit Policy & Procedure MD22

Author & Title	Clinical Audit Policy: Joanne Shillingford (Head of Clinical Effectiveness).
Responsible dept / director:	Office of the Medical Director. Dr Nick Lyons
Approved by:	Quality, Safety and Patient Experience Committee (QSE)
Date approved:	April 2023 Quality Delivery Group (QDG)
Date activated (live):	March 2020
Documents to be read alongside this document:	BCUHB Quality Improvement Strategy (2017-2020). *(Currently under review)*
Date of next review:	Next June 2024
Date EqIA completed:	Jan 2020, reviewed Feb 2023

First operational:	March 2020				
Previously reviewed:	Nov 2020				
Changes made yes/no:	Yes				

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out-of-date date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1.0 Introduction/Overview

1.2 Clinical Audit:

Clinical audit is a multi-professional, multidisciplinary activity.

"Audit is not concerned primarily with fault or discrepancy finding, but with the examination of working practice to improve effectiveness." Dickens (1994)

Figure 1 The Clinical Audit Cycle

Within the Health Board clinical audit is embedded within the future direction of improvement activity. Audit is a tool within the quality framework, identifying and prioritising improvement activities (Quality Planning) and providing assurance about service quality (Quality Control):

"*Clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.*"

New Principles of Best Practice in Clinical Audit (HQIP, January 2011).

Figure 2: Quality Cycle: based on Juran and Godfrey (1999).

2.0 Policy Statement

This policy is applicable across all services participating in clinical audit within the Health Board. It sets out the expectations of the Health Board with respect to audit planning, multidisciplinary participation, and acting on the audit findings to improve clinical services.

Clinical audit planning prioritises externally mandated requirements (as documented in the annual *National Clinical Audit and Outcome Review Plan* from Welsh Government), as well as local priorities in line with the Health Board's strategic objectives and risks.

Services should consider audits that provide information and/or assurance relating to key risks and strategies, such as the quality improvement strategy, and other service improvement activity relevant to the Health Board's priorities.

3.0 Aims / Purpose

This policy aims to support a culture of best practice in the management and delivery of patient care.

The purpose of this policy is to set out the rationale for clinical audit and provide a framework for such activity, including standards, guidance and procedures.

4.0 Objectives

This policy outlines processes in relation to clinical audit activity within BCUHB. It will reinforce its role within the quality framework in delivering quality improvement and quality control.

This includes:

- Topic selection based upon priorities (national and local)
- Local governance arrangements
- Clinical audit and effectiveness training
- Patient and carer involvement
- Roles and responsibilities
- Assurance about the effectiveness of services in relation to best practice

5.0 Scope

This policy relates to all BCUHB staff (including students, volunteers, locums and bank staff) and partner organisations participating in clinical audit activity within BCUHB, either by professional requirement, individual interest or relevance to a specific pathway / care group. This policy is also applicable when BCUHB is working in partnership with other health and social care partners. Where BCUHB commissions activity externally, quality assurance including participation in audit, is included within the contractual arrangements.

6.0 Roles and Responsibilities

6.1 Chief Executive Officer (CEO)

The Chief Executive Officer has overall responsibility in relation to the statutory duty for quality within the organisation and for participation in the mandatory requirements for clinical audit participation, as set out within the Welsh Government's *National Clinical Audit and Outcome Review Plan (NCAORP).*

6.2 Executive Medical Director

The Executive Medical Director is the Executive lead for clinical audit and effectiveness Activity, ensuring that the BCUHB audit plan aligns with mandatory requirements, organisational priorities and is supported across all clinical services including primary, community and secondary care. The Clinical Effectiveness Department is located within the Office of the Medical Director.

6.4 Audit Project Leads

Audit Project Leads are expected to ensure that the clinical audit cycle is aligned to Health Board and their own service's clinical audit annual plan. This will include data collection, discussion of the findings and development and delivery of a SMART action plan to improve patient outcome. It is their responsibility to escalate any delays or concerns through their own service's governance framework.

6.5 Other Staff

All staff have a duty to ensure they are providing effective care to deliver best outcomes for patients. Participation in relevant clinical audit to enable benchmarking against key standards, supporting the development of subsequent action plans and undertaking quality improvement activity is therefore expected.

6.6 Clinical Effectiveness Department

One of the department's key roles is to oversee and manage the audit process. This includes:

- working with services to develop the BCUHB clinical audit plan and dissemination of quarterly audit reports
- provide advice and guidance to BCUHB staff for all stages of the clinical audit cycle, with priority is given to mandatory audits (national or local)
- maintaining and monitoring a central repository of audit activity
- supporting the development of SMART action plans
- escalating the action plans within BCUHB to develop prioritised improvement plans
- providing quarterly reports to the Executive and Board
- delivering of education and training sessions as required

7.0 Organisation structures

7.1 Clinical Effectiveness Group (CEG~~)~~

This is one of the strategic groups reporting into the Quality Delivery Group (QDG) CEG's key roles include:

- Receive, scrutinise, and approve relevant clinical pathways and related documentation

- Advise and support monitoring of newly introduced invasive procedures (New Interventional Procedure Policy)
- Receive and scrutinise reports received from service teams and subgroups to ensure any patient risk is escalated to the QDG

7.2 Quality Delivery Group (QDG)

The purpose of the QDG is to ensure the Health Board provides high quality services to the people it serves, with quality defined as covering patient safety, patient and carer experience and clinical effectiveness – this includes monitoring the standards of quality, identifying areas of concern and risk as well as best practice, and ensuring the continuous improvement in quality.

7.3 Audit Committee

The Audit Committee is the approving committee for the annual audit plan ensuring it is fit for purpose.

7.4 Quality, Safety and Experience Committee (QSE)

The Quality, Safety and Experience Committee requires more detailed assurance that clinical audit is supporting the delivery of effective health care. It requires assurance that clinical audit is used to identify areas for improvement and that subsequent actions deliver better outcomes for patients.

7.5 Service Quality Groups

The 3 IHCs and 4 divisions will be expected to ensure they have processes in place so that they can provide assurance around, and identify by exception, any patient safety concerns.

8.0 Audit classification structure

8.1 Tier 1 and Tier 2 audits

Tier 1: National "must do" audits are mandated by Welsh Government or other regulatory bodies. Local available resources are prioritised to support these audits.

All National Clinical Audit and Outcome Review Plan (NCAORP) projects must be incorporated within relevant Divisional/Directorate annual clinical audit plans.

Tier 2: Local priority audits: are Health Board 'must do' audits which support the delivery of the Quality Improvement Strategy goals and priorities, or those related to identified clinical risks. In addition, it includes any National audits (not part of the WG NCAORP) and any National collaborative/network audit activity that is conducted across BCUHB (all IHC &/or divisions). These audits will take priority over completing Tier 3 audits.

All Corporate projects (Tier 2) agreed at BCUHB Quality & Safety Group as priorities must be incorporated within relevant Division/Directorate annual clinical audit plans.

8.2 Corporate Clinical Audit Annual Plan for Tier 1 and Tier 2

The corporate clinical audit annual plan will be agreed by the end of February each year. Tier 1 audits will capture in-year data collection and/or review of report and action planning. Some audit reports will be an analysis of historic data, usually from the previous year. Tier 2 audits will be based on audits identified by the Clinical Executive Leads as well as Divisional Management teams in line with section 8.1 above.

8.3 Clinical Effectiveness Department Support and Assurance

The Clinical Effectiveness Department is resourced to support Tier 1 and Tier 2 monitoring of activity. Tier 1 activity will be prioritised.

Clinical Audit Facilitator staff will meet with lead auditor(s) through regular meetings to assess the level of advice and guidance they require.

The Clinical Effectiveness department will be responsible for:

- Collating the annual Corporate Clinical Audit Plan each new financial year
- Providing the Quality, Safety and Experience Committee (QSE) with cumulative quarterly reports leading to an annual report that monitors progress against the plan
- Providing Joint Audit and Quality, Safety and Experience (JAQS) with an annual report against plan
- Ensuring that any gaps in service provision identified via an audit inform a SMART action plan to identify what steps need to be put in place to close the gap in provision. This action plan will be shared with Clinical Effectiveness team, and if significant risks are identified then these will be discussed at CEG for agreement regards escalation to the Executive Team via QSE
- The time frame for escalation will be directly proportional to the risk the deficit presents to our patient care. The report will document progress against the plan and highlight key service improvements related to clinical audit activity

8.4 Tier 3 - Local audits and delivering a Clinical Audit Project

Local audits are those undertaken within a single IHC or Division. They should be linked to local service development or identified local risk, or for education / training purposes. Self-registration for these audits is via the Clinical Effectiveness pages on BetsiNet or via this link 7a1a1srvinforep.cymru.nhs.uk/Tier3ClinicalAuditProjectSubmission

8.5 Selection of topic

Audit subject selection should be linked to a specific patient service, either to provide assurance around outcomes or to identify compliance against a pathway e.g. NICE, New Interventional Procedures.

8.6 Multidisciplinary audit

Clinical Leads and lead auditors should assess all audits in relation to their potential for multidisciplinary and multi-professional involvement, with the Health Board favouring those audits demonstrating team collaboration and participation. “Multidisciplinary” refers to a clinician audit team composed of representatives from at least two different disciplines.

8.7 Patient, Public Involvement and Stakeholders

In planning each audit, the potential for service user, carer and/or public involvement should be assessed and promoted. This may involve communication with appropriate forums relevant to the topic and/or the service to achieve this, also considering the communication needs / digital exclusion / cultural considerations for each stakeholder.

8.8 Sharing

All lead auditors will feedback their findings to the relevant service forum, where peer review will confirm that the findings are clinically robust. In addition, findings will be shared as widely amongst the Health Board as appropriate to the topic.

Auditors will agree, in discussion with their Clinical Lead, the use of utilising other media options (poster, circulation of brief written report, intranet, etc.) to promote learning from the audit findings.

Audit results will be written up as an Audit Report. This report, with any specific lessons, will be shared within the host service, the Clinical Effectiveness Department and include dissemination across the Health Board to relevant departments and services. This feedback may take multiple forms such as PowerPoint or poster presentation, SBAR or email. Key lessons should also be shared via the Clinical Effectiveness BetsiNet page.

8.9 Submission of Clinical Audit Report

On completion of the audit, the lead auditor is required to upload a copy of the final report and agreed action plan. (*An SBAR report template and SMART action plan can be accessed on the Clinical Effectiveness webpage via this link Clinical Audit sharepoint.com)*

8.10 Letter of Completion for Project Lead

After uploading the PDF copy of the final report, the e-tool will issue a letter of completion to the Project Lead.

9.0 Equality, including Welsh Language

Betsi Cadwaladr University Health Board is committed to advancing equality and protecting and promoting the rights of everybody to achieve better outcomes for all. The legislative framework requires us to promote equality in everything that we do.

Clinical audit activity should be undertaken with regard to equality and inclusion and opportunities to advance equality optimised. The process for determining choice of clinical audit projects, and identifying service user samples, must be inclusive and representative of the total population and where relevant consider those who share protected characteristics of age, disability, gender reassignment, race, religion/belief, sex, sexual orientation, marriage/civil partnership, and pregnancy/maternity.

An Equality Impact Assessment (EqIA) for this policy has been completed.

10.0 Training

All staff participating in clinical audit activity should have a good understanding of this methodology. *There are links on the Clinical Effectiveness webpage to externally provided training material,* Clinical Effectiveness training (sharepoint.com), *(Healthcare Quality Improvement Partnership (HQIP)*HQIP – Healthcare Quality Improvement Partnership *and Clinical Audit Support Centre (CASC)* Clinical Audit Support Centre

11.0 Review

The Clinical Audit Policy will be reviewed annually.

12.0 References

DICKENS, P. (1994). In: Welsh Assembly Government. (2003). *An introduction to clinical audit.* Wales

Healthcare Quality Improvement Partnership (HQIP). (2011). *New Principles of Best Practice in Clinical Audit.*

JURAN, J.M., GODFREY, A.B. (eds). (1999). *Juran's Quality Handbook.* 5th Edition. New York: McGraw Hill.

Welsh Assembly Government. (2003). *An Introduction to Clinical Audit*. Wales.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	Clinical Audit Policy
Date form completed:	*8th February 2023*

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Clinical Audit Policy for dissemination, implementation and monitoring
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy will act as a foundation to underpin clinical audit project management and guide the enthusiasm of BCUHB staff as they seek to gain an objective measure of their performance and achieve improvement needs through clinical audit activity.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Executive Medical Director. Clinical Effectiveness Group (CEG).
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	BCUHB Quality Improvement Strategy (2017- 2020) (Currently under review)
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	This policy relates to all staff with potential to participate in clinical audit activity within BCUHB; either by professional requirement, individual interest or relevance to the specific pathway / care group related to their practice.

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	There needs to be:
		• Good communication and dissemination regarding the policy. This will be through:
		  ➢ BCUHB Intranet.
		  ➢ Relevant BCUHB groups and forums.
		  ➢ Cascade through Clinical Audit / Governance / Quality leads.
		  ➢ BCUHB Communication Department circulations.
		• Resources to support engagement in participation.
		• Clear understanding of processes related to the policy

Part A Form 1: Preparation

Please answer all questions

7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	BCUHB is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to these commitments. The Health Board will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fully implemented. The Health Board will endeavour to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy or procedures. This may include accessibility of meetings/appointment venues providing translation, arranging an interpreter to attend appointments or meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

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

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

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

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

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below) *for further direction on how to complete this section please click here training vid p13-18)*	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** **Hint/tip: do not say: "not applicable", "no impact" or "regardless of…". If you have identified 'no impact' please explain clearly how you came to this decision.**		

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. **For the definitions of each characteristic please click here**					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. No impacts have been identified for age. The audit policy provides guidance and direction for all audit work within BCUHB which includes services and activity for all ages. (eg children and adult services) Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Considerations for different age groups will be required. Audit work may highlight potential equality related issues which where this is identified, will be integrated within any action plan.	Section 10.3 consideration of the needs of different age groups targeted within Patient and Public engagement.
Disability		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards.	Section 10.3 consideration of the needs of transgender patients and carers within Patient and Public

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					No impacts have been identified for disability. The audit policy provides guidance and direction for all audit work within BCUHB which includes all types of clinical services. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Considerations for involvement with disabled people / people with long-term conditions will be required. Consideration will also be required for the role of advocates and carers. Audit work may highlight potential equality related issues which where this is identified, will be integrated within any action plan.	engagement. Possible links with stakeholder engagement where appropriate.
Gender Reassignment		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. No impacts have been identified for Gender Reassignment. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Considerations for involvement for transgender patients should be given – eg using correct pronouns and name. Audit work may highlight potential equality related issues which where this is identified, will be integrated within any action plan.	Section 10.3 consideration of the needs of transgender patients and carers within Patient and Public engagement. Possible links with stakeholder engagement where appropriate.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Pregnancy and maternity		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. Maternity services will be included within the scope of clinical audit policy. No adverse impacts have been identified for pregnancy and maternity. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Considerations for involvement for this group may be required – exploring the link with Maternity Voices. Audit work may highlight potential equality related issues which where this is identified, will be integrated within any action plan as above.	Section 10.3 consideration of the needs of pregnancy and maternity within Patient and Public engagement. Possible links with Maternity Voices for engagement involvement.
Race		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. No adverse impacts have been identified for Race. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Considerations for involvement need to include translation needs and issues of cultural competency. Audit work may highlight potential equality related issues which where this is identified, will be integrated within any action plan.	Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Considerations for involvement need to include translation needs and issues of cultural competency.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Religion, belief and non-belief		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. No adverse impacts have been identified for religion, belief and non-belief. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement.	Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement.
Sex		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. No adverse impacts have been identified for sex. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement.	Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement.
Sexual orientation		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards . No adverse impacts have been identified for sexual orientation. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement.	Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. Possible links with stakeholder engagement where appropriate.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Marriage and civil Partnership (Marital status)		✓			The policy applies to all relevant individuals regardless of shared characteristics. Actions are based on outcomes in relation to measured standards. No adverse impacts have been identified.	
Socio Economic Disadvantage		✓			No adverse impacts have been identified for people who face socio-economic disadvantage. Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement. This may consider costs of transport to attend meetings or / and considerations for people who face digital poverty.	Section 10.3 Patient and Public Involvement should consider the appropriate methods and needs of different groups which are identified for engagement.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

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

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

	Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes		**No**	**(+ve)**	**(-ve)**			
		✓			None	The policy applies to all relevant individuals regardless of their characteristics. Actions are based on outcomes in relation to measured standards. No, the policy provides a framework of detailed guidance for Health Board staff to follow in respect of providing a systematic process for reviewing, disseminating, implementing and monitoring clinical audit process.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		√			The needs of Welsh speakers will be met.	
Treating the Welsh language no less favourably than the English language		√			See above	

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	Clinical Effectiveness Group will be asked to consult and give feedback. A copy of the policy will be uploaded on to the Betsinet under the Clinical Effectiveness page. Will be reviewed at Executive Delivery Group for Quality (EDG) for discussion and ratification.
Have any themes emerged? Describe them here.	No themes identified.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	No changes made.

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	Clinical Audit Policy for dissemination, implementation and monitoring

2. Brief Aims and Objectives: (Copy from Form 1)	This policy will act as a foundation to underpin clinical audit project management and guide the enthusiasm of BCUHB staff as they seek to gain an objective measure of their performance and achieve improvement needs through clinical audit activity.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	No √
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes	No √
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?**	Yes	No √

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No √
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	No √
	Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes √	No
	How is it being monitored?	The policies and procedures will be monitored to ensure their effectiveness. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Heath Board will investigate and take corrective action to mitigate and prevent any negative impact. The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.
	Who is responsible?	Clinical Effectiveness Group (CEG)

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	Use of existing reports, data.
	When will the EqIA be reviewed?	As review date on Policy every 3 years.

7. Where will your policy or proposal be forwarded for approval?	Clinical Effectiveness Group and Executive Delivery Group for Quality (EDG) 13th February 2023

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Names of people completing the EqIA. NB: this should **not** be a lone individual. All members of the CEG plus: James Risley	Deputy Executive Medical Director, Office of the Medical Director
	Nick Lyons	Executive Medical Director, Office of the Medical Director

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Please Note: The Action Plan below forms an integral part of this Outcome Report

Action Plan

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

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No significant negative impacts identified.		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	Assessment raises consideration around adding / signposting to related policy around issues of consent.	Policy author	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	No significant negative impacts identified.		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	No significant negative impacts identified.		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Monitoring in place to support this policy.		

Report title:	Smoke Free Policy			
Report to:	Quality, Safety and Experience Committee			
Date of Meeting:	Tuesday, 20 June 2023			
Executive Summary:	This is the updated policy for Betsi Cadwaladr University Health Board. Issued to provide guidance to comply with the revised changes to the smoke free legislation for all health board premises and grounds. Updated policy to include Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations") supporting the new legislation that means all hospital grounds, will be required to be smoke-free by law from the 1st March 2021 extending to all Mental Health units to be smoke free by 1st September 2022. This policy has been developed to protect all employees, workers, patients and others from exposure to second-hand smoke, to assist with compliance and to demonstrate due diligence in taking reasonable steps to prevent smoking on hospital sites, in line with Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations").			
Recommendations:	The Committee is asked to approve the policy.			
Executive Lead:	Executive Director of Workforce and Organisational Development			
Awdur yr Adroddiad: ***Report Author:***	Gavin Jones, Lead Health Intervention Co-ordinator			
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:***				
Link to Strategic Objective(s):	Healthy Workforce and population.			

Regulatory and legal implications:	In line with Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations").
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	Not applicable
In accordance with WP68, has an SEIA identified as necessary been undertaken?	Not applicable
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Not applicable
Financial implications as a result of implementing the recommendations	Not applicable
Workforce implications as a result of implementing the recommendations	Not applicable
Feedback, response, and follow up summary following consultation	Not applicable
Links to BAF risks: *(or links to the Corporate Risk Register)*	Not applicable
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: Health Board on 22 June 2023 for approval.	
List of Appendices: None	

Version: 1.15

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

WP31
SMOKE FREE POLICY

Date to be reviewed:	November 2024	**No of pages:**	14
Author(s):	Gavin Jones	**Author(s) title:**	Lead Health Intervention Co-ordinator
Responsible dept. / director:	Executive Director of Workforce and Organisational Development		
Approved by:	Workforce & Organisational Development Committee		
Date approved:			
Date activated (live):			

Date EQIA completed:	November 2022
Documents to be read alongside this policy:	WP6 Code of Conduct (Disciplinary Rules & Standards of Behaviour) WP9 All Wales Disciplinary Policy WP62 BCUHB Dress Code Guidelines WP9 All Wales Disciplinary Policy WP11 NHS Wales Managing Attendance at Work Policy

Purpose of Issue/Description of current changes:
Updated policy for Betsi Cadwaladr University Health Board. Issued to provide guidance to comply with the revised changes to the smoke free legislation for all health board premises and grounds. Updated policy to include Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations") supporting the new legislation that means all hospital grounds, will be required to be smoke-free by law from the 1st March 2021 extending to all Mental Health units to be smoke free by 1st September 2022.

Summary
This policy has been developed to protect all employees, workers, patients and others from exposure to second-hand smoke, to assist with compliance and to demonstrate due diligence in taking reasonable steps to prevent smoking on hospital sites, in line with Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations").

First operational:	November 2011				
Previously reviewed:	July 2013	May 2018	Feb 2021	September 2022	March 2023
Changes made yes/no:	Yes	Yes	Yes	Yes	Yes

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Appendices:

Appendix A - What is in a cigarette?

Appendix B - The effects of quitting smoking

1. Introduction and Policy Statement

Betsi Cadwaladr University Health Board has identified a reduction in smoking prevalence as a priority in its strategy Living Healthier Staying Well. The proportion of adults who currently smoke in North Wales is 13% and a further 14% report that they use e-cigarettes according to the National Survey for Wales.

As an exemplar and practicing public health organisation, the Health Board is committed to creating a smoke-free environment on all its sites to protect employees, workers and all others who enter its premises and grounds from second-hand smoke. It is also committed to ensuring that support is provided for employees and patients who wish to give up smoking. The Health Board / persons responsible for the premises have a duty to take reasonable steps to prevent smoking on all of its grounds and vehicles.

In adults, second-hand smoke increases the risk of cardiovascular and respiratory diseases including coronary heart disease and lung cancer. Ventilation or separating smokers and non-smokers within the same airspace does not stop potentially dangerous exposure.

The Smoke-free Premises etc. (Wales) Regulations 2007 ("the 2007 Regulations") were introduced to protect employees and the public from the harmful effects of second-hand smoke. This legislation prevented smoking in 'enclosed' or 'substantially enclosed' public places, including workplaces and vehicles.

More recently, the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations") introduced on the 1 March 2021 protects people from second hand smoke in hospital grounds and other outdoor areas. The new legislation means that it is now a criminal offence to smoke tobacco on any Health Board grounds, dwellings or vehicles. The definition in the legislation covers the smoking of cigarettes, pipes, cigars, herbal cigarettes and water pipes (often known as hookah or shisha pipes) etc.

These restrictions include all areas up to the Health Board premises, boundaries, and include car parks and vehicles parked on Health Board property, outdoor seating areas, walkways and all other areas. Any person wishing to smoke must first leave the Health Boards grounds.

The implementation of this policy will ensure compliance with both Regulations and will also support implementation of the Corporate Health Standard at Work framework.

The new legislation means that it is now a criminal offense to smoke tobacco on any Health Board grounds, dwellings or vehicles. All staff are encouraged to review the legislation, which sets out the new smoke free law (please see reference section of policy).

The Health Board is committed to implementing the new legislation ensuring that all of our workplaces are smoke-free and all employees and workers have a right to work in a smoke-free environment. The implementation of this legislation is seen as a contribution to the de-normalisation of smoking by providing fewer opportunities for smoking in public areas, supporting smoking cessation and contributing to health improvement.

Definition of groups affected: employees, workers, employers of external agencies, voluntary workers/volunteers, students, contractors, patients and visitors to any Health Board premises, grounds and vehicles. These groups hereafter collectively known as employees and workers, patients and all others.

The Health Board policy is to treat all patients irrespective of whether they smoke or not and is committed to helping patients who wish to stop smoking.

The Health Board is committed to supporting employees who wish to stop smoking and will ensure that the selling or promoting of tobacco products is not allowed on any of its premises.

The difficulty of enforcing a Smoke-Free Policy is acknowledged and employees will receive the full support of the Health Board members.

2. Purpose

This policy has been developed to protect all employees, workers, patients, and others, from exposure to second-hand smoke. The policy also supports compliance with the smoke-free provisions of the Health Act 2006, and the related regulations for Wales, and the requirements in Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations"). Under the new legislation, it is a criminal offence to smoke on any Health Board grounds, dwellings and vehicles.

The Health Board has a responsibility for ensuring compliance with the legislation and must take reasonable steps to prevent smoking on site.

Section 2 of the Health and Safety at Work etc. Act 1974 places a duty of care on employers to 'provide and maintain a safe working environment which is, so far as is reasonably practicable, without risks to health and adequate as regards facilities and arrangements for their welfare at work.'

This policy recognises that second hand smoke adversely affects the health of all employees and its workers. It is not concerned with whether anyone smokes but with where they smoke and the effect this has on employees, patients and others, It is also concerned with the presence of preventable carcinogenic substances in the locality of health sites.

The Health Board encourages its employees to refrain from smoking as set out in this policy, both in their own health interests and as representatives of a major public body, whose purpose is to improve health. The Health Board is committed to supporting employees and workers who wish to stop smoking.

3. Scope

The Smoke-Free Policy applies to all employees and workers, without exception, and will form part of the Health Boards Terms and Conditions of Employment. Employees and workers are expected to comply with the Smoke-Free Policy and the new smoke free law.

Definition of groups affected: employees, workers, employers of external agencies, voluntary workers/volunteers, students, contractors, patients and visitors to any BCUHB premises, grounds and vehicles. These groups hereafter collectively known as employees and workers, patients and all others.

4. Aims and Objectives

Aims:
To protect all employees, workers, patients, and others from exposure to second hand smoke. The Health Board will take reasonable steps to prevent smoking on hospital sites, in line with Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 ("the 2017 Act") and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 ("the 2020 Regulations").

The Health Board will comply with their duty to conform to the legislative requirements and support staff, patients, visitors, contractors and others, to comply with the legal requirements.

Objectives:

1 To abide by the new smoke free law and set an example to our community by making non-smoking the normal practice in the Health board's buildings, grounds and vehicles.

2 To provide a safe and healthy working environment and to ensure that the possible consequences of smoking tobacco are reduced.

3 To reduce incidents of smoking and vaping on BCUHB sites

4 To reduce harm to patients, visitors and staff from exposure to second-hand smoke

5 To promote health and well-being by encouraging and assisting employees, workers, patients and others to make a lifestyle choice to give up smoking and to reap the health benefits.

6 To offer smoking cessation support to both employees and patients to give up smoking

7 To ensure that all managers with responsibilities for the health, safety and welfare of employees have adequate guidance in recognising, supporting and assisting any employees to stop smoking.

8 To fulfil the Board's legal duty of care to all its employees, patients and others to provide a safe working environment

5. Roles and Responsibilities

Overall responsibility for policy implementation and review rests with the Chief Executive Officer (CEO).

The CEO shall delegate operational responsibility to the three Acute Managing Directors based at each of the main DGH sites: Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor. The BCUHB Managing Directors and Area Directors will demonstrate due diligence in respect of the legislation and be responsible for policy implementation at all other BCUHB premises linked with their respective sites. Health Board site leads will ensure that all employees, workers, patients and others are aware of the policy and of their role in the implementation and monitoring of the policy.

All managers are required to familiarise themselves with this policy; to ensure their staff are aware of the policy and new smoke free law. They will support / manage their staff to ensure compliance with the policy. All staff will ensure compliance with the requirements of this policy and refrain from smoking on any Health Board premises; grounds and vehicles at all times.

All staff, irrespective of grade or discipline, should politely remind smokers that smoking is not permitted by law on Health Board premises and request them not to smoke on the premises (see also paragraph 16 - Policy Compliance).
Staff must not take part in smoking behaviour or practice on any Health Board site or encourage patients to leave the premises in order to smoke.

Managers will ensure that all new personnel will have access to a copy of the policy during local induction. Staff bulletin boards and Health Board website will be used to promote the policy and advertise the contact number for Help Me Quit (0800 085 2219) for help and support.

No smoking signs have been clearly displayed at or near the entrances to the premises highlighting the new smoke free law, reminding patients, staff and others that it is now illegal to smoke on health board grounds.

6. Health Board Premises and Grounds

The Health Boards Smoke Free Policy does not permit smoking on any Health Board premises and adjoining grounds. The use of E-cigarettes / vaping is also not permitted. The Health Board has provided appropriate signage at or near the main site entrances to conform to legislation and to ensure that all parties entering are aware that smoking is prohibited on hospital grounds.

There is some evidence on the potential for E-cigarettes / vaping use to have a negative impact on indoor air quality and therefore represent a risk to health. E-cigarettes and Vapes are not commercially available in the UK as licensed medicines. Further, their resemblance to traditional products could create an

unwanted perception by others. Reports from Fire Services indicate that some of these devices present a potential fire hazard.

7. Health Board Vehicles

Health Board vehicles will be smoke-free at all times to safeguard the health of other work colleagues who use the vehicles (with the exception of lease cars when used for private use, which are not used by anyone else in the workplace). This includes all transport provided by the private and voluntary sector organisations.

8. Employees and workers

Employees and workers must never smoke on BCUHB premises, grounds or in vehicles. Employees and workers must not smoke when wearing a visible name badge or whilst in their uniform. Please refer to WP62 Dress Code Guidelines to support the All Wales NHS Dress Code.

Many employees and workers within the NHS are required to enter a patient's home to provide a service. The Health Board recognises that protection of employees and workers from exposure to smoke when making home visits is of paramount importance (see Welsh Government 2007 Supplementary Guidance link in section 17).

The Health Board is committed to supporting employees to quit smoking. A maximum of 6 hours paid time off over a period of 8 weeks (pro rata if working part time) will be given to employees to attend smoking cessation sessions. Staff can decide on whether they wish to attend a stop smoking group or 1-1 support delivered by Help Me Quit or whether they wish to access 1-1 support delivered by a Community Pharmacist. These services can be accessed via Help Me Quit (0800 085 2219).

The allocated time does not include any time taken to travel for these appointments which must be taken in the employees own time. These sessions should be documented and signed by their line manager. The line manager will discuss with the employee the time taken and ensure that it fits with service delivery needs. The line manager will be expected to monitor the time taken.

9. Health Board Residential Accommodation

Smoking is not permitted within any Health Board residential accommodation. This is reflected within the residential booklet given to all staff who live in BCUHB residential accommodation. If a resident wishes to smoke or vape then they must do this away from the hospital grounds, adhering to the BCUHB Smoke Free Policy. The Health Board is committed to supporting our workforce to stop smoking and

any staff who would like information on quitting can contact the Help Me Quit Service. Please refer to section 12 for further information.

10. Patients

Smoking on Health Board grounds is illegal and will not be allowed anywhere on Health Board premises, grounds and vehicles. Staff and patients should be aware that, should patients wish to leave the hospital grounds to smoke, then they would be considered to have left the premises against clinical advice and will be advised of this at the time by staff. They will also be advised that the Health Board cannot be responsible for their safety or equipment in such circumstances.

All documentation sent out or given to patients will highlight that it is illegal to smoke on Health Board hospital premises and include information on Smoking Cessation services.

The Health Board is committed to providing practical help, support and advice to all patients who wish to stop smoking. Individual care plans will incorporate smoking cessation supported by nicotine replacement therapy if required. Support is also available from the Help Me Quit in Hospital service. Further information on community smoking cessation services is available (see Section 16).

11. All others entering Health Board premises

Other individuals (not classed as employees, workers or patients) will not be permitted to smoke in any area of the Health Board, to include premises, grounds and vehicles under this legislation.

12. Implementation

Ultimate responsibility for implementing and monitoring the Smoke-Free Policy rests with the CEO and Executive Team. Under the Smoke-free Premises and Vehicles (Wales) Regulations 2020 (“the 2020 Regulations”), the responsibility for compliance with the legislation lies with the person in charge of the hospital – taking reasonable steps to prevent smoking on hospital grounds. Heads of Service, department and line managers will be responsible for their respective areas and Corporate Services. All employees and workers have a responsibility to ensure that the policy is adhered to.

Employees and workers who are finding it difficult to stop smoking or comply with the requirements of the policy should:

1. Discuss the issue with their line manager for initial support
2. Be encouraged to self-refer to:

- Help me Quit 0800 085 2219 http://www.helpmequit.wales/ for services available in Wales
- https://www.nhs.uk/smokefree/help-and-advice/local-support-services-helplines services available in England.

13. Recruitment Procedures

Job advertisements, job descriptions, interviews and induction sessions, for all staff recruited by the Health Board will include a reference to the WP31 Smoke- Free Policy

All new employees, workers and volunteers will be sent a copy of their Contract of Employment and an appointment letter, which details the WP31 Smoke Free policy.

14. Training

Issues related to smoking and smoking cessation will be included in the following:

- Induction programme
- ESR – access to smoking cessation online training
- Making Every Contact Count (MECC)
- Fire Lectures
- Violence and Aggression Training

15. Policy Compliance

a) Employees and workers

This policy will form part of all employees and workers Terms and Conditions of Employment including employees from external agencies, voluntary workers, students and contractors working on site.

