# Bundle Health Board 4 August 2022

*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."ort - the Chair*

# Betsi Cadwaladr University Health Board (BCUHB)
# <mark>Draft</mark> minutes of the Health Board meeting held in public
# on 26 May 2022 via video conferencing

**Present:**

| Name | Title |
|------|-------|
| Mark Polin | Chair |
| Jo Whitehead | Chief Executive |
| Lucy Reid | Vice Chair |
| Clare Budden | Associate Board Member |
| Cllr Cheryl Carlisle | Independent Member |
| John Cunliffe | Independent Member |
| Morwena Edwards | Associate Board Member |
| Gareth Evans | Acting Executive Director of Therapies and Health Sciences |
| John Gallanders | Independent Member |
| Sue Green | Executive Director of Workforce and Organisational Development |
| Gill Harris | Deputy CEO/Executive Director of Integrated Clinical Services |
| Sue Hill | Executive Director of Finance |
| Jaqueline Hughes | Independent Member |
| Cllr R Medwyn Hughes | Independent Member |
| Dr Nick Lyons | Executive Medical Director |
| Molly Marcu | Interim Board Secretary |
| Richard Micklewright | Independent Member |
| Teresa Owen | Executive Director of Public Health |
| Chris Stockport | Executive Director Transformation, Strategic Planning and Commissioning |
| Gaynor Thomason | Interim Executive Director of Nursing and Midwifery |
| Jane Wild | Associate Member |

**In Attendance:**

| | |
|------|-------|
| Lowri Gwyn | For Translation |
| Simon Evans-Evans | Interim Director of Governance |
| Philippa Peake-Jones | Head of Corporate Office, Corporate Office (Minutes) |
| Matthew Joyes | Acting Associate Director Of Quality, Patient Safety and Experience |
| John Morrell | Senior Server & Cloud Infrastructure Engineer, Informatics (for recording) |
| Fiona Lewis | Corporate Governance Officer, Corporate Office (for recording) |
| Dylan Roberts | Chief Digital and Information Officer |
| Helen Stevens-Jones | Director of Partnerships, Communications and Engagement |
| Heledd Thomas | Audit Wales |

| Agenda Item | Action |
|---|---|
| **22/103 Welcome and Apologies**<br><br>**22/103.1** The Chair welcomed attendees to the meeting noting apologies had been received from Professor Nichola Callow, Linda Tomos and Adrian Thomas. | |
| **22/104 Patient Story**<br><br>**22/104.1** The Acting Associate Director of Quality Assurance shared the patient's story. The Chair asked that the patient be thanked on behalf of the Board for sharing her story.<br><br>**22/104.2** The Acting Associate Director of Quality Assurance advised that the service had undertaken a number of actions following the patient's experience, that current patient leaflets had been reviewed and been taken through the Patient Readers Panel. A review of other organisations post-operative information had been undertaken and the Patient Experience Team had worked with the Service. An intranet library of leaflets was being compiled. It was confirmed that the patient who had shared her story had been involved in the work on the amended discharge leaflet.<br><br>**22/104.3** The Acting Executive Director of Nursing and Midwifery advised that it had been extremely brave of the patient to speak and highlight her concerns, that learning not only with regards to the information she received but the way the staff spoke to her needed to be addressed.<br><br>**22/104.4** The Executive Medical Director advised that thought needed to be given in relation to information on consent, that was routine information in any service and confirmed that he would take this forward as part of the consent and note taking work that was being undertaken.<br><br>**22/104.5** The Chair queried if a process of embedded learning was in place and the Acting Associate Director of Quality Assurance confirmed that it was and that an annual report on Patient Stories would be shared at a forthcoming QSE Committee.<br><br>**22/104.6 It was resolved that** the patient story be received. | **MJ**<br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br><br>**NL** |
| **22/105 Declarations of Interest**<br><br>**22/105.1** There were no declarations to note. | |
| **22/106 Draft Minutes of the Health Board meeting held on 10 and 30 March 2022 for accuracy**<br><br>**22/106.1** The Minutes of the 10 and 30 March 2022 Health Board were agreed as an accurate record subject to a change to the representation of Jacqueline Hughes from "Staff Side" to "Trade Union". | PPJ |

| | |
|---|---|
| **22/106.2 It was resolved that** the Draft Minutes of Health Board Meetings held in public on 10 and 30 March 2022 be approved as accurate records, subject to the two amendments noted above. | |
| **22/107 Matters Arising and Summary Action Log**<br><br>**22/107.1** Board members reviewed the action log, updates to which were recorded therein. | |
| **22/108 Report of the Chair**<br><br>**22/108.1** The Chair advised that the Health Board was currently addressing a a number of significant challenges and concerns, which included the findings from a number of Health Inspectorate Wales inspections, Serious Incidents and Never Events. It was therefore imperative that the Board recognised and responded appropriately.<br><br>He reported that he and the Chief Executive Officer (CEO) had discussed what was required in the medium to long term, as well as more immediately, given the nature of the issues highlighted particularly in terms of leadership, governance and assurance and it was the view of the Chief Executive that the priorities previously agreed remained the right ones and that the proposed Operating Model should still be implemented and would assist. .<br><br>**22/108.2** The Chair advised that the Board would need to form its own view in due course but would want to support the CEO in her proposals to move the organisation forward, whilst recognising that this might take some time. The Board required a greater level of assurance and confidence.<br><br>**22/108.3** It was noted that there were a number of areas that required urgent attention and that were receiving this, specifically concerns had been raised by staff at Ysbyty Gwynedd and both the Acting Executive Director of Nursing and Midwifery and the Executive Director of Workforce and Organisational Development were addressing these. Assembly Members had also been briefed. It was noted that the Ysbyty Glan Clwyd (YGC) improvements would continue to be monitored via the Quality Safety and Experience Committee (QSE) with a number of Executive Directors having recently attended the site along with a number of Independent Members (IM's) including the Chair and Vice Chair.<br><br>**22/108.4** The Chair advised that with regards to the Regulation 28 Notices, these were being scrutinised. Responses were being finalised and would be closely monitored.<br><br>**22/108.5** The Board noted the consistent themes arising from the reports relating to leadership, clarity around responsibilities and accountability, that assurance was weak and that the culture within the organisation needed to be enabling and supportive. In the longer term the Operating Model would assist but it was essential to strengthen governance arrangements as a matter of urgency. The Chair advised that there was a need to better understand the | |

workforce challenges and to support improved recruitment and retention in particular. The ability to select and develop better leaders was essential and this would be a topic for discussion at the forthcoming Board Development session.

**22/108.6** The Chair concluded that given the pressures the Health Board was under he wanted the Board collectively and as individuals to support and exhibit the leadership required.

**22/108.7 It was resolved that** the report of the Chair be noted.

## 22/109 Report of the Chief Executive Officer

**22/109.1** The Chief Executive then provided her opening statement as follows:- *{N.B IT technical difficulties were experienced during the statement}*:

*"The leadership of Betsi Cadwaladr University Health Board (BCUHB) including the Integrated Board has clear work to do to support staff to provide the best care and support to patients and of each other.*

*There is ground to make up as we move out of the pandemic in re-establishing norms of performance, particularly in hospital care as we remove social distancing (for example, it will allow us to re provide around 100 beds and to increase theatre utilisation, diagnostic and outpatient capacity).*

*But more than this, there is work to do in response to clinical concerns raised by HIW inspections, by other regulators and interested persons, and through our own improvement and governance processes. Some of the issues (documentation, observations, falls for example) have proved to be challenging to resolve over time and relate to services across in patient services across Betsi Cadwaladr University Health Board (BCUHB).*

*Some of the issues are basic in their nature and should be and are resolvable (environment for example).*

*And there is work to do to strengthen our governance and assurance processes so that we can support staff to improve helped by feedback on how their improvements are working and satisfy ourselves individually and collectively so that improvements stick over time. This work, planned as part of the operational model is being expedited.*

*I have reflected on our clinical and cultural change approach, using an evidence-based program which is proven to improve outcomes, patient experience, staff involvement and the safety culture which, importantly, has been endorsed by Welsh Government's own improvement agency as the methodology they wish to roll out across Wales.*

*We are using this approach to move from individual improvement plans to a more systematic approach to improvement, based on risk, and put*

*simply listening to staff about the changes they'd like to see, taking into account human factors in implementation and reviewing progress. This approach takes longer but the evidence shows with greater staff buy in, the results stick better. This means that improvement plans or make it safes are important to put in place while we work to develop the plan together. We have tried this approach in YGC ED, implementing a different model of triage recommended by the clinical team, and we see positive changes in the trends for triage and ambulance handover on a day-by-day basis.*

*The program of improvement, which includes work to improve the safety culture is part of our people strategy, improvement activities and operating model work. undoubtedly as we move to implement the changed structure, built on people focussed and clinical design principles, we need to pick up the pace and focus to be able to respond effectively*

*Moving to implementation is an important next step now to create the foundations - thoroughly- upon which the work of systematically applying the science to improvement can be embedded*

**22/109.2** Given the technical difficulties at Carlton Court the Chair requested the Chief Digital And Information Officer to investigate and resolve the issues urgently.

**22/109.3 It was resolved that** the report of the Chief Executive be noted.

**22/111 Targeted Intervention Improvement Framework**

**22/111.1** The Deputy CEO/Executive Director of Integrated Clinical Services introduced the report by describing the improvements that had been made. The Targeted Intervention Improvement Framework (TIIF) process had been strengthened, with further checks and balances in place and Independent Member attendance at meetings to assess and challenge scoring. Chairs and Vice Chairs of Committees also attended the evidence group to ensure that there was objectivity.

**22/111.2** The report set out the scores and recommendations and the adjustments that been made as a result of the system moderation meeting. The Deputy CEO/Executive Director of Integrated Clinical Services emphasised the leap between level 2 and 3 as being significant.

**22/111.3** Members acknowledged further gains from utilising formal governance structures already available. It was noted that as scores increased there would likely be a gap to outcomes, certainly early on, but that there should be confidence that evidence based progress is being demonstrated.

**22/111.4** The Chief Executive advised that at the meeting with Welsh Government (WG) the previous week, WG colleagues had advised that they were comfortable with the proposed scores, that they were working with the organisation from a maturity matrix point of view and understood the governance

| | |
|---|---|
| and appreciated that progress was being made in a measurable and sustainable way.<br><br>**22/111.5** The Chair noted that the Chair of PPPH would like to contribute to the design of the Board Development session scheduled for 14 June, being led by Kings Fund and that Executive Director of Workforce and Organisational Development would link in with her.  She noted that the outcomes described would be more explicit and drive the agenda.  The Chair concluded that there was an opportunity to focus differently on Board to Ward assurance through deep dives, examining areas of concern and that this would give leaders the opportunity to engage with the Board.  He advised that he would like this to be considered   on 14 June in terms of what process would be appropriate.<br><br>**22/111.6 It was resolved that** the Board:<br><br>    1)  Note the progress in delivering Targeted Improvement.<br>    2)  Agree the self-assessment reference points against each matrix<br>         a.  All Ages Mental Health                           2<br>         b.  Strategy, Planning and Performance       2<br>         c.  Leadership Governance and Culture        2<br>         d.  Engagement                            2 (high)<br>    3)  Agree the target reference point for November 2022<br>         a.  All Ages Mental Health                           3<br>         b.  Strategy, Planning and Performance       2 (3 for strategy and planning)<br>         c.  Leadership Governance and Culture        3<br>          d.  Engagement                             4<br>    4)  Request permission from Welsh Government to split the Strategy Planning and Performance Domain into 2 matrices. | LT/SG |
| **22/112 Covid 19 Update**<br><br>**22/112.1** The Deputy CEO/Executive Director of Integrated Clinical Services provided the Covid 19 Update, noting that there was now an intelligence cell in place which would enable escalation should the situation change with regards to Covid.  The Board noted that the vaccination programme was 72% complete with five weeks remaining and that WG had recently issued further guidance around Covid 19 measures.<br><br>**22/112.2** The Chair noted that information was being received about Monkey Pox and the Executive Director of Public Health agreed to update the Board at a future point.<br><br>**22/112.3** An Independent Member enquired about the hospitalisation figures and the Deputy CEO/Executive Director of Integrated Clinical Services agreed to update on the exact numbers outside of the meeting.  It was noted that numbers were low in hospitals due to the successful immunisation programme but patients continued to be screened prior to routine surgery.<br><br>**22/112.4** An Independent Member enquired about the time frame for GP | <br><br><br><br><br><br><br><br><br><br><br><br><br>GH |

surgeries to return back to "normal". It was noted that surgeries were open, and were doing a significant amount virtually and that once WG guidance had been reviewed information would be forthcoming.

**22/112.5 It was resolved that** the report and supporting presentation be noted and the decisions made by the QSE Committee on the Health Board's Gold and Silver command structure stepdown arrangements, be endorsed.

**22.113 ITEM FOR CONSENT Mental Health Act**

**22/113.1 It was resolved that** the report be noted and the approvals in line with the Welsh Government Guidance Mental Health Act 1983 Approval of Approved Clinicians (Wales) July 2018 for Approved Clinicians and the Section 12 Process and Criteria Document for S12 Approved Doctor approvals be ratified.

**22/114 Operating Model Implementation Infrastructure**

**22/114.1** The CEO gave a presentation on the Operating Model, highlighting the implementation of the organisational structure, outlining governance structures and assurance processes. She concluded that the organisation would be in a significantly stronger position as a result of the impending changes. It was agreed that outstanding questions on governance and go-live date would be addressed in detail outside of the meeting with the Chair, the CEO, the Vice Chair and the Deputy CEO.

MP/JW/
LR/GH

**22/114.2 The Executive** Director of Workforce and Organisational Development apologised for errors within the final pack and that these would be amended, noting that the Board was not being asked to agree Executive portfolios.

**22/114.3** The Board discussed their concerns around accountability and governance and how that would flow into to the new senior leadership arrangements, that assurance mapping would be required to understand where the gaps were with regards to governance and that aligning risk management and devolved responsibility would need to link into this. Attendees discussed engagement and communications with staff, ensuring that face to face meetings took place as well as online. Risks to financial control were discussed with the Executive Director of Finance concluding that these were being monitored and there should be no issues.

**22/114.4** It was noted that at the forthcoming Risk Management Group the identified risks would be proposed and incorporated formally onto the risk log but that they had been monitored through datix to date.

**22/114.5** The CEO advised that she and the Executive Team had been in conversations with Directors of Social Services and Local Authority CEO's to ensure that relationships continued to go from strength to strength.

**22/114.6** An Independent Member welcomed the report noting that the previous Operating Model was not fit for purpose, which was possibly the reason behind some of the issues the organisation was currently facing, he asked for clarity

around particular responsibilities with regard to quality, legal and the Welsh language.  The Board discussed that fundamental to any Operating Model was the culture of the organisation.

**22/114.7** Both the Director of Partnerships, Communications and Engagement and the Chief Digital and Information Officer confirmed that they were supportive of the Operating Model.

**22/114.8 It was resolved that** the Board:

- Approve the implementation of the revised Operating Model;
- Note the commitment of the Chief Executive and Executive Directors to ensure a risk based approach is taken to implementation of the different elements of the structure and model, recognising that the changes to governance and infrastructure will be at the final point of implementation; and
- Note the commitment regarding the final point of implementation being no later than the 1st September 2022

**22/114.9** The Chair concluded that the Board would:

- wish to receive reports, at the July and September 2022 Board Meetings on progress on the implementation and any significant changes should be highlighted.
- receive a recruitment and selection timeline that moved the Operating Model forward, sooner rather than later.
- expect that when colleagues left the organisation their cover arrangements were shared with partners.
- expect to  see as permanent recruitment took place the number of interim appointments in the structure reduce and this  should be monitored  by  the Remuneration and Terms of Service Committee (R&TS).
- expect that Executive Portfolios would be finalised and  reported to the Remuneration and Terms of Service Committee and clarity around the Executive Director of Therapies & Health Sciences position would be provided .
- anticipate that  as the Operating Model moved forward the culture and expectations of leaders would witness change..
- like the structures below the higher tiers to be  shared with the Board as these were clarified.
- expect to be clear on the governance, performance and assurance framework and the timing for implementation and that the Vice Chair, Chair of PFIG  and Deputy CEO/Executive Director of Integrated Clinical Services would progress this outside of the meeting.

**22/115 People Strategy and Plan**

**22/115.1** The Executive Director of Workforce and Organisational Development

presented the People Strategy and Plan noting that it had been designed in the light of feedback from the Stronger Together discovery phase. The Strategy was about the organisation delivering and making it easier to do the right thing and harder to do the wrong thing either intentionally or non-intentionally. The strategy was linked to national strategies to ensure that there was a connection to the wider Welsh system.

**22/115.2** The Chair noted that there was to be a deep dive by the People, Partnerships and Population Health Committee (PPPH) into workforce related matters. Clarity was given around measuring vacancies/the establishment. The Executive Director of Workforce and Organisational Development clarified that the appendix in the Integrated Medium Term Plan (IMTP) was the same one as identified in the pack of papers circulated and that this had been the result of a coordinated piece of work alongside the IMTP, clarification around alignment was given.

**22/115.3** The Board discussed process and the Executive Director of Workforce and Organisational Development confirmed that it was the intention to ensure that processes were fit for purpose and highlighted an independent recruitment review which had reported to PPPH.

**22/115.4** The Executive Director of Workforce and Organisational Development advised that there was clarity about forward workforce planning and noted that she was leading a number of national pieces of work which would inform commissioning and alignment of commissioning to workforce planning with a focus on 'growing our own'. It was noted that the Executive Team were working through the arrangements and that as deliverables were finalised they would be presented with outcomes to PPPH. At this point there would be a clear view about tangible outcomes both for the forthcoming year but that it would be a three year strategy.

**22/115.5 It was resolved that** the People Strategy and Plan 2022 – 2025 be approved.

**22/116 Committee and Advisory Group Chair's Assurance Reports**

**22/116.1 Performance, Finance & Information Governance (PFIG) Committee**

> **22/116.1.1** The Chair of the PFIG Committee wished to commend the Finance Team in delivery of a surplus at year end, and the Capital Team in delivering to the Capital Resource Limit in a very challenging year. He highlighted the concerns raised with regards to significant deterioration of stroke service delivery and deteriorating indicators around planned and unscheduled care performance.

**22/116.2 Charitable Funds Committee (CFC)**

> **22/116.2.1** The Chair of CFC noted that the Trustee meeting was currently held annually; and would discuss with the CEO and the Chair

outside the meeting with regards to its frequency.

**22/116.3 Stakeholder Reference Group (SRG)**

**22/116.3.1** The Chair of SRG noted that the Group had discussed how to build engagement and a piece of work around representation would be taken forward.

**22/116.4 Healthcare Professionals Forum (HPF)**

**22/116.4.1** The Chair of HPF noted that the Forum were also discussing wider engagement with the Board.

**22/116.5 Audit Committee**

**22/116.5.1** The Chair of the Audit Committee asked the Board to note that there had been delays in responding to internal audit and that the number of limited assurance opinions had increased. At the Audit Workshop on Monday there had been concerns around the Clinical Audit Plan but noted that it would be discussed at the forthcoming QSE Committee.

**22/116.5 Targeted Intervention Improvement Framework (TIIF) Group**

**22/116.5.1** The Board noted and received the TIIF Chair's report.

**22/117 Quality & Performance Report**

**22/117.1** The Executive Director of Finance advised that this would be the final report in the current format, she highlighted the two new Never Events bringing the total for the year to 12 which was an unprecedented number. It was noted that unscheduled care pressures remained despite teams working very hard. Ambulance handover delays continued, that were being addressed with WAST. The Board noted that with regard to planned care, the impact of Covid on performance meant that at the end of the year there were 61,000 people waiting over 6 weeks for treatment, although diagnostic waits had been managed very well. A discussion on stroke targets took place and the mitigations were highlighted as in page 17 of the presentation. It was noted that the early discharge unit was operational and that monthly stroke improvement meetings were taking place.

**22/117.2** On a positive note, the Executive Director of Finance highlighted childhood immunisation, with the Health Board giving a strong performance above the all Wales average, infection control measures were performing really well as was cancer performance which also continued to remain among the strongest performers in Wales. It was noted that mandatory training was also performing well.

**22/117.3** The Chair highlighted a number of measures of great concern including Planned Care and that that PFIG had also raised this. He noted that on page 3

of the report no indicator was going in the right direction and that combined with the fact that Ysbyty Glan Clwyd (YGC) Emergency Department (ED) was also in a state of serious concern and requiring significant improvement wanted to know what was being done to address the issues.

**22/117.4** The CEO responded that immediate make safes had been put in place and confirmed that all of the immediate action plans had been submitted to Health Inspectorate Wales (HIW). It was noted that the Hospital Management Team and clinicians in YGC were working diligently. She confirmed that things had changed and since the inspection daily data was suggesting that the changed model of service provision was having a positive impact. It was noted that a number of Executive Directors had spent some time in YGC ED. The Chief Executive concluded that the new model taken together with improvement methodologies would be assessed prior to coming to a conclusion that it was the right model going forward. If so it would be rolled out to the other EDs. It was noted that the new IPC guidance WG had issued would allow more hospital beds back into the system and that in itself would create additional capacity to manage flow, working with colleagues in social care.

**22/117.5** The Deputy CEO/Executive Director of Integrated Clinical Services highlighted that agreed trajectories with WAST were resulting in some improvements in terms of handover. It was noted that despite a number of actions to free up beds there were still currently 321 patients medically fit for discharge and that a response from the whole system was critical.

**22/117.6** Concerns were raised with regards to diagnostic waits and the Board noted that soon the Health Board would be in a position to largely reinstate pre-Covid arrangements with regards to x-rays. With some agreed differences this would start to reduce waiting times. It was noted that the Board had agreed outsourcing arrangements and long waiters had been supported to travel to receive eye and joint operations. This would continue and an increase in both insourcing and outsourcing provision would be sought.

**22/117.7** The Deputy CEO/Executive Director of Integrated Clinical Services advised that she had asked for a deep dive into diagnostics delays to examine why they had increased, it was agreed she would report back to the Board with findings.

**GH**

**22/117.8** The Acting Executive Director of Therapies and Health Sciences clarified why the wait times were so high in therapy and how this was likely to be mitigated in the East. The Clinical Head had detailed plans to ensure the ability to deliver against the Welsh Government targets.

**22/117.9** Attendees had a further conversation around stroke, noting that there had been conversations concerning ensuring stroke beds were protected. Teams were also fast tracking stroke patients through ED. Improved trajectories were anticipated.

**22/117.10** The Board noted the increase in sickness absence mainly due to Covid. The Health Board was not an outlier across Wales and although Covid

related sickness was likely to reduce, stress related sickness was likely to increase. A business case seeking additional resource for wellbeing support services was being progressed.  The Board discussed recruitment issues and noted that these were being tracked through the Executive Delivery Groups.

**22/117.11** The Board discussed ophthalmology and it was noted that an urgent piece of work was being undertaken with clinical teams to prioritise and utilise different parts of the pathway to reduce waiting times.

**22/117.12 It was resolved that** the report be noted.

### 22/118 Operational Plan Monitoring Progress Report

**22/118.1** The Chair opened the item seeking assurance that any outstanding actions had been rolled across into the new plan where appropriate.  The Executive Director Transformation, Strategic Planning and Commissioning advised that any actions that had not completed (with the exception of two actions that had been superseded) had been rolled over into the new plan and report.

**22/118.2** The Executive Director of Finance thanked the Performance and Business Intelligence Teams and Independent Members for their input into the new report.

**22/118.3 It was resolved that** the report be noted.

### 22/119 Finance Report

22/119.1 The Executive Director of Finance presented the draft 12$^{th}$ month position giving a £0.3m surplus, an in-month saving of £2.1m against a plan of £1.4m giving a £0.7m favourable position with a year to date figure of £19.2m against a plan of £17m meaning a £2.2m favourable position.  It was noted that the balance sheet was showing £6.6m with income being £151.2m against a budget of £143.4m giving a favourable position of £7.8m.

**22/119.2 It was resolved that** the report be noted and authority to approve the audited annual accounts and returns be delegated to the Audit Committee at their meeting of 13 June 2022.

### 22/120 Vascular Services

**22/120.1** The Executive Medical Director apologised for the report as presented, which was in fact the paper considered by the Executive Team the previous week. It was noted that the consultant double handling had been stepped down and that despite the huge commitment it had not lead to any changes in patient safety.  It was noted that the normal Board Update on vascular would be shared after the meeting and published on the website.

NL

**22/120.2** The Board discussed the cases being sent to Liverpool and it was

noted that the cases were agreed via a multidisciplinary team (MDT) approach and that during these assessments all patients that BCUHB consultants would transfer would be agreed by the MDTs.

**22/120.3** The Chair noted that he would be updating the Minister that day.

**22/120.4** The Executive Medical Director updated on some successful recruitment but noted that until recruitment stabilised the vascular network would always be seen as one that required support and attention, although improved working behaviours were evident.

**22/120.5** The Vice Chair noted that she and the Executive Medical Director were in ongoing dialogue regarding the service. Discussions had taken place with the Chair of the Vascular Quality Panel to understand the detailed work that was being undertaken. It was noted that she was producing a weekly report, copied to the Vice Chair.

**22/120.6 It was resolved that** the vascular update be received and uploaded to the Health Board's website.

**22/121 Quality Highlight Reports**

**22/121.1** The Acting Associate Director of Quality, Patient Safety and Experience highlighted that there had been 42 nationally reportable incidents, including 3 Never Events between the February and March period which was a higher rate than normal and higher than the normal rate in Wales. It was noted that a number of the incidents related to falls that had resulted in serious harm to patients, pressure ulcers and an emerging theme of deteriorating patients whilst in the care of the Health Board. It was noted that QSE had discussed falls and pressure ulcers at a recent meeting, and that a safety programme was due to be considered by the Executive Team. It was noted that of the Never Events over the past year, 11 out of 12 related to surgical safety and seven had been at the YGC site. An Improvement Fellow had been appointed to work closely with theatre staff to ensure that all checklists were being adhered to.

**22/121.2** The Board discussed the increase in complaints and the process around early resolution and timing of when the complaint became formal.

**22/121.3** The Regulation 28's were highlighted, the Board noted the reasons and the time frames for responses. The Executive Medical Director highlighted that the Coroner had a backlog due to Covid whilst noting a good working relationship.

**22/121.4** The Board discussed the review of the Acute Intervention Team and the Acting Associate Director of Quality, Patient Safety and Experience confirmed that he would share this and the baseline after the meeting. The Board discussed the Never Events, the descriptors and the learning, noting that a thematic review was being progressed. The Acting Associate Director of Quality, Patient Safety and Experience agreed to inform members of the number of serious incident reviews that were outstanding and overdue. | MJ

MJ

| | |
|---|---|
| **22/121.5** The Executive Director of Workforce and Organisational Development informed the Board that following the 2021 Health and Safety Executive (HSE) inspection the Health Board had been issued with a Contravention Notice.  The rectification work had been concluded to the satisfaction of the HSE.  A further Notice of Contravention in relation to the tragic death of a patient in the Hergest Unit in 2021 had since been received and teams were working to formulate appropriate actions. These would form part of the overarching plan but with specific actions relating to the contravention.<br><br>**22/121.6 It was resolved that** the report be received. | |
| **CLOSING BUSINESS** | |
| **22/122 Review of Risks Highlighted within the Meeting**<br><br>There was nothing to note. | |
| **22/123 Review of Meeting Effectiveness**<br><br>**22/123.1** Members were asked to reflect on the meeting effectiveness and share these with the Interim Board Secretary or the Deputy Board Secretary. | |
| **22/124 Summary of Private Board Business to be reported in Public**<br><br>**It was resolved that** the report be noted. | |
| **22/125 Date of Next Meeting**<br>• 21 July 2022 | |
| **22/126 Exclusion of Press and Public**<br><br>**22/127.1 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. | |

| | Lead Executive / Member | Minute Reference and Action Agreed | Original Timescale Set | Update | Revised timescale/ Action status (O/C) | RAG status |
|---|---|---|---|---|---|---|
| | | **Actions from Health Board 23.9.21** | | | | |
| 1 | S Hill | **21.175.2 Operational Plan Monitoring Progress Report**<br><br>Work with PFIG and QSE Committee Chairs to resolve their reporting concerns, and to also take on board recent discussions around whether the Board should be receiving a specific report that reflected progress more timely. | November | The new format and content will be presented as a proof of concept at HB Meeting in July. The report for 22/23 is being revised based on feedback received to date and is subject to further review and final approval by the Chair and Chief Executive.<br><br>A meeting was held on 30 June with the PFIG and PPPH Committee Chairs to discuss the future format and content of the operational monitoring progress report. There was agreement that the format of the report should be aligned with the developing Power BI Integrated Quality and Performance Report. | July | |

| 2 | N Lyons | **21.178.2 Vascular**<br><br>Review decision making process following discussion around ensuring clarity on the responsibilities that the hub (Ysbyty Glan Clwyd) had to the network as a whole, and around the responsibilities that site managers had in terms of provision of appropriate services on their sites. | November | It was agreed to leave the action open until the review has been received. The Draft Vascular learning report is undergoing moderation and will be available early June and would be shared as soon as available.<br><br>To be shared as part of the Vascular Update to Board on 4/8/22. | Early June | |
|---|---|---|---|---|---|---|
| 3 | M Marcu | **21.189.1 Review of Meeting Effectiveness**<br><br>Reflect and follow up comments regarding duplication in some papers already having been through the Committee structure and being presented to Board in the same format when perhaps a summary would have sufficed. There were also comments made that information in some papers was out of date by the time it reached Board. | October | Review progress on this at the next Committee Effectiveness Group (Executive Board Development scheduled for 15/6/22)<br><br>This meeting has been postponed and will be arranged as soon as possible | October | |
| | | **Actions from Health Board 18.11.21** | | | | |
| 4 | N Lyons | **21.207.2 Patient Story**<br><br>Feedback to QSE on issue over-normalisation of clinical procedures on ward. | January | This will be reported at the March Quality, Safety and Experience Committee (1.3.22)<br><br>The final report has now been published and has been/ shortly will be shared. | | |

| | | Actions from Health Board 10.03.22 | | | |
|---|---|---|---|---|---|
| 5 | S Green | **22/54 Patient Story**<br><br>Circulate to members ward clerk vacancy detail and current recruitment position across all BCU sites where duties include answering ward phones and liaising with family members. | | Will be circulated as soon as the information is available. | |
| | | **Actions from Health Board 26.05.22** | | | |
| 6 | M Joyce | **22/104 Patient/Staff Story**<br><br>Formally thank the patient on behalf of the Board for sharing her story. | | The team are drafting the response and it will be shared with the Chair once it has been completed. | |
| 7 | N Lyons | **22/104 Patient/Staff Story**<br><br>NL – as part of the ongoing note taking work consider what information is given on consent. | | This is now included in the wider vascular improvement plan and forms of the patient experience review that will take place in July 22 | |
| 8 | P Peake-Jones | **22/106 Minutes**<br><br>Make amendments as described in the meeting "Staff Side to Trade Union and amend 68.3" | | Completed | |
| 9 | P Peake-Jones | **22/110 Report of the Chief Executive**<br><br>Upload CEO Opening Statement on | | Completed | |

Summary Action Plan – Health Board – arising from meetings held in public

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Website. | | | | |
| 10 | D Roberts | **22/110 Report of the Chief Executive**<br><br>Investigate and resolve the ongoing IT difficulties at Carlton Court | | Report circulated to the Chair and CEO. A number of areas have been worked on to address the issues experienced with the IT difficulties. The action will remain open to see if there are any further issues in the next few months. | | |
| 11 | G Harris | **22/112 Covid 19 Update**<br><br>GH to update on hospitalisation numbers outside the meeting | | Numbers shared in the side bar and going to Cabinet | | |
| 12 | S Green | **22/114 Operating Model Implementation Infrastructure**<br><br>Receive an updated report at the July and September Meeting on progress to implementation | July & September | This is on the agenda for both meetings | | |
| 13 | S Green | **22/114 Operating Model Implementation Infrastructure**<br><br>Provide a recruitment/selection timeline that moves the OM forward | | In update on agenda | | |
| 14 | S Green | **22/114 Operating Model Implementation Infrastructure**<br><br>Provide information on what the arrangements will be in terms of cover and share with partners | | In update on agenda | | |

Summary Action Plan – Health Board – arising from meetings held in public

| | | | | | |
|---|---|---|---|---|---|
| 15 | S Green | **22/114 Operating Model Implementation Infrastructure**<br><br>As the number of interim appointment in the structure reduces due to permanent recruitment report the consolidation to R&Ts | | In update on agenda | |
| 16 | S Green | **22/114 Operating Model Implementation Infrastructure**<br><br>Give clarity to the Board, as it becomes clear, the structures that site below the higher tears. | | In update report | |
| 17 | S Green | **22/114 Operating Model Implementation Infrastructure**<br><br>LR, GH with support from JC how the governance, performance and assurance framework will work and when changes will commence. | | In update report | |
| 18 | G Harris | **22/117 Quality & Performance Report**<br><br>GH to report back on the deep dive into diagnostic wait times. | | | |
| 19 | S Hill | **22/117 Quality & Performance Report**<br><br>SH and CB to meet to discuss the | | A meeting took place on 22 June between CB, SH and GH where the QaP report was discussed in detail, after the | |

Summary Action Plan – Health Board – arising from meetings held in public

| | | | | | |
|---|---|---|---|---|---|
| | | performance report and some of its contents. | | session on performance reporting at the Board Workshop on 16 June | |
| 20 | P Peake-Jones | **22/120 Vascular Services**<br><br>Share the correct paper and upload to the web | | The correct version has been circulated. This version has been uploaded to the public website. | |
| 21 | M Joyce | **Quality Highlight Report**<br><br>MJ to share the timescales following the review of the acute intervention team. | | | |

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

V237

Summary Action Plan – Health Board – arising from meetings held in public

| Report title: | Patient Story | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 21 July 2022 | Agenda Item number: | 1.5 |
| Executive Summary: | The digital patient story will be played at the meeting. A short summary is included in the attached paper. | | |
| Recommendations: | The Health Board is asked to receive and reflect upon the patient story. | | |
| Executive Lead: | Gaynor Thomason, Interim Executive Director of Nursing and Midwifery Nick Lyons, Executive Medical Director | | |
| Report Author: | Matthew Joyes, Associate Director of Quality | | |

| Purpose of report: | For Noting ☒ | For Decision ☐ | For Assurance ☐ |
|---|---|---|---|

| Assurance level: | Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |
|---|---|---|---|---|

**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:**

In line with best practice, the patient story is presented to the Health Board in order to bring the voice of the patient directly into the meeting; it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

| Link to Strategic Objective(s): | Quality |
|---|---|
| Regulatory and legal implications | N/A |
| Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) | N/A |
| Financial implications as a result of implementing the recommendations | N/A |
| Workforce implications as a result of implementing the recommendations | N/A |
| Feedback, response, and follow up summary following consultation | N/A |
| Links to BAF risks: (or links to the Corporate Risk Register) | N/A |
| Reason for submission of report to confidential board (where relevant) | N/A |

**Next Steps:** N/A

**List of Appendices:** Patient Story summary sheet – digital story will be played in the meeting

**Betsi Cadwaladr University Health Board**
**Long COVID Service**

*A video of the story, told by the patients supported by the Long Covid Service will be played at the meeting.*

## Overview of the Long Covid Service

As the Covid-19 pandemic progressed, it became clear that Long Covid was becoming a very real public health problem with no capacity in existing services to offer assessment or intervention for patients with long Covid. The Health Board wanted to establish a Long-Covid Recovery Programme in response to people who are experiencing Long Covid symptoms.

The Health Board's vision was to provide the required levels of care and support for our patients and staff to address the longer-term effects of COVID-19.

The following objectives were defined for the initial 18 months of the programme:

- To work with all stakeholders to co-design community pathways as required supporting the local population to manage the long-term health conditions resulting from Long-COVID and to improve their outcomes.
- To develop and evaluate value-based outcome measures, working with partners to improve their knowledge base around recovery.
- To deliver sustainable service improvements for similar longer-term post-viral conditions e.g. chronic fatigue.

Patients diagnosed with Long Covid have been working with clinical staff to co-produce the new Long-Covid Clinical Service. Patients who attended one of the Long Covid self-management courses run by the BCUHB Education Programme for Patients (EPP) expressed an interest in becoming Long Covid Lived Experience Representatives to ensure the voice of the patient is heard throughout the development of this service.

A Long Covid Partnership Group was set up and meets on a monthly basis. The partnership group is led by the Patient and Carer Experience Team within the Quality Directorate, with patients being at the heart of decision-making. The Long Covid Partnership Group includes the following representatives:

- Patients who are experiencing Long Covid
- BCUHB Long Covid-19 Service
- BCUHB Patient and Carer Experience Team
- Community Health Council
- BCUHB Volunteer Service
- BCUHB Education Programme for Patients (EPP).

**Summary of how patients have influenced service design**

Examples of how patients have influenced the Long Covid-19 service design include:

- The suggestion for the inclusion of mental health support services as part of the Long Covid-19 service offer.
- The recommendation to include a self-referral process as well as GP referral process. This is the first self-referral process for Long Covid in the UK. Demand for the service is extremely high, in particular the self-referral process. Since December 2021, the Health Board has received over 1,000 referrals with 80% of them being self-referrals. The self-referral process helps reduce any barriers patients are experiencing contacting their GP and gives patients easier access to services, empowering patients to be responsible for the management of their own care
- Re-shaped the content and delivery of the EPP Long Covid self-management course to ensure it continues to meet the needs of patients.
- Patient involvement in agreeing clinic locations to ensure there is an equal geographical spread across North Wales.
- As directed by Lived Experience Representatives the self-referral process promoted across primary, secondary, community care and third sector organisations such as Carers Wales and Samaritans.
- The development of online group clinic sessions. These groups are clinical intervention but in a group setting rather than 1-2-1 for suitable patients. These online groups can be more accessible for patients to access if they struggle travelling to a clinical setting for their appointment. Patients can also benefit from peer support by attending group clinic sessions.
- Following on the completion of the EPP Long Covid self-management course there is a clear, defined pathway for patients who want to participate in sharing their experiences. A menu of involvement options is developed and given to patients on completion on the course; examples of involvement include sharing their experience through a patient story.
- Lived Experience Representatives are involved in shaping the structure of the monthly partnership meetings and progressing the direction of the group from service design to engagement and experience.

A Long Covid Lived Experience Representative described the service they have been involved in co-producing as a 'gateway', opening the door to where you need to go, signposting and referring patients to different services.

**Success to date**

- The Patient and Carer Experience Lead Manager delivered a breakout session on the development of the service at Improvement Cymru National Conference in May 2022.
- Staff, stakeholders and Lived Experience Representatives are working with What Works Wellbeing to co-develop an Outcome Star PROM for long-term health conditions. There is currently no PROM developed around managing long-term health conditions available in the UK. This will be an evidence-based tool that can be

used by other NHS organisations across Wales and England once it has been approved. Towards the end of the year 100 patients will pilot this PROM before it is approved for use across the UK. BCUHB are leading the way in developing this outcome measure.

- Patient feedback and engagement, through the recruitment of Lived Experience Representatives has played a pivotal role in influencing service design and implementation of the Long Covid-19 service at BCUHB.
- The Delivery Unit, Welsh Government All Wales Patient Experience Feedback Group recognises the success of the lived experience group across Wales. This work is recognised as a one of its kind in Wales as the only Long Covid Lived Experience Partnership Group.
- Ultimately, Long Covid Lived Experience Representatives feel their voice is heard through the capturing of patient stories and their ideas for service development and improvement are being listened to at monthly partnership meetings.
- Having Lived Experience Representatives is a recognised model of good practice across BCUHB and is to be replicated across other services as part of the emerging Quality Strategy priorities.

**Direction of Travel**

Lived Experience Representatives continue to be committed in their engagement of this service. The partnership group recognise that positive patient experience is a key measure of the clinical pathway success and used as a quality indictor. With this as the focus there is a need is to capture patient experience feedback as PREMS and PROMS to ensure the service continues to meet the needs of patients.

The service is soon to be recruiting a Long Covid Lived Experience Officer to support the development of this service, whose role will be to actively network and build relationships across the health board, partner organisations, and the third sector in order to secure their engagement. This role will provide assurance that patients' voices are heard, and will inform service improvements for the long COVID-19 clinical service.

The Long Covid Partnership Group continue to engage with harder to reach communities and patients with protected characteristics across North Wales ensuring that they are aware of Long Covid and the Long Covid service available.

The Patient and Carer Experience Team extend their gratitude and appreciation to all of the patients who shared their experience.

| Report title: | Chief Executive's Report | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 1.8 |
| Executive Summary: | The report provides an update on key meetings and activities undertaken by the Chief Executive since the last Board meeting, including:<br><br>• Safe Care Partnership Foundational Site Visit<br>• Meeting with Healthcare Inspectorate Wales<br>• Meeting with the Chair and Chief Officer of the Community Health Council<br>• Meetings with MS' and MPs<br>• Meeting with the Chief Executive of Digital Health and Care Wales (DHCW)<br>• Thanks from Agoriad<br>• Visits and events<br>• National Meetings | | |
| Recommendations: | That the Board notes the content of the report. | | |
| Executive Lead: | Chief Executive | | |
| Report Author: | Chief Executive | | |

| Purpose of report: | For Noting ☒ | For Decision ☐ | For Assurance ☐ |
|---|---|---|---|

| Assurance level: | Significant ☐<br><br>High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☐<br><br>General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐<br><br>Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐<br><br>No confidence/evidence in delivery |
|---|---|---|---|---|

| 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: |
|---|
| Not applicable |

| Link to Strategic Objective(s): | Meetings cover a range of strategic priorities |
|---|---|
| Regulatory and legal implications | There are no specific implications arising from these meetings |
| Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR) | Reference to clinical risk and risk to the effective delivery of Digital Services |
| Financial implications as a result of implementing the recommendations | There are no immediate financial implications |

| | |
|---|---|
| **Workforce implications as a result of implementing the recommendations** | There are no immediate workforce implications |
| **Feedback, response, and follow up summary following consultation** | Not applicable |
| **Links to BAF risks:** (or links to the Corporate Risk Register) | Links to clinical service risks and digital |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |
| **Next Steps:** **Implementation of recommendations** Not applicable | |
| **List of Appendices:** None | |

**Health Board – 21st July 2022**

**Report Title: Chief Executive's report**

The purpose of the report is to keep Board Members updated with regard to key issues affecting the organisation and highlight topical issues which are of interest to the Board.

Some issues raised in this report feature more prominently with reports of the Executive Directors as part of the Board's public business.

| Background |

This report provides an update Board Members on key issues impacting the organisation, key meetings attended and engagement activities undertaken by the Chief Executive and an overview of local and national matters of interest.

| Assessment and Analysis |

**Improvement Cymru and the Institute for Healthcare Improvement (IHI)**

On 13th and 14th July we welcomed colleagues from Improvement Cymru and the Institute for Healthcare Improvement (IHI) as part of the Targeted Intervention (TI) programme and undertake the Safe Care Partnership Foundational Visit to the Health Board. The Safe Care Partnership is a collaboration between NHS Wales and IHI which aims to support patient safety improvement and spread good practice within and between organisations.

The overall aim of the visit was to understand the current position within the Health Board identifying how our learning system can be developed to support the outcomes associated with the extension of TI. The visit was designed to allow individuals, teams and departments the opportunity to spend time with the visiting team and discuss the opportunities and challenges of delivering and sustaining safe and reliable healthcare in practice. The visit focussed upon Ysbyty Glan Clwyd and services in the Central Area.

The review process will provide an analysis of existing culture, strategies and policies identifying what is needed to build a foundation to promote and sustain a culture of

quality and safety. A report will be prepared summarising the findings from the visit which will be shared with the Board and used to inform our future plans.

**Meeting with Healthcare Inspectorate Wales**

On 12 July clinical Executive colleagues and I met with Healthcare Inspectorate Wales to discuss our ongoing response to the designation of the YGC Emergency Department as a service requiring significant improvement and a recent serious incident.

We shared with HIW details of immediate make safe actions which have been implemented and provided an update on the detailed Improvement Plan which is now in place. We noted the establishment of a "Cabinet", led by the Chairman of the Board provide oversight to the improvement programme and seek positive assurance of the impact of changes made.

We discussed the immediate actions being taken on site by the Hospital Management Team and the increased presence of our clinical Executives on site to provide support and challenge, along with the external support being secured to investigate the recent incident.

We also noted the impending support from the National Unscheduled Care Programme which will bring addition clinical and improvement expertise into the Health Board to support the further development and delivery of our plans.

**Targeted Intervention**

In June the Minister for Health and Social Services announced that the Targeted Intervention arrangements would be extended to incorporate a focus on services at Ysbyty Glan Clwyd (YGC), including vascular services and the Emergency Department. Work has progressed to develop an action plan for improvement in YGC and this was discussed at the Quality, Safety and Experience Committee on 5th July. Progress with the YGC aspects of Targeted Intervention will be overseen by a "Cabinet" established by the Board, led by the Chairman.  Executive lead for the YGC improvement work is Gill Harris, Director of Integrated Clinical Services and Hugh Evans is the lead Independent Member.

Welsh Government have offered further support to ensure an effective response, including support from Improvement Cymru, linked to the work with the Institute for Healthcare Improvement outlined above and the national Unscheduled Care Team. We are working with these colleagues to finalise plans and these will then be reflected in a maturity matrix in the same manner as the other aspects of Targeted Intervention. The maturity matrix for YGC, along with refreshed matrices for other aspects of Targeted Intervention will be presented to the Board at its next meeting in September.

**Meeting with the Chair and Chief Officer of the Community Health Council**

On 4 July the Chairman and I met with the Chair and Chief Officer of the CHC to discuss a number of issues, which included:

- Vascular services
- Robotic surgery plans
- Dentistry
- Targeted intervention; including the escalation of services at Ysbyty Glan Clwyd
- Commissioning of additional care home capacity
- Coroners cases
- Implementation of the Operating Model

We heard feedback from the CHC regarding their observations and concerns on these issues and were pleased to provide updates on the actions we have in place to address concerns and further develop services.

**Meetings with MS' and MPs**

The rolling programme of meetings with individual MS and MPs continues. Issues raised in recent meetings include the escalation of services at YGC into Targeted Intervention, primary care challenges, particularly access to some LHB Managed Practices and services in Tywyn.

In response to the announcement of YGC services moving into targeted Intervention, the Chairman and I joined a meeting with the Minister for Health and Social Care and North Wales MS'. This gave an opportunity for the Minister to clearly set out her expectations of the Health Board and for us to give assurance regarding the immediate work that has taken place and the Improvement Plan which has been developed to drive forward our activities to secure improved quality and safety of care. Further meetings will be held in the future to update on progress.

**Meeting of the Welsh Health Specialised Services Committee (WHSSC)**

A meeting of the Joint Committee was held on 12 July 2022. A number of matters relating to the commissioning and delivery of specialised services were discussed, including:

- Planned Care Recovery for Specialised Services
- Arrangements for the Individual Patient Funding Requests Panel
- Specialised Paediatric Services 5 year Commissioning Strategy
- Hepato-Pancreato-Biliary Services

A summary of the business covered by the meeting is attached at Appendix 1.

**Meeting with the Chief Executive of Digital Health and Care Wales (DHCW)**

On 11 July I met with the Chief Executive of DHCW for our quarterly meeting. We discussed a range of key issues including:

- Our ongoing assessment of strategic priorities in digital and their alignment with the national programme
- The planned piloting and testing of the Welsh Community Care Information System in North Wales
- The implications of current national constraints on capital funding for critical digital programmes such as the Welsh Patient Administration System (WPAS)
- The challenges of increasing our investment in digital

**A note of thanks from Agoriad**

I was delighted to receive an email from Arthur Beechey, Chief Executive or Agoriad, praising the work undertaken by members of our workforce modernisation team.

For the past 6 years the Health Board has been in partnership with Agoriad and Coleg Llandrillo Menai to deliver employment opportunities for young people with learning disabilities and autism, through internships at Ysbyty Gwynedd. The scheme is part of the Big Lottery's Engage to Change project. During the last year this has been extended into Ysbyty Glan Clwyd and more opportunities are being created for young people as a result of this.

In Mr Beechey's words , "the success of this initiative is down to the strong collaborative working relationship between the College, Agoriad and BCUHB". He pays tribute to our team, saying "Their contributions towards the agendas of equality, diversity, and inclusion in respect of supporting the employment aims of Engage to Change have been immense. They have continuously and diligently been at the forefront of tackling barriers and supporting progress for our Interns."

I would wish to echo these thanks to the workforce team and also add my thanks to the managers and staff in Ysbyty Gwynedd and Ysbyty Glan Clwyd who have identified the internship opportunities and supported the young people through these placements.

**Visits and events**

During June and July I have attended a number of site and events –

On 7th June, along with the Chairman, I attended the Kindness and Empathy Awards Ceremony held at Bryn y Neuadd Hospital. This was the inaugural presentation of the Awards which were created by a former member of staff from the Learning Disability Services team, Jon Crabb, who established an annual Kindness and Empathy Awards scheme for staff from the service to recognise those who go over and above what is expected of them to bring warmth and joy to their colleagues and patients.  There were

32 nominations for the 3 awards and the testimonies received demonstrated the wonderful commitment and empathy shown by many staff.

I joined the "Ask the Panel 6" staff engagement event on 24 June along with Sue Green and Dylan Roberts to answer a range of questions posed by staff. Afterwards I visited the paediatric ward and outpatient services at YGC to meet staff and hear about the services they deliver.

I was pleased to be joined by a group of staff for "tea with Jo" on 15 July where I met with a number of Consultant Therapists in Wrexham to hear about the innovative services they are delivering to our population.

Other visits and meetings include -

- Visit with the Chairman to the Emergency Department and Endoscopy Unit at Ysbyty Gwynedd
- Visit to the Oral Rehabilitation (Restorative Dentistry) Service at Wrexham Maelor Hospital
- Meeting with the Chair of Wrexham League of Friends
- Meeting with Ian Smith, North Wales Orthopaedic RTC and Network Clinical Lead to discuss orthopaedic services
- Meeting with the vaccination team at the Catrin Finch Centre in Wrexham
- Visit to the Child Health Centre in Wrexham where I met staff from the Child and Adolescent Mental Health Service, the Neurodevelopment Services and Learning Disability Services
- Visit to podiatry services at the Wrexham Maelor Hospital
- Visit to the Memory Service at Bodnant in Llandudno


**National Meetings**

I have attended the following national meetings –

- Chief Executives Management Team
- NWS Wales Leadership Team
- NHS Collaborative
- Emergency Ambulance Services Committee
- Welsh Health Specialist Services Committee


**Recommendation**

That the Board notes the content of the report.

| Cyfarfod a dyddiad:<br>Meeting and date: | Board Meeting<br>21 July 2022 |
|---|---|
| Cyhoeddus neu Breifat:<br>Public or Private: | Public |
| Teitl yr Adroddiad<br>Report Title: | Mental Health Act 1983 as amended by the Mental Health Act 2007.<br>Mental Health Act 1983 Approved Clinician (Wales) Directions 2018.<br>**Update of Register of Approved Clinicians (All Wales) and Update of Register of Section 12(2) Approved Doctors for Wales.** |
| Cyfarwyddwr Cyfrifol:<br>Responsible Director: | Dr Nick Lyons, Executive Medical Director. |
| Awdur yr Adroddiad<br>Report Author: | Meryl Roberts, All Wales Approvals Manager for Approved Clinicians and Section 12(2) Doctors. |
| Craffu blaenorol:<br>Prior Scrutiny: | Not applicable |
| Atodiadau<br>Appendices: | **Appendix 1:** Mental Health Act 1983 as amended by the Mental Health Act 2007:-<br>Approved Clinician (Wales) Directions 2018.<br>- Update of  Register of Approved Clinicians for Wales.<br><br>**Appendix 2:** Mental Health Act 1983 as amended by the Mental Health Act 2007:-<br>- Update of Register of Section 12(2) Approved Doctors for Wales. |

| Argymhelliad / Recommendation: |
|---|
| The details presented to the Board in this Report is a summary of the approvals which have already received ratification for Approved Clinicians and Section 12(2) Doctor approvals across the Principality.<br><br>This report provides a governance record of compliance with legislative requirements under the Mental Health Act 1983 (as amended 2007) of the approvals and ratification process.<br><br>The Board is asked to note the report and ratify the approvals in line with the Welsh Government Guidance Mental Health Act 1983 Approval of Approved Clinicians (Wales) July 2018 for Approved Clinicians and the Section 12(2) Process and Criteria Document for S12(2) Approved Doctor approvals. |

| Ticiwch fel bo'n briodol / Please tick as appropriate | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval | | Ar gyfer Trafodaeth For Discussion | | Ar gyfer sicrwydd For Assurance | ✓ | Er gwybodaeth For Information | |
| Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol | | | | | | N | |

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

**Sefyllfa / Situation:**

Betsi Cadwaladr University Health Board (BCUHB) undertakes the delegated function of the Welsh Ministers for the approval of Approved Clinicians and Section 12(2) doctors on behalf of all the Health Boards in Wales. The Health Board ensures an effective approval, re-approval, suspension and termination of approval processes for Approved Clinicians and Section 12(2) doctors in Wales.

**Cefndir / Background:**

The Approval Process is part of the legislative process relating to the Mental Health Act 1983 (as amended 2007).

The Welsh Government Mental Health Act 1983 (Approved Clinicians) (Wales) Directions 2018, Approved Clinician Procedural Arrangements (July 2018) and All Wales Section 12(2) Process and Criteria Document (September 2021) set out the eligibility criteria for approval and reapproval for Doctors and non-medical Clinicians who wish to become approved under the Mental Health Act 1983. These documents are used by the Approvals Team and All Wales AC and S12 Panel who scrutinise applications for approval which have been received from Clinicians across the Principality. Applications are received either for Approved Clinician or Section 12(2) applications from Psychiatrists, General Practitioners and other registered professionals who are eligible to apply for approval status under the Mental Health Act (1983) (as amended 2007).

Applications are scrutinised by the approval team for completeness and compliance and then submitted to Panel members for their scrutiny, assessment and recommendation.

Following Panel assessment, any recommendation for approval must receive formal ratification from the Approving Board, for the process of approval to be lawful and to ensure compliance with legislative requirements.

Ratification is sought via a written Chair's Action letter and submitted to the Office of the Board Secretary for co-ordination and completion.

Approval is then received in writing from the Board Chairman, Chief Executive Officer, Board Secretary and two Independent Members and returned to the Approvals Team.

The Clinician is then informed that they have received approval and this is confirmed in writing in a signed Chief Executive Officer approval letter.

The Health Board then formally ratifies decisions through this paper which is submitted on a bi-monthly basis

**Asesu a Dadansoddi / Assessment & Analysis**

The Board continues to exercise this function effectively and to work with Welsh Government to further develop the Directions that underpin this important function.

**Opsiynau a ystyriwyd / Options considered**

This is a factual report for assurance purposes.

**Goblygiadau Ariannol / Financial Implications**

| None |
| :--- |

**Dadansoddiad Risk / Risk Analysis**

To ensure that all Clinicians are approved and reapproved within the agreed timescales, the All Wales Approval Panel assesses applications according to the Procedural Arrangements agreed with Welsh Government.

If Clinicians do not apply for re-approval according to the agreed timescales, their approval could expire and this could have an adverse impact on the availability of Approved Clinicians, Responsible Clinicians and Section 12(2) Approved Doctors across the workforce in the Principality.

Under The Mental Health (Mutual Recognition) Regulations 2008, a Section 12(2) approved Doctor in England is also approved in Wales and vice versa. Due to a current lack of Section 12 Directions for Wales, there is a risk that a Section 12(2) approved Doctor in Wales may not be lawful in England.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance**

The Approval Process meets the legislative requirements of the Mental Health Act 1983 (as amended 2007) and the Mental Health Act 1983 (Approved Clinicians) (Wales) Directions 2018.

The Board is asked to note that Wales does not currently have Section 12 Directions for the approval, re-approval and ending of Section 12(2) Doctor approval. Welsh Government met with the Approvals Team on 20th October 2021 and it was agreed that Section 12 Directions will be made. Welsh Government Legal Team reviewed draft Section 12 Directions for compliance and further meetings between the Approvals Team and Welsh Government took place on 8th December 2021, 4th and 11th February 2022, 11th March 2022 and 20th May 2022 to review and agree the contents. Further meetings will be scheduled to ensure the draft Section 12 Directions are reviewed, agreed and enacted by the Welsh Minister.

**Asesiad Effaith / Impact Assessment**

None.

**Update of Register of Approved Clinicians and Section 12 (2) Approved Doctors for Wales**
**3rd May 2022 – 28th June 2022**

|  | AC | S12 (2) |
|---|---|---|
| **Approvals and Re-approvals** | 17 | 3 |
| **Approvals suspended** | 1 | 0 |
| **Approvals re-instated/ Reinstated and returned to work in Wales** | 1 | 0 |
| **Removed – Expired** | 0 | 0 |
| **Retired** | 1 | 0 |
| **Registered without a licence to practise and retired** | 1 | 1 |
| **Transferred from AC register (to S12 Register)** | 0 | 0 |
| **Transferred/Removed from S12 – Became AC approved** | 0 | 1 |
| **No longer working in Wales** | 3 | 1 |
| **Approval Ended** | 0 | 0 |
| **RIP** | 0 | 0 |

**APPENDIX 1**

## Mental Health Act 1983 as amended by the Mental Health Act 2007

## Mental Health Act 1983 Approved Clinician (Wales) Directions

## Update of Register of Approved Clinicians for Wales

## 3rd May 2022 – 28th June 2022

**Approvals and Re-approvals:  17**

| Surname | First Name | Workplace | Date Approval Expires | Chair's Action |
|---------|-----------|-----------|-----------------------|----------------|
| Harrington | Emily Heather | Cardiff & Vale University Health Board, Headroom, 3rd Floor, Avon House, 19 Stanwell Road, Penarth, CF64 2EZ. | 10th May 2027 | Yes |
| Mittapalli | Govardhan Reddy | Cwm Taf Morgannwg University Health Board, Zone R, Mental Health Wellbeing, Princess of Wales Hospital, Bridgend CF31 1RQ. | 12th May 2027 | Yes |
| Hess | Natalie Lorraine | Swansea Bay University Health Board, Department of Liaison Psychiatry, Morriston Hospital, Morriston, Swansea SA6 6NL. | 15th May 2027 | Yes |
| Letchford | Penelope | Swansea Bay University Health Board, Hafod y Wennol AATU, Hensol, Pontyclun CF72 8YS. | 16th May 2027 | Yes |
| Morgan | Emma Louise | Cardiff & Vale University Health Board, Pentwyn CMHT, Brynheulog, Pentwyn, Cardiff, CF23 7JD. | 17th May 2027 | Yes |
| Ahmed | Zahir | Elysium Healthcare, Cefn Carnau Hospital, Cefn Carnau Lane, Caerphilly, CF81 1LX | 17th May 2027 | Yes |

| Surname | First Name | Workplace | Date Approval Expires | Chair's Action |
|---|---|---|---|---|
| Tyson | Agnieszka | Hywel Dda University Health Board, Hywel Dda Centre, Regent Way, Chepstow, NP16 5BS. | 17th May 2027 | Yes |
| Cribb | Clare Teslin | Hywel Dda University Health Board, Ty Myddfai Psychological Wellbeing Centre, Glien Road, Cillefwr Industrial Estate, Johnstown, Carmarthen, SA31 3RB. | 19th May 2027 | Yes |
| Steadman | Davies | Cardiff & Vale University Health Board, North East Cardiff Community Mental Health Team, Pentwyn Health Centre, Brynheulog, Pentwyn, Cardiff, CF23 7JD. | 22nd May 2027 | Yes |
| Watkins | Lance Vincent | Swansea Bay University Health Board, Ty Penfro, 67a Pembroke Road, Canton, Cardiff, CF5 1QQ. | 23rd May 2027 | Yes |
| Davies | Paul Stephen | Cardiff and Vale University Health Board, Hafan y Coed Unit, University Hospital Llandough (UHL) Penlan Road, Llandough, CF64 2XX. | 23rd May 2027 | Yes |
| Atkins | Maria Cecelia | Hywel Dda University Health Board, Perinatal Mental Health Service, Ty Myddfai, Cillefwr Industrial Estate Glien Road, Johnstown, Carmarthen, SA31 3RB. | 31st May 2027 | Yes |
| Nambiar | Amritha Surendran | Hywel Dda University Health Board, Bro Cerwyn Centre, Fishguard Road, Haverfordwest, Pembrokeshire, SA61 2PG. | 5th June 2027 | Yes |
| Metters | Andrew | Swansea Bay University Health Board, Llwyneryr Unit, 151 Clasemont Road, Swansea, SA6 6AH. | 7th June 2027 | Yes |
| Mlele | Thomas | Hywel Dda University Health Board, Learning Disability Service, 2nd Floor, 1 Penlan Road, Carmarthen, Carmarthenshire, SA31 1DN. | 31st July 2024 | Yes |
| Mansour | Khalid Abd Elazim | Powys Teaching University Health Board, Bronllys Hospital (Erwood Ward), Bronllys, Powys, LD3 0LU. | 30th November 2024 | Yes |
| Chaudhry | Shaheen | Regis Healthcare Limited, Hillview Hospital, Hillside, Ebbw Vale, Blaenau Gwent, NP23 5YA. | 22nd June 2027 | Yes |

**Approvals Suspended: (***Pending Receipt of Completion of Certificate of Training CCT***): 1**

| Surname | First Name | Workplace | Date Approval Expires |
|---------|-----------|-----------|----------------------|
| Slater | Alan | Swansea Bay University Health Board, Neuropsychiatry Department, Hafan Y Coed, University Hospital Llandough, Penlan Road, Penarth CF64 2XX. | 28th March 2027 |

**Approvals re-instated/Reinstated and Returned to Wales: *1**

| Surname | First Name | Workplace | Date Approval Expires | Chair's Action |
|---------|-----------|-----------|----------------------|----------------|
| Heke | Sian Katherine | Swansea Bay University Health Board, Fendrod Ward, Cefn Coed Hospital, Waunarlwydd Road, Cockett, Swansea, SA2 0LB. | 15th February 2026 | No*<br>*pending ratification via a Chair's Action Letter |

**Removed - Approval expired: 0**

| Surname | First Name | Workplace | Date Approval Expired |
|---------|-----------|-----------|----------------------|
|  |  |  |  |

**Retired: 1**

| Surname | First Name | Workplace | Date Approval Expired |
|---------|-----------|-----------|----------------------|
| Jacques | Ray | Formerly: Powys Teaching Health Board, Learning Disability Service, Old College, Station Road, Newtown SY16 1BE. | 21st April 2022 |

**No longer Registered & Retired: 1**

| Surname | First Name | Workplace | Date Approval Expired |
|---|---|---|---|
| Alexa | Arianna Simina | Formerly: Cardiff and Vale University Health Board, Links CMHT, First Floor, Block 11, Cardiff Royal Infirmary, Glossop Road, Cardiff, CF24 0SZ. | 9th May 2022 |

## Transferred from AC Register to S12 Register: 0

| Surname | First Name | Workplace | Date Approval Expires |
|---|---|---|---|
| | | | |

## No longer working in Wales: 3

| Surname | First Name | Workplace | Date Approval Expires |
|---|---|---|---|
| Ur-Rehman | Ijaz | Priory Healthcare Group, Llanarth Court Independent Hospital, Llanarth, NP15 2YD. | 2nd August 2026 |
| Darwish | Ahmed | Cwm Taf Morgannwg University Health Board, Ty Llidiard, Princess of Wales Hospital, Coity Road, Bridgend, CF31 1RQ. | 7th August 2022 |
| Verma | Anupam | Betsi Cadwaladr University Health Board, Ablett Unit, Ysbyty Glan Clwyd, Sarn Road, Bodelwyddan, LL18 5UJ. | 8th August 2022 |

## Approval Ended:  0

| Surname | First Name | Workplace | Date Approval Expired |
|---|---|---|---|
| | | | |

## RIP: 0

| Surname | First Name | Workplace | Date Approval Expired |
|---------|-----------|-----------|----------------------|
|         |           |           |                      |

**APPENDIX 2**

# Mental Health Act 1983

## Update of Register of Section 12(2) Approved Doctors for Wales

### 3rd May 2022 – 28th June 2022

**S12 Approvals and Re-approvals:**

| Surname | First Name | Workplace | Date Approval Expires | Chair's Action |
|---|---|---|---|---|
| Azar | Zeenish | Velindre NHS Trust, Ty Derbyn, Ysbyty Maelor Hospital, Croesnewydd Road, Wrexham, LL13 7TD. | 5th May 2027 | Yes |
| Omisakin | Oluwafunmilayo Mary | Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Mental Health Unit, Llantrisant, CF72 8XR. | 8th May 2027 | Yes |
| Oluwajulugbe | Philip Toluwani | Cwm Taf Morgannwg University Health Board, Royal Glamorgan Hospital, Ynysmaerdy, Pontyclun, Rhondda Cynon Taf, CF72 8XR. | 31st May 2027 | Yes |

**S12 suspended: 0**

| Surname | First Name | Workplace | Date Approval Expires |
|---|---|---|---|
|  |  |  |  |

**S12 Approvals reinstated/Reinstated and returned to Wales: 0**

| Surname | First Name | Workplace | Date Approval Expires |
|---|---|---|---|
|  |  |  |  |

**S12 Expired: 0**

| Surname | First Name | Workplace | Date Approval Expired |
|---|---|---|---|
|  |  |  |  |

**Registered Without a Licence and Retired: 1**

| Surname | First Name | Workplace | Date Approval Expires |
|---|---|---|---|
| Yeates | Caroline | Independent Practitioner c/o Home Address. | 10th January 2023 |

**Transferred from S12 Register & Became AC approved:**

| Surname | First Name | Workplace | Date Approval Expires |
|---|---|---|---|
| Bartlett | Robert Owen | Betsi Cadwaladr University Health Board, Ablett Unit, Ysbyty Glan Clwyd, Rhuddlan Road, Bodelwyddan, LL18 5UJ | 11th January 2026 |

**Transferred from AC Register & Became S12 approved: 0**

| Surname | First Name | Workplace | Date S12(2) Approval Expires |
|---------|-----------|-----------|------------------------------|
|  |  |  |  |

## S12 No longer working in Wales: 1

| Surname | First Name | Workplace | Date Approval Expires |
|---------|-----------|-----------|----------------------|
| Siddarth | Neminathan | Formerly: Betsi Cadwaladr University Health Board, GP Out of Hours Service. | 10th July 2022 |

## S12 Approval Ended: 0

| Surname | First Name | Workplace | Date Approval Expired |
|---------|-----------|-----------|----------------------|
|  |  |  |  |

## RIP: 0

| Surname | First Name | Workplace | Date Approval Expires |
|---------|-----------|-----------|----------------------|
|  |  |  |  |

| Report title: | A Clinical Services Strategy for north Wales | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | |
| Executive Summary: | This paper sets out the key features of the Clinical Services Strategy for north Wales, it summarises the engagement activity undertaken to support the development of the Strategy and details the next steps post approval and implementation. | | |
| Recommendations: | Committee members to: <ul><li>Approve the Clinical Services Strategy for implementation and formal publication.</li><li>Note the work underway to finalise the Health Board Prioritisation Framework.</li></ul> | | |
| Executive Lead: | Dr Nick Lyons, Executive Medical Director | | |
| Report Author: | Kamala Williams, Head of Health Strategy and Planning | | |
| Purpose of report: | For Noting ☒ | For Decision ☒ | For Assurance ☐ |
| Assurance level: | Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |

| 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: | |
|---|---|
| Implementation of the Strategy will utilise the existing IMTP development process. | |
| Link to Strategic Objective(s): | The Clinical Services Strategy is aligned to and consistent with other relevant national and local strategies and plans, as detailed in the Strategy document.<br><br>An approved Clinical Services Strategy is a key requirement under the Welsh Government Targeted Improvement and Intervention Framework. |
| Regulatory and legal implications | N/A |
| In accordance with WP7 has an EqIA been identified as necessary and undertaken? | Yes |
| In accordance with WP68 has an SEIA identified as necessary been undertaken? | Yes |
| Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR) | Without an approved Clinical Services Strategy, there is a risk that Health Board decisions concerning large-scale strategic service change will be sub optimal and inconsistent in approach. |

| | |
|---|---|
| **Financial implications as a result of implementing the recommendations** | There are no specific financial requirements arising from this paper. The IMTP development process will address any financial implications arising from the implementation of the Clinical Services Strategy. |
| **Workforce implications as a result of implementing the recommendations** | There are no specific workforce implications arising from this paper. The IMTP development process will address any workforce implications arising from the implementation of the Clinical Services Strategy. |
| **Feedback, response, and follow up summary following consultation** | The Strategy has been through several iterations with each version scrutinised and refined to reflect feedback from a wide range of individuals and groups including:<br><br>**Internal - BCUHB Committees and Groups**<br>Health Board members<br>Executive Team<br>Executive Management Group<br>Health Professionals Forum<br>Stakeholder Reference Group<br>People, Partnerships and Population Health (PPPH) Committee<br><br>The BCUHB Clinical Senate has acted as the steering group for the Strategy providing overarching oversight and scrutiny throughout the development process.<br><br>**External – Targeted sessions**<br>Engagement sessions with all six north Wales Local Authorities, with attendees including elected members and officials.<br><br>Third sector workshops.<br><br>CHC Board-to-Board meeting.<br><br>**General engagement activity**<br>Engagement sessions with a range of internal and external stakeholders.<br><br>Creation of a Clinical Services Strategy webpage with links to an Engagement Summary document (also available as easy read and as a BSL video and audio format), a questionnaire and supporting papers including the full version of the Strategy and appendices. All content available in English and Welsh. Web page signposted via email and social media |

| | |
|---|---|
| | posts.<br><br>Invitation to participate in the development process with links to webpage disseminated via email to key stakeholders (circa 200+ organisations/ individuals) and to all BCUHB staff (via CEO/Chairs weekly briefing)<br><br>A full Engagement Report will be completed and submitted to Board in September 2022. The report will detail the responses received, summarise the key themes raised and how these have helped to shape the Clinical Services Strategy. The Report will also set out how the feedback will inform the development of the Clinical Services Plan and IMTP. |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | N/A |
| **Reason for submission of report to confidential board (where relevant)** | N/A |

**Next Steps:**
Once the Strategy is approved work will commence on the development of a Clinical Services Plan, this will set out the Health Board strategic intentions and priorities for Clinical Services and will feed into the development of the 2023/26 IMTP.

**List of Appendices:**
A Clinical Services Strategy for north Wales V 1.0
Appendix 1 - Worked Example – Support for Carers
Appendix 2 - Our enablers
Appendix 3 - Service redesign checklist and prioritisation toolkit*
Appendix 4 - High-level Engagement Summary report


*A Health Board Prioritisation Framework incorporating the prioritisation toolkit is currently in development.*

**Thursday 4ᵗʰ August**

**A Clinical Services Strategy for north Wales**

## 1.    Introduction/Background

The Clinical Services Strategy will provide a framework to help shape the future direction and agree the strategic clinical intentions and priorities of the Board by providing a 'blue print' for large-scale service redesign. The Strategy will underpin the development of a Clinical Services Plan that will set out the Health Board strategic intentions and priorities for Clinical Services and will feed into the development of the 2023/26 IMTP.

The Strategy has been through several iterations with each version scrutinised and refined to reflect feedback from a wide range of individuals and groups. A summary engagement report is included as Appendix 4. A full Engagement Report will be completed and submitted to Board in September 2022. The full report will detail the responses received, summarise the key themes raised and how these helped shape the Clinical Services Strategy. It will also set out how the feedback will inform the development of the Clinical Services Plan and IMTP.

## 2.    Body of report

The Clinical Services Strategy for north Wales builds on 'Living Healthier, Staying Well' the Health Board's overarching long-term strategy, which was approved in 2018 and subject to a 'refresh' that concluded in spring 2022. It also draws heavily from other relevant national and local strategies and plans.

Development of the Strategy commenced in 2021 with a series of Health Board workshops that resulted in a set of draft guiding and design principles. Through a process of engagement with internal and external stakeholders these principles were tested, refined, and provide the basis of the Strategy. Overall oversight and scrutiny of the development process was via the BCUHB Clinical Senate, established as a multi-professional group of clinicians to provide independent clinical advice, guidance and leadership at the direction of the Executive Medical Director.

The Strategy sets out the strategic and local context, which has influenced its development. It describes the Health Board's vision for clinical services in north Wales and details the guiding principles and design features that will apply to future large-scale strategic service redesign to turn this vision into reality.

To assist those involved in large-scale strategic service redesign the Strategy includes a checklist, which will enable users to establish that the proposed service change meets the criteria for redesign; ensures that full consideration is given to the key factors that any redesign proposal will need to address and starts to gather the information required for prioritisation to take place. The information collated via the checklist will also support the development of the proposal into an implementation plan or business case if required.

A pan BCUHB Prioritisation Framework that incorporates the prioritisation toolkit is currently in development and will facilitate a consistent approach to the prioritisation of all Health Board plans, including the large-scale strategic service change that falls under the remit of the Strategy. The Framework will support the structured assessment of proposals to inform decisions regarding their relative priority and assist in agreeing the proposals to take forward via the BCUHB Clinical Services Plan and Integrated Medium Term Plan (IMTP). Several Health Board Programmes are currently testing the toolkit and the intention is to complete testing and finalise for use in the 2023/24 planning cycle.

Once approved the Clinical Services Strategy will facilitate development of a north Wales Clinical Services Plan, which will set out the strategic intentions and priority areas for change that will feed into the development of the 2023/26 IMTP.

**3.     Budgetary / Financial Implications**

There are no specific budgetary or financial requirements arising from this paper.  The IMTP development process will address any financial implications arising from the implementation of the Clinical Services Strategy.

**4.     Risk Management**

Risk analysis, mitigation and management of large-scale strategic service redesign will utilise existing risk management arrangements for Health Board strategic change programmes.

**5.     Equality and Diversity Implications**

Equality and Socio Economic Impact Assessments have not identified any specific equality or diversity concerns relating to the Clinical Services Strategy. The impact assessments are available on request.

# BCUHB
# CLINICAL SERVICES
# STRATEGY

**June 2022, v 1.0**

# Contents

**APPENDICES**
**Appendix 1** - Pathways in practice worked example: Support for Carers
**Appendix 2** - Our enablers
**Appendix 3** - Service redesign checklist and prioritisation toolkit
**Appendix 4** - High-level engagement summary report

Despite the many challenges we have faced over the past two years of the pandemic, innovation and collaboration have flourished across the NHS including here in north Wales. As we move forwards, we have an opportunity to build on the excellent foundations this work has provided, to do things differently and to improve the services we provide for the population we serve.

Our Clinical Services Strategy sets out our future direction and strategic intentions for clinical services in north Wales. The Strategy allows us to share with our stakeholders our vision for the future of clinical care in north Wales from health promotion and early intervention through to treatment, ongoing care and support and to describe the culture, practices and processes we will apply to manage and improve our services.

The Strategy sets out the principles and design features, which will guide our decisions around large-scale strategic service change and will help to inform our clinical service priorities. We will detail these priorities in a Clinical Services Plan, which will feed into the development of our 2023/26 Integrated Medium Term Plan (IMTP).

Many of our service users, staff, partner organisations and members of the public have taken the time to contribute to the development of the Strategy. We have held engagement events and sought views on a draft engagement summary document, which we shared extensively with internal and external stakeholders. People have taken the time to tell us what matters to them about their health, their experience of our services and what excellent healthcare in north Wales should look like. We are immensely grateful for the feedback we received. Whilst there has been praise for some of our services and examples provided of excellent care it is evident that we have much more to do. We have analysed and reflected on what you have told us and have sought to address the issues raised in this document.

Although there has been a great deal of support for the Strategy people have questioned our ability to put it into practice. Whilst we have had success in implementing large-scale strategic change in the past, for example, the establishment of the Sub Regional Neonatal Intensive Care Centre (SURNICC), we acknowledge that there have been occasions when this has not been the case. We accept that we must do better in the future by making the right decisions first time and implementing the changes well.

Status quo is not an option, we are committed to making the changes required and do not underestimate the scale of the challenge ahead. The Strategy consolidates our experience, learning and aspiration and provides us with a blueprint to improve our strategic planning processes and develop robust, deliverable plans for the future.

**1.1 What are Clinical Services?**

Clinical services involve contact between an individual and a health care professional; this could be in a hospital or in a community setting including in a person's home.

**1.2 Why do we need a Clinical Services Strategy?**

The Covid 19 pandemic fundamentally changed how we lived our lives and significantly constrained our ability to provide health and care services to the population we serve. Status quo is not an option, as we look towards the future, it is important that we have a clear understanding of the challenges we face and have robust plans in place to address them. We must ensure that we have the right culture, infrastructure and processes to make the most of the opportunities available to us as we seek to transform our services and provide excellent care for the people of north Wales.

Our Clinical Services Strategy will give us a framework to help shape the future direction and agree our strategic intentions for clinical services in north Wales and will provide a 'blue print' for large-scale service redesign.

**1.3 Our Clinical Vision**

The fundamental purpose of the Clinical Services Strategy is to deliver our Clinical Vision and strategic ambition for health care in north Wales. Our Clinical Vision is specific to the Clinical Services Strategy and builds on the overarching vision of the Health Board.

- To create a healthier north Wales, with equality of opportunity for everyone to realise their full potential so that over time the people of north Wales should experience a better quality and length of life.

- To commission and provide excellent person centred care, provided in the right place at the right time, taking a whole system approach that focuses on improving outcomes and user experience and, wherever possible, brings care closer to home.

- To empower our staff to transform and innovate and to be an organisation where the pursuit of continuous improvement is the norm.

- To work in partnership with all our stakeholders - service users, families, carers (paid and unpaid), other public and private sector organisations including the third sector and the wider community to maximise value from the resources we have available to improve health and well-being in north Wales.

**1.4 What will success look like?**

Ultimately, our Clinical Services Strategy will be successful if it helps us to ensure the clinical, financial, operational and environmental sustainability of the services we

provide and commission, and improves the health and well-being of our population.

Specific evidence of success will include:

- Quantifiable evidence that we are meeting the health needs of our population as demonstrated by
  *- A reduction in the burden of disease.*
  *- Ongoing improvement in reported health, quality of life and well-being measures and outcomes.*
  *- A reduction in health inequalities in terms of improved access, experience and outcomes for all.*

- Individuals reporting positive outcomes and experiences of our clinical services.

- Our staff will be empowered to deliver clinical services that are exemplars of prudent value-based health care with outcomes that are comparable to, if not better than, our peers.

- All our clinical services are safe, sustainable and high quality and provided in line with the National Quality and Safety Framework.

- We will be an employer of choice with a reduced reliance on temporary and agency staff.

- We will be at the vanguard of healthcare provision with others seeking to learn from our consistent achievements.

## 1.5 What will be different?

The Clinical Services Strategy will help us make better and more informed choices about the way we provide our services. We want this to include:

- Holistic person centred care that takes account of the individual's mental and physical health and well-being needs.

- Authentic involvement and empowerment of service users their families and carers, staff and partners in the co-design of services.

- Transformation of clinical services through 'end-to-end' pathway redesign, with the starting point being keeping people well.

- An approach to self-management that empowers and supports individuals their families and carers by providing the information they need to make decisions about their care.

- Partnership working leading to new and more effective models of clinical care that improve service user outcomes and experience.

- Improved availability and access to care provided at home or in the community to help reduce acute hospital attendances.

- Appropriate, timely and seamless transition between hospital care and care provided in the primary and community setting and vice versa.

- Greater vertical and horizontal integration of health and care services realised through our plans for three integrated Health Communities, which that will work in partnership with other health and care organisations supported by effective regional level Health Board wide planning and operationalised through the implementation of our Accelerated Cluster Development programme.

- Separation of planned and unplanned hospital care, to minimise the number of elective operations cancelled.

- Seeking out 'Once for north Wales' opportunities to maximise value from the resources we have available, for example, establishing a single point of access to Health Board services, a single waiting list management system and implementing a standardised, consistent approach to IT infrastructure (hardware and software).

- Reduced waiting times with timely access to the right care provided in the right place.

- Reduced lengths of stay in hospital facilitated by an expansion of prehabilitation and reablement services.

- Increased, timely and accessible diagnostic services.

- Providing as much health care within north Wales as possible.

- Maximising the use of digital technology and addressing barriers that may limit benefits from developments in this field for service users and staff.

- Creating a vibrant and thriving health care service with an acclaimed national and international reputation that attracts and retains high quality staff; an organisation where research and innovation are able to flourish.

- Building on the best national and international examples of effective healthcare provision to bring new models of care to north Wales.

> "The strategy should be a pathway focus of interventions and models of patient access…"
>
> *Response to engagement on 'Living Healthier, Staying Well', autumn 2021*

## 2.1 Our population
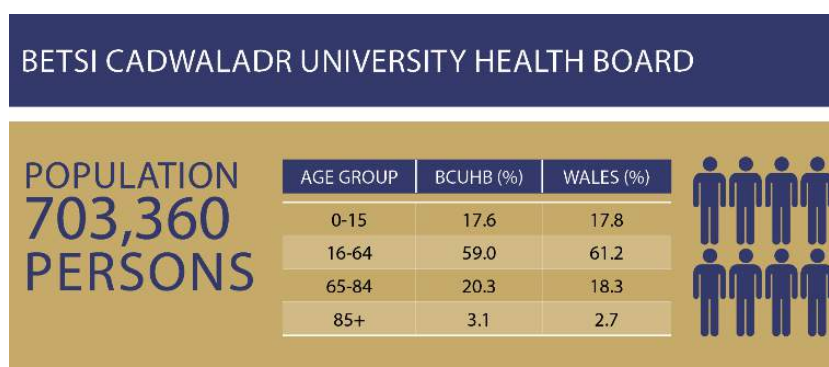


North Wales is the largest geographical region in Wales with approximately half the area officially classified as rural. The more densely populated areas in the region are along an urban strip, which broadly follows the northern coast/A55 and English border. Our diverse geography creates a complex mix of care needs and circumstances that differ significantly between the communities we serve. BCUHB spans six Local Authority areas – Ynys Mon, Gwynedd, Conwy, Denbighshire, Flintshire and Wrexham.

A significant proportion of our residents also use healthcare services and access support outside of the area. This is particularly the case in the rural south Meirionnydd area, where provision of healthcare and support is often from Bronglais Hospital, and there are close links with the Mid Wales area. We work in collaboration with other partners through the Mid Wales Joint Committee to address the needs of this population. Around a third of the population of Flintshire access healthcare services through the Countess of Chester Hospital, and some of our residents in the south of the region receive care from the Shrewsbury and Telford Hospitals NHS Trust. Our residents also access specialist healthcare for example, cardiac surgery and neurosurgery, from providers generally located in the north west of England.

Another important consideration for future service redesign is the significant numbers of Welsh speakers across the region with the greatest percentage of Welsh-speakers in the West. Use of language of choice in healthcare services can be a quality and safety issue, with evidence supporting this for specific services, such as speech and language therapy, but also in urgent or crisis situations, and for example for people with mental health needs. We are committed to providing care for individuals in the language of their choice.

## OLDER PEOPLE

North Wales has an ageing population. The percentage of the population aged 85 years and over is expected to increase by 66% between 2021 and 2043.

Around 10% of people aged over 65 live with frailty, rising to between 25% and 50% for those aged over 85. Frailty is characterised by issues such as reduced muscle strength and fatigue and describes an individual's overall resilience.

Falling is a key concern for older people and a major contributing factor to their social isolation. There were 1,009 hip fracture admissions in BCUHB in 2020.

Flu immunisation uptake in 65 year olds and over is 78% in BCUHB and 77% across Wales.

Older people are vulnerable to experiencing mental health problems. Depression and dementia are the most common problems. Around 11,600 people aged 65 and over in BCUHB with dementia, this number is predicted to increase to around 18,700 by 2040.

2043

2021

aged 85 years+
Increase by 66%

## CHRONIC CONDITIONS

Percentage of patients registered with a North Wales GP surgery as having a chronic condition.

| | BCUHB (%) | WALES (%) |
|---|---|---|
| Hypertension | 16.9 | 15.9 |
| Diabetes mellitus (patients aged 17+) | 7.8 | 7.8 |
| Asthma | 7.6 | 7.4 |
| Cancer | 3.7 | 3.3 |
| COPD | 2.7 | 2.4 |
| Atrial fibrillation | 2.6 | 2.4 |
| Stroke & transient ischaemic attack | 2.2 | 2.2 |
| Heart failure | 1.1 | 1.1 |

Patients with chronic conditions are recorded by GPs on registers are part of the Quality Assurance and Improvement Framework (QAIF). Limitations of the data include variation in practice coding and recording of data.

We know that the size and composition of our population is changing. The most recent north Wales Population Needs Assessment (PNA) published in 2022 (see, North Wales PNA 2022) forecasts an overall increase in the resident population of North Wales by the year 2040. Whilst the overall increase is likely to be relatively small the numbers of older people, particularly in the group aged 85 years and above are likely to increase significantly. This is important because we know that older people are more likely to be living with one or more complex health issues such as diabetes or heart disease. Our clinical services need to be responsive to this by taking a holistic view of the needs of each individual so that we can support people to manage these conditions better and help them to live their lives to the full.

INEQUALITIES

BCUHB has some of the most deprived areas in Wales.

Almost a quarter of children and young people under the age of 20 years live in poverty in Wales. Across BCUHB this ranges from 18% in Gwynedd to 25% in Denbighshire. Rhyl West 2 is the most deprived area in Wales, followed by Rhyl West 1.

| LSOA NAME | LA NAME | WIMD RANK |
|---|---|---|
| Rhyl West 2 | Denbighshire | 1 |
| Rhyl West 1 | Denbighshire | 2 |
| Queensway 1 | Wrexham | 9 |
| Rhyl West 3 | Denbighshire | 11 |
| Rhyl South West 3 | Denbighshire | 19 |
| Glyn (Conwy) 2 | Conwy | 20 |
| Wynnstay | Wrexham | 45 |
| Rhyl South West 1 | Denbighshire | 57 |
| Abergele Pensarn 2 | Conwy | 70 |
| Tudno 2 | Conwy | 78 |

Welsh Index of Multiple Deprivation, 2019.
Ten most deprived areas in Betsi Cadwaladr UHB.

We know that the overall health status of our population compares favourably to other parts of Wales but the benefits are not equal across our population. Feedback from our engagement on the refresh of LHSW emphasised the need for a greater focus on reducing health inequalities and improving health. This is consistent with the overarching national strategy for health and social care, 'A healthier Wales: Our plan for health and social care' (see, A healthier Wales) which seeks to shift resources from hospital-based care to primary and community services and to increase 'upstream' interventions designed to keep people well and avoid or delay the need for treatment.

We recognise that to reduce health inequalities we need a significant change in the way we invest our resources with an increased focus on supporting healthy behaviours and keeping people well. Our Clinical Services Strategy will provide a framework to help us decide how we utilise our budgets to meet population health need, current and forecast.

**MENTAL HEALTH & WELLBEING**

Mental health and wellbeing are impacted by deprivation, housing insecurity, employment, loneliness and ethnicity.

Mental ill health is associated with increased physical ill health and reduced life expectancy.

Poor mental health is also associated with increased risk-taking behaviour and unhealthy life-style behaviours.

BCUHB has a mental wellbeing score of 52.4, which is higher than Wales (51.4), a higher scores suggests stronger mental wellbeing.

It is estimated that the number of people in North Wales with a common mental disorder will increase from about 93,800 in 2020 to 94,200 by 2040.

A large proportion of Emergency Department attendances and general admissions to hospital are related to mental health problems.

94,200 BY 2040

93,800 IN 2020

We know that more people are experiencing mental health issues with one in four of us affected at some point in our lives. We are committed to working with people with experience of mental ill health along with other partners to design and deliver modern services, which do more to support people with long-term mental health problems. This resonates with feedback from our engagement, which also highlighted the wish for a more holistic approach to care that takes account of mental and physical health and well-being needs.

**2.2 How we provide our services**

We provide a broad and diverse range of primary, community, mental health and acute hospital services to the north Wales population as well as some residents from Powys Teaching Health Board, Hywel Dda University Health Board, and the north west of England. We deliver services in a variety of different settings, for example, hospitals, clinics, on an outreach basis as well as in people's homes. We also commission specialised services, for example cardiac surgery and neurosurgery, from other providers predominantly located in the north West of England.

We co-ordinate the work of 98 GP practices (13 are directly managed by us) as well as NHS services provided by 89 dental practices, 74 optometry practices and opticians and 152 pharmacies across north Wales.

We provide acute services from our three main hospitals - Ysbyty Gwynedd in Bangor, Ysbyty Glan Clwyd in Bodelwyddan and the Wrexham Maelor Hospital. We provide orthopaedics and ophthalmology services at Abergele Hospital, adjacent to the tier 4 Child and Adolescent Mental Health Service (CAMHS) unit. We also have a network of community hospitals, health centres, clinics, mental health units and community team bases and provide prison healthcare services within HMP Berwyn, Wrexham.