Education and provision of support are seen as an important part of this policy; however, employees who breach the Policy will be reported to their line manager and will be subject to the Health Boards' Disciplinary Policy and Procedures.

Under the new legislation, it is a criminal offence to smoke on any Health Board grounds, dwellings and vehicles. Failure to comply with the Regulations could result in a fixed penalty notice of a £100, discounted to £75 for early payment.

b) Patients, Relatives and Visitors

All employees irrespective of grade or discipline should inform members of the public about the smoke free law and ask them not to smoke on site. A polite explanation should be given about the Health Board's Smoke-Free Policy and a request made to refrain from smoking for the duration of the visit. Employees should not place themselves at risk of abuse whether it is verbal or physical. If verbal or physical abuse occurs as a consequence of employees implementing the Smoke-Free Policy, Patients/Relatives/Visitors will be subject to the Health Board's Protecting Employees from Violence and Aggression.

c) Additional Guidance for Policy Compliance

Legislation is now in place and therefore staff (& others) need to be aware that there is a means of enforcement via a Fixed Penalty Notice from the Local Authority. Further information can be found via the links in section 17.

17. Legislation

Welsh Government Smoke Free Law 1st March changes https://gov.wales/smoke-free-law-guidance-changes-march-2021-html

Smoke Free Premises and vehicles (Wales) regulations
https://www.legislation.gov.uk/wsi/2020/1211/contents/made

Welsh Government (2017) The Smoke-free Premises etc. (Wales) Regulations 2007
http://www.legislation.gov.uk/wsi/2007/787/contents/made

Public Health Wales Act (2017) – up-dated
http://www.legislation.gov.uk/anaw/2017/2/contents

Health and Safety at Work etc. Act 1974
https://www.hse.gov.uk/legislation/hswa.htm

Welsh Government (2018) The Smoke-free Premises and Vehicles (Wales) Regulations 2018
https://beta.gov.wales/smoke-free-premises-and-vehicles-wales-regulations-2018

18. References

Action on smoking and health Wales (ASH Wales)
https://ash.wales/

Help Me Quit Wales
http://www.helpmequit.wales/

National Survey for Wales
National Survey for Wales: April 2021 to March 2022 | GOV.WALES

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	Title

Engagement has taken place with:

Name	Title	Date Consulted
Smoke Free task and finish group	N/A	05.03.2021

APPENDIX A


What's in a cigarette?
Cadmium
(Batteries)
Butane
(Lighter Fluid)
Stearic Acid
(Candle Wax)
Toluene
(Industrial
Solvent)
Nicotine
(Insecticide)
Hexamine
(Barbecue Lighter)
Ammonia
(Toilet Cleaner)
Acetic Acid
(Vinegar)
Methane
(Sewer Gas)
Arsenic
(Poison)
Carbon
Monoxide
Methanol
(Rocket Fuel)

APPENDIX B

The effects of quitting smoking

Quitting smoking is the best thing any smoker can do for their health - it is a fact that 1 in 2 long-term smokers will die from this deadly addiction. The mantra may be that "we all die eventually" but smokers die on average 10 years earlier and tragically, from much more painful and debilitating illnesses such as lung cancer, heart attacks and strokes.

The sooner a person quits smoking, the sooner the body can begin to repair itself. Any amount of time a person is smoke free can give the body, especially the lungs and bloodstream, the time to 'breath' again and take in the clean air needed to recuperate.
There's some damage caused by smoking, which will never go away, but there is no question about it; when you quit smoking, you will live a much healthier, longer and richer life.

One of the scariest aspects of quitting smoking can be the unknown of what will happen and this often puts people off trying to be smoke free in the first place. Below is a guide as to the effects of quitting smoking.

After 20 minutes

The human body is an amazing thing. After just 20 minutes of not smoking, the body begins to recover. Not long after the last puff of a cigarette, heart rate and blood pressure return to normal.

After 8 hours

Nicotine and carbon monoxide (CO) levels in blood reduce by more than half and continue to fall. Your oxygen levels return to normal.

After 24 hours

Carbon monoxide will be eliminated from the body. Lungs start to clear out mucus and other smoking debris.

After 48 hours

There is no nicotine left in the body. Ability to taste and smell is greatly improved and appetite can return to normal.

After 72 hours

Breathing becomes easier. Bronchial tubes begin to relax and energy levels increase.

After 2-12 weeks

Your circulation will improve and you may start to feel pins and needles throughout your body as blood flow is now being circulated to the outer extremities.

After 3-9 months

Coughs, wheezing and breathing problems improve as lung function increases by up to 10%.

After 1 year

Risk of heart disease is about half compared with a person who is still smoking.

After 10 years

Risk of lung cancer falls to half that of a smoker.

After 15 years

Risk of heart attack falls to the same as someone who has never smoked.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	WP31 BCUHB Smoke Free Policy
Date form completed:	18.11.2022

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Smoke Free Policy WP31
2.	Provide a brief description, including the aims and objectives of what you are assessing.	Reviewing WP31 policy for Betsi Cadwaladr University Health Board. This reflects BCUHB's commitment to safeguarding the health, safety and well-being of employees, patients and visitors. The policy will also serve to improve efficiency of BCUHB by supporting those individuals that smoking cessation support. It identifies the opportunities available to promote and signpost individuals to specialist services, highlights the new all Wales legislation, and provides advice and information for support relating to smoking cessation. The aims of this policy are: • To provide a safe and healthy working environment and to ensure that the possible consequences of smoking tobacco are reduced. • To reduce incidents of smoking and vaping on BCUHB sites • To reduce harm to patients, visitors and staff from exposure to second-hand smoke • Promote awareness through various media to promote the benefits to quitting smoking. • Inform employees of the changes to the new smoke free legislation • To alert employees of the possible consequences arising from smoking tobacco. • To create a climate of openness and encourage employees to seek early support and appropriate help to stop smoking.

Part A Form 1: Preparation

Please answer all questions

		• To ensure that all managers with responsibilities for the health, safety and welfare of employees have adequate guidance in recognising, supporting and assisting any employees to stop smoking. • To raise employees awareness of the harmful effects of smoking tobacco • To prevent the supply or use of illegal substances from occurring on BCUHB premises.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Teresa Owen, Executive Director of Public Health
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Yes: - Staff health and wellbeing guidelines (OHW02) - WP6 Code of Conduct (Disciplinary Rules & Standards of Behaviour) - WP9 All Wales Disciplinary Policy - HS01 Health & Safety Policy - WP11 NHS Wales Managing Attendance at Work Policy - WP62 BCUHB Dress Code Guidelines - WP3a All Wales Capability Policy - Relevant regulatory/professional body guidance <u>Legislation</u> Chapter 1 of Part 3 of the Public Health (Wales) Act 2017 (“the 2017 Act”) and the Smoke-free Premises and Vehicles (Wales) Regulations 2020 (“the 2020 Regulations”)

Part A Form 1: Preparation

Please answer all questions

		Strategy A smoke-free Wales – our long term Tobacco Control Strategy for Wales and Towards a smoke-free Wales delivery Plan 2022-24 Professional guidance: NICE Guidance: Tobacco preventing uptake, promoting quitting and treating dependence NG209
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Employee's and workers Patients and service users The Public Local Authorities in North Wales Any persons residing in BCUHB accommodation Trade Union Partners All others entering BCUHB premises
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	To support the proposed policy: - Clear communication of WP31 policy throughout the organisation - Engagement from all BCUHB employees to implement the policy - Adequate training for supporting and encouraging individuals who wish to stop smoking to ensure referral to HMQ Services - Responsibility of senior managers to enforce the policy and legislation - Staff training to deliver brief intervention to patients and onward referral to HMQ Services

Part A Form 1: Preparation

Please answer all questions

		Potential barriers: - Confidence of staff to manage and implement the policy and its sanctions - Reduced enforcement of the new legislation - Poor communication or lack of engagement with staff and / or public - Lack of understanding around policy implementation - Unwillingness from employees to seek support to remain smoke free during working hours - Unwillingness of patients to access support and quit smoking
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	Leading by example and de-normalisation of smoking, which is a known contributor to health inequalities. Supporting Temporary Abstinence when using BCUHB sites by managing tobacco addiction through licenced nicotine products. Access to NRT for inpatients in addition to support this policy. There will be an opportunity through this proposal for all smokers to have a conversation about the Smoke Free Regulations and the Health Board's policy and the importance of creating and developing smoke free environments. There will also be an opportunity for smokers to learn about the quitting options offered across North Wales – this is significant as smoking is the leading cause of preventable ill health and premature death and the disadvantaged are disproportionately affected.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

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

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

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

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

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below) *for further direction on how to complete this section please click here training vid p13-18)*	Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Guidance for Completion *In the columns to the left – and for each characteristic and each section here and below – make an assessment of how you believe people in this protected group may be affected by your policy or proposal, using information available to you and the views and expertise of those taking part in the assessment. This is your judgement based upon information available to you, including relevance and proportionality. If you answered 'Yes', you need to indicate if the potential impact will be positive or negative.* ***Please note it can be both e.g. a service moving to virtual clinics: disability (in the section below) re mobility issues could be positive, but for sensory issues a potential negative impact. Both would need to be considered and recorded.*** *The information that helps to inform the assessment should be listed in this column.* ***Please provide evidence for all answers.*** **Hint/tip: do not say: "not applicable", "no impact" or "regardless of…". If you have identified 'no impact' please explain clearly how you came to this decision.**		

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

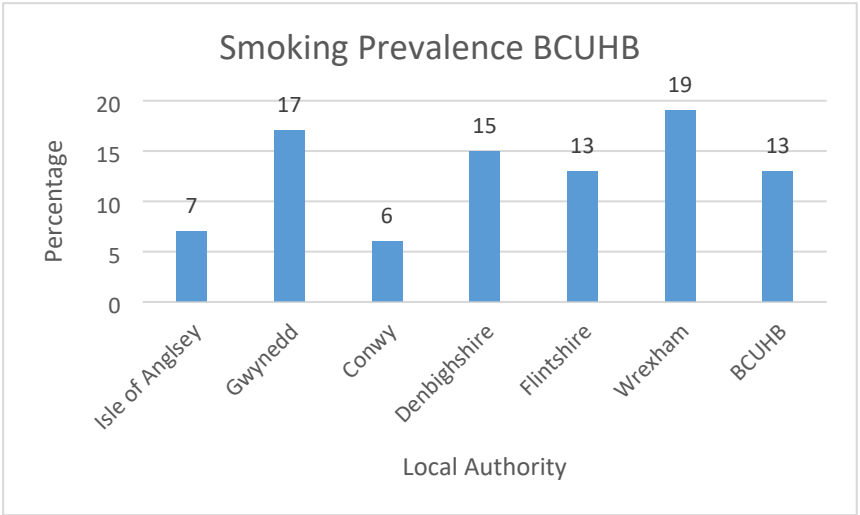
	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. **For the definitions of each characteristic please click here**					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age		X			• As health care providers, we have a duty to protect young people from the harmful effects of tobacco smoke which would have a negative impact on their health and well-being. • Policy prevents discrimination and offers the same level of support regardless of age • The policy aims to de-normalise smoking to all age groups by making smoke free hospital grounds the norm. A reduction in second-hand smoke at entrances will protect them from the harms associated with smoking. • Smoking is the primary cause of preventable illness and death, causing around 200 deaths every day in the UK. Smoking causes a wide range of diseases but kills mainly through causing lung cancer, respiratory diseases and heart disease. • Smoking remains a major cause of premature death in Wales. Smoking and passive smoking have been linked to a range of serious illnesses including cancers and heart disease. • Most smokers start when they are young and adolescents are more susceptible to nicotine	No Detrimental Impact identified

Please answer all questions

					addiction; the younger a person starts to smoke the more likely they are to smoke over a longer period and the more heavily they are likely to smoke in adulthood. • 40% of adult smokers started smoking regularly before the age of 16 • Children are over 70% more likely to start smoking if just one parent smoked • 4% of adolescents reported that they smoke weekly or daily, indicating no change since 2013/14 Across BCUHB, on average 13% of persons aged 16 and over self-reported a smoking status of 'daily smoker' or 'occasional smoker' in the most recent data from the National Survey of Wales 2022. The average for North Wales is 12.8% however there is variation at local authority level. As can be seen from the figure below, the percentage of persons aged 16 and above who smoke is lowest in Conwy (6%) and highest in Wrexham (19%). • Figure 1 – persons aged 16 and over by smoking status (percentage)	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					Figure 1  https://www.gov.wales/national-survey-wales	
Disability	X		X		• Policy provides same level of support regardless of disability • This policy will have a positive impact on this community group with the aim of promoting health by creating a healthy smoke free environment in which, people who wish to withdraw or manage their nicotine intake may choose to do so. • Services provided ensure that the smoking cessation assessment and treatment offered is rigorous, suited and tailored to specific needs, ensuring that the support required is attained within the care pathway from the point of entry to discharge.	Staff enforcing policy should be mindful of neuro diverse conditions and potential mental health conditions and deal with individuals sympathetically and provide appropriate support to meet their needs. HMQ Services are recruiting staff who will be dedicated

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					• Smokers in this group will be offered smoking cessation services routinely so that they can chose to make a cut down or quit attempt with support. • For those who also have a learning disability they are 58 times more likely to die before they reach the age of 50. Respiratory problems are a common feature in the presentation of registered disabled people in our services and we are confident that the smoke free policy will have a positive impact on addressing this, providing better opportunities for enhanced wellbeing and better quality of life. • This may be a factor if the employee affected has difficulty in communicating their concerns with smoking to their manager • There is a potential that people with disabilities may smoke heavier or more frequently but this would not impact on their ability to seek support • Smokers who are unable to leave the home or purchase products for themselves due to a disability may not have the opportunity to find out about Nicotine Replacement Therapy or Nicotine Vapour Products (NRT / NVP) and make an informed choice about whether they wish to switch to them. • People reporting having a long standing illness or disability (LSID) are less likely to report health issues • Common factors such as isolation, exclusion and social distance may be important in leading to increased tobacco smoking • Adults with disabilities are more likely than their peers to smoke. Public health agencies and practitioners may wish to consider what reasonable	to support individuals with mental health issues to quit smoking. Ongoing meetings held in MH&LD directorate to review impact of policy

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					adjustments may need to be made to policies and interventions to ensure that they are effective for adults with disabilities. • Individuals with mental Health conditions may find being unable to smoke very challenging with increased addiction and support required. Smoking cessation is therefore clinically significant to help manage changes with medication as a result of reduced smoking activity. • The impact of this service initiative will be reviewed regularly ensuring that any identified gaps are addressed with appropriate action planning. https://academic.oup.com/jpubhealth/article/40/4/e502/4958209	
Gender Reassignment		X			• The policy prevents discrimination and offers the same level of support for staff and patients regardless of gender reassignment • There are no unique impacts expected for this smoking group. They will be screened for smoking status as any other patient. Those who smoke will have the choice to temporarily abstain or quit either with or without support if they require a hospital admission. • There is lack of data on smoking in relation to the trans community. However, overall data suggests that Lesbian, gay, bisexual, and trans (LGBTQ+) people are more likely to experience health	No Detrimental Impact identified

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					inequalities, report lack of access to services and have higher rates of smoking. • Many within LGBTQ+ communities also report barriers to accessing medical treatment. Services must, therefore, be inclusive and welcoming to LGBTQ+ people. • Lesbian, gay and bisexual people are more likely to smoke than heterosexual people. Rates are particularly high for LGB women and bisexual men, with the inequality particularly pronounced when compared with heterosexual women and men (ONS, 2019). http://ash.org.uk/information-and-resources/health-inequalities/health-inequalities-resources/smoking-and-the-lgbt-community/ https://ash.org.uk/wp-content/uploads/2019/09/HIRP-LGBT-community.pdf https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2018	
Pregnancy and maternity	X		X		• Policy offers same support to individuals regardless of their being pregnant or just having had a baby. • The Health Board has a Help Me Quit for Baby service which is a bespoke service to support pregnant smokers and their partners to stop smoking	No Detrimental Impact identified

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					• Smoking in pregnancy causes an average of 5000 miscarriages and stillbirths each year, and increases the risk of premature birth and low birth weight. Making smoking cessation a routine part of our daily practice will positively impact on creating a culture that supports abstinence and therefore protects expectant mothers and their babies giving them a better start in life and support saving babies lives. • 19.7% of women were recorded as being a smoker at their initial assessment. • 16%, around one in six mothers, were recorded as being smokers at the time of birth in 2018. • 11,864 unborn babies in Wales are exposed to harm from tobacco each year. • Although women are more likely to attempt to quit smoking when pregnant, research shows that 16% of pregnant women in Wales smoke throughout their pregnancy. https://ash.wales/wales-smoking-statistcs/ https://gov.wales/sites/default/files/statistics-and-research/2019-10/maternity-and-birth-statistics-2018-239.pdf	
Race		X			• Policy prevents discrimination and offers the same levels of support regardless of race and or ethnicity • Smokers in this group will be screened for smoking status as any other patient. Those who smoke will have the choice to temporarily abstain or quit either	No Detrimental Impact identified

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					with or without support if they require a hospital admission. • Ethnic minorities in England and Wales represent approximately 14% of the total population • Above average rates of smoking are reported among Pakistani and Bangladeshi men, but women in these ethnic groups are unlikely to smoke (40% of Bangladeshi men, comparing to 2% of Bangladeshi women). • The ethnic groups with the highest rates of smokers are Afro Caribbean men at 37%, followed by Bangladeshi men at 36% • Smoking prevalence in ethnically Indian, Chinese, and Black African population is consistently lower than average. • Non-UK born 'White' and 'Chinese' groups show a strong socio-economic gradient in smoking, which is less prominent in 'mixed' and black groups, and not present in South Asian groups. • In the UK, Smokeless Tobacco (SLT) products are consumed most frequently by ethnic minority groups, predominantly South Asians of Bangladeshi, Indian and Pakistani origin. Among the GB South Asian population, adults of Bangladeshi origin are most likely to use smokeless tobacco, with adults of Indian origin least likely to do so. https://ash.org.uk/wp-content/uploads/2019/08/ASH-Factsheet_Ethnic-Minorities-Final-Final.pdf	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					http://ash.org.uk/information-and-resources/briefings/ash-briefing-health-inequalities-and-smoking/	
Religion, belief and non-belief		X			• Policy prevents discrimination and offers the same level of support regardless of religion, belief or non-belief • Smokers in this group will be screened for smoking status as any other patient. Those who smoke will have the choice to temporarily abstain or quit either with or without support if they require a hospital admission. • After adjusting for age, sex, broad ethnic group and region, smoking prevalence in England and Wales in 2016 to 2018 was significantly higher among those identifying as having no religion (18%) than those who identified as Muslim (11%), Christian (11%), Hindu (5%), Jewish (4%), Sikh (2%), or with "any other religion" (9%) • As well as being less likely to smoke than those of no religion, those who identified as Sikh were also significantly less likely to smoke than those who identified as Christian, Muslim, Buddhist (17%), or with "any other religion"	No Detrimental Impact identified

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/religion/articles/religionandhealthinenglandandwales/february2020	
Sex		X			• Policy prevents discrimination and offers the same levels of support regardless of gender • All smokers will be screened for smoking status as any other patient. Those who smoke will have the choice to temporarily abstain or quit either with or without support if they require a hospital admission. • In the UK, 15.9% of men smoked compared with 12.5% of women • This policy will have a positive impact on both males and females https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2019 https://gov.wales/national-survey-wales	No Detrimental Impact identified
Sexual orientation		X			• This policy does not discriminate against sexual orientation and offers the same level of support to all staff • Smokers in this group will be screened for smoking status as any other patient. Those who smoke will have the choice to temporarily abstain or quit either	No Detrimental Impact identified

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					with or without support if they require a hospital admission. • Smoking prevalence is higher among lesbian, gay and bisexual (LGB) people than in the general UK population. This is despite smokers within the LGB community wanting to quit and making the same number of quit attempts as the general population. • While there is currently limited data on smoking prevalence in the trans and non-binary population, the data that is there suggests that smoking prevalence is also higher. • The 2016 Office for National Statistics (ONS) Integrated Household Survey found that 24.6% of gay/lesbian and 26.1% of bisexual people smoke; this compares to 18.8% of heterosexual people. • One in six LGBTQ+ people (15 per cent) smoke almost every day, however the majority of LGBTQ+ people (70 per cent) have not smoked at all in the last year. • LGBTQ+ people aged 65 and over are less likely to smoke, fewer than one in ten (nine per cent) smoke almost every day. One in five LGBTQ+ people in category C2DE (21 per cent) smoke every day compared to 12 per cent of LGBTQ+ people in category ABC1. • The Annual Population Survey 2018 found that smoking prevalence by sexual orientation in the UK was 23.1% for gay or lesbian people and 23.3% for bisexuals, compared to 15.9% for heterosexual/straight people.	

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					https://ash.org.uk/wp-content/uploads/2020/03/LGBTeip.pdf http://ash.org.uk/information-and-resources/health-inequalities/health-inequalities-resources/smoking-and-the-lgbt-community/	
Marriage and civil Partnership (Marital status)		X			• This policy prevents discrimination and offers the same support regardless of a person being married or in a civil partnership • All smokers will be screened for smoking status as any other patient. Those who smoke will have the choice to temporarily abstain or quit either with or without support if they require a hospital admission. • This policy is in support of all staff regardless of social or marital status. Therefore, no potential equality issue were identified.	No Detrimental Impact identified
Socio Economic Disadvantage	X		X		The latest SHRN survey of 103,971 students in Wales, shows children from more deprived backgrounds were more likely to smoke on a regular basis and experiment with cigarettes earlier, than those from more affluent families. 21% of adults from the most deprived areas of Wales smoke compared to 8% among the least deprived adults	No Detrimental Impact identified

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

					This contrast can also be seen in health outcomes – Public Health Wales reported that smoking-related mortality was around three times higher in the most deprived areas than in the least deprived. The younger the age of uptake of smoking, the greater the harm is likely to be. Research shows the earlier children become regular smokers and persist in the habit as adults, the greater the risk of developing lung cancer or heart disease, which often lead to early death.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

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

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	**No**	**(+ve)**	**(-ve)**			
	X				The Northern Ireland Human Rights Commission considered the issue of smoking and human rights in 1995 and found that "no treaty or other instrument defines a human right to smoke and the Commission does not accept the position, sometimes advanced by the tobacco lobby, that there is such a right." Article 1 of the UK Human Rights Act of 1998 states that: "everyone's right to life shall be protected by law." The Charter of Fundamental Rights of the European Union, signed in 2000, states that: "every worker has the right to working conditions which respect his or her health, safety and dignity." Article 8 of the Universal Declaration of Human Rights provides for the right to a private life. This is a referred to as a 'qualified right', meaning it does not override the protection of the health and freedom of others. Tobacco smoke is a Class A	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

					carcinogen, and exposure to second-hand smoke causes direct harm to non-smokers. Therefore, under the legislation the right to work or be treated in a hospital (or community centre) that has not been polluted by a Class A carcinogen outweighs any perceived right to smoke Example of case law regarding non-smoking policy within mental health unit: During a 2008 legal challenge to a total smoke-free policy in Nottinghamshire NHS trust, legal precedence relating to the implementation of fully smoke-free mental health units was established by the High Court: Rejecting the notion of an absolute right to smoke wherever one is living Rejecting the argument that those responsible for the care of detained people are obliged to make arrangements to enable them to smoke. Concluding that in the interests of public health, strict restrictions on smoking and a complete ban in appropriate circumstances are justified. The Court also noted that none of the various disturbing consequences of a smoke-free policy feared by the claimants, such as an increase in the prescription of sedative drugs, had actually materialised.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

					Our public, patients and service users can be heavily affected by the issues surrounding tobacco smoking. Our duty of care compels us to work to reduce the 'mortality gap', and reducing the impact that smoking can have on an individual's health is a vital step in supporting service users to achieve gains in both quantity and quality of life. Our employees and workers, patients and visitors have a right to work and visit BCUHB in a safe and healthy environment. All employees need to be aware that this policy exists and what routes they can take to seek support, advice and information.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		X			There will be no detriment to Human Rights & use of Welsh Language All signage and support information will be provided in Welsh as well as English. Opportunities for stakeholders/people affected to converse with staff in Welsh is available from HMQ Service staff.	No Detrimental impact
Treating the Welsh language no less favourably than the		X			No difference to language	No Detrimental impact

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

English language						

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	We have produced a briefing up-date to the organisation on the changes to the legislation regarding the smoking law from Welsh Government, to include all new legislation changes and exemptions. This has been distributed across the organisation to inform the workforce of the impact in the new smoking legislation.
Have any themes emerged? Describe them here.	None, this guideline will support adherence to Welsh Government regulations
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	*Describe any changes you have made to the policy/proposal due to feedback from your engagement and consultation.*

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	WP31 BCUHB Smoke Free Policy

2. Brief Aims and Objectives: (Copy from Form 1)	Reviewing WP31 policy for Betsi Cadwaladr University Health Board. This reflects BCUHB's commitment to safeguarding the health, safety and well-being of employees, patients and visitors. The policy will also serve to improve efficiency of BCUHB by supporting those individuals that smoking cessation support. It identifies the opportunities available to promote and signpost individuals to specialist services, highlights the new all Wales legislation, and provides advice and information for support relating to smoking cessation. The aims of this policy are: • To provide a safe and healthy working environment and to ensure that the possible consequences of smoking tobacco are reduced. • To reduce incidents of smoking and vaping on BCUHB sites • To reduce harm to patients, visitors and staff from exposure to second-hand smoke • Promote awareness through various media to promote the benefits to quitting smoking. • Inform employees of the changes to the new smoke free legislation • To alert employees of the possible consequences arising from smoking tobacco. • To create a climate of openness and encourage employees to seek early support and appropriate help to stop smoking.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	• To ensure that all managers with responsibilities for the health, safety and welfare of employees have adequate guidance in recognising, supporting and assisting any employees to stop smoking. • To raise employees awareness of the harmful effects of smoking tobacco • To prevent the supply or use of illegal substances from occurring on BCUHB premises.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	No x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes	No x
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of	Yes	No x

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

- The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes		No x

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x
	Staff enforcing policy should be mindful of neuro diverse conditions and potential mental health conditions and deal with individuals sympathetically..	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes x	No
	How is it being monitored?	Policy monitored through local team engagement, senior management meetings and workforce policies and procedures working group. Forms part of the staff wellbeing support service programme and reported through DATIX of non-compliance with regulations
	Who is responsible?	Teresa Owen – Executive Director Public Health
	What information is being used?	Feedback from Policy implementation group and consultation from organisation prior to implementation of policy
	When will the EqIA be reviewed?	As appropriate and in line with the policy review date – February 2024

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

7. Where will your policy or proposal be forwarded for approval?	BCUHB Workforce Policies and Procedures Working Group Local Partnership Forum Occupational Health, Safety and Security group PPH QSE

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Gavin Jones	Lead Health and Wellbeing Intervention Co-ordinator
	Bethan Wassell	Statutory Compliance, Governance & Policy Manager
	Louise Woodfine	Consultant in Public Health
	Delyth Jones	Principle Public Health Practitioner
	Suzanne Williams	Help Me Quit Service Strategic Lead
	Jennifer Dowell-Mulloy	Equality and Inclusion Manager

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	Proposed document does not indicate any potential significant negative impact		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	This EQIA does not indicate major negative impacts. The guideline will produce positive outcomes for people who smoke as they will be offered an alternative	Each hospital management team will be responsible for any negative impact as a result of the policy	
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	We have a specific legal duty to adhere to Welsh Government regulations for putting in place no smoking on MHLD hospital premises	Each of the Senior leadership Teams are putting in place local actions to bring about complete smoking cessation on hospital grounds by 1st September 2022	Each SLT, MHLD will have systems in place by 1st September 2022

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
	Unintended barriers to using specialist smoking cessation support may be established	Maintain an annual spot check on data related to age, gender, race	Help me Quit Service can produce report on activity at 12 month intervals on referral rates and impact on protected characteristics

Teitl adroddiad: ***Report title:***	MHLD 0043 Restricted Items Policy
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	20 June 2023
Crynodeb Gweithredol: ***Executive Summary:***	This paper advises the QSE Committee that in accordance with OBS1 - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, MHLD 0043 Restricted Items Policy has undertaken a 3 year review. As a result of the review, minor updates, amendments and improvements have been made to the document.
Argymhellion: ***Recommendations:***	*The Committee is asked to:* 1) Note that minor amendments/updates improvements have been made as follows. Additional restricted items added to list: cords including dressing gown cords, Audit form to record compliance with restricted items procedure, control document sections. 2) approve MHLD 0043 Restricted Items Policy
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen - Executive Director of Public Health and Mental Health and Learning Disabilities.
Awdur yr Adroddiad: ***Report Author:***	Adrian Jones Assistant Director of Nursing MHLDS Hilary Owen Head 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* ☒	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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 improve the safety and quality of all services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The Mental Health Act 1983 Code of Practice for Wales (Revised 2016) advises that global/blanket restrictions where possible should be avoided, unless they can be justified as a necessary and proportionate response to risks identified. The purpose of this policy is to provide employees/workers with clear guidance for the safe management of restricted items within the Inpatient Mental Health wards and across community facilities within the MHLD Division.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Yes, as per BCUHB Policy on Policies and WP7 Procedure for Equality Impact Assessments (EqIA), the EqIA is appended to this report.
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?***	No, this report and policy do not relate to a 'strategic decision'.
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)***	Failure to adhere to MHLD 0043 Restricted Items Policy could result in patient safety incidents.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Failure to adhere to MHLD 0043 Restricted Items Policy could result in patient safety incidents, claims and associated costs.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The Health Board has a duty of care to employees/workers, patients and visitors. Both the Health Board and employees/workers could be liable if safety is not maintained.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been routinely reviewed and circulated widely for consultation. The document has been approved at: 1) MHLD Policy Implementation Group – 08/11/2022 2) MHLD QSE – Approved by Chair's Action 29/11/2022 3) Strategic Patient Safety Quality Group – 21/04/2023
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	Not applicable

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: ***1) Place the reviewed*** MHLD 0043 Restricted Items Policy onto the Policies, Procedures and other key documents page. ***2) Raise awareness of the reviewed*** MHLD 0043 Restricted Items Policy throughout the MHLDS Division by inclusion in the staff bulletin and sharing the document via PTR and SQDG ***3)*** MHLD 0043 Restricted Items Policy Audit tool to be completed on a monthly basis as part of the regular audit cycle.	
Rhestr o Atodiadau: ***List of Appendices:*** *1)* MHLD 0043 Restricted Items Policy *2)* MHLD 0043 EQIA	

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.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

V2.0

MHLD 0043

RESTRICTED ITEMS POLICY

Date to be reviewed:		**No of pages:**	17 pages
Author(s):	Rebekah Roshan Julie Macdonald Ruth Joyce **Updated by** Adrian Jones Hilary Owen	**Author(s) title:**	Head of Nursing MHLD SMS Deputy Service Manager SMS Team Manager Assistant Director of Nursing Head of Governance and Compliance.
Responsible dept / director:	Director of Mental Health & Learning Disability Division		
Approved by:	MHLD Policy Implementation Group – 08/11/2022 MHLD QSE – Approved by Chair's Action 29/11/2022 Strategic Patient Safety Quality Group – 21/04/2023		
Date approved:			
Date activated (live):			
Date EQIA completed:	All policies must be Equality Impact Assessed – 8th February 2019 Updated 19th August 2022.		
Documents to be read alongside this procedure:	Any documents this should be read with including supporting procedures/written control documents: Searching Patients and their Property Policy – MHLD 0013 Therapeutic Observation and Engagement Policy – MHLD AC002 Mental Health & Learning Disabilities Acute Care Operating Framework – MHLD 0001 Patients Visitors Protocol Ty Llywelyn Medium Secure Unit – MHLD 0005 Ty Llywelyn Medium Secure Unit Security Procedure – MHLD 0061 BCUHB Medicines Policy - MM01 Physical Restraint Policy - MHLD 0047 Health and Safety Policy – HS01 (Including individual ward/service risk assessments) Control of Substances Hazardous to Health Guidance – HS13 Fire risk from personal rechargeable electronic devices NHS Wales Alert – WG EFA/2018/007 Ingestion of Cleaning Chemicals NHS Wales Alert – WG EFA/2019/002		

	Procedure and Guidance Protecting Employees from Violence and Aggression – HS02 (V2 April 2018) Mental Health Act 1983 Code of Practice for Wales (Revised 2016) Mental Capacity Act (2005) CQC Brief Guide: the use of 'blanket restrictions' in mental health wards (2017) North Wales Suicide and Self Harm Prevention Strategic Plan (2018) Welsh Assembly Government: 'Talk to Me 2', Suicide and Self Harm Prevention Strategy for Wales 2015 - 2020 (2015)

Purpose of Issue/Description of current changes:
New Policy to provide guidance to services and staff regarding the safe management of restricted items on Inpatient Mental Health Wards and in community bases across the MHLD Division.

Additional restricted items added to list: cords including dressing gown cords, Audit form to record compliance with restricted items procedure, control document sections.