In 2022/23, our revenue income is circa £1.8 billion and we employ just over 19,000 people.

The way we are organised is changing and we are moving to a new Health Board 'operating model', which will lead to the majority of our acute hospital, primary and community services being managed within three integrated Health Communities – West, Central and East. This will enable greater integration between primary, community and hospital services in each heath community area.

Management of mental health, women's, cancer, diagnostic and therapy services will continue on a pan north Wales basis, as the operational and strategic management of these services can be more effectively provided at a regional level. We will ensure there are strong links between the Health Communities and regional services and are making changes to our operating model to improve our planning and performance.

At a local level our Health Communities incorporate 14 integrated Health and Social Care Localities, which comprise primary care professionals, Local Authorities and third sector as well as other partners, as per the map below.



Each Locality has a completed Locality Needs Assessments (LNA) (see, Locality Pen Profiles 2022.) The localities are broadly coterminous with primary care Cluster areas.

We are seeking to strengthen the capacity of Clusters in alignment with the national Accelerated Cluster Development Programme to support planning at the local level and to promote place-based collaboration and development. The Programme will also support the development of professional collaborative groups at the local level, bringing together general medical, dental and optometry practitioners, pharmacists, nurses, allied healthcare professionals as well as social care professionals to assess population need and agree service improvement priorities for their local area.

The clusters, and professional collaborative groups supporting them, will work closely with third sector, independent and other community groups to build on local community assets and develop services in a way that addresses local need, and feed into the integrated localities approach as described above.

Our Accelerated Cluster Development (ACD) Programme links to the north Wales Regional Partnership Board and will support us to achieve the objectives in a 'A healthier Wales' working in partnership with other public sector organisations.

The Population Needs Assessment (PNA), previously referenced, along with the LNAs will help us to identify priority areas for improvement and strengths upon which we can build. Both documents will be key resources as we implement our Clinical Services Strategy and develop our Clinical Services Plan.

## 2.3 Our partners

The Health Board's overarching purpose is to improve the lifelong health and well-being of the people of north Wales. We cannot achieve this on our own and are committed to working in partnership with individuals their families and carers, our communities, and other organisations.

We already have established working relationships in place with many of our partners, we will continue to build and grow these relationships to:

- Take a systems-wide approach to meeting health and wellbeing needs, collaborating with partners to deliver what matters to individuals, families and communities.

- Co-design care with the active involvement of our service users their families and carers, staff and the wider community including statutory and non-statutory partners.

- Design and provide services with Local Authority and other partners to provide 'joined up' care, which meets the health and wellbeing needs of individuals as well as the wider population. Recognising that to do this effectively we need to be clear about our contribution to and expectations of partnership working.

- Develop effective partnership working with the third sector maximising their expertise and contribution and creating a culture where the value of our third sector partners is fully recognised.

- Support informal carers to continue the vital role they play in providing care and assistance ensuring we understand and respect them as equal partners in care.

- Continue working closely with the Welsh Ambulance Service Trust (WAST), Local Authority and third sector partners to address the challenges of providing timely access to urgent and emergency care.

- Develop our relationships with Digital Health and Care Wales (DHCW), Health Education and Improvement Wales (HEIW), Welsh Health Specialised Services Committee (WHSSC) and the NHS Wales Health Collaborative to ensure we make the best use of the resources we have available.

- Engage fully with Welsh Government, the Community Health Council (CHC) and regional partners, especially when we need to make major changes to services ensuring that service users their families, carers, and community representatives are involved from the early stages and throughout the change process.

## 2.4 The case for change

We are the largest Health Board in Wales and the only Health Board to have a regional footprint. We have significant resources at our disposal and by taking a strategic longer-term view have the opportunity to reorganise our resources to maximise the value they provide to deliver excellent outcomes and service user experience.

The geography and demography of north Wales means that the health needs of our local populations vary. We need to understand the best way of providing services at a local level by listening and engaging with communities in a meaningful way and working with our partners to provide the right solutions.

Prior to the pandemic, a number of our services were fragile and lacking in resilience primarily due to challenges we experienced in the recruitment and retention of key staff, these challenges persist. A high level of vacancies means that we are heavily reliant on temporary and agency staff and in cases where we do not have the necessary specialist staff in post, we have to refer patients to providers outside north Wales for treatment. Consequently, we are not always able to offer timely access to the full range of services in north Wales that our patients have the right to expect. We must address this issue to ensure that in future all our services are high quality, safe as well as operationally and environmentally sustainable.

We have plans to develop a medical and health sciences school in north Wales; this is a hugely significant and exciting opportunity and we will need to ensure our services can support education, training, workforce development and the retention of graduates.

Through our engagement, you have told us that the lack of timely access to GP services is a significant concern. In keeping with the rest of the UK, we face a national shortage of key primary care staff, particularly GPs and need to look at alternative models for primary care. We are developing a Primary Care Academy to sustain, expand and further develop our primary care workforce to make the best use of the skills of the wide range of primary healthcare professionals to improve access for patients.

The pandemic severely constrained our ability to provide planned care. As is the case for many NHS organisations across the UK, our waiting lists and waiting times have increased significantly over the past 2 years. You told us this is a major concern and that we should prioritise plans to reduce waiting times as soon as possible. To do this

we need to build temporary additional capacity to remove the backlog of long waiting patients as well as retaining sufficient permanent capacity to sustain the delivery of timely access to services as we go forwards.

The pandemic also highlighted the challenges of operating a healthcare system in which there is limited physical separation of planned, emergency and urgent care services. In our case, this significantly curtailed our ability to provide planned care services during the first and subsequent waves of the pandemic. We will review and renew our planned care provision making greater use of alternative models of care. To facilitate this we plan to establish north Wales Regional Treatment Centres (RTCs), which will be standalone facilities providing diagnostic and outpatient services with the potential to undertake some planned day case procedures.

During the pandemic, the way in which we interacted with our service users changed. We were able to offer assessment and treatment in different ways often remotely where safe and clinically appropriate to do so. In several cases, these were changes we had already planned to make but fast tracked due to necessity. Many of our service users reported that these new ways of working were more convenient, increased their involvement and gave them more control of their treatment. We do not want to lose the positive changes we have made and need to find a way to embed them into our 'business as usual.' We acknowledge that virtual/remote access is not always the best approach and does not work for everyone. We will continue to offer face-to-face contact where this is better for the individual.

We are not currently providing timely access to urgent and emergency care and many patients in our acute hospital Emergency Departments could receive care in other settings. Working with our partners in health and social care, we need to ensure that our services are able to meet the whole spectrum of urgent and emergency care needs. This includes supporting individuals to manage minor ailments and injuries themselves as well as being able to provide rapid access to care for life threatening conditions.

In line with national strategy, we need to identify opportunities to reduce the footprint of our hospital-based services. In doing so we recognise that much of the care we currently provide in a hospital setting, could be provided elsewhere, for example, in primary care, the community or at home.

Much of our estate is old and in need of renewal, we currently have a redevelopment programme for the Wrexham Maelor Hospital site and a business continuity programme for Ysbyty Gwynedd, whilst fire safety compliance works are underway. Taken with our intention to develop RTCs the work to modernise our estate provides an opportunity to look at how we currently provide hospital based services and to make best use of all our buildings and facilities.

There have been huge advances in clinical practice, technology and workforce over recent years we want to get the best value from these developments by making sure we are a learning organisation constantly striving for excellence and empowering our staff to transform and improve our services.

**"Need to be radical in transforming services and ensure evidence based findings from service reviews are implemented even though this may not be popular across the different sites and professionals."**
*Response to engagement on Clinical Services Strategy, spring 2022*

**3.1 National and local drivers – the foundations already in place**

Existing national and local strategies and plans provide the foundations for our Clinical Services Strategy. The key strategies and plans we have considered include:

*3.1.1 Living Healthier, Staying Well (LHSW), BCUHB (2018)*

In 2018 following extensive engagement with patients, carers, community organisations, the Community Health Council, other partner organisations, and our staff we produced our long term strategy for health and well-being, 'Living Healthier, Staying Well' (See, Living Healthier, Staying Well 2018). LHSW provides an overarching strategy for the Health Board, describing our long-term objectives for health and well-being, which are to:

- Improve physical, emotional and mental health and well-being for all
- Target our resources to people who have the greatest needs and reduce inequalities
- Support children to have the best start in life
- Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being
- Improve the safety and quality of all services
- Respect people and their dignity
- Listen to people and learn from their experiences

During 2021, in preparation for the development of the Clinical Services Strategy we undertook significant follow-up engagement with the public of north Wales to test whether the goals set out in LHSW remain relevant, three years on, and in the light of the changed environment brought about by the COVID-19 pandemic.

The engagement exercise reaffirmed the Health Board goals although participants highlighted the need for greater focus on improving physical, emotional and mental health; strengthening our commitment to partnership working to shape our future strategies and plans and an increased focus on inequalities, keeping people well and early intervention. We will take these programmes of work forward using the simplified Planning Principles set out within our Integrated Medium Term Plan (IMTP) see section 3.1.6 below.

The LHSW refresh provides the basis for the Clinical Services Strategy.

### 3.1.2 A healthier Wales: our plan for health and social care, Welsh Government (2018)

'A healthier Wales' is the overarching national strategy for health and social care in Wales, it describes a vision in which health and social care are provided seamlessly underpinned by an integrated whole system approach to care. Its principles are reflected in LHSW as it encourages an increased focus on health promotion and keeping people well and the provision of care close to home wherever possible, with hospital care provided only when clinically necessary. It sets out the reasons why we need to move to a smaller acute hospital footprint across Wales with a greater proportion of services provided remotely, by phone or using digital technology, in a primary or community setting or at home.

### 3.1.3 National Clinical Framework (NCF): a learning health and care system, Welsh Government (2021)

The National Clinical Framework (NCF) (see, National Clinical Framework, 2021) seeks to improve patient outcomes and support the planning and provision of resilient clinical services. It provides a vision for the national strategic and local development of NHS clinical services and is a key driver for our Clinical Services Strategy.

The NCF sets out how clinical change should take place across the health system by describing key national, regional and local NHS planning processes. It details how clinical services should be planned and developed in Wales based on the application of prudent and 'value based' healthcare principles, for more detail see 3.1.4 below. By adopting this approach, the Framework highlights the need to shift our focus from care provided in a hospital setting to person centred community based care, particularly, care and support that enables people to stay well and self-manage their condition with access to seamless specialist support when needed. Key to achieving this goal is the national creation and local adoption of higher value pathways that focus on the patient rather than the setting in which care takes place.

We recognise that focussing on the patient journey and adopting an 'end-to-end' pathway approach that begins with opportunities for health promotion and avoidance of ill health will be critical to the successful implementation of our Clinical Services Strategy.

We have established a Health Board Transformation and Improvement Team to embed this approach and have created a 'BCUPathways' programme to support person centred pathway redesign at a local level, see the worked example included as Appendix 1.

### 3.1.4 Prudent and Value Based Health Care (VBHC) - Securing Health and Well-being for Future Generations, Welsh Government (2016 and 2021)

Our Clinical Services Strategy is founded in prudent value based health care, (see Prudent healthcare, 2016) a set of principles developed to ensure that health care in Wales is always adding value, contributing to improved outcomes and is sustainable.

The diagram overleaf depicts the four prudent healthcare principles:

Value Based Health Care (VBHC) is prudent health care in practice and is realised when organisations achieve the best possible healthcare outcomes for their population within the resources, financial and non-financial, that they have available. Organisations are encouraged to aspire to achieve outcomes that are comparable with the best in the world.

VBHC encourages us to find out what matters to patients, it recognises that our resources are finite and that we need to allocate them to maximum effect. The application of VBHC principles prompts us to think carefully about how we utilise our existing resources and to focus on service improvement and where appropriate service transformation. Key to effective use of prudent VBHC will be creating a culture that empowers our staff to reflect on their performance and practice and to make changes so that continuous improvement becomes the norm.

### 3.1.5 Well-being of Future Generations (Wales) Act Welsh Government (2015)

The Well-being of Future Generations Act (WBFGA), (see, Well-being of Future Generations (Wales) Act 2015) seeks to improve the social, economic, environmental and cultural well-being of Wales. The Act puts in place seven well-being goals as detailed in the diagram below. It requires public sector bodies to take a 'generational' long-term view and to work effectively with individuals, communities and partners to focus on preventing health care problems. It encourages a joined-up integrated approach to service provision which takes account of the all the factors that can influence a person's health and well-being.
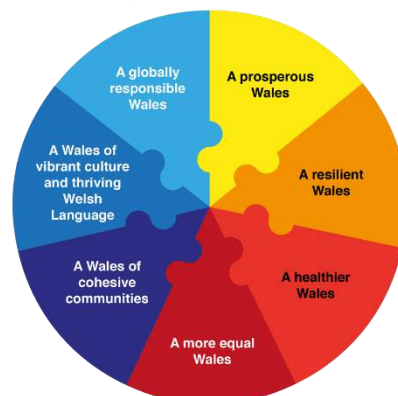
Our Clinical Services Strategy recognises the need for a much longer-term whole system view when we plan our services. This is important because the changes that are required to improve health and well-being will take time to have an effect and because it is only through collaborative working that, we are able to make the most our opportunities to improve health. Directly through the way we provide our services and by positively influencing our partners.

### 3.1.6 BCUHB Integrated Medium Term Plan (IMTP)

Our IMTP is a rolling three-year plan, refreshed each year, which sets out how we will achieve our vision for health care services in north Wales, it takes account of the resources we have available to us and describes our priorities for the three-year period.

We have created a 'Plan on a Page' approach to link together our various strategies, values, and the absolute need and commitment to work in partnership and have distilled them into the '5 BCUHB Planning Principles', see diagram overleaf. We have used these five overarching Planning Principles to shape the guiding principles contained in the Clinical Services Strategy.

Welsh Government approved the 2022/23 element of our 2022/25 IMTP. Further work is underway to develop an approvable 3-year IMTP for the period 2023/26, informed by the Clinical Services Strategy.
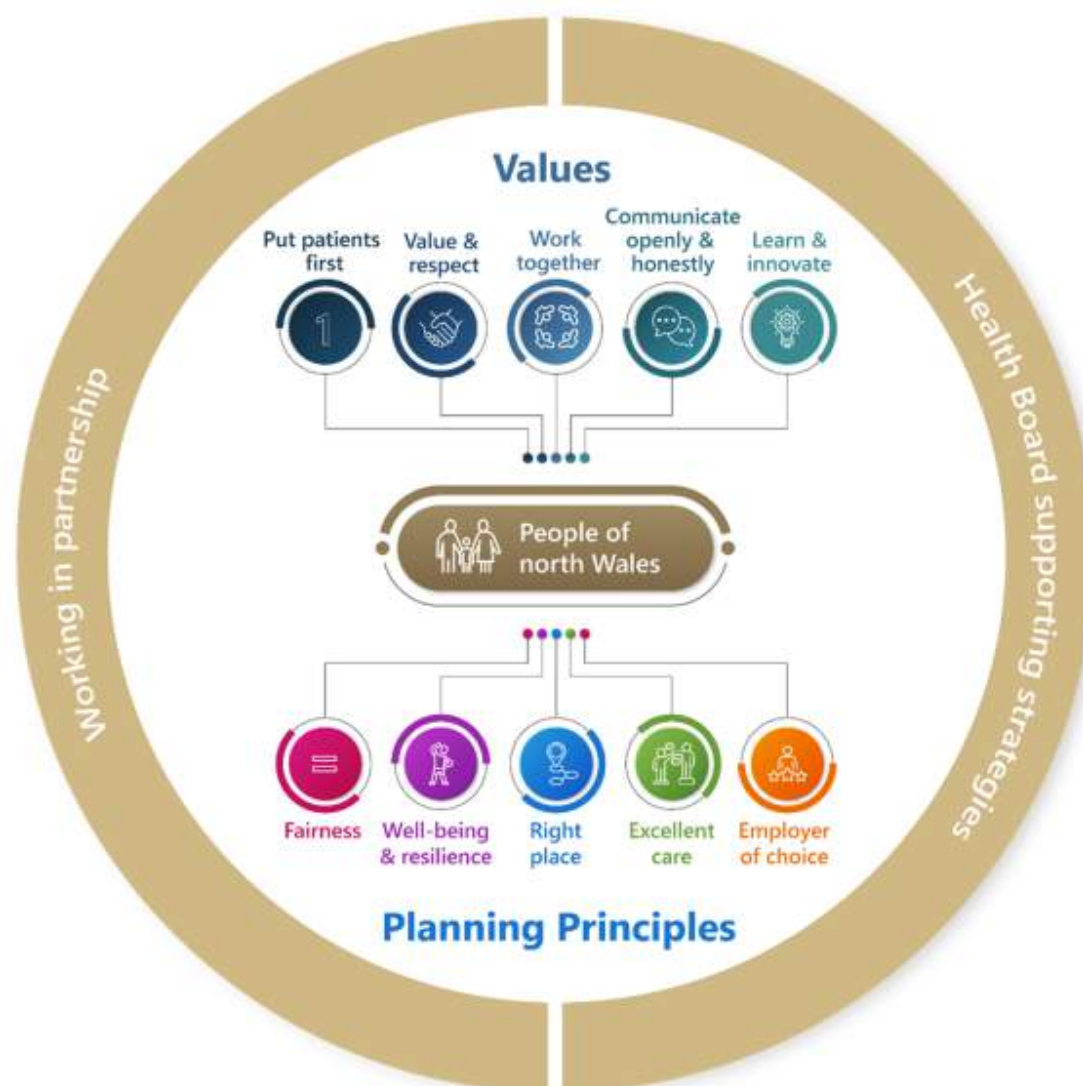
**Values**

Put patients first
Value & respect
Work together
Communicate openly & honestly
Learn & innovate

People of north Wales

Working in partnership

Health Board supporting strategies

Fairness
Well-being & resilience
Right place
Excellent care
Employer of choice

**Planning Principles**

| | | |
|---|---|---|
| Fairness | we will reduce avoidable and unfair differences in health | |
| Well-being & resilience | we will maximise prevention, self-care, well-being, and strong community networks | |
| Right place | we will provide services that are sustainable, delivered close to where people live where it is safe and effective to do so | |
| Excellent care | we will design services that can deliver world-class outcomes and experience for patients | |
| Employer of choice | we will work, and organise, improve and transform ourselves, to support our teams to flourish | |

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

### 3.1.7 Digital, Data and Technology

We want to inform and support our key clinical, business, and professional leaders to understand how they can apply digital, technology and data to enable new models of

care and service design. We will support our workforce to be able to use technology and data, but also ensure that all future investments in digital, technology and data systems align to our clinical priorities and meet the needs of our service users and staff.

We will focus on addressing digital exclusion across north Wales to support our approach of 'Digital first leaving no one behind'. Where individuals want to interact with our staff directly, for example, when booking appointments, we will ensure that they are still able to do so.

We will develop our own in-house data analytic capability to derive new insights from our data helping us to benchmark care delivery and focus our resources on higher value interventions, leading to better quality outcomes for our patients.

We will work with Digital Healthcare Wales (DHCW) and other external organisations to formally assess and benchmark our current Informatics capabilities. Working with our partner organisations at a national and regional level we will identify resources to maintain, develop and assure shared national capabilities and assets, encourage innovation and help make north Wales the best place for 'HealthTech' and for health data research in Wales.

## 3.2 Our Enablers

Enablers are essential supports, which will help us to achieve our clinical vision and strategic ambitions. We already have a number of enabling strategies and plans in place, which we have considered as we have developed and refined the Clinical Services Strategy, see table 1 below with further detail provided in Appendix 2

| Table 1 - Clinical Services Strategy enablers |
| --- |
| Locality Cluster Plans |
| National Networks and Programmes |
| Social Services and Well-being Act (Wales) 2014 |
| BCUHB Quality Improvement Strategy, 2019 - *currently under review with plan to refresh for period 2022-2025* |
| BCUHB Our Digital Future: Digital road map for health in North Wales 2022/24 |
| BCUHB People Strategy and Plan 2022/2025 |
| BCUHB Financial Plan 2022/25 |
| BCUHB Estates Strategy, 2019 – *currently undergoing review and refresh* |
| Together for Mental Health - A Strategy for Mental Health and Well-being in Wales, 2012 |
| Welsh Health Specialised Services Committee (WHSSC) Integrated Commissioning Plan (ICP) 2022/2025 |
| Maternity Care in Wales: a five year vision for the future (2019 – 2024) |
| Mid Wales Joint Committee for Health and Care Strategic Intent |
| More Than Just Words, 2012 and the Welsh Language Standards |
| BCUHB Strategic Equality and Human Rights Plan, 2020/2024 |
| NHS Wales Decarbonisation Strategic Delivery Plan, 2021/2030 |
| Research, Innovation and Improvement Coordination Hub |
| Public Sector Equality Duty |

## 3.3 Engagement and co-design

> *"There are some great initiatives but care would improve greatly if patient facing staff were given more opportunity to input into these services. Many issues missed by management are obvious to staff on the ground"*
>
> *Response to engagement on 'Living Healthier, Staying Well', autumn 2021*

The refresh of LHSW provided the foundations for the development of our Clinical Services Strategy. Alongside the refresh, we reviewed relevant national and local strategies plans and enablers, see section 3.2, from which we synthesised a set of draft guiding principles and design features.

We have tested and iterated these principles with internal and external stakeholders, to arrive at the Vision, set of guiding principles, design features and checklist detailed in this document.

Many individuals took the time to contribute to the development of the Strategy, the feedback they provided was immensely valuable and we are extremely grateful to all who participated. We will publish a full Clinical Services Strategy Engagement Report that details all our engagement activity, summarises the key themes from the engagement feedback and explains how we have responded to the issues raised.

We recognise the importance of clinical engagement and ownership of the Strategy, to help facilitate this we established a Clinical Senate comprising clinicians from different disciplines and areas across north Wales to provide independent professional advice, guidance and leadership and to act as the steering group for the development of the Strategy.

## 3.4 Continuing the conversation and working together

At the heart of the Strategy is a commitment to involve all our stakeholders in the planning, design and delivery of services to ensure we are able meet the needs of our communities both now and into the future.

Successful implementation of the Strategy will require a new approach to engagement and we will strive to create an open and continuous dialogue with our staff and external stakeholders to build a culture of transparency, trust and confidence.

We recognise that we will need to have mature conversations about the challenges we face and the decisions we will need to make. Our model of engagement will seek to establish meaningful connections, building confidence in the plans we develop using different and innovative approaches moving from "doing to/doing for" to "doing together".

> **"A high proportion of the patients we see in our department are elderly, have numerous co-morbidities, severe mobility issues and communication problems etc. They have great difficulties actually getting to areas outside their local vicinity. A lot of these patients have lost confidence alongside health and mobility problems. The patients need to be involved through questionnaires e.g. in newspapers, online, postal or local post offices / shops in small rural areas too and asked for their opinions and contributions to any change proposals."**
> *Response to engagement on Clinical Services Strategy, spring 2022*

## SECTION 4: PRINCIPLES, DESIGN FEATURES AND ENABLING INFRASTRUCTURE

The guiding principles and design features have been developed and refined through a process of engagement and co-design and take account of our vision, values and the strategies and plans we already have in place.

### 4.1 Our guiding principles

These are the principles we will use to underpin our plans for clinical services

- **Person centred and outcome based:** We will plan our services around the physical and mental health needs of the individual and design them to ensure we are achieving good outcomes and positive user experiences.

- **Co-designed and owned:** We want service users their families and carers, our staff and partners to be actively involved in the design of services. We will encourage and support people to participate in this process; this will include working with members of the public to understand their lived experience of health services and providing our staff with the necessary training and tools to ensure we have a consistent approach to co-design across all our services.

- **Population health need and reduction of health inequalities:** We will design our services and take forward interventions based on the health needs of our population and the reduction of health inequalities (unfair and avoidable differences in people's health across the population and between specific groups).

- **Keeping people well, prevention and early intervention:** We want to shift our focus from dealing with health problems after they have developed to keeping people well, prevention and early intervention.

- **Clinically led, digitally enabled and information driven:** We will provide our staff with the information systems and tools needed to understand how our services are performing, to identify areas for improvement and monitor the progress of our plans.   Examples of the systems and information we will use include - demand and capacity analysis, benchmarking (local, regional, national and international), compliance with national and professional standards and pathway mapping.

- **Transformation and innovation**: We recognise that there are opportunities to provide services in a better way. We will take a whole system approach that encourages and accelerates service transformation and innovation, for example, expanding our provision of digital and telehealth services to improve connectivity and integration of primary care and hospital services. We will test our proposals using prudent healthcare and Value Based Health Care (VBHC) principles and will strive to make continuous improvement the norm.

- **Right care, right place**: We recognise that acute care should not always mean hospital care and will adopt a system wide approach that works with the service user to support self-care and management in the community where it is clinically appropriate and safe to do so.

- **Excellent high quality care wherever it takes place:** We want all our clinical services to be high quality, safe, sustainable and resilient. We will develop service models that protect our elective capacity and promote ambulatory care i.e. same day care that does not require hospital admission.

  Working with our partners, we will reduce the number of avoidable conveyances to hospital and preventable admissions by ensuring we have effective pathways to support care in primary and community settings. We will address the backlog of long waiting patients in as short a time frame as possible and make the best use of our resources by adopting a 'Once for North Wales' approach where appropriate.

- **Effective collaboration and partnerships:** We recognise that we cannot meet the health needs of the population we serve on our own. We will seek out opportunities for effective collaboration and partnerships with all our key stakeholders. In addition to improving health and wellbeing, we will also seek opportunities to support positive social, environmental and economic outcomes that recognise and reflect the diversity of the population we serve.

### 4.2 Our design for the future

These are the 'design features', which we will use to help us develop our plans for the future:

- **Primary Care**: The majority of the clinical care we provide is quite rightly through primary care - GPs, dentists, optometrists and pharmacists, this will continue. We will seek to improve and expand the range of health care services provided by primary care healthcare professionals, reducing the demands on our hospital services. We will use our 'Accelerated Cluster Development' Programme to facilitate alternative models of care that utilise the full range of primary healthcare professionals.
- **Community hospitals**: We value our community hospitals and will utilise their potential as local healthcare facilities and resources. Our community hospitals will be integral to our development of health campuses – networks of services, facilities and support at a 'locality' level, which will work together to make the best use of local assets to support well-being and good health.
- For both our **primary care facilities and community hospitals**: We will use these facilities to their full potential providing services closer to home, where appropriate to do so.
- **Acute Hospitals:** There will continue to be three principal acute hospitals in north Wales - Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital, each will provide emergency care and associated clinical services.
- **Regional Treatment Centre(s) RTC(s)**: RTCs are standalone facilities designed to provide a range of outpatient, diagnostic and therapy services and

with the potential to include specified day case procedures. We will establish RTC(s) to increase and protect our planned care capacity.

- **Service models**: We will utilise a range of different service models to make the best use of our resources across the Health Board.
  These models will include:
  *Hub and spoke:* a specialist unit on one site leads and supports services at hospital and community sites across North Wales, such as the North Wales Cancer Centre.
  *Networked:* a single service provided across multiple sites
  *Regional*: planned and provided on a regional basis, for example, mental health care
  *Digital solutions:* Using technology, for example virtual appointments and the introduction of electronic health records.
  Feedback from our engagement on the LHSW refresh indicated that many people would be prepared to travel to have access to quicker treatment with better outcomes; however, this was with the proviso that any plans for change must address the issue of accessibility, particularly in relation to transport and additional support that service users, families and carers may require.
- **Specialised services:** Where we are unable to provide services within north Wales due to their specialised nature, for example neurosurgery or cardiac surgery, with the agreement of the service user and where clinically appropriate, we will seek to provide elements of care locally and will ensure that care is timely and seamless.
- **North Wales Medical and Health Sciences School**: Together with Bangor University, alongside other higher education bodies and partners in the region, we have an ambition to develop a transformational inter-professional Medical and Health Sciences School by 2025. This represents a significant opportunity in north Wales for us to align education and training to our clinical strategy, support the delivery of our research strategy and address key challenges in our clinical workforce including the development of bilingual skills.

> *"I would say that more local services are always better but understand that there are constraints which mean that ensuring top quality at these three sites is key. Access from more rural areas is still an issue."*
> *Response to engagement on 'Living Healthier, Staying Well', autumn 2021*

### 4.3 Enabling infrastructure

This relates to the strategies, plans and processes, which will provide us with the infrastructure to implement the Clinical Services Strategy successfully. Key enabling infrastructure includes People (our workforce), Estates (our building and facilities), Digital (our information technology systems) and Governance (our systems for assuring, quality, patient safety and creating the conditions for excellent clinical care) as summarised below:

### People – our workforce
Our people are our most valuable resource we need to support our staff to realise their full potential if we are to deliver sustainable clinical services now and in the future.

Our aim is to develop a motivated, engaged and valued, health care workforce with the capacity, competence and confidence to meet the needs of the people of north Wales. Specifically this means that:

- Our people will have the right values, behaviours, knowledge, skills and confidence to deliver evidence based care, and support peoples' wellbeing as close to their home as possible.
- We will have sufficient numbers of the right people to be able to deliver proactive and responsive health care that meets the needs of the people of north Wales.
- Our people will reflect the diversity, welsh language, cultural and community identities of the population we serve.
- Our people will feel and be valued.

We will achieve our ambition through implementation plans, co-designed and delivered in partnership with our people and partners. This will lead to:

- A compassionate and inclusive culture with excellent leaders and managers as role models.
- Better and quicker recruitment and retention of staff through attractive and flexible working arrangements and career opportunities.
- Flexible education opportunities and career development.
- Very high levels of staff engagement, motivation, wellbeing and satisfaction.
- Intelligence led workforce planning enabling us to change our workforce to meet our population need.
- Increased levels of Welsh language skills in health and care workforce.

We will continue to support staff welfare and wellbeing building on the resources already in place to create the conditions that make us an attractive, desirable place to work and to become an 'Employer of Choice'. This will allow us to encourage and support the development of innovative models of care that make the most effective use of our clinical and non-clinical workforce. It will create an environment that develops and sustains a culture, which supports and empowers our staff to embrace the value of the services they provide and where continuous improvement is the norm.

**Estates – our buildings and facilities**
We will seek out opportunities to leverage service transformation through our Estate, including our existing commitment to redevelop the Wrexham Maelor Hospital site and plans to develop Regional Treatment Centres (RTCs). In line with our Estates Strategy, we will review our use of local hospitals, primary and community facilities to ensure we are making best use of these resources, particularly to support the provision of services closer to home.

**Digital, data and technology** - **our information technology systems** (see, BCUHB Digital Strategy and section 3.1.7)
In line with our digital strategy we will consider a 'Digital first leaving no one behind' approach to service redesign and improvement. We are committed to implementing an electronic Health Patient Record, improving our digital infrastructure and connectivity and ensuring that we have standardised and consistent systems, which

are fit for purpose and have the confidence of our staff and service users. We want to be at the forefront of the digital revolution in healthcare leading the way in the use of new technologies including Artificial Intelligence including machine learning and robotic assisted surgery.

**Governance – our internal systems and processes**
Our governance processes will add value and will be transparent and ethical, with a focus on tackling operational challenges in ways that complement our vision for the future and support us to achieve the best outcomes for our stakeholders.

## SECTION 5: A BLUEPRINT FOR STRATEGIC SERVICE REDESIGN

**(See Appendix 3)**

### 5.1 A blue print for strategic service redesign

We recognise the importance of having clear, concise, user-friendly guidance to ensure a consistent approach to the identification of services for strategic service redesign and to support the subsequent development and prioritisation of service redesign proposals.

### 5.2 Identifying areas for strategic service redesign

Circumstances under which a proposal may be considered:

- Pertains to a formally agreed pre-existing commitment.
- Meets at least one of the National Clinical Framework criteria for service reconfiguration, as below:
  **Criteria 1**: There is evidence that the outcomes for people are significantly below comparator providers or there are significant patient safety concerns.
  **Criteria 2**: There is no viable prospect of the service meeting professional standards and/or recommended minimum volumes of activity to maintain high standards of care.
  **Criteria 3**: The workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed or retained - or can only be delivered by a dependency on agency or locum staff.
  **Criteria 4:** There is professional consensus on the merits of reconfiguring services to deliver an enhanced pathway or a new service model.
  **Criteria 5:** There is significant public support or democratic mandate to change a service model.
- Delivers BCUHB strategic objectives as per the BCUHB Clinical Services Strategy, including improvements to quality, outcomes and experience.

### 5.3 Strategic service redesign checklist

The checklist will enable the user to confirm whether the proposal fulfils the criteria for service redesign and prompts consideration of the key factors that a proposal will need to address to be consistent with the Clinical Services Strategy.

Completing the checklist will also start the process of gathering the information required for prioritisation to take place. If subsequently identified as a priority, this information will help support the development of the proposal into an implementation plan or business case.

### 5.4 Agreeing our priorities

Our resources are finite and we have to prioritise proposals that may necessitate redistribution of existing resources or require additional investment. We are developing

a Prioritisation Toolkit, which will facilitate structured assessment of the relative merits of each proposal and help to inform decisions regarding the proposals we take forward via the BCUHB Clinical Services Plan and IMTP.

The Prioritisation Toolkit will establish a consistent approach to prioritisation of all our plans including the large-scale strategic change that falls under the remit of the Strategy.

At present, we are piloting the Toolkit with a number of our Programmes. We will use the results of the pilots to refine the Toolkit, which will then be subject to a short period of engagement and testing before formal approval and publishing. We intend to use the Toolkit to support development of the 2023/26 IMTP.

## SECTION 6: DEVELOPMENT OF THE CLINICAL SERVICES PLAN

### 6.1 Why is a clinical service plan required?

Our Clinical Services Plan will clearly set out how, over the period 2023/26, we will use the principles in our Clinical Services Strategy to restore timely access to our services and work towards ensuring that all our services are safe and sustainable in the future. In addition, the Plan will also show how we intend to respond to the changing demands we face, for example caring for the increasing number of older people in our population, and how we will make the most of the opportunities that the rapid increases in technological and medical innovation can provide.

Our Clinical Services Plan will bring together existing and emerging programmes of work to address these changes, and set out how we will achieve our strategic ambitions over the next three years and will be integral to the development of our IMTP.

We believe that through implementing our Plan our service users will have better health outcomes and experiences of the services we provide, we will deliver better value and our staff will have greater satisfaction from the work they undertake.

### 6.2 Our existing priorities

We have a number of existing programmes of work, which the Plan will need to consider, ensure good strategic fit and assess the impact across our entire health care system:
- Regional Treatment Centres
- Planned Care - 'Restore, Recover and Sustain'
- Urgent and emergency care programme
- Major capital schemes - Redevelopment of Wrexham Maelor Hospital and Fire Safety compliance Ysbyty Gwynedd
- Establishing the North Wales Medical and Health Sciences School

We are developing a short narrative that describes the broad shape of future services and the direction for future health care and support, taking account of these major developments.  We will use this as a basis for involving our citizens, partners, staff and other stakeholders in the design of the next layers of detail for our future clinical services within the clinical services plan.

### 6.3 The Programme structure

In development as discussion is ongoing to ensure development of the Plan aligns to existing groups/processes in order to avoid duplication.

### 6.4 Time line

Linked to agreement of 6.3

| | |
|---|---|
| **Accelerated Cluster Development Programme** | The Accelerated Cluster Development Programme is the Primary Care component of 'Place Based Care', delivered through professional collaborative groups and 'Clusters'. Collaborative groups bring together GPs, Dental and Optometric Practitioners, Pharmacists, Nurses, Allied Health Professionals (AHPs) and Social Care professionals, to assess population need and service improvement priorities. Collaborative groups develop solutions through multi-disciplinary Cluster working. |
| **BCUPathways** | A BCUHB Programme to develop pathways* for the Health Board. <br> *_A pathway describes the different components of care for a specific service, health condition or treatment._ |
| **Burden of disease** | The impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators. |
| **CAMHS (Child & Adolescent Mental Health Service)** | The specialist Child and Adolescent Mental Health Services (CAMHS) focus on helping children and young people who experience emotional, behavioural and other psychological difficulties. |
| **Cluster** | A cluster brings together all local services involved in health and care across a geographical area, typically serving a population between 25,000 and 100,000. Working as a cluster ensures care is better co-ordinated to promote the wellbeing of individuals and communities. |
| **Diagnostic services** | Services that carry out tests to diagnose a condition or illness, for example, blood tests, x-ray. |
| **DHCW (Digital Health and Care Wales)** | A national organisation building and designing digital services for health and care in Wales. |
| **DHEW (Digital Health Economy Wales)** | A network connecting developers and companies with innovative digital health solutions with the NHS in Wales. |
| **EPR (Electronic Patient Record)** | A system designed to hold individual patient clinical and health information in one place making it easier for doctors, nurses and healthcare staff to make decisions about care. |
| **HEIW (Health Education and Improvement Wales)** | A national organisation which has a leading role in the education, training, development and shaping of the healthcare workforce in Wales. |
| **Health inequality** | Unfair differences in health between people or groups of people. |

| | |
|---|---|
| **HealthTech** | The use of technology including databases, applications, mobiles and wearables to improve the delivery and experience of care. |
| **IMTP (Integrated Medium Term Plan)** | The IMTP a key planning document setting out the milestones and actions the Health Board is taking in the next 1 to 3 years. |
| **Integrated health planning** | Integrated health planning is an approach characterised by a high degree of collaboration and communication in the preparation of service planning, workforce and finance plans. |
| **Locality** | Defined by geography, the people that live and work in the area, the characteristics of the population and to some extent by existing services such as the location of community hospitals, health centres and social work offices. We have 14 health localities in north Wales. |
| **LNA (Locality Needs Assessment)** | A systematic method for reviewing the health issues facing a defined population, leading to agreed priorities and allocation of resources designed to improve health and reduce inequalities. |
| **Medical and Health Sciences School** | An institution that provides education and training for health care professionals and where research takes place. |
| **National Quality and Safety Framework** | A framework developed by Welsh Government that describes what needs to be in place to ensure all health and care services are of a consistently high quality. |
| **NHS Wales Health Collaborative** | The NHS Wales Health Collaborative works on behalf of the health organisations that make up NHS Wales. It facilitates engagement, networking and collaboration between NHS organisations and other stakeholders to support the improvement of services across organisational boundaries, and to enhance the quality of care for patients. |
| **North Wales Regional Partnership Board** | The North Wales Regional Partnership Board (NWRPB) brings together health and social services providers to work in partnership to improve the wellbeing of people and communities. |
| **Outcome** | A change in health status, usually due to an intervention. |
| **Person centred** | Person-centred care involves knowledge of the individual as whole person, involving them – and where appropriate their family and friends – in helping to assess their own needs and plan their own care. |
| **Point of Care Testing** | Testing carried out at the time of patient care, for example, using portable ultrasound. |
| **Prehabilitation** | Care initiated prior to treatment that prepares an individual for medical intervention and aids recovery. |
| **Primary Care** | Health services provided in the community, for example, care provided by GPs, Dentists, Pharmacists and Opticians. |

| | |
|---|---|
| **Reablement** | Short-term care at home, to aid recovery after discharge from hospital. |
| **Regional Treatment Centre** | Typically a healthcare facility that provides same day care including diagnostics, therapies, day case procedures and outpatient services. |
| **Value Based Healthcare** | Value-based healthcare is the equitable, sustainable and transparent use of the available resources to achieve better outcomes and experiences for every person. |
| **WHSSC (Welsh Health Specialised Services Committee)** | A joint committee of the Local Health Boards in Wales established to ensure that the Welsh population has fair and equitable access to the full range of specialised services. |
| **Ysbyty Glan Clwyd** | The district general hospital in Bodelwyddan, Denbighshire, north Wales. |
| **Ysbyty Gwynedd** | The district general hospital in Bangor, Gwynedd, north Wales. |
| **Wrexham Maelor Hospital** | The district general hospital in Wrexham, north Wales. |

## OUR PERSON CENTRED OUTCOME FOCUSSED END-TO-END PATHWAY APPROACH

### WORKED EXAMPLE – SUPPORT FOR CARERS

We have developed an approach to facilitate the continuous improvement of pathways throughout the Health Board, *designed from the experiences of our patients* and *led by our clinical teams*, in order to deliver a step change in patient outcomes, experience and satisfaction.

Using the 'Betsi Pathways Methodology', as shown in the diagram below, we will use a multidisciplinary team comprising clinical and operational leads from across primary, community and secondary care, along with our service users, carers, families and partner organisations to co-design our pathways.
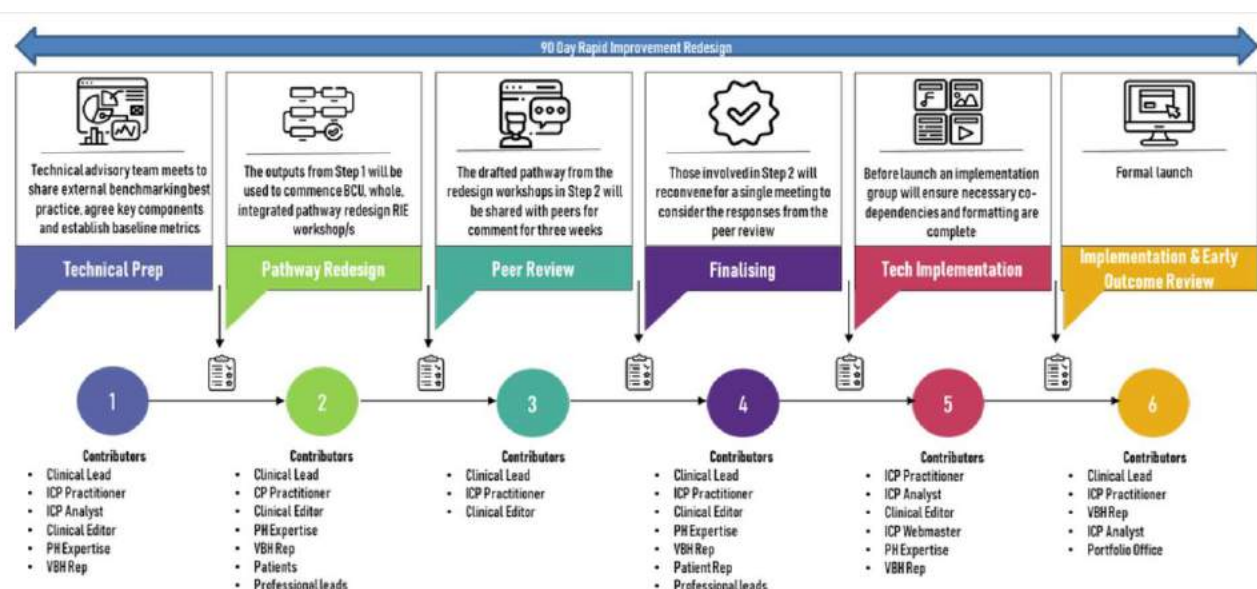


We are currently working to develop a model for the pathway components, which will support integrated pathway design that encompasses holistic, end-to-end support and care.

The components of the person centred pathway approach will utilise existing pathway approaches, linking the clinically focused pathway within the National Clinical Framework with the broader person focused pathway of the Single Integrated Pathway for People, see figure 1 overleaf.

## Figure 1 – A person centred pathway approach



To illustrate how the approach could work in practice please see worked example below:

## Proposed person centred pathway to support carers and those they care for
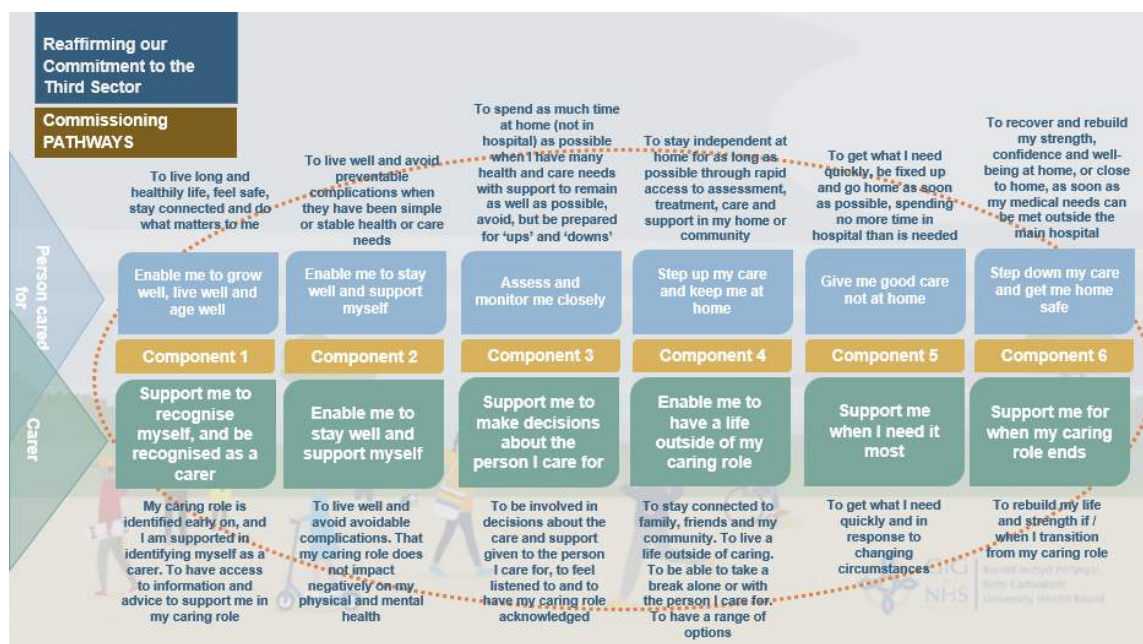
## OUR ENABLERS

| Enabler | Description |
|---------|-------------|
| **Locality Cluster Plans** | Plans developed at locality level based on locality needs assessments. Plans respond to the fact that the primary care and community services meet the vast majority of health and care needs in local communities. |
| **National Programmes** | Established by Welsh Government to provide central direction and support for local service transformation. Programmes enable a national focus on the investigation of systemic service challenges, development of solutions at scale, support to service transformation and provide assurance of equity of service offer across Wales. |
| **Social Services and Well-being Act (Wales) 2014** | The Act imposes duties on local authorities, health boards and Welsh Ministers that require them to work to promote the well-being of those who need care and support, or carers who need support. |
| **BCUHB Quality Improvement Strategy, 2019** *(currently under review with plan to refresh for period 2022-2025)* | Our strategy to deliver safe, effective compassionate care as evidenced by improved outcomes and patient experience. |
| **BCUHB Our Digital Future: Digital road map for health in North Wales 2022/24** | The strategy seeks to enable patients and carers to use digital methods to manage their care and to support staff to get the most out of the technology available to improve the services they provide. |
| **BCUHB People Strategy and Plan 2022/2025** | In development and will support implementation of Stronger Together / Mewn Undod Mae Nerth, a BCUHB programme, which following extensive staff engagement and co-design resulted in the development of our new Operating Model, designed to ensure our structure is clear, transparent and supports effective working. |
| **BCUHB Financial Plan 2022/25** | Our detailed three financial plan aligned to the IMTP and key to facilitating the transformation and improvement required to realise our vision for Clinical Services |
| **BCUHB Estates Strategy, 2019** *(currently under review with plan to refresh)* | BCUHB has one of the largest property portfolios in Wales. Our Estates Strategy details the estate we have available to us and how we intend to use it in the future. |
| **Together for Mental Health - A Strategy for Mental Health and Well-being in Wales, 2012** | Welsh Government's age inclusive, cross-Government Strategy for mental health and well-being, will be key to providing holistic patient centred care, improved outcome and service user experience. |

| | |
|---|---|
| *Maternity Care in Wales: A five year vision for the future (2019 to 2024)* | Welsh Government report that sets out a vision for achieving high quality maternity services in Wales. |
| *Welsh Health Specialised Services Committee (WHSSC) Integrated Commissioning Plan (ICP) 2022/2025* | WHSSC commission a defined range of specialist services on behalf of all Health Boards. The ICP details plans for the year ahead, work plan for the subsequent 2 years, and is important in supporting the development of end-to-end pathways of care |
| *Mid Wales Joint Committee for Health and Care Strategic Intent* | A strategic plan developed in partnership with colleagues from Powys Teaching Health Board and Hywel Dda University Health Board, which describes how we will work collaboratively to meet the health needs of the mid Wales population. |
| *More than just words, 2012* | Welsh Government's strategic framework for Welsh language services in health, social services and social care in Wales |
| *BCUHB Strategic Equality and Human Rights Plan, 2020/2024* | A framework to help us ensure full consideration of equality within our organisation and to influence decision-making at all levels across the Health Board. |
| *NHS Wales Decarbonisation Strategic Delivery Plan, 2021/2030* | Welsh Government's plan for NHS Wales' contribution to tackling climate change. An important consideration in terms of the Well-being of Future Generations. |
| *Research, Innovation and Improvement Coordination Hub, North Wales Collaborative* | The hub promotes and co-ordinates joint health, social care and third sector research, innovation and improvement activity across north Wales. |
| *Public Sector Equality Duty* | As well as improving health and delivering clinical and care services, the Health Board has a wider public sector duty to support national policy, for example in respect of matters such as promoting equality and human rights, the environment, sustainable development, the Welsh Language and in moving forward socio-economically disadvantaged groups. |

# BCUHB STRATEGIC SERVICE REDESIGN CHECKLIST AND PRIORITISATION TOOLKIT*

**(*In development)**

**USING THE STRATEGIC SERVICE REDESIGN CHECKLIST AND PRIORITISATON TOOL KIT**

### STEP 1 – IDENTIFYING AREAS FOR STRATEGIC SERVICE REDESIGN

Circumstances under which a proposal may be considered:

- Pertains to a formally agreed pre-existing commitment.
- Meets at least one of the National Clinical Framework criteria for service reconfiguration, as below:
  **Criteria 1**: There is evidence that the outcomes for people are significantly below comparator providers or there are significant patient safety concerns.
  **Criteria 2**: There is no viable prospect of the service meeting professional standards and/or recommended minimum volumes of activity to maintain high standards of care.
  **Criteria 3**: The workforce required to safely and sustainably deliver the service is not available because it cannot be recruited, developed or retained - or can only be delivered by a dependency on agency or locum staff.
  **Criteria 4:** There is professional consensus on the merits of reconfiguring services to deliver an enhanced pathway or a new service model.
  **Criteria 5:** There is significant public support or democratic mandate to change a service model.
- Delivers BCUHB strategic objectives as per the BCUHB Clinical Services Strategy, including improvements to quality, outcomes and experience.

### STEP 2 – SERVICE REDESIGN CHECKLIST

Using the checklist will, see Table 1 overleaf will:

- Confirm the service redesign criteria apply and the development of a proposal can proceed.
- Ensure full consideration of the key factors that the proposal will need to address.
- Start the process of gathering the information required for prioritisation to take place. If subsequently identified as a priority, this information will also help support the development of the proposal into an implementation plan or business case.

**Table 1: Checklist - Factors to consider**

| Factors to Consider | | Checklist questions | Y | N | n/a |
|---|---|---|---|---|---|
| **1** | **Is change required?** | **(a)** Is this a formally agreed pre-existing commitment? | | | |
| | | **(b)** Does the proposal meet at least one of the National Clinical Framework criteria for service reconfiguration? | | | |
| | | **(c)** Will the change deliver BCUHB strategic objectives? | | | |
| *To proceed to development of a proposal at least one of the above must be 'yes'* | | | | | |
| **2** | **Strategic Fit** | **(a)** Is the proposed change consistent with the guiding principles and design features (where applicable) in the BCUHB Clinical Services Strategy? | | | |
| | | **(b)** Does the proposed change align to other relevant national or local strategies or plans? | | | |
| **3** | **Person centred co-design** | **(a)** Are pathways mapped using the person centred pathway methodology? | | | |
| | | **(b)** Is the proposal co-designed*? *\*Refer to BCUHB co-design guidance to confirm proportionality/requirements.* | | | |
| | | **(c)** Will the change have a positive impact on patient outcomes and experience? | | | |
| **4** | **Health Gain and wellbeing** | *Will the change have a positive effect on:* | | | |
| | | **(a)** Mortality - saving life | | | |
| | | **(b)** Longevity - prolonging life | | | |
| | | **(c)** Health-related quality of life and wellbeing | | | |
| | | **(d)** Population health - improvements against lifestyle indicators | | | |
| | | **(e)** Reducing harm | | | |
| **5** | **Clinical Effectiveness** | *Will the change safeguard or improve the quality, effectiveness and sustainability of clinical services? Specifically:* | | | |
| | | **(a) Impact on clinical outcomes:** will the proposal make a positive difference to clinical outcomes? Will it minimise the harm | | | |

| Factors to Consider | Checklist questions | Y | N | n/a |
|---|---|---|---|---|
| | (physical and psychological) that an illness or health condition could cause? | | | |
| | **(b) Evidence base**: Is supporting scientific evidence base available? For example, national guidelines and standards, NICE, benchmarking, best practice guidance, research etc. | | | |
| | **(c) Sustainability:** Will services be more sustainable i.e. operationally and environmentally, following the proposed change? | | | |
| **6** | **Population Health Need** | | | |
| | **(a)** Does the proposal meet population health need - current and forecast? | | | |
| | **(b)** Is the change proportionate? Does it strike a balance between the needs of a group of patients, the demands of the wider community and the need to respect an individual's human rights? | | | |
| **7** | **Reducing Inequalities** | | | |
| | **(a)** Have relevant Impact Assessments e.g. Equality, Socio-economic, Health, been completed and does the proposal address any issues of concern identified? | | | |
| | **(b)** Have accessibility issues e.g. rurality and availability of transport, been taken into account? | | | |
| **8** | **Value Based Health Care** | | | |
| | **(a)** Is the proposal consistent with Value Based Healthcare principles? | | | |
| | **(b)** Will the proposed change deliver a measurable benefit over the existing service provision e.g. outcomes, efficiency, productivity and effectiveness? | | | |
| **9** | **Transformation opportunities** | | | |
| | **(a)** Is the proposal the best way of delivering the service – have alternative options been considered/assessed? | | | |
| | **(b)** Are there opportunities to deliver the service in partnership? | | | |

| Factors to Consider | | Checklist questions | Y | N | n/a |
|---|---|---|---|---|---|
| | | **(c)** What are the transformation opportunities – shift left, workforce, estate, use of technology? | | | |
| | | **(d)** Does the proposal support and improve integrated delivery of health and social care? | | | |
| **10** | **Impact on other services** | **(a)** Is there an impact on other BCUHB service areas? | | | |
| | | **(b)** Is there an impact for non-BCUHB services? | | | |
| **11** | **Workforce** | **(a)** Will there be changed workforce requirements? | | | |
| | | **(b)** Will the change assist with recruitment and retention? | | | |
| | | **(c)** Will the change help meet training and education needs, including the requirements of the north Wales Medical and Health Sciences School? | | | |
| **12** | **Affordability** | **(a)** Is the cost of the proposal quantified – capital and revenue? | | | |
| | | **(b)** Can existing resources be reallocated to fund the proposed change and if not are alternative funding sources available? | | | |
| | | **(c)** Does the proposal provide an opportunity to release resources (staff time, estate and finance) for alternative uses? | | | |

## STEP 3: USING THE PRIORITISATION TOOLKIT

A pan BCUHB Prioritisation Framework incorporating the Toolkit is currently in development and will facilitate a consistent approach to the prioritisation of all Health Board plans including the large-scale strategic service change, which falls under the remit of the Strategy. The Framework and Toolkit will support the structured assessment of proposals and inform decisions regarding their relative priority to assist in agreeing the proposals to take forward via the BCUHB Clinical Services Plan and Integrated Medium Term Plan (IMTP).

The Prioritisation toolkit will enable a consistent and transparent approach for prioritisation exercises at programme and strategic level across the Health Board. The toolkit will reflect the main questions that require evaluation in order to make a decision based on key considerations around value and deliverability:

- Is this the right approach?
- What outcomes will be realised?
- What is the level of risk involved?
- Are resources available when required?
- Do we have enough detail to make an informed decision?

Testing of an approach is underway and will be refined based on the outcome of this before confirmation of the prioritisation toolkit.

**CLINICAL SERVICES STRATEGY**

**HIGH LEVEL SUMMARY ENGAGEMENT REPORT**

**INTRODUCTION**

This report provides a high level summary of the engagement activity undertaken to support the development of the north Wales Clinical Services Strategy.

Many individuals and organisations took the time to engage with us and we are immensely grateful for the valuable comments and suggestions made, which have influenced the final version of the Strategy submitted for Board approval.

In addition to the summary provided in this report we intend to publish a full engagement report that:

- Details all the engagement activity undertaken.
- Summarises the feedback themes and explains how these have been reflected in the final version of the Strategy.
- Sets out how this information will be used to support development of the Clinical Services Plan.

The report will be made available on the Health Board website with printed copies available on request. The intention is to submit the full enagagement report to the September meeting of the Health Board.

**OVERVIEW OF ENGAGEMENT ACTIVITY**

Engagement to develop the Strategy commenced in October 2021. Work on the Strategy was paused for several months to enable staff to focus on maintaining services over an exceptionally difficult winter period exacerbated by the Omicron variant. Engagement recommenced in March 2022 with the launch of wider engagement on 6th June concluding 30th June.

A number of of approaches to engagement were utilised including sessions with various internal and external stakeholders, for example, the six North Wales local authorities (elected members and officials), third sector partners, BCUHB senior clinical leaders, BCUHB Digital Team, Wrexham Redevelopment Group, Health Board members, BCUHB Stakeholder Reference Group, BCUHB Health Professionals Forum and the Community Health Council amongst others.

A Clinical Services Strategy webpage was created with links to an Engagement Summary document (also available in easy read format and as a BSL video and audio recording), a questionnaire and supporting papers including the full version of the draft strategy and appendices, with all content available in English and Welsh.

An invitation to participate in the Strategy development process, which included a link to the

webpage, was disseminated via email to key stakeholders (circa 250 organisations/ individuals) and all BCUHB staff (via CEO/Chairs weekly briefing), we also publicised via social media posts.

Feedback was reviewed on a regular basis throughout the engagement period and a number of themes emerged, which we have reflected in the Strategy.

## QUESTIONNAIRE

The questionnaire focussed on the key elements of the Strategy – the Vision, guiding principles and design features and enablers. In addition to indicating their agreement or otherwise to these elements respondents had the opportunity to provide comments relating to the questions and were also provided with a link to the full draft strategy engagement document and appendicies.

Respondents were also asked to provide some general non-identifiable details about themselves to help us categorise and analyse the feedback more effectively.

**Respondents -  information/demographics**

**557** survey responses (completed or partially completed)

**76%** female **20%** Male,  **4%** Prefer not to say or "other"  (385)

**37%** carers (147 0f 395)

**22%** state they have a disability (86 of 397)

**27%** (148) of respondents stated they work for a statutory health service organisation in

North Wales, the Health Board or a primary care provider

**Where did respondents come from?**

Responses fairly distributed across the six counties with largests responses coming from Conwy Gywnedd and Flintshire
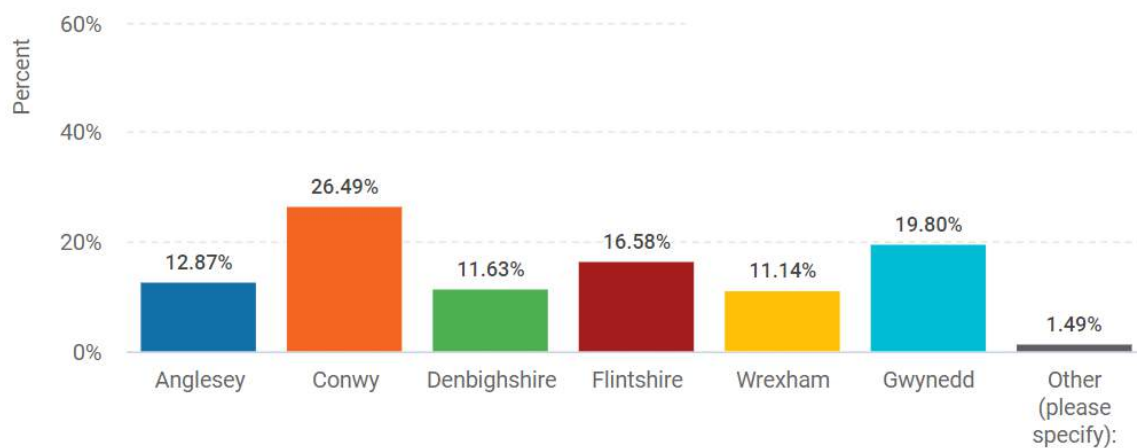


**Age of respondents**

Largest age ranges were between 45- 54 (97), 55-64(122) and 65-74(95)

| Age range | Percent | Count |
|---|---|---|
| 0 -15 Years | 0.50% | 2 |
| 16 – 24 years | 1.01% | 4 |
| 25 – 34 years | 3.53% | 14 |
| 35 – 44 years | 9.32% | 37 |
| 45 – 54 years | 24.43% | 97 |
| 55 – 64 years | 30.73% | 122 |
| 65 – 74 years | 23.93% | 95 |
| 75 and above | 6.55% | 26 |
| Response Total: | | 397 |
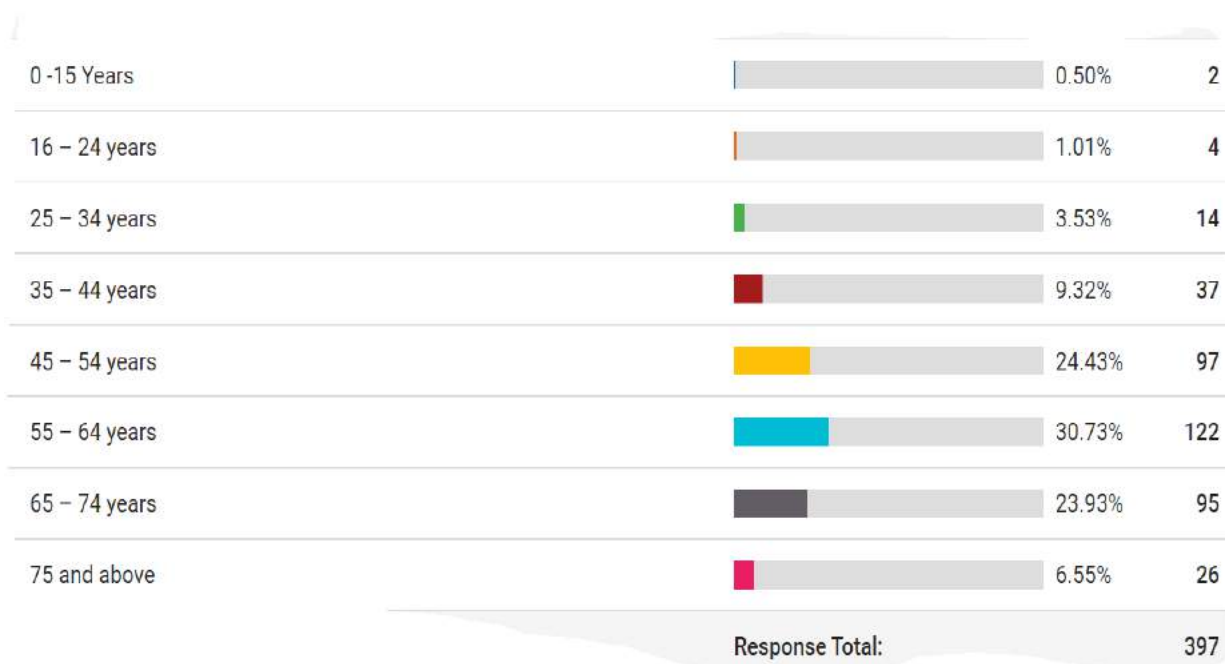
**Ethnicity**

Respondents idenified mainly as British or Welsh with a small number identifying as White/Black and English.
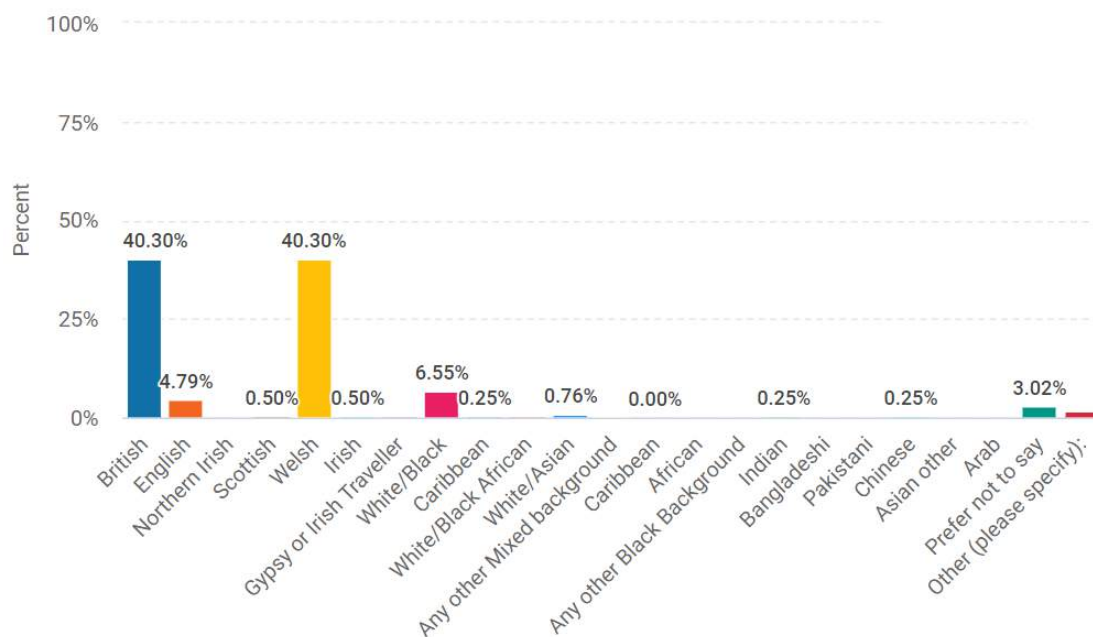


**Survey Results - Summary**

*"Do you agree or disagree that our vision fully captures the ambition we should have for clinical services in north Wales?"*

**78% agreed or strongly agreed**
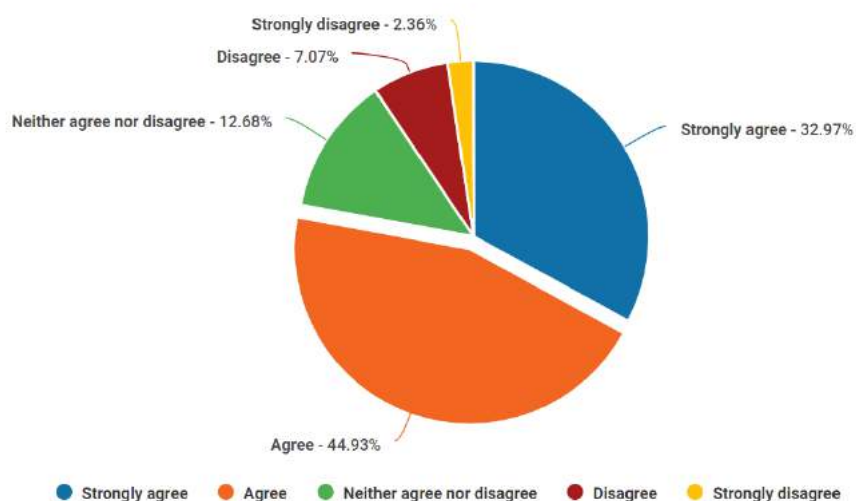
*"Do you agree or disagree that the proposed guiding principles are the right ones to ensure that our plans deliver excellent health and care services for the North Wales population?"*

82% agreed or strongly agreed with the proposed guiding principles
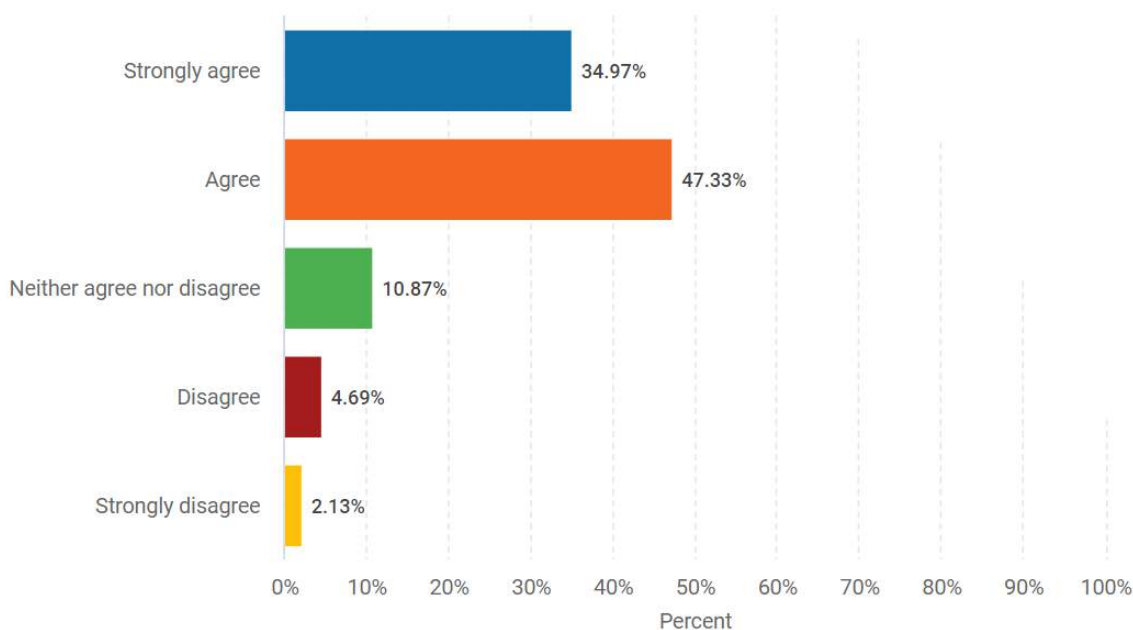


*"Do you agree or disagree that these are the right design features to help us develop proposals, which will result in excellent health and care services for the north Wales population?"*

75% agree or strongly agree, 12% disagree or disagree strongly with 13% neither agree nor disagree.
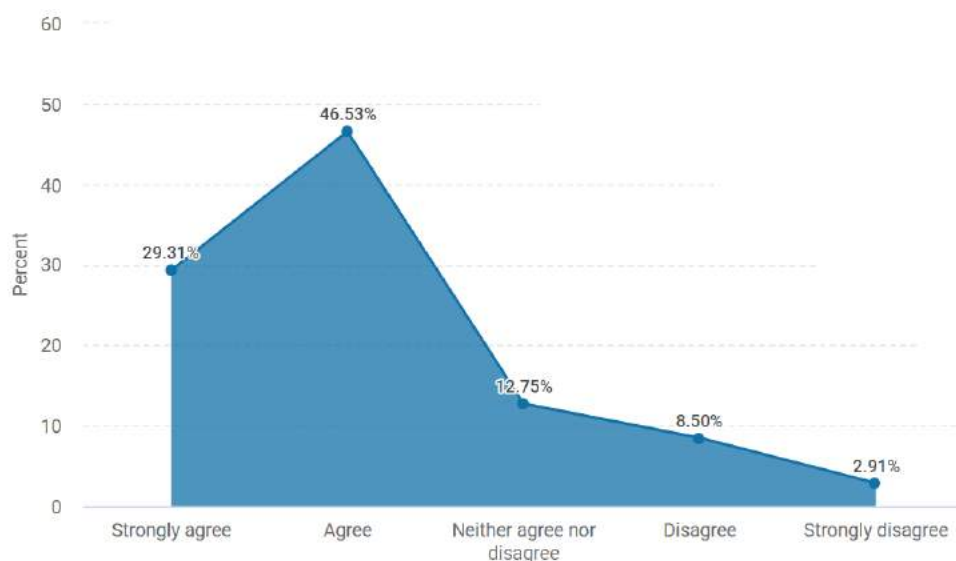
*"Do you agree or disagree that these are the right enablers and will support our plans to provide excellent health and care services for the north Wales population?"*

67% agree or agree strongly, 24% neither agree nor disagree with 9% disagree or disagree strongly. Based on the responses the enablers appear less important to respondents than the guiding and design principles.
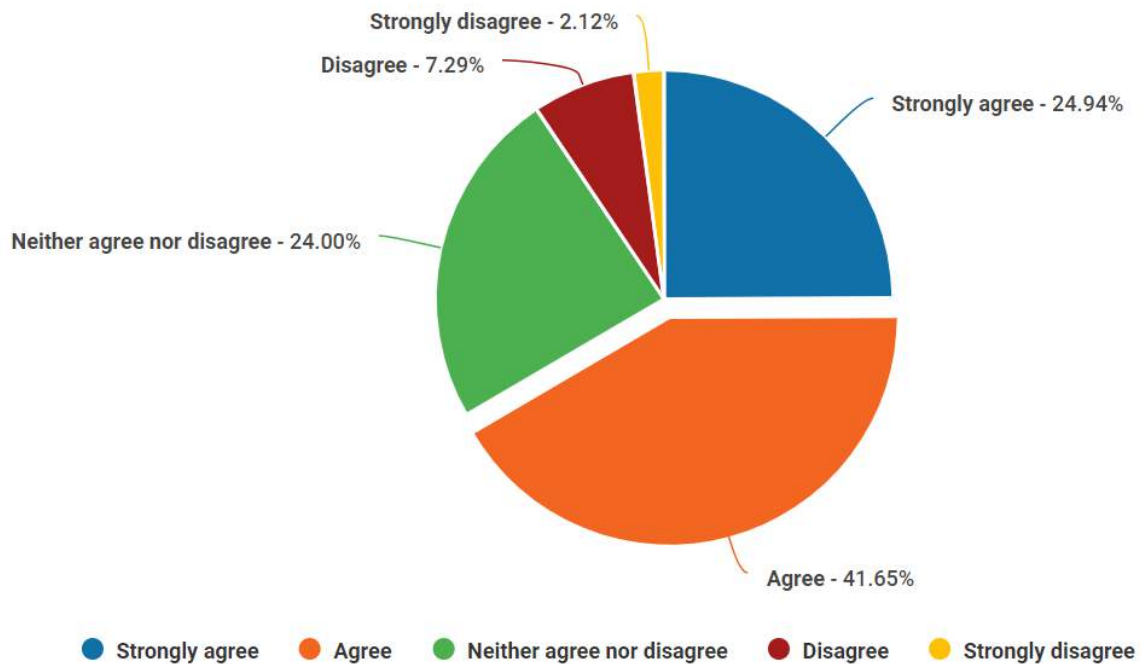


## RESPONSE TO SOCIAL MEDIA POSTS

There were 231 posts in response to information shared about the Strategy, a number of individuals posted multiple times. In general, feedback concerned specific issues relating to individual's current experience of our services.

## RESPONSE TO FACILITATED ENGAGEMENT SESSIONS

Health Board Planning Team members captured and analysed feedback from each session to identify key themes.

## KEY THEMES ACROSS ALL ENGAGEMENT ACTIVITY

Key themes were consistent across all engagement activity and were in keeping with feedback from other recent engagement – the Refresh of Living Healthier, Staying Well (LHSW) and the COVID conversations.

### *Deliverability*
Respondents acknowledged that the Strategy sets out our longer term aspirations but were concerned about our ability to make the changes needed recognising the significant challenges we currently face.

*Accessibility*
Difficulties in accessing primary care services, long waits of emergency care and waiting times were highlighted as priority areas for change.

*Improved communication*
Improvements in communication within the Health Board and between the Health Board and service users was identified as an area for improvement.

*Person centred holistic care and co-design*
Respondents were generally positive about person centred care and the co-design of services but noted the significant barriers to achieving this including – the need for a change in culture, better infrastructure particularly in terms of medical records, more staff and training and support for service users and staff to adopt this approach.

*Workforce, recruitment and retention*
Respondents welcomed developments such as the north Wales Medical and Health Sciences School and the Primary Care Academy but noted the shortage of health care professionals across the UK as well as further afield.

There was also a number of comments suggesting that more could and should be done to support staff welfare, health and wellbeing.

In addition to the above, several new themes emerged specific to the Clinical Services Strategy engagement.

*Virtual services*
There was a concern that whilst this had a place in the delivery of care it shouldn't become the preferred method of service provision.

*Regional Treatment Centres (RTCs)*
Respondents were keen to understand more about RTCs, specifically are they the best way of providing ambulatory care, their location and timescale for completion.

*Increasing the pace of change*
Whilst respondents recognised the complexity or making changes to an organisation as large and diverse as BCUHB, many expressed the view that there needed to be greater pace in our plans to deliver improvements particularly in planned care and unscheduled care.

| Report title: | **Living Healthier, Staying Well strategy refresh** | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 2.2 |
| Executive Summary: | The purpose of this paper is to present to the Board the full engagement feedback and the outcome report on the refresh of the Health Board's long term strategy, **Living Healthier, Staying Well** | | |
| Recommendations: | The Board is asked to receive the report, note the confirmation of the long term goals and the actions being taken in response to feedback. | | |
| Executive Lead: | Dr Chris Stockport, Executive Director of Transformation, Strategic Planning And Commissioning | | |
| Report Author: | Sally Baxter, Assistant Director – Health Strategy | | |

| Purpose of report: | For Noting ☒ | For Decision ☐ | For Assurance ☒ |
|---|---|---|---|

| Assurance level: | Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |
|---|---|---|---|---|

**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:**

N/A

| Link to Strategic Objective(s): | LHSW reflects the strategic direction for health and care set by **A Healthier Wales**. The strategy sets out the Health Board's long-term health and well-being goals as required under the Well-being of Future Generations (Wales) 2015 Act (WFG Act.) The strategy has fed into the draft Clinical Services Strategy, the development of which is a key action within the Targeted Improvement Framework. |
|---|---|
| Regulatory and legal implications | The refresh addressed legal requirements in relation to ongoing engagement and consultation, the equality and human rights specific duties on engagement and the expectation under the WFG Act that the organisational goals are shaped by engagement. |
| In accordance with WP7 has an EqIA been identified as necessary and undertaken? | Yes. An EqIA has been produced to support the review and refresh, and has also linked into impact assessments for the Integrated Medium Term Plan. There was a strong focus on equality and human rights considerations in the development of the initial strategy and we will continue to test with stakeholders that we are ensuring this is sufficiently embedded. The |

| | adoption of the planning principle of Fairness will support this. |
|---|---|
| **In accordance with WP68 has an SEIA identified as necessary been undertaken?** | Yes – a SEIA has been undertaken to support the refresh. |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | There is a risk that there continue to be challenges in delivery against the long-term goals set out within the strategy. The linking of the goals with Executive Delivery Group programmes will support closer connection between goals and delivery. |
| **Financial implications as a result of implementing the recommendations** | No specific financial requirements arising from this paper. The IMTP sets out the financial implications of the proposed investments in initiatives to implement the strategy |
| **Workforce implications as a result of implementing the recommendations** | No specific workforce implications arising from this paper. The IMTP sets out the workforce implications within the initiatives prioritised for implementation. |
| **Feedback, response, and follow up summary following consultation** | The refresh, engagement report and outcome report have been scrutinised by the PPPH Committee and Board in-committee session. The papers attached set out in detail the feedback following engagement and the follow up through linking to the IMTP. |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | N/A |
| **Reason for submission of report to confidential board (where relevant)** | N/A |

**Next Steps:**
**Implementation of recommendations**
- Ensure monitoring and review of the strategic goals annually linked to the IMTP process
- Publish a short summary document to raise awareness of the strategic goals and provide feedback to those who took the time to contribute to the review
-

**List of Appendices:**
Appendix 1 – LHSW refresh outcome report
Appendix 2 – LHSW engagement report

**Living Healthier, Staying Well strategy refresh**

## 1.    Introduction/Background

The Health Board is required to ensure there is a clear organisational strategy and a supporting clinical services strategy in accordance with the NHS planning framework.  These are also requirements under the Targeted Improvement framework.

The **Living Healthier, Staying Well** strategy was approved by the Board in March 2018.  During 2021 an exercise was commenced to review and refresh the strategy, as three years had passed since publication.  The context and environment in which the strategy was produced has also changed.  The publication of **A Healthier Wales,** subsequent to the production of Living Healthier, Staying Well,  set the long-term direction for health and social care in Wales.  The Covid-19 pandemic has also had a significant impact on health and well-being for all in our communities, bringing unprecedented challenges, but also opportunities to develop new ways of working.  It was timely therefore to check whether the goals set out within the strategy remained relevant.

## 2.    Body of report

Engagement was undertaken in late 2021 to support the refresh and an updated summary needs assessment was produced by the Public Health team, including a summary assessment of the impact on population health needs of the Covid-19 pandemic.

The overall feedback confirmed that the long term goals are still relevant.  There was rich and wide ranging feedback on a number of areas which informed the development of the Health Board's Integrated Medium Term Plan (IMTP) which was approved by the Board in March 2022, and will be implemented in 2022 – 23 as an Annual Plan.  Key messages have fed into the draft Clinical Services Strategy, which is submitted to the Board as a separate agenda item.

Feedback has been shared with the Health Board's senior management group so that issues raised in respect of individual service areas can be addressed.

The strategic goals will be used to guide the development of enabling strategies and plans within the Health Board and to inform the Health Board's contribution to partnership strategies and plans.

## 3.    Budgetary / Financial Implications

There are no immediate budgetary implications associated with this paper.  The implementation of the strategic goals will influence the allocation of resources within the Health Board, realised through the IMTP or annual plan.

## 4.    Risk Management

There remain risks associated with delivery against the strategic goals.  The connection of the Executive Delivery Groups with the goals and the linking of supporting strategies will facilitate more robust monitoring and management of risks arising.

**5.    Equality and Diversity Implications**

Equality Impact Assessment and SocioEconomic Duty Impact Assessment were undertaken to support the LHSW refresh prior to submission to the PPPH Committee and subsequently the Board for approval.  These will be kept under review, alongside the review of strategic goals associated with the IMTP refresh process for 2023 - 2026.

**LIVING HEALTHIER, STAYING WELL**
**Improving health, well-being and health care in North Wales**

**Refreshing our strategy**

Report to PPPH Committee May 2022

## Introduction

During 2017, we spent many months discussing what our priorities should be with patients, carers and community representatives, out staff and partner organisations.  This led to the publication of our long term strategy, **Living Healthier, Staying Well** (LHSW) in 2018.

Whilst we have made some progress in many areas, there is a lot more to do to fulfil our ambition and deliver against the priorities we had identified. Much has changed since the strategy was developed, including the onset of the Covid-19 pandemic in early 2020. In 2021, as we entered the later stages of the pandemic and what we hope is the recovery phase, we decided the time was right to review where we were:

- To review our existing plans and priorities, to ensure we are focusing on what is important as we begin to tackle the challenges facing us
- Check with our staff, patients, partner organisations and the public how Covid-19 has affected health and well-being and what we can do to learn from the experience
- And finally, to check whether our long term strategy for health and well-being is still relevant.

We asked people their views to support us in doing this.  A short engagement exercise took place using the discussion document (attached) to describe why we need to review our plans and priorities, recap the priorities we had set out, and describe what has changed.

You can find the detailed engagement report on our website.  This report summarises key areas identified for which our strategic approach is being refreshed, and how we will address these as we take the strategy forward.

## The strategic context

At the time of writing the long-term strategy, the Parliamentary review of Health and Social Care in Wales had recently published its initial report.  Since that time, Welsh Government has published A Healthier Wales: our Plan for Health and Social Care. This describes the ambition for health and social care services to work more closely together, providing services that are designed and delivered around the needs and preferences of individuals and with a much greater emphasis on keeping people healthy and well.  The plan is predicated on the quadruple aim:

The principles of A Healthier Wales are embedded into all of our planning and development work. We are working in partnership, through the North Wales Regional Partnership Board and supporting programmes, to transform how we deliver health and social care. We will work with Local Authorities to continue to deliver the transformation programmes we have commenced, to maximise the outcomes from the new Regional Integration Fund, and respond to the ongoing national work programmes on rebalancing care and support.



The Well-being of Future Generations Act placed new emphasis on improving the well-being of both current and future generations. In addressing the Act we have been moving to plan more for the long-term, work better with people, communities and other organisations, seek to prevent problems and take a more joined-up approach.

We have been working in partnership through the Public Services Boards in North Wales - Gwynedd and Ynys Môn, Conwy and Denbighshire, Flintshire, and Wrexham – to respond to the Act.

We have also increased our emphasis on sustainability, including environmental sustainability, in the Health Board. Green groups are established across North Wales and are introducing innovative practices to improve our response; there are a number of partnership schemes which focus on green health and the environment. We are currently finalising work on a **decarbonisation plan** for the Health Board which will be published shortly. In addition, through our Integrated Medium Term Plan, we have identified long-term sustainable funding for a number of initiatives which were previously funded through short term grant funding.

---

## Getting it right for the future – our long term goals: Responding to the engagement feedback

LHSW described our goals for health and well-being. These are as set out below.

- Improve physical, emotional and mental health and well-being for all
- Target our resources to people who have the greatest needs and reduce inequalities
- Support children to have the best start in life
- Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being
- Improve the safety and quality of all services
- Respect people and their dignity
- Listen to people and learn from their experiences

**The overall feedback on our long term goals was that these are still relevant.** In the online survey undertaken, the overwhelming majority either strongly agreed or agreed with this. Many people identified that the first goal – improving health and well-being for all – was most important, although a similar number felt all the goals should be of equal priority.

Specific feedback was given on a wide range of themes, which have been shared with relevant leads in the Health Board to feed into the planning, development and delivery of their services. There were a number of themes that were more widely recognised and these are summarised below, with our response.

- **Our goals are too aspirational and are not recognised as being delivered**

Notwithstanding the support for the goals as set out, there were many comments that the goals feel aspirational and that delivery has not progressed as it should have. We need clear and measurable objectives, performance indicators and focus on outcomes. Our **Integrated Medium Term Plan for 2022-2025** sets out clear and SMART actions for delivery against priorities, with short, medium and longer term outcomes identified. We are increasing focus and pace to refine or develop high quality, evidence-based pathways to underpin and deliver against both Living Healthier, Staying Well and the developing Clinical Services Strategy.

We are also developing set of clear metrics which will help us to understand and be able to demonstrate how much we have done, how well we have done it, and who is better off as a result. This work will be completed in the early part of 2022-23.

- **Support for children and young people**

Supporting children to have the best start in life was again considered relevant by the majority. It was felt more education would help young people embed the importance of healthy lifestyles including diet and exercise. Infant feeding education for mothers helps promote a health start in life. We know that giving children the best start in life can make a significant difference, and that getting it right can also reduce lifelong health problems such as heart disease, diabetes and cancer. These areas are a key focus of the **Population Health** programme. Partnership working is essential in addressing these needs and there is a newly established children's sub-group of the **Regional Partnership Board** through which we will work to develop our support in this area. We also recognise the levels of concern regarding children and young people's mental health needs, exacerbated by the impact of the pandemic and the CAMHS development programme under the Targeted Improvement Framework is focusing on delivery of improvements.

- **Dignity, respect, quality and safety**

Whilst some felt that dignity, respect, safety and quality should be embedded in all that we do, we know there is further work to do. Our **Strategic Equality Plan** recognises and supports the promotion of FREDA principles – Fairness, Respect, Equality, Dignity and Autonomy - - and as a Health Board we need to continue to strive to embed these in all that we do.
There is also further work to be done to ensure that we understand and address variation in performance against quality standards. Our **Quality Improvement Strategy** is to be reviewed and refreshed and will support this goal. There are specific initiatives within our IMTP such as development of the Atlas of Variation which will facilitate this. The principle of information driven improvement is also key within the draft Clinical Strategy which is currently being developed.

Quality also encompasses the experience of patients and their families, and we need to focus on ensuring compassionate care is delivered consistently.

- **Ability to deliver the strategy due to organisation culture, leadership as well as staff capacity and well-being**

In the original LHSW strategy, the need to support, train and develop our staff to excel in order to fulfil the long-term goals was recognised, and workforce issues were woven into the supporting programmes of action. However, feedback has emphasised the need to recognise and address staff well-being, capacity, recruitment and retention, as well as organisational development, skills and leadership. Our **People Strategy & Plan** addresses these issues and the need for strategic organisational reset, building upon the learning from previous years and particularly through the Covid19 pandemic, working with our people to create the environment for improvement, transformation and ultimately delivering better services, experience and outcomes for our patients and the citizens of North Wales.

- **Mental Health access and waiting times**

There were a number of concerns raised regarding access to and waiting time for mental health support and care, and concerns regarding the levels of support post-pandemic. Improvement plans for mental health are set out within our IMTP and are being taken forward in partnership across health, social care, third sector, those with lived experience of mental health needs, their carers and families. There has however been positive feedback in relation to a number of initiatives including the iCAN programme. The IMTP sets out plans to take forward the improvement plans for mental health care and support as well as extending the iCAN programme.