First operational:	2019				
Previously reviewed:	**Aug 2022**	**Date**	**Date**	**Date**	**Date**
Changes made yes/no:	**Yes**	**Yes/no**	**Yes/no**	**Yes/no**	**Yes/no**
	Addition of a restricted item. **Audit Documentation.**				

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1. Introduction

Suicide and self-harm are considered serious public health issues, both the Welsh Government plan to reduce suicide and self-harm in Wales and the North Wales Suicide and Self Harm Strategic Plan have been considered in the development of this policy. One of the commitments of these plans were to ensure that where possible, those individuals at risk, do not have access to items that could potentially be used for suicide or self-harm. It is suggested that mental health inpatient settings that support individuals at risk, should be risk assessed and all potential aids to self-harm or suicide will be made safe. It is recognised that removal of access to the means of suicide, is an effective strategy in terms of prevention.

The Mental Health Act 1983 Code of Practice for Wales (Revised 2016) advises that global/blanket restrictions where possible should be avoided, unless they can be justified as a necessary and proportionate response to risks identified. The Code of Practice makes specific reference to the restriction of communication devices such as mobile phones and computers, however there is no specific guidance offered in relation to the restriction of items associated with the risk of harm to self or others. The following definition is offered within the Code of Practice:

> *"A blanket restriction or a blanket restrictive practice is any practice that restricts the freedom (including freedom of movement and communication with others) of all patients on a ward or in a hospital, which is not applied on the basis of an analysis of the risk to the individual or others."*

Patients within the Mental Health and Learning Disability (MHLD) Division have a right to privacy and dignity, to be free from unnecessary searches and to retain and use personal property. However patients, staff and visitors to all services also have the right to a safe and therapeutic environment, which under certain circumstances may necessitate taking steps to ensure that patients are not in possession of items that may present a hazard to personal safety, or the therapeutic environment. In order to maintain a safe and therapeutic environment, in addition to the privacy of other patients, services within the MHLD Division may restrict items coming into the inpatient and community facilities. Such restrictions may be justified as a necessary and proportionate response to an identified risk (CQC, 2017).

2. Purpose

The purpose of this policy is to provide employees/workers with clear guidance for the safe management of restricted items within the Inpatient Mental Health wards and across community facilities within the MHLD Division. This in turn will safeguard all patients, staff and visitors to these services.

3. Scope

The contents of this policy applies to all employees/workers working within the Inpatient Mental Health services and community teams across the MHLD Division.

Whilst Ty Llywelyn Medium Secure Unit in Bryn Y Neuadd Hospital is part of the MHLD Division, this service has its own separate procedures and policies in relation to security procedures and staff should consult MHLD 0005.

4. Definition of Restricted Item

A restricted item is an item or substance which could affect the health, safety or welfare of patients, staff and others.

There is an agreed Divisional wide list of items that are restricted within the Inpatient Mental Health wards and community facilities across the MHLD Division:

This list is not exhaustive and removal of items must be underpinned by a risk assessment.

- Illicit Drugs/Substances
- Alcohol
- Non-Prescribed medications including over the counter
- Sharp instruments for example scissors, razors, knives (see footnote* regarding the kirpan)
- Weapons – Firearms (real or replica), clubs
- Solvents and other toxic, hazardous substances
- Plastic bags
- Ignition sources – Lighters, matches, lighter fluid
- Recording or photography equipment (see footnote** regarding mobile phones)
- Items containing violent/racist or pornographic content
- Cords, for example dressing gown cords

***Kirpan -** *It is legal under the Criminal Justice Act 1988 (section 139) and Offensive Weapons Act 1996 (section 3 and 4) for a Sikh to carry a Kirpan as part of their religion. As the Kirpan is not a weapon but an article of faith, most Sikh patients (and/or the family) will be willing to discuss the issue of Kirpan possession in order to come to a pragmatic solution.*

****Mobile Phones** *– It is acknowledged that most mobile phones can now be used as recording devices, it is not suggested that all mobile phones are removed from patients or classed as a restricted item. As part of the discussions on admission to hospital staff will advise patients about the need for confidentiality of others to be maintained and ask that they abide by this. If there is evidence that the confidentiality of others is not being maintained and any patient is observed or reported to be taking photographs or recordings using their mobile phone, consideration will need to be given to the removal of the mobile phone.*

Personal rechargeable electronic devices present a fire risk during use and when being charged, this includes devices such as e-cigarettes, mobile phones, laptops, tablets, etc. Removal of all chargeable equipment would be considered excessively restrictive and disproportionate, however all staff, patients and visitors must be made aware of this risk, through safety briefings and conversations. Signage can be displayed near accessible socket outlets, and can be obtained from Health and Safety advisors (see WG EFA/2018/007).

There are numerous potential risks in the environment that could affect the health and safety of patients during inpatient admissions. Awareness is being raised on an All Wales basis in relation to such risks associated specifically to plastic bags and chemicals. Plastic

bags could be brought in by patients or visitors, or used by staff particularly domestic services, portering and pharmacy department. It would be difficult to completely restrict the use of plastic bags throughout services due to practical requirements, particularly in relation to delivery of items and waste management, similarly whilst hazardous substances are listed as a restricted item, again due to practical reasons cleaning chemicals will be used across services. However all staff should remain vigilant regarding the potential risks associated to plastic bags and chemicals, and access to both by patients should be restricted. Ward Managers must in conjunction with domestic services ensure that there are adequate controls in place to restrict patient access to such items; these controls will be outlined in service environmental risk assessments (see HS01, HS13 and WG EFA/2019/002).

5. Procedure for Inpatient Mental Health Wards

5.1 Disclosure/Non-Disclosure of Restricted Items

On admission to any Inpatient Mental Health ward and on transfer between wards, all patients will be asked if they have brought any of the restricted items into hospital, some of these items are referenced on the disclaimer that patients are already requested to sign on admission as part of the Acute Care Inpatient Pathway (see MHLD 0001 for more information). As the list is not exhaustive staff must remain vigilant and will consider items that may be manipulated to create a sharp object or weapon. If the patient has brought any of these items onto the ward, staff are to ask that they hand the item in for safe keeping or until arrangements can be made for the item(s) to be returned to their home.

Whenever a patient returns to the ward from a period of leave, they must again be asked if they have brought any of the restricted items back to the ward with them.

In the event that a patient denies having brought in any of these items, however staff have evidence to the contrary, a search is to be undertaken and staff are referred to the Searching Patients and their Property Policy MHLD 0013 for full guidance.

5.2 Risk Assessment

Our patients often present as very unwell when requiring an inpatient admission, due to the nature of their illness, symptoms and presentation and potential risk to self and/or others, a comprehensive risk assessment utilising the Mental Health Measure clinical documents, will be undertaken at the point of admission. In order to safeguard individuals a referral to advocacy will be made on admission or at any other point where required, for those patients subject to Mental Health Act (1983) or Mental Capacity Act (2005), this will support application of this policy in patient's best interests.

As the risk assessment will inform care planning and decisions relating to care delivery, it must be current, and reflective of the patient's presentation taking into account both past and present risks. Particular attention must be paid to any risk of self-harm, harm to others, previous use of weapons and arson. Throughout admission, the risk assessment of any patient will be kept under review and amended to reflect any changes in the level of risk posed. Such changes may also require updates to the patient's care plan.

Consideration will also be given to the overall risk any item presents to the general population of the ward, including if it is taken by another patient. Staff will consider what items are appropriate for the environment and the need for urgent access to any particular item; for example items such as scissors are unlikely to be needed urgently and could be accessed on request when needed.

5.3 Information to Patients and Carers

On admission patients are to be asked if they have brought any of the items listed in section 4.1 into hospital with them, the admitting nurse is to provide the patient and their relative/carer with an explanation as to why the use of such items is restricted whilst they are on the ward.

In the event that a patient denies having any of the restricted items with them, if they are accompanied by a relative/carer the admitting nurse should where possible ask the relative/carer to confirm that this is correct. Relatives/carers will also be informed by ward staff about restricted items, and requested to check with staff before they bring such items onto the ward during visits.

It is also important that patients are reminded of the restricted items when they have a period of leave from the ward, and that should they return from leave with a restricted item, they are requested to inform the Nurse in Charge and will be required to hand the item in for safe keeping or until arrangements can be made for the item(s) to be returned to their home.

Each ward will display an information leaflet (see appendix 1), to advise patients and visitors of what items are restricted on the ward.

5.4 Refusal to comply with the requirements of this Policy.

In the event that a patient's relative/carer does not comply with the request to check with staff before handing any restricted items to the patient, staff are in the first instance to politely remind them of this requirement and the reason why. However if they consistently fail to check with staff before handing restricted items to the patient, consideration must to be given to the need to either supervise their visits or bar them from the ward. In such circumstances staff must consult with their Inpatient Clinical Service Manager, or Bronze on call Manager (outside normal working hours) before any decision is made.

5.5 Safe Storage and Disposal of Restricted Items

Any items removed from a patient for safe keeping are to be placed in a plastic belongings bag/box which is to be clearly labelled with the patient's name. There will be an inventory sheet kept with the items (see appendix 2) which is to be dated, timed and signed each time an item is removed or returned.

Each patient is to have their own bag/box, and under no circumstances are these to be shared by patients.

All items kept in safe storage will be returned to the patient when they are discharged from the hospital.

The only items that will not be stored in patient's plastic belongings bag/box or returned to a patient, is any item considered to be a weapon, as there is no reason why a patient would need access to such an item during their stay in hospital.

In the event that a weapon is removed from a patient, consideration will be given to the item's type, purpose and rationale for its possession. This will be documented in the patient's clinical notes and recorded in the risk assessment, where appropriate. Staff will consider contacting the police, who will arrange to collect and dispose of any weapon, if they believe this to be an appropriate action.

Without Police involvement staff do **NOT** have the right to dispose of items without approval of the owner.

In the event that the Police are unable or unwilling to support the disposal of a weapon, but the patient does consent to disposal then the item should be dealt with on a case by case basis with advice/assistance from the Health and Safety advisors and the Hospital Security Team. Some weapons e.g. knives may be suitable to be placed in the larger sharps bins.

If the patient does not agree to disposal then the item will be placed in safe keeping (that is, in a locked area with no patient access) until the patient is discharged.

As discharge approaches, if staff continue to have concerns about the patient being in possession of the item, then this concern will be discussed with the police and their advice sought. All conversations with the police will be documented in the patient's clinical records.

Staff will ensure that a robust and detailed risk assessment is completed to reflect any decision making processes including the involvement of the Multi-disciplinary Team, Senior Management, and the Health and Safety Team were appropriate.

In the event that illicit substances or medications are removed from a patient staff should consult the BCUHB Medicines Code (MM02.1), this provides specific guidance on the handling, storage and disposal of such items. Pharmacy can also be contacted for additional advice.

6. Procedure for Community Settings

6.1 Disclosure/Non-Disclosure of Restricted Items

If a patient discloses information in regard to restricted items, the staff member must approach the situation calmly using de-escalation skills where needed and seeking assistance from colleagues/managers if necessary. As the list is not exhaustive staff must remain vigilant and will consider items that may be manipulated to create a sharp object or weapon. In the event that a staff member believes a patient to be in possession of any restricted item(s), the patient can be directly asked if they have such an item if appropriate to do so, and this policy shared with them.

If the patient has brought any restricted items into a community facility, where necessary to ensure staff and public safety the patient will be asked to leave the premises giving a mutually agreed appointment, instructing the patient not to bring such items to subsequent appointments.

If staff believe that asking a patient to reveal if they have a restricted item would cause undue risk to themselves or others then advice will be sought from police with a detailed explanation as to what the item in question is believed to be, the perceived risk, who may be at risk of harm, the items current location and the patient concerned identifiable details. It is recognised that some confidential information may need to be disclosed - this is permitted in cases where safety and prevention/detection of crime may occur.

In the event that a patient denies being in possession of any of these items, however staff have evidence to the contrary, staff will **NOT** search persons or belongings with the intention of retrieving restricted items.

If restricted items are witnessed or identified on a home visit the staff member will ensure their own safety and leave the visit as soon as it safe to do so; utilising de-escalation skills if required. The appropriateness of future home visits will be discussed with the multidisciplinary team and the risk assessment will be updated immediately following the event to reflect any decisions regarding home visits.

6.2 Risk Assessment

Immediately following any event related to a restricted item, the risk assessment will be updated and the incident will be discussed with the manager and at next multidisciplinary team meeting.

As the risk assessment will inform care planning and decisions relating to care delivery, it must be current, and reflective of the patient's presentation taking into account both past and present risks. Particular attention must be paid to any risk of self-harm, harm to others, previous use of weapons and arson. Throughout an episode of care, the risk assessment of any patient will be kept under review and amended to reflect any changes in the level of risk posed. Such changes may also require updates to the patients care plan.

6.3 Safe Storage and Disposal of Restricted Items

Information will be provided to patients regarding the safe disposal of restricted items via the local police station or amnesty bins when available.

In the event that person voluntarily relinquishes opened containers of alcohol, staff will inform patient that the contents cannot be stored and will be required to be disposed of safely.

Without Police involvement staff do **NOT** have the right to dispose of items without approval of the owner.

In the event that illicit substances or medications are removed from a patient staff should consult the BCUHB Medicines Code (MM02.1), this provides specific guidance on the handling, storage and disposal of such items. Pharmacy can also be contacted for additional advice.

6.4 Information to Patients and Carers

On initial contact with any community service, staff will make the patient and their relative/carer aware of this policy with an explanation as to why the use of such items is restricted whilst they are in the community facility.

In the event that a patient does not comply with the principles of the policy and continues to be in possession of restricted items during appointments, staff may send them an informal letter (see appendix 3), explaining that this is unacceptable and that any further incidents may result in more formal management, including alternative arrangements for their ongoing care and treatment, this policy may also be shared with the patient.

7. Roles and Responsibilities

7.1 Director of Nursing

To ensure the provision and distribution of a comprehensive and up-to-date policy reflecting best practice, fit for purpose across all areas of the Division.

7.2 Heads of Nursing

- To support any training needs for staff in relation to this policy.
- To support staff that care for patients at risk.
- Promoting a positive experience of the service for patients and carers.
- To arrange undertaking of the annual restricted items audit

7.3 Inpatient Clinical Service Managers

- In conjunction with Ward Managers ensure that individual ward risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented.
- Ensure that this policy is consistently implemented across all inpatient units and, with the Ward Manager, monitor the frequency of the policy being put into action.
- Highlight any training needs for staff in relation to this policy.
- Promoting a positive experience of the service for patients and carers

7.4 Ward Managers

- In conjunction with Inpatient Clinical Service Managers ensure that individual ward/service risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented. Assessments must include adequate controls to monitor and restrict access to items that may be found in service areas and could pose a risk to health and safety, such as plastic bags and chemicals.
- To ensure that all relevant staff are consistent in their application of the policy and clear about their individual responsibilities.
- To ensure that all relevant staff have the relevant, up-to-date skills to implement the policy.

- To ensure that all relevant documentation and records are completed to include what restricted items have been handed in or removed and returned, if the Searching Patient's and their property Policy has been utilised, how items are stored/disposed of and where relevant a Datix is completed.

7.5 Service Managers

- In conjunction with Team Managers ensure that individual service risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented.
- Ensure that this policy is consistently implemented across relevant community services and, with the Team Manager, monitor the frequency of the policy being put into action.
- Highlight any training needs for staff in relation to this policy.
- Promoting a positive experience of the service for patients and carers.

7.6 Team Managers

- In conjunction with Service Managers ensure that individual service risk assessments have been undertaken and regularly reviewed to support the application of this policy in areas that it will be implemented. Assessments must include adequate controls to monitor and restrict access to items that may be found in service areas and could pose a risk to health and safety, such as plastic bags and chemicals.
- To ensure that all relevant staff are consistent in their application of the policy and clear about their individual responsibilities.
- To ensure that all relevant staff have the relevant, up-to-date skills to implement the policy.
- To ensure that all relevant documentation and records are completed to include any restricted items that have been handed over to staff, how items are stored/disposed of and where relevant a Datix is completed.

8. Monitoring

Ward Managers and Inpatient Clinical Service Managers will have the responsibility to measure, monitor and evaluate compliance with the policy in the inpatient settings. Monitoring will be undertaken each time the policy is invoked to support the management of restricted items including disclosure, non-disclosure and removal, every such instance must be documented in the patient's clinical records and reported via Datix to support the monitoring. The Inpatient Clinical Service Manager will report directly to the Head of Nursing any deviance from the policy, and where appropriate make further recommendations. The Inpatient Clinical Service Manager will report directly to the policy authors any need to amend the policy in light of changing service need. There will be an annual audit of inpatient areas to review completion of assessment for restricted items at the point of admission.

Team Managers and Service Managers will have the responsibility to measure, monitor and evaluate compliance with the policy in community settings. Monitoring will be undertaken each time the policy is invoked to support the management of restricted items including disclosure and non-disclosure, every such instance must be documented in the patient's clinical records and reported via Datix to support the monitoring. The

Service Manager will report directly to the Head of Nursing any deviance from the policy, and where appropriate make further recommendations. The Service Manager will report directly to the policy authors any need to amend the policy in light of changing service need.

Any breaches or deviance from the policy will be discussed in the Putting Things Right PTR forums and reported to Divisional QSE where appropriate.

9. Equality including Welsh Language

An EQIA has been conducted. This procedure will ensure that patients are treated in line with equality legislation and a Human Rights approach adopted.

10. Well-being of Future Generations

The process of completing the procedure has considered a healthier Wales.

11. Environmental Impact

There is no environmental impact with this procedure.

12. Resources

This procedure details existing duties and responsibilities. Therefore, there are no associated resources with implementation other than relevant employee / workers familiarizing themselves with the document.

13. Training

There is no specific training for restricted items but the Division has a tool kit approach to bring about awareness.

14. Implementation

This updated procedure will be brought to the attention of the SLT's. The MHLD Division tool kit approach to procedures will incorporate restricted items.

15. Further Information

The NMC Code underpins the professional responsibility of all registered nurses. The Division and Health Board also have policies and procedures to be considered alongside this procedure.

16. Audit

An audit form has been included with this procedure to check compliance with application. (See Appendix 4).

17. Review

This document to be reviewed every 3 years or more frequently if information comes through established governance systems that monitor incidents such as DATIX.

18. References

The Code, Nursing & Midwifery Council

INFORMATION LEAFLET / POSTER (Appendix 1)

EITEMAU CYFYNGEDIG / RESTRICTED ITEMS

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

Er mwyn cynnal diogelwch bob claf, ymwelydd a staff, ni chaniateir yr eitemau canlynol ar y ward. Os oes gennych unrhyw un o'r eitemau hyn gyda chi, gofynnir i chi eu rhoi i staff i'w cadw'n ddiogel, a byddent yn cael eu dychwelyd i chi os yw'n briodol pan rydych yn gadael y ward, fel arall, gallwch drefnu i'r eitemau hyn gael eu dychwelyd i'ch cartref.

- Cyffuriau/Sylweddau Anghyfreithlon
- Alcohol
- Meddyginiaethau heb eu Rhagnodi yn cynnwys rhai dros y cownter
- Offer miniog- Siswrn, raseli, cyllyll
- Arfau- Gynnau (gwir neu replica), pastynau
- Hydoddyddion, ac unrhyw sylweddau peryglus, gwenwynig eraill.
- Bagiau Plastig
- Ffynonellau tanio- Tanwyr, matsis, hylif tanwyr
- Offer recordio neu offer tynnu lluniau
- Eitemau sydd â chynnwys treisgar/hiliol neu bornograffig

Os oes gennych unrhyw eitemau eraill sy'n cael eu hystyried yn beryglus neu'n anaddas gan staff, gofynnir i chi roi'r rhain iddynt.

Diolch am eich cefnogaeth i gynnal amgylchedd diogel a therapiwteg.

In order to maintain the safety of all patients, visitors and staff, the following items are not permitted on the ward. If you have any of these items with you, it is requested that you please hand them in to staff for safe keeping, and they will be returned to you if appropriate when you leave the ward, alternatively you can arrange for the items to be returned to your home.

- Illicit Drugs/Substances
- Alcohol
- Non-Prescribed medications including over the counter
- Sharp instruments – Scissors, razors, knives
- Weapons – Firearms (real or replica), clubs
- Solvents and other toxic, hazardous substances
- Plastic Bags
- Ignition sources – Lighters, matches, lighter fluid
- Recording or photography equipment
- Items containing violent/racist or pornographic content

If you have any other items that staff consider to be hazardous or inappropriate, you may also be asked to hand these in.

Thank you for your support in maintaining a safe and therapeutic environment.

INVENTORY OF RESTRICTED ITEMS (Appendix 2) Hospital Number:.....

Patients Name:.....Ward:.....Date of Admission:.....

Item Details	Logged In		Logged Out		Logged In		Logged Out		Logged In		Logged Out	
	Date	Time	Date	Time	Date	Time	Date	Time	Date	Time	Date	Time

INFORMAL LETTER TEMPLATE (Appendix 3)

PRIVATE AND CONFIDENTIAL

Ein cyf / Our ref:
Eich cyf / Your ref:
Rhif Ysbyty / Hospital Number:
Rhif GIG / NHS Number:
☎:
Gofynnwch am / Ask for:
Ffacs / Fax:
Dyddiad / Date:

Dear

It has been brought to my attention that during your appointment on .....at..... you had in your possession a restricted item. The Betsi Cadwaladr University Health Board treats all such incidents extremely seriously, and following careful consideration the Health Board is writing to you on an informal basis at this time.

During the above appointment it is reported that you acted in a manner which can be considered to be unacceptable to the ..... Team/Service. I am therefore writing to inform you that if any further incidents occur involving restricted items within the 6 month period from the date of this letter, this will be considered in a more formal manner using the Betsi Cadwaladr University Health Board 'Procedure and Guidance Protecting Employees from Violence and Aggression (HS02)' and possible liaison with North Wales Police.

Betsi Cadwaladr University Health Board has a duty to ensure that the safety of its employees and the public using their building is maintained, and as such alternative arrangements for your continuing care and treatment may be implemented.

Yours sincerely

Team/Service manager

Appendix 4: Restricted Items Monitoring Audit Form

This audit form is to be completed annually. It is the responsibility of the Head of Nursing to arrange completion of the audit.

Name of HON:
Date of audit:
Name of ward:

1	Does the Hospital ward have clear signage on restricted items on display	Yes	No
2	Is there evidence of a patient being given a copy of the Information Leaflet on restricted items (check 10 patient records) Put number where evidence supports copy being given:	Yes	No
3	At the point of admission is there evidence of a patient being asked if they have restricted items in their possession (check the inpatient nursing record) Put number where evidence supports procedure:	Yes	No
4	Is there evidence of Appendix 2 being used to record restricted items being removed and returned (check 10 patient records) where evidence supports procedure:	Yes	No
5	Ask 5 Registered Nurses and 5 Health Care Support Workers to identify the list of restricted items. Can the sample of staff correctly identify the list of items or say they know where to find the list of restricted items as per procedure Put number of staff where evidence supports procedure:	Yes	No

Restricted Items Monitoring Audit Form:

Local action plan:

Action required:	**By whom:**	**By when:**	**Date of next audit:**
1.			
2.			
3.			
4.			
5.			

Please Note: Audit findings must be addressed in line management supervision where there are discrepancies or learning points identified. Findings must also be reported in local ward meetings and the local and Divisional Quality Safety Experience (QSE) meeting

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	Mental Health and Learning Disabilities Division. Searching Patients and their Property Policy MHLD 0013
Date form completed:	Original 2018 Reviewed August 2022

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

- ✓ *How does your policy / proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?*
- ✓ *What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce / remove these?*
- ✓ *What barriers, if any, do people who share protected characteristics face as a result of your policy / proposal? Can these barriers be reduced or removed?*
- ✓ *Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.*
- ✓ *How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?*

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Searching Patients and their Property Policy.
2.	Provide a brief description, including the aims and objectives of what you are assessing.	This policy, addresses that all patients have the right to receive care in a safe environment whilst an inpatient receiving care in wards and units provided by Betsi Cadwaladr University Health Board (BCUHB). It is recognised, that some patients or visitors may unintentionally or illicitly convey items for use in the inpatient environment that may be harmful to themselves or others. The searching of a patient and/or their belongings is an intrusive procedure and can only take place if there are reasonable grounds to believe that a search is necessary. Moreover, the right to privacy and dignity is a tenet of the Human Rights Act 1998. The aims and objectives of the policy are to keep patients safe, to explain how a search is to be conducted and under what circumstances and the process that needs to take place prior to a search being conducted. This policy adheres to the Mental Health Act 1983 Code of Practice for Wales (revised 2016)
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	MHLD Division Director of Mental Health and Divisional Head of Nursing
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	NICE Guidelines NG10 Mental Health Act 1983- Code of Practice for Wales (Revised 2016) Physical Restraint Guidelines SCH016 Therapeutic Engagement and Observation Policy MHLD AC002

Part A Form 1: Preparation

		WP8 Equality, Diversity and Human Rights policy MM02 Hospital's Medicines Code page 55/56 Section 9.15 Protocol for missing patients – Missing / Absconding patient policy MHLD AC008 Under 18 admissions - Protocol for the exceptional admission of children under the age of 18 years to an acute psychiatric inpatient unit MH02 Restricted Items – Mental Health Inpatient wards – community MHLD 0043 Clinical Risk Management Policy MHLD 0071 NMC (Nursing and Midwifery Council) The Code: Standards of conduct, performance and ethics for nurses and midwives (2018) nmc-code.pdf Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards BCUHB (Betsi Cadwaladr University Health Board) Medicines Policy MM 01 (2019) Procedure for the management of medicines administration incidents and near misses MM12 MHLD 0001 - Acute care operating framework. MHLD 0007 – Open door policy. MHLD 0002 – Seclusion and long-term segregation policy. MHLD AC008 – Missing / Absconding person policy. MHLD 0033 – Policy for the implementation of section 5(4) Nurses holding power. MHLD 0034 – Policy for section 5(2) Doctors holding power in psychiatric units. MHLD 0043 – Restricted items policy.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Patients and carers Inpatient staff Acute Care Staff. Senior managers Consultants. Junior Doctors. Police Patient Visitors

Part A

Form 1: Preparation

6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Compliance from all professionals involved. Training to all staff Policy launch Communication.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The policy covers all wards in MHLD and therefore every patient who is admitted to hospital, whatever the speciality. It promotes engagement with every inpatient whatever the speciality It promotes equality amongst the staff as all nurses will undergo the same induction and training. It promotes privacy and dignity. It considers the Safety of Staff, Patients and Visitors entering BCUHB property (Mental Health Environments) The policy has been developed in line with the Mental Health Act Code of Praxctice five guiding principles: Least restrictive option and maximizing independence- Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Part A

Form 1: Preparation

		Empowerment and involvement- Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this. Respect and dignity- Patients, their families and carers should be treated with respect and dignity and listened to by professionals. Purpose and effectiveness- Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines. Efficiency and equity- Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental health care services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

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

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

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

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

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Age (e.g. think about different age groups)	X		X		The policy relates to all adults (aged 18 and over) in all inpatient settings - acute care, older persons, rehabilitation, forensic services. The policy does not cover Child and Adolescent mental health which is part of a different Division within the Health Board.	The child and adolescent mental health service work to their own ratified policies. However, in the exceptional circumstance of a young person under the age of 18 being admitted to an adult inpatient unit, the policy would apply.
Disability (think about different types of impairment and health conditions:-	X		X		The policy should not affect disabled and non disabled people any differently. There is no identified negative impact for disabled people or people who are neuro divergent. Where identified, reasonable adjustments to meet the needs of disabled people. The policy applies to applies to people who may lack capacity or have cognitive	The activities of the health board are subject to complying with the Equality Act, which require making reasonable adjustments

i.e. physical, mental health, sensory loss, Cancer, HIV)					impairments. The policy applies to people including disabled people, inclusive of those with cognative impairments (including have dementia) and also people with sensory impairments. There are risks associated with personal searches and people with phyisscal impairmentormetn and sensory loss.	where identified to remove barriers to health care. The policy states: Consideration will always be given to communication pathways, for example where the person is deaf, requires the use of a translator or requires alternative means of communication, for example pictures or social stories. An open dialogue will be maintained with the patient and, where appropriate, the patient's carer.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)		X			No impacts have currently been identified. Explaining the purpose of observation to the patient is important. Their perspective on observation, their gender identity and that of the member of staff providing observations must always be taken into account. Furthermore, any relevant aspects and sensitivity of equality and diversity issues must be considered when	The training provided to staff who undertake personal searches will include training in how to ensure dignity for patients.

					addressing the patient's needs for observation and engagement. There is a risk of "outing" a trans or non-binary patient when undertaking a person search.	
Pregnancy and maternity		X			No impacts have currently been identified. The Equality Act 2010	
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.		X			There may be a negative impact in terms of access to translation into any language other than welsh. The Health Board's translation service is freely available to those who would like a welsh language version of the policy. Nursing and medical staff care for people of different ethnic backgrounds and attend mandatory equality and diversity training. Sensitivity for cultural backgrounds should be considered. Furthermore, any relevant aspects and sensitivity of equality and diversity issues must be considered when addressing the patient's needs for observation and engagement.	The BCU translation service and interpreters are available for when required. There is clear guidance to staff for accessing the translation service both in and out of hours.
Religion, belief and non-belief		X			The policy has no impact on this characteristic. Nursing and medical staff care for people of different backgrounds in terms of belief, religion and philosophical belief and attend mandatory equality and diversity training.	

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Sex (men and women)		X			The needs of women and men may require dignity and there may be requests for same sex staff, where possible, due to cultural needs in relation to sex. The policy states that 'Their perspective on observation, their gender and that of the member of staff providing observations must always be taken into account. Furthermore, any relevant aspects of quality and diversity issues must be considered when addressing the ~~paient's~~patient's needs for observation and engagement.	
Sexual orientation (Lesbian, Gay and Bisexual)		X			Staff need to be mindful of the needs of people who share this protected characteristic. Any disclosures regarding sexual orientation should be treated with confidentiality.	
Marriage and civil Partnership (Marital status)		X			The policy treats patients the same regardless of marital status.	
Low-income households		X			The policy treats patients the same regardless of income and financial status.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

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

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
X		X			The following human rights relate to this policy: Article 2 – the right to life: The searching of a patient and/or their belongings is an intrusive procedure and can only take place if there are reasonable grounds to believe that a search is	

					necessary. Moreover, the right to privacy and dignity is a tenet of the Human Rights Act 1998. The risks to compromising the patient's dignity must be outweighed by the risks involved if no action is taken. Article 3 – Prohibition of inhuman or degrading treatment: the policy ensures that before any search is undertaken, full consideration will be given to issues related to the patient's, race, gender, sexual orientation, spiritual/religious beliefs, disability and age to ensure as far as possible privacy, dignity and personal choice is protected. The policy details the importance of the establishment of a two-way relationship that is meaningful, based on trust and is therapeutic in nature. Article 5: the right to liberty and security: patients may be subject to limitations or restrictions as defined by the mental health act 1983. The act ensures that service users are receiving the treatment they need and provides professionals with a clear framework to work too, ensuring that	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

					all patients and staff' safety is protected whilst an in patient in BCHUB. Article 8: right to private and family life: The policy protects the privacy of patients in that any information or correspondence relating to them will only be shared with family members with consent from the patient. The inpatient pathway includes a specific question in relation to confidentiality. Article 14: the right not to be discriminated against: as detailed in part A above, the policy does not discriminate.	

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		X	+ve		Whilst the policy does not discriminate, the assessment has highlighted the need for availability in a welsh language format.	The Health Board's translation service is freely available to those who would like a welsh language version of the policy.
Treating the Welsh language no less favourably than the		x	+ve		Whilst the policy does not discriminate, the assessment has highlighted the need for availability in a welsh language format.	The Health Board's translation service is freely available to those who would like a welsh language version of the policy.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

English language						

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	The policy is progressing thorough the Health Board's consultation, approval and ratification process.
Have any themes emerged? Describe them here.	No
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	N/A

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

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	Searching of Patients and their property Policy

2. Brief Aims and Objectives: (Copy from Form 1)	This policy and procedure, addresses the searching of patients and their property of patients who are receiving care in wards and units provided by Betsi Cadwaladr University Health Board (BCUHB) It reflects contemporary guidance, terminology and definitions for practice issued by the National Institute for Health and Clinical Excellence (NICE 2015), which must be adopted across England and Wales. The aims and objectives of the policy are to keep patients safe, to explain how to manage and record observations, to describe the different intensities of observation, increasing and decreasing observation intensity and how to provide information to patients and staff. The policy adheres to The Mental Health Act 1983 Code of Practice for Wales (Revised 2016).

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No x

Part B Form 5: Summary of Key Findings and Actions

3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance? For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?	Yes	No x

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x
	Record Details:	
6. Are monitoring	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	How is it being monitored?	The policy is monitored through the MHLD policy Group
	Who is responsible?	Director of Nursing.
	What information is being used?	Verbal feedback from the operational group and evidence / data on admissions out of area, DTOC's, out of hours admission's, policy audit.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	The EQIA will be reviewed in line with the policy

7. Where will your policy or proposal be forwarded for approval?	MHLD Policy and Procedure Group, MHLD Senior Leadership Team Quality and Safety Experience Group, Clinical Policy and Procedures Group, Patient Safety and Quality Group, BCUHB QSE,

8. Names of all parties involved in undertaking this Equality Impact	Name	Title/Role

Part B Form 5: Summary of Key Findings and Actions

Assessment – **please note EqIA should be undertaken as a group activity**	Bethan Young	Registered Mental Health Nurse (RMN)
Senior sign off prior to committee approval:	Clinical Policy and Procedures Group	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	N/A		

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	N/A		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	None		

Teitl adroddiad: ***Report title:***	MHLD 0013 Searching Patients and their Property Policy
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 2023
Crynodeb Gweithredol: ***Executive Summary:***	This paper advises the QSE Committee that in accordance with OBS1 - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, MHLD 0013 Searching Patients and their Property Policy has undertaken a 3 year review. As a result of the review, minor updates, amendments and improvements have been made to the document.
Argymhellion: ***Recommendations:***	*The Committee is asked to:* 1) Note that minor amendments/updates improvements have been made as follows. Changes made to the reasons for conducting a search, searching informal patients. Searching staff and visitors has been removed. New section included for post search support. More information for the reasons as to why we may conduct a search and the indicators of why we would conduct a search. Updated to ensure completion and updating of risk assessment in relation to search procedure. Update to documents to be read. Search procedure audit form included Appendix 4. Searching patients and their property form included. 2) approve MHLD 0013 Searching Patients and their Property Policy
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen - Executive Director of Public Health and Mental Health and Learning Disabilities.
Awdur yr Adroddiad: ***Report Author:***	Adrian Jones Assistant Director of Nursing MHLDS Bethan Young PICSS lead.