- **Care closer to home**

There are concerns regarding access to GP and dentist services in particular, considered to be much more difficult because of the pandemic. The role of pharmacists was highlighted as a positive aspect. Both positive and negative aspects of digital appointments were raised, with the recognition that there needs to be flexibility to meet individual needs. It is recognised that these are national challenges which will take some time to address. The IMTP details a range of schemes to be taken forward in North Wales, including the Accelerated Cluster Development Programme, further development of the Primary Care Academy, urgent primary care centres and widening the primary care workforce.

- **Access to hospital care**

Understandably, the engagement exercise generated much comment regarding access to hospital care, both planned and unscheduled (urgent or emergency.) Waiting times have increased significantly during the pandemic, worsening an already challenging position. The planned care programme team is working to refine finalise and deliver the planned care recovery proposals set out in the IMTP, to restore core activity affected by the Covid-19 pandemic and to develop additional activity. Unscheduled care pressures continue to generate high demand on our hospitals and other urgent access services. Our unscheduled care programme is developing proposals to address the local situation aligned to the national six goals identified for unscheduled care, which will be updated early in 2022/23.

Understanding our population health and trends is critical to ensuring we are able to focus on delivery of our strategic goals. We know that some aspects of health and well-being have deteriorated as a result of a number of significant influences over recent years, not least the impact of the Covid-19 pandemic, but also the impact of austerity and economic well-being. We also know from the evidence that the pandemic, and the measures introduced to control this, have exacerbated health inequalities in a number of areas.

During 2021 our Public Health Team reviewed and updated the key data relating to health needs. The summary reports are included as appendix 1. We know that in North Wales we have an ageing population, with the percentage of the population aged 85 years and over expected to increase by 66% by 2043. However, we also know from recent analysis of trends that there has been a stalling in life expectancy and a slowing down of improvements in mortality rates from circulatory diseases. This is similar to trends in other countries.[1]

Covid-19 has had far reaching consequences on all aspects of life, including both physical and mental health and well-being. Some groups have been disproportionately impacted by the pandemic including older people; Black, Asian and minority ethnic groups; children and young people, in particular mental health; low skilled workers and the most disadvantaged members of society. There is also some evidence of similar groups being adversely affected by the impact of Brexit, and at greater risk from the impact of climate change.[2]

During 2021, along with our Local Authority partners on the North Wales Regional Partnership Board (RPB) we have supported the development of the second Population Needs Assessment (PNA.) This assesses the care and support needs of the population and identifies gaps or development needs in the services required to provide this care and support. The PNA was approved by the Health Board and endorsed by the RPB in March 2022. This will inform the revision of the regional partnership action plan (by 2023), and inform the Market Stability Report which is now being developed.

The Public Services Boards (PSBs) are currently producing updated Well-being Assessments. The Well-being Assessments are required by the Well-being of Future Generations Act and will address broader aspects affecting well-being including prosperity, health, resilience, equality, vibrant culture, global responsibility and cohesive communities. Although the PNA and Well-being Assessments are being run as separate processes, there are working links between the teams developing the assessments. The Well-being Assessments will update our understanding of these broader aspects and enable us to work with the wider partnerships to develop well-being plans for each area.

We have also developed Locality Needs Assessment for each of the 14 localities across North Wales, which will enable a greater focus on needs and variation in needs at a local level. These assessments will support the further development of the Integrated Health and Social Care Localities, aligned to the Accelerated Cluster Development Programme, and wider place-based planning.

---

[1] Life Expectancy and Mortality in Wales 2020, Public Heath Wales, 2022

[2] Rising to the Triple Challenge of Brexit, Covid-19 and Climate Change for health, well-being and equity in Wales, Public Health Wales, 2021

# Equality and human rights

The LHSW strategy set out our ambition to adopt a rights based approach which places human rights at the centre of our policies and practice, and the person at the centre of his or her own care. This approach is based on the values of Fairness, Respect, Equality, Dignity and Autonomy.

Feedback on this area shows there is a lack of certainty amongst people responding to our survey as to whether we have delivered on this commitment. However, a range of detailed comments received drew attention to areas of concern. These aspects point to the need to re-emphasise our commitment and to ensure it is enacted.

Since the publication of the strategy, there have been a number of significant developments in the equality and human rights field including:

- Implementation of the socio-economic duty from April 2021 and the requirement to assess the impact of strategic decisions
- Consultation on the Wales Race Equality Action Plan, which will require fresh commitment to delivering on anti-racism and race equality, when the final plan is published
- Emerging evidence of inequalities being exacerbated, as described above, during the pandemic but also as a result of austerity, Brexit, and the potential impact of climate change
- Publication of a range of further important evidence and guidance documents, such as Locked Out - Liberating disabled people's lives and rights in Wales beyond Covid-19, and the Code of Practice on the Delivery of Autism Services, amongst others.

There have been some positive actions during the pandemic which have recognised and addressed the challenges we have faced, such as the Equity Steering Group which has supported the Covid-19 vaccination programme in reaching groups that are seldom heard and less likely to access services. We will learn from the approaches used in this programme to inform future delivery models.

We have committed as an organisation to putting the UN Convention on the Rights of the Child at the centre of all that we do, and work is currently underway to develop a Children's Rights Charter for North Wales. We have also committed to working to fulfil the UN Principles for Older Persons and will ensure that these principles are recognised in our strategic planning and delivery.

Further work is needed to embed equality and human rights, including socio-economic factors, consistently into all that we do, and particularly to be aware of the impact of intersectionality. We are also mindful that the Covid recovery programme, which will address the ongoing impact of the pandemic, access and waiting times, must be responsive to specific needs including digital inclusion, travel and access, and the rebuilding of relationships with groups who have experienced barriers to services during this time.

The **Strategic Equality Plan** sets out more detailed actions to be taken to address equality and human rights matters and is an important enabling plan for the delivery of this strategy.

We are continuing to progress actions to fulfil the Welsh Language Standards and are clear in our commitment to promoting the Welsh language and culture. We recognise people's rights to use the language of choice in healthcare and the positive impact this has on health outcomes for that person and the experience for them and their family.

An Equality Impact Assessment and a Socio-economic Duty Impact Assessment have been undertaken in support of the review and refresh process.

## Taking forward our priorities

A number of messages emerged from the engagement exercise regarding the need for greater clarity on the strategic direction of the Health Board. People reported that the vision within LHSW seemed right but that it was difficult to translate into ideas for service development that fitted together and ensured we prioritised those areas that would best deliver LHSW. This has led to the creation of the 'Plan on a Page' approach to link together our various strategies, values, and the absolute need and commitment to work in partnership and distil them into 5 BCUHB Planning Principles.

Using our Plan on a Page will help simplify our priorities for the whole Health Board and will make sure every change is designed to have the biggest all-round impact.





| | | |
|---|---|---|
| **Fairness** | we will reduce avoidable and unfair differences in health |
| **Well-being & resilience** | we will maximise prevention, self-care, well-being, and strong community networks |
| **Right place** | we will provide services that are sustainable, delivered close to where people live where it is safe and effective to do so |
| **Excellent care** | we will design services that can deliver world-class outcomes and experience for patients |
| **Employer of choice** | we will work, and organise, improve and transform ourselves, to support our teams to flourish |

From 2022 onwards we will test all of our developments against the 5 Planning Principles as a matter of course. The principles are hard-wired into our business case and planning cycle such that an early test against the principles occurs in all cases. Furthermore, our Transformation and Improvement Team will ensure the principles are built into individual pieces of continuous improvement activity, where a more formal business case is usually not required.

## Next steps

We will monitor, review and evaluate to ensure that the refreshed strategic goals and priorities are driving the delivery of improved outcomes, better patient experience and contributing to improved health and well-being for the population.  Work is underway to confirm a set of metrics that will facilitate this clarity.  The linking of the Health Board's delivery groups with the goals is being mapped and will enable greater line of sight from goals to delivery.

During 2022-23 we are also developing our **Clinical Services Strategy and plan**, which will provide the framework for addressing strategic service models and development, based on a set of design principles which will be subject to discussion and debate with our clinicians, our wider staff group, patients, carers, and representatives of partner organisations and the public, before finalising.  The Clinical Services Strategy builds on the goals in Living Healthier, Staying Well and the plan will begin to set out the next layers in relation to design and delivery of our services for the future.  Engagement on the draft strategy is underway, and further more specific engagement will support the co-design and development of specific service plans.    Proposals will need to be consistent with the planning principles, and address the whole pathway of care and support, focusing improving outcomes and quality.  Further details are set out within the draft strategy which is being produced for engagement.

A short, public facing document setting out the key messages from the LHSW engagement and how we are responding to these is being developed, which will be published, together with the full engagement report, in order to ensure people who contributed their views are kept informed about what we are doing to respond and address the issues raised.

## Betsi Cadwaladr University Health Board

### Population

**703,360 persons**

| Age group | BCUHB (%) | Wales (%) |
|---|---|---|
| 0-15 | 17.6 | 17.8 |
| 16-64 | 59.0 | 61.2 |
| 65+ | 23.4 | 21.1 |
| 85+ | 3.1 | 2.7 |

### Children & Young People

5.6% of singleton births in BCUHB are of low birth weight and 5.9% in Wales.

90% of 4 year olds in BCUHB and 88% in Wales are up to date with vaccinations.

70% of 5 year olds in BCUHB are of healthy weight compared to 74% in Wales.

Risk factors for mental illness in childhood include parental alcohol, tobacco and drug use during pregnancy and poor parental mental health.

Poor mental health has a significant impact on a range of outcomes during childhood, including poor educational attainment and a greater risk of suicide and substance misuse, through into adulthood.

| | BCUHB | Wales |
|---|---|---|
| Percentage rating their life satisfaction as 6 or above | 80 | 81 |
| Mean loneliness score** | 5 | 5 |

SWEMWBS: Short Warwick-Edinburgh Mental Wellbeing Scale
*SWEMWBS scores range from 7-35; a higher score reflects more positive wellbeing
** Loneliness scores range from 3 (less frequent loneliness) to 9 (more frequent loneliness)
Estimates show that in BCUHB, around 9,280 children aged 5 to 16 years have a mental health condition.

### Inequalities

BCUHB has some of the most deprived areas in Wales, with 12% of the population living in the most deprived fifth in Wales.

Almost a quarter of children and young people under the age of 20 years live in poverty in Wales. Across BCUHB this ranges from 18% in Gwynedd to 25% in Denbighshire.

Rhyl West 2 is the most deprived area in Wales, followed by Rhyl West 1.

**Welsh Index of Multiple Deprivation, 2019**

Ten most deprived areas in Betsi Cadwaladr UHB.

| LSOA Name | LA Name | WIMD Rank |
|---|---|---|
| Rhyl West 2 | Denbighshire | 1 |
| Rhyl West 1 | Denbighshire | 2 |
| Queensway 1 | Wrexham | 9 |
| Rhyl West 3 | Denbighshire | 11 |
| Rhyl South West 2 | Denbighshire | 19 |
| Glyn (Conwy) 2 | Conwy | 20 |
| Wynnstay | Wrexham | 45 |
| Rhyl South West 1 | Denbighshire | 57 |
| Abergele Pensarn 2 | Conwy | 70 |
| Tudno 2 | Conwy | 78 |

### Main causes of mortality

Cancer, heart disease and respiratory disease are the leading cause of death in BCUHB.

Main causes of death as a percentage of all deaths in BCUHB.

| | |
|---|---|
| Cancer | 27 |
| Circulatory | 25 |
| Respiratory | 11 |
| Mental & behavioural | 8 |
| Other | 30 |
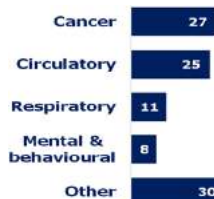
Evidence & data based on latest published sources which are available as an appendix.
The impact of Covid-19 is presented in a seperate infographic.
Infographic created: September, 2021

### Older People

North Wales has an ageing population.
The percentage of the population aged 85 years and over is expected to increase by 66% between 2021 and 2043.

Around 10% of people aged over 65 live with frailty, rising to between 25% and 50% for those aged over 85. Frailty is characterised by issues such as reduced muscle strength and fatigue and describes an individual's overall resilience,

Falling is a key concern for older people and a major contributing factor to their social isolation. There were 1,009 hip fracture admissions in BCUHB in 2020.

Flu immunisation uptake in 65 year olds and over is 78% in BCUHB and 77% across Wales.

Older people are vulnerable to experiencing mental health problems. Depression and dementia are the most common problems.

Around 11,600 people aged 65 and over in BCUHB with dementia, this number is predicted to increase to around 18,700 by 2040.

### Behaviours affecting health

| | BCUHB (%) | Wales (%) |
|---|---|---|
| Smoking | 18 | 17 |
| Use of e-cigarettes | 6 | 6 |
| Drinking above guidelines | 18 | 19 |
| Active at least 150mins in previous week | 55 | 53 |
| Fruit & vegetable consumption | 26 | 24 |
| Overweight/obese | 55 | 60 |
| Follow 0/1 healthy behaviours | 9 | 10 |

### Mental health & wellbeing

Mental health and wellbeing are impacted by deprivation, housing insecurity, employment, loneliness and ethnicity.

Mental ill health is associated with increased physical ill health and reduced life expectancy.
Poor mental health is also associated with increased risk-taking behaviour and unhealthy life-style behaviours.

BCUHB has a mental wellbeing score of 52.4, which is higher than Wales (51.4), a higher scores suggests stronger mental wellbeing.

It is estimated that the number of people in North Wales with a common mental disorder will increase from about 93,800 in 2020 to 94,200 by 2040.

A large proportion of Emergency Department attendances and general admissions to hospital are related to mental health problems.

### Chronic Conditions

**Percentage of patients registered with a North Wales GP surgery as having a chronic condition**

| | BCUHB (%) | Wales (%) |
|---|---|---|
| Hypertension | 16.9 | 15.9 |
| Diabetes mellitus (patients aged 17+) | 7.8 | 7.8 |
| Asthma | 7.6 | 7.4 |
| Cancer | 3.7 | 3.3 |
| COPD | 2.7 | 2.4 |
| Atrial fibrillation | 2.6 | 2.4 |
| Stroke & transient ischaemic attack | 2.2 | 2.2 |
| Heart failure | 1.1 | 1.1 |

Patients with chronic conditions are recorded by GPs on registers are part of the Quality Assurance and Improvement Framework (QAIF). Limitations of the data include variation in practice coding and recording of data.

# Impact of COVID-19 on
# Betsi Cadwaladr University Health Board

COVID-19 has had far reaching consequences on all aspects of life, including both physical and mental health.

Since the start of the pandemic, there have been in BCUHB directly related to COVID-19:
- almost 58,900 confirmed cases
- around 2,100 community onset hospital admissions
- over 1,000 deaths

Some groups disproportionately impacted by Covid including older people; Black, Asian and minority ethnic groups; low skilled workers; and the most disadvantaged members of society.

## Long Covid

Prevalence of long covid ranges from 2.3% to 37% in those infected.

Fatigue is the most common symptom. Almost 6 in 10 of those with long COVID report it has negatively affected their general well-being; their ability to exercise; and their work.

Possible risk factors include increasing age, female sex, overweight/obesity, pre-existing asthma, pre-pandemic poor physical and mental health, and hospitalisation for initial infection.

## Impact on Children & Young People

Childline has reported 'unprecedented demand' for service during the coronavirus pandemic.

32% of young people with mental health needs reported that coronavirus had made their mental health much worse.

The Coronavirus pandemic is likely to have a particularly significant impact on children living in poverty.

## Impact of health & social care staff

Staff fatigue, particularly for those who have been on the front line over the last 12 months.

Staff absence due to infection; isolation; or caring responsibilities.

## Impact on mental health & wellbeing

Drivers of worsening mental health during the pandemic:

- Job and financial loss
- Social isolation
- Housing insecurity and quality
- Working in a front-line service
- Loss of coping mechanisms – contact/exercise/work
- Reduced access to mental health services

People in the most deprived groups are more likely to be very worried about their mental health during the coronavirus pandemic.

## Impact on Older People

Those with pre-existing mental health conditions have experienced an increase in the severity of their symptoms; others are experiencing symptoms for the first time.

1 in 3 older people agree that their anxiety is now worse or much worse than before the start of the pandemic.

Proportion of over 70s experiencing depression has doubled since the start of the pandemic.

Impact of isolation on physical health:
- 1 in 3 have less energy
- 1 in 4 older people are unable to walk as far as before
- 1 in 5 feel less steady on their feet

95.7% of BCUHB residents aged 80 years and over have received 2 doses of the Covid vaccine compared to 95.0% across Wales.

## Impact on health & social care services

COVID-19 has had a major impact on health and social care services across Wales, including:

- Reduced capacity in emergency departments and hospitals as a whole.
- Disruption of clinical service provision resulting in large backlogs in services.
- Number of people waiting over 52 weeks is at its highest ever.
- People delaying contacting GP about worrying symptoms, which could impact on treatment and outcomes.
- Increase in demand for mental health services; estimated 25% increase in demand for hospital services, translating to around 10,000 referrals.
- In mental health services, particular impact on CAMHS, Eating Disorders, Memory Assessment Services and access to Psychological Therapies referrals.
- The coronavirus pandemic has been an exceptionally stressful and challenging time for care home staff, residents and their loved ones.
- Financial impact for many social care providers due to the cost pressures of additional infection prevention and control activity; insurance liabilities; and staffing constraints, along with reduced income.
- Many unseen and unreported issues that have built up during the pandemic will emerge, placing increased demands social care services.

Produced alongside a BCUHB general population health and wellbeing infographic.
Evidence & data based on latest published sources which are available as an appendix.
Infographic created: September, 2021

# Living Healthier, Staying Well:

# Strategy Refresh Engagement Report

## 1. INTRODUCTION

**Living Healthier Staying Well (LHSW),** our long term strategy for health, well-being and healthcare, was published in 2018.

Since the strategy was published, the external environment has changed considerably. We must respond to the unique challenges arising from the Covid-19 pandemic including the increased pressures in primary care services, the increased backlog in planned care and the impact that Covid has had on people's mental health and well-being. We must also respond to the Welsh Government Plan 'A Healthier Wales' which sets out an ambition for health and social care services to work more closely together and deliver services that are better tailored to the needs of communities.

It is timely therefore to review and refresh our strategic goals and priorities to check that our long term strategy for health and well-being is still relevant and to ensure that we focus on what is important as we begin to tackle the challenges that lie ahead. To support this, we asked people's views through a short engagement exercise that took place in the last quarter of 2021. This report summarises the approach and the findings.

## 2. The engagement approach

We have undertaken a range of engagement activities designed to help us understand whether the public, patients, staff and key partners think that the principles and priorities set out in the LHSW strategy are still relevant. We are not starting from scratch, but building upon the extensive programme of engagement undertaken when developing LHSW in 2017 / 2018. For this reason, the engagement has been 'light touch' rather than a full formal consultation. The findings have informed the refresh of LHSW and the development of the Health Board's Integrated Medium Term Plan (IMTP) and will subsequently be used to inform the Clinical Services Plan.

Due to the on-going coronavirus pandemic engagement was undertaken through a number of different channels including:

- An on-line public survey
- Social media platforms such as Facebook and Twitter to promote key messages and a public survey
- Dedicated LHSW web pages
- A dedicated email address and telephone line
- LHSW Wakelet to provide information in a range of accessible formats
- Links to surveys and information shared widely through regional, area and community networks and groups
- Staff engagement through internal communication channels, building on approaches developed through the Stronger Together programme

- Telephone interviews with key partners
- Health Board and partnership forums
- Health Board workshop sessions

Documentation to support the LHSW engagement programme included:

- A bilingual LHSW discussion document and summary document
- A bi-lingual LHSW discussion document in an accessible format

The programme of engagement was formally launched on 15th September 2021 and ran for six weeks, although discussions with key partners such as the North Wales Community Health Council and the Regional Leadership Group had been taking place prior to this date.  A mid-point review took place on the 8th October 2021 to consider the feedback received to date and make adjustments as necessary to the engagement activity e.g. further promotion of the survey with key partners.

As part of our approach, we held a number of focused events and general discussions with a wide range of groups including the Stakeholder Reference Group, Community Health Council (CHC) Service Planning Committee and Full CHC Council, Regional Leadership Group, Equality and Human Rights Strategic Forum, North Wales Cancer Network, Regional Partnership Board, Public Services Board's and Health and Well-being Networks

Targeted engagement sessions were also held with a small number of groups representing different interests:

- Virtual LHSW Q&A Sessions (30 people)
- Fresher's Fair – Wrexham
- (West Area) Engagement Practitioners Forum (42 people)
- (East Area) Engagement Practitioners Forum (25 people)
- Chinese Association lunch (60 people)
- Diabetes Q&A event (24)
- Palliative Care Q & A event (22)

Engagement varied from providing general information and signposting to the LHSW website to more considered and deliberative sessions with groups and stakeholders.

## 3. The online survey

The key engagement tool and source of feedback however was through the online public survey. This was promoted on the Health Board's website, social media, namely Facebook and Twitter, and shared widely with the public, key partners, third and community sector networks and groups.  In total **312** people completed the survey. Key findings are summarized below.

### 3.1 About the respondents

### Geography

Respondents were fairly representative across the six local authorities with a higher response rate coming from Conwy and Flintshire followed by Wrexham. 40% of questionnaires from Gwynedd were completed by BCUHB staff.
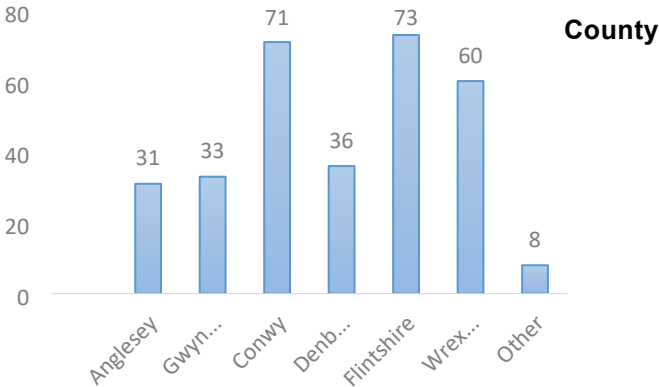


### Age
There was a spread of ages but the largest number of respondents were between the 45-55 and 55-64 age groups.
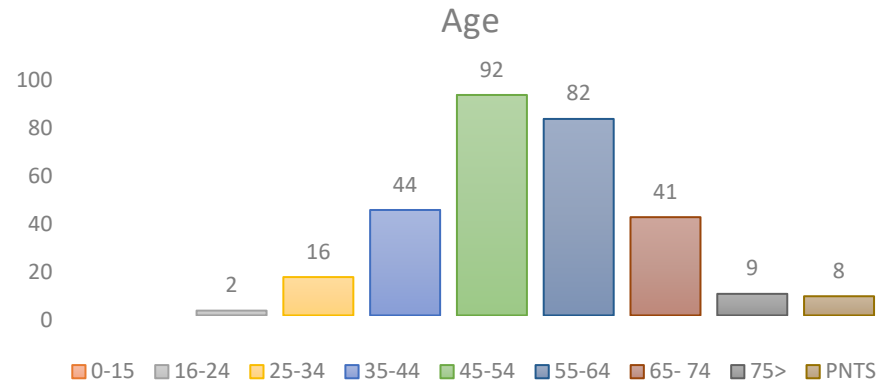
From the completed equality monitoring information it was noted that just over 79% of the respondents were female. 2021 population estimates suggest a ratio of 49% male to 51% female in North Wales.

## Respondents by Sex

12, (4%)

50, (17%)

- Male
- Female
- Prefer Not To Say

230, (79%)

99 (32%)

213 (68%)

- BCUHB Employee
- Non BCUHB Employee

March 2022 final
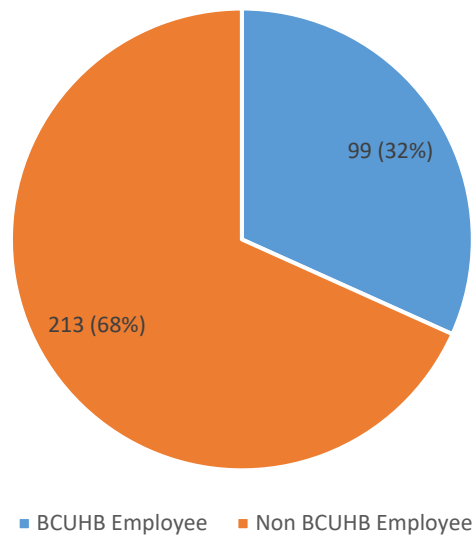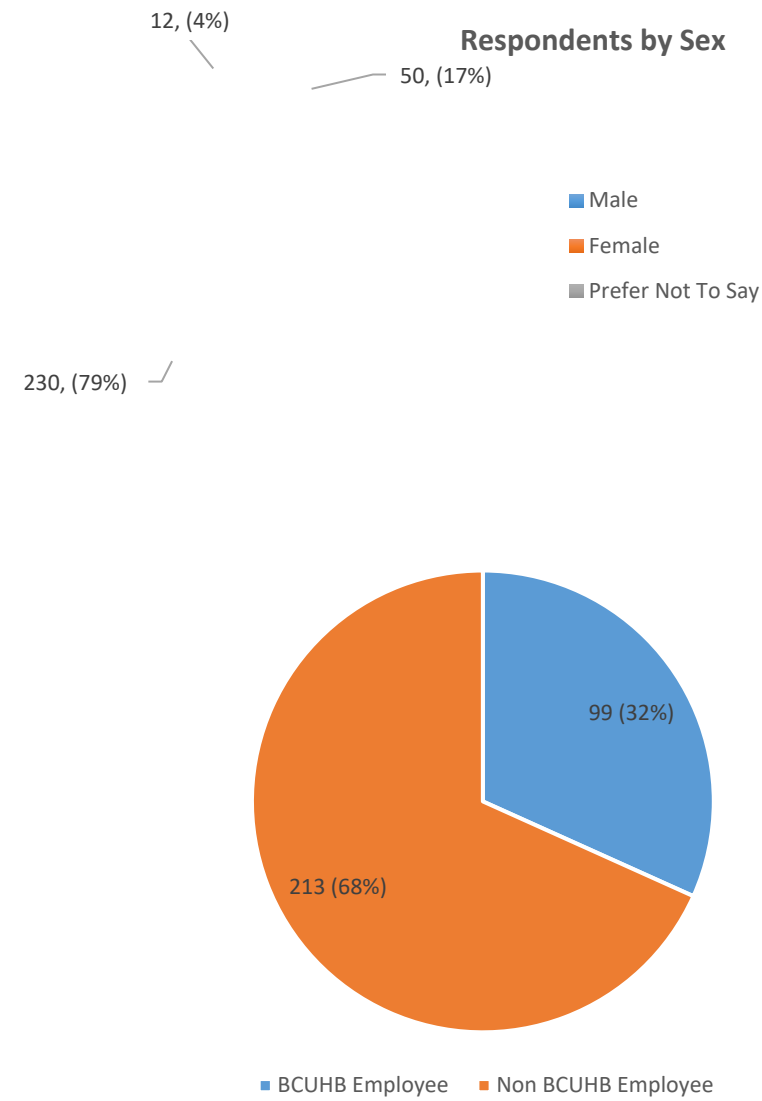
## Ethnicity

| Ethnicity | Count |
|---|---|
| Prefer not to say | 6 |
| Other | 2 |
| Asian Other | 1 |
| Pakistani | 2 |
| Indian | 6 |
| African | 1 |
| Chinese | 22 |
| Caribbean | 1 |
| White/Asian | 1 |
| White/Black | 10 |
| Irish | 4 |
| Welsh | 92 |
| Scottish | 3 |

99 respondents (32%) identified as working for the Health Board

The majority of respondents described themselves as British or Welsh with the next highest ethnicities being English and Chinese. When respondents were asked if they considered themselves to have a disability 47 (19%) stated that they did

## Do you consider yourself to be disabled?

12 (5%)

47 (19%)

183 (76%)

■ Yes  ■ No  ■ Pefer not to say
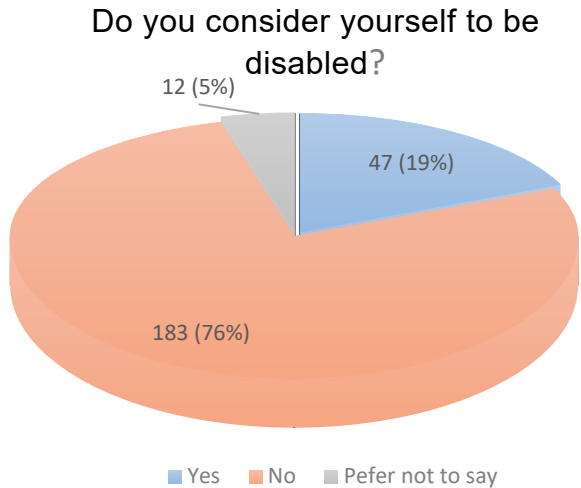
## 3.2 Are our Goals still relevant?



Pie chart legend:
- Strongly agree
- Agree
- Neither agree nor disagree
- disagree
- Strongly disagree

Data labels:
- 160 (51%)
- 99 (32%)
- 24 (8%)
- 13 (4%)
- 16 (5%)
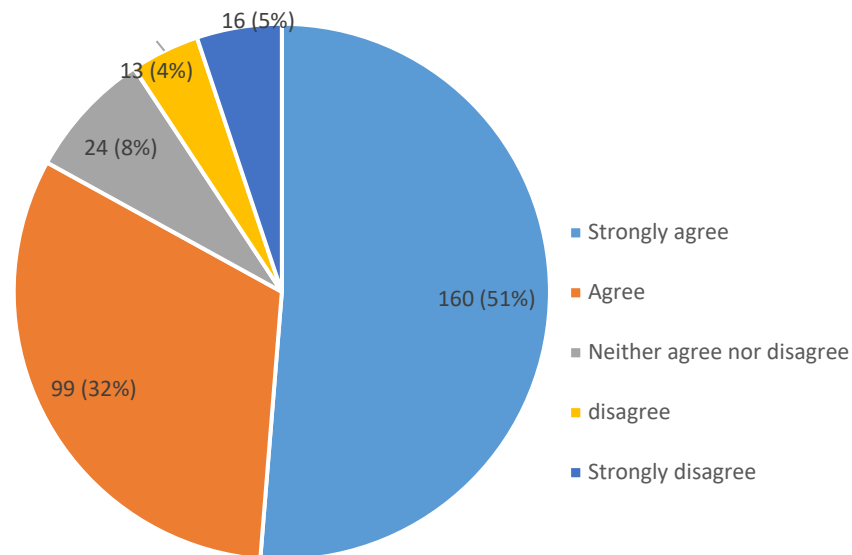
When asked if the strategy goals are still relevant, 259 respondents agreed or agreed strongly that they were.

Although there was significant support for the relevancy of our goals, the comments highlighted a number of concerns or areas for improvement.  A number of themes emerged from this question including that the goals are too **aspirational** and there is **lack of delivery**.  There was a view that the strategy should focus on clear and measurable strategic objectives, improving systems and processes, delivery models and pathways and include Key Performance Indicators (KPIs).

Improvements in **access and waiting times** in both primary, acute care and mental health should be given greater emphasis in the organisations goals especially where intervention is time-critical, for example, in mental health.

The importance of **prevention** was raised with specific references to mental health and early years including educating children, infant feeding, maternal health, and education on the spread of disease.

A number of comments reflected the view that there are **insufficient resources** to deliver the goals and that there should be a greater focus on treating people including **collaboration** with third sector partnerships.

"But we need to know how are they going to be achieved. For example improving mental health by creating x service or employing x number or new physiologist etc."

"I agree with them but feel they are more aspirations rather than goals BCUHB is delivering on"

"General public's perception is that the Trust is not functioning, I think your main priority should be reducing timescales for appt and operations - that's what people really care about"

"The strategy should be a pathway focus of interventions and models of patient access and the attributes (e.g. respect and dignity and Q&A are really a given aren't they - not part of a strategy? It might be helpful to clarify what most people ASSUME is a given - like safety, treating people with dignity and the strategy focus on what service delivery models and pathways."

*Please indicate any goals you think are a priority*

Although the majority of respondents agreed that our goals are still relevant, the survey asked if there were any goals the Health Board should prioritise. Whilst over 44% indicated all goals were equal, respondents indicated that improving physical and mental health & well-being (45%) and listening to people and learn from their experiences (44.7%) should be given priority. Through the comments a number of themes began to emerge.

**Improving access and waiting times:**
In response to this question, over a third of the comments related to improving access and waiting times.  This related to both primary care & acute hospitals and predominantly referred to tackling the backlog of those waiting for treatment due to the pandemic, difficulty accessing GP services and waiting times in emergency departments. There were also specific references to screening, diagnostics, surgery, neurology, dental and emergency care.

New ways of working such as employing the use of digital technology was acknowledged as positive and could be extended to include digital case notes and 24/7 access. Use of this technology should be balanced with the reintroduction of the option for face-to-face appointments with a GP for those who need it and the re-opening of MIUs. Visiting access should be reinstated especially for patients with dementia.

*"It seems impossible to get an appointment, either online or in person at my GP surgery. I'm happy to just speak with someone on the phone but the constant "no appointments left" followed by "go to A&E" is now unacceptable. I know the way this service is delivered is changing but apart from Drs/Nurses not being available nothing else seems to be in its place. 111 is extremely helpful but the help stops when it says you need to see your GP."*

**Workforce:**

Recognising the importance of staff welfare was considered a priority. This included sufficient numbers of GPs, nurses and unqualified staff, better succession planning, faster recruitment, less reliance on temporary staff and ensuring staff feel valued and appreciated. Improving staff retention prospects and support for overseas nurses was considered important. Further suggestions include a reduction or streamlining of management posts and redirecting funding to front-line services.

**Mental Health & Learning Disability:**

The need for extra support for mental health services due to the pandemic was flagged as a priority area. Crisis support and specifically but not exclusively extended support for people with long Covid, children and young people, carers, substance abusers and those experiencing loneliness and on the margins of society. Also highlighted was a desire to improve the knowledge of mental ill-health in some GP practices and again use of Third Sector partners.

 *"The continuing chicken and egg scenario of mental health and substance misuse. Access to mental health services is difficult if you misuse substances. Misusing substances leads to mental health issues. A holistic approach is needed. A more rapid response too - no one should have to wait 6-months to get support when they are in crisis now"*

**Communication:**

Improving the quality of communication with patients and between hospital, primary care and community services was also an emerging theme. This includes frequent and prompt information, ensuring dignity and respect at all times and ensuring proportionate influence. Improved mechanisms for listening and engaging both internally and with partners, and further development of the Welsh language provision were encouraged.

**Leadership & development:**

It was suggested that the Health Board might work differently and more collaboratively with best-performing organisations and that managers should be seen to lead by example.

**Other suggested priorities raised included:**

- Tackling climate change and promotion of the sustainability agenda as an additional organisational goal.

- Prevention and social prescribing with a focus on chronic conditions and obesity and better use of the Third Sector and partnerships.
- Services for minority groups and diverse communities run by staff that are members of these communities e.g. LGBTQIA+, Black and Asian Minority Ethnic people, Gypsy Roma Travellers, disabled people
- The need to improve performance management
- Equalising work standards and policies across North Wales, improve the integration of services and less working in silos.
- Working with partners e.g. care homes and community initiatives
- Parking, transport and outsourcing maintenance
- More help for the terminally ill

**3.3 How the strategy goals are being put into practice?**
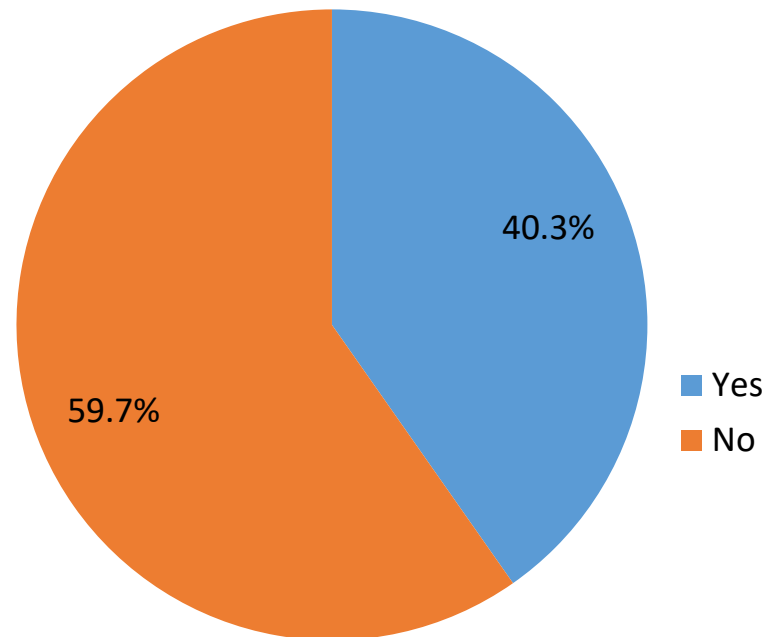


Almost 60% of respondents felt that they had not experienced the strategy goals put into practice. When asked what has worked well or what needs improving, respondents highlighted a number of issues as set out below.

**What's working well**

Most frequently cited areas felt to be working well included aspects of care closer to home. This was mainly around the use of digital technology as an enabler but there were also examples such as specialist teams supporting GPs in the primary care setting (diabetes and spinal services) and Community Resource Teams (CRTs). Referral to rheumatology was considered good; however, the wait for podiatry was felt excessive. Inpatient care was referenced as working well but follow-up and aftercare was in need of improvement.

It was suggested that here are many areas within BCUHB that require a service similar to that provided by the BCUHB Health Improvement Team, which covers Caia Park, Central Wrexham and Flint.

Cancer services were also identified as being considered responsive to people's needs.

**What needs improving**

Access to services was the most frequently commented theme for improvement with GP access being the most frequently cited.

> *"I have seen Primary Care services steadily getting worse over the last 5 years. I have a heart condition but I have to beg and demand a once a year check for blood pressure, blood testing, weight etc. This year they refused to check my weight or blood pressure and said when I eventually get acute symptoms I should present myself to A&E. This is hardly a pro-active approach to holistic care, and is also potentially much worse in terms of health outcomes and resources."*

It was also commented that there is a need to improve hospital admission systems and availability outside of normal working hours. Some felt that the use of digital communications needs to be proportionate and at times used too frequently, whilst others would welcome expanding the use of this medium in more secondary care settings and for more home monitoring.

*"Have a telephone appointment in November with consultant - however, not sure how this will work as I am deaf!"*

Other areas where improved access is required includes community mental health, cardiology, neurology, diagnostics, dental, phlebotomy and podiatry.

*"My father with atrial fibrillation had a TIA but wasn't seen by anyone despite GP referral and went on to have a stroke a week later."*

*"Support for people in crisis whether physical or mental health has reduced. Things like HECS no longer seem able to respond in a timely fashion. Originally set up to support early discharge and preventing hospital admission - now seem to be aimed at palliative care."*

Early intervention is viewed as extremely important for children. The use of community pharmacists as a 'one-stop-shop' and potentially extending well-being support e.g. for alcohol and obesity. The IBD helpline was considered a valuable resource which has now ceased.

There was a view that, with the exception of cardiac rehab referrals (which was an example of a service that works well) rehabilitation services such as pulmonary, falls, and diabetes services were poor at delivering exercise initiatives within rural communities.

**Workforce** related issues such as lack of continuity of care due to the employment of locums and recruitment and retention were flagged for improvement together with staff welfare and well-being and accessibility to the staff well-being centre. Staff attendance at learning disability awareness training was highlighted as an area for improvement.

Several issues were raised in terms of improvements required in hospital care and bed availability. These include speed of access, waiting times, emergency departments and appointments running over; discharge, follow-up processes and quality of care. Safety standards for people entering community hospitals was raised as an area for improvement.

**3.4 How effective do you think the Health Board has been in delivering improvements to the health and well-being of its residents?**



Pie chart legend:
- Extremely Effective
- Very effective
- Somewhat effective
- Not so effective
- Not at all effective
- I haven't noticed any new actions

Pie chart values: 5 (1%), 22 (7%), 98 (32%), 65 (21%), 58 (19%), 62 (20%)
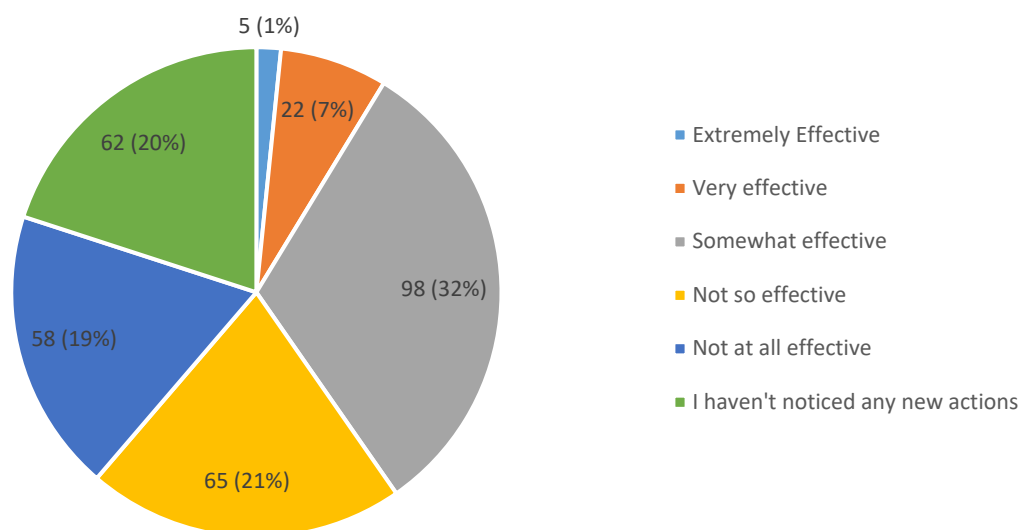
Asked about how effective the Health Board has been in delivering improvements to the health and well-being of its residents nearly 32% said that the Health Board had been somewhat effective. Approximately 60% of respondents said it had not been effective or that they hadn't noticed any new actions. Only 8.5% felt that the health board had been effective in delivering improvements to the health & well-being of its residents.

Of those who felt the Health Board had been somewhat effective in delivering improvement, the view was expressed that the Health Board's ability to implement its plans has been adversely affected by the pandemic and the government could have done more forward thinking to support this. The success of the mass vaccination programme and provision of 'online appointments', which could be expanded further to save patients travelling to hospital, was highlighted as effective.

Comments referenced that reduced services have yet to be reinstated and in some areas telephone consultations are the new norm. Additional stress and pressures placed on staff during the pandemic were acknowledged.

A desire for more working in partnership, prevention of ill health and investment would improve outcomes. A reduction in bureaucracy to facilitate this was also highlighted.

The use of alternative channels to offer advice and support should be encouraged and better facilitated.

*"The pandemic brought its challenges but also brought about opportunities to the way we work. The introduction of greater, slicker IT systems mean that we can connect with our service users however, the GP practices seem even more harder to reach than ever before. It feels like surgeries are using the pandemic as an excuse to not see our service users which in turn puts pressure on the community and acute services."*

*"I noticed the common ailments scheme which has the potential to be helpful, but hasn't worked for me due to the unavailability of the pharmacist during my lunch breaks, and then having to make an appointment with her for ten days later and take time off anyway."*

It was also suggested that staff involvement in service improvement might be improved:

*"There are some great initiatives but care would improve greatly if patient facing staff were given more opportunity to input into these services. Many issues missed by management are obvious to staff on the ground"*

This was an issue reflected at the public Q&A session too.

It was commented that to be successful there needs to be an effectively resourced whole-system commitment across the BCUHB. This should include primary & secondary care and social care.

*"new monies have tended to focus on addressing critical demands for services to "make people better"; rather than working in partnership to keep people well"*

*"It is very difficult to get through to a GP, waiting over 20 minutes in hold to be told "someone" will call you back. At times, there is no call back and you have to begin the process all over again"*

*"Lack of timely assessments and support has exacerbated mental ill-health symptoms for many people."*

There was an acknowledgement that deterioration is in part due to Covid-19, however there was a view that services are not recovering as quickly as they should and problems that existed pre-Covid still persist.

*"I speak to people who feel let down all the time. I had to call the PALS team to help me contact my consultant."*

*"I had a bad experience when referred to MIND and have had no further support. I feel I can't go and see a Dr no matter what is wrong with me, and I'm worried for the future"*

**3.5 Improving Health and Reducing Health Inequalities**
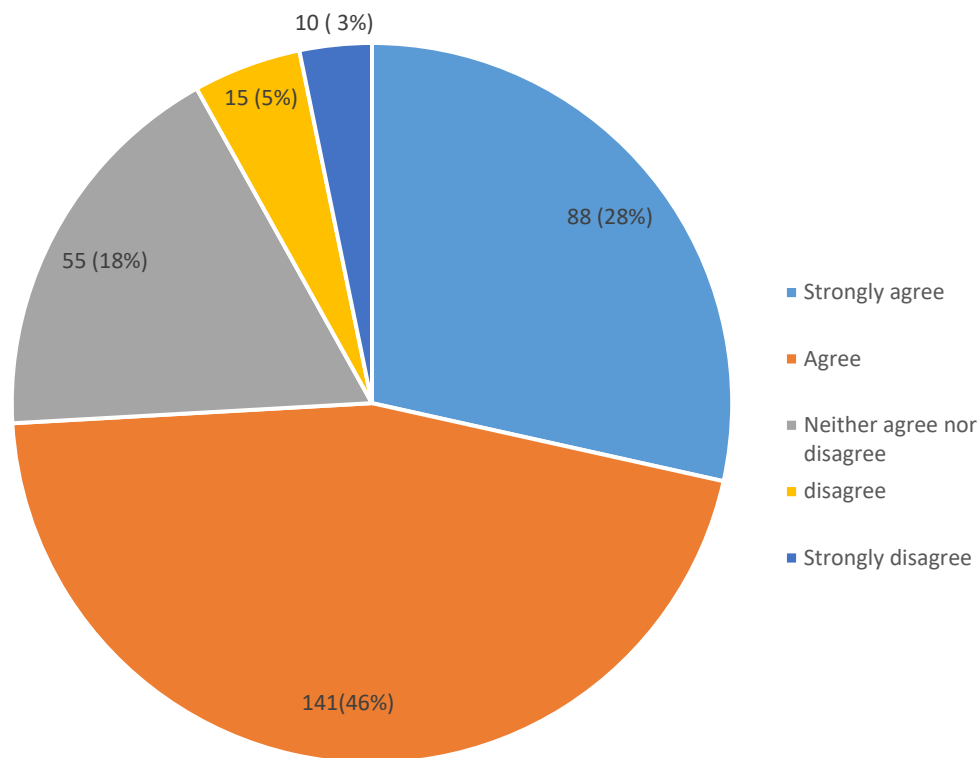


When asked if improving health and reducing health inequalities was still the right approach 74% of respondents agreed or agreed strongly that it is.

Comments reflected the view that empowering people to address their own health and well-being was important. It was felt however that some people did not want to take responsibility for their own health so incentives such as discounted facilities or classes for cooking and fitness for could be offered.

It could also be made easier for people to access help through a combination of options including digital and face-to-face appointments.

Making information available, however, isn't enough and efforts to communicate better and in a non-patronising way such as having honest conversations about weight, smoking and the barriers people experience were considered to be important. Improving staff communication skills was seen as especially important for people with learning difficulties. Other areas included providing more education to children with dietary issues / harmful lifestyle choices and giving patients access to their own health records.

**Early intervention** such as encouraging people to come forward early especially those living in rural areas is important:

*"The NHS are very reactive and I think by providing a yearly check-up for patients, early detection could reduce the demand on secondary care services later on"*

*"For many we still don't step in early enough and the result can be very expensive emotionally for families and more expensive financially for the Health Board and its partners in health and social care."*

It was suggested that the Health Board should invest in more prevention into mainstream services.  Examples include increasing resources for mental health to improve waiting times and ensuring sufficient resources are available when patients are discharged:

*"It seems a patient can still be discharged from hospital into the care of a partner who has a severe medical problem, no carer is available to support the couple.  How can this be acceptable?"*

A number of respondents asked how BCUHB knows if improvement is happening and questioned how improvement is measured.  There was a feeling by some that improvement is not being achieved or evidenced.

There was a view that whilst promoting and supporting healthy lifestyle choices and a focus on the quality and safety of services it should be acknowledged that poverty, poor housing, unemployment, stress, air pollution etc. also have a huge impact on people's health.

## 3.5 Primary and Community Services

Strongly disagree 17 (5%)

Disagree 21 (7%)

Strongly agree 71 (23%)

Neither agree nor

Agree 131 (43%)
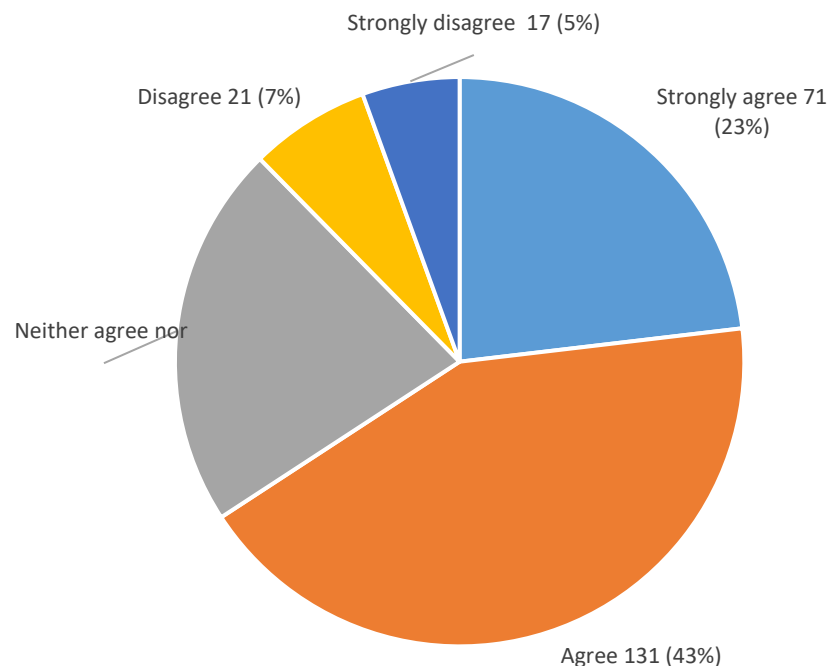
When asked if ensuring local services meet people's needs in the right way and at the right time was the right approach, 66% agreed or agreed strongly.

### Accessibility

Many people who agreed with the approach however felt that help and advice should be more accessible or available, particularly for older people. It should be simple, easy to understand and in different formats and people should be able to speak to someone when more help is needed. There should be time slots for digital appointments and better use of appropriate partnership organisations e.g. the third sector. Quality of information and advice is essential and there must be trust in the competencies of health professionals giving the advice.

There needs to be a way to destigmatise conditions affecting health e.g. diabetes, to allow for better engagement in self-care and there is a responsibility for making 'self-care' decisions on behalf of others e.g. children.

*"I do worry though that when the NHS talks about people 'managing their own heath' that they have the cause and effect the wrong way around e.g. they mean that if only everyone ate healthily and exercised there would be far fewer sick people. I think that misses out on all the things that are actually in the power of the NHS and other public services to change that would improve people's health and living conditions so that they have the time and energy for healthy behaviours."*

**Need to see visible actions**

A number of people felt that initiatives were not visible or that they had not experienced them.

*"I agree it is the right approach but it is not translating into practice."*

**More resources needed to deliver**

Some people gave examples of the areas for investment to deliver this approach more effectively, this included:

- GPs
- Parents of children with complex needs during pandemic
- Practical community support for carers
- Partner organisations capacity to deliver

The following were cited as good examples of this approach:

- Musculoskeletal service signposting
- Amlwch GP use of Facebook for signposting
- Benefit advice for cancer patients

**The limitations of signposting**

A number of respondents however felt that signposting should be complementary and not a replacement for medical care, suggesting people may be less likely to seek treatment when it is needed and that signposting can feel to some like 'passing the buck'. There was a view that some people do not realise that they need the help or sometimes need more practical steps than advice.

There was a worry that underlying issues may not be identified and that some people are left feeling dismissed and being "*bounced around*" and their needs not acknowledged. Responsibility for care was considered by some to sit with the clinician rather than the individual.

*"Too many 'management plans' in mental health signpost people to sources of advice information and support! The buck stops with the clinician (when there is one available) to provide the necessary advice, not to 'signpost'*

**3.6 Addressing more serious needs (hospital care)**
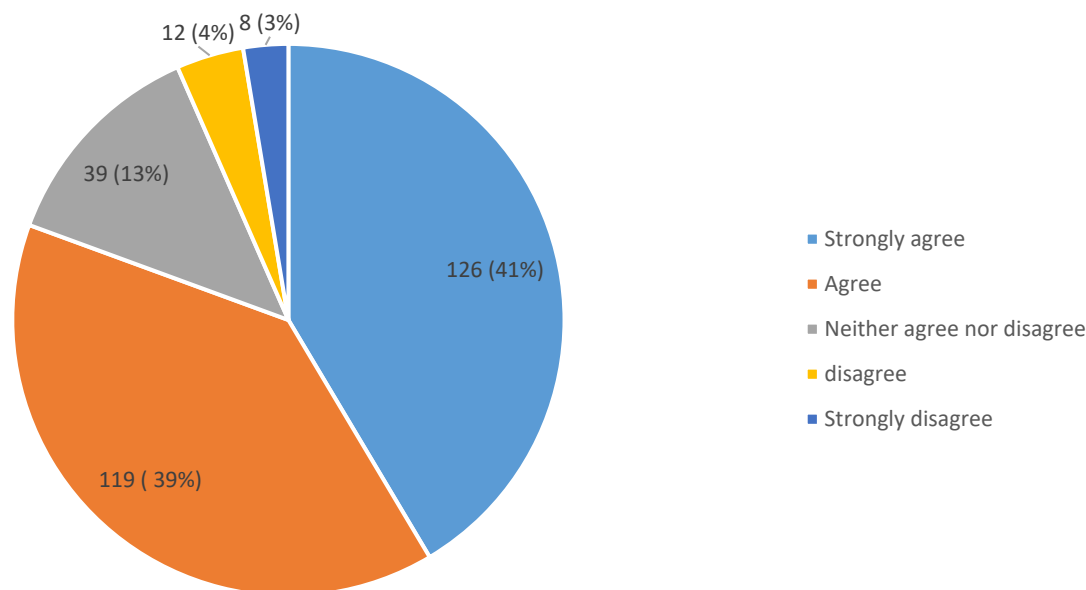


When asked about the Health Board's aim of ensuring people are able to get support more quickly for more serious needs, 80% agreed or agreed strongly that this was the right approach to take. A number of comments stressed the need to improve access to alternatives to emergency departments (EDs).   It was suggested that some people are going to EDs as an alternative when they cannot access a GP. This may have worsened since Covid and the reduction in face-to-face appointments.  Other suggestions to improve this include:

- Minor Injury Units (MIU) - more would help reduce the pressure on EDs
- Community hospitals: review the role with a view to potentially extend
- Self-care - empowering people
- English providers - devolution precluding access to services across the border
- Increase ED support and efficiency
- Better communication including media messages & offer the right / same services
- Improve efficiency at EDs with better monitoring of attendances with triaging by Advanced Nurse Practitioners (before entry) to challenge and deter inappropriate attenders and redirect to, for instance a pharmacy or MIU

- Better understand the pressures on staff
- Properly resource 3 sites and social care to support discharge from hospital
- Medical school and more research in N Wales

*"I think there needs to be a 24 hour out of hours proper triage i.e. can you go home till morning and a clear pathway if deteriorate - genuine integrated working with patients and staff"*

*"The hospitals should be the end of a journey where other alternatives have been utilised in the community - high engagement and support from Primary Care services are needed to support at early stages of treatment"*

*"It is, but Wrexham hospital is complete train smash.... the A&E department actually lost my mother for c 12 hours recently, it clearly struggles from a resource perspective, so how is this being addressed?"*

Some respondents commented on the geography of North Wales, particularly its rurality and the need to maintain hospital emergency services in the three areas, especially during the summer months when demand increases. The proximity to the English border and catchment population of the Eastern area were also referenced.

*"A&E and ambulance services are at capacity and are straggling to meet the need of the patients"*

*"I would say that more local services are always better but understand that there are constraints which mean that ensuring top quality at these three sites key. Access from more rural areas still an issue."*

*"there is too much of a burden on the acute services at the moment as they are also dealing with the chronic care that Primary services are not able to cope with."*

**3.7 What would it mean for you if you were asked to travel further to get treatment sooner or more specialised care?**

Over half the people who answered this question said that they were willing to travel to get treatment sooner or for more specialised care.

*"I would accept this - my daughter has shared care between COCH & Whiston as Whiston is the regional centre for her clinical requirement."*



Legend:
- ■ Willing to travel
- ■ Would / could prove problematic
- ■ Depends on other factors e.g. distance, patient need, circumstances, availability of transport

Pie chart values: 54%, 28%, 18%
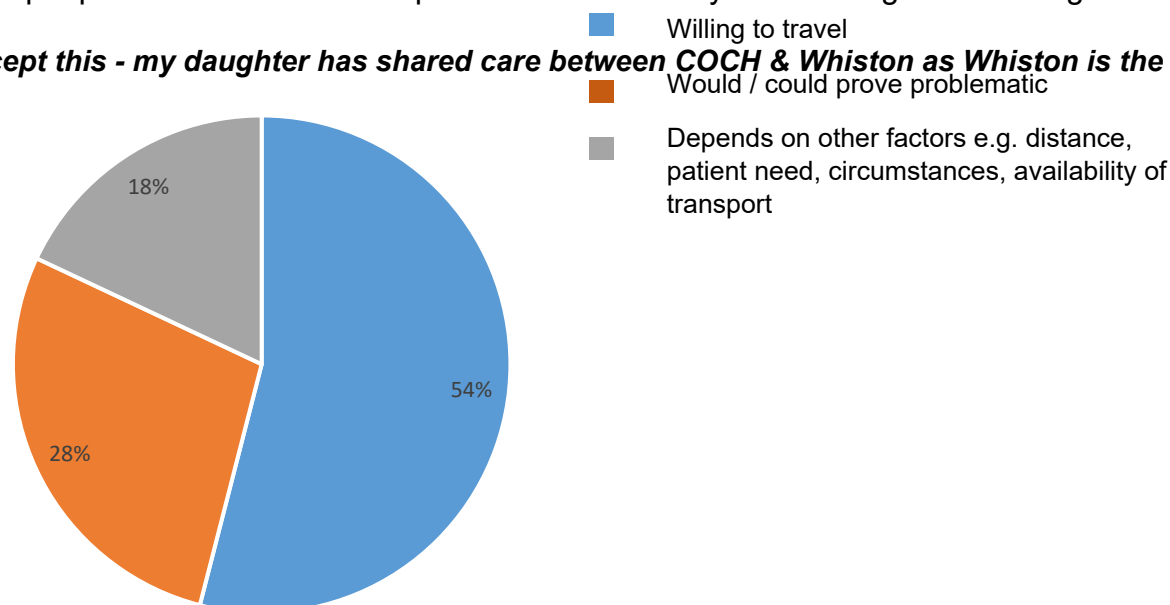
There was largely an acknowledgement that this is dependent upon circumstances including their state of health, the distance and their support network (or lack of) and a recognition that, the implications of travelling would have a much greater impact on some members of society.

*"Not a problem for me personally but aware some people would need to access public transport etc. which is not appealing during the pandemic"*

*"I would be happy to do this to access specialist care but I have my own transport and friends who would help me"*

*"I could accept that but those of more limited means would need support. This might well be cheaper than maintaining so many services on all three sites."*

Other respondents suggested that these types of factors may affect their ability to travel to get treatment sooner or specialist care and would therefore not commit to accepting this approach nor rejecting it.

*"It depends on how far I'd have to travel, whether I was in a healthy enough state to travel on my own, public transport links to the location, and what condition I am in."*

*"Depends upon distance and what you receive when you are there. I waited 2 years for a 5 minute appointment. It was useless. All I was told I knew and then was told to look online! As if I hadn't thought of that!"*

*"Care should primarily be local but if super-hospitals were built and services could be accessed sooner then I agree."*

Other people commented that it would prove problematic for them to travel to get treatment sooner or to receive specialist care. There was a view that travelling to get treatment sooner or for specialist care is likely to create greater inequalities for some of the population of North Wales particularly for older people, those with disabilities or complex needs and those on low incomes.

Insufficient transport infrastructure was a major concern including cost, the road network, availability of public transport especially during the pandemic and lack of hospital transport.  There would be a greater reliance on support networks and carers for transportation purposes and people may be less likely to seek the treatment they need.

Other factors of concern include mobility, the physical and mental health of the patient, urgency, childcare, increased time off work, visiting and communication with relatives. Some people felt that some communities within North Wales already have to travel significant distances to access the nearest hospital.

*"Lots of people already travel long distances - it is not reasonable to expect them to travel further except in exceptional circumstances or for very specialist treatment."*

## 3.8 Equality and human rights matters

When asked if the Health Board had delivered on its commitment to promote equality and human rights just under a third agreed it had. However, 120 respondents neither agreed nor disagreed with this statement, with a further 25% of respondents disagreeing with the statement.

A high number of comments perceived that the Health Board was not delivering on its commitment to promoting equality and human rights. Comments included barriers to accessing services, the need to make reasonable adjustments and working towards improved outcomes for all.
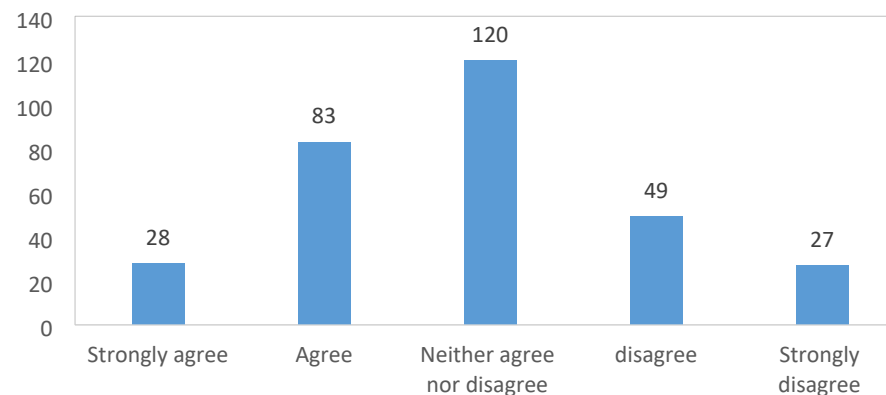


Most commonly referenced were aspects of the patient experience, including:

➢ Quality of care and the variability in service with geographical differences being a contributing factor.
➢ Communication issues such as attitude of staff, both clinical and non-clinical capacity. There was experience of the use of language and terminology for disabled people, which was perceived as patronising and a need for more extensive training to attain minimum standards.
➢ There was a perceived gap in services for non-English / Welsh speakers and a view expressed that Welsh language services could also be improved.
➢ Hospital signage was referenced as potentially confusing for people with learning disabilities or mild dementia.
➢ The partial booking system was not viewed as flexible enough to accommodate those who are not able to respond to their appointment invitation letter and are thereby excluded.

"….*if people don`t respond to PB [partial booking] letters they get no care - these people in my experience are those most disadvantaged and in need of services. There should be different ways to enable service users to flag need for support - unfortunately staff are so worn down that systems are not open and adaptive enough - it`s a self-fulfilling prophecy to make services increasingly difficult to access and so disadvantage certain groups even more.*"

Access to primary and community care was raised citing GPs, dentists, physio and OT as examples where access needs to improve. Methods of accessing services e.g. telephone and digital appointments were not viewed as suitable for all especially for those with sensory impairment and / or older people. There was a view that the rate of expansion of these technologies was increasing the equalities gap.

Extending hours of access to evenings and weekends was proposed to improve accessibility outside of people's normal working hours however this was not specific to primary or acute services.

Some respondents commented that more needed to be done for those who are disadvantaged, on the edge of society and who are unable to travel for appointments due to their age or for socio-economic reasons. Transportation services were not considered to have sufficient capacity to respond in a timely enough manner to meet patients' needs.

*"I think the elderly and infirm are seriously disadvantaged in accessing services.  Patient transport for outpatient appointments is severely over stretched.  I have had elderly and very poorly patients waiting for transport sometimes for 4 hours after a 30 minute OPD appointment. Totally disgraceful."*

*"I don't believe the health board is patient focused and therefore falls down in providing improved outcomes for all.  They don't take into account the patients situations and if they are able to access services, especially those with poor mental health and deprivation."*

*"Please look at the individual needs of every person e.g. a person living alone or who's family live too far away to collect the patients personal washing etc.  That patient left with a bag of dirty laundry and then kept in hospital gowns until being discharged with the dirty washing.  How is this giving equal advantage?*

## 4. Other Engagement Feedback

## 4.1 Partner perception survey

In July 2021, 20 in-depth telephone interviews were carried out with a range of senior partners from local authorities, third sector and other health and public sector organisations. The purpose of this was to gain a better understanding of the relationships between them and the Health Board, particularly during the COVID-19 pandemic.

During the interviews, partners were asked about the Health Board's Living Healthier Staying Well strategy.  This feedback provides a different perspective to public opinion as many of the partners are working in partnership to support delivery of the Health Boards strategic priorities.

Overall, the strategy is still considered to be both highly relevant.

*"I have heard of it and the goals are very relevant - if not more so since COVID 19" (Third Sector)*

*"All relevant, no one can argue with any of the core goals they have" (Third Sector)*

Several partners, however, suggest that while the strategy remains relevant it should still be revisited particularly with a view to:

- Openness about how waiting times will be tackled
- Acknowledging Welsh language and culture
- Working with the Third Sector more to deliver services without placing additional burdens on the NHS

*"It needs to be looked at. There are many cases for the Welsh language and culture not being acknowledged from the Health Board."  (Local Authority & Education)*

*"Yes, have heard of it and still relevant but needs to be refocused on patient expectations and how services are delivered has changed, we need to look at this with new eyes as it were. Maybe look at what direction this needs to go in. Some things in the plan will have moved on and being delivered now not face to face but remotely. Care closer to home, people can stay at home now and the service can come to them online."  (Health Care & Social Housing)*

*" ..still relevant and possibly needs revisiting after Covid to see what the priorities are" (Public Sector / Police)*

For others, while aware of the strategy, it was felt that it does not have much bearing on their own work or organisational goals or that they have neither seen or heard much about it since it was first published:

*"Have heard of it but we don't work on this ourselves" (Health Care & Social Housing)*

*"I am not sure how it is all being delivered; I am familiar with it." (Local Authority & Education)*

Whilst the majority of stakeholders feel that the strategy is still relevant, around three quarters say that they are working with BCUHB to achieve shared aims.  Generally, they emphasise that they work within their own strategic plans but that their aims and objectives are closely aligned:

*"We have our own strategy that is very much aligned with this "(Third Sector)*

*"Shared aims but separate strategies" (Local Authority & Education)*

They highlight the need for the organisations to work flexibly together in order to meet partner and patient needs:

*"Yes we have shared aims and again we need to listen…" (Local Authority & Education)*

*"We work with what our partners need rather than read strategies. We are able to work in an agile way responding to what they need for their strategy."  (Local Authority & Education)*

Among the remaining stakeholders, who do not claim to work with BCUHB on the strategy per se, a number stress that they still share aims and in some cases have aligned goals:

*"We work together but parallel to each other on strategies. We do feel we are working together but we all have our own unique strategies." (Third Sector)*

*"We have our own strategy but it sits parallel to the Health Board one"  (Local Authority & Education)*

*"We have shared aims but we do not work on this particular strategy with the Health Board"  (Local Authority & Education)*

For others there is a sense of frustration that BCUHB expects others to adopt its strategy, ignoring the strategic aims, objectives and priorities of its partners:

*"There are many, many strategies I have to look at, including my own. I feel Betsi like to put their brand on everything and then want us as partners to work to their aims and strategies, without even thinking we may have our own. It's a one size fits all with them and they lack understanding about who we are as partners and what our own aims may be too. "(Local Authority & Education)*

There are positive signs from partners that they feel the strategy is being applied in practice by the Health Board, particularly in the areas of housing and care at home.


## 4.2 Feedback from events and forums

Comments and feedback from the engagement sessions and particularly the two Q&A sessions reflected many of the comments expressed by the survey respondents.  As with the survey feedback there was a general agreement that our goals and priorities were the right ones. Some concerns about primary care and access to GPs were raised and the referral times to specialist services such as mental health. The use of video and telephone consultations was raised, and as with the survey responses, there were mixed views as to whether this was a positive move forward but acknowledgement that it could increase inequalities for some people.

Partner organisations raised the need for joint work to commence from the earliest opportunity for future strategy development, noting that a shared approach, vision and language can make a difference in achieving successful collaborative working.  The Heath Board should place more emphasis on aligning priorities and collaborative working at all levels.

**North Wales Community Health Council**

North Wales Community Health Council (NWCHC), the independent watchdog for health services, was provided with the draft review document for consideration. Evidence of engagement and the methods used were also shared. A presentation on the review was given to all NWCHC members at a Full Council meeting and members were invited to submit comments at the meeting and following the meeting.  Amongst the matters noted in response to the review of the strategy, the following key points were raised by NWCHC:

- The review is welcomed; it was felt the principles are robust, but there has been a significant lack of progress in some areas. The strategy must focus on bringing about visible and measurable improvements for patients of North Wales. NWCHC acknowledged that there is no reason to amend the objectives of the strategy and that the pandemic has certainly interrupted the actions required to meet those objectives.
- Despite the spirit and intention of the review, it was considered that the document contained much rhetoric and in some instances states the obvious. The evidence of success seems sparse and there is no mention of any strategies to improve the situation. There is concern that the review does not provide answers to resolving the difficulties faced by health services and patients and that more focused action is required.
- Significant 'buy-in' is needed from Primary Care, Community Care and Social Care in order to be able to deliver care closer to home.  There are difficulties for many in accessing GP appointments and there is concern about the knock-on effect of this on other services such as Emergency Department and Welsh Ambulance services.
- Primary Care Cluster development work should include other primary care practitioners and stakeholders, not just GPs
- The strategy needs to be honest in what can be achieved, and an example was given of robotic surgery which remains unavailable in North Wales. The review makes no mention of this.
- Concerns were expressed particularly about access to and support from mental health services, despite some improvements in elements of the service
- Notwithstanding the lack of progress noted, the review fails to recognise the successes in some service areas, and more information should be made available to the public such as on the Health Board's website. It was recognised that there needs to be a clear explanation of the impact of the strategy on the patient – i.e. *'What does this mean for me?'* Examples of which services are available would be welcomed, but there is a need to explain how they are relevant to patients and the difference they can make.
- It is recognised that the Health Board needs to be innovative and provide high quality care, but in the aftermath of Covid. There needs to be clarity on what is achievable and deliverable. In some respects the review document seems to be an iteration of what has gone before. The 'community hubs' that are mentioned seem not well known and there appears to be no data relating to who has accessed them and what has been delivered. Part of their function is mental health and wellbeing but where is the evidence of success?
- It was felt that more clinicians and health practitioners need to be involved front and centre in this work

The Health Board will continue to work with the NWCHC to ensure there is ongoing engagement in the further development of the strategy. The NWCHC will continue to monitor and scrutinise the progress made in achieving the objectives of the strategy and the impact on the experiences of patients in North Wales.

**Equality and human rights stakeholder forum**

The promotion of equality and human rights was a key principle of the original LHSW strategy and we are grateful to have had the contribution and constructive challenge of our equality stakeholder forum throughout.  In addition to the comments noted above in response to the online survey, our stakeholder forum contributed their views on progress and the need to refresh.  Amongst the detailed feedback raised the following key points were noted:

- Health and social care need to be more joined up – the processes of care and support need to be more streamlined
- Compassionate care must be a priority for the Health Board
- Many issues relating to dignity and respect were raised – for young people and young parents amongst others
- The importance of considering accessibility, engagement, digital exclusion and digital poverty
- Responding to mental health needs in the same way as physical health needs
- Recognise and support those people subject to long delays because of Covid, recognise that conditions deteriorate with delays, and concern about the impact on quality of life
- The importance of working in partnership in the wider context, to address well-being, environmental sustainability, socio-economic factors, hate crime
- The need to recognise that some 8-10% of the population identify as LGBTQ+

The forum also drew attention to a number of significant publications in addition, including **Locked Out: Liberating disabled people's lives and rights in Wales beyond Covid-19**; the **Code of Practice on the Delivery of Autism Services**; and the draft **Race Equality Action Plan**.

**5. Conclusions**

The feedback gained through the engagement exercise confirmed that the main strategic goals are still relevant, despite the changing environment and the challenges facing the Health Board.

There were some notable issues raised that will inform the strategic direction of the Health Board and the development and delivery of services. The feedback indicates that people are keen to see improvements made and delivery of the aims and aspirations described. The key messages from the engagement are being fed into the strategy refresh and the Integrated Medium Term Plan, and the specific service issues will be shared with relevant service leads.

The nature of the engagement exercise led to some limitations in involvement which will be addressed as the strategy continues to be delivered and informs ongoing plans. Early involvement and co-design of specific service developments will enable a stronger foundation of patient- and citizen-led health care which can better address the needs of our population.

Finally, it must be recognised that the engagement was undertaken during the ongoing Covid-19 pandemic and some may have found it challenging to engage, and particularly to consider longer term strategic direction. We are grateful for the time and effort that people contributed in such difficult circumstances.

The word cloud collates the most prominent feelings and words that appeared most frequently in the survey

**Glossary**

| | |
|---|---|
| ANP | Advanced Nurse Practitioner |
| BAME | Black, Asian and Minority Ethnic |
| BCU / BCUHB | Betsi Cadwaladr University Health Board |
| CCtH | Care Closer to Home |
| CRTs | Community Resource Teams |
| ED | Emergency Department |
| GP | General Practitioner |
| GRT | Gypsy, Roma and Traveller |
| IBD | Inflammatory Bowel Disease |
| KPIs | Key Performance Indicators |
| LGBTQIA+ | Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual. |
| MIND | A mental health charity in England and Wales |
| MIU | Minor Injuries Unit |
| Musculoskeletal | Includes bones, muscles, tendons, ligaments and soft tissues. |
| OT | Occupational Therapist |
| PALS | Patient Advice and Liaison Service |
| PB / Partial Booking | Outpatient Appointment System |
| Q&A | Question and Answer |
| Stronger Together | BCUHB staff engagement programme |
| Wakelet | Electronic platform to save, organise and share content |

| Report title: | Integrated Medium Term Plan refresh process | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 2.3 |
| Executive Summary: | The purpose of this paper is to confirm the outcome of the Welsh Government scrutiny of the three year Integrated Medium Term Plan (IMTP) submitted for 2022 – 2025 and to update the Health Board on the proposed timelines for the development of the IMTP for 2023 – 2026. Confirmation has been received of the Minister's decision that the plan submitted in March does not fully meet the requirements of the NHS Wales framework and therefore is not approved as an IMTP. The plan submitted has been accepted as an Annual Plan and will be subject to ongoing monitoring. The development of the three year plan for 2023 – 2026 is therefore intended to address learning from the process and work towards submission of an approvable IMTP for this period. | | |
| Recommendations: | The Board is asked to receive the proposed high level timeline for refresh of the IMTP for 2023 – 2026 and provide any comments to inform the process. | | |
| Executive Lead: | Dr Chris Stockport, Executive Director of Transformation, Strategic Planning And Commissioning. | | |
| Report Author: | Sally Baxter, Assistant Director – Health Strategy | | |

| Purpose of report: | For Noting ☒ | For Decision ☐ | For Assurance ☒ |
|---|---|---|---|

| Assurance level: | Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |
|---|---|---|---|---|

| 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: |
|---|
| N/A |

| Link to Strategic Objective(s): | The IMTP will set out the Heath Baord's response to the national strategic objectives including A Healthier Wales and Ministerial Priorities, as well as addressing local needs and addressing our strategic goals as described in **Living Healthier, Staying Well** |
|---|---|
| Regulatory and legal implications | The organisation has currently failed to meet its statutory duties to deliver an approvable IMTP in line with the NHS (Wales) Act 2006, as amended by the NHS Finance (Wales) Act 2014. The process proposed for the development of the plan for 2023 – 2026 will facilitate the Board in developing an Integrated |

| | |
|---|---|
| | Medium Term Plan in accordance with statutory duties. |
| **In accordance with WP7 has an EqIA been identified as necessary and undertaken?** | No. An EqIA was produced for the 2022 - 2025 Integrated Medium Term Plan. This will be reviewed and updated alongside the refresh process for the Plan. |
| **In accordance with WP68 has an SEIA identified as necessary been undertaken?** | No. A SEIA was produced for the 2022 - 2025 Integrated Medium Term Plan. This will be reviewed and updated alongside the refresh process for the Plan. |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | There is a risk that there continue to be challenges in delivery arising from current pressures, including potential further waves of Covid-19, which may constrain the level of engagement in the refresh process. There is a risk that the transition to the new operating model may not facilitate fully integrated health community planning. |
| **Financial implications as a result of implementing the recommendations** | No specific financial requirements arising from this paper. The IMTP sets out the financial implications of the proposed investments in initiatives to implement the strategy. |
| **Workforce implications as a result of implementing the recommendations** | No specific workforce implications arising from this paper. The IMTP sets out the workforce implications within the initiatives prioritised for implementation. |
| **Feedback, response, and follow up summary following consultation** | Not applicable currently. There will be engagement over the development of the IMTP as the process progresses. |
| **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:**
**Implementation of recommendations**
- Further revision and refinement of the process following feedback
- Development of detailed project plan to sit beneath the high level timeline
- Respond to further feedback and direction from Welsh Government

**List of Appendices:**
Appendix 1 – IMTP refresh process presentation

**MEETING IN PUBLIC**
**Thursday 4 August 2022**

**Integrated Medium Term Plan refresh process**

### 1. Introduction/Background

The Health Board is required to develop an Integrated Medium Term Plan, financially balanced, under the requirements of the NHS Finance (Wales) Act 2014. The duty requires each health baord to produce a three year IMTP that:

• Improves the health of the population
• Improves the provision of health care
• Is balanced over a three year period and
• Is approvable by Welsh Ministers.

The development of a three year IMTP aligned wth national and Health Board strategies is a also a key element within the Targeted Improvement framework.

### 2. Body of report

A three year IMTP was developed for 2022 – 2025 and approved by the Health Board on 30 March. Formal feedback was received from Welsh Government at the end of July 2022 that the Minister had decided the plan did not fully meet the requirements of the NHS Wales framework, following robust scrutiny, and given the number of challenges the Health Board is currently facing. It was also felt there needs to be greater focus on delivery and improvement over the next months.

The plan submitted has been accepted as an Annual Plan for 2022 – 2023 which will be subject to ongoing monitoring.  The Executive Team are currently reviewing the three year plan in the light of feedback on first quarter performance and to ensure the ongoing focus on delivery and improvement.

BCU Health Board is not alone amongst NHS Wales in failing to submit an approvable IMTP for 2022 – 2025 and a number of organisations will be working to an Annual Plan during this year. The formal correspondence received from WG recognised the submission of an IMTP as a significant step forward for the health board which demonstrates the improved planning approach the health board is taking.

The Health Board will now need to work towards the development of an Integrated Medium Term Plan for 2023 – 2026 in line with the NHS Planning Framework, which will be published later this year.

### 3. Budgetary / Financial Implications

There are no immediate budgetary implications associated with this paper.  The refreshed IMTP will set out the financial plan for 2023 – 1026 together with detailed financial implications of the prioritised initiatives within the Plan.

### 4. Risk Management

The risks arising from the failure to deliver an approvable IMTP will be managed through the monitoring process for the Annual Plan and Executive review, scrutinised through the Performance, Finance and Information Governance Committee for performance and delivery matters.  There are

risks arising from the organisational pressures, which may constrain the capacity of operational and corporate leads to support the development of the refreshed plan including the potential impact of further waves of Covid-19. There are also risks arising from the transition to the integrated health communities under the proposed new operating model.

Ongoing planning forums have been put in place with the shadow integrated health community team and the pan-North Wales services to mitigate against these risks.

## 5. Equality and Diversity Implications

Equality Impact Assessment and SocioEconomic Duty Impact Assessment were undertaken to support the 2022 – 2025 IMTP prior to submission to the PPPH Committee and subsequently the Board for approval. These will be kept under review, alongside the IMTP process for 2023 - 2026.

Proses adnewyddu'r Cynllun
Tymor Canolig Integredig
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
28 Gorffennaf 2022

IMTP refresh process
BCU Health Board
28 July 2022

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

## Adnewyddu'r Cynllun Tymor Canolig Integredig

- Adnewyddu ein cynllun i weithio gyda phartneriaid i hybu iechyd da, mynd i'r afael ag anghydraddoldebau iechyd a diwallu anghenion iechyd

- Dan arweiniad fframwaith GIG Cymru
  *heb gael ei ddiweddaru ar gyfer 2023 - 2026 eto*

- Mynd i'r afael â Blaenoriaethau Gweinidogol

- Mynd i'r afael â'r pum Egwyddor Cynllunio

- Yn gyson â'n cynlluniau partneriaeth – Bwrdd Partneriaeth Rhanbarthol a Byrddau Gwasanaethau Cyhoeddus

- Ymateb i'r Strategaeth Gwasanaethau Clinigol

- Parhau â'n taith adfer a thrawsnewid

## Refresh of the IMTP

- Refreshing our plan to work with partners in promoting good health, addressing health inequalities and meeting health needs

- Guided by NHS Wales framework
  *yet to be updated for 2023 – 2026*

- Addressing Ministerial Priorities

- Addressing the five Planning Principles

- Consistent with our partnership plans – RPB and PSBs

- Responding to the Clinical Services Strategy

- Continuing our recovery and transformation journey

# Blaenoriaethau gweinidogol

- Cymru Iachach
- Iechyd y Boblogaeth
- Ymateb i Covid
- Adferiad y GIG
- Iechyd Meddwl a llesiant emosiynol
- Cefnogi'r gweithlu iechyd a gofal
- Cyllid y GIG a rheoli o fewn adnoddau
- Gweithio ochr yn ochr â Gofal Cymdeithasol
- Cynllunio Clwstwr

# Ministerial priorities

- A Healthier Wales
- Population Health
- Covid response
- NHS recovery
- Mental Health and emotional well-being
- Supporting the health and care workforce
- NHS Finance and managing within resources
- Working alongside Social Care
- Cluster Planning

# Y pum Egwyddor Cynllunio

# The five Planning Principles
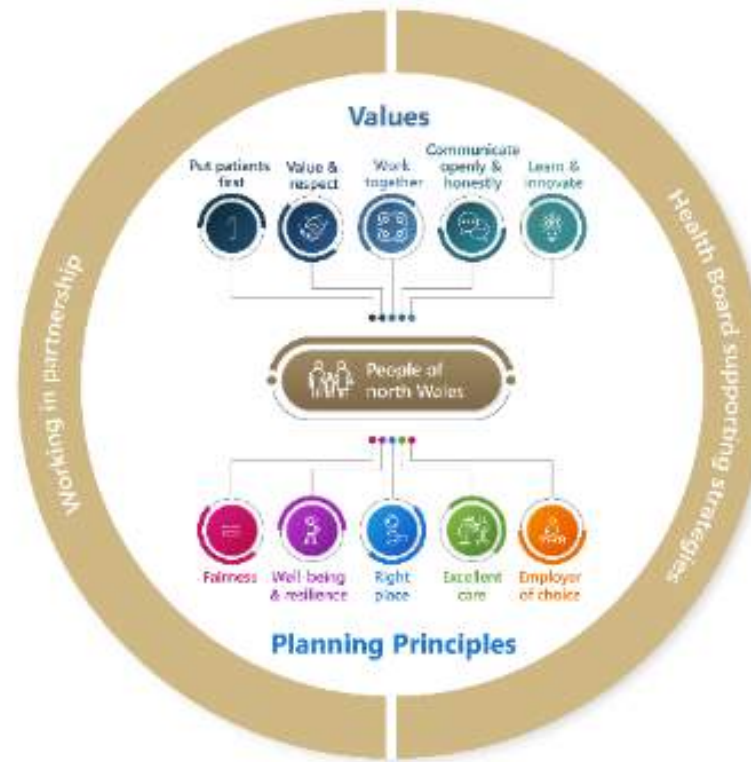
## Dysgu o broses bresennol y Cynllun Tymor Canolig Integredig

- Parhau i adeiladu ar yr integreiddio agosach rhwng cynllunio gwasanaethau, y gweithlu a chyllid

- Datblygu arbedion effeithlonrwydd ac arbedion eraill ochr yn ochr â'r broses o ddatblygu'r Cynllun Tymor Canolig Integredig

- Eglurder prosesau a chyfathrebu

- Cefnogi Cymunedau Iechyd Integredig a gwasanaethau ledled Gogledd Cymru

- Cysylltu â gwaith cynllunio clwstwr

- Ymgysylltu â chynlluniau partneriaeth

- Datblygu dull comisiynu – cynllun ar gyfer yr holl wasanaethau a gomisiynir gennym, nid cynllun darparwr

- Ymateb i adborth gan Lywodraeth Cymru ac yn benodol gan yr Uned Gyflawni

- Tystiolaethu'r capasiti i gyflawni'r cynllun

## Learning from the current IMTP process

- Continuing to build on the closer integration of service planning, workforce and finance

- Building efficiencies and savings alongside the IMTP development process

- Clarity of process and communication

- Supporting Integrated Health Communities and pan-North Wales services

- Linking with cluster planning

- Engagement with partnership plans

- Developing a commissioning approach – a plan for all our commissioned services, not a provider plan

- Responding to Welsh Government and specifically Delivery Unit feedback

- Evidencing the capacity to deliver the plan

# Amlinelliad arfaethedig o'r broses    Proposed outline of process

Datblygu /
Development

Adolygu a
Sicrwydd /
Review and
Assurance

Cyflwyno a
chymeradwyo /
Submission and
approval

| Cam | Gewithrediad | 2022 | | | | | | 2023 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Gorff | Awst | Medi | Hyd | Tach | Rhag | Ion | Chwe | Maw |
| **Datblygu** | Adolygu asesiadau o angen a blaenoriaethau cychwynnol | ■ | | | | | | | | |
| | Adolygu blaenoriaethau clystyrau a phartneriaethau | ■ | | | | | | | | |
| | Digwyddiad Sganio'r Gorwel | ■ | | | | | | | | |
| | Adolygu bwriadau comisiynu | ■ | ■ | | | | | | | |
| | Tybiaethau gofal wedi'i gynllunio a heb ei drefnu | | ■ | ■ | | | | | | |
| | Adolygu blaenoriaethau partneriaid | | | ■ | | | | | | |
| | Egwyddorion cynllunio ariannol | | | ■ | | | | | | |
| | Adolygu tybiaethau'r gweithlu | | | ■ | | | | | | |
| | Cyflwyniadau Cymunedau Iechyd Integredig a gwasanaethau ar draws Gogledd Cymru | | | ■ | ■ | | | | | |
| **Adolygu a sicrwydd** | Profi cynlluniau o ran effaith a chysondeb | | | | ■ | | | | | |
| | Proses flaenoriaethu | | | | | ■ | | | | |
| | Profi ymhellach blaenoriaethau seiliedig ar leoedd a phartneriaid | | | | | ■ | | | | |
| | Cysylltu â Llywodreath Cymru | | | | | ■ | ■ | | | |
| **Cyflwyno a chymeradwyo** | Cynllun draft i'w adolygu gan y Tîm Gweithredol a Phwyllgorau | | | | | | ■ | | | |
| | Cyflwyno er cymeradwyaeth y Bwrdd | | | | | | | ■ | | |
| | Cyflwyno i Lywodraeth Cymru | | | | | | | ■ | | |

| Phase | Action | 2022 | | | | | | 2023 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Development | Review of needs assessment and initial priorities | ■ | | | | | | | | |
| | Review of cluster and partnership priorities | ■ | | | | | | | | |
| | Horizon scanning session | ■ | | | | | | | | |
| | Review commissioning intentions | ■ | ■ | | | | | | | |
| | Planned & unscheduled care assumptions | | ■ | | | | | | | |
| | Joint review of partnership priorities | | ■ | ■ | | | | | | |
| | Financial planning principles | | | ■ | | | | | | |
| | Review of workforce assumptions | | | ■ | | | | | | |
| | Integrated Health Community & pan-North Wales proposals | | | ■ | ■ | | | | | |
| Review and assurance | Test plans for impact and consistency | | | | ■ | | | | | |
| | Prioritisation process | | | | | ■ | | | | |
| | Further testing place based and partnership priorities | | | | | ■ | | | | |
| | Liaison with Welsh Government | | | | | ■ | ■ | | | |
| Submission and approval | Draft plan for review by Executive Team and Committees | | | | | | ■ | | | |
| | Submission for Board approval | | | | | | | ■ | | |
| | Submission to Welsh Government | | | | | | | ■ | | |

| | |
|---|---|
| **Cyfarfod a dyddiad:**<br>**Meeting and date:** | Health Board – 28th July 2022 |
| **Cyhoeddus neu Breifat:**<br>**Public or Private:** | Public |
| **Teitl yr Adroddiad**<br>**Report Title:** | Transformation and improvement update |
| **Cyfarwyddwr Cyfrifol:**<br>**Responsible Director:** | Dr Chris Stockport, Executive Director of Transformation, Strategic Planning, and Commissioning |
| **Awdur yr Adroddiad**<br>**Report Author:** | Paolo Tardivel, Director of Transformation and Improvement |
| **Craffu blaenorol:**<br>**Prior Scrutiny:** | Reviewed by Executive Director of Transformation, Strategic Planning, and Commissioning |
| **Atodiadau**<br>**Appendices:** | Appendix 1: Transformation and Improvement Update for Board members |

| **Argymhelliad / Recommendation:** |
|---|
| The board is asked to note and provide any feedback on the Transformation and Improvement update in this paper |

| **Ticiwch fel bo'n briodol / Please tick as appropriate** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Ar gyfer penderfyniad /cymeradwyaeth**<br>**For Decision/ Approval** | | **Ar gyfer Trafodaeth**<br>**For Discussion** | | **Ar gyfer sicrwydd**<br>**For Assurance** | | **Er gwybodaeth**<br>**For Information** | **x** |
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol**<br>**Y/N to indicate whether the Equality/SED duty is applicable** | | | | | | **N** | |
| N/A | | | | | | | |

| **Sefyllfa / Situation:** |
|---|
| The Transformation and Improvement team has been in the process of establishing itself and building the right strength in foundations to support the organisation in delivery of it's strategic ambitions.  This paper sets out the progress made by the Transformation and Improvement team, for information, feedback and discussion. |

| **Cefndir / Background:** |
|---|
| See appendix |

| **Asesu a Dadansoddi / Assessment & Analysis** |
|---|
| See appendix |

| **Opsiynau a ystyriwyd / Options considered**<br>N/A |
|---|

| **Goblygiadau Ariannol / Financial Implications**<br>N/A |
|---|

| **Dadansoddiad Risk / Risk Analysis**<br>N/A |
|---|

| **Cyfreithiol a Chydymffurfiaeth / Legal and Compliance**<br>N/A |
|---|

| **Asesiad Effaith / Impact Assessment**<br>*N/A* |
|---|

**Appendix 1: Transformation and Improvement update for Board Members**



**Transformation and Improvement Update**

Paolo Tardivel

July 2022

This paper provides a brief update for the Board on progress in establishing and mobilising our new Transformation and Improvement (T&I) function.