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	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	High level of confidence/evidence in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	

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 improve the safety and quality of all services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Doctors, Nurses and Allied Health Professionals must adhere to professional standards set out in GMC, NMC, HCPC and other regulatory guidance. Article 8 of the European Convention on Human Rights requires public authorities to respect a person's right to a private life. This includes people detained under the Mental Health Legislation. Within the Mental Health Act Code of Practice for Wales there is a requirement for managers of hospitals and nursing homes admitting patients under the Mental Health Act 1983 to have a policy in place for the searching of patients, their belongings, surroundings and visitors.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Yes, as per BCUHB Policy on Policies and WP7 Procedure for Equality Impact Assessments (EqIA), the EqIA is appended to this report.
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?***	No, this report and policy do not relate to a 'strategic decision'.
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)***	Failure to adhere to MHLD 0013 Searching Patients and their Property Policy could result in complaints and/or patient safety incidents.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith*	The maintenance of a safe, therapeutic environment can be challenging at times. Failure to adhere to MHLD 0013 Searching Patients and their Property Policy could result

Financial implications as a result of implementing the recommendations	in complaints and/or patient safety incidents could result in patient safety incident, claims and associated costs.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The Health Board has a duty of care to employees/workers, patients and visitors. Both the Health Board and employees/workers could be liable if safety and dignity is not maintained.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been routinely reviewed and circulated widely for consultation. The document has been approved at: MHLDS Division Policy Sub Group 13th December 2022 MHLDS Division Quality Delivery Group 17th January 2023 Strategic Patient Safety Group 21st April 2023 Safeguarding Policy and Procedures Group – 15th May 2023
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)***	Amherthnasol Not applicable

Next Steps:

1) ***Place the reviewed*** MHLD 0013 Searching Patients and their Property Policy onto the Policies, Procedures and other key documents page.
2) ***Raise awareness of the reviewed*** MHLD 0013 Searching Patients and their Property Policy throughout the MHLDS Division by inclusion in the staff bulletin and sharing the document via PTR and SQDG
3) MHLD 0013 Searching Patients and their Property Policy Audit tool to be completed on a monthly basis as part of the regular audit cycle.

Rhestr o Atodiadau:

List of Appendices:

1) MHLD 0013 Searching Patients and their Property Policy
2) MHLD 0013 EQIA

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

MHLD 0013

Version: 3.0

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

Searching Patients and their Property Policy

Date to be reviewed:	2026	**No of pages:**	25
Author(s):	Adrian Jones Beth Young	**Author(s) title:**	ADNS PICSS Lead
Responsible dept / director:	Mental Health and Learning Disabilities Division. Iain Wilkie – Director of MH & LD Paul Lumsdon – Director of Nursing MH&LD		
Approved by:	MHLDS Division Policy Sub Group 13th December 2022 MHLDS Division Quality Delivery Group 17th January 2023 Strategic Patient Safety Group 21st April 2023 Safeguarding Policy and Procedures Group – 15th May 2023		
Date approved:			
Date activated (live):			
Date EQIA completed:	October 2022		
Documents to be read alongside this policy:	• Physical Restraint Guidelines SCH016 • Therapeutic Engagement and Observation Policy MHLD AC002 • MM02 Injectable Medicines Policy • Protocol for missing patients – Missing / Absconding patient policy MHLD AC008 • Under 18 admissions - Protocol for the exceptional admission of children under the age of 18 years to an acute psychiatric inpatient unit MH02 • Restricted Items – Mental Health Inpatient wards – community MHLD 0043 • Clinical Risk Management Policy MHLD 0071 • NMC (Nursing and Midwifery Council) The Code: Standards of conduct, performance and ethics for nurses and midwives (2018) nmc-code.pdf • Mental Health Act, Mental Capacity Act, Deprivation of Liberty Safeguards • BCUHB (Betsi Cadwaladr University Health Board) Medicines Policy MM 01 (2019) • Procedure for the management of medicines administration incidents and near misses MM12 • MHLD 0001 - Acute care operating framework.		

	• MHLD 0007 – Open door policy. • MHLD 0002 – Seclusion and long-term segregation policy. • MHLD AC008 – Missing / Absconding person policy. • MHLD 0033 – Policy for the implementation of section 5(4) Nurses holding power. • MHLD 0034 – Policy for section 5(2) Doctors holding power in psychiatric units. • MHLD 0043 – Restricted items policy. • Wales Safeguarding Procedures 2019

Purpose of Issue/Description of current changes:
Changes made to the reasons for conducting a search, searching informal patients. Searching staff and visitors has been removed. New section included for post search support. More information for the reasons as to why we may conduct a search and the indicators of why we would conduct a search.

Updated to ensure completion and updating of risk assessment in relation to search procedure. Update to documents to be read. Search procedure audit form included Appendix 4. Searching patients and their property form included.

First operational:	May 2017				
Previously reviewed:	August 22	date	date	date	date
Changes made yes/no:	Yes	Yes/no	Yes/no	Yes/no	Yes/no

N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1 Introduction

1.1 Principles

BCUHB is committed to providing the highest standards of care for their patients and believe that all patients have the right to receive care in a safe environment. It is recognized that some patients or visitors may unintentionally or illicitly convey items for use in the inpatient environment that may be harmful to themselves or others.

Article 8 of the European Convention on Human Rights requires public authorities to respect a person's right to a private life. This includes people detained under the Mental Health Legislation. Privacy is therefore an important constituent of a therapeutic environment. Hospital staff should make conscious efforts to respect the privacy of patients while maintaining safety. This encompasses the circumstances in which patients may meet, or communicate with people of their choosing in private and the protection of their private property.

The decision to search in patient settings, patients and or their belongings can only take place if there is a clearly identified risk to staff or patients safety. The loss of regard for the patient's privacy and dignity must be balanced with the risks involved if no action is taken. Before any search is undertaken, full consideration will be given to issues related to the patient's, race, gender, sexual orientation, spiritual/religious beliefs, disability and age to ensure as far as possible privacy, dignity and personal choice is protected. The nurse in charge of the ward should ensure a Mental Health Measure (Part C) risk assessment has been completed to reflect the requirements for a search of the patient and also updated following the search being completed.

There are several indicators that may require a patient, their belongings or the ward environment to be searched in order to maintain a safe and therapeutic environment. These indicators may include:

- Reasonable grounds to suspect that a patient is in possession of an item that is prohibited on the ward –e.g. illicit substances or weapons
- Missing items that if found by a patient could be used to cause harm to either themselves or others –e.g. cutlery items.
- Reasonable grounds to suspect that items belonging to one patient have been taken by another patient. This would involve more than one patients 'word' against another patient
- The intention is to create and maintain a therapeutic environment in which treatment may take place and to ensure the security of the premises and the safety of patients, staff and the public.
- The authority to conduct a search of a person or their property is controlled by law, and it is important that hospital staff are aware of whether they have legal authority to carry out any such search.
- Searching must be proportionate to the identified risk and must involve the minimum possible intrusion into the individual's privacy.
- All searches will be undertaken with due regard to and respect for the person's dignity and privacy

- A patient with a known past or recent history of carrying and/or hiding prohibited items.
- A patient expressing the view that she/he intends to injure her/himself or another person with an implement or when information is received that the patient has a weapon in their possession.
- There is reason to believe that the patient is in possession of items that are potentially dangerous to their own health and safety or that of others – for example, drugs, alcohol, weapons, ligatures or other unsafe items

When making decisions as to the need to search patients, their belongings or ward environments, practitioners must give due regard and consideration to the Mental Health Act Code of Practice, particularly the five guiding principles:

- Least restrictive option and maximizing independence- Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.
- Empowerment and involvement- Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
- Respect and dignity- Patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- Purpose and effectiveness- Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
- Efficiency and equity- Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental health care services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Whilst these principles relate to patients detained under the Mental Health Act (1983, amended 2007), they can equally be applied for informal patients.

In all such cases it is essential that staff first satisfy themselves that the conducting of a search would not place themselves or others in jeopardy.

1.2 Definitions & Types of Searches Undertaken

The decision to search a patient and/or their belongings will be made by members of the Multi-Disciplinary Team (MDT). This must include the Nurse in Charge (NIC) of the ward and a member of the medical team. Should the search occur out of office hours, its rationale and outcomes will be discussed with the clinical team at the earliest opportunity**.**

A search is a methodical and systematic scrutiny of a person, possession or vicinity. Generally this will include a visual or physical process depending on the degree of risk perceived or identified. By their very nature, searches can be intrusive and encroach on individual's privacy. Therefore a fundamental principle of this policy is to ensure that dignity is protected and maintained as far as is possible. Training will be provided in both the rationale and techniques for conducting searches.

Types of searches conducted are:

A property search is a systematic visual and physical inspection of a person's property which exclude items worn on the body i.e. carried items such as bags, suitcases etc. These searches ordinarily takes place with consent but may be undertaken in some instances, without consent

A personal search is a systematic visual and physical inspection of a person which ordinarily takes place with consent but may be undertaken in some instances, without consent. These searches are confined to outer clothing alone and do not involve removal clothing with the exception of jackets, coats, cardigans etc. Staff who undertake personal searches must have received prior training from the Centre for Aggression Management.

An area search is a systematic scrutiny of an environment which has been allocated to a patient for the purposes of care and privacy, for example a hospital bed/bedroom area – such searches are subject to the same consent requirements as property and personal searches. Other areas of BCUHB premises and property such as publicly accessible areas may also require searching but do not normally require consent.

Intimate (e.g. state of undress) or internal (e.g. rectum) searches are not to be undertaken by Betsi Cadwaladr University Health Board staff.

2 Policy Statement

Within the Mental Health Act Code of Practice for Wales there is a requirement for managers of hospitals and nursing homes admitting patients under the Mental Health Act 1983 to have a policy in place for the searching of patients, their belongings, surroundings and visitors. This is captured in the following way in the Code of Practice:

'The objectives for conducting a search are first to create and maintain a therapeutic environment in which treatment may take place and second to

maintain the security of the establishment and the safety of patients, staff and the public. These two objectives may sometimes conflict with each other. Necessary and lawful searches of patients and visitors are important for the effective management of inpatient facilities, but unlawful, insensitive or unnecessary searches can disempower patients and affect their dignity.'
(Mental Health Act Code of Practice for Wales. Chapter 21 p133)

The Health Board's priority is to provide a safe therapeutic environment, reduce the risk of injury and untoward effects caused by the use of illicit and prohibited items, and to reduce the risk of injury to staff, other patients and visitors. This is achieved through staff having access to clear guidance and support in such instances.

3 Purpose of the Policy

The overarching purpose of this policy is to ensure the safety, dignity and wellbeing of patients, staff and visitors by proactively minimizing the risk of restricted or illegal items being brought into clinical settings or to remove existing items which may become an increased risk due to other factors e.g. patient's mental state deteriorates. Such items may include, although the list is not exhaustive, items which are perceived as weapons, illicit drugs, alcohol, sources of ignition, ligatures, etc. For further information prior to conducting a search, staff should refer to the *Policy for Restricted Items, Mental Health Inpatient Wards* (MHLD 0071) on the MHLD intranet site.

The policy also protects the safety of patients who may harm themselves, ensuring that where there is a concern for a patient's safety and a clear procedure is in place to support the searching of them. Moreover, it is commonplace that a patient's belongings are checked on admission and following return from leave – particularly where a previous clinical history indicates potential risk or where previous history is unknown.

This policy illustrates the formal processes of the different types of search patients may be subject to due to potential risks to selves or others. Any search should be conducted in a manner that affords the maximum degree of privacy and dignity. Consent should always, if practicable, be sought before any search or examination is carried out.

4 Scope of the Policy

This policy is to be implemented across all inpatient units in the Mental Health and Learning Disability Division with further consideration given to patients under the age of 18 and patients who are unable to give informed consent.

The policy applies to patients who are detained using the Mental Health Act and to informal patients, however, it must be noted that informal patients cannot be subject to personal searches without their consent.

Searching visitors is not usual practice; however, this policy may apply to some visitors who are suspected to have brought harmful items into the clinical environment (see 6.2).

5. Roles and Responsibilities

5.1 Director of MHLD and Senior Leadership team

To ensure the provision and distribution of a comprehensive and up-to-date policy reflecting best practice, fit for purpose across all care groups.

5.2 Clinical Site Managers

Ensure the policy is consistently implemented across all inpatient units and, with the Ward Manager, monitor the frequency of the policy being put into action. Where the frequency of implementation changes the Clinical Site Manager will raise this as an issue within the clinical team and lead appropriate actions to be taken.

5.3 Ward Managers

- To ensure staff are consistent in their application of the policy and clear about their individual responsibilities.
- To ensure all relevant staff have the relevant up-to-date skills to implement the policy.
- To inform the Clinical Site Manager on each occasion the policy is implemented and of the outcome.
- To ensure that all relevant documentation and records are completed to include why, what and who was searched, how confiscated items are stored/disposed of and where relevant Datix completed.

5.4 Multi-Disciplinary Team

The decision to search a person and/or their belongings will ordinarily be made by members of the multi disciplinary team. This should include, where possible, the patient's named nurse and Responsible Clinician. However, where there are disagreements within the team as to the necessity of the search, the ultimate decision will rest with the Responsible Clinician who must document their rationale. The multi disciplinary team will ensure the patient, and where appropriate the nearest relative are included in a dialogue about the decision to implement a search and will nominate a clinician to ensure consistency and clarity for the patient and where appropriate the nearest relative. A member of the multi disciplinary team will ensure the rationale, detail and outcome of a search is recorded in the clinical notes and that a Datix report is completed. This includes the updating of the risk assessment.

Out of hours, and in circumstances where it is believed that speed is of the utmost importance the decision will rest with the nurse in charge who may seek advice from the on call manager. However, the search, its rationale and outcomes must be discussed with the multi disciplinary team at the earliest opportunity.

6 Procedures

6.1 Procedure for Searching patients

Once a decision has been reached to search the patient he/she will be closely observed using either eyesight or arms length observations until the search can be conducted in accordance with the Observations policy. Every stage of searches undertaken - including the rationale, decision making process, clinical discussions and consent seeking must be fully documented in the patient's clinical records.

A summary of this policy (appendix 3) should be made available to the patient as part of their admission pack and should be offered again before the search is conducted if practicable.

6.1.1 In **all** cases, the consent of a patient will be sought before a search is attempted and the patient will be informed of the rationale for the search. Special consideration will be given to those under 18, those who do not have capacity to consent or those whose condition may require additional processing time, for example someone with learning disabilities or autism. Consideration will always be given to communication pathways, for example where the person is deaf, requires the use of a translator or requires alternative means of communication, for example pictures or social stories. An open dialogue will be maintained with the patient and, where appropriate, the carer. Once the clinical rationale is outlined, the patient will be encouraged to surrender any potentially harmful items they are suspected to have. When an item or items are surrendered, the decision to implement a search will be reviewed.

6.1.2 Consideration will be given to the team's capacity to safely manage the search and to the question of whether police officers need to be involved to prevent harm to the patient or others or a breach of the peace from occurring. If the patient gives consent then the specified search will be carried out with due regard for the privacy and dignity of the individual.

6.1.3 If a patient is assessed as being unable to give consent please refer to section 7.

6.1.4 When a detained patient does not consent or lacks capacity to decide whether or not to consent to the search taking place then initially a discussion must take place within the MDT. This would include the nurse in charge of the ward, the senior nurse bleep holder (out of hours) and a member of medical staff –team doctor (in hours) or duty doctor (out of hours). The Responsible Clinician (or, failing that, another senior clinician with knowledge of the patient's case) must be contacted without delay, if practicable, so that any clinical objection to searching by physical intervention can be raised. The patient must be kept under close observation, while being informed of what is happening and why, in terms appropriate to their understanding. However, searches must not be delayed if there is reason to think that the person is in

possession of anything that may pose an immediate risk to their own safety or that of anyone else. This discussion must consider the safety of the patient, the other patients and staff members. This will include assessing the number of staff members required to safely carry out the search and there may be situations where police assistance will be required.

If the MDT discussion concludes that the search is to be carried out without the patient's consent, then it will be carried out with due regard to the dignity of the individual. All staff members who carry out patient searches without the patient's consent must be trained in the appropriate restraint technique used within the service/unit and only the minimum physical intervention necessary must be used. The patient must be given one final opportunity to consent to a search or hand over the item(s) that are believed to be in their possession. If this is refused, then staff may restrain the patient using the least amount of physical intervention necessary. The welfare, dignity and privacy of the patient must be maintained as much as is practicable by the ward staff.

6.1.5 Informal patients have the right to refuse a search of their person or belongings. In these circumstances the ward team have the following options available:

- Continue to explain to the patient why the search needs to occur to obtain their consent
- Place the patient on close observations to monitor for any risks that may occur
- Consider the use of the Mental Health Act if the criteria is met and the powers of the Act are needed to safely manage the patient
- Inform the patient that they may be discharged from hospital following an MDT discussion if they do not permit the search to occur
- In some circumstances an informal patient may lack capacity in relation to the search and it may be justified under the Mental Capacity Act, therefore the Mental Capacity Act practice guidance document must be consulted. If restraint is used as a part of this then the Mental Health Act Code of Practice states that this must lead to a review of the patient's legal status.
- In exceptional circumstances common law may provide sufficient authority for a search. This must be reasonably necessary and proportionate to protect others from immediate risk of significant harm. If, in exceptional circumstances, common law is used then the person's legal status must be reviewed.

Using physical intervention to search an informal patient without their consent would be considered unlawful unless there is legal authority to undertake it. Staff are responsible for ensuring they have this authority before undertaking a search. Alternatively, if the staff team have due cause to believe that the informal patient has items on their person or in their belongings that may cause a significant risk towards themselves or others, then the team must seek advice from the police.

6.1.6 Use of Hand Held Metal Detector - The searching of individuals and their property can be intrusive and the use of Hand Held Metal Detectors (HHMD)

can reduce the intrusive nature of a search, improve the effectiveness (dependent on the item being searched for), and reduce the time taken to conduct a search. However, due to the possibility of non-metal items staff must be aware that the use of a HHMD should be used to augment staff actions and not replace.

For personal searches scan with wand, ensure full body coverage including head and torso, ensuring this is done in an environment which maximises safety, privacy and dignity.

If the wand sounds staff should ask patient to identify item, if the item is a risk item, then this should be removed if safe to do so.

Training is provided in the use of HHMD by the PICCS team.

6.1.7 If all criteria for searching have been met, staff should follow the guidance as set out in Appendix 1.

6.1.8 Post Search Support- A clinical review of the patient must be undertaken following the search to identify if any areas of the patients management, needs or risks have changed as a result of the search. If this has occurred this must be documented in the patient's records and a care plan written to reflect the updated management of the patients care. With or without patient consent, searching patients is intrusive and potentially distressing for both staff and patients involved. Staff and patients must be given time to reflect on the process and have access to appropriate debriefing.

Staff conducting personal searches must be the same gender as the patient and a minimum of one must be a registered health practitioner.

6.2 Search /Visual Search of Visitors

Visitors will not be searched under the remit of this policy. As occupiers of the premises, the Health Board has the right to direct its staff to search any property being brought in to the ward by visitors for patients. If staff have any suspicions about visitors bringing in prohibited items for patients, they can be refused access to the ward and asked to leave. Alternative options which may be considered by staff are supervision of visits or searching of the patient following the visit where a prohibited item is suspected of being passed over. Special consideration should be given to any religious requirements that may be evident.

6.3 Area Searches

The Health Board is committed to ensuring that its inpatient services provide a safe and therapeutic environment that provide comfort and support the recovery process for the people who use its services. In order to fulfil this, all inpatient services must commit to regular and 'spot check' searches of the inpatient environment.

Regular and spot check searches of the inpatient environment have the following clinical and environmental benefits:

- Ensuring that fixtures and fittings are in good working order
- Enable the early detection of problems that will require maintenance attention
- Promote the patient safety agenda by visibly ensuring a safe environment
- Checking areas that may be used to conceal prohibited items
- Keeping the area clean and hygienic and in line with infection control guidelines
- Timely removal of risk items that may be used to cause harm to either self or others

It should be noted that although patient compliance with this procedure must be sought whenever possible, it must be understood that where compliance is not possible, assessment of risk may dictate that such a search must take place to preserve the safety of patients and staff. Patients should be encouraged to be present during all area searches, unless individual clinical risk assessment and care planning deem this to be unsafe practice. In the event of patients attempting to interfere with the search, or using intimidating behavior towards searching staff, they will not be permitted to be present during the search and will be relocated to the general ward area or appropriate environment until the search is completed. In these circumstances the patient will be informed of the outcome of the search when it is completed.

When a patient's room is searched staff should follow the guidance as set out in appendix 2.

Any items discovered as a result of a search (in addition to illegal items) that are deemed to pose a justifiable risk to the patient and/or others will be confiscated. Such items will be clearly labeled and stored in an appropriate area on the ward and a receipt of such provided to the patient. Such items should not be returned until a full MDT risk assessment has determined this to be a safe and appropriate course of action. Patients may prefer staff of the same gender to search their rooms. Staff must be sensitive to this and ask patients if they have a preference prior to any room search. Any such search must be recorded in the clinical notes and a datix incident form completed the clinical notes. The Responsible Clinician and Clinical Site Manager must be informed.

A search of personal property is considered to be anything exceeding the usual routine check of property on admission or routine visual checks carried out under the Therapeutic Observation & Engagement Policy.

6.4 Personnel Permitted to Undertake Searches

6.4.1 If a search of the patient or their belongings is to take place then at least two members of staff will conduct it and be of the same gender as the patient and one will be a registered healthcare professional. Every effort will be taken to ensure the religion, beliefs, dignity and personal preference of the patient (or visitor) is respected when conducting a search. This may influence who

conducts the search with specific reference to gender and as far as practicable consideration will be given to the items of clothing to be removed in the context of traditional dress. Staff conducting a personal search will have received training as a part of their Restrictive Physical Intervention course in how to conduct this type of search. Only staff who have received such training are permitted to carry out the procedure.

6.4.2 There may be some situations where additional help or police assistance will be required. Police officers may be asked to attend Health Board premises to prevent a breach of the peace, ensure the safety of all involved and to take any necessary actions on the outcome of the search.

6.4.3 In order for staff to provide effective and safe patient care whilst searching patients, their belongings or inpatient environments, staff must have attended training in the following areas:

- Risk Assessment training for all staff
- Bespoke training in how to complete a patient / patient belongings and environmental search provided by the PICSS service as part of the RPI training course.
- All staff members must maintain responsibility for not only attending such training sessions but that they remain in-date with them to enable them to work to best practice guidelines at all times. All inpatient staff will require this training, which will be facilitated as part of the Restrictive Physical Intervention training (RPI). However, those unfamiliar with the procedures or bank/agency staff must only undertake such searches with a regular member of staff who is familiar with these searches and has completed the training. It is vital that the Senior Leadership Team, Clinical Site Managers and Ward Managers accountable for their services can demonstrate that their staff members have attended the above training courses to search patients, their belongings and inpatient environments. This will be achieved through reviews, appraisals and audits of individual and team training records and the PICSS team's training database.

7 Capacity to Consent

If an adult has been assessed as lacking capacity Mental Capacity Act (2005) and is therefore unable to give their consent for a search to be carried out, such a search should only be carried out if it is deemed to be in their best interests. Details of the capacity assessment specific to the decision about a search should be recorded on the appropriate documentation found on the BCUHB Safeguarding Page - Final Version (Expanding Text box) BCUHB Revised Capacity Assessment and Best Interests Form Version 5(3) - January 2021 (1).docx (sharepoint.com)

Consultation with a responsible person, or relative, or an Independent Mental Capacity Act Advocate (IMCA) should take place prior to a search being conducted. An appropriate adult should be available to support the individual during a search and full consideration given to the person's rights at all times.

If all aspects of the Mental Capacity Act and best interest decisions are not followed then this framework has not been lawfully applied. Where there is a breach in relation to the following of this policy then an adult at risk report should be considered and further discussion sought with the Corporate Safeguarding Designated Safeguarding person for the area.

8 Young People

Patients over the age of 16 and under the age of 18 should be assessed regarding their capacity to consent. Where they do not have capacity to consent, an appropriate adult / person with parental responsibility, must always be contacted. Consideration must also be actioned and recorded in relation to Child At Risk as outlined in the Wales Safeguarding Procedures (2019).

If a child (under 18 years) requires admission into an adult acute unit for assessment or treatment- please refer to the Procedure for the Exceptional Admission of Children under the Age of 18 Years to an Acute Psychiatric Inpatient Unit.

9 Outcomes of the Search

In circumstances where police officers have been called and illicit substances or weapons have been found, a discussion with the police should occur as to how the matter should be resolved and proportionate action taken.

If the police are not present and a weapon is found by staff then it should be sealed in a transparent container, clearly labeled and stored as safely and securely as possible (as per 9.1 below) in the most suitable place available until such time as it can be removed from the area. Note, only one item should be stored in each container to prevent cross-contamination. Where sharp items such as blades, edge weapons or needles are to be stored, the container used must be fit for purpose and designed to minimize the risk of injury to those handling it.

If suspicious substances are found then staff must refer to MM01 BCUHB Medicines Policy.

If the police are present and illicit substances or a weapon is found on a patient the police will, in appropriate circumstance and at their discretion, take possession of the substance or weapon and deal with the person under the appropriate legislation.

9.1 Documentation of the Search/Preservation of Evidence

A comprehensive record of every search including the reasons for it, outcomes and items found must be fully recorded in the patient's clinical record (Appendix 5), and where illegal items are found this should be signed and countersigned in the patient's clinical record. If items are removed, this must be fully recorded in the patient's clinical record and the patient should be given a receipt for belongings and told where the items will be stored. During any search, the outcome may be that illegal / dangerous items are found on a patient's person / in a bedroom that may require the notification of the police. The possible requirement to do this must be

discussed with the Responsible Clinician and the Clinical Site Manager. Any such found items must be treated as possible evidence and secured appropriately. In such cases any such items will be secured appropriately in a transparent container with the full details recorded on it as follows:

a. Description of contents.
b. Time/date seized.
c. Where seized
d. Seized by
e. Signed

Each container will have a reference number which will consist of the seizing staff initials, date, and if a number of items were found, the number of the item. An example would be if John Smith seized the item on May 15th 2015; the reference number would be JS1-150515. A second item would be JS2-150515. The bag must be countersigned by a second staff member. The items would then be secured in a secure area for preservation and possible collection by the police. If illicit substances are found then staff must refer to the Health Board's Medicines Code for guidance on whether the police need to be involved and on safe disposal. In all cases where a person or their room is searched, such a decision must be noted in the clinical records and a Datix form completed. The Clinical Site manager and Responsible Clinician must be informed at the earliest opportunity, if possible prior to the searches occurring.

10 Post-Incident Management

The searching of patients or their property will be regarded as an incident and reported as such using the Health Board's incident reporting processes (DATIX). Following the search there should be support for the patient and staff who are affected by the process. This may be particularly necessary when a personal search has to proceed without consent or has involved physical intervention. A general review of the incident will involve the Clinical Nurse Specialists from the Positive Intervention Clinical Support Service (PICCS).

A clinical review of the patient will always be undertaken at the earliest opportunity following the search and if the outcome of the search has altered, the patient's clinical management then the care plan and risk assessment will be revised to reflect this.

With or without consent, this procedure is intrusive and staff, patients and carers involved will need time to reflect on the process and may need to have access to appropriate debriefing.

11 Development, Consultation and Ratification

The policy has been developed in consultation with Clinical Site Manager, Service Managers, Ward Managers, Consultants, Head of Nursing, Head of Operations, Director of MHLD, Governance leads and takes into account national guidance (NICE). The success criteria for this policy would be that when there is due cause to

search a patient, their belongings or an inpatient environment, it is undertaken with regard for the privacy and dignity of the patients on the ward and that it promotes a safe and therapeutic environment for all concerned. This will include:

- Patients are only searched when clinically indicated and in the majority of cases with consent being given
- When patients are searched without their consent, that the minimum amount of physical interventions used and the patients dignity maintained
- Patients' Human and Legal rights are protected and supported
- Inpatient environments being clean, in line with infection control guidelines and all fixtures and fittings of a good working order.
- There must be a notice displayed on all wards indicating the existence of this policy and how to access it. This is for inpatients, Advocates, Carers and relatives.

Results from ongoing audits and spot checks will be taken to staff team meetings and / or individual staff to raise awareness of good and bad practice that may be occurring.

12 Monitoring Compliance

Ward Managers and Clinical Site Managers will have the responsibility to measure, monitor and evaluate compliance with the policy and procedure. Monitoring will be undertaken each time the policy is invoked. An audit form is in Appendix 4. The Clinical Site Manager will report directly to the Service Manager any deviation from the policy and procedure and where appropriate make further recommendations. The Clinical Site Manager will report directly to the policy authors any need to amend the policy in light of changing service need.

The Governance Lead is responsible for informing the Equality and Diversity team of incidents / complaints raised that would constitute a breach of an individual's human rights as a result of the search procedure.

13. Equality including Welsh Language

An EQIA has been conducted in line with the BCUHB Policy on Policies and WP7 – Procedure for Equality Impact Assessment. No negative impacts were identified. This Policy will ensure that patients are treated in line with equality legislation and a human rights approach is adopted.

14. Well-being of Future Generations

The process of completing the Policy has considered a healthier Wales as part of the Future Generations requirements.

15. Environmental Impact

There is no environmental impact with this Policy.

16. Resources

This Policy details existing duties and responsibilities. Therefore, there are no associated resources with implementation other than relevant employee / workers familiarizing themselves with the document.

17. Training

The MHLD Division provides training on carrying out a search and this is contained in the Restrictive Physical Intervention course. In addition to this training, the Division will have awareness training on the Policy arranged via each of the Senior Leadership Teams (SLT).

18. Implementation

This new policy will be circulated electronically to all Clinical Site Manager and Senior Leadership Teams and will be discussed at the Clinical Site Manager meeting and the Divisional Quality Safety Experience (QSE) meeting in addition to the local Quality Safety Experience (QSE) for each area. The policy will be available on the intranet for all staff and services. For existing staff, implementation will take place at a local level, team by team. Training needs will vary between practitioners and will be assessed by the Ward Manager on an individual basis. The policy will be part of the local induction for all registered and non registered nursing staff joining any inpatient team.

The Policy will be implemented through each of the SLT's bringing the Policy to the attention of staff. Staff will also have this Policy brought to their attention via safety briefings and other MDT meetings that provide coordination to hospital care, for example the Acute Care Meeting.

19. Further Information – Clinical Documents

The NMC Code underpins the professional responsibility of all Registered Nurses. The Division and Health Board also have policies and procedures to be considered alongside this Policy.

20. Audit

Each of the SLT's can check application of the procedure through local audit of the Policy contained in Appendix 4.

21. Review

This document to be reviewed every 3 years or more frequently if information comes through established governance systems that monitor incidents such as DATIX.

22. References

The Code Nursing & Midwifery Council

The Children Act (2004) Every Child Matters: Change for Children. HM Government

DH Mental Health Act (1983 – Revised 2007) Code of Practice (2015)

Department of Health and the Welsh Office (1999) Mental Health Act 1983 Code of Practice. London. HMSO

NG10: Violence and aggression: short-term management in mental health, health and community settings. National Institute for Clinical Excellence, London, 2015

Appendix 1: Personal Search Procedure

A minimum of two staff should conduct the search and ensure that protective gloves and apron are worn at all times.

In the case of personal searches the patient should first be asked to remove all their outer clothing (e.g. jacket, shoes and jumper). A visual inspection should then be conducted to ascertain if it is safe or necessary to continue - items of clothing removed should be examined including all pockets. Prior to any intervention, inform the patient of the need to conduct a search and the reasons why. Request and document whether the patient is consenting to the search.

1	Stand facing the individual
▼	
2	Ask the individual if they have anything which they are not authorised to have
▼	
3	Ask the individual to empty their pockets and remove any jewellery including wrist watch
▼	
4	Examine the contents, jewellery and any other items, including bags which may be carried, then place them to one side
▼	
5	Ask the individual to remove any headgear and pass it to the second staff member for scrutiny. Ask the individual to run their fingers through their hair to ascertain if anything is hidden. Ask them to open their mouth and examine inside using a torch if necessary. Repeat the examination to the nostrils and both ears
▼	
6	Ask the individual to lift their collar, feel behind and around it and across the top of their shoulders - search any neckwear and ask them to remove it if necessary
▼	
7	Ask the individual to raise their arms level with the shoulders. Their fingers must be apart with palms facing downwards. Search each arm and hand in accordance with training
▼	
8	Check between the individual's fingers and look at the palms and backs of the hands
▼	
9	Visually check the front of individual's body from neck to waist, the sides, from armpits to waist and the front of the waistband – Do not make any physical contact with this area. If necessary ask the individual to remove their belt and examine.
▼	
10	Ask the individual to turn around and check the back from collar to waist in accordance with training
▼	
11	Ask the individual to turn their feet inwards and crouch briefly – observe for any items which may have fallen to the floor. Check the back and sides of each leg from just below the crutch to the ankle in accordance with training
▼	
12	If necessary, ask the individual to remove footwear and examine

Appendix 2: Area Search Procedure

A minimum of two staff should conduct the search and ensure that protective gloves and apron are worn at all times.

1) On entering the room to be searched, staff should examine the area visually for adjustments or changes to the room layout

2) The room search should begin with one staff member taking the left-hand side of the room and the other the right-hand side – the room should be systematically searched until the whole area has been scrutinised. If the room is patient bedroom then the search should commence with the bed which once searched can be utilised as a 'clean area' for temporary placement of items which may require confiscation or further examination.

3) Bedding should be removed one layer at a time and thoroughly examined.

4) The mattress should be examined for any signs of wear or tampering, particularly around the seams. The bed base and legs should also be examined for signs of damage and concealment of objects.

5) All furniture and fittings should be inspected for signs of abuse or concealment of objects.

6) All electrical items require checking to ascertain if they have been tampered with, paying particular attention to battery compartments and any places items may have been concealed. Ensure all electrical items are unplugged prior to commencing search.

7) All tape, CD cases and books to be opened and inspected, along with correspondence. However correspondence should NOT be read ensuring the privacy of the patient.

8) Each item of clothing should be examined, checking pockets, lining and seams for concealed items.

9) Staff to examine windows for any damage - curtains and curtain rails to be checked, along with exterior windowsill.

10) When checking bedrooms / bathrooms, sink area must be checked for any damage or concealment of restricted items and checks made that the mirror is intact and secure. Staff to ensure door and doorframe, including spy hole, is checked.

11) Staff must ensure that all patients' possessions are treated carefully and with the utmost respect, replaced in the correct position and that the bed is returned to its normal state. Any discrepancies or damage found must be reported to the nurse in charge along with any items felt to be inappropriate – these items should be removed with a full explanation given to the patient.

Appendix 3: Searches - Patient Information Leaflet

This leaflet tries to explain everything you need to know about the hospital's search rules. If you need any help with reading this or don't understand anything please ask a member of staff or your advocate for help.

Why do staff need to do searches?

While you are in hospital it is important that you and other people are safe. For this reason, some items are not allowed in the hospital because they could be dangerous to either yourself, other patients or staff – these items are called **restricted items**.

The nursing staff will let you know which items are restricted and if you do have any they may take them off you and store them safely until it is safe for you to have them back. You will be given a receipt to prove they belong to you.

Staff have had special training in how to do searches and they will always make sure that both you and your property are treated with dignity and respect. Staff will normally only do a search once the whole team agrees it is needed.

What is a search?

There are three types of search:

1. **A Property search:** This is where nursing staff will ask to have a look through your property to make sure you don't have any items which are restricted. When your property is being searched there will be at least two members of staff present and they will be the same gender as you. You can ask to be present while they search your property.

2. **An Environmental Search:** This is where staff will ask to search your hospital bedroom for restricted items. Again, you can ask to be present while they do this and ask for staff who are the same gender as you to do the search.

3. **A Personal Search:** This is where nursing staff may ask to search your body for restricted items – don't worry, you will be allowed to keep your clothes on but may be asked to remove outer clothing such as coats or cardigans. This will be done in a private area and there will be at least two staff present who will both be the same gender as you. Staff know you might find this embarrassing and have been specially trained to make sure you are treated with dignity and respect.

   After the search you will be offered support to make sure you are okay – this might be from nursing staff, specialist staff or an advocate.

Appendix 4. Searching Patients and their property Audit

This audit form is to be completed once every month. It is the responsibility of the clinical site Manager to ensure the audit takes place

Date of audit: **Name of ward:**

1	Has the MDT provided clear and unambiguous instruction in the clinical notes for the reason that the Search needs to be carried out? Was the Risk assessment (Part C) updated to reflect the risk?	Yes Yes	No No
2	**What was the purpose in which the search needed to be carried out** • Patient with a known past or recent history of carrying and/or hiding prohibited items. • A patient expressing the view that she/he intends to injure her/himself or another person with an implement or when information is received that the patient has a weapon in their possession. • There is reason to believe that the patient is in possession of items that are potentially dangerous to their own health and safety or that of others – for example, drugs, alcohol, weapons, ligatures or other unsafe items.	Yes Yes Yes	No No No
3	Was the information leaflet provided to the patient on admission or prior to the search?	On Admission	Prior to search
4	**What type of search was conducted?** A property search A Personal search An Area search	 Yes Yes Yes	 No No No
5	**During the search did the patient-** Consent to search Not consent to the search	 Yes Yes	 No No

	Did the patient have the capacity to give consent at the time of the search	Yes	No
6	**Documentation:** Was a Datix completed? Was the search documented in the patient's notes? Was the Searching Patients and their Property Form completed and filed in the patient's notes Was the Risk assessment updated following the search? Discussion post search with the patient documented?	 Yes Yes Yes Yes Yes	 No No No No No
7	Was the Therapeutic and Observation level reviewed and amended following the search?	Yes	No
8	Were staff conducting the search trained in this procedure (RPI training)	Yes	No
9	Any actions/ learning detailed below	Yes	No

Audit completed by (Name & Designation)

Searching Patients and their Property Audit Form continued:

Local action plan:

Action required:	By whom:	By when:	Date of next audit:
1.			
2.			
3.			
4.			
5.			

Please Note: Audit findings must be addressed in line management supervision where there are discrepancies or learning points identified. Findings must also be reported in local ward meetings and the local and Divisional Quality Delivery Group meeting

Appendix 5:

Searching Patients and their Property Form

PATIENTS NHS DETAIL		PATIENT PRESENT	YES / NO
		TYPE OF SEARCH: (TICK)	PROPERTY PERSONAL AREA
WARD:		ROOM NO:	
DATE:		PATIENT CONSENTING:	YES / NO
IF SEARCH IS DUE TO "CLINICAL CONCERN" PLEASE GIVE REASON:			
SEARCH AUTHORISED BY:			
ITEMS REMOVED AND REASON:			
NURSE-IN-CHARGE SIGNATURE:			
PLEASE ENSURE THAT A RECORD OF SEARCH IS DOCUMENTED IN THE PATIENT'S NOTES			

Teitl adroddiad: ***Report title:***	MHLD 0047 Physical Restraint Policy
Adrodd i: ***Report to:***	QSE Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 20 June 2023
Crynodeb Gweithredol: ***Executive Summary:***	This paper advises the QSE Committee that in accordance with OBS1 - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, MHLD 0047 Physical Restraint Policy has undertaken a 3 year review. As a result of the review, minor updates, amendments and improvements have been made to the document.
Argymhellion: ***Recommendations:***	The Committee is asked to: 1) Note that amendments/updates improvements have been made as follows. Policy amended to comply with newly published national guidelines: NICE Guidelines NG10/11 To include the Police Use of Restraint in Mental Health & Learning Disability Settings 2017. Mental Health Act 1983 – Code of Practice for Wales (Revised 2016) Policy amended to comply with the Welsh Government: Reducing Restrictive Practices Framework 2021. 2) approve MHLD 0047 Physical Restraint Policy
Arweinydd Gweithredol: ***Executive Lead:***	Executive Director – Nursing and Midwifery
Awdur yr Adroddiad: ***Report Author:***	Bethan Young, PICSS Lead Elinor Hughes, PICSS 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* ☒	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

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

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 improve the safety and quality of all services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This policy adheres to the following legislation: 1) Employer Legal Duties – Health & Safety at Work Act 1974 2) Management of Health and Safety at Work Regulations 1999 3) Human Rights Act 1998 4) Mental Capacity Act 2005 5) Mental Health Act 1983 6) Deprivation of Liberty Safeguards 7) Children Act 1989 8) Care Standards Act 2000 9) Safeguarding Vulnerable Groups Act 2006 10) Criminal Law Act (1967) Section 3 (1)
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?***	Yes, as per BCUHB Policy on Policies and WP7 Procedure for Equality Impact Assessments (EqIA), the EqIA is appended to this report.
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?***	No, this report and policy do not relate to a 'strategic decision'.
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)***	Failure to adhere to MHLD 0047 Physical Restraint Policy could result in complaints, claims and/or patient safety incidents.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The maintenance of a safe, therapeutic environment can be challenging at times. Failure to adhere to MHLD 0047 Physical Restraint Policy could result in complaints and/or patient safety incidents could result in patient safety incident, claims and associated costs.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The Health Board has a duty of care to employees/workers, patients and visitors. Both the Health Board and employees/workers could be liable if safety and dignity is not maintained.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been routinely reviewed and circulated widely for consultation. The document has been approved at:

	MHLD Policy/Procedure Group – 21st January 2023 MHLD Divisional Senior Leadership Team Quality Safety and Experience Group – 21st March 2023 Strategic Patient Safety Group- 21st April 2023
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
Next Steps: ***1) Place the reviewed*** MHLD 0047 Physical Restraint Policy onto the Policies, Procedures and other key documents page. ***2) Raise awareness of the reviewed*** MHLD 0047 Physical Restraint Policy throughout the Health Board by inclusion in the staff bulletin and sharing the document via PTR and SQDG	
List of Appendices: **1)** MHLD 0047 Physical Restraint Policy **2)** MHLD 0047 EQIA	

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.

MHLD 0047
Version: 3

PHYSICAL RESTRAINT POLICY

Whilst this Policy is owned and has been developed by MH&LD, there are principles and points that will be applicable outside of the division / on general wards. Employees/workers must ensure that they are familiar with applicable sections and act in accordance with key requirements.

Author & Title	Bethan Young, PICSS Lead Elinor Hughes, PICSS Manager
Responsible Dept / Director:	Executive Director – Nursing and Midwifery
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	Policy & Practice' (2005)Health & Safety at Work Act 1974, The Management of Health & Safety at Work Regulations 1999, Safety Committees and Safety Representative Regulations 1977, The Health Safety (Consultation with Employees) Regulations 1996, The Secretary of State Directions 2003, National Institute for Excellence – Clinical Guidelines 25 Violence, Aggression Training Passport and Information Scheme, Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards – Code of Practice, British Institute of Learning Disabilities – Code of Practice, Mental Health Act 1983 – Code of Practice for Wales (Revised 2016), Human Rights Act 1998, Memorandum of Understanding **–** The Police Use of Restraint in Mental Health & Learning Disability Settings 2017, Social Service Wellbeing (Wales) Act 2014, Patient Safety Notice PSN023 (Welsh Assembly Government, Jan 2016). Reducing Restrictive Practices Framework (Welsh Government 2021) Common Law and Criminal Law Act 1967 Section 3(1)				
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N.B. Employees/workers should be discouraged from printing this document. This is to avoid the risk of out-of-date printed versions of the document. The Intranet should be referred to for the current version of the document.

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1. Statement of Intent

The Betsi Cadwaladr University Health Board (BCUHB) is committed in its duty to provide a safe and secure environment for patients, employees/workers, and visitors and offers its full support to the Welsh Assembly Government, All Wales NHS Violence and Aggression Training Passport and Information Scheme and will endeavour to protect employees/workers and those visiting Health Board premises.

Care will be delivered without discrimination – no service user will receives less favourable treatment than another. This means that no-one should be disadvantaged by reason of any **protected characteristic** which means:

- Disability;
- Gender or gender reassignment;
- Marital status;
- Sexual orientation
- Religion or belief (or non-belief);
- Race (including ethnicity and nationality);
- Age;
- Pregnancy and maternity

2. Introduction and Purpose

This policy aims to set out and articulate Betsi Cadwaladr University Health Board's commitment to reducing restrictive practices and applying the least restrictive principles to all aspects of the Health Board's business and service delivery. This policy has been produced in accordance with the Department of Health Guidance - Positive and Proactive Care, Reducing the Need for Restrictive Practice (2014), the EHRC Human Rights Framework for Restraint (2019) and the Welsh Government Reducing Restrictive Practice Framework (2021). Least restrictive principles relate to applying as few limits as possible to a person's choices, personal rights and freedom while ensuring their support and care needs are being met.

'Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do.
They can be very obvious or very subtle.' (Care Council for Wales, 2016)

This term covers a wide range of activities that restrict people. It includes:

- Physical restraint
- Chemical restraint
- Environmental restraint
- Mechanical restraint
- Seclusion or enforced isolation
- Long term segregation
- Coercion

Welsh Government: Reducing Restrictive Practice Framework (2021)

This policy will guide and demonstrate a clear position to employees/workers to ensure that Betsi Cadwaladr University Health Board and its workforce provide compassionate, trauma-

informed and recovery focused individual care to the people who use our services in the safest and least restrictive manner.

This policy addresses the use of physical restraint relating to a variety of reasons some of which will not relate to violence and aggression.

3. Scope

This document applies to all health board employees/workers, patients and visitors and aims to provide guidance within a legal and ethical framework underpinned by best practice principles for employees/workers implementing restraint intervention.

4. Legal Duties

There is a range of legislation which impacts on restraint. These are (in summary):

Employer Legal Duties – Health & Safety at Work Act (HSWA) 1974

The Health Board's duties with respect to the management of work-related violence are determined by the HSWA 1974, which requires the employer to:

- Ensure so far as is reasonably practicable, the health and safety and welfare at work of all their employees/workers.
- Provide and maintain plant and systems of work that are, so far as is reasonably practicable, safe and free from health risks. ('Plant' refers to equipment, for example hoists, wheelchairs etc).
- Provide such information, instruction, training and supervision as is necessary to ensure so far as is reasonably practicable, the health and safety at work of their employees.

From the Management of Health and Safety at Work Regulations 1999, Employers must:

- Assess all risks to the health and safety of their employees
- Identify the precautions needed
- Make arrangements for the effective management of precautions
- Provide information and training to employees

Human Rights Act 1998

The Human Rights Act 1998 came into force during 2000 and sets out some key principles of fairness, equality, dignity, the right to liberty and security of a person without deprivation of liberty.

The key points are:

- The Act offers a framework to encourage high standards of care and the force of law to make sure that respect of human rights becomes the norm.
- That people should decide and personalise their own care and be treated with respect and dignity when using Health and Social Care Services.
- The use of restraint should only be undertaken in an emergency where employees/workers judge that they must intervene to protect a client /person, someone else or themselves.
- The person affected should be fully involved in all decisions about their care and if the person lacks capacity, the Mental Capacity Act 2005 should be invoked.
- The inappropriate use of restraint is against the law. Physical restrictive intervention can constitute assault, battery or false imprisonment and can lead to both civil and criminal prosecution.

Mental Capacity Act 2005

Section 5 of the Act provides 'protection from liability' for carers and supporters in both everyday tasks of caring and life changing events for people who lack capacity.

However, such action can only receive 'protection from liability' if:

a) The person is reasonably believed to lack capacity to give permission.
b) It is in the person's 'best interests'.
c) It follows the Act's principles.

In relation to restraint, the Act imposes limitations on the protection from liability in "the use of threat or force where a person is resisting and any restriction of liberty of movement, whether or not the person resists".

Mental Health Act 1983

Mental Health Act 1983 Code of Practice for Wales (Revised 2016) sets out the following regarding restraint:

- The employment of de-escalation strategies and approaches should be central to the management of potential violence and aggression. It is recognised that as a last resort, employees/workers may need to employ more restrictive interventions, such as: physical restraint, rapid tranquilisation and seclusion.
- Such physical interventions must never be used to punish a person. Where such interventions are deemed necessary, clinical need and the safety of the persons and others should be the priority.
- When employing such interventions, a balance must be struck between the need to minimise risks to the person and others, and the need to ensure that the least restrictive approach to caring for the person is adopted.

- Any interventions employed to manage disturbed behaviour must be reasonable, proportionate and justifiable, taking into account the risks posed by the person's behaviour or potential behaviour.

Deprivation of Liberty Safeguards

The Mental Health Act 2007 has amended the Mental Capacity Act 2005 to introduce the Deprivation of Liberty Safeguards (DoLS). The Safeguards will apply to hospital and care homes to ensure that people who lack capacity are not deprived of their liberty without lawful authorisation. Employees/workers contemplating restrictive practice must be aware as to what constitutes Deprivation and Restriction of Liberty as defined in the statute and have regard to current case law i.e., Supreme Court judgement in Cheshire West [2014]. Restraint can only be used when:

- The person restraining reasonably believes it is necessary to prevent harm to the incapacitated person; and
- It is proportionate both to the likelihood of harm, and
- The seriousness of harm; and
- It does not constitute detention under Article 5(1) of the European Convention on Human Rights.

The use of a DoLS would be required to authorise detention to lawfully safeguard the person (MCA 2005, Code of Practice, s.6.41).

Children Act 1989

Within the Children Act (1989 and 2004) there is no direct or specific reference to any form of physical restraint management or therapeutic holding of children and young people. However, on page 24 of Children Act (1989) there is a reference in relation to 'secure accommodation by health authorities which states that " the children (secure accommodation) regulations (1991) extend the application of section 25 (restriction of liberty) to children "accommodated by health authorities, and the NHS Trusts established under the section 5 of the NHS and Community Care Act 1990 " who are not being detained under any provisions of the Mental Health Act (1983 regulation 5 & 7)". Under this ruling the child's liberty may be restricted if section 25 (1) above applies and only for 72 hours without court approval".

Although there is no specific reference to physical restraint within these documents employees/workers should adhere to the general principles of safeguarding the child and young person, promoting their well-being and assessing the risk of significant harm occurring when confronted by decisions relating to all aspects of physical restraint. Employee/ worker to ensure any restraint involving children report this to the child's parent where appropriate and/ or the child's advocate.

Care Standards Act 2000

The care standards regulations make a number of references to care that has a bearing on restraint:

"The registered person shall ensure that no person is subject to physical restraint unless restraint of the kind employed is the only practicable means of securing the welfare of that or any other person and there are exceptional circumstances"

Safeguarding Vulnerable Groups Act 2006

The Safeguarding Vulnerable Groups Act 2006 provides that people in certain occupations and carrying out certain activities must be vetted. These are people whose occupation brings them into contact with children and vulnerable adults or puts them in a position of responsibility over children and vulnerable adults ('regulated activity'). The Act provides that people can be barred from participating in regulated activity.

Common Law

Common Law recognises a person's right to protect themselves from attack and to act in the defence of others. If no more force is used than is reasonable to repel the attack, such force is not unlawful and no crime is committed.
Any person has a right

- to protect themselves from attack,
- to act in the defence of others,
- to prevent crime,
- to arrest offenders,

and in doing so may use necessary force to achieve this.

Criminal Law Act (1967) Section 3 (1); A person may use reasonable force to prevent a crime, or in effecting or assisting in the lawful arrest of offenders or suspected offenders or of persons unlawfully at large

5. Responsibilities

All employees/workers within the health board have an individual responsibility to ensure that the health board policies and standards, including Health Care Standards are adhered to and that health and safety arrangements set out in this guidance are appropriately followed. Failure to observe these duties may result in disciplinary action being taken.

The health board recognises and accepts its responsibility as an employer for providing a safe and healthy workplace and working environment for its employees, and a safe environment for persons, visitors and other members of the public. It will discharge these responsibilities through its managers and will expect its employees/workers to comply with procedures and to act at all times in a responsible manner.

The Director of Nursing, Quality & Patient Experience (Executive Lead) responsibilities:

- Advise the Health Board on matters of Reducing Restrictive Practice.
- Ensure that Reducing Restrictive Practice is appropriately considered at county, departmental and committee level with regular reports submitted.
- Ensuring that suitable and sufficient arrangements are in place to protect both employees/workers and patients as far as reasonably practical from restrictive practice.
- Ensure effective monitoring arrangements are in place.

Senior Leadership Team Managers Responsibilities:

- Ensuring effective arrangements are in place for the co-ordination of risk,
- Ensuring health and safety arrangements are in place and effective.
- Ensuring organisational arrangements, policies and procedures and compliance with legislation and guidelines regarding restrictive practices are followed.
- Ensuring that they have knowledge of the range and extent of restrictive practices that are used within the organisation.
- For the development and implementation of this policy and the WG RRP Framework (2021) within their directorate.
- Ensuring safe systems of work are adopted.
- Monitor employees/workers compliance with training.
- Organisations should recognise that workplace stress can have an adverse impact on the quality of practice. Appropriate measures to support the wellbeing of the workforce should be in place.
- That the monitoring and review of individual personal plans includes consideration of planned restrictive practices and reduction guidelines. Particular attention should be paid to the language that is used to describe individuals and incidents; it should be objective, accurate and respectful.
- Ensure that incident reports are investigated.
- Model excellent communication and practice regarding the reduction of restrictive practices.

Clinical Site Managers and/ or Ward Managers

- To access specialist advice by liaising with the relevant Violence and Aggression Case / Security Manager, Positive Intervention Clinical support Service (PICSS)
- To ensure that individuals are aware of their responsibilities for health and safety (Module D) in relation to restrictive interventions.
- For the development and implementation of this policy and the Welsh Government Reducing Restrictive Practices Framework (2021) within their Service/Department
- For identifying hazards and carrying out appropriate risk assessments in line with current legislation including the risk assessment and risk register procedure.
- For employees/workers to have relevant information about the risks they face and preventative measures.
- To prepare and implement safe systems of work.
- To ensure the right level of expertise exists and for individuals to be properly trained on recruitment and when they may be exposed to increased or new risks due to changes in responsibility, the environment or working practices.
- To complete an annual training needs analysis ensuring that training is pertinent and repeated at suitable intervals. This may need to be reviewed sooner if risk indicates.
- To ensure as far as reasonably practicable that sufficient information, training, instruction and supervision is in place to protect the health safety and welfare of employees/workers within the Service / Department.
- To organise the distribution of BCUHB instructions and guidance to employees/workers with the Service / Locality / Department.
- To ensure that those individuals who may display behaviours that challenge are identified so that appropriate holistic therapeutic input is made available to them

- Managers should be watchful for signs of restrictive cultures developing. They should facilitate regular discussion about restrictive practices and create a non-blaming environment where practice can be discussed and questioned
- Supervision and team meetings should include restrictive practices as a standing agenda item to allow for the identification of any issues, to ensure practitioners are clear on the organisational position on reducing restrictive practices and to identify any learning and/or support needs.

The Positive Intervention Clinical Support Service Responsibilities:

- Provide needs based training to BCUHB employees/workers. This training will comply with the All-Wales Violence & Aggression Passport scheme ensuring that adequate and appropriate training is provided in consultation with managers, the Learning and Development Department.
- Provide consultation on complex case management and the use of restrictive interventions in such situations.
- Assist in co-ordinating the provision of advice and monitor implementation of policies related to restrictive practice, risk assessments and safe working practices.
- Provide monthly monitoring of Restrictive Interventions, including the use of seclusion in the MHLD Directorate. This to be fed back into the monthly Divisional Quality and Safety Executive meetings.
- Facilitate debrief/review of any critical incidents involving the use of restrictive interventions.
- Provide support to patients subject to high levels of restrictive interventions within BCUHB.
- Provide competence-based training. Practitioners should receive training in prevention approaches and de-escalation before they receive training in the use of restrictive practices. Measures should be in place to ensure any new starters have timely access to training.
- Ensure the training should also cover the trauma that can be experienced both by people who are subject to restrictive practices and those who carry out restrictive practices. Any training should also include perspectives from people who have lived experience of being subject to restrictive practices.

The Occupational Health Department / Employees/workers Psychological Well Being Service:

- Ensure that, where referral to Occupational Health is necessary, access is expedited. The recommendations of the Occupational Health team must be delivered swiftly and monitored.
- Ensure that victims are offered access to appropriate psychological intervention quickly and effectively.
- Ensure that confidential and independent counselling services are available.

Individual Employees Responsibilities:

- Have a moral and statutory duty of care, both for their own personal safety and that of others who may be affected by their acts or omissions.
- Are required to co-operate with their manager/supervisor to enable BCUHB to meet its legal duties and obligations.
- Are expected, in the course of their employment, to report to their manager/ Supervisor any hazardous situations or defective equipment.
- Where issued with personal protective equipment or personal safety equipment employees will ensure that they have adequate training to use the equipment correctly.
- Where locally accepted safety practices exist such as the use of personal safety alarms or call bells, it is the duty of the individual to adhere to those practices to assist in the personal safety.
- Must report incidents via the incident reporting system (Datix) as soon as practicable where increased risks are evident to any other persons.
- To ensure that those individuals who may display behaviours that challenge are identified so that appropriate holistic therapeutic input is made available to them.

6. Definition of Physical Restraint

Whilst there are alternative terms used for 'physical restraint', for example, NICE use the term 'manual restraint', this document will adopt the term 'physical restraint' as used by the Mental Health Act 1983 Code of Practice for Wales (Revised 2016). In practice, both terms have the same definition:

'A skilled, hands-on method of physical restraint used by trained (in physical restraint techniques) healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user'. (NICE NG10)

7. Guidance on the use of Physical Restraint

The principle aim of physical restraint is to limit an individual's autonomy which if deemed inappropriate could infringe upon an individual's right to liberty. Its use therefore must never be as a matter of course, but rather guided by strict criteria. Restrictive interventions must only be used as a last resort and when all other measures have been unsuccessful and the situation is deteriorating. Consideration must be given to the overall context of care; therefore, employees/workers must take into account the detrimental effect the use of Restrictive Interventions may have to all involved individuals.

In exceptional circumstances, a Restrictive Intervention may form part of a Person-Centred Support Plan, Care Plan or Positive Behaviour Support plan that has been agreed by the multidisciplinary team.
The Mental Health Act 1983 Code of Practice for Wales (Revised 2016) cites the following examples of situations where physical restraint may be deemed reasonable:

- Physical assault
- Dangerous or destructive behaviour
- Non-compliance with lawful treatment (MCA / MHA)
- Likely or actual self-harm

- Sexually inappropriate behaviour
- Extreme and prolonged over-activity on the part of the person, that is likely to lead to physical exhaustion
- Absconding, or the risk of absconding

Any restraint used should:

- Be reasonable, justifiable and proportionate to the risk posed by the patient
- Apply the minimum, justifiable level of restriction or force necessary to prevent harm to the patient or others
- Be used for only as long as is absolutely necessary
- Be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities.

(Mental Health Act Code of Practice 2016)

Where a restrictive intervention has been deemed necessary, the team must ensure that any methods aimed at reducing and eliminating behaviours that challenge should take account of the:

- Patient's preference, if known
- Patient's needs
- Patient's physical condition
- Environment of care
- Employees/workers' duty to protect all those under their care.

(Mental Health Act Code of Practice 2016)

Physical Interventions and Pregnancy:

Special provision should be made for pregnant patients in the event that a physical intervention has to be used. Physical interventions should be adapted to avoid possible harm to the unborn child. Best practice procedures should include:

- Proactive use of holding pregnant patients in a semi-recumbent position
- Employees/workers awareness of the symptoms of Supine Hypotension syndrome how to respond
- Employees/workers releasing holds if the patient moves to prone position
- Pregnant patients being medically assessed at the earliest opportunity after a physical intervention. The medical assessment should be recorded in the patient's digital care record.
- Pregnant patients involved in a physical intervention should be physically/ psychologically monitored during a restrictive intervention, immediately following the intervention and hourly post intervention for a period of 24 hours. Signs and symptoms to observe should be discussed with the multi-disciplinary team and where advised, the local midwifery services

Specific techniques to aid this process will not be taught routinely during physical intervention training, but will form part of a bespoke training package for services.

Reasonable Force:

There is no specific definition of ‘reasonable force’- it depends on the circumstances. Force includes physical, mechanical and chemical restraint as well as seclusion and long-term segregation. Where force is used employees/workers will need to evidence that all other interventions have been unsuccessful, and that any physical interventions that have taken place were carried out as an absolute last resort. No one situation will be the same however, employees/workers will need to evidence that any intervention which includes the use of force is carried out in a trauma- informed, person-centred way. Employees/workers will need to record that any force used is proportionate, reasonable and necessary to that situation. Any force used should be rare and exceptional, rather than a common experience for patients and employees/workers.

Physical restraint techniques are not ‘approved’ nor do they have any legal standing – it is the context of their application which makes them **defensible**.

8. Types of Restraint

Restrictive Practice is something which stops a person from doing what they want to do, or encourages them to do things that they don’t want to do. This does not have to include the use of force.

Welsh Government defines restraint as: ‘An act carried out with the purpose of restricting an individual’s movement, liberty and/or freedom to act independently’ (Welsh Government, 2016).These include:

Physical (see definition part 6.)

Chemical: Chemical restraint involves using medication to restrain. It differs from therapeutic sedation in that it does not have a directly therapeutic purpose but is primarily employed to control undesirable behaviour.

Mechanical: Mechanical restraint involves the use of equipment which may have clinical approval, for example, specially designed mittens in intensive care settings but can also include circumstances where equipment is used inappropriately and has no legal basis such as using a heavy table to stop person getting out of their chair. Employees/workers must exercise judgement and ensure that their actions do not unnecessarily or unlawfully deprive individuals of their human rights.

Environmental: Designing the environment to limit peoples’ freedom of movement such as locking doors, use of electronic key pads, and baffle locks. An example of environmental restraint would be seclusion. Seclusion is defined as: ‘the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others’.

Psychological: Can include constantly telling a person not to do something, or that doing what they want to do is not allowed or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing or keeping the person in nightwear with the intention of stopping them from leaving.

8.1 Restrictive Intervention Reduction Programmes

Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should demonstrate organisational commitment to restrictive intervention reduction at a senior level. The use of data relating to restrictive interventions will inform service developments, continuing professional development for employees/workers and how models of service that are known to be effective in reducing restrictive interventions are embedded into care pathways. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

It is the expectation that all BCUHB employees/workers will pro-actively work to reduce the use of restrictive practices.

Key restrictive intervention reduction approaches include the use of the 6 Key Restraint Reduction Strategies which are:

- Leadership
- Data Collection and analysis
- Workforce Development
- Using prevention tools and strategies
- Involving people with lived experience
- Post incident support and post incident review

(Restraint Reduction Network; 2021)

9. General Principles

There may be occasions when employees/workers need to consider the use of physical restraint as a management strategy. The purpose of restraint is first to take immediate control of a serious, significant or dangerous situation and second to contain or limit the person's freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around.

The person in control of the incident will have to carefully assess the situation and use their own judgement as to what may be deemed 'serious' or 'significant' before employing such interventions. Furthermore, any physical restraint used must **be justifiable, appropriate, reasonable and proportionate to a specific situation and should be applied for the minimum possible duration.**

Restraint should be viewed as a last resort and only used when all other interventions have failed. Following important advances in knowledge pertaining to the management of violence and aggression, all current guidelines (e.g. NICE NG10) convey the same clear and unambiguous directive – any use of coercive measures should be preceded by proactive approaches. Examples of proactive interventions include positive engagement whereby service users are encouraged to participate in the planning of their care, advanced statements (a non-legally binding written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care) and advanced decisions (a written statement made by a person 18 yrs or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future), positive regard, effective communication and de-escalation. It should be remembered that person centred care and effective communication should not cease during restraint as this will help in terms of gaining co-operation and returning autonomy as soon as possible as well as

ensuring that the intervention has therapeutic value and that the therapeutic relationship is maintained.

Unplanned physical restraint refers to those incidents requiring restrictive physical interventions which are unforeseen and unexpected. In these circumstances the immediacy of the incident does not allow time to plan ahead and employees/workers are guided by legislation, case law, best practice guidelines, training or common law.

Planned physical restraint refers to those incidents requiring restrictive physical interventions which have been predicted via risk assessment and where there is an anticipation that they are likely to occur. There is time to plan ahead and such plans are structured and documented in health care records. Areas where planned restraints are likely to occur must ensure that any such interventions are supported by a robust training programme.

Prohibited Interventions: Patients should not be deliberately restrained in a way that impacts their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure applied to the neck region, chest, rib cage, abdomen or back. Prone restraint is only used in exceptional circumstances and where is it essential to maintain the safety of the patient and others.

(Mental Health Act Code of Practice 2016 26.70)

It is recognised that all incidents of restraint are unique and varied in their cause, character, risk and outcome. However, despite these variations, there are common approaches which will ensure the situation is managed as safely as possible.

9.1 Physical Restraint

The following should be adopted prior to the implementation of physical restraint:

- All persons should be treated with dignity and respect, irrespective of race, age, culture, gender, diagnosis, sexuality, disability, ethnicity or religious / spiritual beliefs, gender reassignment or marital status.
- Under no circumstances should the use of physical restraint be threatened or intended as disciplinary sanction, or as a means to intentionally humiliate, degrade or to discriminate e.g. corporal punishment, deprivation of food or sleep, inappropriate clothing and restrictions on visits.
- CPR trained employees/workers and resuscitation equipment, including pulse oximeters must be available in all clinical environments where restraint is likely to take place.
- Should an incident arise, employees/workers assistance should be called for using the appropriate emergency alert system or by calling a pre-determined verbal command.
- Approach the person in a side on stance to maintain balance, reduce target area, protect vital organs and to appear less threatening. Arms should be held upwards for protection although care must be taken not to appear confrontational.
- Make a visual check for weapons. If a weapon is seen or suspected employees/workers should withdraw, isolate the patient and contact the police immediately.
- Employees/workers must adopt a team approach with clearly defined roles - one member of employees/workers assuming responsibility for taking the lead and guiding the team throughout the incident. This person will also take responsibility

for protecting and supporting the patient's head, monitoring the person's breathing - ensuring that the airway and breathing are not compromised, monitoring vital signs and noting the skin tone to ensure adequate blood circulation. Other team members should isolate and support the patient's arms and legs and support the process of monitoring vital signs and blood circulation – if necessary, perform passive exercise of affected limb, alter the person's position or release them if medical concerns arise.