## Reminder of purpose, strategy and approach

The T&I function aims to support the organisation by:

1. Being a single point of coordination for all Transformation and Improvement work across the Health Board

2. Creating a professional, consistent and effective programme, project and improvement centre of excellence which robustly applies evidence-based approaches

3. Enabling and supporting a self improving organisation that prioritises the interventions that make most difference to people

The approach is to focus on how to deliver better outcomes for the population, person or patient, across experience, quality and safety. Through doing this we will remove waste and rework and so become more efficient and deliver financial savings. This aligns well to Value Based Care ambitions of achieving world leading health outcomes in a financially sustainable way.

Operating in this way, the organisation will move from relying on one-off (non-recurrent) transactional savings to a heathier position of recurrent savings that also deliver patient and financial improvements. Longer-term there are more complex and large-scale transformational changes. Prioritisation of work upon these is also required as they take time to formulate, plan, design and deliver. However these too are heavily dependent on the right fundamentals being in place.

There has been a significant amount of work involved in setting the right foundations in place to support the organisation in the areas listed above. There has been a historic skills deficit in regard to improvement science and programme management which has also needed to be addressed through recruitment (now nearing completion) and training.

Evidence shows it is vital to establish the right foundations in governance, approach, capability and infrastructure in order to effect sustainable transformation and improvement.

The paper will now summarise progress and plans associated to each of the core T&I functions.

## Transformation & Improvement Office

The T&I Office has established as a portfolio office to provide a helicopter view of all the transformation and improvement work going on across the organisation.

Reporting lines and governance schema have been established with the key programmes of improvement work predating the establishment of the T&I office. The office now manages a process of reporting into the Executive Delivery Group for Transformation and Finance and then into the Performance, Finance and Information Governance Board Committee.

The T&I Office has also been collating a view of other live projects across the organisation, which will be an on-going and dynamic process.

Presently we are working with corporate colleagues, including Finance colleagues, to build a centralised benefits tracking repository with associated infrastructure and governance, covering both financial and non-financial benefits.

## Programmes

Historically transformation / improvement programmes have been run from various locations across the organisation, with differing levels of resource, following differing methodologies and governance, and with varying degrees of success and sustainability. The introduction of the Programmes function within the T&I team consistently applies Managing Successful Programmes™ (MSP) evidence based best practice across all those areas to support the organisation in delivering sustainably against its programmes' strategic ambitions.

The team have now built the necessary project and programme infrastructure, collateral and governance schema and have started to on-board key programmes. Planned Care and Unscheduled Care have been the first to mobilise, with Mental Health and Learning Disabilities and a number of others to follow. Programmes are taking an expedited scoping approach in order to deliver benefits this year.

The Programmes function acts as a conduit for many of the other functions across the T&I team, bringing skills across project, programme, improvement, pathways, value and innovation together to support the areas of key priority for the organisation.

The YGC Improvement Plan is the first major Programme to mobilise using this approach from the beginning.

## Improvement Science

The improvement function covers two main streams of work:

1. Continuous Improvement – supporting the organisation to become a self improving organisation,
2. Service Improvement – supporting priority projects and programmes with dedicated improvement specialist resource.

The **Continuous Improvement** team have been busy supporting and coaching a number of people across the organisation with their improvement ideas as well as co-delivering the 4 day Improvement In Practice (IIP) training with Improvement Cymru (the first cohort ran in January/February, the second is running now in June/July and a further one is planned for September/October).  They have also been establishing "lean industry partners", the first of which is with Airbus. We have completed a site visit with Airbus who shared how they approach continuous improvement and we are already seeing returns from this partnership in terms of sharing of resources and experience.

The **Service Improvement** team are supporting the two main programmes we have fully on-boarded to date (Planned Care and Unscheduled Care). They are continuing to support Mental Health and Learning Disabilities as they on-board their Improvement Programme.

We have also established a Quality Improvement (QI) Fellow scheme, where individuals from the Clinical / Operational teams are seconded into the T&I team to undertake specific pieces of work (currently one on Theatre never events and the other on the Ysbyty Glan Clwyd Improvement plan), upskill in improvement science leadership and then return to their substantive roles to help spread improvement thinking and approach.

The team have come together to create a common and evidence based improvement methodology and toolkit, inspired by best practice from all main improvement methodologies, with close alignment to Improvement Cymru and Institute for Healthcare Improvement methodologies.  We're calling it "**The Betsi Way**" it is designed to be flexible enough to be used by everyone, whether you've got no improvement experience or are an expert improvement specialist.
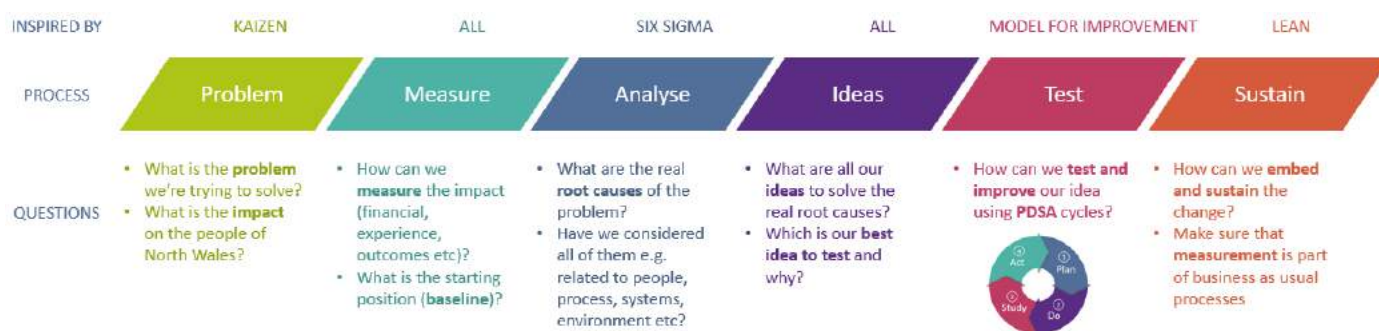
## Value Based Care and Pathways

The **Value Based Care** (VBC) function continues to evolve, and is engaged and working closely with the national VBC team, as well as contributing to and taking part in the Mid Wales Collaborative VBC training and community. The function's aim is to weave VBC principles in to the DNA of everything we do across the organisation and are currently discharging that through:

1. Ensuring VBC principles feature in our key governance processes and infrastructure e.g. business case template, prioritisation tools

2. Creating a virtual programme around VBC projects to promote the great work going on across Betsi and ensure suitable initiatives get considered for the ring fenced VBC funding

The **Betsi Pathways** team comes under the VBC function and has now got an established team who are progressing a number of pathways across Orthopaedics and Cancer. Carpal tunnel and Total hip and knee replacement pathways are at the final stages of completion and have managed to agree a single end to end pathway across North Wales that takes in Getting It Right First Time (GIRFT) best practice. This is a significant achievement. Once the pathways have passed the final internal clinical governance and have all their value-added resources completed (e.g. videos, patient information leaflets, PREM tools etc), they will be loaded onto the Betsi Pathways platform for release.

## Innovation and Analytics

The Innovation and Analytics function is a single point of contact for all innovation related work and funding streams. It is also a conduit for all the T&I team analytics requirements. The main purpose of the team is to provide a pipeline of future opportunities and initiatives for our key programmes of work, through horizon scanning and stitching our data together from an end to end patient journey perspective.

This function is very early in its development whilst further recruitment completes, but is already well integrated into the National Innovation Hub Network, with Bangor University and with a local app development company.  This function is also the point of coordination for the Bevan Exemplar programme and for submissions to their Planned Care Innovation fund.  The Head of Innovation and Analytics is reviewing opportunities and initiatives in both Planned Care and Unscheduled Care with the programme teams, to contribute to the programme's pipelines going forward.

Once the right foundations are in place with this team it will be the conduit for ideas relating to things like machine learning, predictive analytics and robotic process automation.

## Summary

As can be seen above, there has been a large amount of work undertaken to recruit and mobilise the team and associated areas of work, establishing the right strength in foundations to build upon going forward.

There is a lot of good work going on and this will become increasingly visible as we move deeper into implementation phases.  Although much of the first year of work is more Improvement than Transformation, that is to be expected given the maturity and capability of the organisation in this space.  We are however focussed on ensuring the ground work is done this year for future years to benefit from fewer, larger transformations.

Our Transformation and Improvement journey continues to be:

| **CHAPTER 1:** | **CHAPTER 2:** | **CHAPTER 3:** |
|:---:|:---:|:---:|
| **STRONG FOUNDATIONS** | **EVOLUTION** | **WORLD CLASS SERVICE** |
| Creating a consolidated Transformation and Improvement function built on establishing the fundamentals | Building upon strong foundations, evolving our transformational capability to support next level of cutting edge change | Become world renowned for our transformation approach, innovations and achievements, leading the way into healthcare's future transformation |

| Report title: | Draft Risk Management Strategy | | |
|---|---|---|---|
| Report to: | Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 3.1 |
| Executive Summary: | The 2022/2025 Risk Management strategy is presented to the Board for approval.<br><br>A series of informal and formal consultation events have taken place over the last few months, leading up to the document being endorsed by the Quality, Safety and Experience Committee on the 5th of July 2022 as well as the Audit Committee on the 13th of July 2022.<br><br>The objectives of the strategy and approach to managing the Board Assurance Framework were reviewed and agreed at a Board Workshop on the 16th of June 2022.<br><br>Following the progression of the document, the Board is now asked to approve the risk management strategy, attached as **Appendix A.** | | |
| Recommendations: | The Board is asked to:<br><br>• Note and approve the implementation of the risk management strategy<br>• Note and approve the integrated assurance infrastructure approach as set in section 3 of this report.<br>• Approve the revised approach to reviewing and monitoring the BAF as set out in appendix 4<br>• Approve the revised oversight arrangements for risk management as set out in section 4 | | |
| Executive Lead: | Board Secretary | | |
| Report Author: | Molly Marcu, Interim Board Secretary | | |

| Purpose of report: | For Noting ☐ | For Decision ☒ | For Assurance ☐ |
|---|---|---|---|

| Assurance level: | Significant ☐<br>High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒<br>General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐<br>Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐<br>No confidence/evidence in delivery |
|---|---|---|---|---|

**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:**

Not applicable

| Link to Strategic Objective(s): | ALL |
|---|---|
| Regulatory and legal implications | Alignment to regulatory requirements associated with delivery of patient care as well |

| | as a safe working environment under the Health and Safety at Work Act |
|---|---|
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol** <br> **Y/N to indicate whether the Equality/SED duty** <span style="color:red">**is applicable and provide an explanation below**</span> | **Y** |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | (summarise risks here and provide further detail) <br><br> (crynodeb o'r risgiau a rhagor o fanylion yma) |
| **Financial implications as a result of implementing the recommendations** | Risk Management training will be required as part of the process of enhancing the risk maturity of the organisation |
| **Workforce implications as a result of implementing the recommendations** | Not applicable |
| **Feedback, response, and follow up summary following consultation** | Feedback received from <br><br> Executive team, QSE Chair, PFIG Chair, QSE and Audit Committee |
| **Links to BAF risks:** <br> (or links to the Corporate Risk Register) | All |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable <br><br> Amherthnasol |
| **Next Steps:** <br><br> • The Risk Management policy will also be reviewed to ensure it is aligned to the strategy and submitted to the Audit Committee in September 2022 ||
| **List of Appendices:** <br> Risk Management Strategy, Appendix 1 ||

**Board**
**4 August 2022**
**Draft Risk Management Strategy**

## 1. Introduction

The risk management strategy is reviewed annually alongside the risk appetite statement and Board Assurance Framework.

At the June Board workshop, the Board reviewed the proposed objectives to the strategy taking into account the identified gaps in assurance identified through the internal audit and regulatory reviews during the course of the 2021/22 financial period.

The objectives of the strategy are outlined in section 2 of this report and incorporated in further detail in section four of the risk management strategy, whilst section 3 of this report sets out the frequency in which the BAF and corporate risk register will be monitored by the Board, as a result of the adoption of the strategy

## 2. Objectives of the Risk Management Strategy

The objectives of the Risk Management Strategy are:

▪ *To **proactively identify**, manage and monitor significant risks that the Health Board is exposed to during the delivery of patient care, as well as its wider objectives*

▪ *To ensure that risks that can materially impact on the Health Board's key statutory objectives are proactively identified, assessed and managed*

▪ *To enhance the risk maturity of the Health Board from Risk Aware to Risk Enabled*

These specific objectives are pertinent for the purposes of enabling a more pre-emptive approach to identifying and mitigating risks before they crystallise. In order to enable the robust implementation of the strategy, an integrated assurance infrastructure will be put in place to identify early warning indicators of significant risk

## 3. Integrated Assurance Infrastructure

This will consist of representatives from Performance, Health and Safety, Patient Safety, Clinical Audit, Compliance and the Office of the Board Secretary, with the aim of enabling:

▪ A more proactive assessment of risk and assurance information, through triangulation of multiple sources

▪ This integrated assurance infrastructure will enable the Health Board to proactively horizon scan and progress mitigations rather than wait for risks to crystallise

▪ Align performance indicators with corporate risk register and BAF risks in order to clearly track progress
▪ Embed the 3 lines of defence model and track progress by reviewing our own process on a cyclical basis

In addition, having an integrated assurance infrastructure will enable the proactive Identification of regulatory compliance, which will be triangulated against information held in those areas, for example:

- Incidents
- Internal Audit/verification processes of compliance
- Clinical Audit
- Capture and emerging risks
- Whistleblowing incidents
- Counter-fraud
- Complaints

Principally, the outcome of the integrated assurance infrastructure will be considered at the Risk Management Group and to Committees as appropriate.

It is worth highlighting that a range of operational controls will be put in place alongside this strategy. For example, risk management training will be provided to staff as appropriate as part of the three lines of defence model, alongside the implementation of risk management policies.

To this end, a comprehensive piece of work is due to start in relation to the revision of the risk management policy.

All of the above mitigations will be instrumental in the implementation of the operating model, to ensure there is consistency across the organisation and are reflected in the updated operating model paper, which also forms part of this agenda.

## 4. Board Assurance Framework assurance reporting

The strategy proposes that the Board Assurance Framework (BAF) is monitored by the Board on a quarterly basis, and by the board committees on a bi-monthly basis.

This will enable the Board to gain more visibility and assurance on the risks most pertinent to the delivery of the strategy.

In addition, the reports will enable the Board to closely monitor risks outside of the risk appetite of the Board in a more proactive manner. (Further details on this approach are covered in the BAF paper)

In addition, the corporate risk register will be submitted to the Board annually whilst it remains a standing item at committee meetings

The other main recommendation from the strategy is in relation to the oversight of the Risk Management Group, which currently feeds into the Audit Committee. It is proposed that this should now report into the Quality, Safety and Experience Committee.

**Risk Management Strategy**

**2022 - 2025**

| Document Reference No. | V.10 |
|---|---|
| Target audience | Health Board Wide |
| Author | Board Secretary |
| Group responsible for developing document | Risk Management Group |
| Status | Draft |
| Authorised/Ratified By | Health Board |
| Authorised/Ratified On | TBC |
| Review Date | TBC |
| Review | This document will be reviewed prior to review date if a legislative change or other event otherwise dictates. |
| Distribution date | TBC |

# Contents

# 1. INTRODUCTION

1.1. The Betsi Cadwaladar Health Board is committed to providing high quality patient services in an environment where patient and safety is paramount. However, healthcare provision has an inherent level of risk that cannot always be eliminated.

1.2. The Health Board Risk Management Strategy provides a framework for the robust identification, assessment and management of risks to the delivery of strategy and of high quality healthcare by enabling staff to:

1.2.1. Identify actual or potential risks

1.2.2. determine how best to treat them

1.2.3. apply the treatment

1.2.4. monitor the effectiveness of that treatment while supporting the safe development of clinical care and maintaining continuity of service delivery.

1.3. Every member of staff is responsible for effective risk management.

1.4. The Health Board promotes a just, compassionate responsible culture that fosters learning, improvement, and accountability. It intends all staff to be able to raise issues of concern and be listened to.

1.5. The Health Board recognises that complete risk control/avoidance is impossible, but risks can be minimised by making sound judgements from a range of fully identified options.

1.6. The Health Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated and mitigated to an acceptable level in a timely manner wherever possible.

# 2. PURPOSE

2.1. The Risk Management Strategy is a framework for the continued development of the risk management process, building on principles and plans linked to the Board Assurance Framework, the Risk Register and meeting requirements of Regulators such as Health Inspectorate Wales, Health and Safety Executive, along with national priorities.

2.2. The Risk Management Strategy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the "Ward to Board" accountability and devolved governance structure.

## 3. STRATEGIC OBJECTIVES

3.1. This strategy supports the delivery of the Health Board's Living Healthy, Staying Well, strategic aims, agreed by the Board in July 2022, which are outlined below:

  3.1.1. Improve physical, emotional and mental health and well-being for all

  3.1.2. Target our resources to people who have the greatest needs and reduce inequalities

  3.1.3. Support children to have the best start in life

  3.1.4. Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being

  3.1.5. Improve the safety and quality of all services

  3.1.6. Respect people and their dignity

  3.1.7. Listen to people and learn from their experiences

3.2. The Health Board Strategic aims will be delivered through the following enabling strategies:

  3.2.1. Clinical Service Strategy

  3.2.2. People Strategy

  3.2.3. Estates Strategy

  3.2.4. Digital Strategy

  3.2.5. Quality Improvement Strategy

  3.2.6. Risk Management Strategy

3.3. As part of the delivery of these strategies appropriate mitigations will be put in place to ensure significant risks are proactively identified and mitigated as part of their delivery.

3.4. The delivery of this Risk Management Strategy will facilitate the embedding of an infrastructure that enables robust identification and management of risks that may prevent the achievement of Health Board objectives.

3.5. The Board will approve and monitor the delivery of these strategies and mitigations of associated risks through its Committees.

***3.6.*** ***The work plan of each Board committee will incorporate agenda items, which will ensure risks to the delivery of our strategies, are identified and managed as appropriate.***

3.7.  Section 8 provides more detail on Board Committees and their specific responsibilities.

## 4.  OBJECTIVES OF THE RISK MANAGEMENT STRATEGY

4.1.  The objectives of the Risk management strategy are:

> *4.1.1.  To **proactively identify**, manage and monitor significant risks that the Health Board is exposed to during the delivery of patient care, as well as its wider objectives*
>
> *4.1.2.  To ensure that risks that can materially impact on the Health Board's key statutory objectives are proactively identified, assessed and managed*
>
> *4.1.3.  To enhance the risk maturity of the Health Board from Risk Aware to Risk Enabled*

4.2.  The Strategic Objectives of the Health Board evidence the Board prioritising patient safety, quality of care, staff wellbeing and development, and achievement of national standards.

***4.3.***  The Health Board Performance and Risk Management Frameworks will be integrated, to ensure risks related to performance indicators are identified, treated and monitored to minimise the impact on quality. ***Performance indicators will be integrated with the Board Assurance Framework.***

4.4.  At an operational level, the Health Board will apply ***a proactive risk management approach to identify risk through analysis of performance data and an Early Warning Trigger Tool***, described in detail in section 13.

4.5.  A quality impact assessment tool will be used to identify possible risks to quality and safety arising from service re-design savings initiatives or variations in service delivery, such as bed pressures.

4.6. Themes from a number of quality and safety indicators including patient safety incidents, mortality reviews, complaints, and claims will be used to identify risks to quality, and trends used to assess whether previously identified risks are managed appropriately.

4.7. The Health Board will also use learning from experience as a risk mitigation approach.

4.8. This is covered in more detail in section 12.5.

**Objective 3:** *To increase the risk maturity of the Health Board from Risk Aware to Risk Enabled*

**Figure 2: Risk Maturity scale**
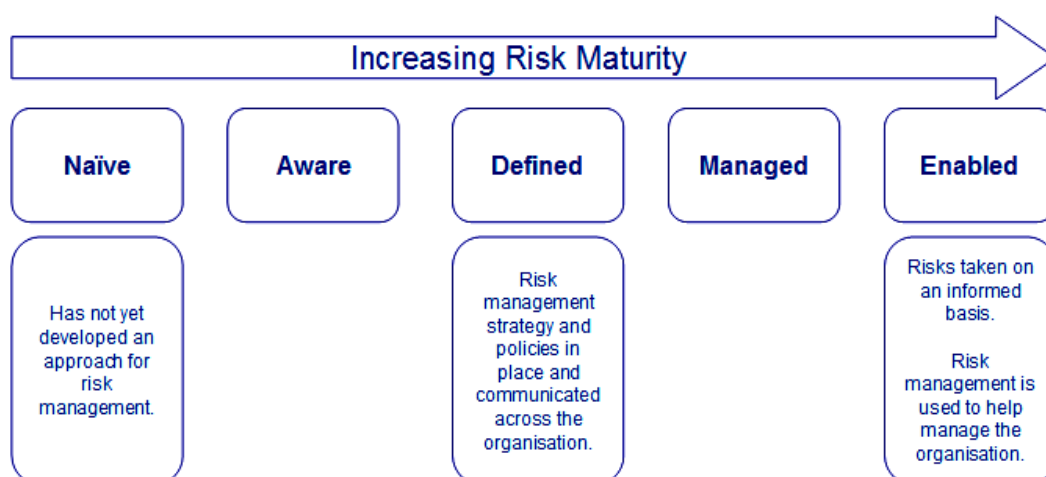


4.9. Figure 2 above shows the different levels of risk maturity that the Health Board can achieve as risk managements becomes embedded in the organisation.

4.10. The Health Board intends to enhance the risk maturity of the organisation to 'Risk Defined by March 2024, and achieve 'Risk Enabled' status by 2025.

4.11. The Board will review its risk maturity, appetite and Board Assurance Framework annually at the end of each financial year.

**4.12. The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Audit Committee will monitor the implementation of any recommendations arising from this audit.**

## 5. RISK APPETITE

5.1. Risk appetite is the total level of risk exposure, or potential adverse impact, that the Health Board is willing to accept in pursuit of its objectives.

5.2. The pursuit of one objective may hinder the achievement of another and this will impact upon the associated risk appetite. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy.

5.3. The Board recognises the importance of a robust and consistent approach to determining risk appetite to ensure:

> 5.3.1. The organisation's collective appetite for risk and the reasons for it are widely known to avoid erratic risk taking, or an overly cautious approach, which may stifle growth and innovation.
>
> 5.3.2. Health Board Managers and senior leaders know the levels of risk that are legitimate for them to take, and opportunities appropriate to pursue, to ensure service improvements and patient outcomes are not adversely affected.

5.4. To value and compare the relative merits and weaknesses of different risks, the Health Board will determine the level of risk the organisation is willing to tolerate in different areas.

*5.5.* This will include deciding whether the Health Board will ***treat, tolerate, transfer or terminate a risk and what the organisation's 'target risk score' should be. Operating within risk tolerances gives the Board assurance that the Health Board will remain within its risk appetite and, as a result, achieve its objectives.***

5.6. The Health Board Executive Team will put systems in place to manage risk to an acceptable level within its agreed risk appetite levels. In setting such levels, the Health Board will take account of the degree of both and opportunity.

5.7. When risks are identified, the Executive Directors will recommend to the Board whether to tolerate or accept them. Executive Directors will provide on-going assurance to the Board that existing controls are sufficient to mitigate risks to within the agreed tolerance levels, and will highlight where the cost of treating the risk is more expensive than the potential benefits to be realised.

5.8. Target risk ratings shall be set for all risks on the Datix Risk Management System. A target risk rating is the estimated residual risk following the application of reasonable mitigating controls.

5.9. The target risk rating is the lowest level of risk acceptable or tolerable for particular risks.

5.10. Some risks tolerance levels will require the approval of the Board or committees where relevant, particularly where the application of controls is restricted by external factors. Where this is the case, it will be outlined clearly in the BAF cover report, which is expanded on in section 6.

5.11. Risks that have reached the agreed target rating will also be treated as tolerated risks.

*5.12.* Risks should be accepted as tolerable only when the mitigation plan has been implemented as far as reasonably practical and *there is assurance that controls are effective.*

5.13. The Health Board regards risks that fall into the red 'high' category as significant and actions to control the risk must be taken immediately.

## 6. RISK APPETITE STATEMENT

6.1. The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

6.2.   The Health Board is committed to ensuring a robust infrastructure to manage risks from ward to board level, and where risks crystallise, to evidencing improvements are put in place.

6.3.   The Health Board's intention is to *minimise* the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks and maximise performance.

6.4.   To deliver *safe, quality* services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to *minimise* risk to the greatest extent possible and promote patient well-being. Additionally, the Health Board seeks to *minimise* the harm to service users arising from their own actions and harm to others arising from the actions of service users.

| RISK APPETITE DEFINITIONS | | | | | |
|---|---|---|---|---|---|
| *None* | *Minimal* | *Cautious* | *Open* | *Seek* | *Significant* |
| *Avoidance of risk is a key organisational objective* | *Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential* | *Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential* | *Willing to consider all delivery options and choices while also providing an acceptable level of reward* | *Eager to be innovated and to choose options offering higher business rewards (despite greater inherent risk)* | *Confident in setting high levels of risk appetite because controls forward scanning systems are robust* |

| Strategic Objectives | Risk Appetite | Risk appetite Statement |
|---|---|---|
| *SO1: Improve physical, emotional and mental health and well-being for all.* | *MINIMAL* | *The Health Board will seek to minimise short-term impact on quality outcomes in order to achieve longer term rewards that will result in outstanding care* |
| *SO2: Target our resources to people who have the greatest needs and reduce inequalities* | *CAUTIOUS* | *The Health Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Health Board is an employer of choice.* |
| *SO3 Respect people and their dignity* | *CAUTIOUS* | *The Health Board will proactively minimise its risk exposure in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.* |
| *SO4: Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being* | *CAUTIOUS* | *The Health Board will proactively minimise risk faced with collaboration and partnerships but this will ultimately provide a clear benefit and improved outcomes for the population of Betsi Cadwaladr University Health Board.* |
| *SO5: Improve the safety and quality of all services, whilst listening to people and learning from their experience* | *CAUTIOUS* | *The Health Board will proactively mitigate risks pertaining to the implementation of digital systems* |

| | | and infrastructure to support better outcomes and experience for patients and public |
|---|---|---|
| SO6: Support children to have the best start in life | CAUTIOUS | The Health Board will proactively reduce risk in pursuit of options that will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements. |

## 7. CORPORATE RISK REGISTER

7.1. The Corporate risk register (CRR) provides a framework for monitoring risks deemed signification to the delivery of corporate objectives set out within the annual plan.

7.2. The CRR is owned by the Risk Management Group, and will be subject to a bi-monthly review as a standing item, and risks with a current rating of 15 and above will be included.

7.3. Risks with a lower rating will be incorporated within Integrated Health Care risk registers, and kept under review in order to ensure escalating risks are proactively identified.

7.4. The CRR will be reviewed on a monthly basis in order to ensure its completeness, alongside risks with a lower current risk rating.

7.5. A formal internal assessment of the CRR's completeness will be undertaken on a bi-annual basis and submitted to the Audit Committee for the purposes of providing assurance on :

7.5.1. The completeness of the clinical and corporate risk profile, when triangulated with significant issues for incorporation with the Annual Governance Statement

7.5.2. Whether any risks on the CRR require inclusion onto the Board Assurance Framework

7.5.3. Reviews undertaken to determine de-escalation of risks as well

7.5.4. Consideration has been given to significant risks arising from internal and external sources (as outlined in section 9 of this document)

7.6. As part of the process of monitoring the CRR, staff will be actively encouraged and empowered to raise any new or emerging risks as part of their day to day work, subject

to independent verification by the lead Executive Director and Risk Management Team.

7.7. The CRR will be reviewed on the following frequency, within the Board and committee structure

| Forum | Frequency | Role/Purpose |
|---|---|---|
| Risk Management Group | Bi-monthly | Assurance, and oversight of maintenance of document |
| Quality, Safety and Experience Committee | Bi-monthly | Assurance on the CRR in its capacity as the Risk Committee of the Board, taking into account assurances received from the work of the Risk Management Group |
| Audit Committee | Quarterly | Independent Scrutiny and Challenge of the risk management process |
| Performance, Finance and Information Governance Committee | Bi-monthly | Assurance and oversight of risks relevant to the Committee |
| Partnerships, People and Population Health Committee | Quarterly | Assurance and oversight of risks relevant to the Committee |
| Mental Health and Capacity Committee | Quarterly | Assurance and oversight of risks relevant to the Committee |
| Board | Annually | Year End assurance, taking into account detailed work undertaken by the Board's Committees |

## 8. THE BOARD ASSURANCE FRAMEWORK (BAF)

8.1. An effective Board Assurance Framework gives the Board a simple comprehensive tool for effective and focused management of the principal risks to meeting its objectives.

8.2. It provides a structure for the evidence to support the Annual Governance Statement disclosure. It simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

8.3. The Board Assurance Framework provides the Board with a mechanism of identifying and assessing risks significant to the delivery of Health Board strategy, whilst evaluating the effectiveness of controls, and the monitoring of action plans.

8.4. The Board Assurance Framework (BAF) is based on six key elements:
   8.4.1. Clearly defined principal objectives aligned to clear lines of responsibility and accountability.
   8.4.2. Clearly defined principal risks with an assessment of potential impact and likelihood.
   8.4.3. Key controls by which these risks are being and can be managed.
   8.4.4. Quantification of the strengths and weaknesses of potential and actual assurances that the risks are being properly managed.
   8.4.5. Reports identifying those risks are being reasonably managed and objectives being met, together with the identification of any gaps in assurances and in control
   8.4.6. Action plans which ensure the delivery of objectives control of risk and improvements in assurances.

8.5. The BAF cover reports will be aligned to incorporate assurances to support the Chief Executive's Annual Governance Statement Disclosure.

8.6. *Specifically, BAF assurance reports to the Board will reflect:*
   8.6.1. *An overview of the strategic objectives new risks added since the last meeting*
   8.6.2. *Changes in risk ratings*
   8.6.3. *Updates on delivery of action plans, at points in which they fall due*
   8.6.4. *Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.*
   8.6.5. *Triangulation with any other items on the agenda, such as performance reports*
   8.6.6. *Recommendations for remedial actions that require detailed board review*

8.7. *Lastly, the BAF reports will flag risks that require escalation to the Board in a timely manner.*

8.8. The BAF will be refreshed annually considering :

*8.8.1. Risks which may prevent the Health Board from achieving the Strategic Objectives will be set out in the Board Assurance Framework.*

***8.8.2. At the end of each financial year, the Board will collectively review the BAF, to identify the risks significant to the delivery of the organisation's strategic objectives.***

8.9. Further new risks proposed for inclusion on the Board Assurance Framework will be added following the agreement of the Board as they arise.

8.10. Each risk in the BAF will be scored using the Health Board's Risk Scoring Matrix, and monitored in accordance with the frequency set out.

8.11. The Board Assurance Framework will be reviewed quarterly by the Health Board.

## 9. RISK MANAGEMENT DUTIES

### 9.1. Chief Executive

9.1.1. As Accountable Officer  of the Health Board, the Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the Health Board's objectives, whilst safeguarding public funds and assets

9.1.2. The Chief Executive will ensure that executive directors have appropriate access to annual training and education for risk management in healthcare to enable them to undertake their roles effectively.

9.1.3. The Chief Executive will ensure that there are robust arrangements for business continuity planning.

9.1.4. The Chief Executive is responsible for ensuring that the Health Board is administered prudently and economically and that resources are applied efficiently and effectively.

### 9.2. Executive Directors and Senior Directors

9.2.1. The Executive Directors and Senior Directors are accountable to the Chief Executive for all areas of risk and assurance in respect of areas in their remit,

including the maintenance of live risk registers, which are monitored regularly, as well as maintaining visibility of assurance and effectiveness of mitigations.

9.2.2. Executive Directors and Senior Managers are collectively accountable for risk management and ensuring risk management arrangements are embedded in their areas of responsibility, with specific roles outlined below:

## 9.3. Executive Medical Director

9.3.1. The Executive Medical Director has delegated overall strategic responsibility from the Chief Executive for the management of risk in the Health Board and is the Executive Lead Director for devising, implementing and embedding all risk processes throughout the organisation.

9.3.2. The Medical Director will provide advice on risk management to the Executive Directors and Board, and will recommend the inclusion of risks on the Board Assurance Framework.

9.3.3. The Executive Medical Director will ensure the corporate risk register is reviewed monthly at the Risk Management Group, with remedial actions put in place to address non-compliance.

## 9.4. Board Secretary

9.4.1. As the Health Board lead for strategic risk, the Board Secretary is responsible for:

9.4.1.1. Drafting and refreshing the risk management strategy

9.4.1.2. Overseeing the process of implementing the strategy

9.4.1.3. Maintaining and updating the BAF, whilst ensuring timely submissions are made to the Board and Assurance Committees as appropriate

9.4.1.4. Ensuring the Annual Governance Statement requirements pertaining to risk management are met on an annual basis

## 9.5. Executive Director of Nursing and Midwifery

9.5.1. The Executive Director of Nursing and Midwifery will ensure nursing and midwifery staff comply with all safety and risk management procedures, providing assurance on the management of risks related to their professional practice, liaising with professional bodies as required.

9.5.2. The Executive Director of Nursing and Midwifery will maintain a live risk register incorporating significant risks pertinent to their area of accountability, and ensure that it is updated on a monthly basis

**9.6. Executive Director of Finance**

9.6.1. The Executive Director of Finance is also the Senior Information Risk Owner (SIRO) and has executive responsibility for the identification, scoping definition and implementation of an information security risk programme.

9.6.2. The SIRO oversees the development of an Information Risk policies and procedures; ensures that the Health Board's approach to information risk is effectively resourced and executed and provides a focal point for resolution of information risk issues.

9.6.3. The SIRO will act as an advocate for information risk on the Board and in internal discussions, and will provide written advice to the Accountable Officer on the content of the annual Governance Statement about information risk.

9.6.4. The Executive Director of Finance has responsibility for ensuring that the Health Board operates within financial constraints and balances competing financial demands and overseeing the delivery of the internal audit plan and associated internal audit recommendations.

9.6.5. The Executive Director of Finance is accountable to the Board for the delivery of the financial plan and digital strategies, and for managing associated risk, and for maintaining a risk register incorporating significant risks.

**9.7. Executive Director of Workforce and Organisational Development**

9.7.1. The Executive Director of Workforce and Organisational Development is responsible for ensuring risks deemed significant to the delivery of workforce objectives are met, with assurance reports feeding into the Workforce Assurance Committee, Board, and elsewhere as appropriate.

9.7.2. As Executive lead for Health and Safety, the Executive Director of Workforce and Organisational Development is responsible for ensuring the timely identification and mitigation of risks to Health and Safety, as well as the maintenance of a live risk register, that is updated at least monthly.

**9.8. Executive Director of Integrated Clinical Services**

9.8.1. The Executive Director of Integrated Clinical Services is responsible for ensuring the delivery safe and effective care whilst mitigating associated risks, such as risks to delivery of targets being achieved.

9.8.2. In discharging this duty, the Executive Director of Integrated Clinical Services will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated.

9.8.3. The Executive Director of Integrated Clinical Services will maintain a live risk register within their scope of responsibility.

## 9.9. Executive Director of Public Health

9.9.1. The Executive Director of Public Health is responsible for ensuring the delivery safe and effective care within Population Health and Mental Health, whilst mitigating associated risks, such as risks to delivery of targets being achieved. In discharging this duty the Executive Director of Public Health will ensure a ***robust divisional accountability*** infrastructure is in place in order to provide assurance that risks are being appropriately mitigated

## 9.10. Executive Director Of Therapies & Health Sciences

9.10.1. The Executive Director of Therapies & Health Sciences is responsible for ensuring the delivery safe and effective care whilst mitigating associated risks, such as risks to delivery of targets being achieved.

9.10.2. In discharging this duty, the Executive Director of Therapies & Health Sciences will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated.

9.10.3. The Executive Director of Therapies & Health Sciences will maintain a live risk register within their scope of responsibility.

## 9.11. Chief Digital and Information Officer

9.11.1. The Chief Digital and Information Officer is responsible for ensuring a robust digital infrastructure is in place to support the delivery of safe and effective care whilst mitigating associated risks, such as risks to delivery of targets being achieved.

9.11.2. In discharging this duty the Chief Digital and Information Officer will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated.

9.11.3. The Chief Digital and Information Officer will maintain a live risk register within their scope of responsibility.

## 9.12. Director of Communications and Engagement

The Director of Communications and Engagement is responsible for ensuring robust arrangements are in place to mitigate risks within their remit, as well as maintaining a live risk register that is updated regularly.

## 9.13. Independent Members

9.13.1. Independent Members (IMs) have an important role in risk management, seeking assurance on the effectiveness of procedures and controls through constructive challenge and holding the Executive Directors and Senior Management to account. The role of IMs is not to manage individual risks, but to satisfy themselves that the Health Board's risk management arrangements are robust and fit for purpose.

## 9.14. All Staff

9.14.1. All staff have a responsibility to:

9.14.1.1. Familiarise themselves with and comply with Health Board Risk Management Policy and processes

***9.14.1.2. Attend appropriate risk management training deemed necessary to enable them to undertake their duties***

9.14.1.3. Mitigate risks over which they have control in their daily work

9.14.1.4. Proactively escalate concerns in instances where gaps in risk management training are identified, as soon as reasonably possible to their line manager.

9.14.1.5. Report breaches of compliance as outlined within the risks management strategy, whether by others or by themselves

## 10. GOVERNANCE ARRANGEMENTS FOR RISK MANAGEMENT

## 10.1. Health Board

10.1.1. The role of the Board includes the identification, treatment and monitoring of risks signification to the delivery of the organisation's strategic objectives, which is aided by the use of a Board Assurance Framework (BAF).

10.1.2. The BAF document has been established by the Board and will be reviewed on a Bi-Monthly basis.

10.1.3. **The Executive Team** will retain operational oversight, application and maintenance of the BAF. Its key elements include:

    10.1.3.1. Identification of the principal risks that may threaten the achievement of Board identified strategic objectives

    10.1.3.2. Identifying the design of controls to manage these principal risks

    10.1.3.3. Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk

    10.1.3.4. Identifying assurances and are gaps in controls and / or assurances

    10.1.3.5. Instigating corrective plans where gaps in control have been identified

    10.1.3.6. Dynamic risk management including a well-founded risk register

10.1.4. The Board, through its Committees, is responsible for monitoring the internal control arrangements in each financial year to support the Annual Governance Statement Disclosure declaration.

10.1.5. As part of the delivery of this strategy, the Board will:

    10.1.5.1. Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner and monitored through the BAF and the Board agenda

    10.1.5.2. Assess and evaluate the appropriateness of risk tolerance levels set out in the risk tolerance matrix and formally agree any amendments.

    10.1.5.3. Monitor significant risks via the BAF, whilst receiving assurance from Board committees, on the implementation of mitigating actions

## 10.2. Board Committees

10.2.1. Each Committee of the Board has specific responsibility for seeking on going assurance on the effectiveness of the arrangements for managing key risks.

10.2.2. The Board will formally review the effectiveness of each Committee annually to support the review of the system of internal control.

10.2.3. Board Committees all have responsibility for elements of the risk management system, with the Audit Committee independently assessing its effectiveness

## 10.3. Audit Committee

10.3.1. The Audit Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The Committee will seek assurance that the Health Board's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.

10.3.2. Independent members of the Audit Committee will play a key role in the internal control assurance processes, by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Health Board risk register.

10.3.3. To aid this assurance, the Committee's work plan incorporates a review of the organisation's risk management processes, and associated risk registers, from divisional to corporate level on a cyclical basis, to gain assurance that systems in place are effective.

10.3.4. The Committee will monitor action plans associated with the delivery of this strategy.

10.3.5. The Audit Committee will provide assurance to the Board on the effectiveness of the system of internal control through:
10.3.5.1. Regular monitoring of significant corporate and strategic risks on behalf of the Board

10.3.5.2. Monitoring of the implementation of the internal audit plan, and of associated internal audit recommendations, requesting further assurance on the management of risks identified from audits with limited assurance opinion

10.3.5.3. Formally reviewing the system of internal control annually taking assurances from Board Committees on management of detailed risks.

## 10.4. Quality, Safety and Experience Committee

10.4.1. The Quality, Safety and Experience (QSE) Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy

10.4.2. As the Risk Committee of the Board, the QSE Committee will meet six times a year and will review significant risks with a Health Board wide impact and the BAF at each meeting

10.4.3. As part of its role the QSE Committee will seek detailed assurance reports on significant risk areas identified through the aggregation of incidents, complaints, never events and claims

10.4.4. The Committee will report to the Board via a Chair's assurance report, with specific assurance given on the action plans to mitigate risks, as well as independent sources of assurance where possible.

10.4.5. The QSE Committee will review risks with a residual rating of 15-25, **with a particular focus on risks to patient safety, quality and patient experience, taking into account risks identified through clinical and internal audit processes**

10.4.6. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will review and monitor progress against mitigation of key risks at each meeting on a bi-monthly basis.

10.4.7. As part of the implementation of this strategy the QSE Committee will:

10.4.7.1. Review assurances on learning and how it is embedded in divisions to manage risks. ***The Committee will regularly review recurring themes from incidents, complaints, Regulation 28 coroner reports as well as serious incidents***

10.4.7.2. Request detailed reports on the top strategic risks as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports

10.4.8. As part of its remit, the Committee has a responsibility to monitor the delivery of the Quality Improvement Strategy, Clinical Strategy and associated risks

## 10.5. Performance, Finance and Information Governance (PFIG) Committee

10.5.1. As part of the delivery of this strategy the Committee will:

10.5.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.5.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.5.1.3. Monitor the implementation of the:

- Digital Strategy
- Integrated Medium Term Plan
- Savings Plan
- Performance recovery plans and associated targets

10.5.2. In addition, the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.5.3. ***The PFIG Committee will review risks with a residual rating of 15-25, with a particular focus on risks to performance, finance and information***

*governance, taking into account risks identified through external and internal audit processes.*

## 10.6. Partnerships, People and Population Health (PPPH) Committee

10.6.1. As part of the delivery of this strategy the Committee will:

10.6.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.6.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.6.2. Monitor the implementation of the People Strategy, Living Healthy Staying Well, and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

***10.6.3. The PPPH Committee will review risks with a residual rating of 15-25, with a particular focus on risks to Population Health, Transformation, people and partnerships, taking into account risks identified through external and internal audit processes***

## 10.7. Mental Health Capacity Compliance Committee

10.7.1. As part of the delivery of this strategy the Committee will:

10.7.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.7.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.7.2. Monitor the implementation of key legislative requirements and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

***10.7.3. The MHCC Committee will review risks with a residual rating of 15-25, with a particular focus on risks to Population Health, Transformation, people and partnerships, taking into account risks identified through external and internal audit processes***

### 10.8. Risk Management Group

10.8.1. The Risk Management Group (RMG) will maintain operational oversight of the risk management systems and process, whilst ensuring they are fit for purpose and embedded across all areas of the Health Board in line with this Risk Management Strategy.

10.8.2. The Group will also maintain oversight of risks and providing scrutiny and oversight of the full Corporate Risk Register prior to review by Board Committees. The Risk Management Group will report to the QSE Committee, providing assurance on arrangements put in place by senior managers to proactively identify and mitigate risk. The RMG will also perform the following functions:

10.8.2.1. Review, scrutinise and challenge the effectiveness of proposed or current mitigations, and actions pertaining to risk register reports, including new risks that have been approved by Executive Directors for inclusion on the CRR/Tier 1.

10.8.2.2. Undertake deep dives and `check and challenge` of risks on the CRR including those that have been approved for the CRR/Tier 1 as well as challenge any change in risk scores that have been approved by Executive Directors and advice appropriately.

10.8.2.3. Receive assurance reports from the Head of Risk Management triangulating risks from other sources (such as clinical audit, never events, serious incidents, internal and external audits) and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.

10.8.2.4. Review and scrutinise risk management performance reports, audits, the updated Risk Management Strategy and its associated procedural documents as well as any other risk management related reports and advise accordingly.

## 10.9. Executive Delivery Groups

10.9.1. The Executive Delivery Group Chair of the organisation have a duty to ensure a live processes ensure risks are identified proactively and robustly mitigated, escalating in a timely manner where appropriate.

10.9.2. The Executive Delivery Groups (EDGs) of the Health Board are:
- Population Health
- People and Culture
- Performance and Finance
- Quality
- Transformation

10.9.3. As part of the implement of this strategy, risk management will be a standing agenda item on the EDG agendas, and a record of appropriate action taken in relation to existing or new risks.

10.9.4. Each EDG Chair will ensure that a process is in place to ensure significant risks are escalated and mitigated in a timely and effective manner.

## 10.10. Local Quality, Safety and Governance Meetings

10.10.1. As part of the implementation of this strategy, all senior managers will put in place the necessary arrangements to maintain oversight of the proactive and effective management of risks through in place for good governance, quality, safety and effective risk management.

10.10.2. Senior managers will ensure monthly Quality and Safety or governance meetings are held, with a particular focus on monitoring and updating their risks, whilst enabling environment for bottom-up risk reporting with Services and Departments under their remits routinely providing their risk register reports for review, scrutiny, assurance and oversight.

10.10.3. Through the implementation of this strategy senior managers will ensure a devolved accountability infrastructure is in place to maintain visibility of risks at all levels

## 10.11. Health and Safety Risks

10.11.1    Employers are required under the Management of Health and Safety at Work Regulations 1999, the Health and Safety at Work etc, Act 1974 and other pieces of legislation to protect their employees, and others, from harm.

10.11.2    Employers and employees thus have a duty of care to protect the health, safety and welfare of anyone who may be affected by their actions and/or omissions. Health and Safety risks, which arise within the context of occupational health and relation to assessment of hazards that could lead to the harm, injury, death or illness of a worker in a workplace.

10.11.3    Examples of Health and Safety risks include fall from height electrocution, water safety, confined spaces, construction, asbestos, COSHH, fire safety, slips, trips and falls , violence and aggression, work-related accidents and ill health.

## 11.  APPROACH TO RISK

## 11.1. Risk Identification

11.1.1.  The risk management process is outlined in detail within the Risk Management Policy.

11.1.2.  As part of the implementation of this strategy, the Health Board will put in place proactive and reactive approaches to the identification of risks, primarily through the risk assessment processes which assess the potential to cause any of the following:

11.1.2.1.  Harm to patients and staff

11.1.2.2.  Complaints

11.1.2.3.  Litigation

11.1.2.4.  Statutory and Regulatory compliance

11.1.2.5.  Damage to the environment or property

11.1.2.6.  Failure to maintain services and/or the quality of services provided by the Health Board,

11.1.2.7. Failure to meet national and organisational targets, loss of reputation and financial loss etc.

## 11.2. Sources of risk identification

11.2.1. There are internal and external sources of risk:

11.2.1.1. Internal risks are identified, in the course of strategic and business planning, adverse incidents, complaints, claims, noncompliance with statutory duties and guidance, enquiries and clinical/nonclinical hazards identified for any Health Board activities, via accountability reviews.

11.2.1.2. External sources of risk are identified in the course of risk alerts, hazard warnings and recommendations received by the Health Board from a recognised external source – e.g. information from the Medicines & Healthcare Products Regulatory Agency (MHRA), HIW, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE), inquiries and other bodies. These will be communicated immediately and applied as appropriate in the Health Board.

11.2.2. In implementing this strategy, the Health Board's goal is to ensure that the effect of any risk is reduced to an acceptable level or negated completely. In practice, this will be executed by using internal and/ or external advice to decide on the most appropriate options to treat risk and by sharing best practice and learning from other organisations.

11.2.3. Risk treatment (means of addressing risks) can be broken down into the following:

11.2.3.1. Terminate - some risks may only be managed by terminating the activity (i.e. avoiding the risk by not undertaking the activity that could lead to the risk occurring)

11.2.3.2. Treatment - preventative controls are measures currently in place when a risk is identified to control the risk i.e. directive controls or

policies and processes, clear labelling of packages, checking a patient's identity before a procedure. If existing controls are shown not to be adequate, e.g., gaps are identified; an action plan should be produced to ensure the risk is mitigated with additional controls. Action plans will be approved initially by a division as per the risk reporting arrangements

11.2.3.3. Transfer - for some risks, the best method of control is to transfer them to a third party to reduce the exposure to the Health Board or because another organisation will manage the risks more effectively, e.g. financial risks can sometimes be transferred by effecting insurance).  However, this process needs to be carefully managed and internally validated to ensure the Health Board's exposure is minimised.

11.2.3.4. Tolerate - the exposure to the risk may be tolerable/accepted without any further controls.

11.2.4. In assessing, any mitigating actions associated with a risk there should also be an assessment of the impact of such actions.

11.2.5. All managers have authority for risks in their areas of responsibility in line with their resources available to them to eliminate or control the risk.  Where the manager does not have suitable or sufficient resources, they should refer the issue to their line manager.

## 12.  RISK MANAGEMENT PROCESS

12.1. The Risk Management process is summarised in figure 4 below, and incorporates a proactive and reactive approach.

12.2. Risk assessment is an iterative process and all risks will be periodically reviewed and re-assessed in view of contextual changes.

12.3. Re-assessment is undertaken proactively at intervals proportionate to the risk magnitude and risk appetite as well as reactively in response to anticipated or known changes.

12.4. The Health Board will explore its risk appetite for significant risks through a review of the Board Assurance Framework, Health Board risk register and evidence considered as to whether residual risks are acceptable or not.

12.5. All strategic risks will be reviewed on a bi-monthly basis by the Executive Directors who confirm their management through the content of the BAF in preparation for presentation to the Board.

12.6. All moderate and significant risks (current risk score 9-25) will be reviewed by the Executive Directors who will confirm their approach to mitigation through the content of the Health Board risks register operationally at Health Board Management Board, and also the Risk Management Committee on an alternate basis in preparation to the Board for their consideration

12.7. All lower level risks (with a current risk score less than 9) are reviewed and managed locally by the Divisional management in their Governance meetings.

12.8. Risks which are not considered acceptable at a local level will be escalated as appropriate, and managed through strategic and operational change or transferred (e.g. by contracting out) leaving acceptable (and opportunity) risks.

12.9. Such risks are managed and mitigated through the Risk Management processes and retained risks are recorded and reviewed through the Health Board's risk registers.

# Figure 4: Risk Management process

**Risk Identification**
- Regulatory requirements
- Quality Metrics
- Quality impact assessment
- Early warning trigger tool
- Information Security
- Incident Claims and complaints (
- Financial Risk
- Clinical Risk
- Fraud Risk
- Clinical Audit
- Strategic and Corporate Objectives

**Risk Assessment**
a)  Assess severity of risk
Ascertain likelihood and impact of risk
= Gross Risk
b)  Identify and grade controls in place
= Risk Mitigation
c)  Reassess severity of net Risk
= Current Risk

**Risk Acceptable?**

**Risk Monitoring**
- Manage locale and review regularly in divisional meetings
- Performance monitoring of divisions at Health Board level meetings

**Risk Evaluation**
- Identify further controls
- Validate proposed controls
- Assign Lead
- Set implementation date
- Set review dates
- Identify and articulate
- Assess resources required

Corporate Risk Register level monitoring

**Risk Monitoring**
- Risk monitoring by Executive Director
- Monitor implementation of risk mitigation plans
- Provide monthly update to Risk Management Committee
- Escalate risks in accordance with risk tolerance matrix
- Monitor progress against residual risk

**Communicate risk to Stakeholders**
**Internal**
- Local Staff
- Managers
- Contractors
- Committees
**External**
- Commissioners

**Review using key indicators**
- Feedback from staff
- Incidents
- Complaints
- Claims
- Performance Reports

**Renew Completed Actions**
- Re – assess and re – grade residual Risk
- Accept sign – off residual Risk
- Set review date

**Risk Acceptable?**

**Risk Monitoring**
Manage and review at Executive Director Level at Risk Management Group

## 13.  PROACTIVE RISK MANAGEMENT APPROACH

13.1. Internal inspections/reviews and assessments

13.2. Risks will be identified, assessed and mitigated through internal inspections or reviews, e.g.:

13.2.1. Statutory/Regulatory gap analysis or internal self-assessment

13.2.2. Delivery of clinical audit plan

13.2.3. Health, safety and fire inspections

13.2.4. Internal infection control visits

13.2.5. Health Inspectorate Wales peer reviews

13.2.6. Internal audit reviews

13.2.7. Internal assessment of risks

13.3. Risks identified will be escalated in accordance with the thresholds set out in the Risk Tolerance Matrix.

### 13.4. Quality impact assessment tool

13.4.1. A Quality Impact Assessment Tool provides a consistent approach to ascertaining the impact on quality associated with service changes.

13.4.2. It is intended to support quality governance by assessing the impact of CIPs and service change on quality.

13.4.3. It involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

13.4.4. Where a negative impact score of nine and above is identified, a detailed quality impact assessment is required, with associated mitigations.

13.4.5. The Quality Assurance Committee will monitor action plans associated with a negative impact score of 15 and above, and also action plans resulting in a

positive impact. Quality impact assessments with an adverse impact will be generated onto the Health Board risk register and monitored in line with other quality risks

13.4.6. Risks will be escalated in accordance with levels set out in the *risk tolerance* matrix.

## 13.5. Learning from external sources

13.5.1. The Health Board will put in place a Development Programme that incorporates learning from various sources, such as coroner interventions and inspections by the Health Inspectorate Wales for example.

13.5.2. Where appropriate and relevant, the Board will delegate the monitoring of action plans to specific Committees, receiving assurance through Chair Assurance reports.

13.5.3. The Health Board ensures that there is a systematic approach to the analysis of incidents, complaints and claims to enable learning and improvement as part of the implementation of this strategy.

13.5.4. The Executive Directors will instigate a robust process to ensure that risks identified from learning are added to the corporate risk register, where appropriate, with associated action plans, which are reviewed regularly by the Risk management Group.

## 13.6. Early Warning Trigger Tool

13.6.1. The Health Board will develop an Early Warning Trigger Tool (EWTT) with a set of automatically weighted indicators (with a possible maximum score of 50) which taken together indicate how well a ward is functioning, and provide an early warning, pre-empting more serious concerns and enabling action before things go wrong.

13.6.2. The output of the EWTT enables ward managers and Divisional directors to benchmark the overall risk on their wards and non-clinical areas , as appropriate with others, resulting in the rapid identification of remedial action

13.6.3. The EWTT provides robust and reliable information from 'Ward to Board' offering the Health Board further assurance of the quality of care specifically at an individual clinical team level.

13.6.4. The EWTT will also be adapted for use in non-clinical areas applying 'early warning' metrics such as sickness absence, freedom to speak up issues, never events, near misses

13.6.5. The table summarises the risk escalation process based on ranges of EWTT scores:

| Score Analysis Guide | Early Warning Trigger Tool score |
|---|---|
| Executive Team monitoring and Health Board escalation and assurance | 40-50 |
| Health Board-wide Performance  monitoring , Executive Director monitoring and Quality Assurance Committee escalation and assurance | 30-40 |
| Divisional Director and Health Board-wide Performance Executive Committee escalation | 20-30 |
| General Manager escalation | 10-20 |
| Service /Ward Manager escalation | 0-10 |

## 14.  REACTIVE RISK MANAGEMENT APPROACH

14.1. As part of delivering this strategy, the Health Board will identify risks arising from serious incidents, claims, complaints and incidents and form action plans to reduce risks to a tolerable level.

14.2. The Health Board operates a fair, just culture to ensure staff feel able and confident to report events or concerns.

14.3. Risks arising from complaints, incidents and near misses rated 9 or above ('amber' or 'red') using the Risk Scoring Matrix will be entered on the Health Board Risk Register

and escalated in accordance with the Health Board's risk escalation process as articulated in the risk tolerance matrix

14.4. Claims scored using the Health Board's Risk Scoring Matrix and those rated 9) or above) will be entered on the Health Board Risk Register and are escalated in accordance with the Health Board's risk escalation process.

14.5. The Medical Director will ensure a process is in place to review reports produced by Internal and External Audit with an audit opinion of limited assurance ensuring risks are identified and placed on the risk register as appropriate.

## 15.  REGULATORY COMPONENTS OF RISK MANAGEMENT

15.1. In delivering this strategy, the Health Board will consider the following aspects of statutory compliance, and the management of associated risks.

15.1.1.  Health and Safety Legislation and policies

15.1.2.  Health Inspectorate Wales

15.1.3.  Statutory Annual Governance Statement Disclosure

15.1.3.1.  The Health Board will put in place robust arrangements to comply with requirements from the Annual Reporting Manual in relation to the production of an annual Governance statement disclosure, which is assured by an effective risk management system.

### 15.2. Monitoring the Implementation of this Strategy

15.2.1.  The implementation of this strategy will be monitored by:

15.2.1.1.  Routine monitoring of the risks by the Quality Safety and Experience Committee, and oversight of the framework relating to risk by the Audit Committee.

15.2.1.2.  The Health Board's progress against its strategic and corporate objectives.

15.2.1.3. Assurance from internal and external audit reports that the Health Board's risk management systems are being implemented.

15.2.1.4. Annual updates to the Board as part of the year-end review.

**15.2.1.5. *An external review of governance and leadership every three years in line with the UK Corporate Governance Code provisions.***

| Report title: | 2022/23 Board Assurance Framework | | |
|---|---|---|---|
| Report to: | Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | |
| Executive Summary: | The purpose of this report is to enable the Board to review and agree the revised BAF for the 2022/23 period and the proposed approach to monitoring the document | | |
| Recommendations: | The Board is asked to:<br><br>• Note and approve the 2022/23 BAF document format and the proposed approach to monitoring the BAF as set out in section two of the report<br>• Note and approve the actions agreed at the June Board workshop for the legacy BAF<br>• Note and approve the adoption of the new BAF risks summarised in section 3 of the report as well as the BAF document | | |
| Executive Lead: | Board Secretary | | |
| Report Author: | Molly Marcu, Interim Board Secretary | | |
| Purpose of report: | For Noting ☐ | For Decision ☒ | For Assurance ☐ |

| Assurance level: | Significant ☐ | Acceptable ☐ | Partial ☒ | No Assurance ☐ |
|---|---|---|---|---|
| | 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 | No confidence/evidence in delivery |

**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:**

The BAF includes the risks deemed most significant to the delivery of the strategic objectives of the Health Board. Of those risks, some are outside of the risk appetite /and have significant gaps in controls and assurance

| Link to Strategic Objective(s): | ALL |
|---|---|
| **Regulatory and legal implications** | Alignment to regulatory requirements associated with delivery of patient care as well as a safe working environment under the Health and Safety at Work Act |
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol**<br>**Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below** | Y |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | (summarise risks here and provide further detail)<br><br>(crynodeb o'r risgiau a rhagor o fanylion yma) |
| **Financial implications as a result of implementing the recommendations** | Risk Management training will be required as part of the process of enhancing the risk maturity of the organisation |
| **Workforce implications as a result of implementing the recommendations** | Not applicable |

| | |
|---|---|
| **Feedback, response, and follow up summary following consultation** | Feedback received from<br><br>Executive team, QSE Chair, PFIG Chair, QSE and Audit Committee |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | All |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable<br><br>Amherthnasol |

**Next Steps:**

- The BAF will be closely monitored at Committees and by the Board on a quarterly basis

**List of Appendices:**
2022/23 Board Assurance Framework Appendix 1

**Board**
**4 August 2022**

**Board Assurance Framework**

## 1. Introduction

The Board Assurance Framework enables the Board to fulfil its obligations of ensuring there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks deemed significant enough to impact on the delivery of strategic objectives.

The BAF also provides the Board with a mechanism of identifying and assessing risks significant to the delivery of Trust strategy, whilst evaluating the effectiveness of controls, and monitoring the action plans.

It provides a structure for the evidence to support the Annual Governance Statement disclosure. This simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

The purpose of this report is to provide enable the Board to review the top risks of the organisation, as well as significant risks falling outside of the Board's risk appetite.

## 2. Structure of the Board Assurance Framework

The revised BAF has been revised to align to the structure set out in section 8.6 of the risk management strategy:

- *An overview of the strategic objectives new risks added since the last meeting*
- *Changes in risk ratings*
- *Updates on delivery of action plans, at points in which they fall due*
- *Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.*
- *Triangulation with any other items on the agenda, such as performance reports*
- *Recommendations for remedial actions that require detailed board review*

Future BAF updates will incorporate the following:

- New risks added since the last meeting
- Changes in risk ratings
- Updates on delivery of action plans, at points in which they fall due
- Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.
- Triangulation with any other items on the agenda, such as performance reports

- Recommendations for remedial actions that require detailed board review, with an alignment to the Board and Committee cycle of business as appropriate.

## 3. Outcome of BAF Refresh process

A series of meetings have taken place with Executive and Independent member colleagues as part of the process of refining the Board Assurance Framework, leading up to a board workshop on the 16th of June 2022, where the legacy BAF was considered, and proposed amendments made.

Tables 1 and 2 summarises the outcome of the review of the legacy BAF risks:

### Legacy BAF Risk Summary Position – Retained and Refined risks

| Summary Risk description | Current Score | Action agreed at June Board workshop |
|---|---|---|
| Unscheduled Care | 20 | Risk retained and refined |
| Sustainable key population health services | 15 | Risk retained |
| Sustainable primary care | 20 | Risk retained and refined |
| Planned care | 20 | Risk retained and modified |
| Safe and effective delivery of Mental Health Serviced | 20 | Risk retained |
| Ineffective MH Leadership Model | 15 | Risk retained and increased from 12 to 15 |
| Adverse events due to failure to embed learning | 20 | Propose to archive and modify – risk too broad |
| Staff engagement | 16 | Risk retained |
| Staff recruitment and retention | 16 | Risk retained, and refined |
| Health and Safety Act non Compliance | 20 | Risk retained and modified |
| Failure to implement digital solutions | 20 | Risk retained and modified, subject to review |
| Limitations in capital funding, resulting in failure to provide a safe and compliant estate | 15 | Risk retained and modified |

### Legacy BAF Risk Summary Position – Risks proposed for transfer to the corporate risk register

| Summary Risk description | Current Score | Action agreed at June Board workshop |
|---|---|---|
| Infection prevention and control | 16 | Transfer to Corporate risk register |
| Failure to provide adequate security and lack of CCTV | 20 | Transfer to Corporate risk register |
| Covid response (x2) | 15 | Transfer to Corporate risk register and merge with IPC risk |
| Effective use of resources | 12 | Transfer to Corporate risk register – risk also doesn't meet threshold criteria for BAF |
| Failure to develop estates and assets | 12 | Transfer to Corporate risk register – risk also doesn't meet threshold criteria for BAF |
| Failure to deliver an approved IMTP | 9 | Transfer to Corporate risk register – risk also doesn't meet threshold criteria for BAF, this has now been subsequently revisited following receipt from Welsh Government feedback on the submitted 2022-2025 IMTP |

Risks taken forward into the revised BAF are incorporated within Appendix A of this report

Further developments have informed a decision to re-instate the risk related to the integrated medium term plan (IMTP) on to the Board Assurance Framework as risk 2.4

## 4. New risks added onto the Board Assurance Framework

As part of the BAF refresh process five new risks were added and these were summarised below:

| Risk ID | Risk Description | Current risk rating |
|---------|------------------|---------------------|
| 1.1 | Failure to consistently provide safe provision of care to patients at YGC, resulting in significant harm to patients, poor patient experience and a high number of complaints and claims, as well as a loss of public confidence | 20 |
| 1.2 | Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety , resulting in a deterioration of care and harm to patients and service users | 20 |
| 1.4 | Risk of a consistent failure to meet performance targets, resulting in an adverse impact on patient experience and quality of care, as well as a loss in public confidence | 16 |
| 1.7 | Risk of significant delays in medically fit for discharge patients, as a consequence of shortfalls in resources within the social care setting, adversely impacting on patient safety and patient flow, and patient experience, as well as causing significant winter pressures | 16 |
| 2.3 | Risk of the Health Board's failure to meet the breakeven duty, due to an inability to meet financial targets (once Strategic Support funding ceases), and an inability to achieve the annual savings target | 16 |

Detailed assurances for these risks are incorporated in appendix A of this report, and will further be reviewed in detail for completeness by the respective Board committees (highlighted against column C of the BAF document), ahead of a further submission to the Board in November 2022.

**2022/23 BOARD ASSURANCE FRAMEWORK - JULY 2022**

| Risk Number | Responsible Director | Assurance Committee | Principal Risk | Controls in place to manage risk (mitigation) | Internal assurances | External Assurances on controls | Gaps in control (where the controls are not working or further controls required) | Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained) | Initial Risk Score (impact x likelihood) | Current Risk Score (impact x likelihood) | Tolerable Risk Score (target by year end) | Action plan description | Action plan due date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Strategic Aim 1: Improve physical, emotional and mental health and well-being for all/ Improve the safety and quality of all services |||||||||||||  |
| 1.1 | Executive Director of Integrated Health Care | Quality, Safety and Experience Committee | Failure to consistently provide safe provision of care to patients at YGC, resulting in significant harm to patients, poor patient experience and a high number of complaints and claims, as well as a loss of public confidence | Implementation of YGC improvement plan | Vascular Steering Group, Vascular Quality panel, Quality Safety, Experience Committee, Cabinet oversight of YGC Improvement Plan | Health Inspectorate wales review of YGC ED in March and May 2022, Royal College Surgeons review of vascular services Internal audit review of YGC Governance in 2021 | YGC improvement plan is currently under development and its effectiveness yet to be embedded. YGC ED and Vascular services are highlighted as services requiring significant improvement | All external assurance review of the YGC ED highlight gaps in compliance assurance, specifically: Health Inspectorate wales review of YGC ED, Royal College Surgeons review of vascular services | 20 (4x5) | 20 (4x5) | 16 (4x4) | continue implementation of YGC Action plan | ongoing |
| 1.2 | Executive Director of Nursing and Midwifery , Executive Director of Therpaies and Health Sciences and Medical Director | Quality, Safety and Experience Committee | Risk of the provision of poor standards of care to the patients and population of North Wales, falling below the expected standards of quality and safety , resulting in a deterioration of care and harm to patients and service users | Monitoring the delivery of the Quality improvement strategy Revised Quality improvement strategy Monitoring of Quality dashboard, series incidents, and never events YGC improvement plan | Quality, Safety and Experience Committee oversight Implementation of clinical audit plan | Health Inspectorate wales review of YGC ED in March and May 2022, Royal College Surgeons review of vascular services CHC review of services in 2021/22 financial year | Limited assurance on embedding HIW requirements in relation to the March and May 2022 inspections | Limited assurance opinion on clinical audit plan | 20 (4x5) | 20 (4x5) | 16 (4x4) | currently under review | |
| 1.3 | Executive Director of Integrated Health Care | Quality, Safety and Experience Committee | Failure to effectively manage unscheduled care demand and capacity infrastructure, adversely impacting on quality of care and patient experience | Revised Unscheduled Care Improvement Group in place to oversee the USC improvement programme of work and monitor performance which provides regular reports to the Performance, Finance & Performance. Governance Committee | QSE and PFIG | none identified | Unscheduled care performance continues to be challenged, impacted by capacity and flow through hospitals. Delays to ambulance handover continue, resulting in poor experience and increased clinical risk across the system | None identified | 20 (4x5) | 20 (4x5) | 16 (4x4) | Review of Phase 1 of the Unscheduled Care Improvement Programme completed and stakeholder engagement for Phase 2 concluded. Transition commenced to 'Six-goals for Urgent & Emergency Care' Programme System wide focus on ambulance delays and reduction on delays with joint working between BCUHB/WAST/DU | |
| 1.4 | Executive Director of Integrated Health Care | Quality, Safety and Experience Committee | Risk of a consistent failure to meet performance targets, resulting in an adverse impact on patient experience and quality of care, as well as a loss in public confidence | Clinical harm reviews, management of overdue follow-up appointments, implementation of clinical prioritisation process. Referrals of P2 Status patients to regional hubs and weekly Clinical review every 7 post P2 Breach. Harm review process. Use of the Independent Sector for Outsourcing and Insourcing for pressured specialties where availability exists. Access/choice policy in place. Detailed operational plans agreed annually | Performance assurance reports to QSE, PFIG and Board | none identified | Substantial challenges remain in delivering elective outpatient activity. There is a gap between capacity and demand in a number of specialties , which has widened since the pandemic | to be confirmed | 20 (4x5) | 20 (4x5) | 16 (4x4) | currently under review | TBC |
| 1.5 | Executive Director of Integrated Health Care | Quality, Safety and Experience Committee | Lack of capacity to manage volume of planned care demand, adversely impacting on quality of care and patient experience, exposing patients to significant patient harm | Manual validation being conducted across all three sites on a daily and end of month basis. Implemented risk stratification system and process for stage 4 patients providing clinical priority with regular monitoring by local Primary targeting list (PTL) and access group. Head of Planned Care overseeing the plan and variance to the plan with monthly reporting to the Director of Regional Delivery and bi-monthly reporting to the Performance, Finance and Information Governance Committee. | Enhanced monthly meetings to focus solely on planned care performance chaired by the Director of Performance, with assurance feeding through to Performance, Finance and Information Governance Committee. revised Monthly meetings to focus solely on planned care performance chaired by the Interim Director of Performance, aligns to Performance, Finance and Information Governance Committee. Introduction of further validation staff in Q3/4 non recurring complete. Review of validation techniques and validation SOP completed; now ready for deployment and adoption. | Audit Wales' review of planned care across North Wales, due to be presented to the Audit Committee in September 2022 Waiting list Limited assurance audit opinion internal audit report | Gaps in control were identified in the risk stratification process as part of the waiting list internal audit review | None identified | 20 (4x5) | 20 (4x5) | 16 (4x4) | Patients on the waiting lists have been prioritised, with those categorised as P1 and P2 still being treated through the pause period. Less urgent cases are now being treated in core activity, however still subject to operational disruptions Outsourcing contracts for Orthopaedics and Ophthalmology were extended to support long waiting patients . Business case for further modular theatre and wards to provide "north Wales" capacity is being finalised | |

**BETSI CADWALADAR UNIVERSITY HEALTH BOARD**

**2022/23 BOARD ASSURANCE FRAMEWORK - JULY 2022**

| Risk Number | Responsible Director | Assurance Committee | Principal Risk | Controls in place to manage risk (mitigation) | Internal assurances | External Assurances on controls | Gaps in control (where the controls are not working or further controls required) | Gaps in assurance i.e. negative/limited or no assurance (where assurance has not been gained) | Initial Risk Score (impact x likelihood) | Current Risk Score (impact x likelihood) | Tolerable Risk Score (target by year end) | Action plan description | Action plan due date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.6 | Executive Director of Public Health | Quality, Safety and Experience Committee | Risk of instability of the Mental Health leadership model due to unstable temporary staffing arrangements and high turnover of staff resulting in poor performance, a lack of assurance and governance, and ineffective service delivery. | Delivery of mental health improvement plan Implementation of recruitment plan for the Mental Health Service Interim senior management is currently in place alongside other key posts; Interim Director, Interim Director of Nursing, Interim Deputy Director and Interim Director of Operations. Each lead specific programmes and will further support and develop leadership, governance and management.] .Business Continuity Plan including essential service sustainability in place, with engagement from the Corporate Business Continuity Team. Ongoing s are regularly reviewed by the Executive Director to ensure the model is effective in discharging its roles and responsibilities. Implementation of the Mental Health Strategy in a consistent manner across the Health Board | Mental Health Act Compliance Committee and Quality , Safety Experience Committee oversight | CHC review of Mental Health services Independent serious incident review | None identified | Mental Health improvement plan is still under development and therefore requires embedding | 15 (5X3) | 15 (5X3) | 12 (4x3) | currently under review | |
| 1.7 | Executive Director of Integrated Health Care | Quality, Safety and Experience Committee | Risk of significant delays in medically fit for discharge patients, as a consequence of shortfalls in resources within the social care setting, adversely impacting on patient safety and patient flow, and patient experience, as well as causing significant winter pressures | patient flow improvement work Care homes 1000 beds initiative spot purchase of care home capacity Collaborative working with partners and stakeholders implementation of urgent care improvement plan | Unscheduled Care Group oversight Performance , Finance and Information Governance Committee | none identified | Significant shortage of care home beds in social care settings | | 20 (4x5) | 16 (4x4) | 16 (4x4) | | |
| 1.8 | Executive Director of Public Health | Quality, Safety and Experience Committee | There is a risk to the safe and effective delivery of Mental Health services, leading to poorer and inconsistent outcomes, poorer use of resources, failure to learn from events or inequity of access. | Delivery of mental health improvement plan Mental Health and Learning Disabilities Divisional Governance Structure is in place and aligned to corporate governance requirements, providing consistent approach across the Division. | Quality, Safety and Experience Committee oversight partnership and assurance structures are in place. These are: Together for Mental Health Partnership Board (T4MHPB), Local Authority Scrutiny meetings, Local Implementation Teams (LIT), North Wales Adult Safeguarding Board is in place and the division is in attendance. All meetings are formerly minuted and reported with membership regularly reviewed according to their Terms | CHC review of Mental Health services | None identified | Mental Health improvement plan is still under development and therefore requires embedding | 16 (4x4) | 16 (4x4) | 16        (4x4) | currently under review | |
| **2. Strategic Objective:** Target our resources to people who have the greatest needs and reduce inequalities | | | | | | | | | | | | | |
| 2.1 | Executive Director of Workforce and Organisational Development | Partnerships, People and Population Health Committee | Failure to attract or retain sufficient staff (core and flexible) to resource delivery of the strategic priorities due to a lack of integrated workforce planning, safe deployment systems and insufficient support for recruitment and on boarding. This could adversely impact on the Board's ability to deliver safe and sustainable services. | Establishment Control Policy and system in place. Implementation of Roster management Policy. Implementation of Recruitment Policy. Review of Vacancy control process underway to establish a system for proactive recruitment against key staff groups/roles. Implementation of People strategy and plan 2. Review of delivery group structure underway to ensure regional over view and leadership of planning, recruitment and retention. Workforce Service Review programme commissioned and commenced. Implementation of Safe Employment Policy | Partnerships, People and Population Health Committee oversight. Monthly monitoring by People Executive Delivery Group | Pipeline reports produced monthly for review and action by managers across the organisation | National shortages in certain roles | Staff turnover rates | 16 (4x4) | 16 (4x4) | 12 (4x3) | currently under review | |
| 2.3 | Executive Director of Finance | Performance, Finance and Information Governance Committee | Risk of the Health Board's failure to meet the break even duty, due to an inabilty to meet financial targets (once Strategic Support funding ceases), and an inability to achieve the annual savings target | deliver services in a different way Regular reports to PFIG to monitor progress on transformation and the savings targets Review of historic budget allocation against population needs assessment Extension of savings programme into 3 year pipeline, in line with operating model | BCUHB IMTP incorporates a clear programme of work over the 3 year period | none identified | None identified | None identified | 16 (4x4) | 16 (4x4) | 12 (4x3) | currently under review | |
| 2.4 | Executive Director of Transformation | Performance, Finance and Information Governance Committee | Failure to deliver an approved integrated medium term plan incorporating service, workforce, financial balance and delivery of key performance targets to Welsh Government (to ensure statutory duties are met) resulting in a regulatory audit opinion | Planning cycle established with outline BCUHB Planning schedule/overall approach for 2022/2025 - plan led by Assistant Director, Corporate Planning and reporting into the Executive Team and the Partnerships, People & Population Health Committee. | Performance, Finance and Information Governance Committee oversight | none identified | 2022/2025 IMTP not accepted by the Welsh Government | None identified | 16 (4x4) | 16 (4x4) | 12 (4x3) | currently under review | |
| 2.5 | Chief Digital Information Officer | Partnerships, People and Population Health Committee | Failure to implement necessary transformation of the current Informatics Service and operating model to be fit for purpose and to effectively implement essential infrastructure and digital solutions to underpin the delivery of BCUHB strategy and IMTP due to lack of available finances, resources and capabilities. This could impact on the safety of our patients, service efficiency and the reputation of the Health Board, or impact on compliance with legislation resulting in significant financial penalties. | New CDIO reviewing the current operating model and developing proposals and plans for its transformation into a minimum viable Digital, Data and Technology operation for the Health Board in the 2020s. Implementation of digital plan with progress updates in place and monitored internally via the PPPH Committee Development of a resource structure, revenue and capital requirements for corporate planning. | Annual Plan delivery assurance report to PPPH Committee | none identified | Some aspects of the digital delivery plans were not implemented in the 2021/22 period due to resourcing gaps and new requirements emerging from recent discovery work | None identified | 16 (4x4) | 16 (4x4) | 12 (4x3) | currently under review | |
| **3. Strategic Objective:** . Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being | | | | | | | | | | | | | |

**2022/23 BOARD ASSURANCE FRAMEWORK - JULY 2022**

| Risk Number | Responsible Director | Assurance Committee | Principal Risk | Controls in place to manage risk (mitigation) | Internal assurances | External Assurances on controls | Gaps in control (where the controls are not working or further controls required) | Gaps in assurance i.e. negative/limited or no assurance (where assurance has not been gained) | Initial Risk Score (impact x likelihood) | Current Risk Score (impact x likelihood) | Tolerable Risk Score (target by year end) | Action plan description | Action plan due date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1 | Executive Director of Finance | Partnerships, People and Population Health Committee | Failure to provide a safe and compliant built environment, equipment and digital landscape due to limitations in capital funding, adversely impacting on the Health Board's ability to implement safe and sustainable services through an appropriate refresh programme, could result in avoidable harm to patients, staff, public, reputational damage and litigation. | Annual Capital Programme in place, based on priorities as identified by divisions, Core Areas (Estates, Informatics and medical devices) feeding into the Capital Investment Group and onward to the Finance and Performance Committee. 1.Development for business case for key projects identified in key strategies. | Performance, Finance and Information Governance Committee oversight of capital programme delivery | none identified | Delays in the completion of the new Estates Strategy and its consequent alignment to enabling strategies such as the clinical services strategy and quality improvement strategy | None identified | 16 (4x4) | 16 (4x4) | 12 (4x3) | currently under review | |
| 3.2 | Executive Director of Workforce and Organisational Development | Partnerships, People and Population Health Committee | Failure to implement and embed learning from experience in order to improve services, resulting in poor staff morale and a lack of trust and confidence in senior management, leading to poor outcomes impacting on the delivery of safe and sustainable services and the reputation of the Health Board. This could be caused by a lack of clear mechanisms for raising concerns at any and every level. | Implementation of revised Speak out safely process as agreed by the Health Board in July 2021. Implementation of Speak out Safely Guardians report directly to CEO, with an independent board member to support and scrutinise Guardians' role Implementation of Raising Concerns Policy Implementation of SOP which includes agreed role outlines for Guardians, Speak out Safely Champions and independent member and terms of reference for MDT | Partnerships, People and Population Health Committee oversight. | none identified | Health inspectorate Wales review of YGC ED , highlighting concerns from staff about raising concerns arrangements | None identified | 16 (4x4) | 16 (4x4) | 12 (4x3) | currently under review | |
| 3.3 | Executive Director of Integrated Health Care | Partnerships, People and Population Health Committee | Risk of significant delays to access to Primary Care Services for the population due to growing demand and complexity, an ageing workforce and a shift of more services out of hospital, resulting in an deterioration in the population health, impacting on other health & care services and the wellbeing of the primary care workforce. | Delivery of All Wales Primary Care Model in place (including innovation and new ways of working), which is monitored by the Strategic Programme for Primary Care. Development of Urgent Primary Care Centre (UPCCs) pathfinders. Delivery of digital solutions (accelerated in response to C-19) Commissioning of community pharmacy enhanced services. Primary Care Transformation Fund in place across the clusters to support local innovation in addressing planned care backlog in primary care | Partnerships, People and Population Health Committee oversight. | | Primary care capacity remains a significant area of concern with: 213 GPs anticipated to retire in North Wales in next 5 years Number of practices identified as being 'at risk' of handing back contract Managed Practice costs pressures (circa £2.79m) | | 16 (4x4) | 16 (4x4) | 16 (4x4) | currently under review | |
| 3.4 | Executive Director of Public Health | Partnerships, People and Population Health Committee | Failure to effectively promote wellbeing and reduce health inequalities across the North Wales population, due to service model restrictions, resulting in demand exceeding capacity | Health Improvement & Reducing Inequalities Group (HIRIG) provides strategic direction and monitors delivery of the Population Health Services. Health Board commitment to establishing priority services including: Programme management and recruitment to posts. Contribution to national delivery programmes and the Public Health Outcomes Framework with monitoring of key indicators in place. Fully integrated Smoking Cessation Service Delivery of Immunisation strategy (2018-2022) Delivery of Infant Feeding Strategy (2019-2022) | HIRIG provide reports nationally regarding expenditure and performance. regional evidence based priorities are developed to meet the needs of the population in North Wales and deliver the greatest impact. Recent appointments of Consultants in Public Health have increased expertise and support across the region [3, one part time] Population Needs Assessment | 1) Embed Public Health Outcomes approach into local planning through local partners and Health Board. 2) The Recovery Co-ordination Group (RCG) is focussing on Public Health actions as part of the recovery plan for North Wales. 3) Population Needs Assessment will provide local analysis for informing plans | | | 15 (5X3) | 15 (5X3) | 12 (4x3) | Embed BCUHB North Wales population health priorities within its operational and strategic plans. | Dec-23 |

**4. Strategic Objective: 3.1.6. Respect people and their dignity , and learn from their experiences** — Implement programme and performance management

# BETSI CADWALADAR UNIVERSITY HEALTH BOARD

## 2022/23 BOARD ASSURANCE FRAMEWORK - JULY 2022

| Risk Number | Responsible Director | Assurance Committee | Principal Risk | Controls in place to manage risk (mitigation) | Internal assurances | External Assurances on controls | Gaps in control (where the controls are not working or further controls required) | Gaps in assurance I.e. negative/limited or no assurance (where assurance has not been gained) | Initial Risk Score (impact x likelihood) | Current Risk Score (impact x likelihood) | Tolerable Risk Score (target by year end) | Action plan description | Action plan due date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1 | Executive Director of Workforce and Organisational Development | Quality, Safety and Experience Committee | Significant risk of avoidable harm to patients and staff, due to a failure by the Health Board provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation | Health and Safety short courses for managers and staff, and mandatory e-learning are in place, with regular monitoring reported to Strategic H&S group. Policies and Sub groups have been established including Asbestos, Water Safety, Fire Electrical Safety etc. to monitor and report into the Strategic Occupational Health & Safety Group and escalate via Quarterly Reports to QSE. Lessons Learnt analysis from COVID reported to Executive Team, through Covid Group and with action to progressed to appropriate Executives. Clear strategy from Board to deal with PPE and suitable control measures to minimise risk of transmission of Covid through risk assessment, safe distancing advice, FAQ's, ICT Audits, guidance and standard operating procedures. Competence in training in service areas has been reviewed. Plan in place through business case (subject to approval) to establish robust Safety Competence and leadership training programme. There is a three year strategy that requires implementing to support the Strategic Objectives of BCUHB. | Clearly identified objectives for the Annual plan to achieve and transfer of risk ownership for a number of high level risks to E/F as duty holder for asbestos, legionella, contractor management and control, Electricity and Fire. RIDDOR reporting in place with robust timeline and tracking through outbreak groups of Datix 72 hour reviews in excess of 820 RIDDOR investigations have been undertaken since April 2020. PPE steering group has weekly meetings and a 'triple A' assurance report is provided to QSG and key issues escalated via QSE. Over 200+ site safety visits undertaken by the H&S Team to review Covid safe environments. Action cards in place to ensure movement of staff effectively managed during outbreak. Robust fit testing programme now in place and the business case for the fit testing co-ordination team has been approved for two years. There has been significant investment with fit testing equipment with an alternative respirator agreed by the Executive Team. | Health and Safer Executive investigative reviews carried out in the 2021/22 period | There have been a number of HSE interventions and internal reviews that have highlighted significant gaps in the OHS system. 3) Estates Business Case requires approval to ensure that the structural elements of the gap analysis are effectively implemented. 4) Manual handling training compliance is currently at 50% there are insufficient trainers to train all new staff (approximately 800) at this time. We have appropriate premises and are advertising to increase capacity within the Team. 5) The HSE have identified gaps in safe systems of work and risk assessment in connection with the sudden death of a patient within mental health. This may result in a prosecution against BCHB by the HSE under Section 3 of HASWA and fines in excess of £1m. | the Health Board was issued a range | 20 (4x5) | 20 (4x5) | 16 (4x4) | A clear strategy and framework for action to firstly identify hazards and place suitable controls in place has been developed. Covid support has significantly effected the delivery of the action plan. 2) IOSH Managing Safely has been implemented and Leading Safely Modules for Senior Leadership to be implemented. | Dec-22 |

| | |
|---|---|
| **Report title:** | Revised Scheme of Reserved Delegation |
| **Report to:** | Board |
| **Date of Meeting:** | Thursday, 04 August 2022 |
| **Executive Summary:** | Between March and June 2022 an extensive piece of work was undertaken in order to consolidate 16 different operational Schemes of Reservation and Delegation (SORD into one document, which is now submitted to the Board for approval, following its endorsement by the Audit Committee on the 30 of June 2022

In line with the move to the new Operating Model, this version of the SORD (attached as Appendix A) has been updated and enabled standardisation, consistency and clarity in relation to the delegation of Matters from the Board through the Executive Team down to the Operational Divisions and Services.

This clarity and standardisation in relation to Delegated Matters will be set and delivered through one single Health Board wide SORD, which covers all Operational Divisions and Support Functions.

A summary of key changes in the document is highlighted as appendix B to this document. |
| **Recommendations:** | The Board is asked to:

1. Note and approve proposed changes to the SORD as highlighted in Appendix B of this document.

2. **Note and approve the continued development of the next level of detail (as posts are agreed within the structures) ready for implementation alongside the Operating Model go-live.**

3. Note and approve continued oversight by the Audit Committee over the next 12 month period. |
| **Executive Lead:** | Molly Marcu, Board Secretary |
| **Report Author:** | Nigel McCann, CFO Central Area |

| **Purpose of report:** | For Noting ☐ | For Decision ☒ | For Assurance ☐ |
|---|---|---|---|

| **Assurance level:** | Significant ☐ | Acceptable ☒ | Partial ☐ | No Assurance ☐ |
|---|---|---|---|---|
| | 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 | No confidence/evidence in delivery |

**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:**

Not applicable

| **Link to Strategic Objective(s):** | | ALL |
|---|---|---|

| | |
|---|---|
| **Regulatory and legal implications** | The SORD is a key component of Financial and Operational Governance within the Standing Orders (SO's) and Standing Financial Instructions (SFI's). |
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol**<br>**Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below** | **N** |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | Until such a time as the new Divisional level management structures are agreed, existing operational SORD authority and approval limits will remain extant. |
| **Financial implications as a result of implementing the recommendations** | Budget and Financial Management training and controls will be strengthened as part of the process of moving to the new Operating Model. |
| **Workforce implications as a result of implementing the recommendations** | Not applicable |
| **Feedback, response, and follow up summary following consultation** | This has been through the Executive Team and the Operating Model Governance and Project Team / SRO meetings |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | All |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |

**Next Steps:**

- Following approval from the Board, the SORD will continue to be developed through the Board Secretary and Executive Team within the Operating Model timescales.