- Aim at restraining arms and legs from behind if possible. Exceptions are persons with hearing difficulties/deafness, children and individuals for whom approaching outside of their field of vision would cause distress.
- Physical restraint must not be used in a way that interferes with a person's breathing, circulation or dignity, for example, by applying pressure to the neck, chest, abdomen or groin, or obstructing the airway.
- Physical restraint must not be used in a way which impedes a person's ability to communicate or orientate themselves, for example, obstructing the eyes, ears or mouth.
- When using physical restraint, avoid taking the person to the floor unnecessarily. If it does become necessary, use the supine position (face up) if possible. If it is necessary to use prone position (face down), for example, to administer dorsogluteal intra-muscular medication, use for as short a time as possible. Do not routinely use the prone position.
- Do not routinely use physical restraint for more than 10 minutes. Instead, consider alternatives such as rapid tranquilisation or seclusion.
- In some community settings there may not be a possibility to easily access other members of employees/workers. These situations need to be addressed individually with employees/workers safety in mind. The relevant Divisions will develop guidance for their employees/workers based on this document.
- All persons and employees/workers not directly involved in the incident will leave the immediate area of restraint but be prepared to support colleagues if necessary – audiences are known to escalate violence.
- Employees/workers involved will be allocated specific tasks in relation to the person being restrained.
- During restraint, employees/workers should maintain communication with the person. Employees/workers should explain the reasons for action taken and seek to gain his/her co-operation as soon as possible.
- In situations where a person is attacked by another person, sufficient employees/workers must be present to ensure that both aggressor and victim can be contained. This is important to ensure that the victim is unable to carry out a reprisal attack. Where employees/workers are not able to safely contain such a situation the police should be contacted.
- To mitigate risk, as far as is reasonably practicable, a registered practitioner must be present to oversee any incidents of physical restraint. This is an important measure to ensure that quality and safety standards are maintained and that non-qualified employees/workers are supported during such duties.
- On rare occasions, incidents may occur which are unforeseen and where a registered practitioner may not be present. To lessen the likelihood of this, employees/workers should ensure that risk assessments are completed as appropriate and that robust care plans are produced to include clear guidelines relating to the use of physical restraint. Such incidents must be reported immediately to a registered practitioner who will be expected to attend if available
- Whilst all incidents of restraint will differ in nature and severity, it must be recognised that the ability and confidence of employees/workers to effectively

manage such events will vary from person to person. It is therefore extremely important that employees/workers are able to access additional support to ensure a safe and satisfactory outcome for all concerned.

- The person in charge of the incident will be responsible for deciding when additional support is required and who should be notified. Where incidents are considered serious (e.g. injury to persons), the Senior Clinical Manager and on-call Consultant should be notified. When the person's Consultant is in the locality, they should personally attend to offer clinical expertise and support to employees/workers.
- When it is safe to do so, restraint will be relaxed in gradual manner to allow the individual to regain autonomy.
- It has become increasingly recognised that harm can also occur during and in the period following restraint. The person's physical and psychological health must be monitored during and after restraint for as long as is clinically necessary and in any event for a minimum of 24 hours. Further guidance on the importance of this is given in the **Patient Safety Notice PSN023 (Jan 2016)**.

9.2 Unplanned physical restraint

These incidents carry greater risks than planned and should only be carried out when employees/workers are satisfied that they have the skills and resources necessary to do so safely. Extreme care should be taken under these circumstances to minimise risks to all concerned.

9.3 Planned physical restraint

These incidents also carry risks to all concerned and should be afforded extreme care – risk factors should anticipated whenever possible in advance and sufficient resources made available to manage the situation as safely as possible. Any plans along with advance statements/decisions should be documented carefully in the person's positive behavioural support plan. Planned physical restraint may occur in connection with Mental Capacity Act Best Interest decisions to treat or examine, in which case the use of the Health Board's "Assessment of capacity and best interest decision form" is recommended.

9.4 Chemical restraint

If chemical restraint is needed please refer to MHLD 0004 – Rapid Tranquillisation Protocol for further information.

9.5 Mechanical restraint

The use of mechanical restraints is normally only permitted in high-secure settings, however in some exceptional circumstances, where the severity of a patient's behaviour leads to an identification of such a management strategy, then mechanical restraint may be considered - however this decision must be agreed by the hospital managers and made in collaboration with Healthcare Inspectorate Wales (HIW).

9.6 Restrictive Intervention Reduction Programmes

Restrictive intervention reduction programmes are overarching, multi-component action plans which aim to reduce the use of restrictive interventions. They should demonstrate organisational commitment to restrictive intervention reduction at a senior level. The use of data relating to restrictive interventions will inform service developments, continuing

professional development for employees/workers and how models of service that are known to be effective in reducing restrictive interventions are embedded into care pathways, how people using BCUHB services are engaged in service planning and evaluation and how lessons are learned following the use of restrictive interventions. They should ensure accountability for continual improvements in service quality through the delivery of positive and proactive care. They should also include improvement goals and identify who is responsible for progressing the different parts of the plan. A key indicator that a plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.

It is the expectation that all BCUHB employees/workers will pro-actively work to reduce the use of restrictive practices.

9.7 Primary Prevention Strategies

These aim to reduce behavioural disturbance by ensuring that people's needs are fully and appropriately assessed, well understood, formulated and met. It will be recognised that people are central to their own recovery plans; that risks are recognised and mitigated; and that care and support minimises the potential for conflict.

Assessment and the management of risk is key to minimising the use of all forms of restrictive interventions. They are essential elements of the care and treatment provided to people using BCUHB services and are an integral component of the Wales Mental Health Measure. Accordingly, it is essential that on admission / referral, a risk assessment is carried out and a risk management plan is put into place. This should be undertaken in collaboration with the person using health services and their carer / family wherever possible.

Risk assessments and risk management plans must be regularly reviewed with people using BCUHB services and their carers whenever possible. Plans should record known triggers for risk behaviours based on current observations, previous history and discussion with the person and their carers / families. Changes in levels of risk should be recorded, communicated and risk management plans revised accordingly.

Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural disturbance occurs. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behavioural disturbance. Assessments should seek to understand behaviour in its broader context and not presume it to be a manifestation of a mental disorder.

Employees/workers should wherever possible, proactively support people using BCUHB services to make advance decisions or advance statements about the use of restrictive interventions.

The approach to risk assessment must be multi-disciplinary and reflect the care setting in which it is undertaken. Any risk factors relating to a person using BCUHB services must be communicated appropriately across care settings.

The physical and therapeutic environment within which services are delivered can have a strong mitigating effect on the levels of agitation, frustration and boredom that can be experienced by people using BCUHB services.

Subject to any individually required security measures, care environments must make provision for people using BCUHB services to have predictable and routine access to preferred items and a range of appropriate occupational, social and recreational activities (including evening and weekend activities), taking into account people's abilities, level of functioning and the resources available. Care environments should also be organised to provide for different needs, for example, quiet rooms, recreation rooms and access to open spaces and fresh air.

People using BCUHB services should be engaged in all aspects of care and support planning. This should include identification of any trigger factors and early warning signs of behavioural disturbance and how employees/workers should respond to them. Any individual cultural, spiritual and communication needs should be taken into account when facilitating this engagement including where applicable and practicable, meeting any language preference needs the person may have.

Meetings to discuss an individual's care must occur in a format, location and at a time of day that promotes engagement of people using BCUHB services, families, carers and advocates.

All employees/workers must demonstrate a positive attitude when communicating with people using BCUHB services. Employees/workers must never use language that could be construed as supporting negative stereotypes. This would include verbal or non-verbal responses that could be interpreted as carrying aggressive, threatening, sarcastic or disrespectful intent and this would also include the use of micro aggressions.

Individualised, positive behaviour support plans or care plans must take account of each person's unique circumstances, their background (including any trauma history), priorities, aspirations and preferences. Care plans should be formatted in a manner that renders them accessible and understandable for those who will implement them. Care plan summaries in a suitably accessible format, should be available to people using BCUHB services and their families.

9.8 Secondary Preventative Strategies

These aim to guide and inform the actions of employees/workers, in response to a person beginning to show signs of agitation and / or emotional arousal that may indicate an impending behavioural disturbance and risk behaviour.

De-escalation strategies refers to the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

An individualised account of bespoke de-escalation strategies should be contained within the person's Positive Behaviour Support Plan. This should be prepared with them and in

consultation with families / carers. This element of the care plan should be regularly reviewed and forms an essential component of the risk management plan.

There may be occasions where enhanced observation may temporarily act either as a primary or secondary preventative strategy and this should always be undertaken in line with the BCUHB MHLD AC002 Therapeutic Engagement and Observation Policy. A careful judgement will be required however, as for some individuals; increasing observation may escalate the risks. The key consideration is that enhanced observation is about support and engagement, rather than mere observation.

9.9 Tertiary Reactive Strategies

Whilst the overarching aim is always to reduce the need for the use of restrictive interventions, it is recognised that there may be times when a person's behaviour places themselves or others at imminent risk of significant harm and that where de-escalation strategies have not been enough to prevent a crisis, a restrictive intervention may be necessary as a proportionate and reasonable response to the risk posed.

There are non-restrictive interventions that could be an approach response to crisis e.g., evasion, these should always be considered as the least restrictive option if it is possible to maintain the safety of the person and others.

Where risk assessments identify that restrictive interventions could potentially be needed, their implementation should so far as possible, be planned in advance and recorded as tertiary reactive strategies within the care / risk management plan. Here, the choice of restrictive intervention will be informed by the preference of the people using BCUHB services; any particular risks associated with their general health (e.g., musculoskeletal problems, or poor cardiovascular health); any known trauma history; and an appraisal of the immediate environment. Employees/workers must always ensure that they utilise the least restrictive option for the least amount of time required to ensure safety of the person and others. The type of restriction/s should also be recorded along with any preferences of the person. For any planned restrictive intervention identification of the legal framework and justification for use of the intervention must be documented and regularly reviewed.

9.9.1 Consent and Capacity

Consent is the principle that a person must give permission before they receive any type of medical care, treatment, test or examination. This must be carried out on the basis of an explanation by a clinician. Consent from a patient is needed regardless of the procedure.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

Voluntary – the decision to either consent or not to consent to treatment must be made by the person them self and must not be influenced by pressure from medical employees/workers, friends or family.

Informed – the patient must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and any consequences if treatment does not go ahead.

Capacity – the patient must be capable of giving consent, which means they understand the information given to them, they can consider and weigh up that information (are aware of the

pros and cons of the decision being discussed) and they can retain and use that understanding to make an informed decision.

Any unauthorised or unjustified use of restrictive interventions could be considered legally, to be trespass or assault and it is therefore imperative that all practice is carefully considered and justified. Under certain circumstances, it may be necessary to provide treatment to an individual against their expressed wishes. Further guidance regarding this is available in the Mental Health Act Code of Practice and/or the Mental Capacity Code of Practice.

9.9.2 Security employees/workers

The Health Board will through its procurement processes ensure that there is evidence of appropriate and ongoing training for all security employees/workers employed directly by the Health Board or through a third party. Whilst it is appropriate for BCUHB employees/workers to call upon the services of security employees/workers in violent/aggressive situations in circumstances that may lead to "unplanned physical restraint " as per explanation in this policy,it should be appreciated that security employees/workers will not have undertaken training to the same level as Mental Health/Learning Disabilities employees/workers and any "use of force" will be reasonable as considered within common law, the Criminal Law Act 1967 & Criminal Justice & Immigration Act 2008.

Security employees/workers **will not** be called upon to administer **any** "planned physical restraint", as per explanation in 9.3 of this policy as due to the nature of the event suitably trained "clinical persons" can be assembled to carry out such interventions.

10. Minimising Physical Restraint

All episodes of restraint involve a degree of risk to the recipient, which can include restraint related deaths. Furthermore, employees/workers who carry out restraint can be exposed to risk particularly when the individual is aggressive or violent. **Before using physical restraint other strategies must be considered. For details see pathways for planned and unplanned restraint (Appendices 2 and 3).**

The Department of Health's '*Positive and Proactive Care: reducing the need for restrictive interventions*' (April 2014) emphasises the importance of delivering person-centred care whereby treatment should take into account individual needs and preferences. Service users should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Part 36 of this document gives specific guidance on an appropriate care plan structure. All service users who exhibit, or by virtue of risk assessment, are likely to exhibit behaviours which challenge services, including violence and aggression, should have in place a person centred behavioural support plan (**appendix 5**).

Whilst training will significantly reduce the risks, restraint should be avoided where possible and alternatives considered. Effective communication between employees/workers and aggressor is proven to have positive value in the implementation of restraint, and should be regarded as the underpinning principle. The following are examples of effective non-physical interventions which are intended to de-escalate situations.

- Employees/workers should ensure that their own body language does not convey hostile intentions. Adopt a non-threatening side-on stance, employ fluid gestures and use only intermittent eye contact to avoid staring.

- Maintain and allow the person sufficient space to avoid a sense of being trapped.
- Employ the principles of two-way communication – actively listen to what the individual is trying to communicate.
- Use the components of speech to emphasise what is being said – pay attention to pitch, tone, volume and pace.
- Use open-ended questions to encourage dialogue (e.g. why do you feel angry?) and use closed questions to clarify issues (e.g. are you saying that you want to go for a walk?).
- Empathise with the individual – show concern and attentiveness through appropriate verbal and no-verbal responses.
- Avoid negative responses such as refusals whenever possible – negotiate and offer alternatives and solutions where available. When negative responses are unavoidable consider apologising for the situation.

11. Persons with potential vulnerabilities

- Elderly and learning disabilities patients often have higher risk of cardiac or pulmonary complications. Elderly patients are particularly vulnerable to fractures as well as other age-related conditions and employees/workers should adapt physical restraint techniques, adjusting them for age and frailty – where possible employees/workers should avoid taking an elderly person to the floor.
- Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken.
- Consideration should be given to the person's gender – restraint should not be applied in a way that could be construed as sexual. If appropriate (e.g., has a history of sexual abuse), at least one member of the restraining team should be the same gender as the person.
- Consideration should be given to the person's cultural and ethnic background. In the event of language barriers, please refer to interpretation and translation policy.
- Pregnant women must not be placed in the prone position – a wedge or cushion should be placed under their right side so that they are tilted over slightly; this stops the baby pressing on the large vessels (if more than 5 months pregnant). A record of this should be entered in the person's healthcare record.
- Employees/workers who are responsible for providing clinical care to children should familiarise themselves with relevant local policy and guidelines. It is important that children are not seen as 'small' adults (WHO 2008) – children have anatomical and physiological differences compared to adults.
- All employees/workers who are responsible for providing care to people from disadvantaged vulnerable or underrepresented groups e.g., groups that may experience social exclusion, for example gypsy, roma or traveller, lesbian, gay, bisexual, transgender and queer (LGBTQ plus) people, should ensure that the delivery of care is commensurate with that person's needs. Particular care must be taken not to perpetuate stereotypes.
- Any restraint of persons with physical impairments should be tailored to that individual's needs. Care should be taken not to cause pain or aggravate any physical conditions.

12. Physical Restraint in the Administration of Treatment without Consent

There may be occasions where it is necessary to administer lawful treatment to a person without their consent (MHA/MCA). In such circumstances, it is deemed good practice to use effective communication skills in an attempt to gain the person's cooperation before considering the use of physical restrictive intervention. Furthermore, employees/workers should familiarise themselves with the relevant legislation and satisfy themselves that the use of force to administer treatment is both urgent and necessary (MM54- Rapid Tranquillisation Protocol for use in Adults over 18 years in the psychiatric inpatient setting).

13. External Agency Involvement (Police)

Employees/workers should follow the process for safe management of a person displaying behaviours that challenge that may cause harm to self or others. This may include the attendance of suitably trained employees/workers from the ward area, putting out a security call for assistance. Employees/workers will need to familiarise themselves with the process for the area they are working in.

At no time will employees/workers put themselves at risk if the individual is armed with a weapon or if the risk to employees/workers and others is deemed too high for employees/workers to safely manage the incident. The Police should be summoned immediately by dialling for the emergency services. All those within the area should keep a safe distance from the armed/violent aggressor and, where possible, lock the area off.

The Nurse in Charge and/or the senior manager on site will brief the Police on their arrival. The Police must be given the relevant information on the incident and the risk and physical health history of the aggressor. This is to ensure that the intervention adopted is a proportionate and reasonable response. Following this handover, the Police will (working in conjunction with the employees/workers from the hospital) assume control of the incident. The Police will make a judgement as to which intervention they will employ bearing in mind the safety and risks to all involved.

Further guidance can be found in:

Memorandum of Understanding **–** **'**The Police Use of Restraint in Mental Health & Learning Disability Settings' (2017). (https://rcem.ac.uk/wp-content/uploads/2021/11/Police_Use_of_Restraint_in_Mental_Health_and_LD_Settings.pdf)

14. Post Incident

The Doctor or On-Call Doctor must be informed of Restrictive Interventions that have resulted in injury, harm or use of seclusion, as soon as possible after the event. All incidents involving physical interventions must be recorded in accordance with BCUHB policy.
As a minimum standard the Datix record should clearly indicate:

- What was the reason for use of the restrictive intervention
- What primary/secondary interventions were tried
- How the person was held / in what position?
- How long were they held?
- Who was holding them and which parts of the person's anatomy were held
- Who was monitoring physical health during intervention
- What legal framework was applicable or what was the course of action taken if the person was informal? (i.e., review of legal status)
- CR1 form completed and attached

The statistics from these incident reports will be included in the monthly Divisional Quality and Safety report.

- Following all incidents of restraint measures should be taken to ensure the continued health and well-being of the restrained person. For persons these measures will include incident and care plan recording, monitoring the individual's welfare and health, responding to any injuries or health concerns and ensuring that the individual has the opportunity to make representation or complaint.
- All incidents that involve physical restraint should be subject to a post incident review that allows lessons to be learned for both individuals and professionals.
- Line managers are required to assess whether employees/workers involved in an incident require help / support.
- Support should be offered to ALL employees/workers who have been subject of an assault to avoid discrimination, and thus avoid acceptance of help by members of employees/workers.

- Clinical restraint incidents should be entered in the healthcare record and the care plan reviewed accordingly. Additionally, the care plan should include under what circumstances restraint may be used and what form the restraint may take.
- Physical observations to be taken and recorded following restraint. If patient is non- cooperative Respiration, complexion, level of consciousness to be recorded in the patient notes and on Datix.
- Dr to attend post incident to carry out a physical health check on the patient (within 6 hours of the Restraint- unless National Early Warning signs (NEWS) indicates otherwise)
- **In certain circumstances it may be useful to assess the patient's capacity after the incident to aid potential future prosecutions by the Crown Prosecution Service. It is the senior clinicians' responsibility to document carefully in the notes the details of the incident and the capacity of the patient at the time of the incident. There is also an expectation that BCUHB employees/workers assist the police and provide witness statements where appropriate.**
- Following any incident of restraint involving persons, support should be offered and the opportunity to review the circumstances that led to their being restrained.
- In some circumstances it may be appropriate to offer additional support to other persons who may have been directly or indirectly affected by the incident. It is important however to maintain confidentiality.
- Following a restraint incident, employees/workers should review the incident. Divisions will develop their own incident review processes. Any review should be conducted within a climate of open and honest discussion where employees/workers can express concerns, learn from the incident and consider the precipitating factors and alternatives that may have been used.
- For a quick reference to the restraint process, employees/workers should refer to **Appendix 7**.
- Following any serious incident of aggression or violence, the nominated
- Divisional Lead may meet to perform a post-incident investigation which will include root cause analysis.

15. Risk Assessment & Prediction

All service areas must undertake an identification of hazards and determine the significant risks caused by or affecting their particular areas of responsibility. The risk assessment must be as comprehensive as possible. It is recommended that where appropriate, a multidisciplinary approach be taken using available skills and resources e.g., departmental/ward employees/workers, risk assessors, safety representatives, technical employees/workers etc.

Employees/workers must use an actuarial prediction instrument rather than unstructured clinical judgement alone to monitor and reduce incidents of violence and to help develop a risk management plan, for example the **Dynamic Appraisal of Situational Aggression (DASA) (Appendix 6)**.

Where possible and appropriate it is advised that risk assessment is undertaken in conjunction with partner agencies and persons/carers. It is the responsibility of the relevant Division to ensure that a robust mechanism is in place for risk assessment in their respective area of responsibility

The DASA is extremely useful to use as a tool on wards because its predictive validity is higher than unaided clinical assessments made by senior clinicians. Moreover, the DASA

which is undertaken on a daily basis is now incorporated into nursing handovers and this means employees/workers have to discuss patients with the view to offering patient support especially when their scores are high on the rating scale. The DASA also ensures that nursing employees/workers now come onto a ward where they have an understanding of who among their patients are at increased risk of violence over the next twenty-four hours and who they need to be providing increased support to. The most important aspect of using the DASA is that it changes the culture on a mental health ward from being a reactive caring environment to one that proactively supports patients rather than waiting for incidents to take place.

There are significant benefits which are expected to be achieved if there is an overall reduction in incidents. Individual service users who have complex needs and those that have predictable violent episodes will see an increase in the amount of support they receive which will lead to a reduction of serious violence and serious incidents. This will also mean that individuals who have complex needs and are at imminent risk of violence will have increased input from nursing employees/workers in order to reduce the likelihood of serious violence.

16. Training

The importance of training cannot be over-emphasised. As well as satisfying legal obligations, training ensures that employees are equipped with the skills necessary to fulfil their duties in a confident and safe manner within a legal and ethical framework.

The BCUHB is committed to providing its employees with an ongoing training programme within this field and is a participant of the '**All Wales NHS Violence and Aggression Training Passport and Information Scheme**' which sets an approved national standard against which NHS employers in Wales can be judged. Moreover, it signifies the Health Board's willingness to educate and train its employees/workers to a consistent standard.

Whilst the Passport Scheme sets out minimum expected standards, the Health Board endeavours to exceed these standards to ensure that employees/workers receive the best possible support in the course of their duties.

Restrictive Intervention training does not rely upon physical strength but managing movement safely by maximising the use of biomechanics. Therefore, the training is suitable for a wide range of employees/workers in healthcare settings. Employees/workers attending this training should expect that the fitness level and range of movement required is no more than required in a busy care environment.

Service users will be given the opportunity to become actively involved in the design of training agenda to ensure that programmes are commensurate to the needs of person groups, in particular those with potential vulnerabilities.

The level and frequency in which employees/workers are trained in physical restraint will be determined by their area of work and risk assessment. Managers will be responsible for ensuring that employees/workers (including External Employees/workers) receive training, which appropriately reduces risk and enhances service provision during the execution of their duties.

It will be left to the respective divisions to decide the level of risk requiring appropriate training strategy, i.e., whether such is defined as mandatory or statutory. However, all clinical areas which experience aggression and violence are expected to train up the

appropriate number of employees/workers to allow a safe and appropriate response to a violent incident, including the need for restraint.

Any member of employees/workers using Restrictive Intervention techniques must be in-date with their relevant training for each type of intervention unless they have been afforded a grace period by the training team due to unforeseen circumstances. Employees/workers should only implement Restrictive Physical Intervention Techniques that are taught to them by recognised BCUHB Positive Interventions Clinical Support Trainers and any deviation from these techniques necessitated should be recorded on the electronic incident record (Datix) with a justification for why this was done.

All employees/workers employed in inpatient settings must complete NEWS – (National Early Warning Score) physical health monitoring training within two weeks of commencing employment. This is to ensure they are skilled in carrying out accurate physical health monitoring tasks for people using BCUHB services in ward environments, who may be subject to restrictive interventions or for whom there may be concern over their physical health deterioration or status. This training should be organised through the BCUHB Induction programme (ESR). Employees/workers trained in RPI must also be trained and annually updated in ILS (for inpatient ward areas). Moreover, all employees/workers providing care to older adults and those with dementia will receive lawful and safe interventions in relation to restrictive practice management across all care and treatment settings within BCUHB.

17. Links to Governance & Communications

Divisions contemplating developing local policy or procedures specific to restrictive practice for their clinical areas should use this policy as a reference. This will ensure that policies, protocols and guidelines are developed in line with BCUHB policy and Welsh Government Assembly guidelines. Issues relating to the use of restraints such as monitoring and data collection will be presented to Divisional Safety and Standards Groups.

18. References

1. DOH 2008 Safeguarding Adults.
2. A consultation on the review of “No Secrets” Department of Health 2007 Independent, choice and risk. Lyon CM and Pilmer A 2004
3. Physical interventions and the law, legal issues arising from the use of Physical intervention is supporting children, young people and adults with learning disabilities, Kidderminster, British Institute of Learning Disabilities. Commission for Social Care Inspection (2007).
4. Rights, Risks, Restraint. An exploration into the use of restraint in the in care of older people. RCN 2008.
5. “Let’s talk about restraint” Rights, risk and responsibility. - RCN 2008
6. Restraint revisited – Rights, Risk and Responsibility. – RCN 2004
7. National Person Safety Agency.
8. Dignity in Care DOH 2007.
9. Action on Elder Abuse.
10. Safe use of bedrails NHS NPSA Feb 2007.
11. NG10 Nice Guideline (2015) Violence and Aggression: Short-term management in mental health and community settings. NG10
12. NG11 Nice Guideline (2015) Challenging Behaviour and Learning Disabilities: Prevention and Interventions for people with learning disabilities whose behaviour challenges. NG11

13. “Children Are Not Little Adults” (WHO 2008)
14. Welsh Government (2016) Mental Health Act Code of Practice for Wales
15. Department of Health and Social Care (2007) Mental Capacity Act Code of Practice
16. Restraint Reduction Network Training Standards (2021)
17. All Wales Violence & Aggression Training Passport & Information Scheme
18. Department of Health (2014) - Positive & Proactive Care: Reducing the Need for Restrictive Practice
19. European Human Rights Commission (2019) - Human Rights Framework for Restraint
20. Welsh Government (2021) - Reducing Restrictive Practice Framework
21. Human Rights Act (1998)
22. Deprivation of Liberty Safeguards (2016)
23. Huckshorn, K A (2004) – Reducing Seclusion & Restraint Use in Mental Health Settings: Core Strategies for Prevention
24. NEWS2 – (National Early Warning Score)

This table should be completed and added at the end of the document:

Members of the Working Group:

Name	**Title**
Elinor Hughes	PICSS Manager
Bethan Young	PICSS Lead

Appendix 1

MENTAL CAPACITY ACT 2005 – 10 key points

1. Everyone aged 16 or over is assumed to have capacity unless proven otherwise. However, whenever a particular intervention or treatment is being proposed for a patient, the health professional has a duty on every occasion to assess that patient's capacity to make the decision to agree to or refuse what is being proposed.

2. Capacity only ever relates to a particular point in time and a particular decision that needs to be made. A patient's capacity can fluctuate and may recover.

3. All practicable and appropriate steps should be taken to enable the patient to make the particular decision.

4. A patient should not be treated as being unable to make a decision merely because their decision is unwise in your opinion. However, seek advice if a young person aged 16 or 17 is refusing treatment, particularly when this decision is against the wishes of a person with parental responsibility.

5. Somebody lacks capacity if they have an impairment or disturbance of the mind or brain **and** they are unable to do one or more of the following: understand **or,** retain **or** weigh up the information given to them **or** if they are unable to communicate a decision.*

6. If a patient is assessed as lacking capacity to make a particular decision, the health professional or treating team (the decision maker(s)) has to decide whether the patient should undertake the intervention or treatment in their best interests on their behalf.

7. When making best interest decisions, decision makers should do all of the following: encourage the patient's participation, identify all relevant circumstances, find out the patient's views, avoid discrimination, consider whether the patient will regain capacity, consult others and use the least restrictive option of treatment. Any decision made under the Mental Capacity Act is protected by law if the requirements and terms of the act are followed and documented correctly. *

8. Where necessary, proportionate and reasonable restraint that is necessary to prevent the patient from harm can be used to implement best interest decisions. However, authorisation to deprive the patient of their liberty under the Deprivation of Liberty Safeguards may have to be applied for in cases where the patient is under continuous supervision and continuous control and not free to leave

9. Patients may have appointed an Attorney under a Lasting Power of Attorney or a Deputy appointed by the Court who can make personal health (medical) and welfare decisions on their behalf if they lose capacity. They may also have an advance decision to refuse certain treatments, which is legally binding if valid and applicable. Advanced statements detailing the patient's past and present wishes and feelings are **not** legally binding upon the decision-maker, but ought to be seriously considered when best interest decisions are made.

10. In certain situations, a patient who lacks capacity and who has no-one else to represent them or no-one appropriate to consult, has a right in law to the support of an

Independent Mental Capacity Advocate (IMCA). An IMCA **must** be instructed by the decision-maker, when serious medical decisions or a prolonged stay in (or move to) a hospital or care home is proposed. An IMCA **may** be instructed for care reviews. In adult protection cases an IMCA may be instructed, despite the availability of friends or family. An IMCA makes recommendations about what is in the patient's best interests, but does **not** make decisions on behalf of the decision maker.

* Use the 'Assessment of Capacity' and 'Best Interest Decision' form to assist you.

Appendix 2

UNPLANNED RESTRAINT

Immediate risk to staff, patient or member of public by patient, member of public or staff

↓

Assess risk

↓

Call police or other assistance if risks are significant

↓

Optimise safety of patients, staff and public
Use least restrictive measures first:
Distraction, de-escalation, withdrawal from situation, additional support (staff, family, friends)

↓

If restraint has been used assess need for continuation if situation does *not* resolve (see planned restraint)

↓

Further action depends on circumstances
Consider medical assessment of assailant

↓

Document actions and, when appropriate, capacity assessment; complete BCUHB safety learning report and document post incident review

REMEMBER
BE PROACTIVE
PREPARE
PLAN
PREVENT
INCIDENT
POST INCIDENT
REVIEW

Appendix 3

PLANNED RESTRAINT

Usually no emergency, reason is to aid treatment, investigation or for patient safety

↓

Document reason and legal basis (MCA, MHA, best interest decision)

↓

Need for possible restraint identified

↓

Consider proportionality and alternatives

↓

Reassess need for treatment/investigation/safety

↓

If still needed, use least restrictive measure first
distraction
de-escalation
additional support from relatives, staff or patient's friends

↓

Reassess need, can we defer? → yes, then defer

↓

If no, plan whether physical, mechanical and/or chemical restraint will be needed (for injections see local guidelines)

↓

Define and document how (what technique), how long and how often, consider proportionality

↓

Use least restrictive option
Could be physical and/or chemical restraint (sedation, lowest dose, shortest time)

↓

Use proportionate, reasonable and necessary restraint

↓

Before any repeat, reassess need and proportionality, alternatives and option to defer

↓

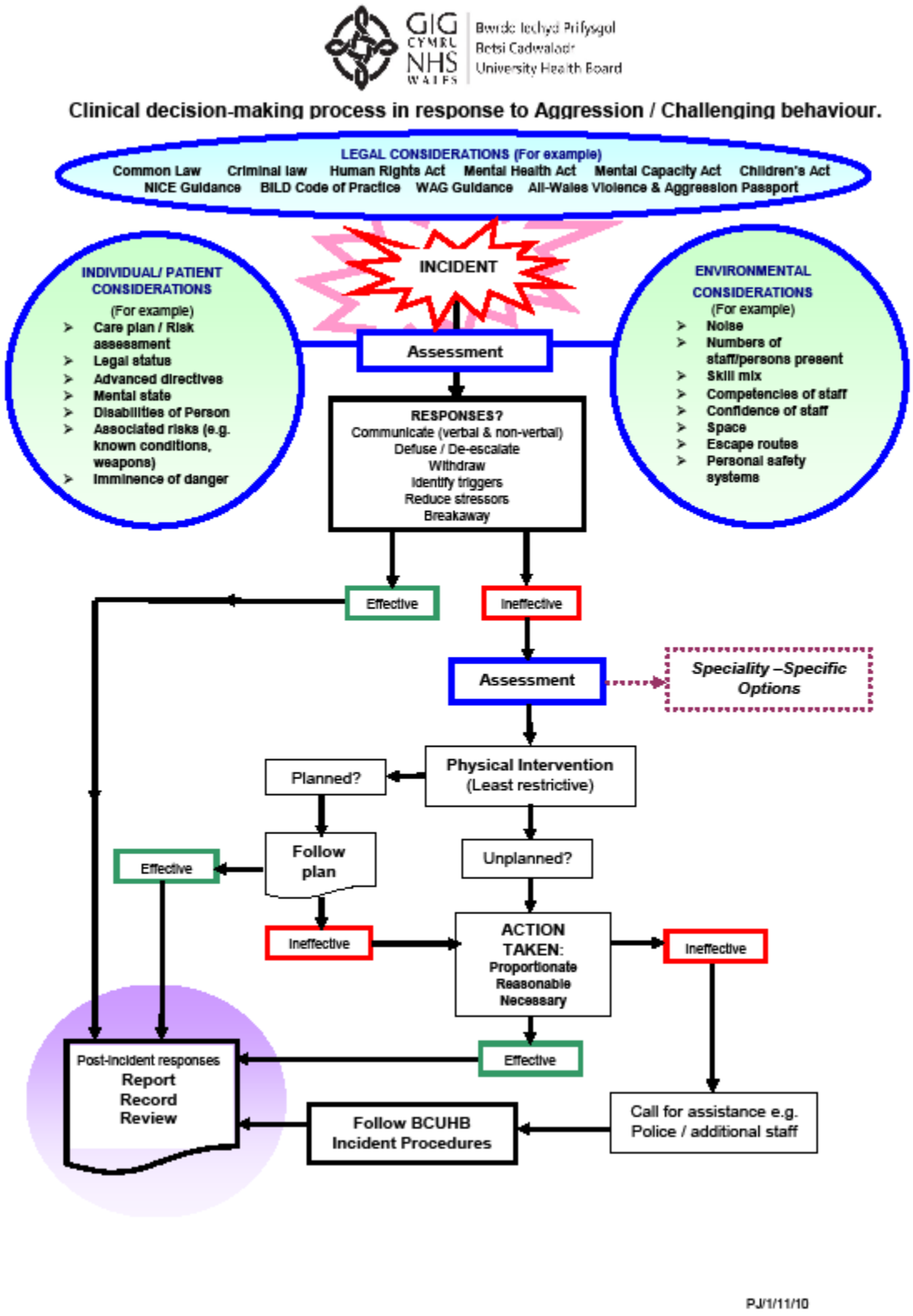
Document actions & capacity assessment in notes, complete BCUHB safety learning report and document post incident review

↓

Initiate incident review with staff and patient, document

REMEMBER
BE PROACTIVE
PREPARE
PLAN
PREVENT
INCIDENT
POST INCIDENT
REVIEW

Appendix 4


GIG CYMRU NHS WALES
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Clinical decision-making process in response to Aggression / Challenging behaviour.
LEGAL CONSIDERATIONS (For example)
Common Law Criminal law Human Rights Act Mental Health Act Mental Capacity Act Children's Act
NICE Guidance BILD Code of Practice WAG Guidance All-Wales Violence & Aggression Passport
INCIDENT
INDIVIDUAL/ PATIENT CONSIDERATIONS
(For example)
Care plan / Risk assessment
Legal status
Advanced directives
Mental state
Disabilities of Person
Associated risks (e.g. known conditions, weapons)
Imminence of danger
Assessment
ENVIRONMENTAL CONSIDERATIONS
(For example)
Noise
Numbers of staff/persons present
Skill mix
Competencies of staff
Confidence of staff
Space
Escape routes
Personal safety systems
RESPONSES?
Communicate (verbal & non-verbal)
Defuse / De-escalate
Withdraw
Identify triggers
Reduce stressors
Breakaway
Effective
Ineffective
Assessment
Speciality –Specific Options
Physical Intervention (Least restrictive)
Planned?
Follow plan
Effective
Ineffective
Unplanned?
ACTION TAKEN:
Proportionate
Reasonable
Necessary
Ineffective
Effective
Post-incident responses
Report
Record
Review
Follow BCUHB Incident Procedures
Call for assistance e.g. Police / additional staff
PJ/1/11/10

Appendix 5

Positive Behavioural Support Plan

PATIENT I.D. LABEL	Ward:	
	Named Nurse:	
	Date:	

These are the early signs that behaviour is escalating:

These are the behaviours that other people may find challenging or risky:

.

Slow triggers for behaviours *(These are the events that build up slowly and may affect behaviour over time):*

Fast triggers for behaviours *(These are the events that may immediately affect behaviour*):

What may be the reasons for the behaviours?

Primary Prevention*: What can reduce the risk of challenging behaviour. (Prevent triggers from occurring)*

Secondary Prevention*: What can be done to reduce the impact of triggers.*

Crisis Management*: How to Provide Support in a Crisis.*

Employees/workers Signature: _____ **Date Reviewed:** _____

Patient Signature: _____ **Date Reviewed:** _____

Carer Signature: _____ **Date Reviewed:** _____

Please tick if care-plan was completed on behalf of patient. ☐

Appendix 6

Dynamic Appraisal of Situational Aggression (DASA)

Instructions for Use

The Dynamic Appraisal of Situational Aggression (DASA) allows for the risk of aggression to be assessed on a day-to-day basis. It is a simple, efficient tool which should be filled out by the patients' key-worker (e.g., named nurse) and should take about five minutes to complete. The results will give an indication of the likelihood of aggression being exhibited by the patient along with suggested actions to mitigate the risk.

Step 1
The DASA chart should be filled out at the same time each day so that a consistent 24-hour period is assessed. The person completing the assessment will be required to gage seven behaviours over the past 24 hours and provide a score against each. If the behaviour is present then a score of **1** is given and if the behaviour is absent then a score of **0** is given for example, when scoring the patients' level of irritability – if they are calm and relaxed whilst alone or in the company of others, a '**0**' should be recorded. If, however, they are easily annoyed or angered and unable to tolerate the presence of others, a '**1**' should be recorded.

N.B. Where a well-known patient habitually exhibits behaviours such as irritability but has not become aggressive, a score of '0' should be recorded.

Step 2
Having completed the chart, they key-worker should total the score and record this. The total score will indicate the level of risk (low, moderate or high) and the appropriate action should be taken as indicated in the **'Actions Required'** section.

DASA Simplified Scoring Guide

Name:	Ward:	Score						
Item	**Basic Description of Patient *Relating only to past 24 hours***	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Irritability	**0** = Has been calm and relaxed. They are comfortable and relaxed in the company of other patients and employees/workers.							
	1 = Is considered easily annoyed or angered and unable to tolerate the presence of others.							
Impulsivity	**0** = Has been affectively and behaviourally stable.							
	1 = Has been sudden, impulsive and unpredictable in their affect or behaviour.							
Unwillingness to follow directions	**0 =** Is generally compliant with any requests and directions.							
	1 = Becomes angry and/or aggressive when they were asked to adhere to some aspect of their treatment or to the ward's routine.							
Sensitivity to perceived provocation	**0** = Does not tend to get angry or see everything around them as provocative. Not being overly sensitive or provocative.							
	1 = Has tended to see others' reactions as deliberate and harmful. May misinterpret others' behaviour or respond with anger in a disproportionate manner to the extent of provocation. Over sensitive and quick to anger.							
Easily angered when requests are denied	**0** = Is calm and accepting when they are asked to wait whilst their request is attended to. Understands and accepts if							

	their request is unable to be fulfilled at that time.							
	1 = Has tended to become angry when their requests have not been granted immediately. Does not accept the delay in gratification of their request.							
Negative attitudes	**0** = No negative attitudes apart from occasional pessimism.							
	1 = Definite/serious negative attitudes exhibited.							
Verbal Threats	**0** = Has not been verbally aggressive.							
	1 = Verbally aggressive or has displayed a verbal outburst (more than just a raised voice) where there is a definite attempt to intimidate or threaten another person. The person may shout angrily, insult others or curse.							
	Total Score:							

0-1 = Low Risk 2-3 = Moderate Risk 4-7 = High Risk

Actions Required Based on DASA Scores

Score	Level of Risk	Actions Required
0-1	Low	Continue with the positive behavioural support plan's ***primary prevention*** strategies
2-3	Moderate	The patient should be monitored for additional indicators of risk Implement the positive behavioural support plan's ***secondary prevention*** strategies
4-7	High	The patient should be monitored for additional indicators of risk Implement the positive behavioural support plan's ***secondary prevention*** strategies Consider the positive behavioural support plan's ***crisis management*** strategies Consider undertaking a clinical team review

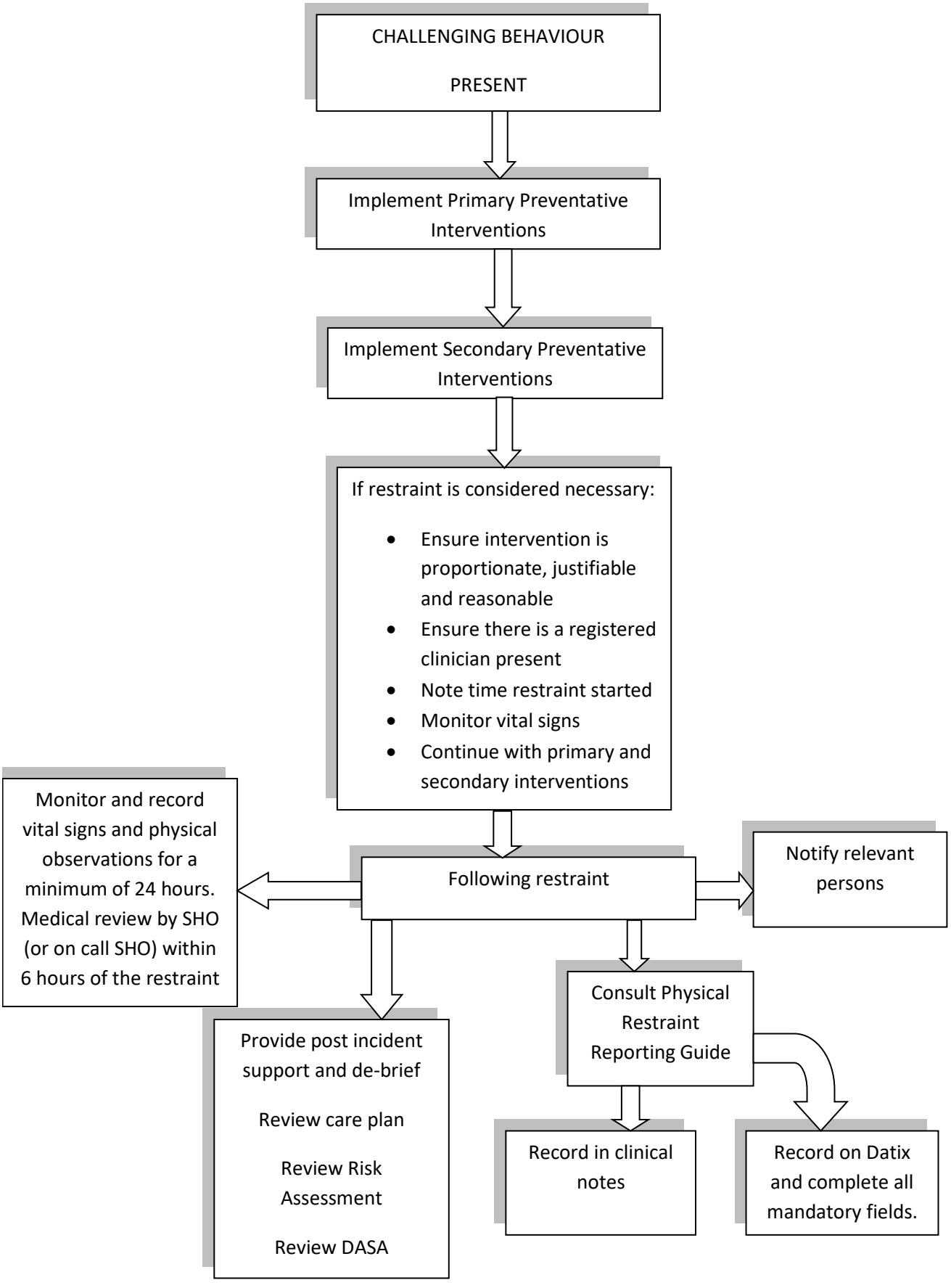
Persistent moderate/high scores may indicate a need for the clinical team to review care and treatment programmes (care plans, medication, involvement of other agencies, supervision/observation levels, risk management strategies etc).

Wards with high number of patients scoring high risk:

- Are there any know dynamic tensions (conflict) between individual patients? If so, tensions should be discussed and attempts at remediation considered.
- Consider enhancing environmental security e.g., Give warm drinks rather than hot until the risk is reduced, remove items which may be dangerous etc.
- Consider the skill /gender mix of the employees/workers on duty.
- Identify an appropriate response plan.

Appendix 7

Physical Restraint Clinical Pathway



APPENDIX 8

COVID-19: Guidance on the use of Personal Protective Equipment (PPE) during Restrictive Physical Interventions (RPI)

COVID-19 is a highly infectious respiratory disease caused by novel corona virus. For employees/workers who may have to utilise restrictive physical interventions, this generates an infection transmission risk associated with close proximity/physical contact which may be exacerbated given the potential for increased transmission of oral fluids through shouting, spitting and biting.

Implementing restrictive physical intervention with a person who is suspected or confirmed as COVID-19 positive should be considered one of the highest infection risk procedures that will be carried out in mental health in-patient services. To mitigate these risks, the following guidance represents the most up-to-date evidence-based practice relating to minimising risk during RPI activities:

Face Masks

- **Fluid repellent surgical face masks must be worn** -These have proved viable in Restrictive Physical Intervention scenarios without presenting significant difficulties other than a tendency for the wearer to experience mild discomfort due to raised temperature resulting from the face covering.

EyeShields & Visors

- **Eye Shields/Visors must be worn** - Preliminary tests have indicated that these are effective when used during Restrictice Physical **I**ntervention scenarios. There appears to be minimal condensation resulting in diminished vision**.** NOTE - There can be issues these being dislodged during episodes of RPI which may require the availability of another person to replace headwear for those engaged in implementing holds.

Gloves

- **Gloves must be worn** - Rubber gloves and elbow length gloves have proved effective during episodes of Restrictive Physical Intervention**.** NOTE - There is an increased risk of pinching the skin for those subject to RPI due to the increased grip that can be achieved from the glove over that that would normally be experienced by the naked hand. Caution should be excercised particularly with Older Adults.

Plastic Aprons

Preliminary tests indicate that aprons prove a hindrance to those engaged in Restrictive Physical Intervention and become easily displaced or ripped off - thereafter providing a slip hazard. **At this stage, significant caution should be given to the use of aprons during RPI.**

- As with current practice, it is important that any restrictive interventions are only used when absolutely necessary and in the context of infection risk are underpinned by the usual principles of proportionality, necessity and reasonableness.

- Where the likelihood of RPI being utilised is foreseeable, for example where the DASA risk score is above 4, the patients Positive Behavioral Support Plan should account for the additional risk of COVID-19 and include appropriate mitigations of risk.

- Considerable care should be taken when putting on PPE as this could perceived as threatening and may suggest that the decision to use physical interventions has already been reached. Employees/workers should offer reassurance and emphasise the intention of attaining non-confrontational resolutions.

- During any restrictive physical interventions, employees/workers should be careful not to touch their own faces, for example, to wipe their brow as this can increase the risk of viral transference.

- An additional member of employees/workers will be required to wear the PPE to act as a 'relief' person for any employees/workers member who has had their PPE dislodged or damaged during restraint. This will give the 'outgoing' employees/workers member the opportunity to re-apply PPE and then become the 'relief' person.

- Post Incident, when taking off the PPE, a 'buddy' system should be employed to help ensure that PPE is removed in the correct order and hands are sanitised prior to proper hand washing later. A change of scrubs will be required.

- Any subsequent post- examination of the individual who was subject to restraint should be conducted as usual – again with employees/workers wearing appropriate PPE.

- The PPE should be treated as clinical waste and placed in an **ORANGE** bag (for infectious clinical waste).

- **ALL** incidents of RPI regardless of intensity or duration and including those regarded as 'clinical holding', 'therapeutic touch' or 'safe holding' which involve a person suspected or known to be COVID-19 positive should be reported via DATIX.

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IT FORMS

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	**PHYSICAL RESTRAINT POLICY MHLD0047**
Date form completed:	3rd November 2020

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

- ✓ *How does your policy / proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?*
- ✓ *What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce / remove these?*
- ✓ *What barriers, if any, do people who share protected characteristics face as a result of your policy / proposal? Can these barriers be reduced or removed?*
- ✓ *Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.*
- ✓ *How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?*

Part A Form 1: Preparation

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	PHYSICAL RESTRAINT POLICY- Whilst there are alternative terms used for 'physical restraint', for example, NICE use the term 'manual restraint', this document will adopt the term 'physical restraint' as used by the Mental Health Act 1983 Code of Practice for Wales (Revised 2016). In practice, both terms have the same definition: 'A skilled, hands-on method of physical restraint used by trained (in physical restraint techniques) healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the service user'. (NICE NG10)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	There may be occasions when staff need to consider the use of physical restraint as a management strategy. The purpose of restraint is first to take immediate control of a serious, significant or dangerous situation and second to contain or limit the person's freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree/approve any changes you identify are necessary?	MHLD Director of Nursing
4.	Is the Policy related to, or influenced by, other Policies/areas of work?	Observation and Therapeutic Engagement Policy (MHLD AC002) Searching Patients and their Property Policy (MHLD 0013) Mental Capacity Act Code of Practice for Wales MHA Code of Practice for Wales (Revised 2016) MHA Code of Practice for England Rapid Tranquillisation Protocol (MHLD 0004) MH02 Protocol for the Exceptional Admission of Children under the Age of 18 Years to an Acute Psychiatric Inpatient Unit.

Part A

Form 1: Preparation

		Safeguarding Adult at Risk Procedure (SA01) Proactive Reduction & Therapeutic Management of Behaviours which Challenge (MHLD0049) Seclusion and long term segregation policy (MHLD0002) Human Rights Act 1998. Mental Capacity Act 2005 – Code of Practice. Deprivation of Liberty Safeguards – Code of Practice.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Patients. BCUHB Staff. Police.
6.	What might help/hinder the success of whatever you are doing, for example communication, training etc.?	Ensuring that there is an up to date policy in place which reflects current national guidelines. Ensuring that staff are in receipt of training in the use of physical restraint (Module D of the welsh passport scheme) Ensuring that the use of physical restraint is closely monitored and reported to appropriate governance structures for review. Training, Fiscal Resources, National Guidelines, Staff Attitudes.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The policy refers to the Equality ~~at Work~~ Act and encapsulates its content. The policy is based upon the principles of physical restraint set out in section 9.1 which includes: All persons should be treated with dignity and respect, irrespective of race, age, culture, gender, diagnosis, sexuality, disability, ethnicity or religious / spiritual beliefs, gender reassignment or marital status.

Part A

Form 1: Preparation

		Under no circumstances should the use of physical restraint be threatened or intended as disciplinary sanction, or as a means to intentionally humiliate, degrade or to discriminate e.g. corporal punishment, deprivation of food or sleep, inappropriate clothing and restrictions on visits. Section 11 makes clear that all employees/workers who are responsible for providing care to people from disadvantaged vulnerable or under represented groups e.g. groups that may experience social exclusion, for example gypsy, roma or traveller, lesbian, gay, bisexual, transgender and queer (LGBTQ plus) people, should ensure that the delivery of care is commensurate with that person's needs. Particular care must be taken not to perpetuate stereotypes.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. *(Please refer to the Step by Step guidance for more information)* It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.

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

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

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

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

Part A

Form 2: Record of potential Impacts - protected characteristics and other groups

Protected characteristic or group	Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here	How will you reduce or remove any negative Impacts that you have identified?
	Yes	**No**	**(+ve)**	**(-ve)**		
Age (e.g. think about different age groups)	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005,Healthcare Commission National Audit of Violence 2006-7 Final Report - Older people's services, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for	• Elderly and learning disabilities patients often have higher risk of cardiac or pulmonary complications. Elderly patients are particularly vulnerable to fractures as well as other age related conditions and employees/workers should adapt physical restraint techniques, adjusting them for age and frailty – where possible employees/workers should avoid taking an elderly person to the floor. • Patients with cognitive impairment will often not understand oral explanations, and additional consideration has to be taken. ~~N/A~~ • The policy states that where possible employees/workers should avoid taking an elderly person to the floor.

					restrictive interventions - DoH 2014. Equality Act 2010. The policy recognises that Elderly and learning disabilities patients often have higher risk of cardiac or pulmonary complications. Elderly patients are particularly vulnerable to fractures as well as other age related conditions and employees/workers should adapt physical restraint techniques, adjusting them for age and frailty	
Disability (think about different types of impairment and health conditions:- i.e. physical, mental health, sensory loss, Cancer, HIV)	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010. There are particular issues in regards to physical restraint and	~~N/A~~ This policy is clear that, in alignment with the Mental Health Act Code of Practice 2016 any restraint should: • Be reasonable, justifiable and proportionate to the risk posed by the patient • Apply the minimum, justifiable level of restriction or force necessary to prevent harm to the patient or others • Be used for only as long as is absolutely necessary

					mental capacity, and there is also an increased risk of harm to the patient when the patient has physical impairments or long-term physical or mental health conditions.	Section 9.9.1 lays of the prinicples of consent and capacity: Consent is the principle that a person must give permission before they receive any type of medical care, treatment, test or examination. This must be carried out on the basis of an explanation by a clinician. Consent from a patient is needed regardless of the procedure. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below: - Voluntary – the decision to either consent or not to consent to treatment must be made by the person them self and must not be influenced by pressure from medical employees/workers, friends or family. - Informed – the patient must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and any consequences if treatment does not go ahead. - Capacity – the patient must be capable of giving consent, which means they understand the information given to them, they can consider and weigh up that information (are aware of the pros and cons of the decision being discussed) and they can retain and use that understanding to make an informed decision.

						Furthermore, Where a restrictive intervention has been deemed necessary, the team must ensure that any methods aimed at reducing and eliminating behaviours that challenge should take account of the: • Patient's preference, if known • Patient's needs • Patient's physical condition • Environment of care • Employees/workers's duty to protect all those under their care.
Gender Reassignment (sometimes referred to as 'Gender Identity' or transgender)	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.	This policy is clear that, in alignment with the Mental Health Act Code of Practice 2016 any restraint should: • Be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities. ~~N/A~~

Pregnancy and maternity	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010. There are clear implications for pregnant patients in physical restraint.	Special provision should be made for pregnant patients in the event that a physical intervention has to be used. Physical interventions should be adapted to avoid possible harm to the unborn child. Best practice procedures should include: • Proactive use of holding pregnant patients in a semi-recumbent position • Employees/workers awareness of the symptoms of Supine Hypotension syndrome how to respond • Employees/workers releasing holds if the patient moves to prone position • Pregnant patients being medically assessed at the earliest opportunity after a physical intervention. The medical assessment should be recorded in the patient's digital care record. • Pregnant patients involved in a physical intervention should be physically/ psychologically monitored during a restrictive intervention, immediately following the intervention and hourly post intervention for a period of 24 hours. Signs and symptoms to observe should be discussed with the multi-disciplinary team and where advised, the local midwifery services Specific techniques to aid this process will not be taught routinely during physical intervention training, but will form part of a bespoke training package for services. • Pregnant women must not be placed in the prone position – a wedge or cushion should be placed under their right side so that they are tilted over slightly; this

						stops the baby pressing on the large vessels (if more than 5 months pregnant). A record of this should be entered in the person's healthcare record. ~~N/A~~
Race (include different ethnic minorities, Gypsies and Travellers) Consider how refugees and asylum-seekers may be affected.	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010. There may be implications arising from race and culture when it comes to physical restraint. There may also be commuincation issues arising from language and interpretation issues.	This policy is clear that, in alignment with the Mental Health Act Code of Practice 2016 any restraint should: Be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities • Consideration should be given to the person's cultural and ethnic background. In the event of language barriers, please refer to interpretation and translation policy. ~~N/A~~

Religion, belief and non-belief	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014	This policy is clear that, in alignment with the Mental Health Act Code of Practice 2016 any restraint should: Be carried out in a way that demonstrates respect for the patient's gender and cultural sensitivities N/A
Sex (men and women)	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 201. Equality Act 2010.	• The policy includes this guidance: ~~N/A~~ Consideration should be given to the person's gender – restraint should not be applied in a way that could be construed as sexual. If appropriate (e.g. has a history of sexual abuse), at least one member of the restraining team should be the same gender as the person.

					There may be issues surrounding sex and gender identity arising from cultural or dignity issues.	
Sexual orientation (Lesbian, Gay and Bisexual)	Y		Y		This policy has been written to align to: Stonewall Cymru website, NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care: reducing the need for restrictive interventions - DoH 2014. Equality Act 2010.	N/A
Marriage and civil Partnership (Marital status)	Y		Y		This policy has been written to align to: NICE Guidelines NG10/11, WP8: Equality, Diversity & Human Rights Policy, Mental Health Act 1983 Code of Practice for Wales (Revised 2016), Framework for Restrictive Physical Intervention Policy & Practice - WAG 2005, Patient Safety Notice PSN 023, Positive and proactive Care:	N/A

					reducing the need for restrictive interventions - DoH 201. Equality Act 2010.	
Low-income households	Y		Y		N/A	N/A

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights? For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166

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

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	N				This policy protects the persons human rights. Section 8 directly states that "Employees/workers must exercise judgement and ensure that their actions do not unnecessarily or unlawfully deprive individuals of their human rights."	N/A

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Welsh Language:

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

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

Part A Form 4: Record of Engagement and Consultation

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.	The policy has been sent out for a period of consultation where staff have been given the opportunity to feedback. All feedback has been considered and implemented where appropriate
Have any themes emerged? Describe them here.	No
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	

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

Part B Form 5: Summary of Key Findings and Actions

1. What has been assessed? (Copy from Form 1)	**Physical Restraint Policy** The purpose of restraint is first to take immediate control of a serious, significant or dangerous situation and second to contain or limit the person's freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around

2. Brief Aims and Objectives: (Copy from Form 1)	There may be occasions when staff need to consider the use of physical restraint as a management strategy. The purpose of restraint is first to take immediate control of a serious, significant or dangerous situation and second to contain or limit the person's freedom for no longer than is necessary to end or reduce significantly the threat to themselves or those around.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal?	Yes	No x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation?	Yes	No x
3c. Is your policy or proposal of high significance?	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x	
	Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x	
	Record Details: No		
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes x	No	
	How is it being monitored?	The policy addresses monitoring requirements. All incidents are reported via DATIX and are reviewed on an individual basis by the V&A Leads. A monthly report is submitted to QSEEL for scrutiny and review.	

Part B Form 5: Summary of Key Findings and Actions

implement your policy or proposal?	Who is responsible?	MHLD Divisional leads
	What information is being used?	Monthly reports are submitted to MHLD QSE for scrutiny by divisional leads.
	When will the EqIA be reviewed? (Usually the same date the policy is reviewed)	01/11/2021

7. Where will your policy or proposal be forwarded for approval?	MHLD Divisional Policy Approval Group

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Gareth Owen Bethan Young	PICSS lead PICSS nurse specialist

Part B Form 5: Summary of Key Findings and Actions

Senior sign off prior to committee approval:		
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

	Proposed Actions	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:			
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?			

Part B Form 5: Summary of Key Findings and Actions

	Proposed Actions	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?			
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.			
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.			

<table>
<tr><td>Teitl adroddiad:

Report title:</td><td colspan="4">Policy review: BCUHB RP02 NON-IONISING RADIATION PROTECTION POLICY version 3</td></tr>
<tr><td>Adrodd i:

Report to:</td><td colspan="4">Quality, Safety and Experience (QSE) Committee</td></tr>
<tr><td>Dyddiad y Cyfarfod:

Date of Meeting:</td><td colspan="4">Thursday, 26 May 2022</td></tr>
<tr><td>Crynodeb Gweithredol:

Executive Summary:</td><td colspan="4">What is the purpose of this paper, is it a standing/one off item?
The policy is issued to provide direction and arrangements for the safe management of non-ionising radiation within the BCUHB in compliance with Statutory Duties. This policy has undergone a regular review, and minor updates, amendments and improvements have been made to the document.

What is required from the Board as a result of this report?
The Board is requested to endorse this new edition of the policy. No further action is required.</td></tr>
<tr><td>Argymhellion:

Recommendations:</td><td colspan="4">The Board is asked to: approve the minor amendments to the RP02-Non-Ionising Radiation Protection Policy in order to comply with the requirements of regulations and guidance related to the safe use of non-ionising radiation throughout the Health Board</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Executive Director of Therapies and Health Sciences</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Mr Peter A. Hiles, Head of Radiation Physics
Dr D Ravindranathan, Clinical scientist lead for non-ionising radiation</td></tr>
<tr><td>Pwrpas yr adroddiad:
Purpose of report:</td><td>I'w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☒</td><td>Am sicrwydd
For Assurance
☐</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>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</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">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:</td></tr>
</table>

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 improve the safety and quality of all services
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Health and Safety Executive (Control of Artificial Optical Radiation at Work Regulations 2010; Control of Electromagnetic Fields at Work Regulations 2016)
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	Yes, EQIA is applicable and was first completed in 2012. This has been reviewed with no substantial changes in 2022. The EqIA is appended to this report.
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?***	No, the assessment is that an SEIA is not required. *This policy is based on regulatory requirements and therefore it is assumed that a socio-economic impact assessment, if required, has been performed at a national level.*
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)***	This is not a risk that sits on the risk register as it a review of a policy, with minimal implications for continued practice. However, if the policy is not approved then a risk will be raised
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	Failure to follow regulatory compliance could have enforcement consequences including suspension of services, which would have financial consequences. However, the policy allows for continued compliance with regulations as part of current daily business and does not have any financial implications if approved.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	None
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This policy has passed through the Radiation Protection Committees (local and overarching) and the Clinical Effectiveness Group. Since this policy applies across the whole of the Health Board and covers patients, staff and public, approval is required at Health Board level
Cysylltiadau â risgiau BAF:	This is not a risk that sits on the risk register as it a review of a policy, with minimal

(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	implications for continued practice. However, if the policy is not approved then a risk will be raised
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Next Steps: Place the reviewed RP02 Non-ionising radiation protection policy onto the Policies, Procedures and other key documents page	
List of Appendices: 1. *RP02 Non-ionising Radiation Protection Policy* 2. *RP02 EQIA*	

Version: 3.0

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

RP02

NON-IONISING RADIATION PROTECTION POLICY

Date to be reviewed:	October 2021	**No of pages:**	17
Author(s):	Mr P Hiles Dr D Ravindranathan	**Author(s) title:**	Head of Radiation Physics Non-Ionising Radiation Lead Clinical Scientist
Responsible dept / director:	Executive Director of Therapies and Health Sciences		
Approved by:	BCULHB Overarching Radiation Protection Committee (06/12/22) / Clinical Effectiveness Group (??)		
Date approved:	3rd December 2018		
Endorsement by:	Quality, Safety and Experience Committee of the Health Board		
Date endorsed:	March 2019		
Date activated (live):			

Date EQIA completed:	June 2012, reviewed February 2019 (no changes), Dec 2022 new submission
Documents to be read alongside this policy:	Health and safety policy HS01
Review	**Purpose of Issue/Description of current changes:** Issued to provide direction and arrangements for the safe management of non-ionising radiation within the BCUHB in compliance with Statutory Duties. Version 3 Added clarifying text; revised Appendix 1 on radiation protection organisation and updated references to revised guidance [ICNIRP 2020 and MHRA 2021]. Also included modifications suggested by external non-ionising radiation physics expert and Laser Protection Adviser (LPA).

First operational:	August 2012				
Previously reviewed:	Dec 2018	Dec 2022	date	date	date
Changes made yes/no:	Yes	Yes	Yes/no	Yes/no	Yes/no

NON-IONISING RADIATION PROTECTION POLICY

Contents

1. Introduction
2. Policy statement
3. Aims
4. Objectives
5. Organisation and responsibilities
6. Protection of staff and patients
7. General management of radiation sources
8. References

Appendix 1 Radiation protection organisation
Appendix 2 General guidance on entitlement
Appendix 3 Example non-ionising radiation equipment and uses in Health Board

1. Introduction

1.1 The main source of non-ionising radiation is electromagnetic radiation, which covers ultraviolet (UV), visible, infrared, microwave, radio frequency (RF) and laser radiation. Other sources include ultrasound (US), audio frequency sound (noise) and magnetism.

1.2 There are a number of different sources of non-ionising radiation used on Health Board premises (see Appendix 3). These produce a range of effects in the body, some of which are potentially hazardous to patients and staff in the clinical environment. Therefore protection measures may be needed to ensure that exposure is kept within acceptable levels.

1.3 The use of non-ionising radiation in health establishments in the UK is governed by statutory instruments and good practice guidance (refer to section 8). The legislation is enforced as health and safety regulations made under the Health and Safety at Work Act 1974. They cover general health and safety of staff and members of the public and impose responsibilities on both the employer and employees.

1.4 This policy document sets out the Betsi Cadwaladr University Health Board (BCUHB) aims and objectives in connection with the use of non-ionising radiation on its premises. It also outlines the general arrangements in force within the Health Board for implementing the policy.

1.5 Under the authority of this policy, Departments using non-ionising radiation are required to produce their own operating procedures and local rules for implementing the policy within their area of responsibility.

1.6 The policy has been endorsed by the BCUHB Executive Board and forms part of the Health Board's Health and Safety Policy.

2. Policy Statement

2.1 The BCUHB is committed to providing and maintaining a safe working environment for all its employees, patients and any other persons who may be affected by its activities involving non-ionising radiation.

2.2 The Board's commitment applies to all premises and activities involving non-ionising radiation within its control.

2.3 The Board is committed to establishing good communication between all those involved in the implementation of this policy.

3. Aims

The purpose of this policy is to ensure that non-ionising radiation exposures of staff, patients and members of the public resulting from work carried out in the BCUHB are as low as reasonably practicable.