- The Audit Committee will received regular updates on the development and implementation progress, specifically noting any and all changes and amendments made between Committee meetings

4. Note the addition and clarity of the flow of Delegated Matters through the Board & Executive to the Operational front-line (as per the 3 columns within Schedule 1 of the SORD)

5. Table B2 will be populated as and when the next tier of structures are agreed, either in the IHC, other Division or Support Function, as such this SORD will continue to be updated during the next 6 to 12 months.

6. Note that implementation locally (in the first instance) will be through the Chief Finance Officers (CFO's) working with their IHC / Divisional Management Teams; as this is largely in relation to Financial Limits & Controls it is logical for it to be via the CFO's. This will be implemented as part of the overall Governance & Assurance Framework.

**List of Appendices:**

- Appendix A SORD Version 6
- Appendix B SORD summary of changes

**SECTION 2: SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS,**

**OTHER DIRECTORS AND OFFICERS**

The Health Board (HB) Standing Orders and Standing Financial Instructions specify certain key responsibilities of the Chief Executive, the Executive Director of Finance and other officers.

The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the Standing Financial Instructions form the basis of the HB's Scheme of Delegation to Officers.

| Delegated Matter | Table Reference No. |
|---|---|
|  |  |
| STANDING ORDERS/STANDING FINANCIAL INSTRUCTIONS | 1 |
| MEETINGS | 2 |
| FINANCIAL PLANNING/BUDGETARY RESPONSIBILITY | 3 |
| BANK/PGO ACCOUNTS (EXCLUDING CHARITABLE FUND ACCOUNTS) | 4 |
| UNALLOCATED | 5 |
| NON PAY EXPENDITURE | 6 |
| STORES AND RECEIPT OF GOODS | 7 |
| CAPITAL INVESTMENT MANAGEMENT | 8 |
| QUOTATIONS, TENDERING & CONTRACT PROCEDURES | 9 |
| FIXED ASSETS | 10 |
| PERSONNEL & PAY | 11 |
| ENGAGEMENT OF STAFF (NOT ON THE ESTABLISHMENT) | 12 |
| CHARITABLE FUNDS HELD ON TRUST | 13 |
| PRIMARY CARE PATIENT SERVICES/HEALTHCARE AGREEMENTS | 14 |
| INCOME SYSTEMS, FEES & CHARGES | 15 |
| DISPOSAL AND CONDEMNATIONS | 16 |
| LOSSES, WRITE-OFFS & COMPENSATION AND EX-GRATIA PAYMENTS | 17 |
| REPORTING INCIDENTS TO THE POLICE | 18 |
| FINANCIAL PROCEDURES | 19 |
| AUDIT ARRANGEMENTS | 20 |
| LEGAL PROCEEDINGS | 21 |
| INSURANCE POLICIES AND RISK MANAGEMENT | 22 |
| CLINICAL AUDIT | 23 |
| PATIENTS' PROPERTY | 24 |
| PATIENTS' & RELATIVES' COMPLAINTS | 25 |
| SEAL | 26 |
| GIFTS & HOSPITALITY | 27 |
| DECLARATION OF INTERESTS | 28 |
| INFORMATICS AND THE DATA PROTECTION ACT | 29 |
| RECORDS | 30 |
| AUTHORISATION OF NEW DRUGS | 31 |
| AUTHORISATION OF RESEARCH PROJECTS | 32 |
| AUTHORISATION OF CLINICAL TRIALS | 33 |

| Delegated Matter | Table Reference No. |
|---|---|
| INFECTIOUS DISEASES & NOTIFIABLE OUTBREAKS | 34 |
| REVIEW OF FIRE PRECAUTIONS | 35 |
| HEALTH & SAFETY | 36 |
| MEDICINES INSPECTORATE REGULATIONS | 37 |
| ENVIRONMENTAL REGULATIONS | 38 |
| LEGAL & RISK PAYMENTS | 39 |
| INVESTIGATION OF FRAUD/CORRUPTION OR FINANCIAL IRREGULARITIES | 40 |
| COMMERCIAL SPONSORSHIP | 41 |
| COSTS/NOTIONAL RENT/THIRD PARTY DEVELOPER/IMPROVEMENT GRANTS | 42 |
| FREEDOM OF INFORMATION | 43 |
| COMPLIANCE LEAD ROLES: CALDICOTT GUARDIAN, DPO, SIRO | 44 |
| EMERGENCY PLANNING | 45 |
| NHS ACT 2006 (WALES) SECTION 33 AGREEMENTS | 46 |
| STATUTORY COMPLIANCE WITH RESPECTIVE LEGISLATION | 47 |
| APPOINTMENT OF MEDICAL & DENTAL CONSULTANT POSTS | 48 |
| INDIVIDUAL PATIENT FUNDING REQUESTS | 49 |
| CARBON REDUCTION COMMITMENT ORDER | 50 |
| HUMAN TISSUE ACT 2004 | 51 |
| IONISING RADIATION (MEDICAL EXPOSURE) REGULATIONS 2017 [IR(ME)R] | 52 |
| NURSE STAFFING LEVELS (WALES) ACT 2016 | 53 |
| WELSH LANGUAGE STANDARD REPORTING | 54 |
| CONTROLLED DRUGS ACCOUNTABLE OFFICER | 55 |
| UPHOLDING PROFESSIONAL STANDARDS IN WALES (UPSW) | 56 |

# Schedule 1

| SCHEME OF RESERVATION AND DELEGATION OF POWERS |
| :---: |

## Table A – Scheme of Delegation to Officers

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
| --- | --- | --- |
| **1. Standing Orders / Standing Financial Instructions** | | |
| a)  Final authority in interpretation of Standing Orders | Chair | Chair |
| b) Notifying Directors, employees and agents of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities | Executive Director of Finance/Board Secretary | Directors |
| c) Responsibility for the security of the HB's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures | Executive Director of Finance | Directors |
| d) Ensuring Standing Orders are compatible with Welsh Government requirements re building and engineering contracts | Chief Executive | Executive Director of Finance |
| | | |
| **2. Meetings** | | |
| a) Calling meetings of the HB | Chair | Board Secretary |
| b) Chair all HB Board meetings and associated responsibilities | Chair or Vice Chair in Chair's absence | Chair or Vice Chair in Chair's absence |
| | | |
| **3. Financial Planning/Budgetary Responsibility** | | |
| a) Setting:<br><br>Submit Three Year Plan and Annual Operating Plan to the HB Board | Chief Executive | Executive Director of Transformation and Improvement |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| Submit budgets to the HB Board | Chief Executive | Executive Director of Finance |
| Submit to Board financial estimates and forecasts | Chief Executive | Executive Director of Finance |
| b) Implementing financial policies, plans and procedures, providing advice and co-ordinating any corrective action necessary | Executive Director of Finance | Director: Operational Finance |
| c) Issuing Budgets | Executive Director of Finance | Finance Director: Operational Finance |
| d) Monitoring:<br><br>Monitor performance against budget | Executive Director of Finance | Executive and Associate Directors |
| Submit monitoring returns | Chief Executive | Executive Director of Finance |
| Effective budgetary control and a balanced budget | Executive Director of Finance | Executive and Associate Directors |
| Preparation of annual accounts and returns | Executive Director of Finance | Executive Director of Finance |
| Identifying and implementing cost improvements and income generation initiatives | Executive Director of Finance | Executive and Associate Directors |
| e) Authorisation of Virement<br><br>It is not possible for any officer other than the Executive Director of Finance to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders (Directors) requires the agreement of both parties and the Executive Director of Finance | Executive Director of Finance | Please refer to Table B – Delegated Limits |
| f) Maintaining an effective system of internal financial control | Chief Executive | Executive Director of Finance |
| g) Delivery of financial training to budget holders (Directors) | Executive Director of Finance | Finance Director: Operational Finance |
| **4. Bank/PGO Accounts (Excluding Charitable Fund Accounts)** | | |
| a) Operation:<br><br>Managing banking arrangements and operation of bank accounts | Executive Director of Finance | Finance Director: Operational Finance |
| Opening bank accounts | Executive Director of Finance | Finance Director: Operational Finance |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | | |
| Authorisation of transfers between HB bank accounts | Executive Director of Finance | Finance Director: Operational Finance |
| Authorisation of:<br>-PGO/GBS Schedules<br>-BACS Schedules<br>-Automated cheque schedules<br>-Manual cheques | Executive Director of Finance | Finance Director: Operational Finance |
| **5. Non Pay Expenditure** | | |
| For details of Delegated Limits please refer to Table B | | |
| a) Completion of an Operational Scheme of Delegation and Authorisation by each Budget Holder ensuring maintenance of a list of officers authorised to place requisitions/orders (including emergency verbal orders) and record receipts within the E-Financials Business Suite. | Executive Director of Finance | Executive and Associate Directors |
| b) Obtain the best value for money when requisitioning goods/services | Executive Director of Finance | Executive and Associate Directors |
| c) Ensuring expenditure is within budget | Chief Executive | Executive and Associate Directors |
| d) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement | Chief Executive | Executive Director of Finance |
| e) Orders exceeding 12 month period | Executive Director of Finance | Finance Director: Operational Finance |
| f) Prompt payment of accounts | Executive Director of Finance | Finance Director: Operational Finance |
| g) Financial Limits | Executive Director of Finance | Please refer to Table B – Delegated Limits |
| h) Maintenance of sufficient records to explain the HB's transactions and report on the HB's financial position | Executive Director of Finance | Finance Director: Operational Finance |
| i) | | |
| j) Provision of electronic signatures within the E-Financials Business Suite in accordance with each Budget Holder's Operational Scheme of Delegation and Authorisation | Executive Director of Finance | Finance Director: Operational Finance |
| **6. Stores and Receipt of Goods** | | |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| a) Responsibility for the systems of financial control over all stores including receipt of goods and returns | Executive Director of Finance | Directors |
| b) Responsibility for the control of stores and receipt of goods, issues and returns: All stores (excluding pharmaceutical, – see following) | Executive Director of Finance | Directors |
| Pharmaceutical Stores | Executive Medical Director | Chief Pharmacist |
| c) Stocktaking arrangements | Executive Director of Finance | Directors |
| **7. Capital Investment Management** For details of Delegated Limits for Delegated Matter 8d, please refer to Table B – Leases. In accordance with Welsh Government guidance: | | |
| a) Programme: | | |
| Preparation of Capital Investment Programme | Chief Executive | Executive Director of Finance |
| Completion and signing off of a business case for approval | Executive Director of Finance | Director of Finance; Operations |
| Appointment of Project Directors | Chief Executive | Executive Director of Finance with support from relevant Directors |
| Financial monitoring and reporting on all capital scheme expenditure including variations to contract | Executive Director of Finance | Executive Director of Finance with support from relevant Directors. |
| Issuing of guidance on management of capital schemes | Executive Director of Finance | Executive Director of Finance with support from relevant Directors. |
| b) Contracting – Selection of 3rd party developers, architects, quantity surveyors, consultant engineers and other professional advisors within EC regulations and HB tender procedures | Chief Executive | Executive Director of Finance |
| c) Private Finance – Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector | Chief Executive | Executive Director of Finance |
| d) Leases – Granting and termination of leases | Chief Executive | Executive Director of Finance |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | | |
| e) Financial control and audit-Arrangements are in place to review building and engineering contracts and property transactions comply with Welsh Government guidance. | Chief Executive | Executive Director of Finance |
| **8. Quotations, Tendering & Contract Procedures**<br><br>For details of Delegated Limits, please refer to Table B – Quotations/Tenders. | | |
| a) Services: | | |
| Best value for money is demonstrated for all services provided under contract or in-house | Chief Executive | Directors |
| Nominate officers to oversee and manage the contract on behalf of the HB | Chief Executive | Directors |
| b) Quotations – Total value of the contract over its entire period: | | |
| | | |
| Seeking quotations up to £5,000 in value | Executive Director of Finance (per SFI 11.7.1) | Directors - For details of delegated limits, please refer to Table B |
| Obtaining minimum of 3 written quotations for goods/services of value between £5,000 and £25,000 | Executive Director of Finance (per SFI 11.1.2) | Directors - For details of delegated limits. Please refer to Table B |
| c) Competitive Tenders – Total value of the contract over its entire period: | | |
| Obtaining a minimum of 4 written competitive tenders for goods/services of value between £25,000 and the OJEU threshold (in compliance with EC Directives as appropriate) | Executive Director of Finance | Relevant Directors - For details of delegated limits, please refer to Table B |
| Obtaining a minimum of 5 written competitive tenders for goods/services of a value in excess of the OJEU threshold (in compliance with EC Directives as appropriate) | Executive Director of Finance | Relevant Directors - For details of delegated limits, please refer to Table B |
| Receipt and custody of tenders prior to opening | Executive Director of Finance | Relevant Directors - For details of delegated limits, please refer to Table B |
| Opening Tenders and Quotations | Executive Director of Finance | Relevant Directors - For details of delegated limits, please refer to Table |
| Decide if late tenders should be considered | Executive Director of Finance | Relevant Directors - |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | | For details of delegated limits, please refer to Table |
| d) Waiving the requirement to request quotes or tenders – subject to SFI Schedule 1 Para. 4.2 & 4.3 – Formally reported to the Audit Committee | Executive Director of Finance | Finance Director: Operational Finance (who can escalate to the Executive Director of Finance or Chief Executive if necessary) The Chief Executive and Director of Finance cannot approve their own waiver and must seek approval from.one other Executive Directors |
| | | |
| **9. Fixed Assets** | | |
| a) Maintenance of asset register | Executive Director of Finance | Finance Director (Operational Finance) |
| b) Calculate and pay capital charges in accordance with Welsh Government requirements | Executive Director of Finance | Finance Director (Operational Finance) |
| c) Responsibility for fixed assets – Land & Buildings | Executive Director of Finance | Director of Estates |
| d) Responsibility for all other fixed assets (Plant, Machinery, Transport, IT assets including software, Furniture & Fittings) | Executive Director of Finance | Director of Estates and Director of Digital, Deputy CEO with support from relevant Directors. |
| e) Responsibility for security of HB assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with HB procedures | Chief Executive | Executive Director of Finance, with support from relevant Directors. |
| | | |
| **10. Personnel & Pay** | | |
| a) Nominate officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts in accordance with the "Policy for the Safe Recruitment and Selection Practices" together with accompanying guidance, particularly the need for pre-employment checks. | Chief Executive | Executive Director of Workforce & OD |
| b) Approve the commencement of employment prior to all pre-employment checks being completed. | Executive Director of Workforce & OD | Deputy Director of Workforce & OD |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| c) Authority to fill funded post on the establishment with permanent staff. | Executive Director of Workforce & OD | Directors |
| d) The granting of additional increments to staff within budget in accordance with Terms & Conditions of Service | Executive Director of Workforce & OD | Executive Directors with advice from Executive Director of Workforce & OD |
| e) All requests for upgrading/ regrading/ major skill mix changes shall be dealt with in accordance with HB Procedure | Executive Director of Workforce & OD | Executive Directors with advice from Executive Director of Workforce & OD |
| f) Authority to agree acting up salaries for staff other than Executive Directors, within budget (Approval of acting up salaries for interim Executive Directors to be retained by Remuneration & Terms of Service Committee) | Chief Executive to agree acting up arrangements of Band 9 and above (Excluding Executive Directors) | Executive Directors lead for acting up salaries up to Band 8d or equivalent. |
| g) Establishments: | | |
| Locum/additional staff to the agreed establishment with specifically allocated finance | Executive Director of Finance | Directors with support from the Director of Finance (Operational) |
| Locum/additional staff to the agreed establishment without specifically allocated finance. | Chief Executive | Executive Director of Finance |
| Variation to the funded establishment | Chief Executive | Executive and Associate Directors with approval from Executive Director of Finance |
| h) Pay | | |
| Authority to complete standing data forms effecting pay, new starters, changes and leavers | Executive Director of Workforce & OD | Directors, and approved managers |
| Authority to complete and authorise timesheets and payroll returns | Executive Director of Workforce & OD | Directors, and approved managers |
| Authority to authorise overtime | Executive Director of Workforce & OD | Directors, and approved managers |
| Authority to authorise travel & subsistence expenses | Executive Director of | Directors, and approved managers |

| DELEGATED MATTER | | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|---|
| | | Workforce & OD | |
| | Maintenance of a list of managers authorised to sign payroll and travel expense documentation. | Executive Director of Workforce & OD | Directors, and approved managers |
| i) | Leave | | |
| | Approval of annual leave in accordance with HB policy | Executive Director of Workforce & OD | Directors, and approved managers |
| | Carry-over of annual leave in exceptional circumstances up to a maximum of 5 days | Executive Director of Workforce & OD | Directors, and approved managers |
| | Compassionate leave | Executive Director of Workforce & OD | Directors, and approved managers |
| | Special leave arrangements (to be applied in accordance with All Wales Policy) | Executive Director of Workforce & OD | Directors, and approved managers |
| | Leave without pay | Executive Director of Workforce & OD | Directors, and approved managers |
| | Medical Staff Leave of Absence – paid and unpaid | Executive Director of Workforce & OD | Directors, and approved managers |
| | Consultants Special Leave | Executive Medical Director | Directors, and approved managers |
| | Time off in lieu | Executive Director of Workforce and OD | Directors, and approved managers |
| | Maternity / Paternity Leave – paid and unpaid | Executive Director of Workforce & OD | Directors, and approved managers |
| j) | Annualised hours/flexible working hours system- maintenance of adequate records | Executive Director of Workforce & OD | Directors, and approved managers |
| k) | Sick Leave | | |
| | Extension of sick leave on half pay up to three months | Executive Director of Workforce & OD | Directors, and approved managers , in conjunction with Executive Director of |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | | Workforce & OD/delegate |
| Return to work part-time on full pay to assist recovery | Executive Director of Workforce & OD | Directors, and approved managers , in conjunction with Executive Director of Workforce & OD/delegate |
| Extension of sick leave on full pay | Executive Director of Workforce & OD | Directors, and approved managers , in conjunction with Executive Director of Workforce & OD/delegate |
| l)  Study Leave | | |
| Study leave outside the UK (non-medical staff excluding clinical staff) | Executive Director of Workforce & OD | Directors, and approved managers |
| Medical staff study leave (UK) | Executive Medical Director/ Executive Director of Workforce & OD/ Executive Director of Integrated Clinical Services | Directors, and approved managers |
| Consultant Medical Staff Leave (UK) | Executive Medical Director | Directors |
| All Medical and non-Medical Clinical Staff study leave outside the UK | Executive Medical Director/ Executive Director of Nursing & Midwifery/ Executive Director of Therapies & Health Science/ Executive Director of Integrated Clinical Services | Directors |
| All other study leave (UK) | Executive Director of | Directors, and approved managers |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | Workforce & OD | |
| m) Removal Expenses | | |
| Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview) | Executive Director of Workforce & OD | Directors, and approved managers accordance with BCU HB policy/approval from the Executive Director of Workforce & OD |
| n) Grievance Procedure | Executive Director of Workforce & OD | Directors, and approved managers |
| o) Professional Misconduct/Competence-Medical and Dental Staff | Executive Medical Director/ Executive Director of Workforce & OD | Assistant Medical Director supported by Workforce & OD |
| p) Suspension of Doctors employed directly by the HB | Executive Medical Director | Assistant Medical Director supported by Executive Director of Workforce & OD |
| q) Removal of Practitioner from the Performers List | Chief Executive | Executive Medical Director supported by Executive Director of Workforce & OD and Executive Director of Integrated Clinical Delivery |
| r) Requests for new posts to be authorised as car users | Executive Director of Finance | Directors and Managers |
| s) Renewal of Fixed Term Contract | Executive Director of Workforce & OD | Directors and Managers |
| t) Voluntary Early Release Scheme | Remuneration and Terms of Service Committee (supported by Executive Director of | Executive Director of Workforce & OD, with Executive Director of Finance for sign off of financial viability |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | Workforce & OD) | |
| u) Settlement on termination of employment | Chief Executive | Executive Director of Workforce & OD with approval from Welsh Government where the payment is Ex-gratia and exceeds the delegated limit of £50,000 |
| v) Ill Health Retirement<br>Decision to pursue retirement on the grounds of ill-health following advice from Workforce & OD Department | Chief Executive | Executive Director of Workforce & OD |
| w) Disciplinary Procedure(excluding Executive Directors) | Executive Director of Workforce & OD | Directors and approved managers |
| **11. Engagement of Staff Not On the Establishment** | | |
| For details of Delegated Limits, please refer to Table B | | |
| a) Non clinical Consultancy Staff | Executive Director of Finance | Director accountable for relevant service |
| b) Medical Locum staff | Executive Medical Director | Director accountable for relevant service. |
| c) Booking of Agency Nursing Staff | Executive Director of Nursing & Midwifery | Director accountable for relevant service |
| d) Booking of Bank Staff: | | |
| Nursing | Executive Director of Nursing & Midwifery | Director accountable for relevant service |
| Other | Executive Director of Workforce & OD | Director accountable for relevant service |
| | | |
| **12. Charitable Funds Held on Trust** | | |
| For details of Delegated Limits, Please refer to Table B | | |
| a) Management: | | Directors |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| Funds held on Trust are managed appropriately | Executive Director of Finance | |
| b) Maintenance of authorised signatory list of Authorised Fund Holders | Executive Director of Finance | Executive Director of Finance |
| c) Expenditure | Executive Director of Finance | Refer to Table B – Delegated limits |
| d) Fundraising Appeals – Preparation/Monitoring/Reporting progress and performance | Director of Communications and Partnerships | Fundraising manager, |
| e) Operation of Bank Accounts: | | |
| Managing banking arrangements and operation of bank accounts | Executive Director of Finance in conjunction with Corporate Trustees | Director of Finance, Operational Finance |
| Opening bank accounts | Corporate Trustee | Executive Director of Finance |
| f) Investments – Policy and Arrangements | Executive Director of Finance in conjunction with Corporate Trustees | Executive Director of Finance |
| g) Authority to accept the discharge of a donor's estate | Executive Director of Finance | Executive Director of Finance |
| | | |
| **13. Primary Care Patient Services/ Healthcare Agreements**<br><br>For details of Delegated Limits, please refer to Table B – Healthcare Agreements | | |
| a) Contract negotiation and provision of service agreements | Executive Director of Finance / Executive Director of Integrated Clinical Services | Executive Director of Finance / Executive Director of Integrated Clinical Delivery |
| b) Reporting actual and forecast contract income | Executive Director of Finance | Finance Director: Operational Finance. |
| c) Pricing of all contracts and SLAs | Executive Director of Finance | Finance Director: Operational Finance. |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| d)  Signing agreements | Chief Executive | Executive and Associate Directors |
|  |  |  |
| **14. Income Systems, Fees and Charges** |  |  |
| a)  Private Patients, Overseas Visitors, Income Generation and other patient related services | Executive Director of Finance | Director of Finance, Operational Finance |
| b)  Pricing of NHS agreements | Executive Director of Finance | Associate Directors of Finance |
| c)  Informing the Executive Director of Finance of monies due to the HB | Executive Director of Finance | Directors, and approved managers |
| d)  Recovery of debt | Executive Director of Finance | Finance Director: Operational Finance. |
| e)  Security of cash and other negotiable instruments | Executive Director of Finance | Finance Director : Operational Finance., Directors and approved managers |
| f)  Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due | Executive Director of Finance | Director of Finance: Operational Finance |
| g)  Non patient care income | Executive Director of Finance | Finance Director: Operational Finance. |
|  |  |  |
| **15. Disposal and Condemnations**<br><br>Disposal of all property and land requires formal approval by the Minister for Health and Social Services |  |  |
| a)  Issuing procedure for the disposal of assets obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively | Executive Director of Finance | Executive Director of Finance |
| b)  Notification to Director of Finance prior to disposal | Executive Director of Finance | Directors, and approved managers |
|  |  |  |
| **16. Losses, Write-offs & Compensation** |  |  |
| a)  Prepare procedures for recording and accounting for losses and special payments including preparation of a fraud response | Executive Director of Finance | Finance Director: Operational Finance |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| plan and informing Counter Fraud Operational Services of frauds. | | |
| b) Losses of cash due to theft, fraud, overpayment of salaries, fees, allowances & other causes up to £50,000 | Chief Executive | Executive Director of Finance |
| c) Fruitless payments (including abandoned Capital Schemes) up to £250,000 | Chief Executive | Executive Director of Finance |
| d) Bad debts and claims abandoned: Private patients; overseas visitors & other cases up to £50,000 | Chief Executive | Executive Director of Finance |
| e) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other up to £50,000 | Chief Executive | Executive Director of Finance |
| f) For personal and public liability claims, under the Legal & Risk scheme, authorisation from Legal & Risk is required before admissions may be made and monetary compensation offered. (Ex-gratia settlements offered by the HB are by definition not payments based upon legal liability and are, therefore, not reimbursable under the WRP scheme) | Chief Executive | Executive Director of Nursing & Midwifery supported by the relevant Director after seeking appropriate legal advice, up to a max £150,000 |
| g) Compensation payments made under legal obligation: | Chief Executive | Chief Executive, Executive Director of Finance or Executive Director of Nursing & Midwifery |
| h) Extra contractual payments to contractors – Up to £50,000 as specified within the Losses and Special Payments Manual of Guidance | Chief Executive | Executive Director of Finance with reporting to the Audit Committee |
| | | |
| **16.1 Ex-Gratia Payments:** | | |
| a) Patients and staff for loss of personal effects up to £50,000 | Chief Executive | Executive Director of Finance- Refer to Finance Policy on Losses and Special Payments |
| b) For clinical negligence up to £250,000 (negotiated settlements)*.  Report to Board > £50,000 (see also table B para.15) | Chief Executive | Executive Director of Finance/Executive Director of Nursing & Midwifery |
| c) For clinical negligence over £250,000 and up to £1,000,000* (negotiated settlements). Report to Board> £50,000 (see also table B para.15) | Chair Board | Chief Executive/ Executive Director of Finance/Executive Director of Nursing & Midwifery |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| d) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £250,000 (including plaintiff's costs) Report to Board > £50,000 | Board | Chief Executive/ Executive Director of Finance/Executive Director of Workforce & OD/ Executive Director of Nursing & Midwifery |
| e) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to £1,000,000 Report to Board > £50,000* | Board | Chief Executive/Executive Director of Finance/Executive Director of Nursing & Midwifery |
| f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000 | Chief Executive | Executive Director of Finance/Executive Director of Nursing & Midwifery |
| * For all clinical negligence and personal injury cases(including Court cases) the use of structured settlements should be considered involving costs to the NHS of £250,000 or more – All structured settlements require approval from the Welsh Government | Board | Chief Executive Executive Director of Finance/Executive Director of Nursing & Midwifery |
|  |  |  |
| **17. Procedure to follow after reporting of incidents to the Police** |  |  |
| a) Where a criminal offence is suspected | Executive Director of Finance | Directors and approved managers |
| Criminal offence of a sexual or violent nature | Executive Director of Workforce & OD | Directors and approved managers |
| Arson or theft | Executive Director of Finance | Appropriate Director and approved managers |
| Other | Chief Executive | Directors (dependent upon the nature of the suspected offence) |
|  |  |  |
| **18. Financial Procedures** |  |  |
| a) Maintenance & Update of HB Financial Procedures | Executive Director of Finance | Finance Director : Operational Finance |
|  |  |  |
| **19. Audit Arrangements** |  |  |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| a) Review, appraise and support in accordance with Internal Audit standards for NHS Wales and best practice | Chair of the Audit Committee | Board Secretary/Head of Internal Audit |
| b) Provide an independent and objective view on internal control and probity | Board Secretary | Head of Internal Audit/ Audit Wales |
| c) Ensure Cost-effective external audit | Chair of Audit Committee | Executive Director of Finance |
| d) Ensure an adequate internal audit service | Chief Executive | Board Secretary |
| e) Implement recommendations | Board Secretary | All relevant Directors |
| | | |
| **20. Legal Proceedings** | | |
| a) Engagement of HB's Solicitors | Chief Executive | Board Secretary for all Board related matters/Executive Director of Workforce & OD for all employment related matters/Executive Director of Finance for all estate related matters/Executive Director of Integrated Clinical Delivery for all Primary Care related matters. |
| b) Approve and sign all documents which will be necessary in legal proceedings | Chief Executive | Any Executive Director of the Board or an officer formally nominated by the Chief Executive |
| c) Sign on behalf of the HB any agreement or document not requested to be executed as a deed | Chief Executive | Any Executive Director of the Board or an officer formally nominated by the Chief Executive |
| | | |
| **21. Insurance Policies and Risk Management** | Chief Executive | Executive Director of Finance and Executive Medical Director |
| | | |
| **22. Clinical Audit** | Chief Executive | Executive Medical Director |
| | | |
| **23. Patients' Property (in conjunction with financial advice)** | | |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| For details of Delegated Limits, please refer to Table B – Petty Cash/Patients Monies | | |
| a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission | Executive Director of Nursing & Midwifery | Executive and Associate Directors and approved managers |
| b) Prepare detailed written instructions for the administration of patients' property | Executive Director of Nursing & Midwifery | Executive and Associate Directors and approved managers |
| c) Informing staff of their duties in respect of patients' property | Executive Director of Nursing & Midwifery | Executive and Associate Directors and approved managers |
| d) Issuing property valued >£5,000 only on production of a probate letter of administration | Executive Director of Finance | Director: Operational Finance. |
| | | |
| **24. Patients & Relatives Complaints** | | |
| a) Overall responsibility for ensuring that all complaints are dealt with effectively | Chief Executive | Executive Director of Nursing & Midwifery |
| b) Responsibility for ensuring complaints are investigated thoroughly | Chief Executive | Executive Director of Nursing & Midwifery |
| c) Medical – Legal Complaints Co-ordination of their management | Chief Executive | Executive Director of Nursing & Midwifery |
| | | |
| **25. Seal** | | |
| a) The keeping of a register of seal and safekeeping of the seal | Chief Executive | Board Secretary |
| b) Attestation of seal in accordance with Standing Orders | Chief Executive/ Chair | Board Secretary |
| | | |
| **26. Gifts and Hospitality** | | |
| a) Keeping of gifts and hospitality register | Chief Executive | Board Secretary |
| | | |
| **27. Declaration of Interests** | | |
| a) Maintaining a register of interests | Chief Executive | Board Secretary |
| | | |
| **28. Informatics and the Data Protection Act** | | |
| a) Review of HB's compliance with the Data Protection Act | Chief Executive | Director of Digital and Data Protection Officer |
| b) Responsibility for Informatics policy and strategy | Executive Medical Director | Director of Digital |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| c) Responsibility for ensuring that adequate management (audit) trails exist in Informatics systems | Executive Medical Director | Director of Digital |
| | | |
| **29. Records** | | |
| a) Review HB's compliance with the Retention of Records Act and guidance | Chief Executive | Director of Digital / Executive Medical Director |
| b) Approval for the destruction of records | Chief Executive | Director of Digital / Executive Medical Director |
| c) Ensuring the form and adequacy of the financial records of all departments | Executive Director of Finance | Director: Operational Finance |
| | | |
| **30. Authorisation of New Drugs** | Chief Executive | Executive Medical Director on the advice of the appropriate professional bodies |
| | | |
| **31. Authorisation of Research Projects** | Executive Director of Therapies & Health Sciences | Director of Research & Development |
| | | |
| **32. Authorisation of Clinical Trials** | Chief Executive | Medical Director |
| | | |
| **33. Infectious Diseases & Notifiable Outbreaks – outbreak control / public health monitoring and surveillance / provision of public health advice** | Chief Executive | Executive Director of Public Health |
| | | |
| **34. Review of Fire Precautions** | Chief Executive | Executive Director of Finance |
| | | |
| **35. Health & Safety** | | |
| Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations | Chief Executive | Executive Director of Workforce & OD |
| | | |
| **36. Medicines Inspectorate Regulations** | | |
| Review Regulations Compliance | Chief Executive | Executive Medical Director supported by Chief Pharmacist |
| **37. Environmental Regulations** | | |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| Review of compliance with environmental regulations, for example those relating to clean air and waste disposal | Executive Director of Finance | Director of Estates and Facilities |
| | | |
| **38. Legal & Risk Payments** | Chief Executive | Executive Director of Nursing & Midwifery/Executive Director of Finance |
| | | |
| **39. Investigation of Fraud/Corruption or Financial Irregularities** | Executive Director of Finance | Lead Local Counter Fraud Specialist |
| | | |
| **40. Commercial Sponsorship** | | |
| Agreement to proposal in accordance with BCU HB procedures | Chief Executive | Executive Director of Finance |
| | | |
| **41. Cost/Notional Rent/Third Party Developer/Improvement Grants** | | |
| Approval of all schedules of payments | Chief Executive | Executive Director of Integrated Clinical Delivery |
| Submission to Welsh Government for all new GP premises or major extensions in accordance with BCU HB Primary Care Estates Strategy | Chief Executive | Executive Director of Integrated Clinical Delivery |
| | | |
| **42. Freedom of Information** | Chief Executive | Director of Digital |
| | | |
| **43. Compliance Lead Roles:** | | |
| a) **Caldicott Guardian** | Executive Medical Director | Senior Associate Medical Director |
| b) **Data Protection Officer** | Chief Executive | Assistant Director of Information Governance and Assurance |
| c) **Senior Information Risk Owner** | Chief Executive | Executive Director of Finance |
| | | |
| **44. Emergency Planning & Major Incidents – Civil Contingencies Act (Category 1 Responder)** | Chief Executive | Executive Director of Transformation and Improvement |
| | | |
| **45. National Health Services (Wales) Act 2006 Section 33 Agreements: Arrangements between NHS Bodies and Local Authorities** | Chief Executive | Executive Director of Finance |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| | | |
| | | |
| **46. Statutory compliance with respective Legislation** | Chief Executive | Board Secretary and Executive Directors |
| **47. National Health Service (Appointment of Consultants) (Wales) (Amendment) Regulations 2005 (Statutory Instrument 2005: 3039) Appointment of all Medical and Dental Consultant posts.  Consultant posts within Public Health that are open to both medically qualified and those qualified in other disciplines other than medicine should follow this process, even though they fall outside of the requirements of the Statutory Instrument.** | Chief Executive | Executive Directors |
| | | |
| **48. All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)** | Chief Executive | WHSSC IPFR Panel £300,000 to £1,000,000; Chief Executive up to £299,999; Chair and Vice Chair of Health Board IPFR Panel together sign up to £125,000 |
| * The IPFR Panel cannot make policy decisions for the health board.  Any policy proposals arising from their considerations and decisions must be reported to the Health Board Quality, Safety & Experience Committee | | |
| | | |
| **49. Carbon Reduction Commitment Order (Phase 2) Agency Registration** | Chief Executive | Executive Director of Finance |
| | | |
| **50. Human Tissue Act 20014** | Chief Executive | Executive Director of Therapies & Health Sciences |
| | | |
| **51. Ionising Radiation (Medical Exposure) Regulations 2017** | Chief Executive | Executive Director of Therapies & Health Sciences |
| | | |
| **52. Nurse Staffing Levels Act (Wales) 2016** | Chief Executive | Executive Director of Nursing & Midwifery |
| | | |
| **53. Welsh Language Standard Reporting** | Chief Executive | Executive Director of Public Health |
| **54. Controlled Drugs Accountable Officer** | Chief Executive | Chief Pharmacist |

| DELEGATED MATTER | DELEGATED TO | OPERATIONAL RESPONSIBILITY |
|---|---|---|
| **55. Upholding Professional Standards in Wales (UPSW):** | | |
| **Responsible Officer** | Executive Medical Director (Responsible office) | Deputy Medical Director (Deputy Responsible Officer) |
| **Appointing a Designated Board Member** | Health Board Chair | Vice Chair |

**Table B – Scheme of Financial Delegation**

*Financial Limits are subject to funding available within relevant budget(s) and are inclusive of VAT irrespective of recovery arrangements.*

*All purchases must ensure compliance with Standing Financial Instruction Schedule 1 –*

*Procurement of Works, Goods and Services with regard to the required quotation or Tendering exercise.*

| | Budget changes | General expenditure | Healthcare agreements | Capital (Business Case and Contractual Commitment approvals) | | | Specialist | | | | Charitable Funds | | Procurement waivers | Staffing | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | |
| | Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements) | Individual orders / requisitions / annual order value or total contract value (unless otherwise noted) | Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board) | Building and engineering orders; related consultancy support(individual contractual commitment) | Medical devices; plant; machinery; related consultancy support(individual contractual commitment) | IM&T; telecoms systems; software; related consultancy support(individual contractual commitment) | Property or equipment leases(granting or termination of leases; annual value) | External consultancy support (total contract value for duration of service) | Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee) | New drugs (value based on annual costs) | Locally held funds(total funding bid value) | General funds(total funding bid value) | All values | New posts (additional establish't) | Agency and Waiting List Initiatives (all values) |
| WG (In advance of contract planning) | No requirement | £1m plus | £1m plus (Private sector) | £1m plus | £1m plus | £1m plus | No requirement | £1m plus | See Manual of Guidance for losses and SFIs, as special rules apply for certain losses and ex gratia payments. | No requirement | No requirement | No requirement | No requirement | No requirement | No requirement |
| Board following Chief Executive approval | £1m plus | £1m plus | Over £10m approved in advance, below £10m retrospectively reported. Over £1m for Private sector. | £1m plus | £1m plus | £1m plus | £0.5m plus or any which need signing under seal (Reservation of Power, Number 33) | £0.5m plus | | £1m plus | No requirement | No requirement | No requirement | No requirement | No requirement |
| Audit Committee | | | | | | | | | | | | | Retrospective reporting | | |
| Charitable Funds Committee (all Executives can authorise use of charitable funds up to £5k) | | | | | | | | | | | Over £5k (Up to £25k scrutinised by CF Advisory Group) | Over £5k (Up to £25k scrutinised by CF Advisory group) | | | |
| CEO through Executive Team | £0.5m to £1m | £0.5m to £1m | New or contract variation to £10.0m. | £0.5m to £1m | £0.5m to £1m | £0.5m to £1m | £250k to £0.5m | £250k to £0.5m | £0.5m to £1.0m | £0.5m to £1.0m | Up to £5k | Up to £5k | As escalated by DoF | Can approve new posts across HB | No requirement |
| Deputy CEO | £0.5m to £1m | £0.5m to £1m | New or contract variation to £10.0m. | £0.5m to £1m | £0.5m to £1m | £0.5m to £1m | £250k to £0.5m | £250k to £0.5m | £0.5m to £1.0m | £0.5m to £1.0m | Up to £5k | Up to £5k | As escalated by DoF | Can approve new posts across HB | No requirement |
| Any 2 of CEO, Executive Director of Integrated Clinical Delivery and DoF (must include DoF) | | Up to £0.5m | New or contract variation to £5.0m (To £1m for Private sector). | | | | | Up to £250k | | Up to £0.5m | | | As escalated by DoF | | |
| Executive Director of Finance | £0.5m to £1m | £0.5m to £1m | New or contract variation to £10.0m. | £0.5m to £1m | £0.5m to £1m | £0.5m to £1m | £250k to £0.5m | £250k to £0.5m | £0.5m to £1.0m | £0.5m to £1.0m | Up to £5k | Up to £5k | As escalated by DoF | Can approve new posts across HB | No requirement |

**Any expenditure approval must be within funding limits of approved budgets.**
**Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.**
**Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.**

| | Budget changes | General expenditure | Healthcare agreements | Capital (Business Case and Contractual Commitment approvals) | | | Specialist | | | | Charitable Funds | | Procurement waivers | Staffing | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Any expenditure approval must be within funding limits of approved budgets. Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals. Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures. | | | | | | | | |
| | Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements) | Individual orders / requisitions / annual order value or total contract value (unless otherwise noted) | Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board) | Building and engineering orders; related consultancy support(individual contractual commitment) | Medical devices; plant; machinery; related consultancy support(individual contractual commitment) | IM&T; telecoms systems; software; related consultancy (individual contractual commitment) | Property or equipment leases(granting or termination of leases; annual value) | External consultancy support (total contract value for duration of service) | Losses / Special Payments (Terminations approved by Exec.Director of W&OD; VERS by RATS C'ttee) | New drugs (value based on annual costs) | Locally held funds(total funding bid value) | General funds(total funding bid value) | All values | New posts (additional establishm't) | Agency and Waiting List Initiatives (all values) |
| Executive Directors, Board Secretary (unless noted below) | | Up to £250k | | | | | | Up to £100k | | | | | Waivers must be approved by FD: OF and Exec.Director of Finance or Chief Executive if escalated by FD: OF | Can approve new posts within own structure. | Must approve in advance in own structure. |
| Executive Director Transformation and Improvement | | Up to £250k | | | | | | Up to £100k | | | | | | Can approve new posts within own structure. | Must approve in advance in own structure. |
| | | | | | | | | | | | | | | | |
| Executive Medical Director | | Up to £250k | | | | | | Up to £100k | | | | | | Can approve new posts within own structure. | Must approve in advance in own structure. |
| Executive Director of Public Health | | Up to £250k | | | | | | Up to £100k | | | | | | | |
| Executive Director of W&OD | | Up to £250k | | | | | | Up to £100k | Terminations up to £50k (over this to WG) | | | | | Can approve new posts within own structure. | Must approve in advance in own structure. |
| Executive Director of Nursing & Midwifery | | Up to £250k | | | | | | Up to £100k | Up to £150k | | | | | Can approve new posts within own structure. | Must approve in advance in own structure. |
| Executive Director of Therapies & Health Sciences | | Up to 250k | | | Up to £150k | | | Up to £100k | ------------------ | | | | | | |

| | Budget changes | General expenditure | Healthcare agreements | Capital | | | Property or equipment leases | Specialist | | | Charitable Funds | | Procurement waivers | Staffing | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Capital | | | | Specialist | | | Charitable Funds | | | Staffing | |

**Any expenditure approval must be within funding limits of approved budgets.**
**Approval limits are cumulative, and therefore higher level approval limits must be supported by lower level approvals.**
**Executive Directors and Directors, Integrated Health Care Directors, and Hospital Care Directors to determine scheme of delegation within their structures.**

| (Role) | Budget transfers between Corporate Departments, Area Teams or Hospital Teams(Virements) | Individual orders / requisitions / annual order value or total contract value (unless otherwise noted) | Healthcare agreements (NHS and Private sector)(annual value) (Primary Care contracts approved by Board) | Building and engineering orders; related consultancy support(individual contractual commitment) | Medical devices; plant; machinery; related consultancy support(individual contractual commitment) | IM&T; telecoms systems; software; related consultancy support(individual contractual commitment) | Property or equipment leases(granting or termination of leases; annual value) | External consultancy support (total contract value for duration of service) | Losses / Special Payments (Terminations only approved by Exec Director of W&OD; VERS require RATS Committee) | New drugs (value based on annual costs) | Locally held funds(total funding bid value) | General funds(total funding bid value) | All values | New posts (additional establishm't) | Agency and Waiting List Initiatives (all values) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Integrated Health Care Directors , Health Community Director of Operations, Director of Mental Health & Learning Disabilities | | Up to £250k | New or contract variation to £1.5m | | Up to £250k | | | Up to £100k | | Up to £100k, following Med Mgt Group | Up to £5k | | | Can approve new posts within own team. | As escalated by Direct Reports* |
| Associate Directors | | Up to £150k | | | Up to £150k | | | Up to £150k | | | Up to £5k | | | | Medical staff* |
| Assistant Directors | | Up to £75k | Up to £75k | | Up to £75k | | | Up to £75k | | | Up to £5k | | | | |
| Head of Investigations and Redress | | | | | | | | | Up to £20k | | | | | | |
| Claims Managers | | | | | | | | | Up to £5k | | | | | | |
| Authorised fund holder (Charitable Funds) | | | | | | | | | | | Up to £5k | | | | |
| Medicines Management Group | | | | | | | | | | All new drugs, unless cheaper than existing | | | | | |

* Agency and Waiting List Initiatives must generally be approved in advance. However, in exceptional circumstances when staff are required out of hours, they can be approved retrospectively.

This scheme only relates to matters delegated by the Board to the Chief Executive and Directors, together with certain other specific matters referred to in Standing Financial Instructions.  Each Director is responsible for delegation within their department.  They should produce an Operational Scheme of Delegation and Authorisation for matters within their department, which should also set out how departmental budget and procedures for approval of expenditure are delegated.

**Appendix A Scheme of Reserved Delegation**

**Summary of key changes**

**DELEGATED MATTERS**

| Original | Changed to |
|---|---|
| **10. Personnel & Pay**<br>n) Grievance Procedure | **10. Personnel & Pay**<br>n) Respect & Resolution Procedure |
| **16 Ex-Gratia Payments:** | **16. Ex-Gratia Payments:**<br>(per Manual for Accounts Chapter 6) |
| **16.1 Ex-Gratia Payments:**<br>a) Patients and staff for loss of personal effects up to £50,000 | **16.1 Ex-Gratia Payments:**<br>a) Patients and staff for loss of personal effects up to £50,000<br><br>Above £50k to Welsh Government |
| **16.1 Ex-Gratia Payments**<br>e) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to,000,000 Report to Board > £50,000* | **16.1 Ex-Gratia Payments**<br>e) For personal injury claims involving negligence where legal advice has been obtained and guidance applied up to, £1,000,000 Report to Board > £50,000<br>(>£1m to Welsh Government) |
| **16.1 Ex-Gratia Payments**<br>f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000 | **16.1 Ex-Gratia Payments**<br>f) Other, except cases for maladministration where there was no financial loss by claimant, up to £50,000<br>Above £50k to Welsh Government |
| **24. Patients & Relatives Complaints** | **24. Putting Things Right** |
| **35. Health & Safety**<br><br>Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations | **35. Health & Safety**<br><br>Review of all statutory compliance legislation and Health and Safety requirements. |

**TABLE A : DELEGATION TO OFFICERS**

| Original | Changed to |
|---|---|
| Two Columns:<br>- Delegated to (typically Executive)<br>- Operational Responsibility (Divisions) | We have clarified the levels and flow of Delegation:<br>- Board Member<br>- Specific Delegation where relevant / applicable<br>- Operational responsibility |

| | |
|---|---|
| | In doing this we have also clarified a number of Matters that cannot be Delegated, or that we do not wish to Delegate. (Ill Health Retirements which is an NHS Pensions Authority Decision) |
| **10. Personnel & Pay**<br>• Nominate officers to enter into contracts of employment | Was "Chief Executive"<br><br>Changed to "Executive Director of WOD" |
| **10. Personnel & Pay**<br>g) Variation to the funded establishment | Was "Chief Executive"<br><br>Changed to "Executive Director of Finance / Executive Director of WOD" |
| **24. Patients & Relatives Complaints**<br><br>Specific delegation via the Executive Director of Nursing | **24. Putting Things Right**<br><br>Specific delegation via the Executive Director of Nursing and Associate Director of Quality (PTR Deputy Responsible Officer and Senior Investigations Officer |
| **31. Authorisation of Research Projects** | Was "Executive Director of Therapies"<br><br>Changed to "Executive Medical Director" |
| **43. Compliance Lead Roles:**<br><br>• **Data Protection Officer** | Was "Assistant Director of Information Governance 7 Assurance"<br><br>Changed to "Director of Digital" |
| **44. Emergency Planning & Major Incidents** | Was "Executive Director of Transformation & Planning"<br><br>Changed to "Executive Director of Integrated Clinical Delivery" |
| **50. Huma Tissue Act 2014** | Was "Executive Director of Therapies"<br><br>Changed to "Executive Medical Director" |
| **55. Appointing a Designated Board Member** | Was "Vice Chair"<br><br>Changed to "RATS Committee" |

**TABLE B: SCHEME OF FINANCIAL DELEGATION**

- We have added in the "PFIG Committee" to recognise its approval route
- We have added in the Director roles to reflect the Operating Model

- We have created Table 2B to recognise the detailed posts within the Divisional Sub-Structures and we will add these posts as and when they are agreed, recognising that in the interim all existing SORDS remain extant.
- We have reflected the role of Finance is one of review, ratify and challenge, as opposed to approving Divisional level expenditure

| Report title: | Corporate Risk Register Report | | |
|---|---|---|---|
| **Report to:** | Board | | |
| **Date of Meeting:** | Thursday, 21 July 2022 | Agenda Item number: | 3.4 |
| **Executive Summary:** | The purpose of this standing agenda item is to provide a position of activity for the Corporate Risk Register (CRR) since the Board's review of the document in January 2022, taking into account the oversight of the Board's committees as well as the work of the Risk Management Group. The report also summarises the changes that have been captured following a review and update of the risks on the CRR, noting the support provided by the Corporate Risk Team.<br><br>The CRR enables the Board to fulfil its obligations of ensuring there are effective and comprehensive systems and processes in place to identify, understand, monitor and address current and future risks deemed high enough to negatively impact on the delivery of operational objectives, whilst evaluating the effectiveness of their controls, and monitoring associated action plans.<br><br>The risk management strategy incorporates a proposal for the corporate risk register to be monitored annually by the Board,( taking into account assurance given through Committee Chair's reports on a bi-monthly basis by the Board's committees)at the same time as the year end refresh of the BAF.<br><br>For completeness this is incorporated within this paper. | | |
| **Recommendations:** | The Board is asked to:<br>  1. Note and review the top corporate risk, and the updates in risks movement in section 3 scrutinise and discuss the report. | | |
| **Executive Lead:** | Nick Lyons, Executive Medical Director | | |
| **Report Author:** | Justine Parry, Assistant Director of Information Governance and Risk | | |

| **Purpose of report:** | For Noting ☐ | For Decision ☐ | For Assurance ☒ | |
|---|---|---|---|---|
| **Assurance level:** | Significant ☐<br>High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☐<br>General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☒<br>Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐<br>No confidence/evidence in delivery |

**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:**

| | |
|---|---|
| The assurance report is allocated a partial assurance rating on the basis that it incorporates significant corporate risks with a significant residual risk exposure. Furthermore, some of the associated mitigations for in | |
| **Link to Strategic Objective(s):** | See the individual risks for details of the related links to Strategic Objectives. |
| **Regulatory and legal implications** | Some risks are directly associated with regulatory requirements |
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol** | **N** |

| Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below | |
|---|---|
| If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.<br><br>*A Quick Guide as to which decisions need an EqIA / SEIA is available <u>here</u>.* | |
| **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. |
| **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. |
| **Workforce implications as a result of implementing the recommendations** | Failure to capture, assess and mitigate risks can impact adversely on the workforce. |
| **Feedback, response, and follow up summary following consultation** | The Risk Management Group met on the 5th April and 31st May 2022 and further updates to the risks have been incorporated. Please see the individual progress notes on each risk. |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | See the individual risks for details of the related links to the Board Assurance Framework. |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |
| **Next Steps:**<br>**Work continues**<br>The Risk Management Group will be meeting on the 2nd August 2022, therefore an updated position of the risks will be presented during Committee meetings during the next quarter and again to the Board in January 2023. | |
| **List of Appendices:**<br>Appendix 1 – Corporate Risk Register<br>Appendix 2 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score<br>Appendix 3 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels | |

**Board**
**4 August 2022**
**Corporate Risk Register Report**

1. **Introduction/Background**

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

2. **Top Risks on the corporate risk register**

The corporate risk register report incorporates risks with a residual rating of 15 and above. Of those risks, the ones with the highest residual rating of 20 are summarised in the table below and also in further detail within Appendix A of this report.

| Risk ID | Responsible Committee | Risk Owner | Risk Description |
|---|---|---|---|
| | | | |
| CRR20-05 | Quality, Safety and Experience Committee | Executive Director of Integrated Healthcare and Deputy Chief Executive | Timely access to care homes |
| CRR20-08 | Quality, Safety and Experience Committee | . Executive Director of Integrated Healthcare and Deputy Chief Executive | Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients. |
| CRR21-14 | Mental Health Act Compliance Committee | Executive Director of Public Health | Risk that the increased level of DOLS activity may result in the unlawful detention of patients |
| CRR21-22 | Quality, Safety and Experience Committee | Executive Medical Director | Delivery of safe and effective resuscitation may be compromised due to constraint in training capacity issues |
| CRR22-23 | Quality, Safety and Experience Committee | Executive Director of Integrated Healthcare and Deputy Chief Executive | Inability to deliver safe, timely and effective care |
| CRR21-11 | Partnerships, People and Population Health Committee | Chief Digital and Information Officer | Potential exposure to ransomware and zero-day cyber risks attacks |
| CRR21-20 | Partnerships, People and Population Health Committee | Executive Director of Public Health | There is a risk that adults who are overweight or obese will not achieve a healthy weight as a result of wider determinations |
| CRR4476 | Quality, Safety and Experience Committee | Executive Director of Integrated Healthcare and Deputy Chief Executive | Risk of significant patient harm *as a consequence of the sustainability of the acute vascular service* *New risk* |

With the exception of risk CRR4476, all the above risks have been presented to their respective committees, as part of the regular review of the corporate risk register.  In order to enhance the effectiveness of the scrutiny around these top risks, it is proposed that going forward, the committees will receive detailed assurances relating to the mitigations aligned with the top risks, either as a specific report or a broadened report.  For example, the vascular report is a standing item at the Quality Safety and Experience Committee, which will be significantly strengthened to incorporate risk assurance.

In addition, further work will be undertaken to ensure any papers on the agendas of Board or committees, include detailed assurance on risk mitigations as part of the overall assurance report. Further work is ongoing to ensure the corporate risk register captures all significant clinical and corporate risks, as agreed at the March meeting of the Quality Safety and Experience Committee. The outcome of this work will be presented to the September meeting of the QSE Committee, and subsequently the Board meeting, via the Committee Chair's assurance report.

3.    **New Risks**

Since the last update to the Board, the following risks have been escalated and incorporated onto the Corporate Risk Register

- CRR22-18 – Inability to deliver timely Infection Prevention and Control services due to limited capacity.

- CRR22-19 – Potential that medical devices are not decontaminated effectively so patients may be harmed.
- CRR22-22 - Delivery of safe & effective resuscitation may be compromised due to training capacity issues.
- CRR22-23 – Inability to deliver safe, timely and effective care.
- CRR22-24 - Potential gap in senior leadership capacity/capability during transition to the new Operating Model.

All these risks have either been presented to the Quality, Safety and Experience Committee, and the operating model risk was discussed at the May Board workshop.

4.    **Budgetary / Financial Implications**

4.1    There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

5.    **Risk Management**

5.1    See the full details of individual risks in Appendix 1.

6.    **Equality and Diversity Implications**

6.1    A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

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

| CRR20-01 | **Director Lead:** Executive Director of Finance | **Date Opened:** 07 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 27 April 2022 |
| | **Risk** Asbestos Management and Control | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 31 March 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 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group.<br>2. Annual programme of re-inspection surveys undertaken.<br>3. An independent audit of internal asbestos management system completed by an independent UCAS accredited body.<br>4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group.<br>5. Asbestos register available. | 1. Health and Safety Leads Group.<br>2. Strategic Occupational Health and Safety Group.<br>3. Quality, Safety and Experience Committee.<br>4. Internal Audit review undertaken against the gap analysis. |

| | |
|---|---|
| 6. Targeted surveys where capital work is planned or decommissioning work undertaken.<br>7. An annual training programme for operatives in Estates is in place.<br>8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition.<br>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.<br>10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework. | 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%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by quarter one in 2022.

## Progress since last submission

1. Controls in place reviewed to ensure relevance with current status of the risk.
2. Gaps in controls reviewed to ensure relevance with current risk position.
3. Target Risk Due date has been extended from the 31/03/2022 to the 31/3/2023 to allow sufficient time for:
    a. full implementation of actions
    b. training to be fully rolled out across the Health Board
    c. the digital platform is fully rolled out across the Health Board.
4. Action ID 12243 – Extension to the action due date to the 31/03/2023 to allow sufficient time to fully implement and roll out the digital platform.
5. Action ID 12248 – Action closed, updated Asbestos policy/procedure is available on the BCUHB Intranet, and communicated across the Health Board via the corporate weekly bulletin.
6. Action ID 18686 – Action closed, schedule now in place for training in 2022/23 which will ensure turnaround of training compliance. Training now embedded as business as usual.
7. Action ID 19758 – Action closed, audit report completed with no outstanding actions. Outcome of the report to be reported to the Occupational Health and Safety Group in May 2022.

8. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads with a proposal to re-score the current risk rating from 15 (C=5, L=3) to 12 (C=4, L=3) due to the completion of a number of actions.

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

| Risk Response Plan | Action ID | Action | Action Lead/ Owner | Due date | State how action will support risk mitigation and reduce score | RAG Status |
|---|---|---|---|---|---|---|
| Actions being implemented to achieve target risk score | 12243 | Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system. | Mr Rod Taylor, Director of Estates & Facilities | 31/03/2023 | 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.<br><br>This information is currently held by a third party. With the implementation of the MiCAD system, this will digitalise the information held locally by the Health Board.<br><br>April 2022 progress update – | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Extension to the action due date to the **31/03/2023** to allow sufficient time to fully implement and roll out the digital platform. | <span style="color:red">red</span> |
| | 12248 | Update intranet pages and raise awareness with staff who may be affected by asbestos. | Mr Rod Taylor, Director of Estates & Facilities | 31/03/2022 | Creating staff awareness of the presence of asbestos thus reducing any potential impact.

Updated Asbestos policy/procedures is available on the BCUHB Intranet, and communicated via corporate weekly bulletin.  Asbestos awareness is delivered by the Estates Team upon request.  Internal Audit completed providing a level of assurance.

Action closed. | Completed |
| | 18686 | Ensure 100% compliance with asbestos awareness training for Operational Estates maintenance staff. | Mr Arwel Hughes, Head of Operational Estates - Interim | 31/03/2022 | Ensure compliance with training legislation and help to reach the target risk score.

Currently on 86% compliance.

Action closed, schedule now in place for training for 2022/23 which will ensure turnaround of training compliance. Training now | Completed |

| | | | | | |
|---|---|---|---|---|---|
| | | | | embedded as business as usual. | |
| | 19758 | Undertake audits by the independent asbestos consultant to audit compliance with legislation and provide assurance in relation to asbestos management. | Mr Rod Taylor, Director of Estates & Facilities | 31/03/2022 | Provide a level of assurance in terms of compliance with legislation and provide assurance in relation to asbestos management to validate compliance and support the reduction in the risk score.

April 2022 progress update - Action closed, audit report completed with no outstanding actions. Outcome of the report to be reported to the Occupational Health and Safety Group. | Completed |

| CRR20-02 | **Director Lead:** Executive Director of Finance | **Date Opened:** 07 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 27 April 2022 |
| | **Risk:** Contractor Management and Control | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 30 September 2022 |

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

| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 5 | 4 | 20 |
| Current Risk Rating | 5 | 3 | 15 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | 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.<br>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.<br>3. Permit to work paper systems in place across the Health Board.<br>4. Pre-contract meetings in place.<br>5. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place. | 1. Health and Safety Leads Group.<br>2. Strategic Occupational Health and Safety Group.<br>3. Quality, Safety and Experience Committee. |

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.

## 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 updated to include the mitigation in place.
3. Action ID 12256 – Action delayed due to delays in mobilising the adoption of the SHE software which required Data Protection compliance checking to be completed.  Anticipated implementation of the system is aimed for June 2022.
4. Action ID 12258 – Action delayed, Estates and Facilities have started to engage with key stakeholders around their management of control of contractors pertinent to their areas, awaiting nominated persons to be identified by relevant stakeholders.
5. Action ID 12254 – Action completed and previously approved for closure at Executive Team on the 22/12/2021, closure to be included for noting on the next Quality, Safety and Experience Committee papers prior to being archived and removed from the next iteration of the report.
6. Action ID 12255 – Action closed as processes are now in place.  This action will now be archived and removed from the next iteration of the report.
7. Action ID 12259 – Action closed as processes have been reviewed and deemed fit for purpose, until such time as the current system is superseded by the new digital process.  This action will now be archived and removed from the next iteration of the report.

8. Action ID 12260 – Action closed in relation to the lack of consistency and standardisation in implementation of contractor management procedure. A review of all standard current procedures has been undertaken and deemed them fit for purpose. New digital platform for the management of contractors also agreed.  This action will now be archived and removed from the next iteration of the report.

9. Action ID 18688 – Action closed due to this action being incorporated within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case', managed at Tier 2 level, which includes the action to submit a business case for Executive level approval.  This action will now be archived and removed from the next iteration of the report.

10. Action ID 19759 - Action closed due to this action being incorporate within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case', managed at Tier 2 level, which includes the action to submit a business case for Executive level approval.  This action will now be archived and removed from the next iteration of the report.

11. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads.

| 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 | On track |

| | | | | | Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH) and Inspection process to ensure compliance. | |
|---|---|---|---|---|---|---|
| | 12254 | Identify current tender process & evaluation of contractors, particularly for smaller contracts. Consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum Health & Safety requirements are implemented and externally checked prior to coming to site. | Mr Rod Taylor, Director of Estates & Facilities | 31/01/2022 | ACTION CLOSED 05/11/2021<br><br>Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system.<br><br>05/11/2021 - Action closed ahead of the action due date. | Completed |
| | 12255 | Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. | Mr Rod Taylor, Director of Estates & Facilities | 31/01/2022 | ACTION CLOSED 12/01/2022<br><br>Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Processes are in place and current paper form completed and assessed.<br><br>Action closed, system to be digitalised following the implementation of the SHE software. | |
| | 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.<br><br>Current robust paper based system is in place. Delays in mobilising the adoption of the SHE system in relation to Data Protection compliance checking, anticipated implementation of the system in aimed for June 2022. | Delay |
| | 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. | On track |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | 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. | |
| | 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.<br><br>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 | Delay |

| | | | | | areas to ensure compliance with the Health Board Contractor Management Processes.<br><br>April 2022 progress update - Estates and Facilities have started to engage with key stakeholders around their management of control of contractors pertinent to their areas, awaiting nominated persons to be identified by relevant stakeholders. | |
|---|---|---|---|---|---|---|
| | 12259 | Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis. | Mr Rod Taylor, Director of Estates & Facilities | 31/03/2022 | ACTION CLOSED 12/01/2022<br><br>A Permit to Work system will be adopted as part of implementation of SHE software.<br><br>Current paper based processes have been reviewed and deemed fit for purpose, until such time as the current system is superseded by the new digital process.<br><br>Action closed. | Completed |
| | 12260 | Lack of consistency and standardisation in | Mr Rod Taylor, | 31/05/2022 | ACTION CLOSED 12/01/2022 | Completed |

| | | | | | |
|---|---|---|---|---|---|
| | implementation of contractor management procedure picked up in Health & Safety Gap Analysis Action Plan. | Director of Estates & Facilities | | Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.<br><br>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.<br><br>Review of all standard current procedures undertaken and deemed them fit for purpose and improved standardisation of the contractor framework. New digital platform for the management of contractors also agreed. | |

| | | | | | Action closed. | |
|---|---|---|---|---|---|---|
| | 12552 | Induction process to be completed by all contractors who have not yet already undertaken. | Mr Rod Taylor, Director of Estates & Facilities | 30/09/2022 | Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for 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 and Inspection process to ensure compliance.<br><br>Regional framework of contractors for minor works in place, review of systems and procedures undertaken. Induction process is in place however potential gaps due to resources to align with capacity. Business case to be re-presented to the Executive Team. | On track |

| | | | | | |
|---|---|---|---|---|---|
| | 18688 | An annual review of business as usual capacity to be developed to ensure estates project management capacity is not exceeded. | Mr Arwel Hughes, Head of Operational Estates - Interim | 31/03/2022 | Create assurance that there is sufficient estates management capacity and technology to ensure that projects can be delivered safely.<br><br>Action closed as this action is incorporated within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case' which includes the action to submit a business case for Executive level approval. | Completed |
| | 19759 | Funding to be secured for additional authorised/competent persons to mitigate the resource gap. | Mr Rod Taylor, Director of Estates & Facilities | 31/03/2022 | A revenue business case for additional authorised/competent persons has been prepared and has been put forward for financial/resource consideration on a recurrent basis and will address the gap identified and support the reduction in the risk score to achieve the target.<br><br>Action closed as this action is incorporated within risk ID 4283 'Health & Safety and Statutory Compliance Resources Business Case' | Completed |

| | | | | which includes the action to submit a business case for Executive level approval. | |
|---|---|---|---|---|---|

| CRR20-03 | **Director Lead:** Executive Director of Finance | **Date Opened:** 07 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 27 April 2022 |
| | **Risk:** Legionella Management and Control. | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 30 September 2022 |

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



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Legionella and Water Safety Policy in place, reported to and signed off by the Water Safety Group. <br> 2. Risk assessment undertaken by clear water, with action and issues reported to the water Safety Group. <br> 3. High risk engineering work completed in line with Clearwater risk assessment. <br> 4. Bi-Annual risk assessment undertaken by clear water. <br> 5. Water samples taken and evaluated for legionella and pseudomonas. <br> 6. Authorising Engineer water safety in place who provides annual report. | 1. Health and Safety Leads Group. <br> 2. Strategic Occupational Health and Safety Group. <br> 3. Strategic Infection Prevention Group. <br> 4. Quality, Safety and Patient Experience Committee. |

| | |
|---|---|
| 7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety Team.<br>8. Water Safety Group has been established to better provide monitoring, oversight and escalation.<br>9. Internal audit of compliance checks for water safety management regularly undertaken.<br>10. Alterations to water systems are now signed off by responsible person for water safety.<br>11. Local Infection Prevention Groups in place with oversight of water safety. | |

**Gaps in Controls/mitigations**

1. There is a weakness that little used outlets are not reported to Estates for management and control. For example - ward shower temporarily used as a store, therefore it is not part of Estate flushing programme. Regular topic of the Water Safety Group which has clinical representation and feeds into local Hospital Management Teams.
2. BCUHB wide Water Safety Plan – Plan has been developed, consulted upon and final draft is being produced.  Plan has also had approval from the authorising Welsh Government Appointed Engineer - Water Safety, which will provide the legal requirement under L8 for processes and controls for water safety systems.  Final version completed and to be submitted in May 2022 for ratification by Infection Prevention Sub-group.
3. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case is currently unfunded and provides supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety, which forms part of the ongoing business case. Included in the Integrated Medium Term Plan, supported by risk ID 4283.

**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. Assurances updated to ensure relevance with current risk position.
4. Action ID 12265 - Action closed as water testing is carried out by Public Health Wales who store the information on their servers.  This action will now be archived and removed from the next iteration of the report.
5. Action ID 12268 - Action remains delayed with a BCUHB Water Safety Plan to be completed and submitted for ratification by the Infection Prevention Sub-Group.

6. Action ID 12270 – Action closed as a standardised maintenance strategy adopted and in place by means of single service provider.  This action will now be archived and removed from the next iteration of the report.

7. Action ID 19015 - Business case now included in the scope of priorities for Integrated Medium Term Plan, which will result in a delay to the action due date of the 31/03/2022 to appoint Senior Estates Officers (Competent Persons) for water safety.

8. Action ID 19760 – Action closed as Authorising Engineer for water safety appointed in December 2021.  This action will now be archived and removed from the next iteration of the report.

9. Action ID 19761 – Action closed, flushing of little used outlets now reported as part of the water safety group, currently quarterly, however will move to become bi-monthly from April 2022.  This action will now be archived and removed from the next iteration of the report.

10. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads.

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

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

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Contract, which has been approved by the Health Board in January 2021. | |
| | 12263 | Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed. | Mr Rod Taylor, Director of Estates & Facilities | 30/06/2022 | All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.  Progress update – Information reported through local Infection Prevention and Control Groups.  Process for information collection has been described, with the collection of information underway. | On track |
| | 12264 | Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person. | Mr Rod Taylor, Director of Estates & Facilities | 30/06/2022 | This forms part of the Water Safety Plan to ensure water safety compliance.  This will be completed and submitted in March 2022 for ratification by Infection Prevention Sub-Group. | On track |
| | 12265 | Water quality testing results and flushing to be logged on single system and | Mr Rod Taylor, Director of | 31/12/2021 | ACTION CLOSED 12/01/2022 | Completed |

| | | | | | |
|---|---|---|---|---|---|
| | | shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales). | Estates & Facilities | | Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.<br><br>Water testing carried out by Public Health Wales who store the information on their servers, BCUHB keeps the information within log books for each area and accessible upon requests by departments.<br><br>Action closed. |
| | 12266 | Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting. | Mr Rod Taylor, Director of Estates & Facilities | 30/09/2022 | Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).<br><br>Progress update - Escalation process is included in the Water Safety Policy, exception reports provided to the Infection Prevention |

| | | | | | Group from the Water Safety Group. | On track |
|---|---|---|---|---|---|---|
| | 12267 | Awareness and training programme in place to ensure all staff aware as part of Departmental Induction Checklist. | Mr Rod Taylor, Director of Estates & Facilities | 30/09/2022 | A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.<br><br>Progress update – Awareness and Training Programme now in place. | On track |
| | 12268 | BCUHB Policy and Procedure in place and ratified, along with any department-level templates for Standard Operating Procedures and check sheets. | Mr Rod Taylor, Director of Estates & Facilities | 30/11/2021 | A policy for Water Safety Management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.<br><br>As part of the Water Safety Plan infection prevention will need to be integrated within key sections of the plan.<br><br>April 2022 progress update - Comments and recommendation from authorising engineer for | Delay |

| | | | | | water, infection prevention, microbiology and health and safety incorporated into the plan, to be presented in May. 2022 for ratification by Infection Prevention Sub-Group. | |
|---|---|---|---|---|---|---|
| | 12270 | Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the Health & Safety Gap Analysis Action Plan. | Mr Rod Taylor, Director of Estates & Facilities | 31/01/2022 | ACTION CLOSED 12/01/2022<br><br>Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.<br><br>Standardised maintenance strategy adopted and in place by means of single service provider.<br><br>Action closed. | Completed |
| | 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. | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | April 2022 progress update - Business case now included in the scope of priorities for Integrated Medium Term Plan, which will result in a delay to the action due date of the 31/03/2022 to appoint Senior Estates Officers (Competent Person) for water safety. | |
| | 19760 | Confirmation that the Health Board has an Appointed Authorising Engineer for water safety, a function that is provided by NHS shared services (specialist estates services). | Mr Rod Taylor, Director of Estates & Facilities | 31/12/2021 | ACTION CLOSED 31/12/2021<br><br>Provide an independent Water Safety Specialist Engineer to ensure Health Board is compliant in its duties in terms of water safety, which in turn will increase the controls in place and support the reduction in the likelihood of the risk materialising.<br><br>Appointed Authorising Engineer – appointed December 2021.<br><br>Action closed. | Completed |
| | 19761 | Improve on the consistent reporting and the identification of little used | Mr Arwel Hughes, Head of | 28/02/2022 | Substantiate the adjusted lower risk score that has been signed off at committee. | Completed |

| | | | | | |
|---|---|---|---|---|---|
| | | outlets in both community and acute settings. | Operational Estates - Interim | | Action closed, flushing of little used outlets now reported as part of the water safety group, currently quarterly, however will move to become bi-monthly from April 2022. | |

| CRR20-04 | **Director Lead:** Executive Director of Finance | **Date Opened:** 07 January 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 27 April 2022 |
| | **Risk:** Non-Compliance of Fire Safety Systems | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 30 September 2022 |

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



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | low level | | 1-8 |

| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged |
|---|---|

| Controls in place | Assurances |
|---|---|
| 1. Fire Safety Policy established and implemented, annual report reported to Board and supported by Welsh Government. <br> 2. Fire risk assessments in place. <br> 3. Fire Engineer regularly monitors Fire Safety Systems. <br> 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. <br> 5. Annual Fire Safety Audits undertaken. <br> 6. Escape routes identified and evacuation drills undertaken, established and implemented. | 1. Health and Safety Leads Group. <br> 2. Strategic Occupational Health and Safety Group. <br> 3. Quality, Safety and Experience Committee. <br> 4. Annual Compliance returns submitted to Welsh Government. |

| 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.

## 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. Assurances updated to ensure relevance with current risk position.
4. 2022 Fire Safety Audit completed, undergoing validation prior to submission to Welsh Government by the 31/05/2022.
5. Action ID 12274 – Extension to the action due date from the 31/3/2022 to the 31/07/2022 to allow the implementation into the new operating model for governance accountability and responsible senior staff members to be identified.
6. Action ID 12275 – Action closed as 80% compliance target rate has consistently been achieved over the past 3 years and is monitored via the Fire Safety Group.  This action will now be archived and removed from the next iteration of the report.
7. Action ID 12279 – Action closed as Albac Mat training is now in place. Estates and Facilities Department provided support to develop the training programme. Manual handling training on Albac Mats is delivered by the manual handling team with refresher training delivered on request. Closure of the action recognises the link on training compliance with the manual handling department.  This action will now be archived and removed from the next iteration of the report.
8. This risk will be presented to the Strategic Occupational Health and Safety Group for future collaborate monitoring with Estates and Health and Safety Leads.

## Links to

| Strategic Priorities | Principal Risks |
|---|---|
| Strengthen our wellbeing focus<br>Making effective and sustainable use of resources (key enabler) | BAF21-13<br>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 | 12274 | Identify how actions identified in the site Fire Risk Assessments are escalated to senior staff and effectively implemented. | Mr Rod Taylor, Director of Estates & Facilities | 31/07/2022 | Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on implementation of actions outstanding.<br><br>April 2022 progress update - Extension to the action due date from the 31/03/2022 to the **31/07/2022** to allow the implementation into the new operating model for governance accountability, anticipated action completion will be 31/07/2022. | Delay |
| | 12275 | Identify how site specific fire information and training is conducted and recorded. | Mr Rod Taylor, Director of | 30/06/2022 | ACTION CLOSED 21/01/2022<br><br>Database located within the fire safety files, managed and | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Estates & Facilities | | updated by the fire safety trainer.<br><br>Action closed as 80% compliance target rate has consistently been achieved over the past 3 years and monitored via the fire safety group. | Completed (green) |
| | 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.<br><br>April 2022 progress update - Betsi Cadwaladr Health Board are part of the all Wales groups looking into the evacuation of bariatric patients, reviewed locally under the guidance of the Hospital Management Team's. | On track |
| | 12279 | Albac Mat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved. | Mr Rod Taylor, Director of Estates & Facilities | 31/03/2022 | ACTION CLOSED 21/01/2022<br><br>Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling Team. | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Action closed recognising the link into the Health & Safety Team on Manual Handling Training compliance rates. | |
| | 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.<br><br>April 2022 progress update - Following a successful recruiting campaign, a full complement of Fire Safety Advisors is now in place which will assist with delivering the Health Board programme of Fire Risk Assessments in a risk assessed priority. | On track |
| | 21491 | Develop and implement a BCU Fire Safety Strategy. | Mr Rod Taylor, Director of Estates & Facilities | 30/09/2022 | Fire Safety Strategy will bring all procedures, action plans etc. together to improve governance control and oversight of Fire Safety Management. | On track |

| CRR20-05 | **Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning | **Date Opened:** 11 May 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 28 April 2022 |
| | **Risk:** Timely access to care homes | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 30 September 2022 |

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



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Multi-Agency Oversight Group and Care Provider Operational Group continue to meet to oversee the ongoing Covid response, to support recovery and ensure sustainability of the sector to respond to care home and domiciliary care demand with clear pathways for escalation in place.<br>2. North Wales care homes single action plan provides the framework for the Multi-Agency response and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). This group will now review the Health Boards current position against the recommendations of Operation Jasmine. | 1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW).<br>2. Oversight by the Regional Commissioning Board who report to the Regional Partnership Board. |

| | |
|---|---|
| 3. Development of the Quality Assurance Framework - this work is overseen by a Multi-Agency Implementation Group with sign up from the 6 Local Authorities and the RPB. The work is supported by 6 work streams which picks up the ongoing work around Covid and recovery.<br>4.  Continuing Health Care Operations Group in place 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. | |

| 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 is not due until September 2022.  Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report.<br>2.  Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge, but insufficient domiciliary care provision to step down to. Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report.<br>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. This has been escalated to the Silver Command Operations Resilience Meeting. Work ongoing with IT department to develop digital system.  This will ultimately be part of the revised Discharge Policy. Interim solution for providing consistent data will be implemented by May 2022.<br>4. No signed Pre Placement Agreement (PPA) - lack of controls in place for addressing concerns, monitoring quality - there is only informal voluntary co-operation.  This gap in control is shared with the 6 Local Authorities.  There is a joint PPA working group in place but failure to 'sign off' continues.  Regional Commissioning Board has sought legal advice.<br>5. Commissioned Placement Fee Setting - Health Board has agreed to make an interim uplift whilst awaiting national pay awards.<br>6. 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. |

| Progress since last submission |
| --- |
| 1. Controls in place reviewed and updated to reflect current risk position.<br>2. Gaps in controls updated to reflect that there is a work programme in place to review the discharge policy which will include a task and finish group to address the gaps in medically fit for discharge with a report providing a standardised approach for North Wales.  In addition work progressing with IT looking at a national data set.<br>3. Assurances updated to reflect current risk position.<br>4. Proposal to Risk Management Group increase the target risk score from 3x2 to 4x2 for an increase from a 6 to an 8 recognising that this remains with in the Health Board risk appetite statement as the impact should the risk materialise would not reduce to a 3 from 5.<br>5. Proposal to Risk Management Group to extend the Target risk due date from the 30/06/2022 to 30/09/2022. The Health and Social Care transition plan is dated from April to June 2022, the extension to the Target risk due date will to allow time to interpret and implement the next stages required.<br>6. Pre-placement agreement now agreed by the 6 Local Authorities and Care Forum Wales and will be sent out to providers within the next two months.<br>7. Action ID 14949 - Action closed as now completed. This action will now be archived and removed from the next iteration of the report.<br>8. Action ID 18024 – Action closed as this is now captured within the current controls in place in relation to the Multi-Agency Cell which undertake the activity.  This action will now be archived and removed from the next iteration of the report.<br>9. Action ID 18025 – Action delayed due to Regional Workforce Board not having met, this action links to action ID 20074.<br>10. Action ID 18646 – Action closed as this is now embedded into the controls in place identified in relation to the Multi-Agency Cell Action Plan.  This action will now be archived and removed from the next iteration of the report.<br>11. Action ID 20074 - Action remains delayed as meeting not re-established as anticipated by the Regional Partnership Workforce Board therefore March 2022 target completion date not anticipated, work remains ongoing to progress with plan for this to be established prior to this year's winter pressures, anticipated completion by end of August 2022.<br>12. Identification of new action ID 22182 to review and update Health Board Discharge policy, which will support the assessment around medically fit for discharge patients.<br>13. Further consideration taken to develop a care provider risk, work is ongoing to develop this risk. |

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

| Risk Response Plan | Action ID | Action | Action Lead/ Owner | Due date | State how action will support risk mitigation and reduce score | RAG Status |
|---|---|---|---|---|---|---|
| Actions being implemented to achieve target risk score | 14949 | Development of resources support capacity and demand for care homes. | Mrs Marianne Walmsley, Lead Nurse Primary and Community | 28/02/2022 | ACTION CLOSED<br><br>This will help eradicate delays in discharge through better co-ordination.<br><br>Action Closed as completed, staff returned to primary roles. | Completed |
| | 18024 | To work with LAs to review domiciliary care resource across North Wales. | Ms Jane Trowman, Care Home Programme Lead | 28/02/2022 | ACTION CLOSED 06/01/2022<br><br>It will improve patient flow by enabling patients to be discharged to their own homes.<br><br>This action is now captured within the current Multi-Agency Cell control in place which undertake this activity. | Completed |
| | 18025 | Working with the North Wales Regional Workforce | Mrs Marianne Walmsley, | 30/04/2022 | It will prevent admissions from Care Homes which have | Delay |

| | | Board to develop an improvement recruitment package for Independent Providers. | Lead Nurse Primary and Community | | no staff and improve patient flow to enable discharge.<br><br>April 2022 progress update - Action Delayed due to Regional Workforce Board not having met, this action links to action ID 20074. | |
|---|---|---|---|---|---|---|
| | 18646 | MFD - Work with local authorities and care provides to implement an agreed action plan. | Ms Jane Trowman, Care Home Programme Lead | 31/12/2021 | ACTION CLOSED 31/12/2021<br><br>Improved flow and discharge of patients in a more timely manner, and improve the quality of care to patients.<br><br>This action is now captured and embedded into the Multi-Agency Cell Action Plan control in place. | Completed |
| | 20074 | Development of an interim relief bank for health and social care | Mrs Marianne Walmsley, Lead Nurse Primary and Community | 31/01/2022 | Allow flexibility in relation to staffing within homes.<br><br>This action remains delayed due to resources within the Health Board and with partners to support the COVID vaccination programme and general staffing shortages. | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | April 2022 progress update - Action remains delayed as meeting not re-established as anticipated by the regional partnership workforce board therefore March 2022 target completion date not anticipated, work remains ongoing to progress with plan for this to be established prior to this year's winter pressures, anticipated completion by end of August 2022. | <span style="background-color:red"> </span> |
| | 22182 | Review and update Health Board Discharge policy. | Ms Jane Trowman, Care Home Programme Lead | 30/09/2022 | Discharge policy reviewed and updated will support the assessment around medically fit for discharge patients. | On track |

| 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:** 23 May 2022 |
| | **Risk:** Informatics - Patient Records pan BCUHB | **Date of Committee Review:** 20 May 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 January 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Informatics Strategy in place, with regular reporting to Partnership, People and Population Health Committee.<br>2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB and monitored via the Patient Records Group.<br>3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place to govern the management and movement of patient records.<br>4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group).<br>5. Centralised Team to manage 'Subject Access Requests' for Patient Records pan-BCUHB established with project complete March 2021, ensuring compliance with legislation and supporting the rectification of commingling within patients clinical notes.<br>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.<br>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. | 1. Chairs reports from Patient Record Group presented to Information Governance Group.<br>2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee.<br>3. Information Commissioners Office Audit. |

| 8. Baseline audit undertaken in acute mental health and Children and Adolescent Mental Health Service (CAMHS) with monitoring and oversight by the patient record group reporting to the Information Governance Group. | |
|---|---|

| **Gaps in Controls/mitigations** |
|---|
| 1. Lack of ability of project resources to be able to digitalise all specialties within 4 years. Phased approach for digital implementation introduced.<br>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. |

| **Progress since last submission** |
|---|
| 1. Controls in place reviewed to ensure relevance with current status of the risk.<br>2. Gaps in controls reviewed to ensure relevance with current risk position.<br>3. Action ID 12425 – Proposal to the Risk Management Group for an extension of the action due date from the 30/06/2022 to the 31/12/2022 due to a delay in the start of the Medical Transcribing Electronic Discharge project due to the inability to recruit resources for the project.<br>4. Action ID 12423, 12424 and 12429 – Action Lead/Owner updated to reflect current position. |

| **Links to** | |
|---|---|
| **Strategic Priorities** | **Principal Risks** |
| Making effective and sustainable use of resources (key enabler)<br>Transformation for improvement (key enabler) | BAF21-16<br>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 | 12423 | Development of a local Digital Health Records system. | Mrs Nia Aspinall - Head of Patient Records and Digital Integration | 30/09/2024 | Vascular Multi Disciplinary Team eForm and process has finished redesign and is in second stage of testing. Site visits have taken place with process mapping to follow for Central and West Health Records. Initial engagement continues with Lung Cancer Nurses Central and Rheumatology with progress on their eForms. Risk Sub-Group and Project | On track |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Board remain updated via e-mail as unable to meet due to Covid pressures on key attendees.<br><br>Phase 3.0 – Scanning & Upload Interviews and scoring concluded, panel have agreed to proceed with Supplier. Contract Award is pending sign off and will require Welsh Government approval. 2 Compliance & Assurance roles are with job evaluation and Work Package commenced to review new working processes and regulatory compliance.<br><br>Phase 4.0 – 3rd Party Integrations EPRO can now open within Cito, testing is underway. Ingestion of 750,000 historical clinical letters has commenced. Digital Health Care Wales have acknowledge receipt of request made Summer 2021, no timescales have been provided. | |
| | 12425 | Digitise the clinic letters for outpatients. | Mrs Nia Aspinall - Head of Patient Records and Digital Integration | 30/06/2022 | Central – Phase 3 Completed.<br>East - Phase 4; The following departments are now live on EPRO, Long Covid Service, CMATS, Paediatrics, Vascular, Breast, Palliative Care. Planning is underway with the remaining departments keeping the project on track for completion June 2022. | On track |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | May 2022 progress update - Proposal to the Risk Management Group for an extension of the target action due date from the 30/06/2022 to the 31/12/2022 due to a delay in the start of the Medical Transcribing Electronic Discharge project due to the inability to recruit resources for the project. | On track |
| | 12426 | Digitise nursing documentation through engaging in the Welsh Nursing Care Record. | Jane Brady, Assistant Business Support Manager | 30/09/2024 | Business Case still not formally approved and is currently with Executive Director of Finance. Plan formalised for continued roll-out Pan-BCU dependant on business case approval, in order to recruit into posts required for full implementation. | On track |
| | 12429 | Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records. | Mrs Nia Aspinall - Head of Patient Records and Digital Integration | 31/01/2023 | ON HOLD until the Mental Health Business Case is progressed with the Welsh 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. | On track |

| CRR20-08 | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 14 September 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 09 May 2022 |
| | **Risk** Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients. | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 31 Dec 2022 |

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

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

| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 5 | 5 | 25 |
| Current Risk Rating | 5 | 4 | 20 |
| Target Risk Score | 3 | 2 | 6 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Outsourcing process and group in place to review progress against the contract. <br> 2. Cataract - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first. | 1. Risk is regularly reviewed at local Quality and Safety meetings. <br> 2. Risk reviewed at monthly Eye Care Collaborative Group. <br> 3. Monthly reports to Welsh Government against Key Performance Indicators for eye care measure and Key Quality Indicators. |

| | |
|---|---|
| 3. 'Once for North Wales' process is in place, partially across all sites, Cataract patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access.<br>4. Once for North Wales process allows partial flexibility for cross region movement of Cataract and Intra Vitreal Injection patients and the ability to allocate further clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed.<br>5. Diabetic Retinopathy Integrated Pathway now in place across all 3 sites.<br>6. Monthly monitoring of the application of the Cataract Priority Targeting List (PTL) to ensure Pan BCU reduction of access inequity.<br>7. ODTC STW enabled continuation of use of Primary Care Optometry (6 until September 2022).<br>8. Clinical condition dashboard now available for beta stage testing to support documentation and site self-management of clinical condition use to manage services.<br>9. Pan BCU Clinical Lead now appointed. | 4. All Wales and Mersey Internal Audit Agency audits have taken place, and reports received to which BCUHB is responding. In addition two clinical condition audits are undertaken annually by Welsh Government.<br>5. Performance reviewed at Secondary Care Accountability Meetings. |

## Gaps in Controls/mitigations

1. Further table-top risk stratification is challenged by reduced office based decision making for clinicians as a consequence of their return to expanded clinical activities. Continuing to stratify patients into R1, R2 and R3 to enable prioritisation of those at risk of permanent sight lost. In addition further capacity is planned for Intra Vitreal Therapy (IVT) across all regions as part of the approved business case and additional Central region business case.
2. Outsourcing of the cataract activity is in place along with additional temporary administration support, however, there is need for sustainability moving forward.
3. Current partnership pathways which mitigates waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition. A significant number of patients do not have a clinical condition logged on the system. Standard Operating Procedure has been refreshed and a review is undertaken with a monthly clinical condition report to monitor data quality against clinical condition and sites produce redress action plans.
4. National standard currently not being met, guidance for number of cataracts being undertaken per list is currently set to 6-8, the Health Board is running at 2.8-3.6, differences in national standards between number of cataract procedures per list.

Regional Treatment Centres and Clinical Pathways contract formally with Get it right first time (GIRFT) in ophthalmology to review, design and implement new pathways to deliver high volume low capacity productive theatre sessions. First session took place on the 28th February 2022.

| Progress since last submission |
|---|
| 1. Controls in place reviewed and updated to reflect current risk position.<br>2. Gaps in controls reviewed and updated to reflect current risk position.<br>3. Proposal to the Risk Management Group to extend the target risk due date from the 30/06/2022 to the 31/12/2022 due to the services' proposal to review the risk with a view to reflect various eye conditions as separate risks and propose the development of separate risks moving forwards.<br>3. Recovery funding received and additional capacity currently being implemented.<br>4. Action ID 14908 – Action closed following completion, and the introduction of retinal cameras across all 3 sites. This action will be archived and removed from the next iteration of the report.5. Action ID 15662 – Action closed following initiation of the pathway pan BCUHB.  This action will be archived and removed from the next iteration of the report.<br>6. Action ID 20392 – Action delayed, recruited across all 3 sites with the exception of Consultant posts, which are currently being re-advertised.<br>7. Action ID 22092 – Action closed, Pan BCU Clinical Lead appointed, commenced May 2022.  This action will be archived and removed from the next iteration of the report.<br>8. Identification of new action ID's 22092 and 22093 for the replacement of Clinical Lead for Ophthalmology and Optometric advisor. |

| Links to | |
|---|---|
| **Strategic Priorities** | **Principal Risks** |
| Recovering access to timely planned care pathways<br>Strengthen our wellbeing focus | BAF21-02<br>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 | 14908 | The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources. | Mr Srinivas Singaram, Specialty Doctor | 31/12/2021 | ACTION CLOSED 07/01/2022  This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.  Progress to date - Action has been completed, equipment now in place across all 3 sites. | Completed |
| | 15662 | Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress. | Mr Srinivas Singaram, Specialty Doctor | 31/12/2021 | ACTION CLOSED 07/01/2022  This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.  Progress to date – Action closed following completion. | Completed |
| | 20392 | Following approval of business case, recruitment of clinical and admin posts for Intra Vitreal Therapy capacity and technical posts for the digital project. | Alyson Constantine, Site Acute Care Director | 31/12/2021 | Additional Intra Vitreal Therapy capacity and more patients can be seen within target time. Technical posts will allow progression of digital implementation. | Delay |

| | | | | | May 2022 progress update - All posts for IVT services recruited except for Consultants. | |
|---|---|---|---|---|---|---|
| | 20995 | Training of additional non medic Intra Vitrael Therapy (IVT) injectors. | Mrs Jackie Forsythe, Eye Care Co-ordinator | 30/06/2022 | Additional non medic injectors will reduce waiting times for new Intra Vitrael Therapy patients which will reduce the likelihood of the risk materialising.<br><br>May progress – All 3 site injectors have completed the accreditation course and are moving to practical train and treat stage. | On track |
| | 22092 | Replacement of Clinical Lead for Ophthalmology. | Alyson Constantine, Site Acute Care Director | 31/05/2022 | The action will result in support in the review of services across North Wales, standardisation and best practice within the service.<br><br>Action Closed - Pan BCU Clinical Lead appointed, commenced May 2022. | Completed |
| | 22093 | Replacement of Optometric advisor. | Alyson Constantine, | 30/06/2022 | To support the communication between the Health Board and the Optometrists during the | On track |

| | | | | | |
|---|---|---|---|---|---|
| | | Site Acute Care Director | | implementation of the National optometry reform contract currently with Welsh Government.<br><br>May 2022 progress update – Interviews for the substantive post due on the 9th June 2022, with the recruitment process and shortlisting taken place. | |

| CRR21-13 | **Director Lead:** Executive Director of Nursing and Midwifery | **Date Opened:** 01 December 2017 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee Quality and Safety Group | **Date Last Reviewed:** 12 May 2022 |
| | **Risk:** Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce) | **Date of Committee Review:** 01 March 2022 |
| | | **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 Covid 19 pandemic.

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



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Workforce Recruitment and Retention Strategy in place and actively monitored with initiatives in place to maximise recruitment and retention across the nursing workforce.<br>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 Strategic Workforce Group.<br>3. Bi-annual Nurse Staffing calculations 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 | 1. Risk CRR21-13 is reviewed and monitored at the respective local Quality and Safety meetings.<br>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. |

| |
|---|
| calculations are also undertaken in other areas of acute services such as admission portals, Emergency Departments and areas of high care.<br>4. A 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.<br>5. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to ensure roster performance is actively managed to enable maximum utilisation of nursing workforce across the Health Board.<br>6. Managing Attendance at Work Policy WP11 in place with sickness, absence and wellbeing pro-actively managed to ensure the nursing workforce is optimised.<br>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.<br>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.<br>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.<br>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. | 3. Monthly roster KPI reports are issued to identify areas in need of improvement and areas requiring targeted support.<br>4. 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.<br>5. Nurse Recruitment and Retention workplan aligned to organisational priorities, CNO principles and key national drivers/strategy. |

## 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 has been developed and 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, paediatrics and Mental Health are yet to implement. 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 not everyone is IT literate, due to personnel changes there is a requirement for refresher training. Plan being developed to move all nurse staff groups onto roster with a specific IT training plan aligned to this initiative.
4. Whilst the recruitment and retention strategy and plan are in place, this needs updating in line with the update of the Health Board's People strategy. Individual initiatives are in place to inform data analysis and the revised strategy 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. Controls in place reviewed and updated to align with current risk position. |
| 2. Gaps in controls reviewed to ensure relevance with current risk position. |
| 3. Proposal to the Risk Management Group to extend the target Risk Due date from the 30/12/2022 to the 30/12/2025 to align the risk with the Health Board's Integrated Medium Term Plan. |
| 4. Proposal to the Risk Management Group to re-score the Target Risk Score from the current score of 6 (Impact = 3, Likelihood = 2), to a score of 8 (Impact = 4, Likelihood= 2). |
| 5. Action ID 15635 – Action remains delayed, this action is now delayed because the new People Operating Model (Workforce) has been pulled back as it will be in place by 30/09/2022. |
| 4. Action ID 17433 - Action remains delayed, meeting held between Nursing team and Workforce to review the action and agreement that further review in 3 months would be required. |
| 5. Action ID 17509 – Proposal for an extension to the action due date. Following a request from the Executive Team for clarification on the time extension, this is due to the action now becoming a National Programme, looked at in the context from an All Wales perspective, and led by the office of the Chief Nursing Officer.  Timeframe for completion is therefore outside the control of the Health Board which is the reason for the proposal to the timeframe extension until the 30/11/2022 is presented. |
| 6. Action ID 18834 - Proposal for an extension to the action due date to the 30/06/2022, due to system pressures and the management of the COVID pandemic. System has developed and is in place to be implemented however due to current instability in workforce and current pressures, implementation has been delayed. |
| 7. Identification of new action ID 23095 to develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially. |

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

| Risk Response Plan<br><br>Actions being implemented | Action ID | Action | Action Lead/ Owner | Due date | State how action will support risk mitigation and reduce score | RAG Status |
|---|---|---|---|---|---|---|
| | 15635 | Development of a recruitment and resourcing business case to go to Executives. | Mr Nick Graham, Workforce | 30/11/2021 | This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the | Delay |

| to achieve target risk score | | | Optimisation Advisor | | ability to expedite recruitment and increase volume.

The individual benefits and Key Performance Indicators of the business case are linked to the relevant sections of our corporate risk register.

May 2022 progress update – this action is now delayed because the new People Operating Model (Workforce) has been pulled back as it will be in place by 30/09/2022. | |
|---|---|---|---|---|---|---|
| | 17433 | Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes. | Mrs Joy Lloyd, Senior OD Manager | 31/03/2022 | This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.

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.

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 | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | 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.<br><br>May progress update - Action remains delayed, meeting held between Nursing team and Workforce to review the action and agreement that further review in 3 months would be required. | |
| | 17509 | Exploration of the Welsh equivalent Global Learning Programme. | Mrs Alison Griffiths, Director of Nursing Workforce | 30/11/2021 | The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS.<br><br>This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development.<br><br>May 2022 progress update - Action remains delayed due to the action now being superseded by the once for Wales National initiative and remains outside the Health Board | Delay |

| | | | | | control, BCU is part of the national group. | |
|---|---|---|---|---|---|---|
| | 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 | 31/12/2021 | Effective utilisation of substantive staff.<br><br>May 2022 progress update - Proposal of extension to the action due date to the 30/06/2022, due to system pressures and the management of the COVID pandemic. System is developed and in place to be implemented however due to current instability in workforce and current pressures. | **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. | Mrs Alison Griffiths, Director of Nursing Workforce | 30/12/2022 | This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce.<br><br>May 2022 progress update - Action remains on track for December 2022. | On track |
| | 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.<br><br>May 2022 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is ongoing to implement the programme. | On track |
| | 22121 | Implement Allocate Safecare system to all clinical areas and | Mrs Alison Griffiths, | 30/09/2022 | Ensure that Health Board has increased visibility of the Nursing | On track |

| | | | | | |
|---|---|---|---|---|---|
| | | associated training requirements. | Director of Nursing Workforce | | workforce to ensure efficient utilisation of nursing staff and better identify areas of risk to enable appropriate mitigation at a local level. |
| | 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.

May 2022 - There are actions being captured within the Workforce delivery plan including rotation, supervision and development opportunities. | On track |
| | 23095 | Develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially. | Mrs Alison Griffiths, Director of Nursing Workforce | 30/11/2022 | The infrastructure will enable the delivery of nursing workforce staffing and professional standards agenda/portfolio. | On track |

| CRR21-14 | **Director Lead:** Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services | **Date Opened:** 20 August 2021 |
|---|---|---|
| | **Assuring Committee:** Mental Health and Capacity Compliance Committee | **Date Last Reviewed:** 10 May 2022 |
| | **Risk:** There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients. | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 31 October 2023 |

This may be caused by the increased number of patients who are refusing admission or who have 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.

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 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 2022.** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health and Capacity Compliance Committee (MHCCC), Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework.<br>2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework.<br>3. BCUHB mandatory adult at risk training levels 2 and 3 is 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. | 1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group.<br>2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings.<br>3. The risk is reviewed and scrutinised at the Executive Business Meeting. |

| | |
|---|---|
| 4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a].<br>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.<br>6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings.<br>7. Welsh Government interim 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. | 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis.<br>5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews.<br>6. Mental Capacity Act training compliance and DoLS backlog is monitored by the Safeguarding Governance and Performance Group reported into Welsh Government.<br>7. Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the Safeguarding Team, which is reported to the Mental Health and Capacity Compliance Committee. |

## 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 UK Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. Preparation and the implementation is dependent upon capacity, resource and expertise with the awaited revised code of practice. A business case has been approved as part of the Integrated Medium Term Plan 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score.
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. | |

| Progress since last submission |
|---|
| 1. Controls and Assurances reviewed to reflect current risk position. |
| 2. Gaps in Controls reviewed to reflect current risk position. |
| 3. Terms of Reference for Liberty Protection Safeguards Strategic Implementation Task and Finish group ratified and approved by Mental Health and Capacity Compliance Committee. |
| 4. Date set for the inaugural Liberty Protection Safeguards Strategic Implementation Task and Finish group. |
| 5. Integrated Medium Term Plan has acknowledged funding for additional resources, awaiting allocation and remains on reserve list for release in quarter 3. |
| 6. Action ID 15708 - Action delayed, consultation completed, with governance approval following the Health Board's policy on policies. |
| 7. Action ID 18117 - Action delayed with business case to be re-submitted to Executive team to support the release of monies from Quarter 3 22/23. |
| 8. Action ID 18118 - Action delayed, consultation completed, with governance approval following the Health Board's policy on policies. |
| 9. Action ID 20957 – Action delayed, due to UK and Welsh Government for release of code of practice, consultation due for July 2022. Anticipated due date for local implementation plan by end of August 2022. |
| 6. Identification of new action ID 23066 to improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'. |

| 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 | 15708 | The Deprivation of Liberty Safeguards Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non compliance with legislation for the both the Managing | Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business | 31/10/2021 | The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention.<br><br>May 2022 progress - Action delayed, consultation completed, governance | Delay |

| | | Authority and Supervisory Body. | Support Manager | | approval following the Health Board's policy on policies is in progress. | |
|---|---|---|---|---|---|---|
| | 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.<br><br>May 2022 progress update - Action delayed with business case to be re-submitted to Executive team to support the release of monies from Quarter 3 22/23. | Delay |
| | 18118 | Implement and monitor a Court of Protection Engagement and Standard Operating Procedure for Deprivation of Liberty Safeguards / Liberty Protection Safeguards. | Michelle Denwood, Director of Safeguarding and Public Protection | 31/10/2021 | The pathway will reduce delay, improve communication and reinforce organisational accountability.  This will improve activity with the Court of Protection and meet the needs and safeguards of service users.<br><br>May 2022 progress - Action delayed, consultation completed, governance approval following the Health Board's policy on policies is in progress. | Delay |
| | 20957 | Development of implementation plan 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.<br><br>May 2022 progress update - Delay due to UK and Welsh Government for release of the code of practice. Consultation had now commenced, end date is July 2022. Anticipated | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | due date for local implementation plan by end of August 2022. | <span style="background:red"> </span> |
| | 21213 | Utilise agreed funding for the increased activity within Safeguarding. | Michelle Denwood, Director of Safeguarding and Public Protection | 31/10/2022 | Enable implementation of the Social Services and Well-being Act to support the increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. | On track |
| | 23066 | Improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'. | Michelle Denwood, Director of Safeguarding and Public Protection | 30/11/2022 | Welsh Government monies will support additional resource and educational tools to inform the workforce regarding capacity and harm which will reduce risk and improve patient care. | On track |

| | **Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services | **Date Opened:** 21 December 2020 |
|---|---|---|
| CRR21-15 | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 26 April 2022 |
| | **Risk:** There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014 | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 31 October 2023 |

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

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

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



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 4 | 3 | 12 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged | | |

| **Controls in place** | **Assurances** |
|---|---|

| | |
|---|---|
| 1. All Wales and North Wales Safeguarding procedures approved and in place.<br>2. BCUHB local work programmes in place and aligned to the national strategies which are regularly reported to Welsh Government.<br>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.<br>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.<br>5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [Wales] Act 2014 and National Safeguarding Procedures 2019, which came into force in November 2020. Mandatory training continues to be delivered using a variety of IT platforms.<br>6. The BCUHB Children's Division are managing the recruitment process for the replacement of the named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor.<br>7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings.<br>8. Welsh Government interim monies has been utilised to increase physical capacity out of hours.<br>9. Sexual Abuse Referral Centre (SARC) lead has been identified for the Health Board to support the implementation and compliance against the SARC accreditation. | 1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group.<br>2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings.<br>3. The risk is reviewed and scrutinised at the Executive Business Meeting.<br>4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis.<br>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.<br>6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government. |

**Gaps in Controls/mitigations**

1. The increase in safeguarding activity, with enhanced complexity as a result of COVID, and the increase in victims recognised as a result of Domestic Abuse and Sexual Violence, refugees, modern day slavery/Human trafficking 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.
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 with alternative platforms in place when they have limited digital patient records.
4. Lack of consistent approach by the 6 Local Authorities in North Wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible.
5. Named Doctor Safeguarding Children - this post remains vacant.  Currently working in conjunction with the Paediatric Team to ensure local arrangements are in place to support the Safeguarding agenda/portfolio.
6. 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 plan.

| Progress since last submission |
|---|

1. Controls in place updated to reflect current position with the identification of additional controls.
2. Assurance sources updated to reflect the addition of new controls in place.
3. Gaps in controls reviewed and updated to reflect current risk position.
4. Extension to the Target Risk Due date from the 01/04/2022 to the 31/10/2023 to allow time for organisational processes to be followed and to be able to fully implement organisational process and new statutory legislation using the agreed funding.
5. Action ID 18113 - The action remains delayed due to North Wales Safeguarding Board supporting a Welsh Government task group to review the position of trust procedure to support the development of regional procedures, this still causes a delay against internal BCU activity.
6. Action ID 18115 – Action closed due to the duplication with the Childrens Services Risk, also recognising that whilst the responsibility for the recruitment to the vacant post of Named Doctor Safeguarding, alternative actions are being put in place supported by Corporate Safeguarding to support the mitigation of this risk.  This action will now be archived and removed from the next iteration of the report.
7. Action ID 18116 - Action remains delayed, however, the re-deployed staff for COVID management have now returned to the substantive posts which will support progress of the action. A single point of contact for BCU is now in place with estimated completion and approval of the Terms of reference expected by end of July 2022.

8. Action ID 18120 -  Action delayed as The North Wales Safeguarding Board is developing a task and finish group to receive national documentation to support implementation and process across North Wales. Anticipated delay to this action due to the Home Office delayed agreement relating to process and information governance for domestic homicide reviews which are expected to be part of the unified review which is currently out of the Health Board's control, and negotiations are being led by Welsh Government.

9. Action ID 21217 – Action closed as reviews have been undertaken between the Paediatrician/Paediatrics and the Corporate Safeguarding Teams with consideration given to the future role of the named Dr for Safeguarding Children against safeguarding legislation and statutory duties. The responsible service for the recruitment of the post have advertised for the role.  This action will now be archived and removed from the next iteration of the report.

10. The risk associated with safeguarding and public protection will remain high due to the likelihood of injury (physical, emotional, sexual and neglect) and the impact on individuals as a result of abuse or omission of care and/or criminal exploitation.

| 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. | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | April 2022 progress update - North Wales Safeguarding Board are supporting a Welsh Government task group to review the position of trust procedure to support the development of regional procedures, this still causes a delay against internal BCU activity. | |
| | 18115 | Advertisement and Recruitment of the Named Dr Safeguarding Children/Children at Risk. | Miss Andrea Davies, PA to Director of Safeguarding and Public Protection /Interim Business Support Manager | 20/12/2021 | ACTION CLOSED 31/12/2021, due to duplication with the Childrens Services Risk.

Ensure full compliance with legislation and ensure clinical strategic and operational safeguarding responsibilities are met.

To support the mitigation of the actual risk, the Safeguarding Team are working in conjunction with the BCUHB Consultant Community Paediatricians to provide an alternative solution until the vacancy can be filled. Therefore a further action is taking place to review current and future role and | Close |

| | | | | | responsibilities. See action 21217.<br><br>Action closed taking the above duplication and alternative actions / mitigations being put in place. | |
|---|---|---|---|---|---|---|
| | 18116 | To Implement and monitor strengthened governance and reporting pathways for Sexual Assault Referral Centre. | Michelle Denwood, Director of Safeguarding and Public Protection | 10/01/2022 | Compliance with legislation and early identification of risk and harm.<br><br>April 2022 progress update - Action remains delayed, however, the re-deployed staff for COVID management have now returned to the substantive posts will support progress of the action. Identified lead for SARC accreditation has been moved and is now the responsibility (as of February 2022) of the Corporate Safeguarding Team for the Health Board. As a result links have been strengthened with the Welsh Government national SARC lead and North Wales Police project lead (North Wales Police who hold the legal entity for this activity). Implementation plan has been developed and the | Delay |

| | | | | | implementation of a SARC steering group will monitor progress. A single point of contact for BCU is now in place with the development of a Project Board, the estimated completion and approval of the Terms of reference is expected by end of July 2022. | |
|---|---|---|---|---|---|---|
| | 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.<br><br>April 2022 progress update - The North Wales Safeguarding board is developing a task and finish group to receive national documentation to support implementation and process across North Wales. Anticipated delay to this action due to the Home Office have delayed agreement relating to process and information governance for domestic homicide reviews which are | Delay |

| | | | | | expected to be part of the unified review which is currently out of the Health Board's control and negotiations are being led by Welsh Government. | |
|---|---|---|---|---|---|---|
| | 21216 | 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 activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan.<br><br>April 2022 progress update - Intermediate Medium Term Plan and the additional funding identified is now on the reserve list, with planned streamline of the Business case to support a total review of the Safeguarding structure. | On track |
| | 21217 | Review current and future Paediatrician role and responsibility to comply with Safeguarding legislation. | Michelle Denwood, Director of Safeguarding and Public Protection | 31/03/2022 | Ensure roles and responsibilities meet Safeguarding legislation requirements both operationally and strategically.<br><br>Working in conjunction with the BCUHB Consultant Community Paediatricians. | Completed |

| | | | | March 2022 progress update - Reviews have been undertaken between the Paediatrician/Paediatrics and the Corporate Safeguarding Team with consideration given to the future role of the named Dr for Safeguarding Children against safeguarding legislation and statutory duties. The responsible service for the recruitment of the post have advertised for the role.<br><br>Action closed. | |

| 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:** 10 May 2022 |
| | **Risk:** Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients. | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 20 June 2023 |

There is a risk that insufficient 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.



| | 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 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Health & Safety Strategy has been approved and implemented which includes Manual Handling.<br>2. Training work programme is in place specifically in relation to Manual Handling.<br>3. Recruitment programme has been approved and is in place as part of the Health & Safety business case.<br>4. Risk assessments in place to provide safe training environment. | 1. Regular oversight and review by the Occupational Health & Safety Team.<br>2. Reviewed at the Strategic Occupational Health and Safety Group. |

| 5. Two year training plan in place which will cover delivery of training and current shortfalls in training. | 3. Risk Management Group oversight. |
| 6. 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. | 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.
3. Lack of integrated booking system 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 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 for two years but this remains a gap in the controls until recruitment has been successful. Current compliance for Patient Handling refresher is now at 49%.
6. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments, Action plan has been incorporated and the HSE verified compliance.

## Progress since last submission

1. Risk Description updated to reflect current risk position so that the risk is more clearly articulated.
2. Controls in place reviewed and updated to reflect current risk position.
3. Gaps in controls reviewed and updated to reflect current risk position and updated in relation to the reduction in current compliance for Patient Handling refresher training from 55% to 49%.
4. Health and Safety Team are preparing for a visit from the Health and Safety Executive due 18 May 2022 to carry out an inpatient manual handling risk assessment and patient falls risk assessment review.
5. Action ID 17978 – Action closed, premises on all 3 regions now secured, and fully functional. IT infrastructure is now in place.
6. Action ID 17979 - Action remains delayed, interviews for the Manual Handling Manager posts held, they are due to start 01 August 2022. Further adverts for the vacant band 6 Manual Handling Trainer/ Adviser posts will be out by the end of May

7. Action ID 17980 – Extension to the action due date from the 31/12/2021 to the 01/04/2023 to allow sufficient time for the training provision to reach an acceptable level in line with the action plan to be presented to the Health and  Safety Executive. Action plan presented to the Health and Safety Executive on the 14th March 2022 with details on how the training will be focused within the Health Board. HSE approved the response and the notice was complied with.
8. Action ID 18859 – Action remains delayed. Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 September 2022.
9. Action ID 18860 – Action closed as Patient Falls Training Modules 1A and 1B are now available on the ESR system.
10. Targeted intervention training trialled within 2 areas on the East and Central sites, with subsequent roll out of the training within 4 areas of the Wrexham site currently ongoing.

| 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 | 17978 | Renting of temporary training rooms in West, Central & East. Report has been approved for 2 year leases on the premises, awaiting contracts to be finalised. | Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security | 30/11/2021 | Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing and increasing the number of courses that can be delivered, increase the number of staff trained and increase compliance for BCUHB.<br><br>April 2022 progress update - Premises on all 3 regions now | Completed |

| | | | | | secured, and fully functional. IT infrastructure is now in place. | |
|---|---|---|---|---|---|---|
| | 17979 | Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide. | Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security | 30/11/2021 | Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB.

April 2022 progress updates - Interviews for the Manual Handling Manager posts held, references received with start date of the 01/08/2022.

Band 6 Manual Handling training posts will be re-advertised by the end of the month. | Delay |
| | 17980 | Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training. | Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security | 01/04/2023 | Progress update - Extension of the action due date from the 31/12/2021 to the 01/04/2023 to allow sufficient time for the training provision to reach an acceptable level in line with the action plan to be presented to the Health and  Safety Executive. Action plan has | On track |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | been presented to the Health and Safety Executive on the 14th March 2022 with details on how the training is to be focused within the Health Board.<br><br>Targeted training on patient falls and handling risk assessments has commenced on 4 areas on the Wrexham site.<br><br>The porters load handling risk assessments have been revised to include TILE. Supervisors have been re-trained on risk assessments and particularly load handling risk assessments. All porters to be given information, instruction and training on the risk assessments.<br>An audit programme has commenced for both patient falls and patient handling risk assessments. | |
| | 18859 | Finalise, approve and implement Manual Handling Policy and Plan. | Mr Peter Bohan, Associate Director Of | 31/12/2021 | Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Occupational Health Safety and Security | | likelihood of injury to both patients and staff.<br><br>April 2022 progress update - Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 September 2022. | <span style="background:red"> </span> |
| | 18860 | ESR to be reviewed to include the patient falls 1A and 1B training courses for inanimate load level 1. | Mr Peter Bohan, Associate Director Of Occupational Health Safety and Security | 31/03/2022 | Support the risk and allow correct compliance and correct level of training, reducing the risk of injury for those attending class for a competency assessment.<br><br>Completion of the patient falls risk assessment template is trained by the Manual Handling team along with the Patient Handling template.<br><br>Action closed as Patient Falls Training Modules 1A and 1B are now available on the ESR system. Workbooks have also been created for use by staff, under manager supervision, | Completed |

who have limited access to computers.

| | | |
|---|---|---|
| **CRR21-17** | **Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services | **Date Opened:** 26 July 2021 |
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 12 May 2022 |
| | **Risk:** The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours. | **Date of Committee Review:** 01 March 2022 |
| | | **Target Risk Date:** 31 October 2022 |

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

This may be caused by a number of contributory factors, the list below is not exhaustive:
• Current operational hours of CAMHS is 9am-5pm over 7days a week.
• CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.
• increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
• crisis presentations to 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.
• awaiting a CAMHS Tier 4 bed following a mental health assessment.

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

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

| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 4 | 2 | 8 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in January 2022** | Unchanged | | |

| Controls in place | Assurances |
|---|---|
| 1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Area Team. <br> 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Area Teams as part of the risk assessment and risk management processes. <br> 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. <br> 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). <br> 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. <br> 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. <br> 7. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. <br> 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. <br> 9. Safeguarding discharge Standard Operating Procedure for young people in place. | 1. A scoping exercise or report of Child and Adolescent Mental Health Services (CAMHS). Unscheduled/Crisis Care has been completed. <br> 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB approach. <br> 3. Risk also regularly discussed at the Area - Quality and Safety Group. <br> 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. <br> 5. Pre Jet Meeting with Welsh Government, joined with Mental Health Division on a quarterly basis. |

| 10. Daily situation report (SITREP) reporting between Paediatrics and CAMHS, which includes incident notifications. 11. Analysis of intelligence from 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 availability, staff shortages and availability of appropriately trained staff, which has been exacerbated by the lockdown arising from Covid-19. Currently working with recruitment agency and established multi-disciplinary team is already in place.
2. Lack of suitable 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 health economy areas 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 to ensure relevance with current risk position.
2. Gaps in controls reviewed and updated to ensure relevance with current risk position.
3. In line with the new Operating Model the Executive Director has been amended.
4. Bid submitted for Executive approval, if supported will be presented to Welsh Government for Mental Health improvement funding for alternatives to admission to provide safe place to pilot across all 3 health communities.
5. Action ID 17961 – Action closed due to risk assessments from all 3 regions having now been received
6. Action ID 17962 – Action closed with the successful commissioning of the "Just R" recruitment and ongoing campaign. Wider workforce strategy is in development under the targeted intervention programme.
7. Action ID 17963 - Action remains delayed, consultation ongoing with NICE from 18/01/2022 to 01/03/2022 expected publication date 06/07/2022. Draft Operational Standard Operating Procedure for BCU has been updated and currently being reviewed by clinicians to ensure clarity on roles and responsibilities whilst BCU awaits the new guidance.
8. Action ID 17964 – Approve the extension to the action due date from 31/03/2022 to 31/10/2022 to allow sufficient time for the development and implementation of the action. Following review of the training requirement, it was identified that there is a need

for the development of an ongoing training programme rather than one off training sessions, therefore this will require some scoping and resourcing.

9. Action ID 19594 - Action remains delayed, currently liaising with the Heads of Nursing in Central and West area to progress the action following the pause in December/January due to Covid 19.

10. Action ID 19595 – Action closed as completed, incidents reviewed and now included within daily Sit Reps.

11. Identification of new action ID 23091 to progress with recruitment to bespoke campaign for Child Psychiatry.

| Links to | |
|---|---|
| **Strategic Priorities** | **Principal Risks** |
| Improved Unscheduled Care pathways<br>Integration and improvement of Mental Health Services | BAF21-01<br>BAF21-08 |

| Risk Response Plan<br><br>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 |
|---|---|---|---|---|---|---|
|  | 17956 | Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed. | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 31/10/2022 | This will enable us to divert young people at the front door and support their needs in different ways.<br><br>Progress - Draft currently being circulated for final comments prior to approval at | On track |

| | | | | | |
|---|---|---|---|---|---|
| | | | | the BCUHB Regional Children's Services Group and Together Mental Health Partnership Board. | On track |
| | 17957 | To use a collaborative multi agency partnership approach in addressing the needs of young people accessing Child and Adolescent Mental Health Services (CAMHS). | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 31/10/2022 | This will enable us to meet the needs of young people before crisis occur as most of their needs are pyscho-social and not just Mental Health.

Progress - Draft currently being circulated for final comments prior to approval at the Childrens Sub Group of the Regional Partnership Board and Together Mental Health Partnership Board. | On track |
| | 17961 | Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place. | Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services | 29/10/2021 | ACTION CLOSED 13/01/2022

Ensure a safe environment by identifying all ligature points on the ward.

Ligature point assessments received from East, West and Central. | Completed |
| | 17962 | To recruit additional staff/agency to support individual young people as required. | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 31/03/2022 | ACTION CLOSED 31/03/2022

It will support timely access to support and treatment in relation to the demand that | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | has been experienced. The increase in workforce will enable us to provide more out-of-hour response.<br><br>Progress update - Action closed with the successful commissioning of the "Just R" recruitment and ongoing campaign. Wider workforce strategy is in development under the targeted intervention programme. | |
| | 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 / CAMHS Clinical Lead | 30/12/2021 | This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.<br><br>Progress update - Action remains delayed, consultation ongoing with NICE from 18/01/2022 to 01/03/2022 expected publication date 06/07/2022. Draft Operational Standard Operating Procedure for BCU has been updated and currently being reviewed by clinicians to ensure clarity on roles and responsibilities | Delay |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | whilst BCU awaits the new guidance. | |
| | 17964 | Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ Emergency Department staff, Local Authority and North Wales Police. | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 31/10/2022 | Create awareness and develop skill in assessment and improve staff morale.<br><br>Progress update – Extension to the action due date from 31/03/2022 to 31/10/2022 to allow sufficient time for the development and implementation of the action. Following review of the training requirement, it was identified that there is a need for the development of an ongoing training programme rather than one off training sessions, therefore this will require some scoping and resourcing. | On track |
| | 18334 | Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies. | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 31/10/2022 | Provision of an age appropriate environment that provides an appropriate alternative to hospital.<br><br>Progress to date - Safe space pilot to take place from the 31/1/2022 in the East area operating over 3 evenings with access to various specialties. In the process of arranging | On track |

| | | | | | dates for the West area for conversation on how to take a similar pilot forward. | |
|---|---|---|---|---|---|---|
| | 19594 | Develop a programme of auditing risk assessments as part of the admissions pathways on a quarterly basis. | Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services | 01/02/2022 | The Risk Assessment and audit process will support the reduction in the risk score whilst recognising that the paediatric wards cannot be a completely ligature free environment.

Progress update - Action remains delayed, currently liaising with the Heads of Nursing in Central and West area to progress the action following the pause in December/January due to Covid 19. | Delay |
| | 19595 | Further analysis of the incidents reported in order to determine what further actions are required to ensure appropriate reporting of the incidents. | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 31/01/2022 | ACTION CLOSED 31/01/2022

Provides a greater understanding of the incidents occurring and the measured required to be put in place to support both staff and patients and supports a safer environment. | Completed |

| | | | | | Action closed as completed, incidents reviewed and now included within daily Sit Reps. | |
|---|---|---|---|---|---|---|
| | 21236 | Implementation of recommendations following the Delivery Unit Crisis Care Review. | Marilyn Wells, Head of Nursing / CAMHS Clinical Lead | 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.<br><br>Progress update - Verbal feedback received in relation to the action, formal report remains awaited. | On track |
| | 23091 | Progress with recruitment to bespoke campaign for Child Psychiatry. | Mrs Louise Bell, Assistant Area Director | 31/10/2022 | Implementation will help to deliver a safe and sustainable service within BCU. | On track |

| 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:** 04 May 2022 |
| | **Risk:** Inability to deliver timely Infection Prevention & Control services due to limited capacity | **Date of Committee Review:** New Risk |
| | | **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 - New Risk not presented to Board** | New Risk | | |

| Controls in place | Assurances |
|---|---|
| 1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. <br> 2. Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. <br> 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. <br> 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which Infection Prevention risk is lower. <br> 5. Reviewing and prioritising attendance at meetings and on groups etc. <br> 6. Employed senior manager via an agency to support the team. <br> 7. Supporting and protecting existing team with measures including weekly team meetings and reviews. | 1. Infection Prevention Audits reported at local groups and to the Infection Prevention Sub Group. <br> 2. Alert organism statistics. <br> 3. Compliance with Welsh Health Circular 2021 Number 028 reported to Infection Prevention Sub Group and to Quality Safety and Experience Committee. <br> 4. Patient incident reviews. <br> 5. Regular review of Datix Incidents which are alerted to the team when logged on the system, for learning purposes and for rectification. <br> 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.<br>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.

**Progress since last submission**

1. Controls in place reviewed and strengthened to align with current risk position.
2. Gaps in controls reviewed and updated to align with current risk position.
3. Contacted international nurses - 4 have been interviewed to date and have been asked to apply for vacant posts once advertised.
4. An experienced Infection Prevention nurse known to the Director of Infection Prevention now in post from an agency part time for 6 months.
5. New SBAR completed and approval given to refresh the band 8a job description used in the past and then advertise for band 8as. 8c (and 8b) will then provide additional support to help them develop and some of their work will be picked up by the agency nurse in point 4.
6. Working wherever possible as one Infection Prevention team as opposed to three, to allow experienced Infection Prevention nurses to support remotely across the sites and increase junior staffing to increase visibility of band 4's and band 6s.
7. Trajectory for C. difficile has improved over the past 6 months and the Health Board now has the lowest rate of all Health Boards across Wales.

**Links to**

| Strategic Priorities | Principal Risks |
|---|---|
| Transformation for 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 | 20654 | Use Infection Prevention Champions to promote good practice. | Mr Dafydd Williams, Infection Prevention Nurse | 30/09/2022 | To help promote Infection Prevention in their own departments whilst visibility of the Infection Prevention team will be low. | On track |
| | 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. | On track |
| | 21696 | Recruit to current vacant Infection Prevention posts. | Mrs Andrea Ledgerton, Specialist Matron Infection Prevention | 30/09/2022 | Fill current vacant posts. | On track |
| | 21698 | Work with Communications and Workforce to develop a Recruitment Campaign for Infection Prevention nurses. | Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination | 31/12/2022 | To help attract Infection Prevention staff to BCU. | On track |
| | 21702 | Draw up a development programme and a succession plan to 'grow our own'. | Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination | 29/07/2022 | To develop own Infection Prevention staff and support recruitment and retention. | On track |
| | 22927 | Promote Infection Prevention Massive Open Online Course education programme. | Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination | 30/09/2022 | To improve knowledge, practice and compliance with IP in wards and departments. | On track |

| 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:** 04 May 2022 |
| | **Risk:** Potential that medical devices are not decontaminated effectively so patients may be harmed. | **Date of Committee Review:** New Risk |
| | | **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 in endoscopy 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 - New Risk not presented to Board** | New Risk | | |

| Controls in place | Assurances |
|---|---|
| 1. Decontamination audits have been increased to twice yearly.<br>2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units.<br>3. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning.<br>4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board.<br>5. Single use scopes are being used where possible removing the requirement for decontamination.<br>6. Engineering support is presented from the in-house facilities team and is generally to a high standard. | 1. Regular review by Decontamination Group.<br>2. 6 monthly decontamination audits by Infection Prevention team.<br>3. Decontamination audits by Authorised engineers.<br>4. Sterile services departments have audits carried out by notified bodies in accordance with the Medical Device Directives/Regulations.<br>5. Risk register on decontamination. |

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.
9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership.

## 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.
2. Some Consultants do not want to use single use scopes – rep coming in to discuss with them.
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. There needs to be review of all risks relating to Decontamination and updates requested from de-contamination group members.
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. Controls in place reviewed and strengthened to align with current risk position.
2. Gaps in controls reviewed and updated to align with current risk position.
3. Agencies have been contacted for a Decontamination Specialist advisor to work for BCU for minimum of 3 months. However, due to no suitable candidates, internal team member currently acting up to the role.
4. Single use scope representative has attended all acute sites to update Consultants on the latest technology available.
5. Request made to Shares Services to carry out a review of the decontamination infrastructure in Sterile Services departments to identify priority areas. Anticipated review by July 2022.
6. Action ID 23024 - New action identified to seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.

## Links to

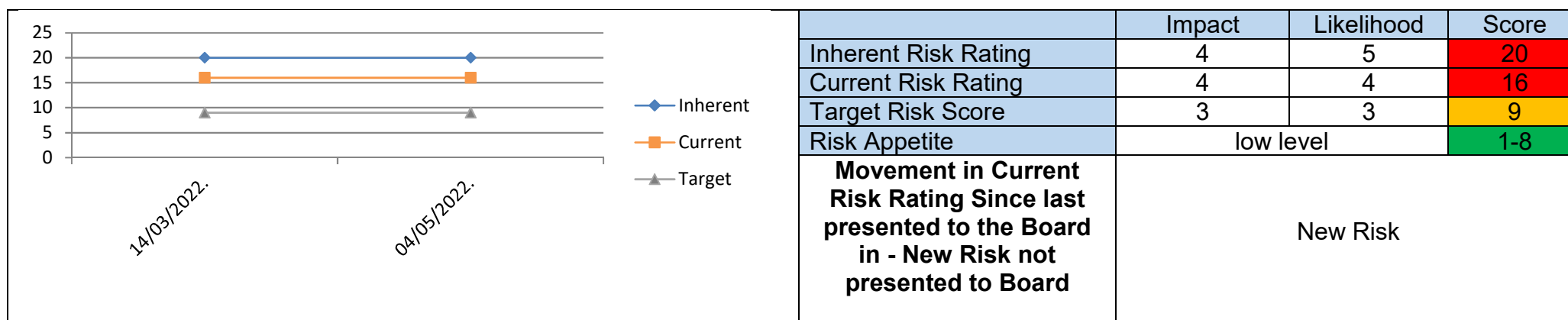| Strategic Priorities | Principal Risks |
|---|---|
| Making effective and sustainable use of resources (key enabler)<br>Transformation for improvement (key enabler) | BAF21-02<br>BAF21-09 |

| 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 | 22146 | Revise and approve the Decontamination group terms of reference. | Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination | 30/06/2022 | To ensure appropriate and robust membership of the group and a process of monitoring and continual improvement.<br><br>Terms of reference drafted and awaiting approval by Infection Prevention Sub Group. | On track |
|---|---|---|---|---|---|---|
| | 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.<br><br>The action will focus on policies and procedures due for review by the end of 2022. | On track |
| | 22148 | Purchase new washer disinfector for endoscopy unit at Ysbyty Gwynedd. | Mrs Joanna Elis-Williams, Head of Secondary Care Office | 31/08/2022 | To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated. | On track |
| | 22149 | Meet with key stakeholders re scope issues at Ysbyty Glan Clwyd and Wrexham Maelor. | Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination | 31/07/2022 | To highlight key issues and establish a way forward. | On track |
| | 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. | On track |
| | 22153 | Estates to meet with sterile services managers. | Mr Arwel Hughes, Head of | 30/09/2022 | To revise risk assessments and make plan for upgrading Sterile services departments. | On track |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Operational Estates - Interim | | Action will take place following a review by Shared Services to identify priority areas, anticipated by July 2022. | |
| | 22931 | NHS Wales Shared Services review of Sterile Services and Disinfection Units. | Mr Arwel Hughes, Head of Operational Estates - Interim | 31/07/2022 | To outline the specific risks and help BCU identify priorities. | On track |
| | 22932 | Carry out an audit of decontamination of all ultrasound machines and the use of ultrasound gel. | Sandra Lorraine Jones, Decontamination & IP Sister | 30/06/2022 | To ensure machines are being decontaminated appropriately and sterile gel is being used where indicated to reduce infection risks. | On track |
| | 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. | On track |

| CRR22-20 | Director Lead: Executive Director of Public Health | Date Opened: 26 November 2021 |
|---|---|---|
| | Assuring Committee: Partnership, People and Population Health Committee | Date Last Reviewed: 04 May 2022 |
| | Risk: There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinants | Date of Committee Review: New Risk |
| | | Target Risk Date: 31 December 2025 |

There is a risk that residents in North Wales may be unable to achieve a healthy weight and may become overweight and obese.

This may be caused by behaviours involving food intake, current circumstances, lack of physical activities, the living environment, food production and consumption, socio-economic factors and a lack of engagement with health professionals.

This may have an impact on or lead to unhealthy weight and obesity and place them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression.



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| 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 |
|---|---|
| 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. <br> 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. <br> 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. <br> 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. | 1. Building a Healthier Wales Programme and Healthy Weight Healthy Wales Programme (both nationally funded). <br> 2. Reporting progress to National team (Public Health Wales/Welsh Government/Regional Partnership Board). <br> 3. Progress on mitigating and managing risks reviewed locally via the Public Health Team and Health Improvement |

| | |
|---|---|
| 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.<br> 6. Lets Get Moving North Wales - a continuing programme encouraging residents of North Wales to move more often will operate alongside Sport North Wales, physical literacy development in schools and communities.<br> 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.<br> 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.<br> 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 Group, Primary Care groups and via the Well North Wales Programme (including Partner organisations). | and Reducing inequalities Group (chaired by DoPH).<br>4. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25). |

| Gaps in Controls/mitigations |
|---|
| 1. The risk requires System-wide approach to tackling the wider determinants of health.<br>2. The current Health Board provision is not operating at scale to meet the current and forecast needs of the population.<br>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. |

| Progress since last submission |
|---|
| New Risk |

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

| Risk Response Plan<br><br>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 |
|---|---|---|---|---|---|---|
| | 22372 | Whole system approach to healthy weight. | Teresa Ann Owen, Executive Director of Public Health | 31/03/2025 | Taking a whole system approach to healthy weight will ensure that all partners are prioritising the issue of healthy weight and considering the impact of their decision-making on the populations' 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. | On track |
| | 22373 | Healthy Choices in the workplace. | Teresa Ann Owen, Executive Director of Public Health | 31/03/2023 | The working age adult population spend a significant amount of their time in the workplace.  As a result it is crucial that we support workplaces to be health promoting. This means ensuring staff have access to healthy food choices, equipment to make healthy meals, enough time away from work to prepare and eat a healthy meal.  It is also crucial that the workplace supports their staff to remain active while at work as both diet and physical activity are crucial to achieving a healthy weight. | On track |
| | 22374 | Spatial planning and public health. | Teresa Ann Owen, Executive Director of Public Health | 01/09/2022 | The environment that we live in has a significant impact on our health and wellbeing.  A range of factors that impact on obesity are within the control of spatial planners including, the number of food outlets in an | On track |

| | | | | | area, the design of homes we live in, the design of roads to enable active travel (pavements for walkers and cycle paths for cyclists).  Having access to green spaces and play environments are crucial to ensuring people are given opportunities to remain active.  Working with spatial planners to understand this and their role in taking a public health perspective across their work is crucial to reducing obesity. | |
| --- | --- | --- | --- | --- | --- | --- |
| | 22375 | Social prescribing. | Teresa Ann Owen, Executive Director of Public Health | 01/11/2022 | 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 peoples appreciation for nature and the need to protect it.  One way of doing this is to optimise access through social prescribing. | On track |
| | 22376 | Pre-diabetes programme. | Teresa Ann Owen, Executive Director of 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 | On track |

| | | | | | |
|---|---|---|---|---|---|
| | | | | across North Wales it is hoped more of the population who are overweight or obese will seek support to achieve and maintain a healthy weight. | On track |
| | 22377 | Weight management services. | Teresa Ann Owen, Executive Director of 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. | On track |

| CRR22-21 | **Director Lead:** Executive Director of Public Health | **Date Opened:** 26 November 2021 |
|---|---|---|
| | **Assuring Committee:** Partnership, People and Population Health Committee | **Date Last Reviewed:** 04 May 2022 |
| | **Risk:** There is a risk that adults who are overweight or obese will not achieve a healthy weight due to engagement & capacity factors. | **Date of Committee Review:** New Risk |
| | | **Target Risk Date:** 31 December 2025 |

There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to non-engagement with services or demand for services exceeding capacity.

This could impact on the health outcomes for these individuals by placing them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression.



| | Impact | Likelihood | Score |
|---|---|---|---|
| Inherent Risk Rating | 4 | 5 | 20 |
| Current Risk Rating | 4 | 4 | 16 |
| Target Risk Score | 3 | 3 | 9 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board** | New Risk | | |

| Controls in place | Assurances |
|---|---|
| 1. Healthy Weight Healthy Wales funding to support with the implementation of the All Wales Adults Weight Management Pathway.<br>2. Additional investment in Foodwise for life for those residents with a BMI of 25-35.<br>3. The establishment of Level 2 weight management services through Foodwise for residents with a BMI of 25-35 and Slimming World vouchers for residents with a BMI of 30-35 with certain health conditions.<br>4. The establishment of a Level 3 weight management service KindEating programme for residents with a BMI of between 35-45.<br>5. Investment in dedicated obesity leads within each of the LA National Exercise Referral programmes.<br>6. The establishment of a BCU Healthy Weight Healthy North Wales group to oversee the delivery of specialist weight management services. | 1. Building a Healthier Wales Programme and Healthy Weight Healthy Wales Programme (both nationally funded).<br>2. Reporting progress to National team (Public Health Wales/Welsh Government/Regional Partnership Board).<br>3. Progress on mitigating and managing risks reviewed locally via the Public Health Team and Health Improvement and Reducing inequalities Group (chaired by DoPH).<br>4. Work plans are reflected in Health Board Annual Operating Plan, Living |

|  | Healthier staying well strategy and draft Integrated Medium Term Plan (22-25). |
|---|---|

| **Gaps in Controls/mitigations** |
|---|
| 1. The current provision does not meet the scale required to address current or forecast North Wales population requirements.<br>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. |

| **Progress since last submission** |
|---|
| New Risk |

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

| Risk Response Plan<br><br>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 |
|---|---|---|---|---|---|---|
| | 22357 | Insight work. | Steven Grayston, Assistant Area Director of Therapies (Central) | 31/03/2023 | 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 | Pregnancy weight management service. | Steven Grayston, Assistant Area Director of Therapies (Central) | 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 | Performance management dashboard. | Steven Grayston, Assistant Area Director of Therapies (Central) | 31/03/2023 | Developing a performance management dashboard will ensure that we are able to monitor the uptake of the service by population groups that are at increased risk of adverse outcomes from obesity. The dashboard will enable us to monitor both uptakes and outcomes by ethnicity, gender and deprivation decile. | On track |
| | 22943 | Implement Healthy Weight Healthy Wales Programme Plan. | Steven Grayston, Assistant Area Director of Therapies (Central) | 31/03/2024 | Funded activity targeted at improving healthy eating habits and tackling obesity. | On track |

| CRR22-22 | **Director Lead:** Executive Medical Director | **Date Opened:** 03 November 2020 |
|---|---|---|
| | **Assuring Committee:** Quality, Safety and Experience Committee | **Date Last Reviewed:** 19 May 2022 |
| | **Risk:** Delivery of safe & effective resuscitation may be compromised due to training capacity issues. | **Date of Committee Review:** New Risk |
| | | **Target Risk Date:** 30 September 2022 |

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 | 1 | 4 |
| Risk Appetite | low level | | 1-8 |
| **Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board** | New Risk | | |

| Controls in place | Assurances |
|---|---|
| 1. Resuscitation Policy and Guidance is in place for the Health Board with compliance overseen by the Resuscitation Committee. <br> 2. Training plan in place governed by the UK core skills framework. <br> 3. Resuscitation training is a mandatory training programme across the Health Board. <br> 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. <br> 5. Systems and processes are in place to manage attendance at training sessions. | 1. The risk is reviewed monthly by the Resuscitation Services Senior Management Team, and is presented to the Resuscitation Committee on a quarterly basis. <br> 2. Training figures and capacity are regularly reviewed on a quarterly basis at the Resuscitation Committee via site reports. <br> 3. The risk has been presented to Performance Safety & Quality (PSQ), 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 designated 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 approximately £136k 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.

**Progress since last submission**

1. Controls in place updated to reflect current position
2. Gaps updated to reflect current position.
3. Actions updated to reflect current position.

**Links to**

| Strategic Priorities | Principal Risks |
|---|---|
| COVID 19 response<br>Strengthen our wellbeing focus<br>Primary and community care<br>Making effective and sustainable use of resources (key enabler) | BAF21-01<br>BAF21-04<br>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 Bellis Hollway, 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"

Progress to date - Discussion ongoing with YGC site management. | On track |
| | 23207 | Allocation of training room in West to support Central site with ILS/pILS training as a short term. | Mr Christopher Glyn Shirley, Resuscitation Officer | 30/06/2022 | The action will enable us to mitigate and manage this risk by delivering training in the short term. | On track |
| | 23208 | To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues. | Ms Jane Woollard, Director of Nursing | 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. | On track |

| 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:** 26 April 2022 |
| | **Risk:** Inability to deliver safe, timely and effective care | **Date of Committee Review:** New Risk |
| | | **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 to accommodate patients awaiting specialty beds (Medicine/Surgery).

This could lead to delay/inability to triage new attendants within 15 minutes of arrival as per national recommendations, 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 social distancing measures, which would increase spread of infection and/or potential outbreak. Inability 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.

| **To be populated following approval** | | 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 - New Risk not presented to Board** | New Risk | | |

| **Controls in place** | **Assurances** |
|---|---|
| 1. Site escalation policy in place.<br>2. Infection prevention policy in place.<br>3. Welsh Government guidelines in place.<br>4. Standard Operating Procedure (SOP) for the management of patients held in ambulances outside ED.<br>4. Pathways in place for re-direction of appropriate patients to services such as Urgent Primary Care Centre (UPCC), fracture clinic and mental health liaison from triage.<br>5. Matrons documentation audit in place to identify areas i.e. welfare checks.<br>6. Unscheduled care improvement plan group in place to improve patient flow throughout the organisation. | 1. Risk is reviewed at Emergency Care meeting and escalated to East Site Risk Management Group.<br>2. Risk is reported to East site Local Infection Prevention Group (LIPG) and Emergency Department and East Site Patient Safety and Quality Groups (PSQG).<br>3. Triage waits Key Performance Indicator data reported each month through the site finance meeting. |

| | |
|---|---|
| 7. Additional health care support workers shifts generated to increase ability to perform welfare checks throughout the department with the increase volume of patients.<br>8. Installed shelter at the point of entry to reduce exposure to the elements whilst awaiting screening. | 4. Report to Clinical Effectiveness Group.<br>5. Performance is monitored through harms, incidents, complaints and handovers. |

## Gaps in Controls/mitigations

Insufficient Capacity/physical environment to mitigate overcrowding.

## Progress since last submission

New Risk

## Links to

| Strategic Priorities | Principal Risks |
|---|---|
| COVID 19 response<br>Making effective and sustainable use of resources (key enabler) | BAF21-01<br>BAF21-14 |

| Risk Response Plan<br><br>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 |
|---|---|---|---|---|---|---|
| | 19510 | Review and update ED escalation plan. | Mrs Lindsey Bloor, Directorate General Manager | 31/05/2022 | This will highlight the demands in the department at the time and ensure named individuals have allocated actions to assist in de-escalating of patients in ED to maintain patient safety. | On track |
| | 19516 | Review the action plan for Unscheduled care Improvement Group and identify action holders for updates. | Mrs Hazel Davies, Acute Site Director | 06/06/2022 | This will de-congest ED of the excessive volume of patients who reside in Ed awaiting specialty beds | On track |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 20605 | Increase establishment for additional HCSWs. | Mrs Rachel Bowen, Deputy Head of Nursing EC | 22/07/2022 | This will increase availability of un-registered workforce to support registered workforce in providing safe and effective care to patients in ED. | On track |
| | 21359 | Implement ED risk status. | Mr Nathan Rogers, Lead Manager – Emergency Care | 31/05/2022 | This will provide awareness to the Site team of the risks being held in Emergency Department and highlight actions to be taken. | On track |
| | 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. | On track |
| | 23001 | Ongoing recruitment to approved business case. | Mrs Lindsey Bloor, Directorate General Manager | 31/08/2022 | This will support staffing in additional areas of ED once available. | On track |
| | 23002 | Increase the number of ambulant patient at Ambulatory Emergency Care/ Same Day Emergency Care (SDEC). | Mrs Jackie Evans, AMU Matron | 16/09/2022 | This will reduce the number of patients in ED waiting room. | On track |

| CRR22-24 | **Director Lead:** Executive Director of Workforce and Organisational Development | **Date Opened:** 04 April 2022 |
|---|---|---|
| | **Assuring Committee:** Partnership, People and Population Health Committee | **Date Last Reviewed:** 16 June 2022 |
| | **Risk:** Potential gap in senior leadership capacity/capability during transition to the new Operating Model. | **Date of Committee Review:** New Risk |
| | | **Target Risk Date:** 31 October 2022 |

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)in readiness for the yet to be agreed go-live date.

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 - New Risk not presented to Board** | New Risk | | |

| 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 we will then look to use to 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 us including the | 1. Risks are reviewed every 8 weeks by the Risk Management Group (Board and Director level). |

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 September 2022. There will be additional management oversight of the How We Organise Ourselves programme, as well as the 'Roles and People' project team.

## Gaps in Controls/mitigations

1. Capacity of Executive Directors to respond to rapid decision making requirements. How We Organise Ourselves now has regular weekly slot on the Executive agenda.
2. The management of the East, Central and West IHC 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.
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.

## Progress since last submission

New Risk

## 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 | 23233 | Inform relevant groups of interim backfill arrangement opportunities - current structure | Gill Harris, Deputy CEO/Executive Director of Integrated Clinical Services | 03/06/2022 | Action completed 20/06/2022. No gaps in senior leadership roles | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 23234 | Equitable backfill selection process | Lesley Hall, Assistant Director – Employment Strategies & Practices | 03/06/2022 | Action Completed 31/05/2022<br><br>No gaps in senior leadership roles | Completed |
| | 23236 | Recruitment agencies on standby if required | Mr Steven Gregg-Rowbury, Head of Resourcing | 03/06/2022 | Action Completed 16/06/2022<br><br>No gaps in senior leadership roles | Completed |
| | 23319 | Search and selection agencies on standby once the outcome of the preference processes are complete | Mr Steven Gregg-Rowbury, Head of Resourcing | 03/06/2022 | Action Completed 16/06/2022<br><br>No gaps in senior leadership roles | Completed |
| | 23332 | Set-up internal selection process for Senior Management posts (format, panel representation) | Lesley Hall, Assistant Director – Employment Strategies & Practices | 27/06/2022 | No gaps in senior leadership roles. | On track |
| | 23333 | Set-up external selection process for Senior Management posts (format, panel representation) (If required) | Lesley Hall, Assistant Director – Employment Strategies & Practices | 25/07/2022 | No gaps in senior leadership roles. | On track |
| | 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. | On track |
| | 23335 | Set-up internal selection process for Senior Medical posts (format, panel representation) | Lesley Hall, Assistant Director – Employment | 18/07/2022 | No gaps in senior leadership roles. | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | Strategies & Practices | | | |
| | 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. | On track |
| | 23337 | Set-up external selection process for Senior Medical posts (format, panel representation) (If required) | Lesley Hall, Assistant Director – Employment Strategies & Practices | 22/08/2022 | No gaps in senior leadership roles. | On track |

**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. | Executive Director Transformation, Strategic Planning, And Commissioning | Quality, Safety and Experience | 20 |
| 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. | Executive Director of Nursing and Midwifery | Quality, Safety and Experience | 20 |
| CRR20-09 | Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2 | | | |
| CRR20-10 | GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2 | | | |

| Reference | Title | Executive Lead | Committee Oversight | Current Risk Score |
|---|---|---|---|---|
| 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 | | |
| 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. | Executive Director Transformation, Strategic Planning, And Commissioning | Quality, Safety and Experience | 16 |
| CRR21-18 | Inability to deliver timely Infection Prevention & Control services due to limited capacity. | Executive Director of Nursing and Midwifery | Quality, Safety and Experience | 15 |
| CRR21-19 | Potential that medical devices are not decontaminated effectively so patients may be harmed. | Executive Director of Nursing and Midwifery | Quality, Safety and Experience | 16 |

| Reference | Title | Executive Lead | Committee Oversight | Current Risk Score |
|---|---|---|---|---|
| CRR21-20 | There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents. | Executive Director of Public Health | Partnerships, People and Population Health | 20 |
| CRR21-21 | 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 |
| CRR21-22 | 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 |

# Appendix 3 - 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. |

## Appendix 3 - 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.<br>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].<br>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<br>- Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective<br>- Training in place, monitored, and reported for assurance<br>- Compliance audits<br>- Business Continuity Plans in place, up to date, tested, and effectively monitored<br>- 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<br>- Business Case agreed and implemented<br>- Using a different product or service<br>- 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. |

| Report title: | Operating Model Update on Implementation | | |
|---|---|---|---|
| **Report to:** | Health Board | | |
| **Date of Meeting:** | Thursday, 04 August 2022 | Agenda Item number: | 4.2 |
| **Executive Summary:** | This report provides an update to Board members on the timescale and arrangements in place to commence implementation of the new Operating Model for the organisation, and particularly the creation of the Integrated Clinical Delivery structure on 1st August 2022. It provides the outline structures to Tier 4 of the organisation, an update on the recruitment and appointment to roles in this structure, the governance and assurance framework and communications and engagement plan | | |
| **Recommendations:** | The Health Board is asked to: <br> i. NOTE the commencement date and arrangements in place to implement the new Operating Model for the organisation | | |
| **Executive Lead:** | • Jo Whitehead, Chief Executive Officer <br> • Gill Harris, Deputy Chief Executive/Director Integrated Clinical Delivery (SRO) | | |
| **Report Author:** | • Gill Harris, Deputy Chief Executive/Director Integrated Clinical Delivery <br> • Molly Marcu – Interim Board Secretary <br> • Helen Stevens Jones, Director Partnerships, Engagement and Communications <br> • Sue Green, Executive Director of Workforce and Organisation Development | | |

| **Purpose of report:** | For Noting ☐ | For Decision ☐ | For Assurance ☒ |
|---|---|---|---|

| **Assurance level:** | Significant ☐ | Acceptable ☒ | Partial ☐ | No Assurance ☐ |
|---|---|---|---|---|
| | 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 | No confidence/evidence in delivery |

| **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):** | |
|---|---|
| **Regulatory and legal implications** | HIW, HSE non-compliance should the structures within the Operating Model not be robust. |

| | |
|---|---|
| **Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)** | The risks associated with this programme are included in the Corporate Risk Register. An additional risk not yet on the risk register is described in the risk log - attachment Appendix 4. |
| **Financial implications as a result of implementing the recommendations** | No financial Implications as a direct result of the recommendations in this report |
| **Workforce implications as a result of implementing the recommendations** | No financial Implications as a direct result of the recommendations in this report |
| **Feedback, response, and follow up summary following consultation** | 26 May 2022 – Board of Directors<br><br>10 May 2022 – Executive Directors – Review of Readiness Assessment<br><br>The draft Governance and Assurance Framwork has been considered in full and part at Executive Directors Team at meetings held on 10.5.22,4.5.22,20.4.22,2.3.22,23.2.22.<br><br>21 April 2022 – Health Board Workshop – further review of background and risks management of change<br><br>30 March 2022 – Health Board – review of the timetable for consideration of the Final Operating Model<br><br>10 March 2022 – Health Board – Considered readiness Assessment and draft Operational Governance Framework<br><br>3 February 2022 - The Health Board approved the Operating Model Structure<br><br>The Remuneration and Terms of Service Committee (RTS) has considered some specific posts associated with the model. These meetings occured on :- 22.7.21, 17.08.21, 21.10.21, 2.12.21, 18.1.22 and 03.02.22 |
| **Links to BAF risks:** (or links to the Corporate Risk Register) | All |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |
| **Next Steps: Implementation of recommendations** | |
| **List of Appendices:**<br>Appendix 1 – Integrated Clinical Delivery Structure<br>Appendix 2 – Operational Governance and Assurance Framework<br>Appendix 3 – Communications and Engagement Plan | |

Appendix 4 – Programme Risk Log

**HEALTH BOARD MEETING IN PUBLIC**

**4 August 2022**

**Operating Model Update on Implementation**

**1. Introduction/Background**

1.1 There are a wide variety of sources that consistently and compellingly tell us the structure of the Health Board and its existing Operating Model need to improve.

Over the course of the last year, and following extensive engagement, the Health Board approved the implementation of the revised Operating Model.

The model:-

- Builds on the strength of geographically based arrangements;
- Removes the structural division between acute, primary and community services;
- Increases the collaboration and pathway approach between Health Communities (locally managed services) and Pan North Wales Services (regionally managed services);
- Focusses on specific areas of support services and leadership that directly meet the aspirations of the improvement aims including digital, partnership working and transformation.

It is based upon and provides design principles to empower and provide a level of consistency for emerging structures to build on.

At its meeting on 26th May 2022, the Health Board approved delegated authority to the Chair, Chief Executive, advised by the Vice Chair and Deputy Chief Executive to make the decision on the commencement date for implementation of the revised model, and particularly the Integrated Clinical Delivery Structure.

**2. Update on key elements of implementation**

2.1 Integrated Clinical Delivery Structure and Appointment- Phase 1

The main changes in the operational structure of the organisation has been to bring previously separate structures together into Integrated Health Communities, with services that are already established and managed on a pan north wales basis, together with a strengthened pan north wales oversight function. This Integrated Clinical Delivery structure is led by the role of Executive Director Integrated Clinical Delivery.

Phase 1 of the structure redesign is in place and will commence operationally on 1st August 2022. This overall structure and detailed management structure to level 4 in the hierarchy (to show direct reports of new top tier) is attached at Appendix 1.

Appointments to the new roles at level 3 of the structure and hierarchy have been made to the following non-medical roles in the first instance in accordance with the All Wales Organisational Change Policy:

*Table 1 – Appointment made following Organisational Change Process*

| Role | Health Community | Appointee |
|------|------------------|-----------|
| Integrated Health Community Director | West | Ffion Johnstone |
| Integrated Health Community Director of Nursing | East | Andrea Hughes |
| Integrated Health Community Director of Operations | East | Ian Donnelly |
| Integrated Health Community Director of Operations | Centre | Alyson Constantine |
| Integrated Health Community Director of Operations | West | Neil Rogers |

Also in post at level 3 are existing colleagues in the realigned/revised roles of Integrated Health Community Directors of Therapies and Health Sciences and Pharmacy & Medicines Management respectively. Details are set out in Appendix 1.

Having concluded this stage for all non-medical roles, substantive competitive recruitment is now underway for the following roles at level 3:

*Table 2 – Appointment timetable for remaining vacancies at level 3*

| Role | System Oversight/Health Community | Search/Advert live | Selection Centre |
|------|-----------------------------------|--------------------|------------------|
| Deputy Director Integrated Clinical Delivery Regional Services | System Oversight | w/c 18th July | w/c 26th September |
| Deputy Director Integrated Clinical Delivery Primary Care | System Oversight | w/c 18th July | w/c 26th September |
| Integrated Health Community Director | East | w/c 18th July | w/c 26th September |
| Integrated Health Community Director | Centre | w/c 18th July | w/c 26th September |
| Integrated Health Community Director of Nursing | Centre | w/c 8th August | w/c 3rd October |
| Integrated Health Community Director of Nursing | West | w/c 8th August | w/c 3rd October |

In the intervening period, recruitment is underway to appoint to these roles on a temporary basis. This process includes both internal expression of interest and external agency search. Interviews for these temporary appointments are in place for w/c 1st August and w/c 8th August.

Finally, the revised structure for medical leadership within the Office of the Medical Director and Integrated Health Communities is being finalised following the consultation stage of the Organisational Change process. The appointment to the Integrated Health Community Medical Director roles through this process is planned for w/c 29 August.

2.2    Integrated Health Community Structure Review – Phase 2

Following the completion of Phase 1 of the structure redesign, work will commence on the co-design of the health community structures below tier 4 to ensure that in bringing the component parts of the health communities together, we are optimising the structures aligned to the design principles of the operating model. This will be based upon a consistent model across the 3 communities.

As part of this phase, we will also conclude the alignment of the overall management of clinical networks into the system oversight function. Whilst there will no doubt be changes to some roles and responsibilities, line management, at this stage, we do not envisage this requiring large scale change through the whole system organisational change process.

2.3    Complimentary and enabling operating structure reviews

We have always been clear that whilst not pivotal for the commencement of the new model/structure, all pan BCU and support services would be required to review their structures/models of delivery against the design principles.
Services have been supported to undertake these reviews and plans are either in place or emerging for changes to the following structures:

Mental Health and Learning Disabilities (including review of therapies interface/provision)
Psychology Services
Workforce & Organisational Development
Multi Professional Education and Learning
Transformation & Planning – Commissioning
Finance, Performance and Estates
Clinical Effectiveness and Assurance functions

Progress against these plans will be overseen through the How We Organise Ourselves Programme, through People & Culture Executive Delivery Group to Health Board Leadership Group/Executive Team and to Partnerships, People & Population Health Committee.

2.4    Supporting our Emerging Teams

To date 16 senior leaders going through change have been offered career coaching using Silver maple (aligned to Gwella/HEIW). 8 colleagues have been offered Leaving Well support (as part of our knowledge transfer learning) and colleagues supporting the transition in acting roles have been offered support through coaching.

We are concluding procurement for dedicated coaching for new leaders/leaders in new roles at level 3 and 4 and this will commence in September. An initial Network/launch event is scheduled for 30th September with the aim of bringing our

new leadership teams, together with our support service teams and the Executive team to begin to build "Team Betsi" and to support them in developing "Team Health Community".

The next phase of our leadership and cultural development is being driven through the How we Transform and Improve Programme, through People & Culture Executive Delivery group as above. This work will align with the rollout of the Betsi Way Improvement System and with the collaboration with Improvement Cymru and Institute of Healthcare Improvement (IHI).

2.5    Governance and Assurance Framework

As part of the process of enhancing the integrated assurance arrangements, a range of improvements have been introduced during the course of the financial year, which will enable us to effectively embed the governance and assurance arrangements aligned to the operating model.

These aspects include the implementation of the risk management strategy, the Scheme of Reserved Delegation, as well as the Quality improvement strategy, which will be approved the Board in September 2022.

The revised Scheme of Reserved Delegation consolidates 16 local documents into one, and is streamlined to be consistent with the IHC infrastructure and therefore will reduce likelihood of ultra vires actions or deviation from process

The updated risk management strategy provides a comprehensive approach to managing and escalation of risk. Specifically, as part of the implementation of the strategy we will:

Triangulate sources of risks quickly before they crystallise
Proactively ensure that mitigations are put in place and continuously reviewed to avoid a recurrence, working in partnership with the patient safety, health and safety and compliance teams
Align performance indicators with corporate risk register and BAF risks in order to clearly track progress
Embed the 3 lines of defence model and track progress by reviewing our own process on a cyclical basis

2.6    Communications and Engagement Plan

The Board first received a version of the communications and engagement plan to support the implementation of the Operating Model in May 2022. An updated version (July 2022) is attached to this paper which includes an update on the actions underway and an additional section which outlines the communications and engagement actions to support the 'go live' date of August 1st 2022. Work to deliver the actions within the plan are ongoing and are on track.

**3.    Budgetary / Financial Implications**

There are no direct financial implications as a result of this report

**4. Risk Management**

4.1 There are 17 risks on Datix linked to this area: 4359/4361/4362/4364/4365/4366/4367/4368/4369/4370/4371/4372/4373/4360/4393/ 4395//4406.

4.2 There is 1 risk relating to YGC improvement plan which has yet to be added to Datix.

4.3 There is a full programme risk log attached at Appendix 4

**5. Equality and Diversity Implications**

5.1 Full equality and socio economic impact assessment and action planning has been undertaken and will be updated through implementation.

# Integrated Clinical Delivery Structure 1 August 2022

**Chief Executive**
**Jo Whitehead**

**Executive Director Therapies & Health Sciences (Acting) Gareth Evans**

**Executive Director Nursing & Midwifery Angela Woods**

**Executive Medical Director Nick Lyons**

**Deputy Chief Executive/Executive Director Integrated Clinical Delivery Gill Harris**

**Director of Midwifery & Women's Services Fiona Giraud**

**Integrated Health Community Director East**

**Integrated Health Community Director Centre**

**Integrated Health Community Director West Ffion Johnstone**

**Deputy Director of Integrated Clinical Delivery – Regional Services Phil Orwin (i)**

**Deputy Director of Integrated Clinical Delivery – Primary Care**

**Chief Pharmacist Berwyn Owen**

## Legend

**Professional Responsibility T&HS**

**Professional Responsibility N&M**

**Professional Responsibility MD**

Integrated Health Community

Pan Service

System Oversight Function

(a) = Acting up
(i) = interim

## East

**IHC Medical Director**

**IHC Director of Nursing Andrea Hughes**

**IHC Director of Operations Ian Donnelly**

**IHC Associate Director of Therapies Nesta McCluskey (A)**

**IHC Associate Director Pharmacy &Medicines Management Sue Robinson**

## Centre

**IHC Medical Director**

**IHC Director of Nursing**

**IHC Director of Operations Alyson Constantine**

**IHC Associate Director of Therapies Steve Grayston**

**IHC Associate Director Pharmacy & Medicines Management William Duffield**

## West

**IHC Medical Director**

**IHC Director of Nursing**

**IHC Director of Operations Neil Rogers**

**IHC Associate Director of Therapies Carys Norgain (A)**

**IHC Associate Director Pharmacy & Medicines Management Susan Murphy**

## Regional Services

**DGM Diagnostic & Clinical Support Services David Fletcher**

**DGM Lead Cancer Services Geraint Roberts**

**Associate Director Unscheduled Care**

**Associate Director Planned Care Nicky Foulkes (a)**

**Head of Facilities Paul Clarke**

**EPPR Lead Debbie Lewis (A)**

**Programme Director RTC Development**

## Primary Care

**Associate Director Primary Care (Strategy) Jo Flannery (A)**

**Clinical Director North Wales Dental Service Sandra Sandham**

**Assistant Director North Wales Dental Service Peter Greensmith (a)**

Design Principle - Pan Clinical Network Management will form part of the System Oversight Function

Clinical Network Management

## Structural Hierarchies
## Integrated Clinical Delivery Structure
## System Oversight Function

**Legend:**
- Integrated Health Community
- Pan Service
- System Oversight Function

(a) = Acting up
(i) = interim

**Chief Exec Officer**
Jo Whitehead

**Executive Director of Integrated Clinical Delivery / Deputy CEO**
Gill Harris

Associate Director of Governance
**Phil Meakin**

**L3** Director of Midwifery & Women's Services
**Fiona Giraud**

**L3** Integrated Health Community Director East
**TBC**

**L3** Integrated Health Community Director Centre
**TBC**

**L3** Integrated Health Community Director West
**Ffion Johnstone**

**L3** Chief Pharmacist
**Berwyn Owen**

**L3** Deputy Director of Integrated Clinical Delivery – Primary Care
**TBC**

**L3** Deputy Director of Integrated Clinical Delivery – Regional Services
**Phil Orwin** (i)

Associate Director Primary Care (Strategy)
**Jo Flannery** (a)

Clinical Director North Wales Dental Service
**Sandra Sandham**

Assistant Director North Wales Dental Service
**Peter Greensmith** (a)

Divisional General Manager Diagnostic & Clinical Support
**David Fletcher**

Divisional General Manager Lead Cancer
**Geraint Roberts**

Design Principle - Pan Clinical Network Management will form part of the System Oversight Function

Clinical Network Management

Associate Director Unscheduled Care
**TBC**

Associate Director Planned Care
**Nicky Foulkes** (i)

Programme Director RTC Development
**TBC**

EPPR Lead
**Debbie Lewis** (i)

Head of Facilities
**Paul Clarke**

# Structural Hierarchies
## Integrated Clinical Delivery Structure
## East Integrated Health Community (IHC)

(a) = Acting up
(i) = interim

**Chief Exec Officer**
**Jo Whitehead**

**Executive Director of Integrated Services / Deputy CEO**
**Gill Harris**

**L3** Integrated Health Community Director
**TBC**

**L4** Integrated Health Community Medical Director
**TBC**

**L4** Integrated Health Community Director of Nursing
**Andrea Hughes**

**L4** Integrated Health Community Director of Operations
**Ian Donnelly**

**L4** Integrated Health Community Director Therapy/HS
**Nesta McCluskey** (a)

**L4** Integrated Health Community Director Pharmacy and Medicines Management
**Sue Robinson**

Medical Director **Stephen Stanaway**

Medical Director **Gareth Bowdler**

Associate Director of Nursing **Naomi Holder**

Hospital Director of Operations **Hazel Davies**

Head of Healthcare HMP Berwyn **Simon Newman**

Associate Director of Childrens **Andrew Gralton**

Associate Director Community **Dominique Campbell** (a)

Associate Director Primary Care **Rachael Page**

Head of Facilities **Gwen Scotson**

Business Support Manger **Amy Edwards**

Heads of Nursing

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Current structure pending finalisation of revised structure

Current structure pending re-alignment

**Integrated Clinical Delivery Structure**
**Centre Integrated Health Community** (IHC)

(a) = Acting up
(i) = interim

**Chief Exec Officer**
**Jo Whitehead**

**Executive Director of Integrated Services / Deputy CEO**
**Gill Harris**

**L3**
Integrated Health Community Director
**TBC**

**L4**
Integrated Health Community Medical Director
**TBC**

**L4**
Integrated Health Community Director of Nursing
**TBC**

**L4**
Integrated Health Community Director of Operations
**Alyson Constantine**

**L4**
Integrated Health Community Director Therapy/HS
**Steve Grayston**

**L4**
Integrated Health Community Director Pharmacy & Medicines Management
**Louis Lloyd** (01/09)

Medical Director
**Balasundaram Ramesh**

Medical Director
**Mark Walker** (a)

Associate Director of Nursing
**Jane Woollard**

Associate Director Childrens
**Alison Cowell**

Assistant Director CAMHS
**Louise Bell**

Hospital Director of Operations
**Paul Andrew** (a)

Associate Director Intermediate Care and Medical Specialties
**Nicola Etherington**

Associate Director Primary & Community services
**Alison Kemp**

Head of Facilities
**Helen Sheridan**

Business & Planning Manager
**Emma Lea**

Currently William Duffield until 01/09

Heads of Nursing (Secondary Care)

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Current structure pending finalisation of revised structure

Current structure pending re-alignment

# Structural Hierarchies
## Integrated Clinical Delivery Structure
## West Integrated Health Community (IHC)

(a) = Acting up
(i) = interim

**Chief Exec Officer**
Jo Whitehead

**Executive Director of Integrated Services / Deputy CEO**
Gill Harris

**L3** Integrated Health Community Director
**Ffion Johnstone**

**L4** Integrated Health Community Medical Director
**TBC**

**L4** Integrated Health Community Director of Nursing
**TBC**

**L4** Integrated Health Community Director of Operations
**Neil Rogers**

**L4** Integrated Health Community Director Therapy/HS
**Carys Norgain** (a)

**L4** Integrated Health Community Director Pharmacy & Medicines Management
**Susan Murphy**

Medical Director
**Karen Mottart**

Medical Director
**Jim McGuigan (a)**

Associate Director of Nursing
**Sue Heyes** (i)

Hospital Director of Operations
**Barry Williams**

Associate Director Childrens
**Liz Fletcher**

Associate Director Community
**Eleri Roberts**

Associate Director Primary Care
**Wyn Thomas**

Head of Facilities
**June Davies**

Business Manager
**Hannah Roberts**

Heads of Nursing (Secondary Care)

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Reporting structures below are as current structure

Current structure pending finalisation of revised structure

Current structure pending re-alignment

# Operational Governance and Assurance Framework 2022

**Draft v 3.1**

# Operational Governance and Assurance Framework 2022

# 1. Introduction

a. The proposed Operational Governance & Assurance Framework builds upon the Integrated Governance framework approved by the Health Board on 15th July 2021 and covers a range of structural elements aligned to the new operating model. The Integrated Assurance infrastructure has been redesigned as part of the implementation of the risk management strategy for the purposes of strengthening corporate governance, The purpose of this framework is to supplement and not to replace the operational management

b. Some elements of the operational framework are already in place (e.g. Executive Delivery Groups) others can be implemented through the Transition Phase (e.g. Health Communities Management Structures) others will need to be implemented in line with the Operating Model Go Live phase.

c. The proposals are designed to:

   i. Support the Executive Team to balance its responsibilities in relation to delivering the strategy of the Health Board, ensuring the organisational culture is reflective of the current five values, holding the organisation to account for the service it provides and providing assurance to the Health Board

   ii. Improve the focus, consistency, co-ordination and relevance of operational groups

   iii. Improve integrated working of all elements of the Health Board in delivery of approved strategies and plans e.g. Living Healthier Staying Well, the Clinical Services Strategy/Plan, the Integrated Medium Term Plan (IMTP), Together for Mental Health, Cluster Plans and plans in partnership as well as service specific or corporate strategies or plans

   iv. Support oversight of quality (both in terms of health board provided services and commissioned and contracted services), transformation (including population health), finance and the people agendas

   v. Give the Board assurance of delivery structures and clarity of lines of accountability

   vi. Improve information flow, with no orphan groups and to improve the line of sight from Floor to Board through increased governance discipline and application

## 2. Operational Governance and Assurance (including standard practices) – Health Board Leadership Team

    a. Executive Directors will meet as a team, within the formal governance arrangements as a point of escalation, and accountable to the Board of Directors. The Executive Directors meeting will remain a forum to discuss highly confidential matters and other business as defined by the Chief Executive or on the advice of the Chair. The Health Board Leadership Team remains the default decision-making forum to support becoming a clinically led organisation.

    b. A new Health Board Leadership Team (HBLT) will be created which will include Executive and Directors, Integrated Health Community Directors, System Oversight/Pan North Wales Service Directors to enhance and inform decision making across the organisation. The Executive Directors will remain as the primary decision making body, with accountability to the Board of Directors for delivery of strategy

    c. Executive Management Group (EMG) will be disbanded and will be replaced by a new Leadership Network. This will build upon the Leadership Network formed pre pandemic and the Stronger Together Community and will draw in leaders (both formal and informal) from across the organisation. This will not be a decision making body but will help shape plans / strategy and develop leadership across the organisation and be an open forum for discussion.

    d. Delivery of Board agreed strategies in a matrix style through the five Delivery Groups.

- Executive Delivery Group - People and Culture
- Executive Delivery Group – Quality
- Executive Delivery Group – Population Health
- Executive Delivery Group - Transformation
- Executive Delivery Group – Performance and Finance

## 3. Operational Governance and Assurance (including standard practices) – Health Communities, Pan BCU Services and Service Support Functions

    a. Precise structures will be confirmed, but will replicate the Board governance structures, ensuring a floor to Board and board to floor consistency of application. This will ensure application of minimum standards assurance requirements and delivery expectations .

b.  An illustration of the governance and lines of accountability from Board to individuals is attached at Appendix 1.

c. The Scheme of Reserved Delegation has been updated to reflect these changes and is to be approved by the Board on the 4th August 2022

d. A senior leader, within each leadership team, will take responsibility for Governance within the team structure and link in with the Associate Director of Governance within the Office of the Deputy Chief Executive.

e.  . This model will be reflected across the new operating model, this structure, together with the Performance and Accountability Framework and the Chair's Assurance Reports model starts to give more assurance of action and sight of front line teams to the Board.

## 4. Ways of working

a. A central integral assurance function to be created to proactively manage external reports (e.g. HIW, Royal Colleges) coming into the organisation. Proactively managing the reports will include ensuring that reports are managed at an appropriate level, the quality control of responses as well as the timeliness of responses.

b. Cycles of business will  be used to proactively manage the workload of groups, streamlined to focus meeting time to the most appropriate agenda's and comply with terms of reference.

c. Consistent use of Chair's Assurance Reports for informing, escalating, assurance and accountability, with any variation/exceptions monitored by the HBLT

d. Duty to cascade and make accessible decisions made by groups with regular testing of effectiveness

e. Duty to identify and share issues, concerns and learning

f. Consistent Terms of Reference: "parent" groups responsible for the governance structures beneath them.

g. The Health Board priorities will be a golden thread that runs through each group with Health and Safety and Equalities maintaining the existing structure reporting directly into the Board level structure.

h. Templates will be developed along with standard terms of reference for all leadership teams and delivery groups, a governance handbook will be developed to provide guidance in good governance and support consistency in definitions across the Health Board (for instance in RAG ratings)

## 5. Distributed Leadership and Leadership Compact

a. Distributed leadership is about mobilising leadership at all levels to build capacity for improvement and change. It is aligned to the formal decision making defined within the Health Board's hierarchy and the Scheme of Reservation and Delegation and allows for the action and influence of people at all levels to be recognised as integral to the overall direction and functioning of the Health Board. It is characterised by:

   i. Decisions closer to the patient – the right decision made by the right person with the right information at the right time.

   ii. A recognition of the importance of leadership by expertise as well as leadership by role

   iii. High levels of trust, transparency and mutual respect, including agreement on deliverable outcomes within the resources allocated.

   iv. More equitable distribution of tasks and decision-making

   v. Consultation and consensus seeking

   vi. Change and improvement driven from the bottom-up

   vii. Agreement of plans, standards, targets and objectives will be a two way process and it will set out what is deliverable within the resources available to support delivery.

## 6. Issues and information cascade and escalation

a. Meetings should receive Chairs Assurance reports from reporting groups and provide a decision summary for information cascade

b. Duty and expectation on all leaders to identify issues within their areas of responsibility and to share this with peers and line management – through the formal meeting structures. This enables issues to be raised through the chairs assurance reports and an adult-to-adult discussion on whether the issue can be managed locally (the expectation) or if more senior support is required to co-ordinate a wider response, allocate or redistribute additional resource etc. Issues will include delivery issues that could have an impact on areas including (but not limited to) safety, quality, health and safety, staff wellbeing, performance, reputation, relationships etc.

c. Executive Directors and senior leaders have a specific duty to cascade relevant information to teams and other managers that may affect that person's ability to do their job.

d. Escalation reflects an increased level of concern by Leaders in relation to issues and risks, operational delivery or performance that could require more intense focus, action, support or scrutiny in order to bring about improvement.

## 7. Risk and risk appetite

a. As part of the implementation of the  Health Boards Risk Management Strategy , the risk appetite will be consistently applied as part of the go live

b. Staff are encouraged to integrate risk management into all planning, priority setting, and decision-making, as due diligence in support of good governance, reflecting any performance risks identified within their risk registers.

## 8. Quality Governance

a. The Health and Social Care (Quality and Engagement) (Wales) Act sets out statutory duties for quality. The Act requires NHS bodies to exercise their functions with a view to securing improvement in the quality of health services.

b. The OM will be supported by the transformation team with this.

## 9. Performance

a. There is a need to include revamped performance management and accountability processes in the governance framework.

b. Each Leadership Team should have a Performance and Delivery Meeting monthly (as a minimum) and where applicable with external partners present to:
   i. Mange local performance against the Health Board performance framework and priorities taking account matrix delivery of many performance measures.

   ii. Report to the (Title) Senior Leadership Teams on performance matters that require escalation or further consideration/awareness

   iii. Commission, implement, manage or monitor Impact Improvement Plans to improve performance and outcomes

   iv. Provide assurance reports through the Delivery Group Structure

c. Performance meeting agendas will cover the board definition of performance management and cover the what and the how of performance :

- Quality and compliance including (but not limited to) key learning from incidents and events, including patient feedback
- Service performance against patient outcome targets
- Contribution to or service performance against Health Board strategic, tactical and operational standards and targets
- Delivery of the Equality Duties
- Financial performance
- Workforce engagement and performance
- Governance (including assurance measures and key risks)
- Celebrating excellence and success
- Impact Improvement Plans
- Other agenda items as agreed

## 10. Contribution and Accountability

a. Teams and Individuals will be supported to contribute to the development of, the improvement of, the delivery of and held to account of:

    i.  IMTP Delivery

    ii.  Delivery of priority quality and performance standards and targets and maintenance of other performance targets

    iii.  Professional standards and Personal Accountabilities

    iv.  Living the organisational values

b. Clear accountability agreement to be developed for each Health Community, Pan North Wales Service and Service Support Function/Service to be known as a Strategic Improvement Plan

c. A Strategic (Health Community) Improvement Plan will be for the whole Health Community, including the input and impact of the Pan North Wales Services and vice versa.

d. Plans will take a medium term look over three years, formally agreed each year and reviewed three times per year.

e. A combined framework to be developed in each Health Community on the basis of:

    i.  Plans on a page for each service block and every Health Community Director (example attached at Appendix 2)

ii.  Weekly Director Quality & Safety Huddles.

iii.  Monthly operational performance reports and associated management process

iv.  Annual Plan approval 3 formal reviews in year

v.  Escalation to senior management as appropriate

## 11. Partnership Governance

Partnership Governance arrangements will; be clearly defined so that

a.  Partnership meetings should be seen as similar to an internal Health Board meeting, in that they should have a link to an appropriate group/ meeting in the Governance structure to which progress and issues are reported.

b.  Decisions made in partnership meetings align to the Health Board representative's decision-making authority.

c.  Where a decision needs to be taken in the partnership space that exceeds and individual's authority, pre-discussions should be held at the appropriate level and formal delegation confirmed in writing to the individual to negotiate and agree decisions in the partnership space.

d.  The Lead Health Board representative will be responsible for providing a Chairs Assurance Report of the partnership meeting to the appropriate group/meeting in the Health Board Governance structure

e.  Clarity in the SoRD on authority to spend Partnership Funds held by the Health Board.

f.  Clarity that our statutory responsibilities must be met even when working in the partnership space (e.g. completing EQIA for new strategies), the partnership space cannot be used to bypass our statutory responsibilities

## 12. Information governance

a.  The Board has in place an Information Governance Framework and a series of best practice guidelines and principles in relation to the handling of information. This shall apply to all personal information, including sensitive information, of both employees and patients and to the management of the Board's corporate information.

b. The Information Governance Framework sets out the Board's approach within which accountability, standards, policies and procedures are developed and implemented.

Integrated Management and Delivery Structure
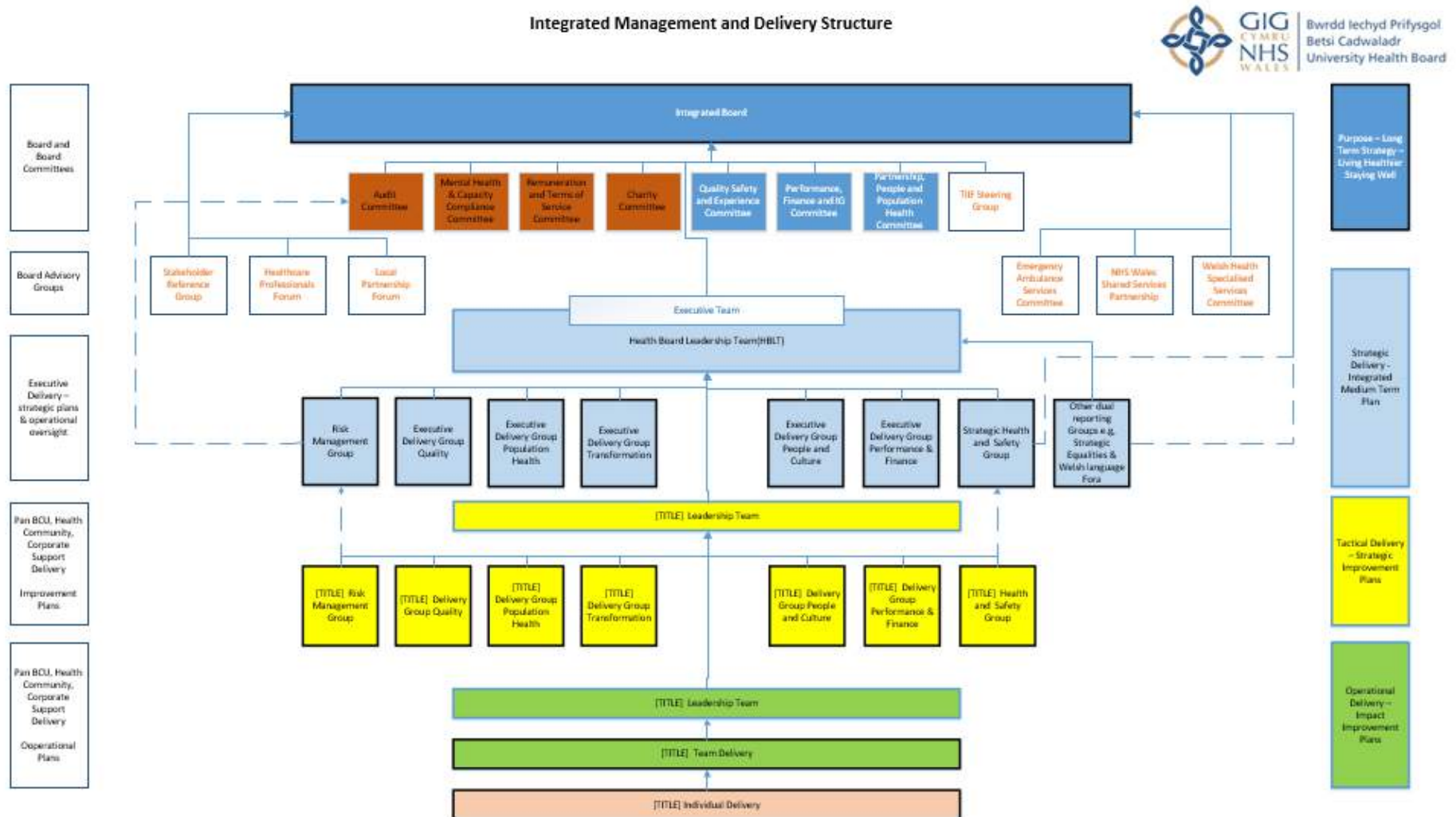
# Appendix 2 Example Service Plan on a Page



Primary Care: North Wales Dental Service Plan on a Page
April 21 – March 22

a) Executive Team have been placed in the governance structure above the Health Board Leadership Team as a point of escalation, forum to discuss highly confidential matters and other business as defined by the Chief Executive or on the advice of the Chair. The Executive Director Team remains the default decision-making forum (supported by the HBLT) to support becoming a clinically led organisation.