4. Objectives

The Health Board, in pursuing this policy, is committed to the following key objectives for its use of non-ionising radiation:

4.1 To comply with all relevant statutory requirements and guidance documents (see section 8).

4.2 To identify radiation hazards, assess and control risks and prepare contingency plans;

4.3 To ensure that diagnostic procedures are performed in such a way that the non-ionising radiation exposure to the patient is as low as reasonably practicable and that therapeutic procedures are consistent with the required clinical outcome;

4.4 To ensure that employees, contractors and others are adequately informed of identified radiation risks and, where appropriate, ensure they receive instruction, training and supervision;

4.5 To consult with employees' representatives on radiation safety issues;

4.6 To make arrangements for liaison with other employers, where the activities of one employer could affect the safety of individuals associated with the other;

4.7 To safeguard the environment from the effects of the Health Board's activities;

4.8 To make available records at the request of authorised external agencies;

4.9 To monitor and review the effectiveness of the policy and, where appropriate, implement improvements.

5. Organisation and Responsibilities

5.1 The Chief Executive

Under *The Control of Artificial Optical Radiation at Work Regulations* [SI 2010] and *The Control of Electromagnetic Fields at Work Regulations* [SI 2016], the Employer is ultimately responsible for the radiation protection of all workers on its premises and for work with non-ionising radiation carried out by its staff at other sites. For the BCUHB this responsibility rests with the Chief Executive.

5.2 The Health Board

5.2.1 The responsibility for monitoring of the operation of this policy lies with the Board of the BCULHB and its Chief Executive.

5.2.2 The employer is also responsible for establishing a Radiation Protection Committee (RPC) to assist it in the discharge of its duties.

5.2.3 The BCULHB is responsible for appointing one or more Laser Protection Advisers (RPAs) [MHRA 2015] and Magnetic Resonance Safety Experts (MRSEs) [MHRA 2021] to advise on compliance with statutory requirements and safety. They should be members of, and report to, the RPC.

5.3 Board Level Directors

5.3.1 The Chief Executive has appointed the Executive Director of Workforce and Organisational Development (WOD) as Board level director for health and safety.

5.3.2 The Chief Executive has appointed the Executive Director of Therapies and Health Sciences to be responsible for the co-ordination of radiation-related Health Board activities. This board-level director shall be responsible, through a process of nomination, for the implementation of this policy, facilitating the Overarching Radiation Protection Committee and acting as the Board representative in communications with external radiation inspectorates, including the Healthcare Inspectorate Wales (HIW) and Health & Safety Executive (HSE).

5.4 Overarching Radiation Protection Committee (RPC)

5.4.1 The Overarching RPC is responsible for overseeing the management of radiation safety throughout the organisation; it reports to the Clinical Effectiveness Group (CEG) of the Executive Delivery Group (EDG) for Quality and hence to the Executive Team (see Appendix 1).

5.4.2 The Overarching RPC is responsible for formulating and reviewing this policy on non-ionising radiation, and for recommending appropriate action to the Chief Executive via the formalised route where necessary.

5.4.3 In addition, three local RPCs, chaired by the Assistant Director of Therapies and Health Sciences or RPA, will consider operational issues and report to the BCUHB Overarching RPC chaired by the Executive Director.

5.5 Ultrasound Governance Group

5.5.1 The Ultrasound clinical governance group is responsible for promoting the safe use of Ultrasound within the Health Board and to ensure compliance with Welsh Ultrasound Governance requirements [WSAC 2013]. This group reports to the Overarching Radiation Protection Committee (see Appendix 1).

5.5.2 The US group oversees replacement of equipment, the establishment and maintenance of service standards and the processes of training, supervision and audit. This will provide assurance on the achievement and maintenance of high levels of competence, performance and patient safety).

5.6 Departmental Responsibilities

5.6.1 The Health Board management arrangements place the responsibility for the day to day operational delivery of services on the Heads of Department.

5.6.2 In every department where radiation is used, the responsibility (under the Chief Executive) for ensuring compliance with this policy and the requirements of legislation and guidance and Local Rules lies with the Head of Department. However, these responsibilities may be delegated to a designated senior member of the Department.

5.6.3 Within each Department the designated officer has the following responsibilities:

5.6.3.1 To ensure that responsibilities for radiation protection are documented.

5.6.3.2 To ensure that there exist written Local Rules, Operating Protocols and Risk Assessments and that these are reviewed regularly.

5.6.3.3 To ensure that, for medical exposures, there exist for each procedure, protocols that describe the eligible referrer(s), the practitioner(s) and the Operator(s).

5.6.3.4 To ensure that all non-ionising equipment users receive appropriate training and that records of training are maintained.

5.6.3.5 To ensure that suitable personal protective equipment is available.

5.6.3.6 To ensure that for medical exposures, rigorous patient and subject identification procedures are followed.

5.6.3.7 To ensure that all radiation equipment is selected, installed, acceptance tested and maintained to satisfy radiation safety requirements, and included in their equipment inventory and planned equipment replacement programme.

5.6.4 In some departments where non-ionising radiation is used, the Head of Department will appoint sufficient competent persons to assist the Head of Department and to ensure that protection measures are implemented, e.g. Laser Protection Supervisor [MHRA 2015] or Magnetic Resonance Responsible Person [MHRA 2021]. Their role should be specified in their appointment letter. General guidance on entitlement to appoint an LPS or MRRP is covered in Appendix 2.

5.6.5 Before introducing new procedures or equipment, radiation risk assessments should be undertaken, in conjunction with the relevant Medical Physics staff. Thereafter, risk assessments should be dated and reviewed regularly.

5.6.6 The supervision of the health ~~medical supervision~~ of staff is the responsibility of the Occupational Health & Wellbeing Service.

5.6.7 North Wales Medical Physics aims to provide radiation protection support for medical lasers, phototherapy equipment, MRI and ultrasound imaging equipment.

https://nhswales365.sharepoint.com/sites/BCU_Intranet_MEDPHYS/SitePages/Radiation-Physics.aspx

5.7 Individual Responsibilities

5.7.1 It is the duty of all members of staff to protect themselves and others from any hazard arising from their work. Members of staff must not knowingly expose themselves or any other person to non-ionising radiation to an extent greater than is reasonably necessary for the purposes of their work, and shall exercise reasonable care while carrying out such work. Failure to comply with Local Rules or written procedures and protocols for medical exposures may result in disciplinary action.

5.7.2 Members of staff must make full and proper use of any personal protective equipment provided and shall report to the Safety Officer or Head of Department any defect in such equipment or any suspected fault in safety warnings or interlocks.

6. Protection of Staff and Patients

6.1 Local Rules

6.1.1 Local Rules should be issued for every department using lasers (Class 3B and 4) and MRI equipment. They should be regularly reviewed and

major changes reported to the RPC. Local rules should be readily available to staff for reference and relevant sections may be displayed in the locations to which they refer.

6.1.2 Where relevant, the control of access to areas where non-ionising radiation sources are used should be identified in the Local Rules. Health Board staff and visitors may only enter these in accordance with the written Systems of Work. Patients may enter a Controlled Area for the purpose of undergoing medical exposures.

6.2 Risk Assessments, Policies and Procedures

Risk assessments regarding the use of non-ionising equipment should be performed, dated and reviewed regularly. Also, written procedures and protocols should exist for the use of all non-ionising equipment.

Magnetic Resonance Imaging (MRI) and diagnostic ultrasound (US) are both deemed safe for use on pregnant patients. However, the MHRA and BMUS require application specific guidelines for examinations during pregnancy (see references).

6.3 Training

Heads of Departments must ensure that adequate training is provided for all staff working in departments using potentially hazardous levels of non-ionising radiation or who regularly enter areas where equipment is used.

7. General Management of Radiation Sources

7.1 Equipment Maintenance and Quality Assurance

All departments using non-ionising radiation equipment on patients must ensure that the equipment is regularly maintained and subject to suitable quality assurance (QA) checks at suitable intervals (see BCUHB Medical Devices Policy). A QA programme may include:

7.1.1 Acceptance testing of new equipment before it is used for clinical procedures.

7.1.2 Adequate testing of the performance of the equipment at appropriate intervals and after any major maintenance procedure.

7.1.3 A programme for testing active engineering controls and warning devices, including lights.

7.1.4 Regular assessments of non-ionising radiation exposure delivered to persons undergoing medical procedures.

7.1.5 An up-to-date inventory of radiation equipment at each installation.

7.1.6 The QA programme shall specify action levels and appropriate remedial actions when these levels are exceeded, including removal from service when necessary.

7.2 Incidents and Overexposures

All radiation work shall be conducted with due regard to minimising exposure of persons (patients, staff and public), in accordance with Local Rules. Breaches of Local Rules, suspicions of over-exposure, equipment faults leading to staff or patient exposures greater than intended, must all be investigated by following procedures for reporting and dealing with incidents involving non-ionising radiation. Non-ionising radiation Incidents will be reported as Clinical Incidents on the appropriate forms and will be reported to the Radiation Protection Committee.

Further details in respect of the incident and reporting process can be found in the BCUHB Incident reporting and Investigation Procedure.

8 References

8.1 General health and safety of staff from artificial optical radiation is specified in the *Control of Artificial Optical Radiation at Work Regulations 2010* [SI 2010] and for electromagnetic fields in the *Control of Electromagnetic Fields at Work Regulations* [SI 2016].

8.2 Written guidance on good practice is provided for various non-ionising radiation uses including: *Lasers, intense light sources and LEDs - guidance for safe use in medical, surgical, dental and aesthetic practices* [MHRA 2015]; *Safety guidelines for magnetic resonance imaging equipment in clinical use* [MHRA 2021]*;*

8.3 A range of safety advice statements for ultrasound are provided by the British Medical Ultrasound Society – Physics and Safety *Statements* https://www.bmus.org/policies-statements-guidelines/safety-statements/

8.4 Further references are provided below regarding safety guidance for other sources of non-ionising radiation.

BIR 2012. The safe use of ultrasound in medical diagnosis, 3rd edition. British Institute of Radiology. London: BIR
https://www.birpublications.org/page/ultrasound

BMUS 2010. Guidelines for the safe use of diagnostic ultrasound equipment. The British Medical Ultrasound Society.

https://journals.sagepub.com/doi/full/10.1258/ult.2010.100003

BSI 2006. Safety of laser products-Part 8:Guidelines for the safe use of laserbeams on human. British Standards Institution PD IEC/TR 60825-8:2022. London: BSI.

BSI 2011. Medical electrical equipment. Part 2-57. Particular requirements for the basic safety and essential performance of non-laser light source equipment intended for theraputic, diagnostic, monitoring and cosmetic/aesthetic use British Standards Institution BS EN 60601-2-57:2011 London: BSI.

BSI 2014. Safety of laser products – Part 1: equipment classification, and requirements. British Standards Institution BS EN 60825-1:2014+A11:2021. London: BSI.

BSI 2017. Personal eye-protection equipment. Filters and eye-protectors against laser radiation (laser eye-protectors). British Standards Institution BS EN 207:2017. London: BSI.

BSI 2020. Medical electrical equipment. Particular requirements for basic safety and essential performance of surgical, cosmetic, theraputic and diagnostic laser equipment. British Standards Institution BS EN 60601-2-22:2020 London: BSI.

BSI 2022. Safety of laser products. A user's guide. British Standards Institution PD IEC TR 60825-14:2022London: BSI.

EC 2006. Directive 2006/25/EC of the European Parliament and of the Council of 5 April 2006 on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation). Available from:

https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32006L0025&from=EN

EC 2010. Non-binding guide to good practice for implementing Directive 2006/25/EC 'Artificial Optical Radiation'. Available from: https://op.europa.eu/en/publication-detail/-/publication/556b55ab-5d1a-4119-8c5a-5be4fd845b68/language-en/format-PDF

EC 2013 Non-binding guide to good practice for implementing Directive 2013/35/EU Electromagnetic Fields. Volume 1, Practical guide

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ICNIRP 2020. Guidelines for limiting exposure to electromagnetic fields (100 kHz to 300 GHz). International Commission on Non-Ionizing Radiation Protection. Published in Health Physics 118(5): 483–524; 2020. Available from: https://www.icnirp.org/cms/upload/publications/ICNIRPrfgdl2020.pdf

MHRA 2015. Lasers, intense light source systems and LEDs – guidance for safe use in medical, surgical, dental and aesthetic practices Medicines and other Healthcare products Regulatory Authority, London: Department of Health.

https://www.gov.uk/government/publications/guidance-on-the-safe-use-of-lasers-intense-light-source-systems-and-leds

MHRA 2021. Safety guidelines for magnetic resonance imaging equipment in clinical use 4th edition. Medicines and other Healthcare products Regulatory Authority, London: Department of Health.
https://www.gov.uk/government/publications/safety-guidelines-for-magnetic-resonance-imaging-equipment-in-clinical-use

NRPB 2002. Health effects from ultraviolet radiation. Documents of the National Radiological Protection Board, Vol. 13 No. 1 2002. Didcot: NRPB.
https://www.gov.uk/government/publications/ultraviolet-radiation-uvr-health-effects-from-exposure

SI 1999. The Management of Health and Safety at Work Regulations 1999. Statutory Instrument 1999 No. 3242. London: HMSO
http://www.legislation.gov.uk/uksi/1999/3242/contents/made

SI 2002. The Medical Devices Regulations 2002. Statutory Instrument 2002 No. 618. London: HMSO
http://www.legislation.gov.uk/uksi/2002/618/contents/made

SI 2005. The Control of Noise at Work Regulations 2005. Statutory Instrument 2005 No. 1643. London: HMSO
http://www.legislation.gov.uk/uksi/2005/1643/contents/made

SI 2010. The Control of Artificial Optical Radiation at Work Regulations 2010. Statutory Instrument 2010 No. 1140. London: HMSO
http://www.legislation.gov.uk/uksi/2010/1140/contents/made

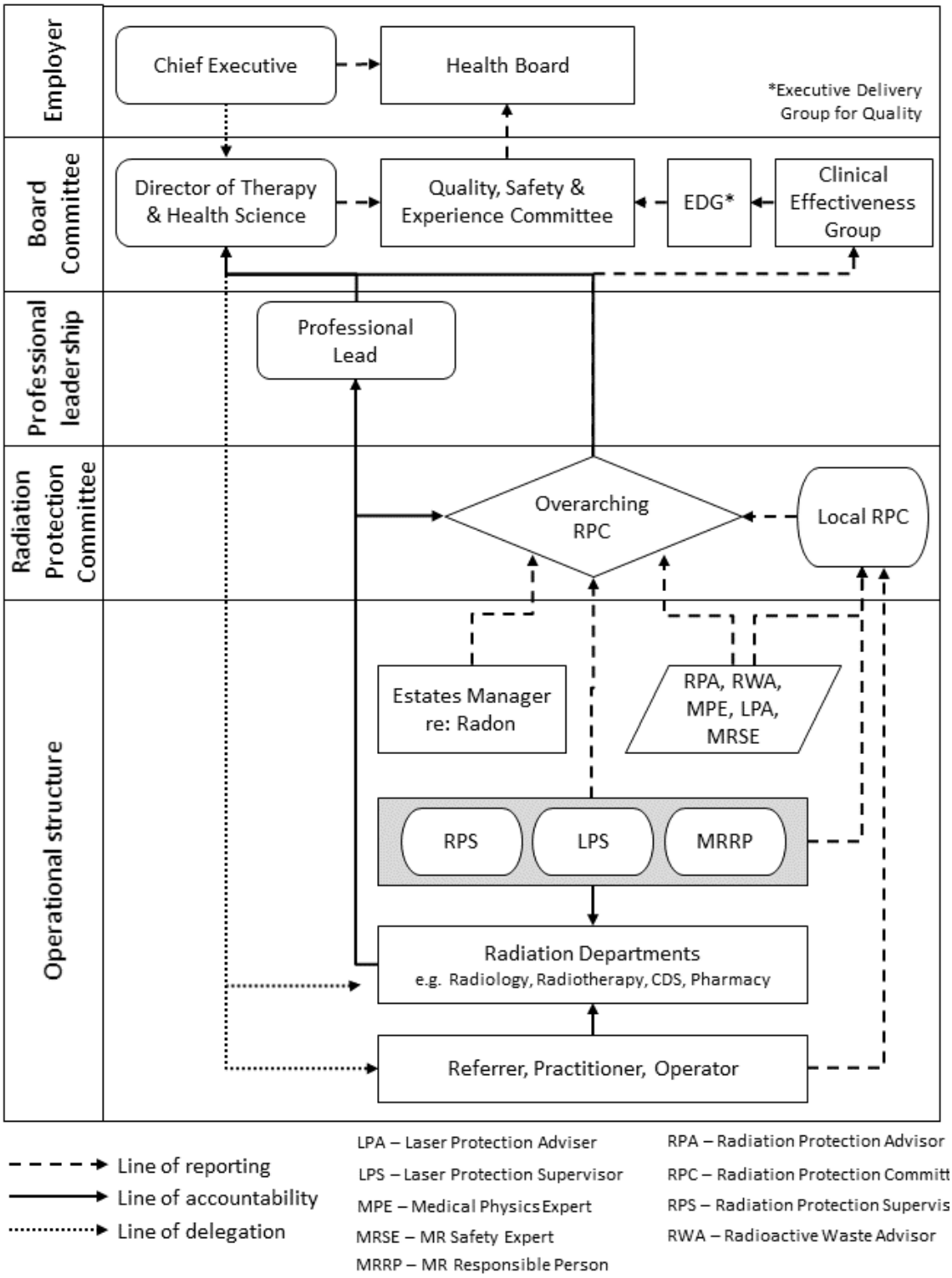
SI 2016. The Control of Electromagnetic Fields at Work Regulations 2016. Statutory Instrument 2016 No. 588. London: HMSO
http://www.legislation.gov.uk/uksi/2016/588/contents/made

WG 2018. Guidance on safe clinical use of Magnetic Resonance Imaging (MRI). Welsh Health Circular WHC/2018/001. Cardiff: Welsh Assembly Government
https://gov.wales/topics/health/nhswales/circulars/health-professional/?lang=en

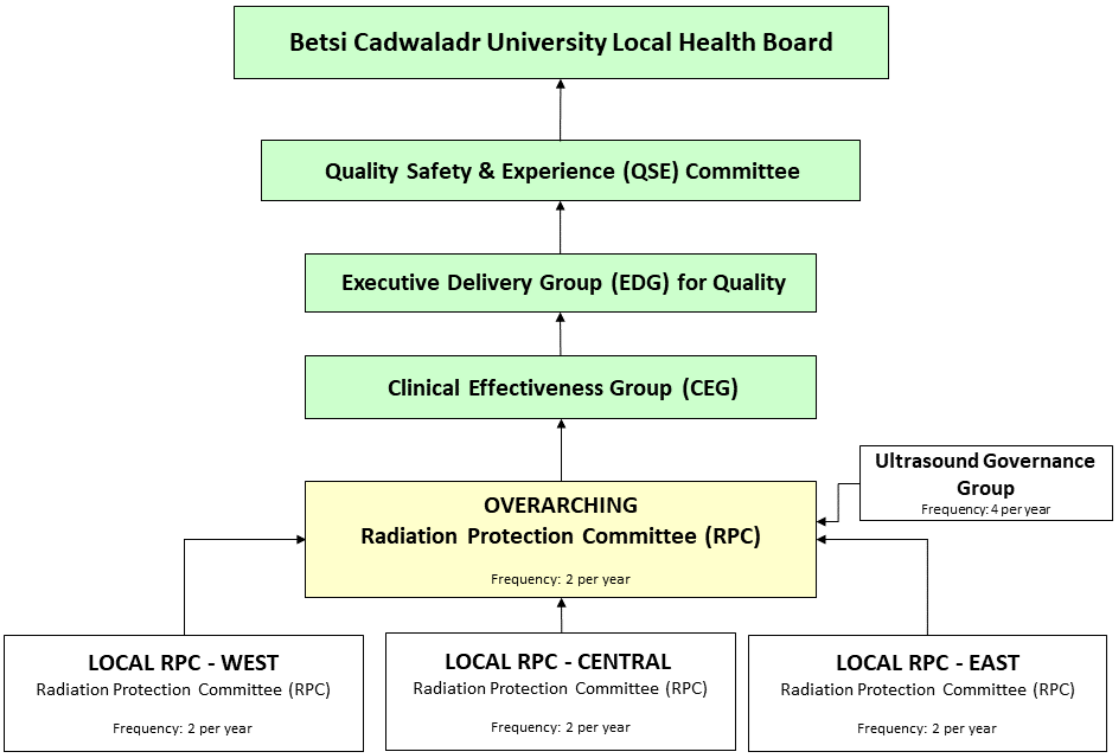
WSAC 2013. Ultrasound and clinical governance in Wales. The Medical Imaging Sub-Committee (MISC) of the Welsh Scientific Advisory Committee. [Currently under revision. Only available locally here:
https://nhswales365.sharepoint.com/sites/BCU_Intranet_MEDPHYS/SitePages/Radiation-Protection-forms-and-documents.aspx

APPENDIX 1 Radiation Protection Organisation

A1.1 Employer line of delegation, Radiation Protection Governance Structure



A1.2 Meeting and Reporting Structure



APPENDIX 2 General Guidance on Entitlement

As discussed above, the legislation and guidance requires the appointment of specified officers. The following gives general guidance on who is permitted by the Health Board to appoint staff into such positions.

A2.1 **Laser Protection Adviser** (LPA)
Since LPAs are required to provide advice throughout the organisation, they should be appointed by the BCULHB Executive Director of Therapies and Health Science.

A2.2 **Laser Protection Supervisor** (LPS)
Due to the need to appoint staff who are aware of and can deal with local issues, they should be appointed by the Head of Department responsible for the member of staff.

A2.3 **MR Safety Expert** (MRSE)
Since MRSEs are required to provide advice throughout the organisation, they should be appointed by the BCULHB Executive Director of Therapies and Health Science.

A2.4 **MR Responsible Person** (MRRP)
Due to the need to appoint staff who are aware of and can deal with local issues, they should be appointed by the Head of Department responsible for the member of staff.

APPENDIX 3 Examples of Non-ionising Radiation Equipment and Uses in Health Board

A.2.1 **Lasers**

High power lasers are used in ophthalmology and surgery. Lower power lasers are used in physiotherapy.

Local Rules to be written and Authorised Users to be approved, for all lasers of Class 3B and 4.

A.2.2 **Ultraviolet**

UVA and UVB are used for phototherapy, and photo chemotherapy, in Dermatology and physiotherapy departments. UVC sources are used for room decontamination and also Ultrasound probe decontamination.

A.2.3 **Visible Light** (excluding lasers)

Ophthalmic instruments are high intensity sources of optical radiation, and blue light phototherapy sources are used in Special Care Baby Units (SCBU).

A.2.4 **Radiofrequency and Microwave Radiation**

Shortwave RF, microwave diathermy and surgical diathermy are used in clinical environments (physiotherapy, theatres) to produce local heating and cutting.

Sources in non-clinical environments include communication systems (see BCUHB policy on radio communication equipment on Health Board premises), microwave ovens, VDUs (see BCUHB policy on Display screen equipment at work).

A.2.5 **Magnetic Fields**

Magnetic Resonance Imaging (MRI) units, used in imaging departments.

Detailed guidance [MHRA 2021] requires Local Rules to be written.

A.2.6 **Ultrasound**

Used in a number of departments for diagnosis or image guidance (including joint injections, biopsies, line-insertions) and for treatment in physiotherapy.

In non-clinical environment, used for cleaning equipment.

A.2.7 **Acoustic Noise**

Many types of powered machinery and power tools produce acoustic noise which may be hazardous if the noise is particularly loud or exposure is prolonged. (see BCUHB policy on Safe management of noise).

Members of the Working Group:

Name	Title
Mr P Hiles	Head of Radiation Physics
Dr D Ravindranathan	Non-ionising Radiation Physics lead

Engagement has taken place with:

Name	Title	Date Consulted
	Radiation Protection Committee (Central)	22nd November 2022
	Radiation Protection Committee (East)	21st November 2022
	Radiation Protection Committee (West)	15th November 2022

PARTS A (Screening – Forms 1-4) and B (Key Findings and Actions – Form 5)

For:	*The BCUHB Non-Ionising Radiation Protection Policy 3rd edition*
Date form completed:	*6th December 2022*

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

- ✓ How does your policy or proposal promote equality for people with protected characteristics (Please see the General Equality Duties)?
- ✓ What are the possible negative impacts on people in protected groups and those living in low-income households and how will you put things in place to reduce or remove these?
- ✓ What barriers, if any, do people who share protected characteristics face as a result of your policy or proposal? Can these barriers be reduced or removed?
- ✓ Consider sharing your EqIA wider within BCUHB (and beyond), e.g. ask colleagues to consider unintended impacts.
- ✓ How have you/will you use the information you have obtained from any research or other sources to identify potential (positive or negative) impacts?

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	The Non-Ionising Radiation Protection Policy (3rd edition)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The use of non-ionising radiation in health establishments in the UK is governed by a series of statutory instruments (enforced as health and safety regulations made under the Health and Safety at Work Act 1974) and good practice guidance. This policy is issued to provide direction and arrangements for the safe management of non-ionising radiation within the BCUHB in compliance with Statutory Duties as detailed in the Control of Artificial Optical Radiation at Work Regulations 2010 [SI 2010] and for electromagnetic fields in the Control of Electromagnetic Fields at Work Regulations [SI 2016] and other relevant legislation, codes of practice and guidance. The current revision is due to clarifying text; revised Appendix 1 on radiation protection organisation and updated references to revised guidance [ICNIRP 2020 and MHRA 2021]. Also included modifications suggested by external non-ionising radiation physics expert and Laser Protection Adviser (LPA).
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	*Executive Director of Therapies & Health Sciences*
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Health and safety policy HS01 EqIA originally completed in 2011, last reviewed December 2022.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	BCUHB Board, all non-ionising radiation users, staff and service users
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Lack of engagement by staff in the implementation of the Policy Inadequate training and staff understanding of the procedure Inability to get up-to-date information to staff on radiation safety

Part A Form 1: Preparation

Please answer all questions

7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	Policy covers radiation safety for all employees, patients and members of public.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Please complete the next section to show how this policy / proposal could have an impact (positive or negative) on the protected groups listed in the Equality Act 2010. It is important to note any opportunities you have identified that could advance or promote equality of opportunity. This includes identifying what we can do to remove barriers and improve participation for people who are under-represented or suffer disproportionate disadvantage.
Lack of evidence is not a reason for *not assessing equality impacts*. Please highlight any gaps in evidence that you have identified and explain how/if you intend to fill these gaps.

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

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

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

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

<table>
<tr><th>Protected characteristic or group</th><th>Will people in each of these protected characteristic groups be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)
for further direction on how to complete this section please click here training vid p13-18)</th><th>Reasons for your decision (including evidence that has led you to decide this) A good starting point is the EHRC publication: "Is Wales Fairer (2018)?" You can also visit their website here</th><th>How will you reduce or remove any negative Impacts that you have identified?</th></tr>
<tr><td rowspan="3"></td><td colspan="3">Guidance for Completion

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

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

NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.
For the definitions of each characteristic please click here</td><td></td></tr>
<tr><td>Yes</td><td>No</td><td>(+ve)</td><td>(-ve)</td><td></td><td></td></tr>
</table>

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Age		No			No negative impact identified. However, it is recognised that there are further considerations for the exposure of young people in certain cases. The MHRA guidance on MRI requires special care when imaging infants, pregnant women and people with impaired thermoregulatory ability as a result of age, disease or the use of medications. Whilst it is recognised that dementia can affect younger people, it is more common in people over the age of 65 (alzheimers.org.uk). For patients suffering with capacity issues, consent to treatment will also require further consideration. The various guidelines referred to provide for the provision of written instruction and information for patients deemed to have the capacity to consent, children and for instances where the patient is an adult who lacks the capacity to consent.	No negative impact identified. The requirements of the legislation and guidance are reflected in the policy.
Disability		No			No negative impact identified. However, it is recognised that high acoustic noise levels can occur during MRI examinations and MHRA guidance requires provision of suitable hearing protection.	No negative impact identified. The requirements of the legislation and guidance are reflected in the policy.
Gender Reassignment		No			Trans and non-binary people make up at least 1.5% of the UK population and 41% have reported that they avoid seeking healthcare due to fear of ridicule, harassment or violence (The Society of Radiographers). The policy has been reviewed to ensure gender-neutral language is used throughout.	Whilst there is the potential for negative impact, all clinicians are bound by the common law of confidentiality, their professional codes of

						conduct, and the BCUHB Confidentiality Policy.
Pregnancy and maternity		No			No negative impact identified. Magnetic Resonance Imaging (MRI) and diagnostic ultrasound (US) are both deemed safe for use on pregnant patients. However, both the MHRA and BMUS require application specific guidelines for examinations during pregnancy.	No negative impact identified. The referenced guidance and the policy require specific protocols for pregnant patients.
Race		No			No negative impact identified. There are known differences in the effectiveness of phototherapy due to skin type, which is not directly addressed in this policy as this specific issue is managed within dermatology.	No negative impact identified
Religion, belief and non-belief		No			No negative impact identified. There may be issues identifying pregnancy where the patient is unwilling or afraid to answer truthfully (unmarried). However, there are no additional precautions needed with non-ionising radiation due to undeclared pregnancy.	No negative impact identified.
Sex		No			No negative impact identified.	No negative impact identified.
Sexual orientation		No			No negative impact identified.	No negative impact identified.

Part A Form 2: Record of potential Impacts - protected characteristics and other groups

Please answer all questions

Marriage and civil Partnership (Marital status)		No			No negative impact identified.	No negative impact identified.
Socio Economic Disadvantage		No			The treatment must be carried within BCUHB premises. Some patients may experience difficulties in meeting travel costs. Patients who have difficulty in attending appointments due to financial circumstances can apply for reimbursement as per F09 – Reimbursement of travel to hospital costs.	Patients may incur travel costs to hospital sites. Reimbursement may be available.

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

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

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				**Which Human Rights do you think are potentially affected**	**Reasons for your decision (including evidence that has led you to decide this)**	**How will you reduce or remove any negative Impacts that you have identified?**
Yes	**No**	**(+ve)**	**(-ve)**			
	No				This policy follows national guidance and complies with UK legislation. No negative impacts have been identified	*Please explain how you intend to remove or reduce any negative impacts you have identified.* **Be specific.**

Part A Form 3: Record of Potential Impacts – Human Rights and Welsh Language

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	x		x		Welsh language is considered with all necessary radiation warning signage. This policy will be translated once approved.	None identified
Treating the Welsh language no less favourably than the English language		No			Welsh language is considered with all necessary radiation warning signage. This policy will be translated once approved.	*Please explain how you intend to remove or reduce any negative impacts you have identified.* ***Be specific.***

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

Please record here details of any engagement and consultation you have undertaken. This may be with workplace colleagues or trade union representatives, or it may be with stakeholders and other members of the community including groups representing people with protected characteristics. They may have helped to develop your policy / proposal, or helped to identify ways of reducing or removing any negative impacts identified.

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	*Representatives of all non-ionising radiation user groups via local and overarching Radiation Protection Committees (RPC)* *This is the third edition of this policy. The first edition passed through the EQIA process in 2012 and involved engagement with Staff representatives, equalities and human resources*
Have any themes emerged? Describe them here.	Pregnancy and age. Both are thoroughly considered and provided for by the legislation and the BCUHB policy
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	As per above – provision made within the policy in accordance with the legislation.

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	The Non-Ionising Radiation Protection Policy (3rd edition)

2. Brief Aims and Objectives: (Copy from Form 1)	The use of non-ionising radiation in health establishments in the UK is governed by a series of statutory instruments (enforced as health and safety regulations made under the Health and Safety at Work Act 1974) and good practice guidance. This policy is issued to provide direction and arrangements for the safe management of non-ionising radiation within the BCUHB in compliance with Statutory Duties as detailed in the Control of Artificial Optical Radiation at Work Regulations 2010 [SI 2010] and for electromagnetic fields in the Control of Electromagnetic Fields at Work Regulations [SI 2016] and other relevant legislation, codes of practice and guidance. The current revision is due to clarifying text; revised Appendix 1 on radiation protection organisation and updated references to revised guidance [ICNIRP 2020 and MHRA 2021]. Also included modifications suggested by external non-ionising radiation physics expert and Laser Protection Adviser (LPA).

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	No X
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes	No X

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

4. Did your assessment	Yes	No X

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	*Record here the reason(s) for your decision i.e. what did Forms 2 & 3 indicate in terms of positive and negative impact for each characteristic, Human Rights and Welsh Language?*	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	X
	Record Details: This will be a summary of any actions identified in the far right-hand column of forms 2 and 3.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes x	No
	How is it being monitored?	Any incidents involving non-radiation are logged via datix and sighted on by Head of Department. A summary of radiation incidents (including trend analysis) is routinely reviewed at the radiation protection committee (RPC) meetings. Regular audits of compliance with the legislation and this policy are performed in each department using non-ionising radiation
	Who is responsible?	Head of department using non-ionising radiation
	What information is being used?	Datix and audit results
	When will the EqIA be reviewed?	*October 2025 in line with the periodic policy review or as required (changes in legislation / best practice).*

7. Where will your policy or proposal be forwarded for approval?	*December 2022*

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Peter Hiles.	Head of Radiation Physics, Medical Physics
	Devi Ravindranathan	Non-Ionising Radiation Lead Clinical Scientist
	Name of senior sign off prior to committee approval	
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	*none*		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	*None* ,		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	*None*		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	None		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	*None*		