2) Local Teams defining their own governance structures could lead to complexity in the floor to board visibility

a) This provision is designed to allow for efficiency in local decision making and empowerment, however it is not intended to create multiple unrecognisable structures. Within each Leadership Team, a member of the team will be charged with ensuring good governance and working with the Associate Director of Governance. The areas of delivery and assurance will be defined from the Board's strategy by the Executive Delivery Groups, if for instance a Corporate Support Service finds that it has the same personnel in the Delivery Group for Quality and For Finance, then that service should be allowed to combine those meetings.

b) There will be different needs for supporting groups in difference services due in part to scale and scope whilst we would expect commonality in the Integrated Health Communities that does not necessary apply to Support Services or smaller Pan BCU services such as Cancer Services

3) Need to set out the Cultural piece, as what will make a difference is teamwork, leadership, performance management, reporting, etc.

a) the Operating Model sits within a big improvement portfolio under the People Strategy & Plan, Stronger Together which identifies 5 programmes of work
   i) Culture – our way of working and what we value and how we should treat each other.
   ii) Strategic deployment for everybody across the organisation to understand their own individual role.
   iii) Operating model – how we organise ourselves work stream
   iv) Best of our abilities - to make it easier to get our skills and capacity across the whole of the organisation and what they need to support their work
   v) How as an organisation we improve and transform.

   Each of these work streams has an Executive Director as an SRO – the operating model nestles within the programme – only by working across the programme will we be able to deliver.

4) Scenarios would be helpful to understand the governance in practice. The structures within this framework are clear for staff, the duty to escalate and cascade, the central co-ordination of external reviews, personal contribution and

accountability and the leadership compact should all contribute to the appropriate and timely escalation of risk, issues and concerns. However, this is contingent on individuals are enabled to meet their accountabilities and being held to account for complying with the framework and leadership, at all levels, working together to embed the framework.

**Scenario 1 – failure of escalation system of control or application in relation to issues within a clinical service**

- Within the proposed governance and accountability framework, as now, the primary route for escalation of a clinical concern should be through the line management route. The framework introduces a specific duty to escalate.
- The five opportunities of reporting a quality concern are:
    - o the line management line (in place currently but strengthened by this framework). This is the fastest route through the organisation, escalated concerns should also be taken to relevant management meetings, and through the Chairs Assurance Reports allow senior managers to triangulate responses and gain assurance whether the issue is being managed at the appropriate level or needs to be escalated for information or action. .
    - o the performance conversion (in place currently but strengthened by this framework). This should triangulate management concerns with quality date (SI, Clinical Audit Etc.), internal and external reviews, performance information, workforce, finance etc. and escalate as appropriate for information or action.
    - o the Quality delivery group structure (New) – escalation though this route will inform future quality strategies and enabled the quality team to respond to quality concerns appropriately and in a co-ordinated manner across BCU
    - o Appropriate management of external concerns will be centrally and proactively managed and coordinated (New)
    - o the Risk Management Framework – in place currently but being revised
- Consistent use of Chair's Assurance Reports, duty of cascade and duty of issue and risk escalation should allow for identification of learning where issues are not raised
- Consistent use of Chair's Assurance Reports, duty of cascade and duty of issue and risk escalation should allow for evidence for investigations where consistent or systemic non-reporting occurs

**Scenario 2 – failure of performance system of control or application in relation to significant variance in performance against plan for a clinical service**

- Within the proposed governance and accountability framework, as now, the primary route for escalation of a performance concern should be through the line management route. The framework introduces a specific duty to escalate.
- The five opportunities of reporting a performance concern are:

- the line management line [in place currently but strengthened by this framework].  This is the fastest route through the organisation, escalated concerns should also be taken to relevant management meetings, and through the Chairs Assurance Reports allow senior managers to triangulate responses and gain assurance whether the issue is being managed at the appropriate level or needs to be escalated for information or action. .
- the performance conversion [in place currently but strengthened by this framework].  This should triangulate management concerns with quality date (SI, Clinical Audit Etc.), internal and external reviews, performance information, workforce, finance etc. and escalate as appropriate for information or action.
- the Performance and Finance delivery group structure [New] – escalation though this route will inform future quality strategies and enabled the quality team to respond to quality concerns appropriately and in a co-ordinated manner across BCU
- Appropriate management of external concerns will be centrally and proactively managed and coordinated [New}
- the Risk Management Framework – in place currently but being revised
- Performance conversations should be happening in every tier of the organisation monthly, with a duty to cascade and duty of issue and risk escalation, therefore performance issues should be addressed at operational level and quality assured at the operational management and the management tier above
- Performance Team also has the ability to raise performance concerns directly with the Executive Delivery Group for Performance and Finance
- Performance Framework requires Impact Improvement Plans where performance is consistently failing


**Scenario 3 – Delay in clear decision making in relation to a Case for investment/efficiency**

- oRD is being revised to be clear at high and operational level on the power of initial decision
- Priorities have been set by the Board, the Contribution and Assurance Framework details requirements on staff team to support the delivery of organisational objectives as well as personal objectives
- Team priorities clearly laid out in Team Accountability Agreements and Strategic [SERVICE NAME] Improvement Plans
- Escalation via integrated Risk Register and Board Assurance Framework if risk not promptly mitigated

**Scenario 4 – Health Communities working in isolation or competition with each other or other services**

- Health Community Leadership Teams to be drawn from local, Pan BCU and Support Services to ensure connectivity. (Health Communities to also be represented on Pan BCU and Support Services Leadership Teams)
- Health Community priorities laid out in Strategic [SERVICE NAME] Improvement Plans, delivery against which will be reported through:
    - Line management structures
    - Performance Conversations
- Delivery against IMTP and BCU priorities will be reported
- through the Executive Delivery Group structures (as proposed) for:
    - Performance and Finance
    - Population Health and Transformation
    - People and Culture
    - Quality and Quality Improvement

**Engagement and Communications handling plan**

**Operating model implementation**

## Issue

This engagement and communications handling plan outlines our suggested approach to keeping key audiences informed of the progress regarding the implementation of the new Operating Model, as part of the Stronger Together programme of work.

Our key audience is Health Board staff, and in particular, at this stage, those senior leaders directly affected by the changes. However, we are mindful of the implications for joint working with partners and have also built-in measures to ensure they are kept informed throughout the process. Workforce colleagues continue to engage with staff directly and this plan provides an overarching approach to ensuring that all colleagues can easily access clear, up to date information.

Complementing this is the development of our People Strategy and Plan for 2022 – 2025, which has been approved and is due to be published alongside the IMTP in late July.

## Background

During the Stronger Together Discovery phase, we listened to and heard the voices of around 2,000 colleagues from across all pay bands, professions, and locations across the Health Board. From the feedback we received, five common themes emerged where our colleagues told us we needed to focus to deliver improvement and transformation. . These five programmes are:

Operating Model Engagement and Communication Plan 20022 FINAL

- Our Way of Working

- Strategic Deployment

- How we Organise Ourselves – this programme is well underway to implement the new Operating Model

- The Best of our Abilities

- Improvement and Transformation.

For all five programmes, we intend to continue with our co-design principles, maintaining connections and conversations - building and strengthening our Stronger Together community in order to co-design our way of working for the future.

A Stronger Together information hub has been created by the Communications Team on BetsiNet, the new and improved intranet and is the one-stop-shop where staff can find out the latest news and developments about the programme and the Operating Model [Stronger Together - Home (sharepoint.com)](Stronger Together - Home (sharepoint.com))

## **<u>Key messages</u>**

- Over time there have been a number of significant changes to the design of the Health Board and how we work, resulting in roles and structures becoming more complicated and difficult to understand. These changes led by numerous Chief Executives and a high number of senior interim posts over a relatively short period of time have created instability and confusion around who we are and where we are going. As a consequence, we have been unable to consistently deliver our quality, performance and productivity goals as a result.

Operating Model Engagement and Communication Plan 20022 FINAL

- During the Stronger Together Discovery phase, you told us that the way we were organised made it more difficult to deliver our services, provide care to consistent standards and avoid unnecessary variations in clinical practice and understand who reports into who for what.

- So, with your help and suggestions, we have designed new ways of working which bring together Primary Care, Community Services, Secondary care (Acute) and Children's services into three Health Communities in the East, Central and West. Each Health Community will be led by an accountable Director. There will also be four Pan North Wales Services. With the exception of Mental Health Services, they will all be led by the Deputy Chief Executive/Executive Director of Integrated Clinical Delivery.

- In the new ways of working, there are some differences:

    o Health Communities will be accountable for ensuring a focus on population, prevention and public health

    o Health Communities will manage inpatient beds and theatres that are physically within their geography

    o Operational facilities management arrangements move to the Health Community

    o Single BCUHB wide waiting access and lists for care delivery will become the norm

    o A unified, population based, commissioning function will be developed - bringing together all of the commissioning work

    o A holistic education function will be developed -bringing together all education & learning work

- o   Corporate Functions will be re-named Service Support functions

- And there are some things that will stay the same:

  - o   Children's services will stay within Health Communities

  - o   Therapies operational management arrangements will stay within Health Communities

  - o   Existing support arrangements for services with hub/spoke or hosted arrangements will stay as they are where it is felt they are best designed for patient and community

  - o   Diagnostics and Specialist Clinical Support Services will stay as a Pan North Wales management arrangement

  - o   Women's Services will stay as a Pan North Wales management arrangement

  - o   Cancer Services will stay as a Pan North Wales management arrangement

  - o   Mental Health & Learning Difficulty services will stay as a Pan North Wales management arrangement

- There is still some work to do on the design of clinical services, service support functions and governance. Much of the design of clinical services will be completed by July but will it continue to evolve. Support functions are reviewing their own ways of working to reflect the new ways of working and the timescales will vary across the functions. The governance work will be completed by June.

- Every leadership group – the Board, the Executive and each Senior Leadership Team, ultimately all of us have a unique role in collectively ensuring organisation functions as it should.

- Stronger Together is a three-year journey which will take the organisation through a complete cycle of Discovery, Design and Delivery to enable delivery of our new People Strategy and Plan

- Our COVID-19 response has demonstrated what we are capable of as a team when we have a very clear purpose and set of goals. The pandemic has seen us innovate in the face of crisis and work with courage, commitment and creativity across different teams.

- We are determined to build on what we have already accomplished and need everyone on board to keep moving forward.

- We believe that we will see benefits within the next three years, but this is very much about the medium to long-term.

- Ask your supervisor, matron, team leader etc for more information or pop into a drop-in session near you (see noticeboards for more details). If you have access to a computer, there is lots of information on the intranet (BetsiNet) where you can get more details about the new ways of working or you can join one of the Ask the Panel sessions coming up in June and July.

**Communications sequencing**

The table below outlines the communications activity that will be undertaken in line with the Operating Model project plan.

| DATE | AUDIENCE | CHANNEL AND ACTION | LEAD | NOTES |
|---|---|---|---|---|
| For the GO LIVE (1st August 2022) | | | | |
| For the GO LIVE: From Thursday 21st July | Health Board Members (Thursday 21st July) | Email | MM | Agreed core copy as below, tailored to each audience. |
| | Trades Unions (Tuesday 19th July at routine LPF meeting) | Local Partnership Forum | LH | It has been agreed that our new Operating Model will go live on 1st August. This is the culmination of many months' hard work and is now not far away. This is a really important milestone in our improvement journey and we'd like to thank everyone for their input and contribution to getting us to this point in the implementation process. Integrating our services and bringing together primary, community and acute care is a critical part of our work to improve how our organisation is run, so that everyone |
| | Executive Management Group (Thursday 21st July) | Email – for cascade with teams | MS | |
| | All staff (Friday 22nd July and Monday 25th July) | CEO/Chair bulletin and Weekly Bulletin | KS | |
| | Partners (includes directors of adult social care, LA CEOs and | Partner Bulletin | AM | |

| | Leaders, MPs, MSs, WAST) (Friday 22nd July) | | | is supported to be as effective as possible in their roles. We are investing in developing and supporting our new leaders and teams so that they can be truly responsive to the needs of those we serve – the people of North Wales. We are confident that those who use our services will have a better experience as a result of this work.<br><br>Although some key leadership roles have yet to be filled, the process to recruit to new posts is progressing well. We expect all key leadership posts to be filled by September and for everybody to have started in their new roles by the end of the calendar year. |
| | Other Health Boards and Welsh Government (Friday 22nd July) | Email | JW | |
| Ongoing | | | | |
| Ongoing | All staff | Updates on BetsiNet | Stronger Together team | Comms team arrange video updates from CEO and other senior leaders as appropriate |

| | | | | Add as a feature item when new information comes on stream<br><br>Information on Site Unique Visits and Hots being collected on a weekly basis<br><br>Changes to updates and signposts highlighted on Weekly Engagement & Distribution Weekly Dashboard for review. |
|---|---|---|---|---|
| Ongoing as and when updates are required | All staff | CEO and Chair message (global email on a Friday) | KS/MS | |
| Fortnightly from April 14th | Senior Leaders (via the Executive Management Team) | Fortnightly update for EMG by email | MS/KS/HSJ | Latest operational detail |
| | Line Managers (see my previous comment) | | | |
| August | All staff | Video update from Jo and Sue G – cascaded via EMG for playing in team meetings | Comms Team | Update from after the Board to share progress and what to expect next. To provoke discussion and to feed questions back into the loop (via the Stronger Together email) |
| Monthly from May | Stronger Together Community (ambassadors) | Monthly update by email | EG | Latest details, with an ask to share headlines with colleagues, signpost to BetsiNet and remind their networks of the Stronger Together email address |

| Ongoing as and when updates are required | Partners including Members of the Senedd, Members of Parliament, CHC | Weekly partner briefing (email issued each Friday) | HS-J | |
| --- | --- | --- | --- | --- |
| | Public | Papers on Operating Model for Board meeting published on BCUHB website | MS/EG | |

## Engagement with staff and partners

The table below outlines the opportunities for staff to discuss the impact of the new Operating Model on their team, services, areas etc. Some are bespoke meetings or sessions that are being set up specifically for local teams, some are suggestions of routine meetings where senior leaders can take their teams/colleagues through the proposals and discuss local impact in more detail. Trades Union partners will be involved in the planning and consulted in advance of the sessions going live so they can shape the timings and dates.

| DATE | AUDIENCE | CHANNEL AND ACTION | LEAD | NOTES |
| --- | --- | --- | --- | --- |
| From August 2022 | All staff<br><br>We will invite all colleagues across | Drop in (one off) face to face sessions at the following locations: | Stronger Together team with support from Interim Communications | Within larger venues sessions to be led by senior leaders from acute or community directorates, |

| | | | |
|---|---|---|---|
| | primary, community, acute, pan-North Wales services and corporate services to the sessions. | West:<br><br>• Ysbty Gwynedd<br>• Ysbty Alltwen<br>• Bryn Beryl Hospital<br>• Cefni Hospital<br>• Dolgellau and Barmouth Hospital<br>• Ysbty Eryri<br>• Tywyn Hospital<br>• Ysbyty Penrhos Stanley<br><br>Central:<br><br>• Ysbyty Glan Clwyd<br>• Abergele Hospital<br>• Colwyn Bay Hospital<br>• Llandudno Hospital<br>• Denbigh Hospital<br>• Royal Alexandra, Rhyl<br>• Ruthin Hospital<br><br>East:<br><br>• Ysbyty Wrexham Maelor<br>• Deeside Community Hospital | to set up the sessions | supported by the Stronger Together team/Interim Communications support<br><br>With the potential impact of Covid the plan for an Infographic with Voiceover has been developed and will deliver End July/ Early August 2022<br><br>With the new Health Economies drive, the team has sought the help of the IHC Business Managers to gain their insight into the dispersal of the message for the smaller sites. There is also a drive to have them involved in the delivery of the message across their area gaining "buy in" and ownership<br><br>Posters for individual meetings are being |

| | | • Holywell Hospital<br>• Chirk Hospital<br>• Mold Hospital | | developed and Content being collated |
|---|---|---|---|---|
| From late May | Staff Networks | RespectAbility<br>Celtic Pride<br>BCUnity<br>Gender<br><br>Dates for next meetings to be explored and added | EG/Interim Communications Support to set up the sessions | Sessions to be led by Executive Directors/Senior Leaders<br><br>Content and dates for further involvement being explored |
| Late August / September | Stronger Together Champions (includes equality champions, speak out safely champions, wellbeing champions and infection prevention champions) and staff ambassadors | Specific sessions to bring together all the champions | Stronger Together Team | Sessions to be led by ST team with support from Interim comms<br><br>Content and dates for involvement being explored |
| From June – through into September | Staff Groups | By site/profession/forum routine meetings (taking care to attend those where conversations have already taken place as part of the Stronger Together programme) | MS/NT/EG/Interim Communications Support to set up the sessions | Sessions to be led by local Senior Leaders with support from OD/Interim Comms support<br><br>Content and further dates being explored |
| Sessions in lAugust & September | All Staff | Online Ask the Panel x 2 | EG/NT | Sessions to include an executive director and senior leaders from acute, |

| | | Specific to the Operating Model | | community, primary pan-NW services<br><br>Ask the Panel 7 – 26/8/22 is booked to include New Operating Model |
|---|---|---|---|---|
| July | EMG to include newly appointed Senior Leaders | Update session at the Oriel Hotel with Execs and IMs | MS/HSJ | Session to set out the vision, inspire the leadership of the developing new infrastructure |
| Throughout May, June and July | Partners | Attend scheduled meetings to raise the profile of the new ways of working and to field questions. | Executive Directors MS/HSJ | Using the latest slide pack/briefing |

**ENDS**

| Impact | Likelihood Level | Impact Level | Priority Level | Mitigation Notes | Score Post Mitigation (Likelihood x Impact) | Owner | Date Raised | Date Reviewed | Added to Datix (Risk form 1) | Risk form 2 completed on Datix | Risk ID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| The desired organisational change may not be achieved. Conducting this work during winter, our busiest time, may add additional stress and pressure to staff. This could result in timelines slipping as well as staff being less willing to engage with the change. | 3 | 4 | 12 | Colleagues have told us through Stronger together that we need to improve the structure of the organisation and how we do business as it is getting in the way of 'getting things done'. Any work on structure and process only truly becomes effective if our behaviour supports what we are trying to do as well, so work is underway to align developments in these areas. Whilst it would be ideal to undertake the organisational development and design work in a sequence, these things all take time. We have had to balance the time for the work with the need to take action. There is ongoing information sharing across strategic development work to ensure, whilst the pace is different, alignment is in mind. Section 2 shows how the Operating Model will be developed with complimentary work relating to Organisational People and Development Strategy (the How). Similarly, we have considered the timing of this work and its adjacency and now ongoing development in an incredibly pressured winter. Unfortunately, looking ahead to the likely demand on all of our services, there was no 'ideal' time for this work. Close attention is being paid to operational pressures during implementation and due consideration given. | 8 (2 x 4) | Gill Harris / Sue Green | 15/09/2021 | 01/07/2022 | Yes | Yes | 4359 |
| Services may be negatively impacted during organisational change if staff lose motivation and/or focus. Staff may be confused by conflicting change programmes and lose faith in the organisation's ability to produce effective changes. | 3 | 4 | 12 | Colleagues have told us there is a need to improve clarity in the Operating Model, including accountabilities and how we are organised, for quality of care and population health. This does need to be addressed so people can be clear about how we are organised, the new Operating Model will do this. Any change is unsettling, keeping colleagues informed on its development helps some people understand the change and how it might or might not affect them. We have ensured the Operating Model and its development are published on the intranet. This is 'signposted' through leadership cascades and inclusion in 'all-staff' emails, so anyone can find out more, comment or ask questions. | 9 (3 x 3) | Gill Harris | 15/09/2021 | 01/07/2022 | Yes | Yes | 4361 |
| Staff continue to think that acute services dominate preventive services regardless of any changes implemented. This could negatively impact the message that the Health Communities have a balanced view of both services. This could further impact staff behaviours to focus on acute treatments rather than prevention and well-being. | 3 | 3 | 9 | The proposed model is intended to bring a more cohesive arrangement for a Health Community to take a balanced pathway view of services although it is possible this risk will remain. Leadership at all levels of the organisation will require support with taking a system and partnership view of pathways and services to bring balance. | 6 (3 x 2) | Gill Harris | 15/09/2021 | 01/07/2022 | Yes | Yes | 4362 |

| Impact | Likelihood Level | Impact Level | Priority Level | Mitigation Notes | Score Post Mitigation (Likelihood x Impact) | Owner | Date Raised | Date Reviewed | Added to Datix (Risk form 1) | Risk form 2 completed on Datix | Risk ID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| This could disrupt working relationships and processes that are already in place and effective. This could then negatively impact the delivery of services to patients and staff. | 3 | 3 | 9 | The model has been designed to principles that set out how we will improve our arrangements for patients and the people we serve.  During recent engagement, many colleagues told us what works well and needs to be retained.  Good leadership and good relationships make management arrangements effective.  Through earlier phases of development, clarity had been sought on the high-level model and the mechanism to meet local community needs while considering what is best for the whole of the Health Board.  Services will be requested to describe what systems, processes, and networks they would need to put in place to ensure that quality and clinical governance that works well now is not lost. Acute Site Directors and Area Directors (Centre, East & West) are leading the development and delivery of Integrated Healthcare Community Operational transition plans. | 6 (3 x 2) | Gill Harris / Sue Green | 15/09/2021 | 01/07/2022 | Yes | Yes | 4364 |
| Staff will not feel involved in the improvement of their organisation and therefore less likely to engage with the new changes, especially if they think we do not know how the changes will impact their areas for the better. | 3 | 3 | 9 | Colleagues were invited to join Stronger Together Discovery sessions.  The outputs of those sessions have informed this work and were shared during feedback sessions in November/December 2021.  In addition to this, senior managers have been engaged through Executive Management Group conversations.  Through the recent feedback exercises, we received feedback from some people that we are taking too long, that the pace was just right and also that we are moving too quickly to improve our Operating Model and address issues.  We have had to balance a variety of views on the timing. | 4 (2 x 2) | Michael Shaw/Helen Stevens Jones | 15/09/2021 | 01/07/2022 | Yes | Yes | 4365 |
| The organisation will not learn from previous mistakes and will inevitably repeat them in the future. This will be demotivating for staff who have been in the organisation a long time and have seen the same mistakes being repeated. | 3 | 4 | 12 | Organisational changes happen in many health care organisations and there are a variety of ways this risk is addressed.  The current model considers changes at the most senior tiers of the organisation.  Organisation-specific knowledge is held by many people, in many parts of the organisation.  Senior leaders work in teams, knowledge is shared across and through the team.  When people change roles knowledge transfer will be part of anyone's change or transfer plan.  Arrangements have developed for these leaving us 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. Implementation of change is being phased to further reduce any risk, should it materialise. | 8 ( 4 x 2) | Sue Green (SRO's) | 12/01/2022 | 01/07/2022 | Yes | Yes | 4366 |
| Public money is wasted that could have been used effectively elsewhere for a greater impact. As a result the change required will not be achieved. | 3 | 3 | 9 | Financial analysis of the model has been undertaken and will continue to be closely reviewed and overseen by the Executive team throughout. Finance tracking of results of investment - measures in place | 6 (3 x 2) | Sue Hill | 12/01/2022 | 01/07/2022 | Yes | Yes | 4367 |

| Impact | Likelihood Level | Impact Level | Priority Level | Mitigation Notes | Score Post Mitigation (Likelihood x Impact) | Owner | Date Raised | Date Reviewed | Added to Datix (Risk form 1) | Risk form 2 completed on Datix | Risk ID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff may be worried about changes and how they will impact them and their team. Patients may be worried about changes and disruptions to services. | 2 | 4 | 8 | Many aspects of the Operating Model link to the improvement journey we need to take. The need for change has been identified by colleagues through Stronger Together Discovery feedback and organisational effectiveness improvements identified as part of targeted Intervention status. Therefore, change is required, any significant organisational change comes with some level of disruption. To not make a change would generate a different risk caused by not responding to the improvement opportunities available. The model has been designed to improve how we manage the organisation for the population we serve. Design has put the population at its centre. It has considered how we can arrange ourselves and manage the business of the health Board more effectively, to ultimately provide a better service and a better organisation to work with and for. Keeping patients at the very heart of what we do, patient and staff (authored) stories frame every design conversation. Health Care Organisations management arrangements, the value they add and the cost are of interest to many. It is important that when we are implementing the model, that the benefit of what we are doing is described well, alongside the change being taken. | 4 (2 x 2) | Helen Steven-Jones | 12/01/2022 | 01/07/2022 | Yes | Yes | 4368 |
| Staff may lose faith in their managers and leaders, which may also impact motivation and therefore service performance and the implementation of the desired change. | 3 | 2 | 6 | A comprehensive delivery plan in place including communications, organisational development, systems/infrastructure and Operational Transition. The comprehensive communication and engagement plan is built on the principle of continued dialogue with those staff directly affected and their direct reports and wider internal messaging via existing channels. Our existing and open channels of information flow with our external partners will/are being used to inform and listen. | 4 (2 x 2) | Gill Harris | 15/02/2022 | 01/07/2022 | Yes | Yes | 4369 |
| Misconception that change has not happened as a result of the new operating model and there is a focus on corporate development over clinical investment. This could impact staff engagement in future stages of Stronger Together and therefore reduce the efficacy of the overall transformation. | 3 | 2 | 6 | IMTP demonstrates majority of investment in direct patient/citizen services. People centred outcome measures developed for inclusion in full Operating Model and delivery plan. | 4 (2 x 2) | Helen Stevens-Jones | 16/02/2022 | 01/07/2022 | Yes | Yes | 4370 |
| Lack of confidence in the operating model and the direction being set, could impact staff motivation and potentially harm the overall performance of the organisation. | 3 | 3 | 9 | Programme subject to central orchestration through Transformation and planning structure including clear executive accountability. Outcome measures incorporated into IMTP, enabling Strategies and Targeted Intervention maturity matrices. | 6 (3 x 2) | Sue Green & Sue Hill | 16/02/2022 | 01/07/2022 | Yes | Yes | 4371 |

| Impact | Likelihood Level | Impact Level | Priority Level | Mitigation Notes | Score Post Mitigation (Likelihood x Impact) | Owner | Date Raised | Date Reviewed | Added to Datix (Risk form 1) | Risk form 2 completed on Datix | Risk ID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Confusion about organisational structure, lines of communication and processes could result in a negative impact for services. Continuity of services may also be impacted during structure change. | 3 | 3 | 9 | Health Community Directors will be involved in establishing the minimum structure framework for Health Communities to ensure consistency across. The implementation of the new operational governance framework in conjunction with the System Oversight Function will provide the capability to monitor and manage quality, performance and productivity variation, significant divergence and internal competition. | 6 (3 x 2) | Gill Harris | 16/02/2022 | 01/07/2022 | Yes | Yes | 4372 |
| Interims may be required which was not a desired outcome of the new structure. This will delay the full implementation of the new structure and reduce its effectiveness. | 4 | 3 | 12 | The use of interims will not delay the implementation of the new Operating Model. Where needed they will provide short-term capacity & capability.  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. Where this is not possible we will then look to use to experienced external interims. 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. | 6 (3 x 2) | Sue Hill / Sue Green | 04/04/2022 | 01/07/2022 | Yes | Yes | 4373 |
| 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 | 5 | 3 | 15 | 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 September 2022. There will be additional management oversight of the How We Organise Ourselves programme, as well as the 'Roles and People' project team | 6 (3 x 2) | Gill Harris / Sue Green | 04/04/2022 | 01/07/2022 | Yes | Yes | 4360 |

| Impact | Likelihood Level | Impact Level | Priority Level | Mitigation Notes | Score Post Mitigation (Likelihood x Impact) | Owner | Date Raised | Date Reviewed | Added to Datix (Risk form 1) | Risk form 2 completed on Datix | Risk ID |
|---|---|---|---|---|---|---|---|---|---|---|---|
| This could lead to an inability to manage significant clinical variation and therefore negatively impact patient experience and safety. | 3 | 4 | 12 | The implementation of existing operational governance framework as well as a plan for on-boarding of transitional and new roles to manage transition into the new structure, which will also have Executive Director oversight between April and September 2022 . Phased Leaving Well strategy for VERS and other leavers, affected by the operating model will reduce the organisation memory loss during the transition to Health Communities. The collective Executive Director team are monitoring VERS departures, aligned to organisational requirements (e.g. year end and Covid inquiry),a recruitment plan to identify high calibre clinical leaders,  regular management oversight of the How We Organise Ourselves programme, as well as the 'oversight of IHC Operational Transition plans.  There is also implementation of the operational governance framework. | 6(3 x 2) | Gill Harris / Sue Green | 20/04/2022 | 01/07/2022 | Yes | Yes | 4393 |
| Health communities working in isolation or competition could negatively impact the services being delivered to patients, and disrupt the pan BCU developments also to the detriment of patient and staff services. | 3 | 4 | 12 | The implementation of the new operational governance framework in conjunction with the System Oversight Function and Clinical Effectiveness Unit (hard wired to the Quality, Risk Performance and Governance Teams) will provide the capability to monitor and manage quality, performance and productivity variation, significant divergence and internal competition. | 8(4 x 2) | Gill Harris / Nick Lyons | 21/04/2022 | 01/07/2022 | Yes | Yes | 4395 |
| Silver on-call rota gaps appear as the existing pool members may decline to cover the gaps. | 3 | 4 | 12 | The interim Director of Regional Delivery has been working with members of the Operational Tactical control centre and member of the Roles and the People project group to ensure business continuity of the Gold and Silver on-call rota pre and post the implementation of the OM. The interim Director of Regional Delivery has been asked in conjunction with Executive Director of Therapies & Health Sciences, Associate Director – Human Resources, Head Of HR - East Locality, Head Of Tactical Control Centre and the EPRR Lead to take forward the macro on-call review which pre-dates the proposed new OM. | 8(4 x 2) | Gill Harris | 18/03/2022 | 01/07/2022 | Yes | Yes | 4406 |
| Significant drop in the pace of the improvement activities – therefore a delay in progression of the outputs and outcomes as described in the targeted improvement framework. | 3 | 4 | 15 | 1. Replace named Operational Leads with Executive Sponsors 2. Recruit interim change management subject matter experts to create an multi-disciplinary change cell to support Executive leads and level 5 Operational Leads | 8(4 x 2) | Gill Harris /Chris Stockport | 01/07/2022 | TBC | Awaiting addition | Awaiting addition | TBC |

| Health Board 4.8.22 | | To improve health and provide excellent care |
|---|---|---|

## Committee Chair's Report

| Name of Committee: | Quality, Safety and Experience (QSE) |
|---|---|
| Meeting date: | 3 May 2022 |
| Name of Chair: | Lucy Reid, Committee Chair and Independent Board Member |
| Responsible Director: | Gill Harris, Executive Director of Nursing / Deputy CEO |
| Summary of business discussed: | <ul><li>Carer Story about difficulties encountered with his mother's dementia care associated with a lack of training and awareness for patient's with dementia. The Committee asked for the Dementia leads to be invited to a future meeting</li><li>Update on Psychological Therapies where 3 actions were supported to include mapping the current position against Matrics Cymru, reviewing the terms of reference for the Psychological Therapy Management Committee and that Committee would oversee the construction of a plan to develop a psychologically informed care framework across BCUHB</li><li>Dementia Hospital Charter was received and supported by the Committee</li><li>Covid19 Update including the decision to step down Gold Command</li><li>Quality/Safety Awards and Achievements</li><li>Update on the Urology Transformation Programme highlighting that the Ombudsman's actions were complete and an improvement group had been set up</li><li>HIW Reports update and Action Tracker</li><li>Mental Health & Learning Disabilities update</li><li>QS22/93 Chair's Reports from Strategic and Tactical Delivery Groups<ul><li>Clinical Effectiveness Group</li><li>Patient and Carer Experience Group</li><li>Infection Prevention Steering Group</li><li>Report on Accreditation</li><li>HSE</li></ul></li><li>Audit Wales Quality Governance Report</li></ul> |

| | |
|---|---|
| **Key assurances provided at this meeting:** | • The Committee received a report from Mental Health and Learning Disabilities Service on the phased closure of mixed cohorting practice at Hergest Unit |
| **Key risks including mitigating actions and milestones** | • The Committee raised concerns again about the learning arising from patient safety incidents and whether basic training and fundamentals of care were not being implemented. The Committee requested that the report needs to focus on near misses and risks rather than actual outcomes and the need to see the impact of actions being taken to improve safety. <br>• The Clinical Audit Plan was scheduled 2 to be discussed but the overarching plan had not been provided 2 the Committee. It was agreed that an extraordinary meeting would be arranged to review it. This was arranged for 26th May 2022. <br>• The Committee received an update on the make safe plans for vascular and it was agreed that the vascular quality panel would provide regular reports on their work to the Committee. <br>• The Committee had requested an improvement plan for YGC but had only been provided with an action plan for the emergency department. It was agreed that an improvement plan would be presented to the Extraordinary QSE Committee meeting due to the urgent nature of the concerns. <br>• The Committee had requested an improvement plan for the Mental Health and Learning Disabilities Service but this had still not been provided. The Committee requested full support for the Division to be given and all the tools made available to enable the plan to be urgently progressed. |
| **Targeted Intervention Improvement Framework Domain addressed** | • Mental Health (adult and children) <br>• Strategy, planning and performance <br>• Leadership (including governance, transformation and culture) <br>• Engagement (patients, public, staff and partners) |
| **Issues to be referred to another Committee** | No issues to be referred |
| **Recommendation/ Matters requiring escalation to the Board:** | No issues to be referred |
| **Well-being of Future Generations Act Sustainable Development Principle** | The Committee gave adequate consideration to the sustainable development principles: <br>1.Balancing short term need with long term planning for the future; <br>2.Working together with other partners to deliver objectives; <br>3. Involving those with an interest and seeking their views; <br>4.Putting resources into preventing problems occurring or getting worse; and <br>5.Considering impact on all well-being goals together and on other bodies) |

| | |
|---|---|
| **Planned business for the next meeting:** | Range of regular / standing items plus:<br>• Quality Annual Report<br>• Putting things Right Annual Report<br>• Health and Safety Annual Report |
| **Date of next meeting:** | 5.7.22 |

V0.2

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

*To improve health and provide excellent care*

## Committee Chair's Report

| | |
|---|---|
| **Name of Committee:** | Extraordinary Quality, Safety and Experience (QSE) |
| **Meeting date:** | 26 May 2022 |
| **Name of Chair:** | Lucy Reid, Committee Chair and Independent Board Member |
| **Responsible Director:** | Gill Harris, Executive Director of Nursing / Deputy CEO |
| **Summary of business discussed:** | The Extraordinary meeting of the QSE Committee was convened to receive the Clinical Audit Plan for 2022/23 and the improvement plan for Ysbyty Glan Clwyd following an escalation of concerns internally and by Healthcare Inspectorate Wales<br><br>The Committee also received the full HIW reports for the visits to YGC in both March 2022 and May 2022 as well as the immediate assurance plans. |
| **Key assurances provided at this meeting:** | • The Committee approved the clinical audit plan which has been devised on the basis of recognised high level risks and Health Board priorities. It noted the plan for it to be linked more directly to the Corporate Risk Register in the future. |
| **Key risks including mitigating actions and milestones** | • The Committee received an update on the approach to be taken to develop a site wide improvement plan for YGC using evidence based methodology. The Committee welcomed the proposed approach and identification of five key themes to enable a more comprehensive plan incorporating actions required for the emergency department and vascular services as well. The Committee reiterated the need for the plan to be site wide, evidence based and outcome focused with a need to clearly demonstrate progress to safeguard patients. |
| **Targeted Intervention Improvement Framework Domain addressed** | • Mental Health (adult and children)<br>• Strategy, planning and performance<br>• Leadership (including governance, transformation and culture)<br>• Engagement (patients, public, staff and partners) |
| **Issues to be referred to another Committee** | No issues to be referred |

| | |
|---|---|
| **Recommendation/ Matters requiring escalation to the Board:** | No issues to be referred |
| **Well-being of Future Generations Act Sustainable Development Principle** | The Committee gave adequate consideration to the sustainable development principles:<br>1.Balancing short term need with long term planning for the future;<br>2.Working together with other partners to deliver objectives;<br>3. Involving those with an interest and seeking their views;<br>4.Putting resources into preventing problems occurring or getting worse; and<br>5.Considering impact on all well-being goals together and on other bodies) |
| **Planned business for the next meeting:** | Range of regular / standing items plus:<br><ul><li>Quality Annual Report</li><li>Putting things Right Annual Report</li><li>Health and Safety Annual Report</li></ul> |
| **Date of next meeting:** | 5.7.22 |

V0.1

## Committee Chair's Report

| Name of Committee: | Quality, Safety and Experience (QSE) |
| --- | --- |
| Meeting date: | 5 July 2022 |
| Name of Chair: | Lucy Reid, Committee Chair and Independent Board Member |
| Responsible Director: | Gill Harris, Executive Director of Nursing / Deputy CEO |
| Summary of business discussed: | <ul><li>A Patient Story about the excellent care that had been received at the Emergency Department in YGC by a mother who had brought her child in.</li><li>Report of the Lead Executive highlighting that that new Director of Governance would be undertaking a review around the Ockenden and HASCAS reports to ensure the actions have been embedded</li><li>A Community Health Council review of Speech and Language Therapy Services</li><li>A Discharge Standard Operating Procedure to standardise processes across the Health Board whilst the Strategy was being drafted</li><li>Medical Devices Training Policy would be amended and circulated for Chair's Action</li><li>Corporate Risk Strategy was endorsed along with the decision for the Risk Management Group to report into the QSE Committee</li><li>Quality Performance Report was discussed including areas of concern such as sepsis, CAMHS performance and access to psychological therapies</li><li>Patient Safety Report was received and the commissioning of AQUA training discussed</li><li>Quality/Safety Awards and Achievements</li><li>YGC Improvement Plan update was provided, noting the plan itself would be received at Cabinet</li><li>A verbal update was received on Urology Services and the multidisciplinary workshops that was scheduled to discuss priorities</li><li>Chair's Assurance Reports from Strategic and Tactical Delivery Groups<ul><li>Patient Safety Quality Group</li></ul></li></ul> |

| | |
|---|---|
| | • Strategic Occupational Health and Safety Group<br>• Clinical Effectiveness Group<br>• Patient and Carer Experience Group<br>• Infection Prevention Steering Group<br>• Vascular Quality Panel<br>• Vascular Steering Group<br>Two reports were withdrawn from the agenda due to quality issues and revised reporting arrangements agreed. |
| **Key assurances provided at this meeting:** | • |
| **Key risks including mitigating actions and milestones** | • An update on Vascular Services was received and the Committee raised concerns about the failure to appoint to the clinical director post and the impact this may have on the service. The findings of the Vascular Quality Panel were also discussed which at this point raised mainly post-operative care concerns.<br>• The Committee received an update on the development of the YGC Improvement Plan and noted that the plan itself would be received and monitored by Cabinet<br>• Despite previous Committee requests, the Mental Health Improvement Plan was not provided to the Committee. Concern was noted about recurring themes across the service and a high number of vacancies across the Division which is impacting upon the ability to progress with service improvement. It was agreed that the Committee Chair and Independent Member lead would meet with the Executive Director of Public Health and the Executive Director of Transformation, Strategic Planning and Commissioning to review the plan outside of the Committee. |
| **Targeted Intervention Improvement Framework Domain addressed** | • Mental Health (adult and children)<br>• Strategy, planning and performance<br>• Leadership (including governance, transformation and culture)<br>• Engagement (patients, public, staff and partners) |
| **Issues to be referred to another Committee** | It was recommended that the processes around mandatory training should be reviewed by the PPPH Committee with a report provided by the Executive Director of Workforce and Organisational Development |
| **Recommendation/ Matters requiring escalation to the Board:** | The Committee expressed concern around the delays in providing a Mental Health Improvement Plan despite previous requests. The Committee decided to escalate this matter to the Board due to the length of time that has passed without the plan being received. The Board is asked to endorse the Committee's concern in this matter and support priority being given to this area of work and the assurance process now required in this regard. |
| **Well-being of Future Generations Act Sustainable** | The Committee gave adequate consideration to the sustainable development principles:<br>1.Balancing short term need with long term planning for the future;<br>2.Working together with other partners to deliver objectives; |

| | |
|---|---|
| **Development Principle** | 3. Involving those with an interest and seeking their views;<br>4.Putting resources into preventing problems occurring or getting worse; and<br>5.Considering impact on all well-being goals together and on other bodies) |
| **Planned business for the next meeting:** | Range of regular / standing items plus:<br>• Quality Annual Report<br>• Putting things Right Annual Report<br>• Health and Safety Annual Report |
| **Date of next meeting:** | 5.7.22 |

V0.2

| | |
|---|---|
| |  **GIG CYMRU NHS WALES** \| Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board |

# Chair's Report

| **Name of Committee:** | Targeted Intervention Improvement Framework (TIIF) Steering Group |
|---|---|
| **Meeting date:** | 04.07.22 |
| **Name of Chair:** | Gill Harris, Deputy Chief Executive / Executive Director of Integrated Clinical Delivery |
| **Responsible Director:** | Gill Harris, Deputy Chief Executive / Executive Director of Integrated Clinical Delivery |
| **Summary of business discussed:** | <ul><li>The Chair made reference to the recent Welsh Government announcement of Targeted Intervention (TI) arrangements which have been extended to include a specific focus on services at Ysbyty Glan Clwyd (YGC) which will include Vascular and ED as specific services.</li><li>Welsh Government have suggested the maturity matrices are reviewed and may require rewording to reflect the additions.</li><li>The development of the maturity matrix for the YGC domain and the separation of Performance from Strategy and Planning domain is to be completed by the end of July. These will then be presented to a Board Workshop for scrutiny prior to formal presentation to the Board.</li><li>Discussions are ongoing with WG regarding the YGC element and possibly the Mental Health element as there will be an increase in focus on governance and oversight in these specific work streams.</li><li>The terms of reference for the Steering Group, Evidence Group and Outcomes Group will be reviewed to reflect the governance arrangements going forward.</li><li>An SBAR on the Performance domain was presented to formalise the agreement by WG to separate the Performance element from the Strategy and Planning element within the Strategy, Planning and Performance domain.</li><li>The group discussed the proposed changes which have been put forward for the CAMHS element of the Mental</li></ul> |

| | |
|---|---|
| | Health domain, the Engagement domain and the Strategy and Planning domain. |
| **Key assurances provided at this meeting:** | • Governance arrangements are in place to monitor TI progress via Steering Group oversight. |
| **Key risks including mitigating actions and milestones** | • No risks were raised |
| **TIIF Domain addressed** | • All |
| **Issues to be referred to another Committee** | • None |
| **Matters requiring escalation to the Board:** | • None |
| **Well-being of Future Generations Act Sustainable Development Principle** | *Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.*<br>*1. Balancing short term need with long term planning for the future* – covered by the strategy, planning and performance domain.<br>*2. Working together with other partners to deliver objectives* – covered by the engagement work<br>*3. Involving those with an interest and seeking their views* – covered by the engagement work;<br>*4.Putting resources into preventing problems occurring or getting worse* – via WG funding allocation;<br>*5. Considering impact on all well-being goals together and on other bodies* – covered by engagement work. |
| **Planned business for the next meeting:** | • This will be a sub set of the Steering Group and will concentrate on the development YGC and Performance maturity matrices. |
| **Date of next meeting:** | 18.07.22 |

*V1.0*

**Chair's Report**

| Name of Committee: | Targeted Intervention Improvement Framework (TIIF) Steering Group |
|---|---|
| **Meeting date:** | 12.05.22 |
| **Name of Chair:** | Gill Harris, Deputy Chief Executive / Executive Director of Integrated Clinical Delivery |
| **Responsible Director:** | Gill Harris, Deputy Chief Executive / Executive Director of Integrated Clinical Delivery |
| **Summary of business discussed:** | • The TI Steering Group took the form of a Moderation Meeting for this individual meeting.<br>• Joanna Watson and Sam Newton from Good Governance Institute joined the meeting to discuss the recommendation to the Board on the TI scores for the May self-assessment.<br>• Individual Moderation Meetings with each of the SROs and IMs have recently taken place as requested by the Board to gain assurance on the TI process.<br>• Good Governance Institute raised specific questions with the group and responses were provided by the domains.<br>• The suggested levels were agreed:<br> ➢ All Ages Mental Health     2<br> ➢ Strategy, Planning & Performance   2<br> ➢ Leadership         2<br> ➢ Engagement        2 (high) |
| **Key assurances provided at this meeting:** | • Governance arrangements are in place to monitor TI progress via Steering Group oversight. |
| **Key risks including mitigating actions and milestones** | • No risks were raised |
| **TIIF Domain addressed** | • All |
| **Issues to be referred to another Committee** | • None |

| | |
|---|---|
| **Matters requiring escalation to the Board:** | • None |
| **Well-being of Future Generations Act Sustainable Development Principle** | *Describe how the items of business and the development of any proposals considered by the Committee gave adequate consideration to the sustainable development principles or if not indicate the reasons for this.*<br>*1. Balancing short term need with long term planning for the future –* covered by the strategy, planning and performance domain.<br>*2. Working together with other partners to deliver objectives –* covered by the engagement work<br>*3. Involving those with an interest and seeking their views –* covered by the engagement work;<br>*4.Putting resources into preventing problems occurring or getting worse –* via WG funding allocation;<br>*5. Considering impact on all well-being goals together and on other bodies –* covered by engagement work. |
| **Planned business for the next meeting:** | • Monitoring progress against the framework and identification of any issues. |
| **Date of next meeting:** | 28.06.22 |

*V1.0*

| **Health Board** |  **GIG CYMRU NHS WALES** Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board |
|---|---|
| | *To improve health and provide excellent care* |
| | **Committee Chair's Report** |

| **Name of Committee:** | **Remuneration & Terms of Service (R&TS) Committee** |
|---|---|
| **Meeting dates:** | 18.1.22; 3.2.22; 30.3.22; 26.4.22 and 12.7.22 |
| **Name of Chair:** | Mark Polin |
| **Responsible Director:** | Sue Green, Executive Director of Workforce & OD |
| **Summary of business discussed:** | The Committee considered the following issues:<br><br>18.1.22 (public)<br>• Matters considered in private at the last meeting – these were noted in public session<br>18.1.22 (private)<br>• Operating Model and VERS update<br>• Executive appointments and PADR objectives update (deferred)<br><br>3.2.22 (Extraordinary Private)<br>• Operating Model and VERS update<br>• Executive appointments and PADR objectives update<br>• Executive Director appointments<br><br>30.3.22 (Extraordinary Private)<br>• VERS Round II<br>• Executive Director VERS<br>• Director Appointments<br>• Pension Recycling<br><br>26.4.22 (public)<br>• Matters considered in private at previous meeting, and noted in public<br><br>26.4.22 (private)<br>• Upholding Professional Standards in Wales (UPSW) Designated Board Member Report<br>• Professional Standards Case Management Report<br>• NHS (Performers List) (Wales) Regulations 2004 Update<br>• Employment Tribunals and High Profile Disciplinary Case Report |

| | |
|---|---|
| | • Executive Director and Very Senior Manager Appointments Report<br>• Senior Interim Agency Compliance Report<br>• Pension Recycling<br>• Speak out Safely<br>• VERS Update Report<br><br>12.7.22 (public)<br><br>• Remuneration Report 2021/22<br>• Performance and Development Review – Executive Directors |
| **Key assurances provided at this meeting:** | • Appropriate governance processes are being followed and improved where necessary<br>• Following approval of the Committee to approve 15 applications for Voluntary Early Release (VERS) in Round 1 and to approve a further five applications in Round II in accordance with the national scheme, the Committee received a report which provided an update on Round 1 and II. The Committee formally received the additional information requested in respect of three applications and approved them. (Post meeting note: Whilst a member of the Committee, as he was not present at the meeting, the Chair of the Audit Committee considered and endorsed the five applications – confirmed via email dated 7th April 2022).<br>• The Committee noted and approved the 2021/22 Remuneration Report as part of the Annual report approval process, subject to any material changes arising from the ongoing Audit Wales process.<br>• The Committee resolved that the Executive Director objectives be refined as outlined within the minutes of the meeting and agreed by the Chief Executive in consultation with the Chair and Vice-Chair of the Health Board and Chair of Audit Committee. |
| **Key risks including mitigating actions and milestones** | • Potential risks and mitigations formed part of the discussions in private. |
| **Issues to be referred to another Committee** | Audit Wales findings pertaining to the remuneration report will be monitored by the Audit Committee |
| **Matters requiring escalation to the Board:** | None. |
| **Well-being of Future Generations Act Sustainable Development Principle** | *1.Balancing short term need with long term planning for the future –* consideration of future processes<br>*2.Working together with other partners to deliver objectives –*working with trade union partners |

|  | |
|---|---|
|  | 3. *Involving those with an interest and seeking their views – via* consultation with trade union partners and engagement with colleagues<br>4. *Putting resources into preventing problems occurring or getting worse* – plans for management process improvements<br>5. *Considering impact on all well-being goals together and on other bodies* – noted. |
| **Planned business for the next meeting:** | A range of standing items plus Executive objectives/appraisal update. |
| **Date of next meeting:** | 1.9.22 |

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

*To improve health and provide excellent care*

## DRAFT Committee Chair's Report

| | |
|---|---|
| **Name of Committee:** | **Partnerships, People and Population Health Committee** |
| **Meeting date:** | 20.5.22 |
| **Name of Chair:** | Linda Tomos, Independent Member |
| **Responsible Director:** | Chris Stockport Executive Director Primary Care and Community services |
| **Summary of business discussed:** | The meeting noted the following reports: <ul><li>North Wales Regional Partnership Board Meeting Update</li><li>Living Healthier, Staying Well (LHSW) Strategy Refresh</li><li>Draft People Strategy & Plan – Stronger Together</li><li>Third Sector Framework and Approach</li><li>Response to the Review of Emergency Preparedness Resilience and Response (EPRR) Arrangements</li><li>Operational Plan Monitoring Report 2021-22 Position as at 31st March 2022</li><li>Corporate Risk Register</li><li>Population Health : Update on Tobacco Control in BCUHB reviewed</li><li>Test, Track and Trace Update</li><li>People/Workforce Performance Report</li><li>Codi Llais yn Ddiogel/Speak Out Safely (CLYD/SOS) Year 1 Progress Report</li><li>Annual Equality Report</li><li>Consultations and engagement update April 2022Partnership Governance Arrangements Update</li><li>Annual Workshop Plan 2022/23</li></ul> Papers for the meeting can be accessed via the link below: [Partnerships, People and Population Health Committee - Betsi Cadwaladr University Health Board (nhs.wales)](#) |
| **Key assurances provided at this meeting:** | <ul><li>The Living Healthier, Staying Well update addressed questions previously raised regarding public engagement surrounding the refresh.</li><li>Following further engagement with staff and public during June, a final draft of the Clinical Services Strategy will be available to go to Board in July.</li></ul> |

| | |
|---|---|
| | <ul><li>Assurance was received that the updated draft People Strategy and Plan (PS&P) was better aligned with the IMTP and that previous comments made by Committee members had been incorporated into the latest draft.</li><li>Regarding the Third Sector Framework and Approach, when it is next brought before the Committee it will formally include the Volunteering element of the strategy.</li><li>Assurance was received that the work being carried out on the Review of Emergency Preparedness Resilience and Response Arrangements will not be delayed by proposed changes in the Operating Model.</li><li>Regarding the new format for the Operational Plan Monitoring Report, it was noted that close collaboration between PFIG and PPPHC Committees will be needed to ensure that key issues, including workforce matters, are scrutinised effectively.</li><li>The Committee acknowledged the progress being made to implement the Tobacco Control policy in BCUHB and the remaining challenges.</li><li>The Committee welcomed the Health Board's commitment to support staff to find alternative employment following the announcement of changes to the Test, Track and Trace Programme and the reduction in funding.  It also welcomed the continuation of the six community hubs going forward.</li><li>The Committee noted the progress made during the first year of the Codi Llais yn Ddiogel /Speak out Safely platform and the fact that staff are using the anonymous platform to raise concerns.</li><li>The Committee was pleased to commend the work and the progress being made by the Corporate Equality Team as shown in their Annual Equality Report.</li><li>The new structure around partnership governance and the reference to the memorandum of agreement, with regards to other partnerships were welcomed as being timely and needed</li></ul> |
| **Key risks including mitigating actions and milestones** | <ul><li>The Committee discussed the level of scrutiny required to assess the effectiveness of the delivery of the People Strategy and Plan and agreed to hold a joint workshop with PFIG Committee to conduct a deep dive into key workforce issues.</li></ul><br><ul><li>The Committee expressed concerns regarding the potential impact on key strategies, including the Clinical Services Strategy, of the 13 month delay in developing a new Estates Strategy and noted that the revised strategy would be brought to the July meeting.</li></ul> |
| **Matters requiring escalation to the Board:** | <ul><li>The Committee agreed to highlight the joint workshop to be arranged with PFIG to conduct a deep dive into key issues relating to the successful delivery of the People Strategy and Plan. The aim will be to better prepare both Committees to be</li></ul> |

| | |
|---|---|
| | able to provide assurance to the Board that the objectives of the Strategy to improve areas such as recruitment, retention and staff morale are being achieved. |
| **Planned business for the next meeting:** | • Living Well, Staying Healthy update<br>• Partnership (TBC)<br>• Monitoring Tier 2 strategies for Committee approval – NHS Wales Decarbonisation Strategic delivery Plan 2021-2030<br>• Policy status update including relevant policies reserved for Executive approval<br>• Medical and Health Sciences school progress update<br>• University status update<br>• Board Assurance Framework related to committees<br>• Population Health – Adverse Child Experience<br>• Informatics (Digital) assurance report incl KPIs<br>• CEO Digital Health and Care Wales update<br>• IMTP - Annual Plan and compliance with the Wellbeing of Future Generations (Wales) Act (2015)<br>• Test, Track and Trace Programme Update<br>• Workforce (People) Annual Report<br>• Welsh Language service Annual Monitoring report incl WL Standards<br>• Chairs Assurance reports<br>• Partnership Meetings – Regional Partnership Board, Mid Wales Joint Committee<br>• Transformation Fund updates – Children Young People / CAMHS and Innovation |
| **Date of next meeting:** | 12.7.22 |

v.01 draft for Committee Chair approval

| Health Board<br>*21 July 2022* | GIG CYMRU NHS WALES<br>Bwrdd Iechyd Prifysgol<br>Betsi Cadwaladr<br>University Health Board<br><br>*To improve health and provide excellent care* |
|---|---|

<div align="center">

**Advisory Group Chair's Report**

</div>

| **Name of Advisory Group:** | Healthcare Professionals Forum (HPF) |
|---|---|

| **Meeting date:** | 10 June 2022 |
|---|---|

| **Name of Chair:** | Jane Wild, Scientific Advisory and HPF Chair |
|---|---|

| **Responsible Director:** | Gareth Evans, Acting Executive Director of Therapies & Health Science and Executive Lead HPF |
|---|---|

| **Summary of key items discussed:** | **H22/12 Welcome, Introductions and Apologies**<br><br>**H22/12.1** The Chair opened the meeting, Jane Wild's first meeting as Chair and welcomed those present.  The Chair extended a special welcome to new member, Dr Tim Davies who joins us as the Primary and Community Care Medical representative.  The HPF members made their introductions for the benefit of the guest presenters and the new member.<br><br>**H22/16 Clinical Services Strategy Update -** "Developing the Clinical Strategy for North Wales" presentation by  Colin Fitzpatrick (CF),  Interim Deputy Medical Director, Conrad Wareham (CW), Interim Deputy Medical Director and Sally Baxter (SB), Assistant Director - Health Strategy.<br><br>The Chair welcomed Colin Fitzpatrick and Sally Baxter to present "Developing the Clinical Strategy for North Wales".   The presentation slides shared with the Forum members prior to the meeting introduced by CF is in the stage of engagement with various stakeholders including the HPF.  The presentation outlined the clinical strategy prioritisation framework, identifying key drivers nationally and locally, the progress to date and the proposed clinical strategy guiding principles, design features and the alignment to existing enabling strategies.  The final slide identified next steps and projected timescales, with submission to the Health Board for formal approval at the end of July 2022.<br><br>An interesting and engaging discussion and queries regarding the strategy ensued. Conrad Wareham joined the discussion and apologised for joining later than planned due to unforeseen circumstances |
|---|---|

| | |
|---|---|
| | The Chair thanked Colin Fitzpatrick, Sally Baxter and Conrad Wareham very much for joining the Forum to discuss the Clinical Services Strategy. The Executive Lead also gave thanks and requested if the Forum could be utilised going forward on an ongoing basis for views, opinion and advice particularly as the strategy moves into more operational plans.<br><br>**H22/18 Targeted Intervention Improvement Framework (TIIF) update -** Apologies received from Simon Evans-Evans (SEE), Interim Director of Governance.<br><br>A number of documents were shared with the Forum members prior to the meeting. The Chair noted that unfortunately Simon Evans-Evans has since left BCUHB and his replacement is yet to take up the post. The Chair suggested that given the level of information shared in the documents, it would be best that the Forum members focus on the contribution of the HPF representatives at the Targeted Intervention Evidence and Outcomes groups. As one of the representatives, Sue Murphy, had given apologies for today's meeting, Fiona Giraud was asked to offer some feedback from the Evidence group meetings.<br><br>It was reported that the process for presenting the evidence was improving, however there continues to be a huge amount of evidence to seek assurance on. It was suggested that the representation of HPF at the groups should continue, and that HPF will continue to receive the bi-annual progress update once SEE's replacement is in post.<br><br>**H22/19 Chair's and members summary reports:**<br>H22/19.1 HPF Member Report_Dentistry<br>H22/19.2 HPF Member Report_Nursing<br>H22/19.3 HPF Member Report_Pharmacy and Medicines Management<br>H22/19.4 HPF Member Report_Primary and Community Care<br>H22/19.5 HPF Member Report_Women's Directorate<br>H22/19.6 HPF Member Report_Optometry<br>H22/19.7 HPF Member Report_Health Care Science<br>H22/19.8 HPF Member Report_Specialist and Tertiary Care (verbal) |
| **Key advice / feedback for the Board:** | **H22/21 Summary of information to be included in Chair's report to the Board**<br><br>The Forum discussed the role of current members as representatives on the TI Outcomes and Evidence groups and support the continuation of this HPF representation going forward.<br><br>The HPF welcomed the opportunity to comment on the Clinical Strategy and supporting documents. Forum members discussed the importance of the timely progress and implementation of the enabling strategies that support the Clinical Strategy, specifically |

| | |
|---|---|
| | the People and Digital Strategies. The Forum are keen to continue to be utilised going forward on an ongoing basis for views, opinion and advice particularly as the strategy moves into more operational plans.<br><br>It was noted from the Midwifery representative members' report that there has been significant success recently with recruitment. There are potential lessons to be shared related to coordinated workforce planning and commissioning and the training provision and opportunities being offered to new recruits. |
| **Targeted Intervention Improvement Framework Domain addressed** | • Mental Health (adult and children)<br>• Strategy, planning and performance<br>• Leadership (including governance, transformation and culture)<br>• Engagement (patients, public, staff and partners) |
| **Planned business for the next meeting:** | Range of standing items plus:<br><br>• Public Health Update – Executive Director of Public Health<br>• Workforce & Organisational Development – People's Strategy (Postponed from June's meeting)<br>• Quality Strategy Update |
| **Date of next meeting:** | Friday, 2nd September 2022 |

| Health Board | | |
|---|---|---|
| | **GIG CYMRU NHS WALES** Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board | |
| | *To improve health and provide excellent care* | |

| **Advisory Group Chair's Report** |
|---|

| **Name of Advisory Group:** | **Stakeholder Reference Group** |
|---|---|

| **Meeting date:** | **06.06.22** |
|---|---|

| **Name of Chair:** | **Mike Parry, Vice Chair of Stakeholder Reference Group** |
|---|---|

| **Responsible Director:** | **Helen Stevens-Jones, Director of Partnerships, Communications & Engagement** |
|---|---|

| **Summary of key items discussed:** | • Planning Update<br>• Clinical Strategy<br>• Parnership Strategy |
|---|---|
| **Key advice / feedback for the Board:** | • The Group welcomed the planning update highlighting the 'plan on a page' and the progress of the Regional Treatment Centres to date and going forward.<br>• The Third Sector was discussed highlighting that work has commenced in terms of engagement with carer services as part of the implementation element and a request was made for volunteers from the SRG to provide input to strengthen the work.<br>• The Group discussed the Third Sector work and it was confirmed that members of the Group are involved in work stream highlighting representation from the SRG.<br>• A recommendation has been made for the Chair to contact Mark Polin with a request to contact the Local Authorities to address the lack of attendance and determine why the SRG is not functioning to capacity.<br>• The Group shared their views and comments on the IMTP and these will be fed back to the relevant team.<br>• The Group received an update on the Clinical Strategy as a blueprint for large scale service redesign and agreed the importance of members to provide input and make comments.<br>• An overview of the current issues faced by the Welsh Ambulance Service Team (WAST) were highlighted. |

|  | <ul><li>In terms of the Partnership Strategy, the Chair highlighted the importance of having strategic partnership and engagement with partners.</li><li>It was noted that the current discussions taking place with the SRG, the Board and the stakeholders are around what does good look like, taking into account local knowledge and expertise with the aim of building this into a strategic approach.</li><li>There was a discussion regarding consultation with the public and third sector and the need to listen to the views of the public through providing feedback and ensuring there is a connection with the local public.</li><li>It was recognised that there is a need to capture comments from all people within all of the communities which exist and make every effort possible to take all of the comments on board.</li></ul> |
|---|---|
| **Targeted Intervention Improvement Framework Domain addressed** | <ul><li>Strategy, Planning and Performance</li><li>Engagement (patients, public, staff and partners)</li></ul> |
| **Planned business for the next meeting:** | <ul><li>Transformation Programme</li><li>Quality Strategy 2022-2025</li><li>Further items to be confirmed</li></ul> |
| **Date of next meeting:** | Monday 5th September 2022 |

*Advisory Group Chair's Report Template V6.0 May 2021*

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

*To improve health and provide excellent care*

## Committee Chair's Report

| | |
|---|---|
| **Name of Committee:** | **Partnerships, People and Population Health Committee** |
| **Meeting date:** | 12.7.22 |
| **Name of Chair:** | Nichola Callow, Vice Chair of PPPH - Independent Member |
| **Responsible Director:** | Chris Stockport Executive Director Primary Care and Community services |
| **Summary of business discussed:** | The meeting noted and received the following reports:<br><br>• Annual Plan and compliance with the Wellbeing of Future Generations (Wales) Act (2015)<br>• The Digital Strategy Review<br>• Integrated Digital Informatics Assurance Review<br>• Test, Track and Trace Programme Update<br>• The Well North Wales<br>• Planning for workforce Deep Dive<br>• People (Workforce) Performance Report<br>• Medical and Health Sciences school progress update<br>• Chair's Assurance Reports from Strategic and Tactical Delivery Groups<br>• Partnership Meetings - Regional Partnership Board<br>• Corporate Risk Register<br><br>In private session the Committee discussed and contributed to the Penrhos Care Home Public Sector Partnership Report and the Corporate Risk Register in relation to CRR21 – 11 Cyber Security.<br><br>Papers for the meeting can be accessed via the link below:<br>Partnerships, People and Population Health Committee - Betsi Cadwaladr University Health Board (nhs.wales) |
| **Key assurances provided at this meeting:** | • The Committee acknowledged the progress in relation to the annual plan and compliance with the Wellbeing of Future Generations (Wales) Act (2015).<br>• Assurances received regarding progress levels of key points and achievements made, in relation to the Digital Strategy |

Review. The "Partial" achievements and the vulnerabilities of recruitment and retention were to be further revisited in light of the slippage and priorities, as well as the risk exposure (as outlined in the BAF), which was noted to have changed from the time of the original assessment.

- The Committee specifically agreed an action for the Executive Medical Director, Board Secretary and Chief Digital information Officer to the clinical risk exposure associated with the delivery of the digital priorities.

- The Test, Track and Trace Programme update was provided, and in particular the Committee noted the articulate update and recent recruitment changes within the Team. Work was ongoing, in support of other health protection issues, with the support from Welsh Government. It was agreed that the Director of Public Health would provide an assurance report on the flu vaccination programme to the next meeting of the Committee,

- The Committee acknowledged Dr Glynne Roberts' contributions to the "Well North Wales" updates, specifically in relation to supporting inequalities, along with partnership working links.

- At the meeting it was determined that the deep dive briefing paper needed to be strengthened considerably, with further detail needed around problem statements linked to workforce, ensuring that the content is aligned to the strategic risks that fall within the remit of PPPH and PIFG , and mapped through to questions previously poised by the CE/IMs.

- It was agreed that an updated deep dive briefing paper would be in place by the 20th of July 2022, with a view to finalising the report ahead of the August deep dive workshop.

- The Committee received the Workforce Performance Report, and the Committee provided feedback about the reporting format going forwards, for example further detail needed on sickness/absence/gaps in banding grade/length of time individuals stay in post before being promoted.

- Following the Medical and Health Sciences school progress update, the Committee had been assured that a formal paper will be taken to Board when there is further clarify on capital. It was agreed that the risk register for the development should be brought to PPPH.  .

- The Committee acknowledged the ongoing work, in relation to the detail received; via the Chairs Assurance Reports from Strategic and Tactical Delivery Groups, *namely –*

| | |
|---|---|
| | <ul><li>○ Together 4 Mental Health Partnership Board (T4MHPB)</li><li>○ Population Health Group</li><li>○ Executive Delivery Group – Transformation</li></ul><ul><li>Assurances received regarding four recent Partnership Meetings, (Regional Partnership Board Meetings) – via the NW Regional Collaborate Lead and BCU Health Board Lead.</li></ul><ul><li>In respect of the Corporate Risk Register, the Committee noted progress regarding the management of the Corporate Risks and of the new escalated risk aligned to the Committee.</li></ul> |
| **Key risks including mitigating actions and milestones** | <ul><li>The Committee discussed the level of "partial" achievements within the Digital Strategy Review, and the vulnerabilities of recruitment and retention. Cross escalation of key drivers, relating to risks on the BAF and CRR would be reviewed.</li></ul><ul><li>In respect of elements of the Digital Informatics Assurance Review. It was agreed to escalate issues, in relation to timescales, funding, clinical risks, delays and progress. Work was ongoing to understand the extent of the specific risks.</li></ul><ul><li>The Committee expressed concern regarding the new Estates Strategy (now Asset Management Strategy, AMS) not being available to the Committee, but noted that a draft would be circulated to committee members ahead of the October meetings.</li></ul><ul><li>The committee requested that the draft AMS paper incorporate an overview of current and potential risks associated with delivery.</li></ul><ul><li>Lastly, the Committee requested a specific assessment of the impact of the delayed completion of the strategy on enabling strategies, such as the clinical service strategy, action plans (for example carbon reduction), and statutory compliance requirements, noting the Health and Safety Act update provided by the Executive Director of Workforce and Organisational Development.</li></ul> |
| **Matters requiring escalation to the Board:** | The Board's attention is drawn to the escalate the non-delivery of the AMS over a period of 14 months, which has adversely impacted on the effectiveness of the Committee<br><br>In this instance, the Committee is requesting the Chief Executive to provide assurances that the strategy will be issued to members ahead of the October meeting.<br><br>This is alongside a clear timeframe of delivery, taking into account the committee's request that this also incorporates a |

| | |
|---|---|
| | robust assessment of the impact of the delay on the development of the clinical services strategy, which is due for Board approval on the 4th of August 2022.<br><br>As a result of the prolonged delay the Committee is also seeking agreement from the Board that going forward any instances resulting in non-delivery of key documents will be escalated to the Chief Executive and Board following one instance of non-compliance |
| **Planned business for the next meeting:** | • Corporate Strategy<br>• Living Healthier, Staying Well Refresh<br>• IMTP<br>• Mental Health Strategy<br>• Board Assurance Framework related to committee<br>• Population Health (Including Adverse Child Experience, Smoking Cessation, Healthy Lives, Well North Wales Inequalities, Alcohol Use, Vulnerable Groups)<br>• People Workforce (People) report / Incorporate Staff survey reports in appendices<br>• Corporate Health at Work<br>• Test, Track and Trace Programme Update<br>• Welsh Language service Annual Monitoring report including WL Standards<br>• Area Planning Board – Substance Misuse – annual report<br>• International Health Annual report<br>• Chairs Assurance Reports from Strategic and Tactical Delivery Groups (for assurance)<br>• Chairs Assurance Reports (for information)<br>• Transformation Fund updates |
| **Date of next meeting:** | 13.9.22 |
| **Recommendations to the Board** | The Board is asked to :<br><br>• Note and receive the PPPH Chair's report<br>• Note and agree the proposed approach to the escalation pertaining to the AMS strategy<br>• Note and approve the recommendation pertaining to the escalation approach from Committees |

| Health Board<br><br>28/07/2022 | GIG CYMRU NHS WALES \| Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board<br><br>*To improve health and provide excellent care* |
|---|---|

## Audit Committee: Chair's Report

| Name of Committee: | Audit Committee |
|---|---|
| Meeting date: | 30/06/22; 13/07/22 and 22/07/22 |
| Name of Chair: | Richard Medwyn Hughes, Independent Member |
| Responsible Director: | Molly Marcu, Interim Board Secretary |
| Summary of business discussed: | **30/06/22 Meeting**<br>• Minutes and Action log review from the previous meeting (public and private).<br>• Details of Breaches in terms of publication of Board/Committee papers.<br>• Private Session Items Reported in Public Report.<br>• Executive Director of Finance verbal briefing on Financial Accounts<br>• External Audit progress update report and Audit Plan for 2022/23<br>• Internal Audit Progress update report together with five limited assurance reports (listed below) and Head of Internal Audit Opinion and Annual Report 2021/22<br>• Claims Report (public and private session)<br>• Clinical Audit Plan (verbal briefing)<br>• Risk Management Strategy<br>• Chair's Assurance Report – Risk Management Group<br>• Corporate Risk Register (public and private session)<br>• Operational Scheme of Reservation and Delegation<br>• Financial Conformance Report and bi-annual update of details of Chair's actions<br>• Local Counter Fraud Annual Work Plan<br>• Update on Internal and External Audit actions (Tracker Tool)<br>• Revised Performance and Accountability Framework (verbal briefing)<br><br>**13/07/22 Meeting (private session)**<br>• Financial Accounts<br>• End of Year Reporting<br>• Risk Management Strategy Updated<br><br>**22/07/22 Meeting (private session)**<br>• Accountable Officer recommendations to the Audit Committee<br>• Consideration of Audit Wales report recommendations |

| Key assurances provided at the meetings: | The Audit Committee:<br>• Received and noted the External Audit Progress update and approved the Annual Plan. With regard to the Structured Assessment for 2022, fieldwork was to commence in July, with a draft report to be issued in the autumn. Members' attention was also drawn to the work undertaken by Audit Wales regarding NHS related national studies and related products and in particular the 'Tackling Planned Care Backlog in Wales' findings.<br>• Received and noted the Internal Audit Progress update and endorsed the change in process regarding the issuing of draft reports and removal of issuing discussion draft reports. Members noted the significant improvement in overall management response turnaround times. Members also supported the proposal by Internal Audit to cease issuing 'not applicable' ratings with effect from the 2022/23 financial period.<br>• Received and noted the Chair's Assurance Report from the Risk Management Group.<br>• Approved the Counter Fraud Annual Work Plan<br>• Received the Claims report (public and private session)<br>• Received the Corporate Risk Register (public and private session)<br>• Recommended approval of the revised Operational SORD and implementation approach to the Board<br>• Received the Conformance Report and approved the Losses and Special Payments as detailed therein.<br>• Received the Audit Recommendation Tracker, noted the progress and implementation of actions outlined<br>• Noted the Register of Chair's Actions covering the period up to 13/6/22.<br>• Noted the position regarding the revised Performance and Accountability Framework, which was to be presented to the July Board and would be a key building block of the new Operational Model.<br>• Endorsed the updated Risk Management Strategy for submission and approval by the Board. |
|---|---|
| Key risks including mitigating actions and milestones | The Committee:<br>• Was briefed on the issues relating to the external audit of accounts for 2021/22. As part of the further testing, auditors had identified over £10.3m of expenditure accrued in the 2021/22 period, which related to the 2022/23 financial year and were only one third of the way through the further testing.<br>(It was subsequently identified in early July 2022 that this amount was actually £9.4m, following the identification of duplicated amounts)<br>• As the Health Board's accounts formed part of the consolidated accounts for NHS Wales and Welsh |

| | |
|---|---|
| | Government it had been decided to cease further testing and instead for the accounts to be qualified via a true and fair view, on a limitation of scope basis.<br>• The Committee met on 13<sup>th</sup> July and again on 22<sup>nd</sup> July in private session to receive a further update report on the position relating to the draft accounts given that the audit had not been concluded. An Audit Wales Quality Assurance Check is ongoing to allow the audit to be finalised, approve the accounts and hold the Annual General Meeting. The Auditor General intends issuing a qualifying true and fair opinion, as he has been unable to obtain sufficient appropriate audit evidence that accruals, payables and related expenditure has been properly accounted for in the correct accounting period. Work is ongoing to reduce any residual uncertainty with the balances. As a result of this the Audit Committee have not been able to sign off the Annual Governance Statement or the Annual Report and in lieu of this the Annual General Meeting has had to be deferred thus resulting in the Health Board having breached its Standing Orders.<br>• Concerns were raised in relation to the status of the clinical audit plan which is under review, with a further update to be given to the Committee at the September meeting<br>• Expressed concern at the number of limited assurance internal audit reports being presented (listed below) and expressed concern and disappointment in the limited assurance Head of Internal Audit Opinion.  Progress of the implementation of the actions from each of the audit reviews continued to be closely monitored by the Committee. |
| **Issues to be referred to another Committee** | No matters were referred to another Committee. |
| **Matters requiring escalation to the Board:** | The Committee agreed to bring to the attention of the Board the following limited assurance reports in addition to the limited assurance Head of Internal Audit Opinion for the 2021/22 financial year:-<br>• Waiting List Management<br>• Clinical Audit<br>• Nursing Roster Management – Introduction of e-timesheets for Agency Staff<br>• On-call arrangements<br>• Business Continuity Plans<br><br>The Committee recommended approval of the revised Operational SORD and approach to the Board *(see separate item on the Board Agenda).* |

| | The Committee recommended approval of the updated Risk Management Strategy to the Board. *(See separate item on the Board Agenda).*<br><br>The Committee agreed to bring to the attention of the Board its concerns and dissatisfaction relating to the position regarding the Financial Accounts for 2021/22. |
|---|---|
| **Well-being of Future Generations Act Sustainable Development Principle** | The purpose of the Audit Committee is to advise and assure the Board and the Accountable Officer on whether effective arrangements are in place – through the design and operation of the Health Board's system of assurance. As such, the Committee considers the sustainable development principles in their widest sense but in particular, the focus on progress of internal and external audit reports supports the principle of putting resources into preventing problems occurring or getting worse. |
| **Planned business for the next meeting:** | • Annual Report and Accounts – End of Year Reporting. |
| **Date of next meeting:** | To be confirmed. |

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

*To improve health and provide excellent care*

# Committee Chair's Report

| | |
|---|---|
| **Name of Committee:** | **Performance, Finance and Information Governance Committee** |
| **Meeting date:** | 30.6.22 |
| **Name of Chair:** | John Cunliffe, Independent Member |
| **Responsible Director:** | Sue Hill, Executive Director of Finance |
| **Summary of business discussed:** | The Committee – <br> *Approved* <br><br> *Noted* <br> • Month 2 Finance Report <br> • Shared Services Partnership Assurance Report <br> • Capital Programme Monitoring Report <br> • Procurement of Construction Consultant Framework <br> • Quality & Performance Report to 31.05.22 <br> • Planned Care Status Report <br> • Unscheduled Care <br> • Business Case Tracker <br> • AAA Report on Information Governance Group |
| **Key assurances provided at this meeting:** | *Finance* <br><br> • The Month 2 Finance Report highlighted a £0.9m deficit in month with a £2.2m deficit year-to-date. This was a slightly improved position on Month 1 and the forecast is still a break-even position. <br> • Savings have not been fully identified to meet the target for the year. There is a high level of expectation that a workshop on 11th July to review savings targets, will provide more, tangible savings <br> • In relations to Covid, there were no cost implications associated with closing the field hospitals. |

- It was noted that CHC and FNC costs have increased. The committee was advised that at the most recent Accountability Review meeting, the West team had intimated they would look at the best practices of the East team (who had reduced their CHC costs considerably, without impacting on the quality of care pre-Covid).
- The Executive Director of Finance agreed to provide an itemised listing of all planned savings, including the amounts involved and who is responsible for delivering them.

*NWSSP*

- The NWSSP Recruitment Modernisation Plan is expected to improve performance by shortening the time between creating a vacancy and providing an unconditional offer
- Performance responding to internal audit reports was noted as 53% against an 80% target. However the committee was advised that it had now improved to 70%.

*Capital*

- Executive Director of Finance advised the Committee that an update on revised reporting would be brought to the October meeting.
- The Committee was advised that for the £250m Ysbyty Gwynedd Infrastructure Compliance (YGIC) risk, mitigating measures had been implemented following dialogue with North Wales Fire & Rescue. Further discussions had been held with Welsh Government and a response was awauted.

*Planned Care*

- Following new Welsh Government ministerial targets for Planned Care, the trajectories in the IMTP are being revised. Once agreed with the WG delivery unit they would be brought back through the board governance processes.

*Unscheduled Care*

- There are problems with the 111 service failing to direct people to Preswylfa's MIU centre (and causing increased pressure at Wrexham ED). Ongoing discussions with WAST may release some of their staff to help keep the Preswylfa MIU open and allow 111 to direct people there.
- Work is underway to define a consistent MIU service offer which will enable the 111 and ambulance service to refer to them.

*Business Case Tracking*

| | |
|---|---|
| | • The Committee was advised that partners were being sought to progress the Residential Accommodation business case (of £55.8m) as joint ventures were not permitted. |
| **Key risks including mitigating actions and milestones** | • Publishing of the 2021/22 accounts has been delayed and work with Audit Wales was progressing. <br><br> • Lack of identified savings (in particular transformational savings) required to deliver priorities in the IMTP. Focussed meetings with executive leads were taking place to identify savings required. <br><br> • The unexpected rise in inflation, particularly around CHC and FNC provision, is causing significant cost pressures. A pan-Wales plan is being sought to approach this and NWSSP is doing strategic work to identify specific areas of concern. <br><br> • There is a risk that new planned care targets set by Welsh Government might not be achievable. Analysis suggestes that orthopaedics, dermatology, urology, orthodontics, gynaeclogy and general surgery will be significantly challenged to reach their targets. To mitigate this a North Wales approach is being sought along with provision of additional clinical sessions through insourcing and outsurcing. <br><br> • The Committee expressed concern that there were still considerable savings to be made and that the actions that could enable these savings to be made had yet to be identified. The Committee requested an itemised listing of all planned savings, the amounts involved who would be responsible for delivering these savings <br><br> • Pay settlements may present a risk as the current nationally agreed 3% pay increase was unlikely to be accepted by the trade unions. Further guidance from Welsh Government is awaited. <br><br> • Through the Quality & Performance report, the lack of clinical engagement was identified as a threat. There are pockets where clinical ownership of real performance and quality issues is a problem. The committe were advised that the operating model and other initiatives were starting to embed better clinical leadership. |
| **Issues to be referred to another Committee** | None |

| | |
|---|---|
| **Matters requiring escalation to the Board:** | None |
| **Planned business for the next meeting:** | |
| **Date of next meeting:** | 25.8.22 |

V0.2

| Cyfarfod a dyddiad:<br>Meeting and date: | Health Board<br>04.08.2022 | | | | | |
|---|---|---|---|---|---|---|
| Cyhoeddus neu Breifat:<br>Public or Private: | Public | | | | | |
| Teitl yr Adroddiad<br>Report Title: | Integrated Quality & Performance Report (IQPR) to 31.05.2022 | | | | | |
| Cyfarwyddwr Cyfrifol:<br>Responsible Director: | Sue Hill,<br>Executive Director of Finance | | | | | |
| Awdur yr Adroddiad<br>Report Author: | Edward Williams,<br>Deputy Director of Performance Assurance | | | | | |
| Craffu blaenorol:<br>Prior Scrutiny: | The data and information in this report was reviewed by the Performance, Finance & Information Governance Committee in June 2022, and by the Quality, Safety & Experience (QSE) Committee on 05.07.2022. | | | | | |
| Atodiadau<br>Appendices: | None | | | | | |
| **Argymhelliad / Recommendation:** | | | | | | |
| The Health Board is asked to scrutinise the report. | | | | | | |
| **Ticiwch fel bo'n briodol / Please tick as appropriate** | | | | | | |
| Ar gyfer<br>penderfyniad /cymeradwyaeth<br>For Decision/<br>Approval | | Ar gyfer<br>Trafodaeth<br>For<br>Discussion | | Ar gyfer<br>sicrwydd<br>For<br>Assurance | ☞ | Er<br>gwybodaeth<br>For<br>Information |
| Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol<br>Y/N to indicate whether the Equality/SED duty is applicable | | | | | N | |

**Sefyllfa / Situation:**

This report is the first publication of the IQPR and reflects the ambition of the Health Board in moving to utilise technology to gain greater insight into performance across North Wales. The report has been built in Microsoft PowerBI and is a product of close collaboration between the performance and informatics teams.

The report is based on the Hywel Dda model and utilises NHS Improvement's 'Making data count' methodology by presenting data in statistical process control (SPC) charts where appropriate. This report provides the capability to access data at integrated health community level as well as at a Health Board level.

This is the first phase of the development. The next phase, now underway is to build committee level views.

The report will be under continued review and improvement until such a time when all stakeholders are satisfied it meets the needs of Health Board and its committees. At this point the report will then be published in both Welsh and English and will be accessible via different platforms, such as tablets and smartphones.

**Cefndir / Background:**

The National Performance Framework combines the old National Delivery Framework and the new Ministerial Priority Measures and is aligned to the Quadruple Aims set out in 'A Healthier Wales', Welsh Government's long term plan for health and social care. However, to provide clearer focus, the structure of the IQPR is aligned to the Health Boards current high priority areas.

A full 'User Guide' is included within the Report.

The user can 'click' through to each measure from the graphics or from the menu on the left hand side. Alternatively, the user can search for a particular measure using the search tool in the top right hand corner.

The graphic summary page of the IQPR sets out performance against the key measures contained within the 2022/23 Welsh Government National Performance Framework and that are key priority areas for the Health Board.

**Asesu a Dadansoddi / Assessment & Analysis**

**Goblygiadau Strategol / Strategy Implications**

The National Performance Measures align to the National Performance Framework and Ministerial Priorities, which support 'A Healthier Wales' and the Health Board's Plan.

**Opsiynau a ystyriwyd / Options considered**

After a number of constructive workshops and meetings with Board members, development continues on the suite of performance reports presented to the Board and Committees.

We are implementing an automated process which will support a Health Board performance dashboard with functionality to drill down into integrated health community data to support evidence based decision making.

The quarterly accountability reviews are ongoing and any changes agreed as part of the operating model discussions will be reflected in both the future accountability reviews and the revised performance reports.

**Goblygiadau Ariannol / Financial Implications**
The delivery of the measures contained within the Health Board's Annual Plan will have direct and indirect impact on the financial position of the Board.

**Dadansoddiad Risk / Risk Analysis**
The COVID-19 pandemic has produced a number of direct and indirect risks to the delivery of care across the healthcare system.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance**
This report will be available to the public in both interactive and PDF formats once published for the Health Board.

**Asesiad Effaith / Impact Assessment**
The Equality Impact Assessment and Socio-economic duties Impact Assessments will be completed before the next presentation of the report in September 2022.

## Summary for Inaugural IQPR

**Welcome** to the first draft of the new Integrated Quality & Performance Report (IQPR) for Health Board. There are 30 measures included in this first phase of development. Further measures, and a cut of measures for each of the scrutinising committees* will be added as the development progresses over the next three committee cycles.

Using Microsoft PowerBI to create the report enables it to be interactive. You can either, follow each link to locate the measure you would like to view, or you can search for a measure using the search bar. Most of the measures can be 'drilled' through to Integrated Health Community (IHC) level (i.e. West, Centre and East). Eventually, as the development progresses, IHC level data will be available for all measures.
Where appropriate, there is a Statistical Process Control Chart (SPC) for each of the measures.
This chart shows where there has been a significant variation in performance and whether this variation is good or bad. A narrative accompanying each chart provides further information regarding performance against the measure.
The report employs the 'Making Data Count' methodology from NHS Improvement to provide objective and easy interpretation of the charts.

The report utilises Risk Management tools and methodologies to illustrate areas requiring focus and attention, whilst providing assurance on the remainder of the measures.

We will continuously develop and improve the IQPR throughout 2022-23 and it will be coupled to the Integrated Medium Term Plan (IMTP) Monitoring Report for 2022-25 (due for first presentation in August 2022).

Production of the IQPR is a continuous collaboration between the Performance Directorate and Informatics Business Intelligence Teams.

*Performance, Finance & Information Governance Committee*
*Quality, Safety & Experience Committee*
*Partnerships, People & Population Health Committee*

# Graphic Array - Overall Summary

## Planned Care

| | |
|---|---|
| **Cancer 62...** Recent Value 62.31% Cancer 62DAY | **Diagnostic...** Recent Value 8,399 Diagnostics 8WEEKS |
| **Eye Care ...** Recent Value 44.39% Eye Care Measure | **Follow-up ...** Recent Value 56,714 Follow-up Overdue |
| **Follow-up ...** Recent Value 191,532 Follow-up Total | **RTT 104W...** Recent Value 16,820 RTT 104WEEKS |
| **RTT 26WE...** Recent Value 51.56% RTT 26WEEKS | **RTT 36WE...** Recent Value 63,290 RTT 36WEEKS |
| **RTT 52WE...** Recent Value 43,481 RTT 52WEEKS | **Therapy 1...** Recent Value 6,682 Therapy 14WEEKS |

## Unscheduled Care

| | |
|---|---|
| **Ambulance ...** Recent Value 1,884 Ambulance Handovers | **Ambulance ...** Recent Value 49.70% Ambulance Red Calls |
| **ED 12HRS** Recent Value 3,253 ED 12HRS | **ED 24HRS** Recent Value 1,117 ED 24HRS |
| **ED&MIU 4H...** Recent Value 59.75% ED&MIU 4HRS | **Stroke 4HRS** Recent Value 13.60% Stroke 4HRS |

## Workforce

| |
|---|
| **Mandato...** Recent Value 84.70% Mandatory Training |
| **PADR** Recent Value 65.27% PADR |
| **Sickness** Recent Value 6.48% Sickness Absence |

## Efficiency

| |
|---|
| **CC DTOC** Recent Value 29.90% CC DTOC |
| **Sepsis ED** Recent Value 22.73% Sepsis ED |
| **Sepsis IP** Recent Value 26.32% Sepsis IP |

## CAMHS

| |
|---|
| **CAMHS Assess** Recent Value 25.00% CAMHS Assess |
| **CAMHS CTP** Recent Value 93.30% CAMHS CTP |
| **CAMHS Therapy** Recent Value 18.18% CAMHS Therapy |

## Primary Care

| | | | |
|---|---|---|---|
| **NHS GP** Access to GP's | **Pharmacy Escalation** | **GP Referrals UPCC** | **ED Referrals - UPCC** |
| **EPS** Pharmacy Enhanced Services | Primary Care Complaints | MEDICAL REPORT Primary Care Incidents | |

## Adult Mental Health

| | |
|---|---|
| **AMH Assess** Recent Value 62.45% AMH Assess | **AMH Psych** Recent Value 64.41% AMH Psych |
| **AMH Thera...** Recent Value 78.49% AMH Therapy | **AMH CTP** Recent Value 86.70% AMH CTP |

# Summary

| Measure | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|
| Number of Ambulance Handovers over 1 Hour | 0 | 0 | 2022-05 | 1,884 | | | |
| Number of Emergency Department patients waiting over 12 hours | 0 | 0 | 2022-05 | 3,253 | | | |
| Number of Emergency Department patients waiting over 24 hours | 0 | 0 | 2022-05 | 1,117 | | | |
| Number of patients waiting for a follow-up outpatient appointment | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 2022-05 | 191,532 | | | F |
| Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100% | 30% reduction on March 2021 [West <=5741] [Central<=19916] [East<=11492] | 30% reduction on March 2021 [West <=5741] [Central<=19916] [East<=11492] | 2022-05 | 56,714 | | | |
| Number of patients waiting more than 104 weeks for treatment | 0 | 0 | 2022-05 | 16,820 | | | |
| Number of patients waiting more than 14 weeks for a specified therapy | 0 | 0 | 2022-05 | 6,682 | | | |

# Summary

| Measure | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|-----------|----------|--------------|--------------|----------------|----------|----------|
| Number of patients waiting more than 36 weeks for treatment | 0 | 0 | 2022-05 | 62,866 | | | |
| Number of patients waiting more than 52 weeks for treatment | 0 | 0 | 2022-05 | 43,481 | | | |
| Number of patients waiting more than 8 weeks for a specified diagnostic test | 0 | 0 | 2022-05 | 8,399 | | | |
| Percentage Adults assessed within 28 Days of referral | >= 80% | >= 80% | 2022-05 | 62.45% | | | |
| Percentage Adults starting therapy within 28 days of assessment | >= 80% | >= 80% | 2022-05 | 78.49% | | | |
| Percentage Adults waiting less than 26 weeks for psychological therapy | >= 80% | >= 80% | 2022-05 | 64.41% | | | |
| Percentage CAMHS assessed within 28 Days of referral | >= 80% | >= 80% | 2022-04 | 25.00% | | | |
| Percentage CAMHS starting therapy within 28 days of assessment | >= 80% | >= 80% | 2022-04 | 18.18% | | | |

# Summary

| Measure | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|
| Percentage compliance with Sepsis Six 1 hour bundle - Emergency Department | =12m improvement trend | =12m improvement trend | 2022-05 | 22.73% | | | |
| Percentage compliance with Sepsis Six 1 hour bundle - inpatients | =12m improvement trend | =12m improvement trend | 2022-05 | 26.32% | | | |
| Percentage of Critical Care beddays lost to Delayed Transfers | <=5% | <=5% | 2022-03 | 29.90% | | | |
| Percentage of Emergancy Department patients waiting less than 4 Hours | >= 95% | >= 95% | 2022-05 | 59.75% | | | |
| Percentage of patients starting treatment for cancer within 62 days | >=75% | >=75% | 2022-05 | 62.31% | | | |
| Percentage of patients waiting less than 26 weeks for treatment | >= 95% | >= 95% | 2022-05 | 50.82% | | | |
| Percentage of sickness absence rate of staff | <=5% | <=5% | 2022-05 | 6.48% | | | |
| Percentage Ophthalmology patients within 25% excess of target date | >= 95% | >= 95% | 2022-05 | 44.39% | | | |
| Percentage Over 18 with Care Treatment Plan | >= 90% | >= 90% | 2022-04 | 93.30% | | | |

# Summary

| Measure | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|-----------|----------|--------------|--------------|----------------|----------|----------|
| | | | | | M A M J J A S O N D J F M | | |
| **Percentage Red call Ambulance arrivals within 8 minutes** | >= 65% | >= 65% | 2022-05 | 49.70% | | | |
| **Percentage Stroke patients admitted to Stroke Unit within 4 Hours** | >=47% | >=47% | 2022-05 | 13.60% | | | |
| **Percentage under 18 with Care Treatment Plan** | >= 90% | >= 90% | 2022-05 | 86.70% | | | |

# Unscheduled Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|------|-----------|----------|--------------|--------------|----------------|----------|----------|
| **Number of Ambulance Handovers over 1 Hour** | **BCU** | 0 | 0 | 2022-05 | 1,884 | | | |
| | **West** | 0 | 0 | 2022-05 | 526 | | | |
| | **Central** | 0 | 0 | 2022-05 | 818 | | | |
| | **East** | 0 | 0 | 2022-05 | 540 | | | |
| **Number of Emergency Department patients waiting over 12 hours** | **BCU** | 0 | 0 | 2022-05 | 3,253 | | | |
| | **West** | 0 | 0 | 2022-05 | 679 | | | |
| | **Central** | 0 | 0 | 2022-05 | 1,335 | | | |
| | **East** | 0 | 0 | 2022-05 | 1,239 | | | |

# Unscheduled Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| **Number of Emergency Department patients waiting over 24 hours** | BCU | 0 | 0 | 2022-05 | 1,117 | | | |
| | West | 0 | 0 | 2022-05 | 227 | | | |
| | Central | 0 | 0 | 2022-05 | 313 | | | |
| | East | 0 | 0 | 2022-05 | 577 | | | |
| **Percentage of Emergancy Department patients waiting less than 4 Hours** | BCU | >= 95% | >= 95% | 2022-05 | 59.75% | | | |
| | West | >= 95% | >= 95% | 2022-05 | 68.33% | | | |
| | Central | >= 95% | >= 95% | 2022-05 | 60.94% | | | |
| | East | >= 95% | >= 95% | 2022-05 | 48.68% | | | |

# Unscheduled Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| Percentage Red call Ambulance arrivals within 8 minutes | BCU | >= 65% | >= 65% | 2022-05 | 49.70% | | | |
| | West | | | | | | | |
| | Central | | | | | | | |
| | East | | | | | | | |
| Percentage Stroke patients admitted to Stroke Unit within 4 Hours | BCU | >=47% | >=47% | 2022-05 | 13.60% | | | |
| | West | >=47% | >=47% | 2022-05 | 6.70% | | | |
| | Central | >=47% | >=47% | 2022-05 | 20.70% | | | |
| | East | >=47% | >=47% | 2022-05 | 10.30% | | | |

# SPC Charts for Unscheduled Care Measures



**Number of Ambulance Handovers over 1 Hour**
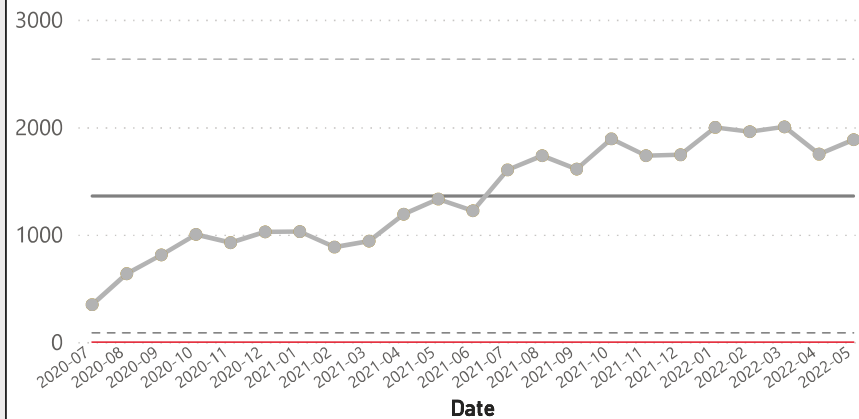
**Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge**
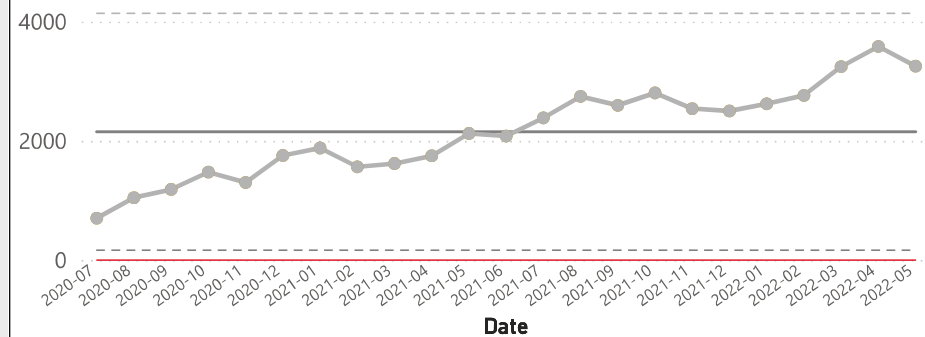
**Number of patients who spend 24 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge**
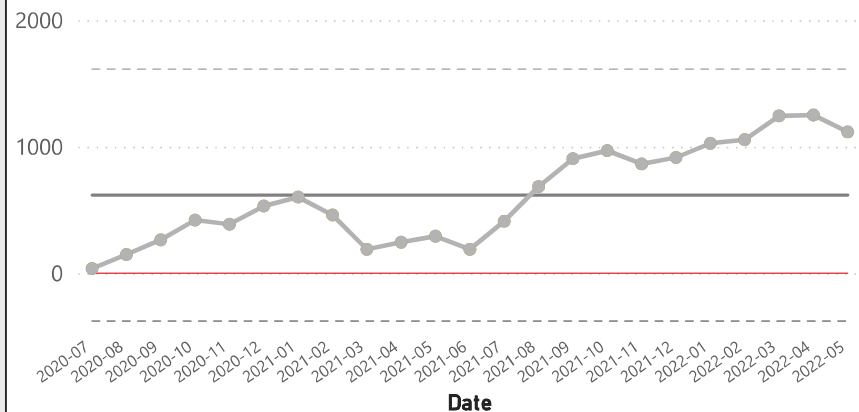
**Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge**
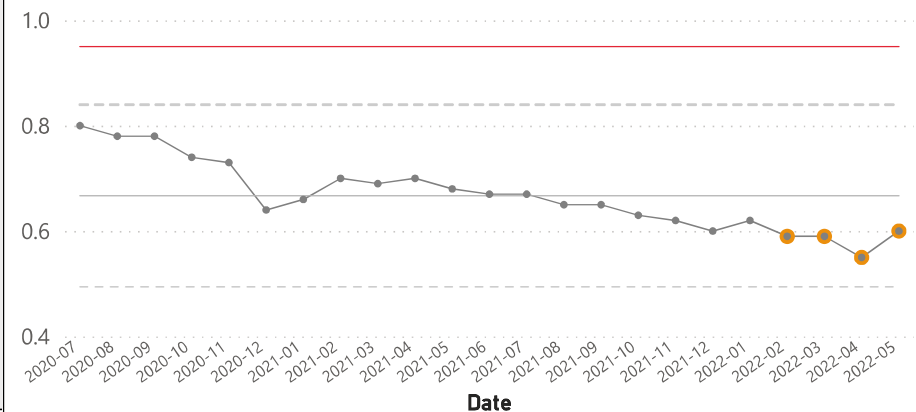
Actual ———  Target ———  Average ———  Upper Control Limit -------  Lower Control Limit -------

# SPC Charts for Unscheduled Care Measures

## Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes
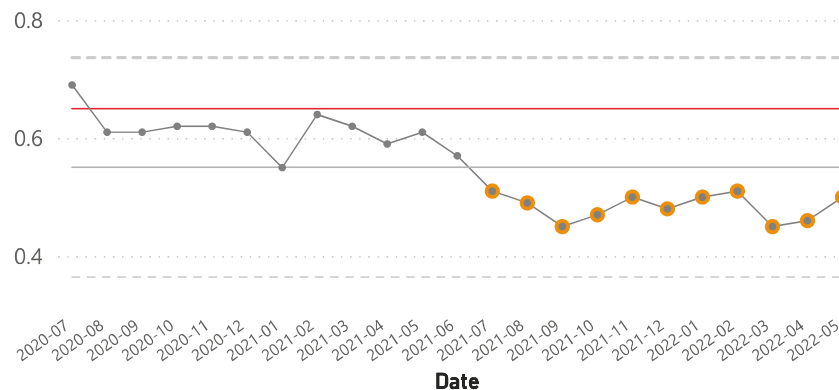


## Percentage of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patients clock start time



## Number of Ambulance Handovers over 1 Hour



## Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge



Actual ——— Target ——— Average ——— Upper Control Limit - - - - - - - Lower Control Limit - - - -

*Page 11*

# Narrative for Unscheduled Care Measures

### What are the key issues/ drivers for why performance is where it is?

The business case was approved by Performance, Finance & Information Governance (PFIG) Committee in March 2021 and articulated benefits as follows:
ensures detection and management of Atrial Fibrillation enabling prevention of 78 strokes Year 2, enables 37% earlier discharges of current Strokes (515 in 2019/20), enables 12% reduced bed days (2,575 in 2019/20), enables reduced Length of Stay (LOS) of 5 days per site, ensures that eligible patients offered thrombolysis 24/7 achieved within the first six months of additional Specialist nurses and SSNAP clerks in post, to support achievement of:
40% improvement in door to needle times
25% improvement in 1 hour Computed Tomography (CT) scanning improved compliance with Welsh Government (WG) targets and Sentinel Stroke National Audit Programme (SSNAP) level improvement to consistent B Level across all sites.
Delay in triage at front door due to pressures, Delays with CT requests, Swallowing assessment within 4 hrs not being undertaken, Delay in out of hours review by medics.
Lack of available Stroke Assessment Bed due to: Site pressures, Inability to discharge due to lack of peripheral hospital beds and lack of care package support in the community, Stroke Specialist Nurse vacancies.

### What actions are being taken to improve performance and by who?

These performance improvements are dependent on the full implementation of Phase 1 of the Stroke Service Improvement Programme: Early Supported Discharge (ESD) service in Quarter 4 of 2021/22 Inpatient Rehabilitation at 3 community sites, Eryri, West, end March 2022, East and Central sites by September 2022 (paper drafted for February Executive Management Group (EMG) to confirm sites) waiting CHC sign off Roll out of improved Atrial Fibrillation (AF) management and detection, speedily initiated anticoagulation and robust monitoring Improved Acute service response through additional Specialist Stroke Nurse roles  Further improvements in performance will be enabled through the Hyper Acute pathway, currently in development for Phase 2 implementation.  Delivering the straight to test CT across the 3 sites and a meeting with WAST is arranged 14.6.22. Ring-fencing of acute stroke beds by Lead Clinical Site Managers on all 3 sites to achieve 4 hour time to ASU target, in addition part of the daily system lead tasks. Monthly breach analysis reports continue to be shared with the MDT, with review of actions at the monthly locality Stroke Improvement Group reporting to the performance meeting chaired by ID and the Steering Group chaired by ID.

### When performance is going to improve by and by how much?

Improved accountability meetings across each site will see delivery of site improvement plans Ring fenced protected beds will ensure improvements happen at pace Work on Swallow assessments in ED are being completed by site ED Teams with further training rolled out Performance improvements are expected to start by middle of 2022/23 and tracking is being put in place. In line with Integrated Medium Term Plan (IMTP), a review of financial commitments and performance will be undertaken mid-year and appropriate adjustments made. The full performance improvement would be 2023/24.

### What are the risks to this timeline?

### What are the mitigations in place for those risks?

Performance improvement in SSNAP scores is expected to start in April the ESD service will be building up across the 3 Areas, enabling a managed return home and rehab support at home for people following Stroke, and the West Rehabilitation unit will be live. East and Central Rehabilitation units will be ready by end Quarter 2 and the full ESD team and acute nursing team will be in place by end Quarter 1.  Weekly analysis and actions from data Right Patient right bed first time dashboard at YGC as part of SMART boards Job planning as part of reconfiguration

# Narrative for Unscheduled Care Measures

## What are the key issues/ drivers for why performance is where it is?

The business case was approved by Performance, Finance & Information Governance (PFIG) Committee in March 2021 and articulated benefits as follows:

ensures detection and management of Atrial Fibrillation enabling prevention of 78 strokes Year 2, enables 37% earlier discharges of current Strokes (515 in 2019/20), enables 12% reduced bed days (2,575 in 2019/20), enables reduced Length of Stay (LOS) of 5 days per site, ensures that eligible patients offered thrombolysis 24/7 achieved within the first six months of additional Specialist nurses and SSNAP clerks in post, to support achievement of:

40% improvement in door to needle times

25% improvement in 1 hour Computed Tomography (CT) scanning improved compliance with Welsh Government (WG) targets and Sentinel Stroke National Audit Programme (SSNAP) level improvement to consistent B Level across all sites.

Delay in triage at front door due to pressures, Delays with CT requests, Swallowing assessment within 4 hrs not being undertaken, Delay in out of hours review by medics.

Lack of available Stroke Assessment Bed due to: Site pressures, Inability to discharge due to lack of peripheral hospital beds and lack of care package support in the community, Stroke Specialist Nurse vacancies.

## What actions are being taken to improve performance and by who?

These performance improvements are dependent on the full implementation of Phase 1 of the Stroke Service Improvement Programme: Early Supported Discharge (ESD) service in Quarter 4 of 2021/22 Inpatient Rehabilitation at 3 community sites, Eryri, West, end March 2022, East and Central sites by September 2022 (paper drafted for February Executive Management Group (EMG) to confirm sites) waiting CHC sign off Roll out of improved Atrial Fibrillation (AF) management and detection, speedily initiated anticoagulation and robust monitoring Improved Acute service response through additional Specialist Stroke Nurse roles  Further improvements in performance will be enabled through the Hyper Acute pathway, currently in development for Phase 2 implementation.  Delivering the straight to test CT across the 3 sites and a meeting with WAST is arranged 14.6.22. Ring-fencing of acute stroke beds by Lead Clinical Site Managers on all 3 sites to achieve 4 hour time to ASU target, in addition part of the daily system lead tasks. Monthly breach analysis reports continue to be shared with the MDT, with review of actions at the monthly locality Stroke Improvement Group reporting to the performance meeting chaired by ID and the Steering Group chaired by ID.

## When performance is going to improve by and by how much?

Improved accountability meetings across each site will see delivery of site improvement plans Ring fenced protected beds will ensure improvements happen at pace Work on Swallow assessments in ED are being completed by site ED Teams with further training rolled out Performance improvements are expected to start by middle of 2022/23 and tracking is being put in place. In line with Integrated Medium Term Plan (IMTP), a review of financial commitments and performance will be undertaken mid-year and appropriate adjustments made. The full performance improvement would be 2023/24.

## What are the risks to this timeline?

## What are the mitigations in place for those risks?

Performance improvement in SSNAP scores is expected to start in April the ESD service will be building up across the 3 Areas, enabling a managed return home and rehab support at home for people following Stroke, and the West Rehabilitation unit will be live. East and Central Rehabilitation units will be ready by end Quarter 2 and the full ESD team and acute nursing team will be in place by end Quarter 1.  Weekly analysis and actions from data Right Patient right bed first time dashboard at YGC as part of SMART boards Job planning as part of reconfiguration

# Planned Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| Number of patients waiting for a follow-up outpatient appointment | BCU | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 2022-05 | 191,532 | | | F |
| | West | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 2022-03 | 46,065 | | | ? |
| | Central | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 2022-03 | 77,752 | | | ? |
| | East | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 30% reduction on March 2021 [West <=28799] [Central<=53719] [East<=43126] | 2022-03 | 61,476 | | | ? |

# Planned Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|------|-----------|----------|--------------|--------------|----------------|----------|----------|
| | | | | | | M A M J J A S O N D J F | | |
| ⊟ **Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%** | **BCU** | 30% reduction on March 2021 [West <=5741] [Central<=19916] [East<=11492] | 30% reduction on March 2021 [West <=5741] [Central<=1991 6] [East<=11492] | 2022-05 | 56,714 | | | |
| | **West** | 30% reduction on March 2021 [West <=5741] [Central<=19916] [East<=11492] | 30% reduction on March 2021 [West <=5741] [Central<=1991 6] [East<=11492] | 2022-03 | 9,877 | | | |
| | **Central** | 30% reduction on March 2021 [West <=5741] [Central<=19916] [East<=11492] | 30% reduction on March 2021 [West <=5741] [Central<=1991 6] [East<=11492] | 2022-03 | 29,198 | | | |
| | **East** | 30% reduction on March 2021 [West <=5741] [Central<=19916] [East<=11492] | 30% reduction on March 2021 [West <=5741] [Central<=1991 6] [East<=11492] | 2022-03 | 15,740 | | | |

# Planned Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| | | | | | | M A M J J A S O N D J F | | |
| **Number of patients waiting more than 104 weeks for treatment** | BCU | 0 | 0 | 2022-05 | 16,820 | | | |
| | West | 0 | 0 | 2022-05 | 5,323 | | | |
| | Central | 0 | 0 | 2022-05 | 6,041 | | | |
| | East | 0 | 0 | 2022-05 | 5,456 | | | |
| **Number of patients waiting more than 14 weeks for a specified therapy** | BCU | 0 | 0 | 2022-05 | 6,682 | | | |
| | West | 0 | 0 | 2022-03 | 2,023 | | | |
| | Central | 0 | 0 | 2022-03 | 1,955 | | | |
| | East | 0 | 0 | 2022-03 | 2,101 | | | |

# Planned Care - Performance Scorecard

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | M A M J J A S O N D J F | | |
| **Measure** | **Area** | **WG Target** | **BCU Plan** | **Actual Month** | **Actual Value** | **12 Month Trend** | **SPC Var.** | **SPC Ass.** |
| ⊟ **Number of patients waiting more than 36 weeks for treatment** | **BCU** | 0 | 0 | 2022-05 | 62,866 | | | |
| | **West** | 0 | 0 | 2022-05 | 19,027 | | | |
| | **Central** | 0 | 0 | 2022-05 | 22,395 | | | |
| | **East** | 0 | 0 | 2022-05 | 21,868 | | | |
| ⊟ **Number of patients waiting more than 52 weeks for treatment** | **BCU** | 0 | 0 | 2022-05 | 43,481 | | | |
| | **West** | 0 | 0 | 2022-02 | 12,148 | | | |
| | **Central** | 0 | 0 | 2022-02 | 15,378 | | | |
| | **East** | 0 | 0 | 2022-02 | 15,701 | | | |

# Planned Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| Number of patients waiting more than 8 weeks for a specified diagnostic test | BCU | 0 | 0 | 2022-05 | 8,399 | | | |
| | West | 0 | 0 | 2022-03 | 2,023 | | | |
| | Central | 0 | 0 | 2022-03 | 1,955 | | | |
| | East | 0 | 0 | 2022-03 | 2,101 | | | |
| Percentage of patients starting treatment for cancer within 62 days | BCU | >=75% | >=75% | 2022-05 | 62.31% | | | |
| | West | >=75% | >=75% | 2022-05 | 69.63% | | | |
| | Central | >=75% | >=75% | 2022-05 | 53.85% | | | |
| | East | >=75% | >=75% | 2022-05 | 63.20% | | | |

# Planned Care - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|------|-----------|----------|--------------|--------------|----------------|----------|----------|
| Percentage of patients waiting less than 26 weeks for treatment | BCU | >= 95% | >= 95% | 2022-05 | 50.82% | | | |
| | West | >= 95% | >= 95% | 2022-05 | 52.62% | | | |
| | Central | >= 95% | >= 95% | 2022-05 | 51.35% | | | |
| | East | >= 95% | >= 95% | 2022-05 | 50.84% | | | |
| Percentage Ophthalmology patients within 25% excess of target date | BCU | >= 95% | >= 95% | 2022-05 | 44.39% | | | |
| | West | >= 95% | >= 95% | 2022-05 | 95.56% | | | |
| | Central | >= 95% | >= 95% | 2022-05 | 46.00% | | | |
| | East | >= 95% | >= 95% | 2022-05 | 42.42% | | | |

# SPC Charts for Planned Care Measures

## Number of patients waiting for a follow-up outpatient
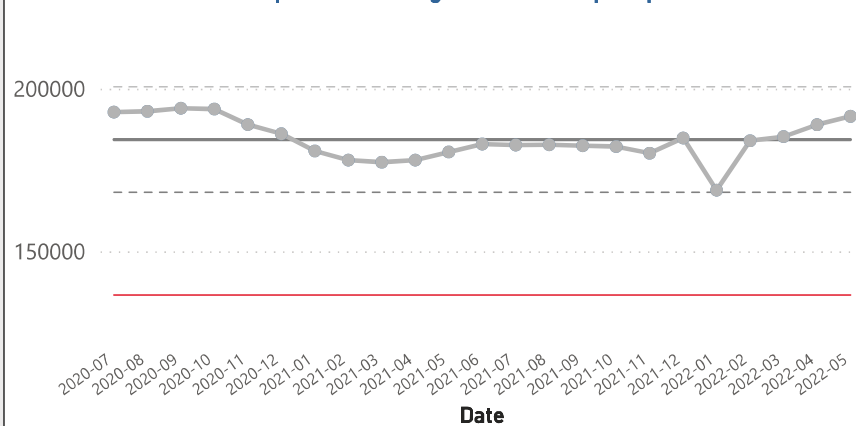


## Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%
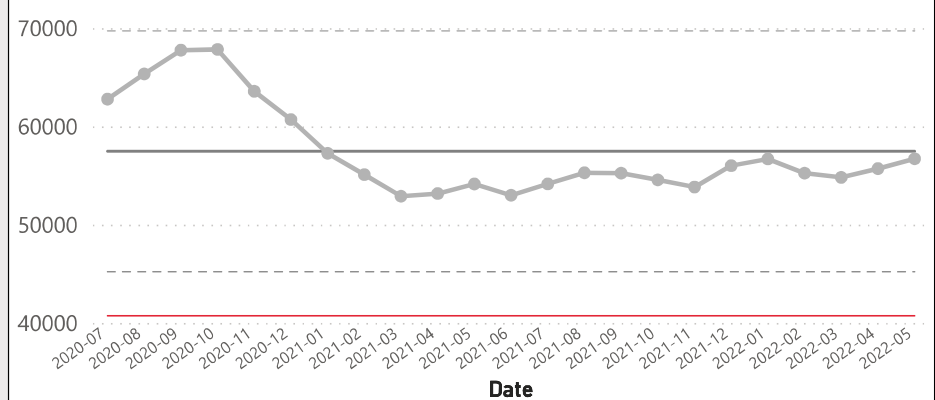


## Number of patients waiting more than 104 weeks for treatment
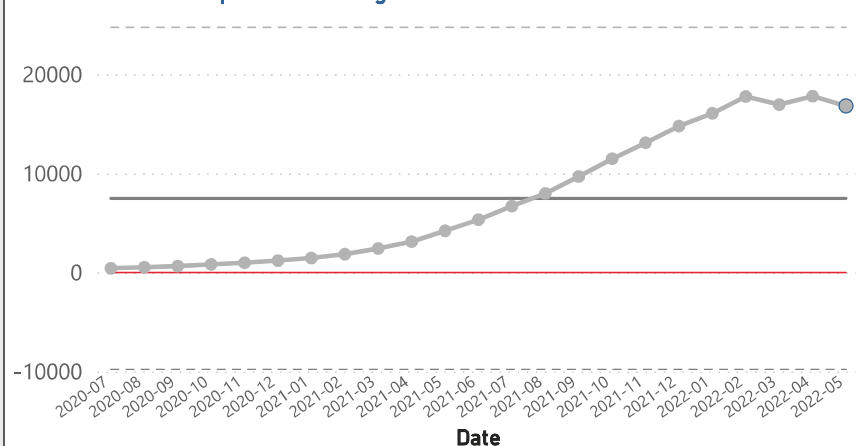


## Number of patients waiting more than 14 weeks for a specified therapy
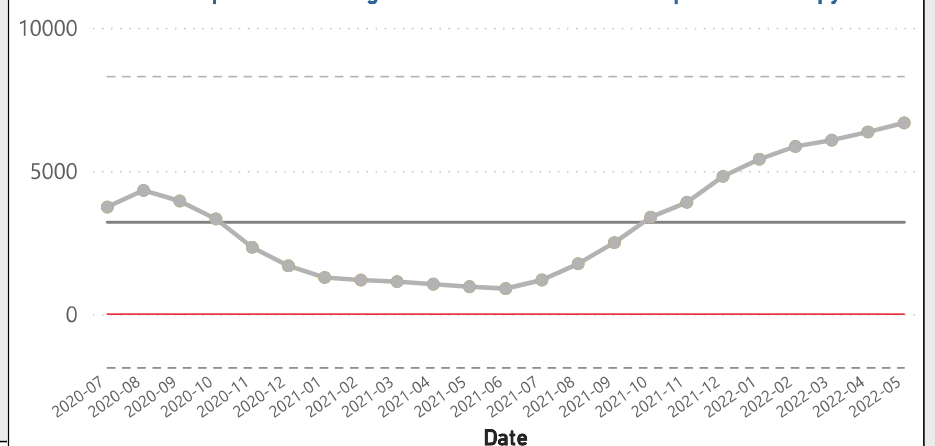


Actual _____  Target _____  Average _____  Upper Control Limit -------  Lower Control Limit -------

# SPC Charts for Planned Care Measures

## Number of patients waiting more than 36 weeks for treatment
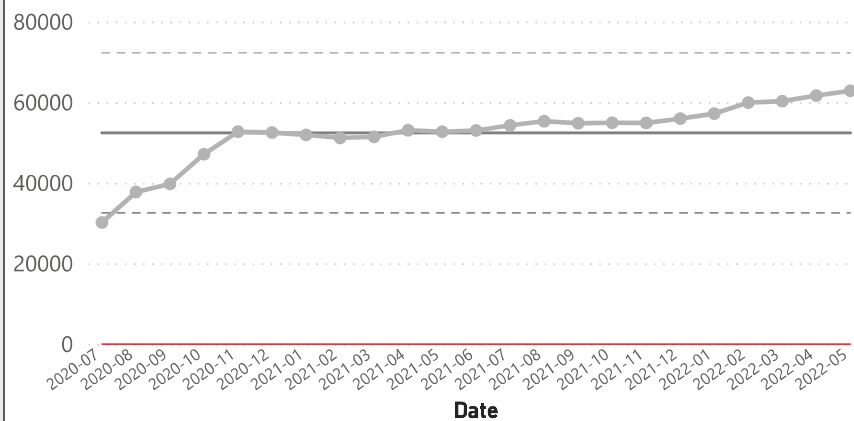


## Number of patients waiting more than 52 weeks for treatment
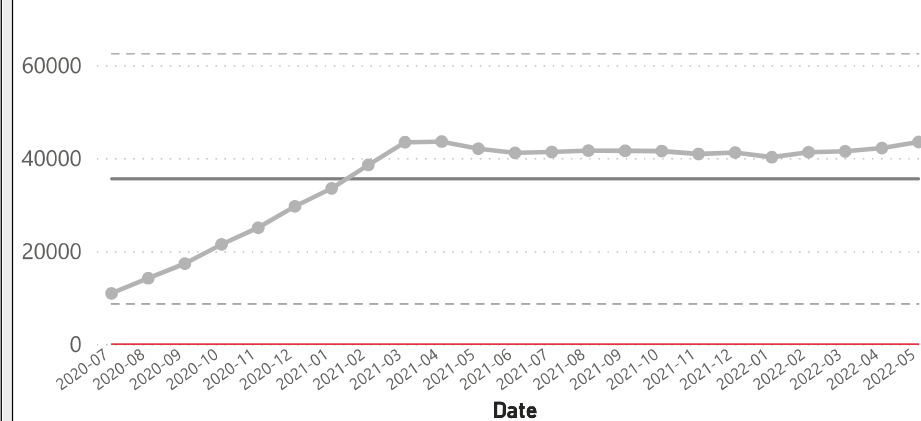


## Number of patients waiting more than 8 weeks for a specified diagnostic
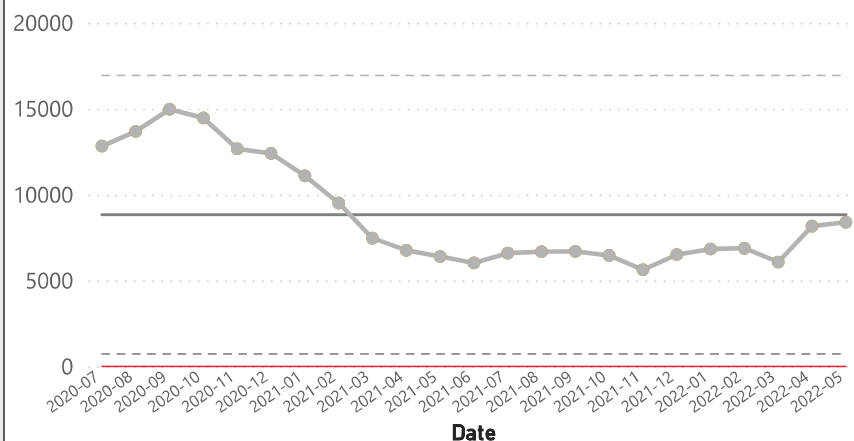


## Percentage of patients starting first definitive cancer treatment within 62 days from point of suspicion
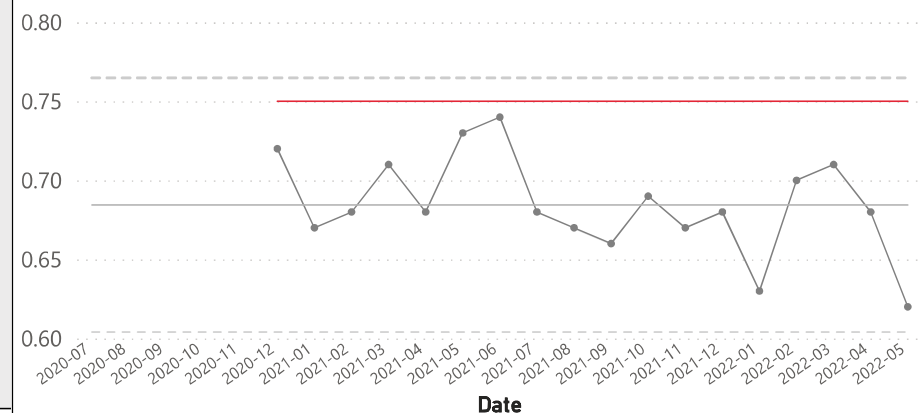


Actual ———  Target ———  Average ———  Upper Control Limit - - - - - -  Lower Control Limit - - - - - -

# SPC Charts for Planned Care Measures

## Percentage of patients waiting less than 26 weeks for treatment



## Percentage of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments
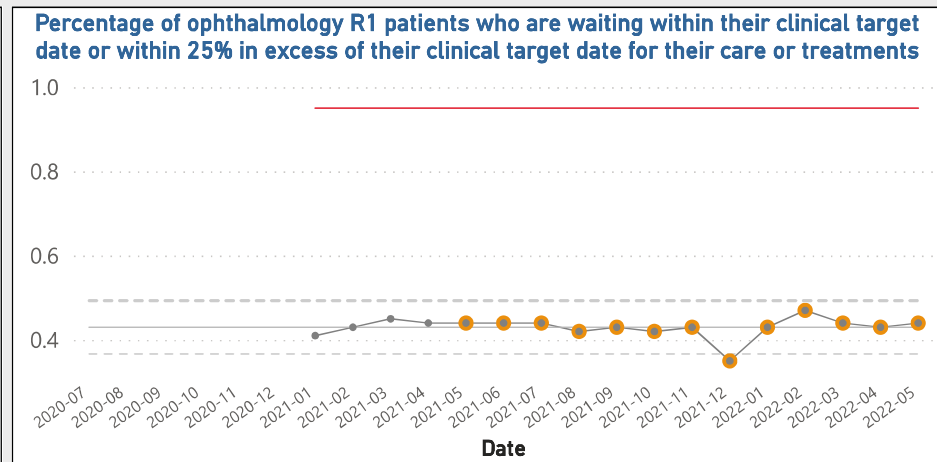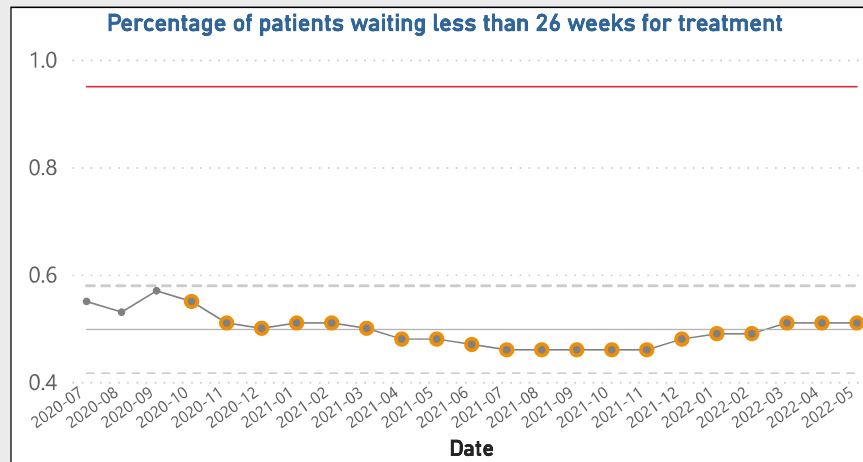


Actual _____  Target _____  Average _____  Upper Control Limit -------  Lower Control Limit -------

# Narrative for Planned Care Measures

### What are the key issues/ drivers for why performance is where it is?
Waits exceeding 2 years for some outpatient appointments
Covid-19 backlog

### What actions are being taken to improve performance and by who?
The local lead and team are engaged nationally (SOS & PIFU National Project Group) in the development and scale up of SOS and PIFU pathways, sharing resources and good practice pan-Wales to deliver an equitable experience for patients. WG have delivered a Best Practice Carousel for SOS and PIFU. The local team directly engage with individual Health Boards in Wales for support and resource share.

### When performance is going to improve by and by how much?
20% of all outpatient reviews will have an outcome of SOS or PIFU, by Mar 2023
All SOS and PIFU pathways in place are standardised pan-BCU, by Mar 2024

### What are the risks to this timeline?
Additional revenue request for Project Manager not granted (WG Outpatient Transformational fund).
Lack of clinical engagement from specialties to implement.
Specific conditions for which an SOS or PIFU pathway will not be suitable
Funding not granted for Project Manager

### What are the mitigations in place for those risks?
Letter sent from Executive Medical Director to all clinicians advising on adoption of SOS/PIFU pathways.
Specific conditions will be reviewed as part of engagement with each speciality and recorded with a reason for the exception to ensure equitability pan-Wales.

# Narrative for Planned Care Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?
Update on validation of WLs:

There is a review of the validation team as they are coming to the end of Phase 1. They have reviewed patients within S1 at East and subsequently Central, which is in addition to the internal validation that takes place as Business as Usual. A meeting has taken place with Source (External Validation) to determine productivity, value for money and ensure that this is reflected within agreed KPI metrics. Patients that have been contacted via phone calls have identified potential issues with calls showing as â€˜spam'. As of 31st May 2022, 8,442 patients have been contacted since the start of the project on 07/03/2022, with 12% removed from waiting lists.

Next steps are to meet with Source again to determine revised patient cohort. In addition, we will look to determine how we pull the data from WPAS to assess the level of patients contacted, validated and removed from the waiting list by our internal validators to get an accurate overall position.

### What actions are being taken to improve performance and by who?
The Original IMTP was submitted, and has been questioned by WG Delivery Unit. Therefore, we are working with the DU to submit a revised and realistic IMTP.

### When performance is going to improve by and by how much?
Agreement has been gained to submit trajectories against the ministerial priorities from the revised model, this will be at a point in time (31/05/2022). The next step will be to complete the Q1 refresh, which is in line with rest of Wales, but will enable us to take into consideration the Covid de-escalation measures and the directive of delivering 100% of 20/19/20 outturn. This will be submitted by 22/06/2022, with an action plan inclusive of solutions to get us to the 2019/20 outturn, plus the additionality required to reduce the backlog. The specialities that will not meet the first ministerial priority of no 52-week breaches at S1 (December 2022) are Urology, Orthopaedics and Orthodontics. However, the Specialties predicted to not meet the second ministerial priority of no 104-week breaches at all stages (March 2023) are significantly more and include General Surgery, Urology, Orthopaedics, ENT, OMFS and Gynaecology. Solutions are inclusive of the normal BAU options, i.e. WLIs, Locums etc., but we are also in the process of sourcing additional capacity through Insourcing (tenders close 01/07/2022), and further Outsourcing with our current contracts and further outsourcing opportunities. Service Improvement has been assigned to drive and embed initiatives such as SOS/PFIU, alongside other transformational projects that will include a Perioperative Programme.

### What are the risks to this timeline?
Further Covid spikes and/or staff sickness rates could limit capacity Non-Clinical staff performing WLIs as BAU due to pay rates

### What are the mitigations in place for those risks?
Risk assessment process complete A&E due to be considered by ISG on 12/04/2022 Waiting for agreed pay rates for Non-Clinical staff

# Narrative for Planned Care Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?
Demand on cardiac physiology service remains high with patients waiting over 52 weeks for an echo
Patients in YGC are waiting over 52 weeks for a first outpatient appointment
The Heart Failure Nurses have withdrawn inpatient service due to staff shortages
Two business cases with IMTP

### What actions are being taken to improve performance and by who?
An exercise to equalise echo waiting times across the region is underway with YGC expected to support YG significantly.
A regional led demand and capacity exercise within cardiac physiology to be commenced Q2
Heart Failure business case and rhythm monitoring submitted to IMTP
Heart failure teams working with Matrons and Consultants to mitigate risk where possible.
Funding agreed for a 12 month fixed term Consultant in YGC who will support the pacing service and outpatients
Review of PPCI rota to be commissioned to review the impact on planned care.

### When performance is going to improve by and by how much?
Individual sites working with planned are and the access group to agree timelines to address various backlogs.
Efficiency working group re-established with PABC to monitor booking efficiencies, HICs and forecasting capacity.

### What are the risks to this timeline?
Support from the informatics team to complete demand and capacity
Appointment of a locum with the correct expertise
Diagnostics demand increases

### What are the mitigations in place for those risks?
Plans for regional diagnostic and treatment centres for BCU will include some elements of cardiac diagnostics
Workforce planning for challenged areas with business case is underdevelopment
Planned Care recovery plan
Directorate and North Wales meetings monitor risk and provide support

# Narrative for Planned Care Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

In April 2022, 223 out of 327 (68.2%) of patients were treated in target. Main reasons for patients not being treated in target were:

Complex diagnostic pathways (8%) and patient related reasons e.g. patient unavailability for next stage of pathway (11%)

Delay to endoscopy (5%) and delays to other diagnostics, primarily urology biopsy (17%)

Delay to surgery (14%)

Delay to first outpatient appointment (6%), primarily skin, and delay to results or treatment planning appointment (10%) A&E primarily skin and oncology

### What actions are being taken to improve performance and by who?

All services are prioritising suspected cancer patients. All clinic templates are being reviewed to ensure sufficient capacity to meet 80th percentile (and 95th where possible) weekly demand for suspected cancer patients. Dermatology teams have increased capacity across the Health Board with Central and East teams providing support to West in order to equalise waiting times Endoscopy insourcing continues and capacity has increased with the opening of the 3rd room in East New rapid diagnosis clinics for patients with vague but concerning symptoms commenced in March 2022 in Central and East in April 2022 in West  One stop neck lump clinic to commence June 22nd

### When performance is going to improve by and by how much?

The Health Board aims to achieve the 75% target by end of 2022

### What are the risks to this timeline?

Suspected cancer referrals remain at 120% of pre-COVID levels which is placing pressure on all parts of the cancer pathways Cancer recovery funding from Welsh Government ran out at the end of March 2022

### What are the mitigations in place for those risks?

Additional capacity created where possible  Cancer pathway practitioners recruited in order to review and streamline pathways

# Narrative for Planned Care Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

Capacity loss due to Covid-19 social distancing mitigation (circa -2 patients capacity reduction per clinic versus Pre-Covid-19)
Historic Data Quality & Completeness are impacting on data quality and effectiveness of planning and delivery.
Conflicting priorities are impacting on Clinician and Operational Management engagement.
National Delay in Digital programme delivery, which is a key enabler of Eye Care Measure and sustainable/efficient pathways.
Cataract Outpatient and theatre utilisation due to estate limitations & capacity.

### What actions are being taken to improve performance and by who?

Get it right first time (GIRFT) Cataract partnership (Autumn 2022 and Regional Treatment Centre delivery for Short/Long Term sustainability improvement)
Outsourcing & Pan BCU Patient Treatment List for improved sustainability and redress of >36 waits backlog (On Track)
Data Quality/Redress action plan (all sites) for clinical condition.( East & Central Outstanding)
ECM Pathway "Continuous Improvement" Networks with linked KPI Action Trackers.  (West Achieved. East & Central Outstanding).
Transformational Integrated Primary/Secondary Care pathways are 30% below delivery (Primary Care unplanned leave/Covid19 impacts)
Nurse-Led Intravitreal (IVT) Pathways (Partial IVT recruitment & delivery achievement)

### When performance is going to improve by and by how much?

Cataract: PTL in place for ongoing site management.
Action Plans being reset by sites following IMTP refresh.
Outsource 400 Cataracts/month: Trajectory On Track. (see chart)
GIRFT partnership with BCU (Actions/Outcomes to follow)
300 additional IVT Injections by Autumn 2022

### What are the risks to this timeline?

Clinical/Operational/Informatics conflicting priorities, leadership and key staff resource capacity gaps
Delivery impacted by inconsistent realisation of quorate Local Eye Groups: key enablers of Communication/Engagement/Action setting and monitoring.
Data quality (Clinical condition) assurance to maximise flow to Integrated services

### What are the mitigations in place for those risks?

Senior management support of untangling conflicting clinical priorities. Recruitment: Optometric advisor/Central and West Clinical Lead/Pan BCU leads.
Escalation via Eye Care Collaborative Group

# Efficiency - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| Percentage compliance with Sepsis Six 1 hour bundle – Emergency Department | BCU | =12m improvement trend | =12m improvement trend | 2022-05 | 22.73% | | | |
| | West | =12m improvement trend | =12m improvement trend | 2022-05 | 29.55% | | | |
| | Central | =12m improvement trend | =12m improvement trend | 2021-05 | 33.33% | | | |
| | East | =12m improvement trend | =12m improvement trend | 2022-05 | 9.09% | | | |
| Percentage compliance with Sepsis Six 1 hour bundle - inpatients | BCU | =12m improvement trend | =12m improvement trend | 2022-05 | 26.32% | | | |
| | West | =12m improvement trend | =12m improvement trend | 2022-05 | 31.25% | | | |
| | Central | =12m improvement trend | =12m improvement trend | 2021-05 | 33.33% | | | |
| | East | =12m improvement trend | =12m improvement trend | 2022-05 | 17.86% | | | |

# Efficiency - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|------|-----------|----------|--------------|--------------|----------------|----------|----------|
| Percentage of Critical Care beddays lost to Delayed Transfers | BCU | <=5% | <=5% | 2022-03 | 29.90% | | | |
| | West | | | | | | | |
| | Central | | | | | | | |
| | East | | | | | | | |

# SPC Charts for Efficiency Measures

## Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening
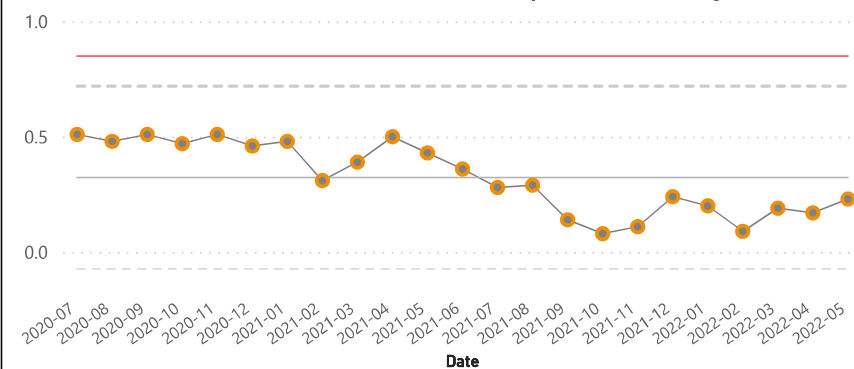


## Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening
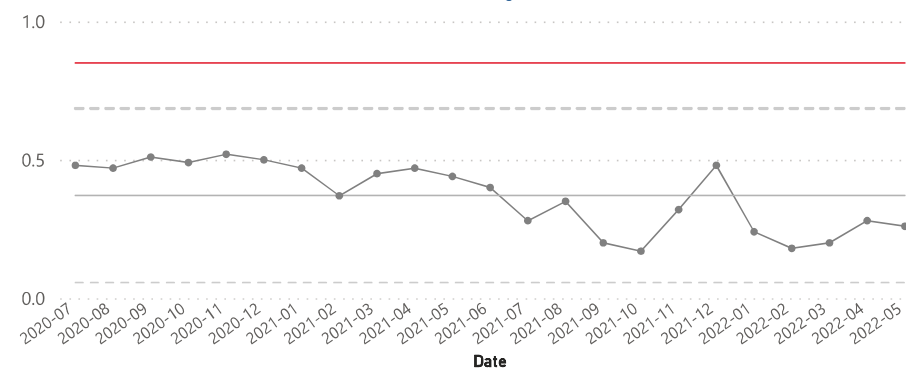


## Percentage of critical care bed days lost to delayed transfer of care – Intensive Care National Audit & Research Centre (ICNARC) definition
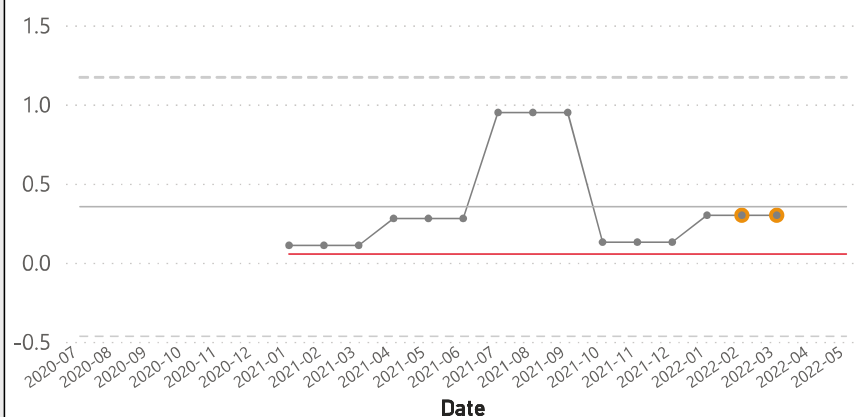


Actual _____  Target _____  Average _____

Upper Control Limit - - - - - -   Lower Control Limit - - - - - -

# Narrative for Efficiency Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

Sepsis is a huge area- and has ramifications across many different specialties and areas in North Wales. Traditionally in BCUHB A&E death around sepsis has not been captured A&E and looked at in isolation, whether be systems based i.e. Respiratory, ITU, urological, post op etc. The coding for sepsis does not allow interrogation on this system basis, but identifies on organisms- such as pneumococcal or gram negative- so interpretation of CHKS results has to be taken with some caution. Therefore it is imperative that there is cross triangulation with other areas such as the independent ME service and inquests where sepsis is cited. Only by looking at sepsis from different aspects will issues emerge that need addressing. With the above caveats- review 2022 data around streptococcal sepsis reveals a mortality rate is higher in BCUHB compared to peer of Welsh Hospitals A&E in the first three months of 2022 mortality rate is A&EBCUHB 22%, 30%, and 29%-compared to peer of 21%, 30% and 21%-this puts us in the bottom three in terms of performance of the nine HB's in Wales. Looking at the ME referrals there have been 71 referrals from Jan A&EMay 2022 to BCUHB due to concerns of sepsis.44% YGC, 36 %YG, 14% WXM. This ranges between 15-20 cases per month.

### What actions are being taken to improve performance and by who?

With regards to the above there is a huge amount that still needs to be done to build the governance and the informatics around sepsis to connect bedside to boardroom and this can come through many avenues. The learning from mortality panel- reviews cases and where there are specific issues around sepsis this is flagged up to the site and local Health Economy. Of note, this has not yet emerged as a theme A&E but reviews are ongoing. We are also keen to have the data for BCUHB around puerperal and neonatal sepsis being collected and focused centrally. Whilst there may actions taken in various departments to address issues to improve sepsis- at present there appears to be no specific capture of these at a corporate level- either by site, or by discipline and this is certainly a theme across BCUHB where are yet to develop the intelligence and networking around many aspects of care.

### When performance is going to improve by and by how much?

It is envisaged that by fortnightly learning form mortality panels reviewing mortality- where trends emerge, and cases are presented A&E specific issues can be captured A&E and an action plan produced. We are also setting up a joint clinical coding board, for which the AMD Mortality will Chair- so we make sure that we can harness the write questions from CHKS.

### What are the risks to this timeline?

### What are the mitigations in place for those risks?

# Workforce - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---------|------|-----------|----------|--------------|--------------|----------------|----------|----------|
| ⊟ **Percentage of sickness absence rate of staff** | **BCU** | <=5% | <=5% | 2022-05 | 6.48% | | | |
| ⊟ **Percentage Staff compliant with Mandatory Training requirements** | **BCU** | >= 85% | >= 85% | 2022-05 | 84.70% | | | |
| ⊟ **Percentage staff had Personal Appraisal and Development Review (PADR)** | **BCU** | >= 85% | >= 85% | 2022-05 | 65.27% | | | |

# SPC Charts for Workforce Measures

## Personal Appraisal and Development Review (PADR)
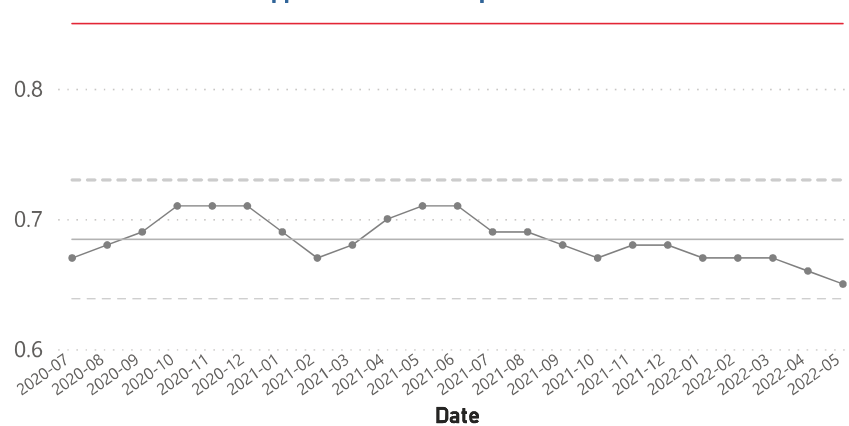


## Percentage of sickness absence rate of staff
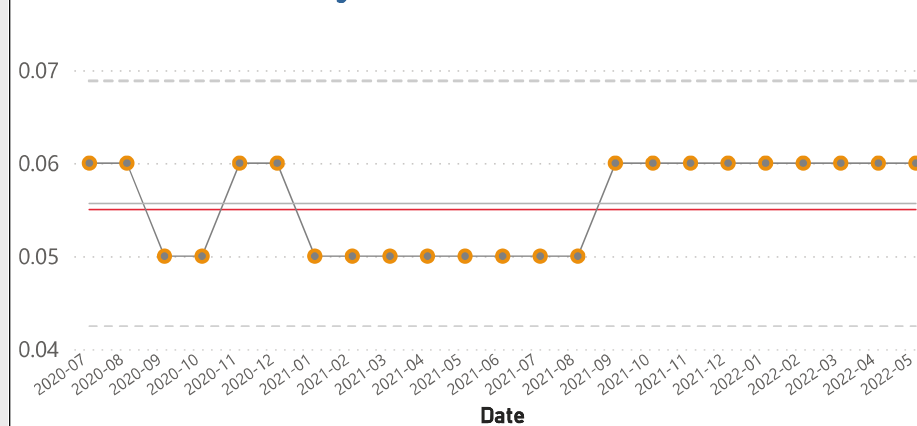


## Percentage compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation
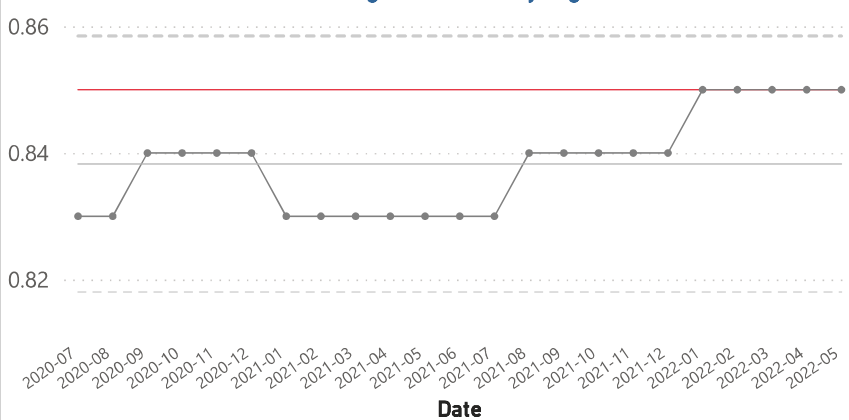


| Actual | _____ | Target | _____ | Average | _____ |
| Upper Control Limit | ------- | Lower Control Limit | ------- | | |

# Narrative for Workforce Measures

## Narrative

**What are the key issues/ drivers for why performance is where it is?**
PADR compliance for May is 65.3%, a decrease from 66.7% for March 2022.

**What actions are being taken to improve performance and by who?**
With Pay Progression being implemented on the 1st October, a group has been established to monitor progress. Whilst Pay Progression and PADR are separate processes, they are intrinsically linked as progression through increments will not be approved unless a PADR conversation has taken place. Actions from the group include:- Sharing FAQ's and guides with staff across the organisation to highlight the Pay Progression process and links with PADR. Updating the PADR Policy to reflect the changes in Pay Progression. Arranging PADR / Pay Progression face to face and virtual clinics to answer any queries and questions managers and staff may have relating to PADR and Pay. Progression. Tailored local support to support managers to understand any barriers that may exist to completing PADR's and how to overcome these barriers.

**When performance is going to improve by and by how much?**
It is expected that the implementation of Pay Progression will ensure that PADR's are being conducted effectively and recorded accurately in ESR which will impact positively on compliance. Whilst recognising ongoing operational pressures, the aim remains to achieve 75% compliance by the end of Q2, 80% compliance by the end of Q3 and 85% compliance by the end of Q4.

**What are the risks to this timeline?**
Continued operational pressures may impact on the capacity of line managers and staff to complete PADRs, although the links between PADR completion and pay progression should support an increase in completed PADRs.

**What are the mitigations in place for those risks?**
Continue to work with divisions in a supportive manner to achieve sustainable increase. Concurrent communication across the health board as a gentle reminder of the importance of conducting PADR'sand its links to Pay Progression.

# Narrative for Workforce Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

Rolling sickness absence performance is at 6.48% an increase of 0.18% (April 22) and the highest level for over 12 months.

COVID19 related sickness absence has decreased by 0.9% to 0.8% (1.7% in April 22). This reflects a decrease in Covid within the North Wales community.

Non COVID19 related sickness absence has decreased to 4.9% from 5.1% (April22).

Stress related absence remains the biggest cause of absence with approximately 50% more days lost than the 2nd largest cause ( infectious diseases). The highest levels of sickness absence are in Additional Clinical services , Estate and Ancillary and Nursing and Midwifery. Estates and Ancillary sickness rates are the highest across the organisation at 8.55% a reduction of 0.87% on April 22. Additional Clinical services have decreased to 7.75% from 8.63% in April 22. Nursing levels have decreased to 6.06% from 7.16% in April 22.

### What actions are being taken to improve performance and by who?

Sending out Health Matters newsletters to staff who are off with work due to stress

A focus on long term sickness

Meetings between Well-being, HR and Occupational Health colleagues to look at hotspot areas and support options.

Refresher training for managers on the Managing attendance at work policy

Monthly MDT Case management meetings are taking place to provide support for staff with more complex needs and include staff, managers, occ health, H&S and well-being colleagues as needed.

Promote the Staff wellbeing and support services including counselling and psychological therapies

### When performance is going to improve by and by how much?

Covid restrictions now removed, community cases declining, so should see an improvement in Covid sickness cases over the summer months

### What are the risks to this timeline?

All Wales decision to extend Covid sickness pay until end June 2022 or for a period of 12 months for more recent diagnoses of long Covid

Potential for an increase in Covid infection rates within the community as restrictions are relaxed.

Further increase in stress related absence, particularly given recent the media and social media coverage of BCU

### What are the mitigations in place for those risks?

Increased communications to further promote access to the Wellbeing Services available for staff

Focus on early intervention support

Support in helping managers to have conversations with staff around wellbeing (from OH/HR)

Use of Health Working Relationships training and implementation of facilitated discussions

# Narrative for Workforce Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

Mandatory Training compliance at level 1 for May 2022 has decreased by 0.25% and is currently at 84.74%. Level 1 Compliance for April 2022 was just over the national target at 85.01%. Level 1 training illustrates a decrease of between 0.5% and 1% for Equality & Diversity, Health and safety, Infection prevention and Safeguarding Adults and an increase of 0.5% for Manual Handling. It is important to note that level 1 Manual Handling has increased by 2% over the last four months.

Level 2 training has increased again, this month's increase of 0.5% places level 2 compliance at 76.73%. Overall level 2 compliance has risen by almost 7% in the last twelve months. Level 2 training illustrates a decrease of 1% for Safeguarding Adults and an increase of 2.5% for Patient Handling.

### What actions are being taken to improve performance and by who?

Mandatory Training Manager will continue to work with Manual Handling department to identify and report areas of low compliance.

### When performance is going to improve by and by how much?

Following the detailed data analysis and review of process around recording of Manual Handling training, May 2022 has reported the first increase in Manual Handling compliance for both level 1 and level 2 training for this year. As this work continues we anticipate a further increase in both level 1 and level 2 Manual Handling compliance for June 2022 which should place level 1 training again above the national target of 85%.

### What are the risks to this timeline?

Practical sessions continue to be risk assessed with occupancy of rooms reduced to allow safe delivery, this continues to affect the delivery of training sessions which require a practical application.

### What are the mitigations in place for those risks?

Blended training approaches are utilised wherever possible.

# Adult Mental health - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| ⊟ Percentage Adults assessed within 28 Days of referral | BCU | >= 80% | >= 80% | 2022-05 | 62.45% | | | |
| | West | >= 80% | >= 80% | 2022-05 | 59.17% | | | |
| | Central | >= 80% | >= 80% | 2022-05 | 55.56% | | | |
| | East | >= 80% | >= 80% | 2022-05 | 69.69% | | | |
| ⊟ Percentage under 18 with Care Treatment Plan | BCU | >= 90% | >= 90% | 2022-05 | 86.70% | | | |
| | West | >= 90% | >= 90% | 2022-05 | 87.72% | | | |
| | Central | >= 90% | >= 90% | 2022-05 | 73.78% | | | |
| | East | >= 90% | >= 90% | 2022-05 | 94.36% | | | |

# Adult Mental health - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| | | | | | | M A M J J A S O N D J F | | |
| **Percentage Adults assessed within 28 Days of referral** | **BCU** | >= 80% | >= 80% | 2022-05 | 62.45% | | | |
| | **West** | >= 80% | >= 80% | 2022-05 | 59.17% | | | |
| | **Central** | >= 80% | >= 80% | 2022-05 | 55.56% | | | |
| | **East** | >= 80% | >= 80% | 2022-05 | 69.69% | | | |
| **Percentage under 18 with Care Treatment Plan** | **BCU** | >= 90% | >= 90% | 2022-05 | 86.70% | | | |
| | **West** | >= 90% | >= 90% | 2022-05 | 87.72% | | | |
| | **Central** | >= 90% | >= 90% | 2022-05 | 73.78% | | | |
| | **East** | >= 90% | >= 90% | 2022-05 | 94.36% | | | |

# SPC Charts for Adult Mental Health

## Percentage of mental health (Adult) assessments undertaken within 28 days of referral
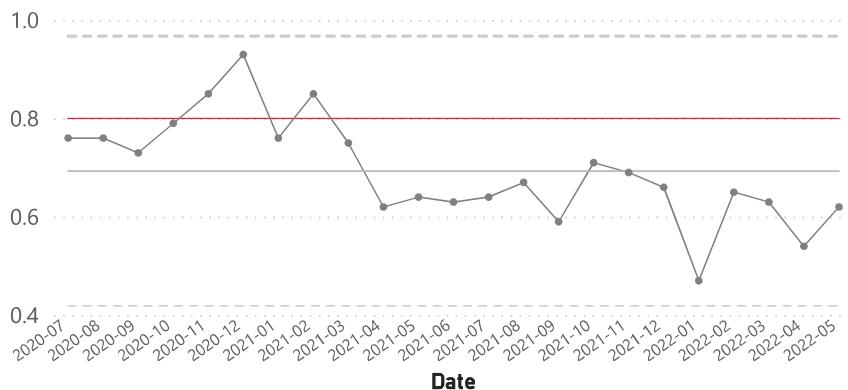


## Percentage of therapeutic interventions (Adult) within 28 days of assessment
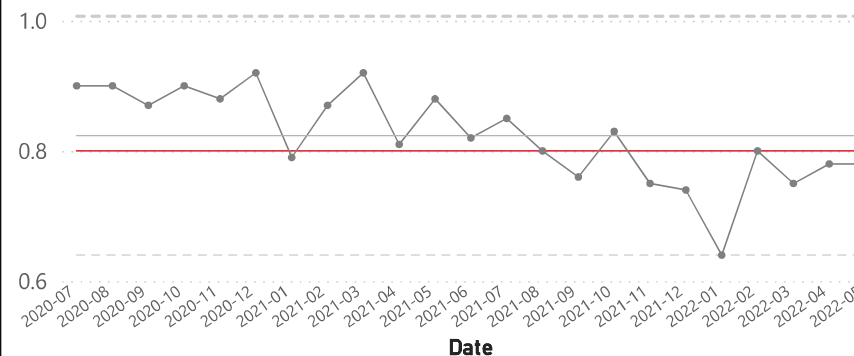


## Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy
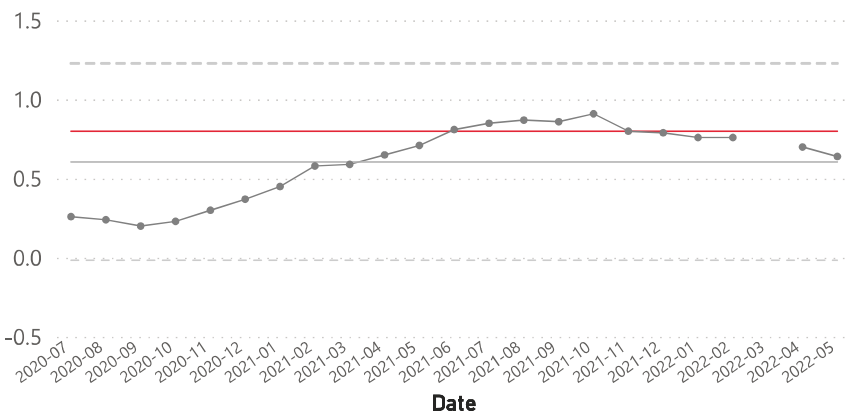


## Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)
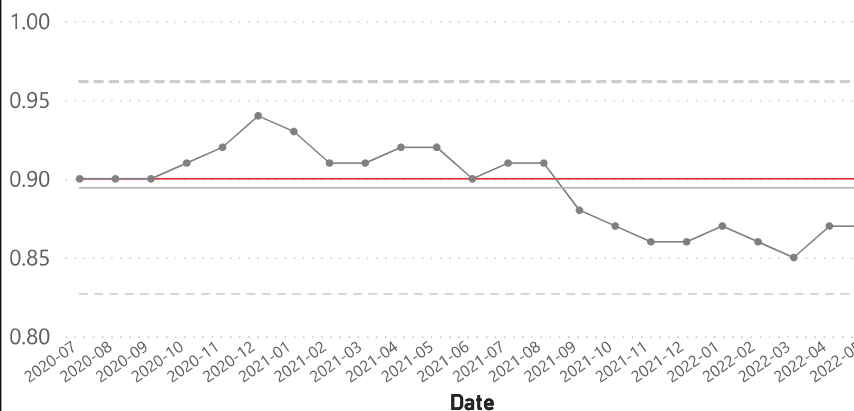


Actual _____  Target _____  Average _____  Upper Control Limit - - - - - - -  Lower Control Limit - - - - - - -

# Narrative for Adult Mental Health Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

Achievement of staffing level to establishment is the key issue in supporting compliance against all parts of the Mental Health Measure. Due to the fragility of maintaining services without full establishment of staff even a relatively small increase in referrals into service are compounding our ability to deliver in line with Key Performance targets.

### What actions are being taken to improve performance and by who?

We have a dual approach to improving performance for our patients. The first is our immediate recovery plans which focus on recruitment to establishment posts, recruitment to interim additional posts to support the management of the backlog, undertaking additional sessions along with streamlining and improving our processes. These recovery plans will remain in place whilst we develop the second fundamental element to our improvements which is the development of our Tier 0/1 services. This is being developed collaboratively with colleagues across the divisions, clusters and informed by the feedback from our services users. Development of the model will strengthen the offer of our divisional expertise into a multi-disciplinary team that ensures we are removing the wait to assessment for service users, ensuring they are receiving the right level of care, in the right place at the right time.

### When performance is going to improve by and by how much?

We have variance in capacity and demand across our region and recovery will be dependent on those variables. Our East area is projected to be compliant with all parts of the measure by the end of Quarter 1 2022. Both the West and Central teams are focusing on the longest waiters which, whilst clinically the appropriate action, will in the short term have a negative impact on compliance with the measure. Addressing the waiting list backlog will by year end result in compliance against the measure for all areas and most importantly timely access to care for our service users.

### What are the risks to this timeline?

Any significant increase in demand will impact on our ability to achieve compliance as will any delays with recruitment to the existing and new posts.

### What are the mitigations in place for those risks?

# Narrative for Adult Mental Health Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?
Our West and Central Regions are fully compliant against the Adult Psychological Therapies Key Performance target and have maintained this achievement throughout the year. The position in the East has deteriorated due to vacancies in some key roles.

### What actions are being taken to improve performance and by who?
Focus on recruitment to the vacant roles, included some changes to posts to make them more effective and attractive.

### When performance is going to improve by and by how much?
Recruitment to posts and addressing of the backlog is anticipated to bring us back to fully compliant levels by end of Quarter 2 2022

### What are the risks to this timeline?
Any significant increase in demand or delays to recruitment will impact on our recovery.

### What are the mitigations in place for those risks?
We are increasing focus on recruitment with internal scrutiny of progression through Trac. We have reviewed roles to make them more effective and attractive.

# CAMHS - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| | | | | | | M A M J J A S O N D J F | | |
| Percentage CAMHS assessed within 28 Days of referral | BCU | >= 80% | >= 80% | 2022-04 | 25.00% | | | |
| | West | >= 80% | >= 80% | 2022-03 | 41.18% | | | |
| | Central | >= 80% | >= 80% | 2022-03 | 52.78% | | | |
| | East | >= 80% | >= 80% | 2022-03 | 27.27% | | | |
| Percentage CAMHS starting therapy within 28 days of assessment | BCU | >= 80% | >= 80% | 2022-04 | 18.18% | | | |
| | West | >= 80% | >= 80% | 2022-03 | 22.22% | | | |
| | Central | >= 80% | >= 80% | 2022-03 | 35.00% | | | |
| | East | >= 80% | >= 80% | 2022-03 | 31.82% | | | |

# CAMHS - Performance Scorecard

| Measure | Area | WG Target | BCU Plan | Actual Month | Actual Value | 12 Month Trend | SPC Var. | SPC Ass. |
|---|---|---|---|---|---|---|---|---|
| ⊟ **Percentage Over 18 with Care Treatment Plan** | **BCU** | >= 90% | >= 90% | 2022-04 | 93.30% | | | |
| | **West** | >= 90% | >= 90% | 2022-03 | 100.00% | | | |
| | **Central** | >= 90% | >= 90% | 2022-03 | 100.00% | | | |
| | **East** | >= 90% | >= 90% | 2022-03 | 82.43% | | | |

# SPC Charts for CAMHS Measures

## Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral
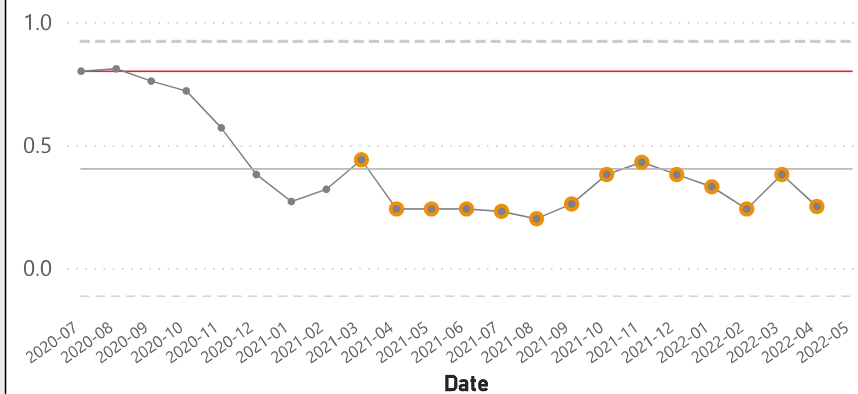


## Percentage of therapeutic interventions (CAMHS) within 28 days of assessment



## Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged under 18 years)
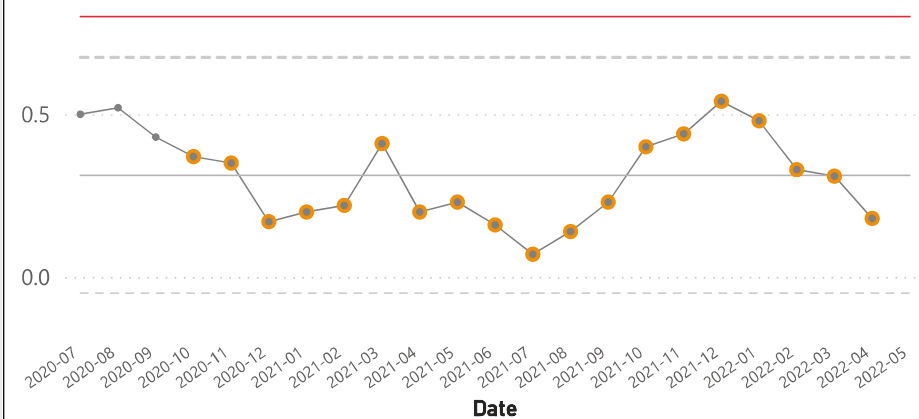


Actual _____    Target _____    Average _____
Upper Control Limit ------- Lower Control Limit -------

# Narrative for CAMHS Measures

## Narrative

### What are the key issues/ drivers for why performance is where it is?

Increased in demand for Mental Health Assessment; there has been an increase of 5% when compared to 2019/20 pre-pandemic levels, referrals increasing further during the latter part of Q3 and during Q4. Impacted significantly on the waiting list backlogâ€‹. Increased sickness / Covid-related absences during last quarter impacting on core capacity to deliver assessment and interventionsâ€‹. Requirement to clear backlog of patients via internal and external commissioned activity to support ongoing improvement in terms of MHM delivery of target impacting on numbers seen within 28 days. Performance at end of April 25% for assessment and 18% for interventions. Unvalidated position for May indicates 25% for assessment and 31% for intervention. Position against trajectory is on track, with significant decrease in numbers waiting for assessment over 28 days.â€‹ Diversion of core service capacity to increase resource for crisis and eating disorder service capacity noting the increased demand for both elements of the service nationally.

### What actions are being taken to improve performance and by who?

Contract being agreed with private providers, work ongoing to ensure maximisation of capacity with private providers to support improvements. CAMHS Regional Performance Recovery Plan submitted to EMT for IQPD meeting with WG/DU. Monitoring of performance against improvement trajectory and recovery planning is ongoing across all teams through the established Regional CAMHS Performance Delivery Group with escalation to Assistant Area Directors via Strategic Improvement & Development Group for oversight. A Performance Management Framework is being developed to ensure increased clarity of KPIs, responsibilities and accountability. Choice and Partnership Approach (CAPA) framework continues to be a priority across the region to inform team job planning and throughput for planned care core service. Additional 2022/23 WG funding bids submitted across the service to ensure adequate resources for sustained delivery against performance. Emphasis on early intervention and prevention services to improve the early help x

### When performance is going to improve by and by how much?

Trajectories and recovery plans xxxxx.

### What are the risks to this timeline?

Increased sickness absences across xxxxx.

### What are the mitigations in place for those risks?

Development of workforce plan and support by xxxxx.

# Primary Care

**Access to General Practices (GP)**

**Number of Pharmacies at Escalation Level of 3 or above**

**Number of GP Referrals into Urgent Primary Care Centres (UPCC)**

**Number of Emergency Department (ED) Referrals into Urgent Primary Care Centres (UPCC)**

**Rate of Pharmacy Enhanced Services accessed**

**Number of Complaints Primary Care**

**Number of Incidents Primary Care**

# Access to General Practices (GP)



Bonus Achieved

**Infrastructure System**

Understanding the Patient Needs

**CURRENT QUARTER**

% Practices Group Achieved
**96.9%**

Number of Practices Group Achieved
**94**

Access Standards Groups Achieved

● Practices ● Achieved ● *% Achieve Standard Points
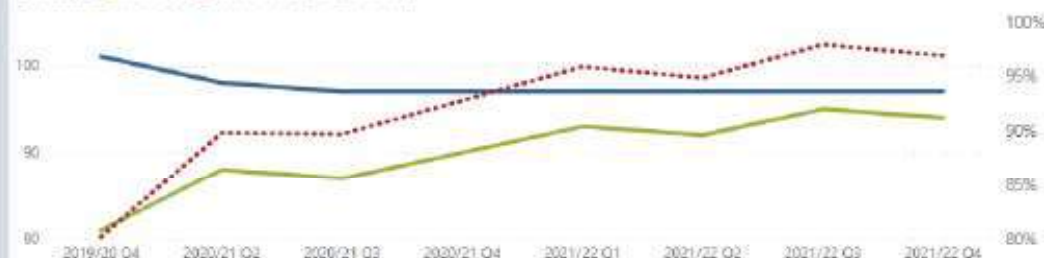
**PREVIOUS QUARTER**

% Practices Group Achieved
**97.9%**

Number of Practices Group Achieved
**95**

Access Standards Group Achieved % by Cluster

● Anglesey ● Arfon ● Central & Sout... ● Conwy East ● Conwy West ● Dwyfor ● Meirionnydd ● North Denbighs... ● North East Flint ▶

# Access to General Practices (GP)

**Bonus Achieved**

**Infrastructure System**

**Understanding the Patient Needs**



**CURRENT QUARTER**

% Practices Group Achieved

**92.8%**

Number of Practices Group Achieved

**90**

**Access Standards Groups Achieved**

● Practices ● Achieved ● *% Achieve Standard Points

**PREVIOUS QUARTER**

% Practices Group Achieved

**93.8%**

Number of Practices Group Achieved

**91**

**Access Standards Group Achieved % by Cluster**

● Anglesey ● Arfon ● Central & Sout... ● Conwy East ● Conwy West ● Dwyfor ● Meirionnydd ● North Denbighs... ● North East Flint
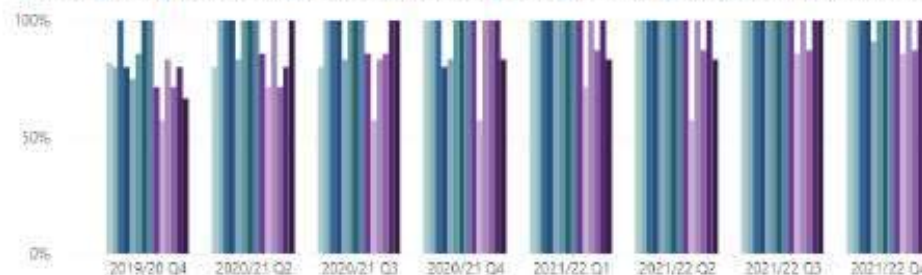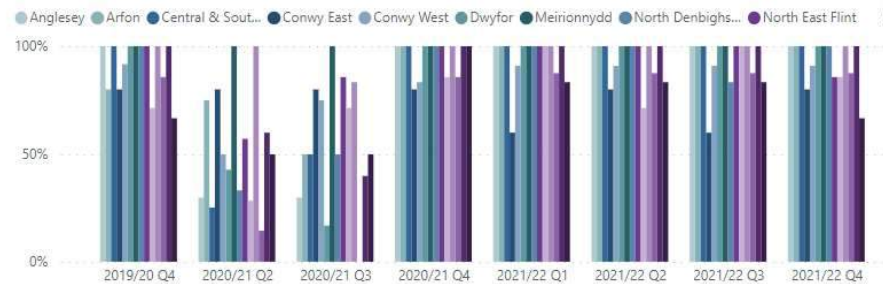
**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Access to General Practices (GP)

**Bonus Achieved**

**Infrastructure System**

**Understanding the Patient Needs**



**CURRENT QUARTER**

% Practices Achieving All Standards
**76.3%**

Number of Practices Achieving All Standards
**74**

% All Access Standards Achieved

● Practices ● Achieved ● % Achieved All Standard

**PREVIOUS QUARTER**

% Practices Achieving All Standards
**75.3%**

Number of Practices Achieving All Standards
**73**

% All Access Standards Achieved by Cluster

● Anglesey ● Arfon ● Central & ... ● Conwy East ● Conwy West ● Dwyfor ● Meirionny... ● North Den... ● North East ...

# Number of Pharmacies at Escalation Level of 3 or above



Proportion of pharmacies reporting each pressure level by cluster
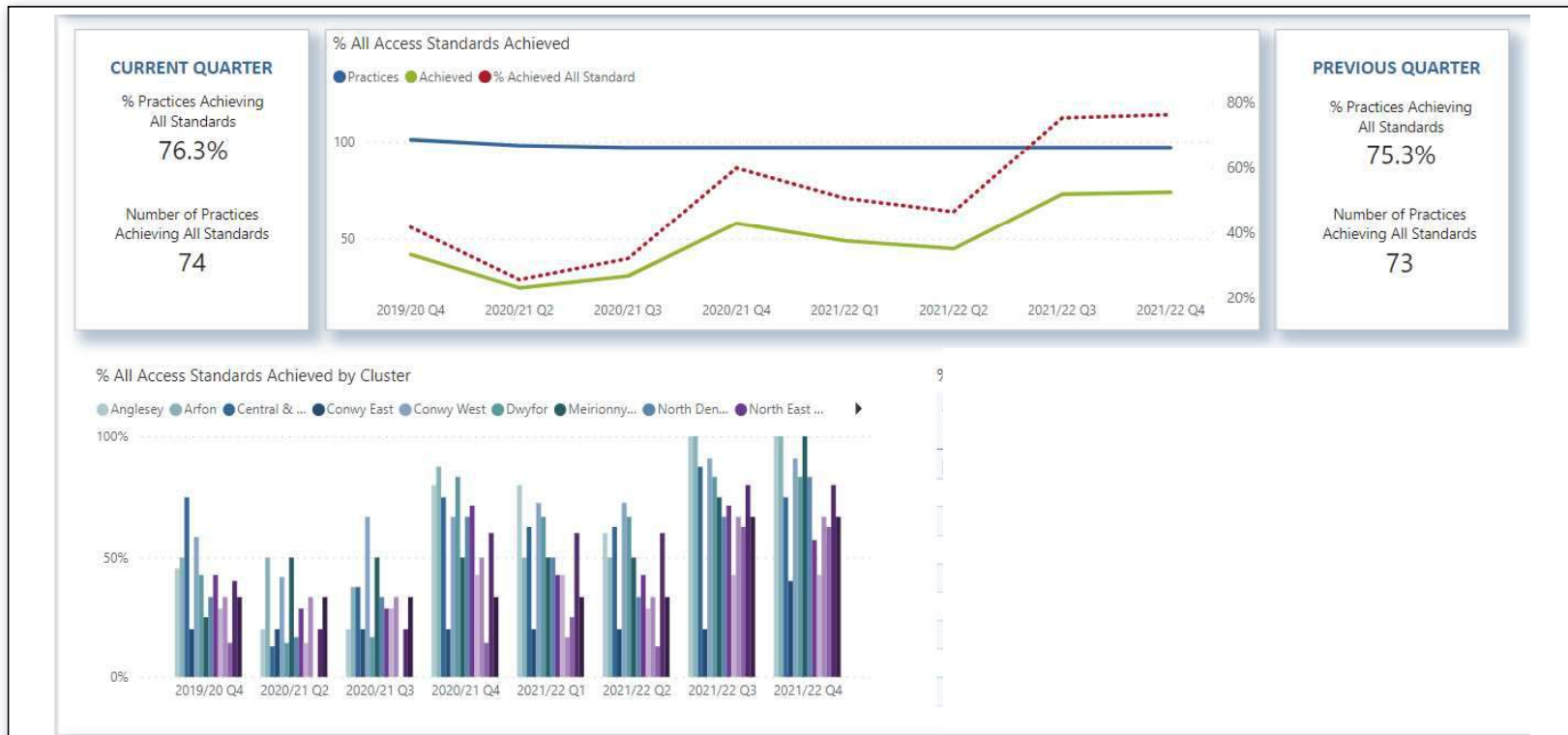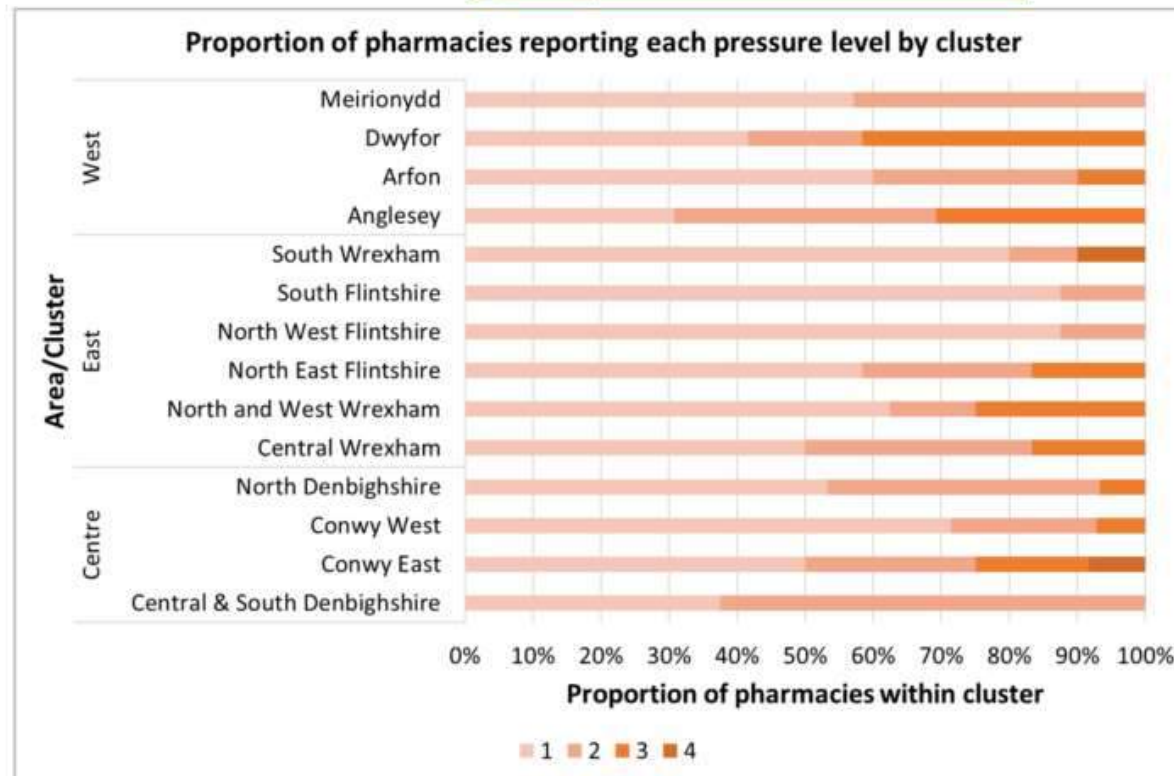
**Level Indicators**

**Level 1:** Business as usual

**Level 2:** Increased workload

**Level 3:** Significant increase in workload – service delivery modestly impacted

**Level 4:** Unsustainable workload – service delivery significantly impacted

**Level 5:** Closed in normal business hours – with no services being provided for a minimum period of 24 hours

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Urgent Primary Care (UPCC)



## Urgent Primary Care Centres (UPCC)

- The UPCC in East Area has been operational since December 2020, with a further programme in North Denbighshire in early stages of delivery and a UPCC in the West Area commenced late May 2022. The current data applies to East Area only, however data reporting is now being progressed for Central and West areas.
- Referrals to the service continue on an upward trend, with the majority coming from GP practices and Minor Injuries Units (MIUs). Referrals from Emergency Departments (ED) are being actively encouraged as part of Work-stream 1 in the unscheduled care programme.
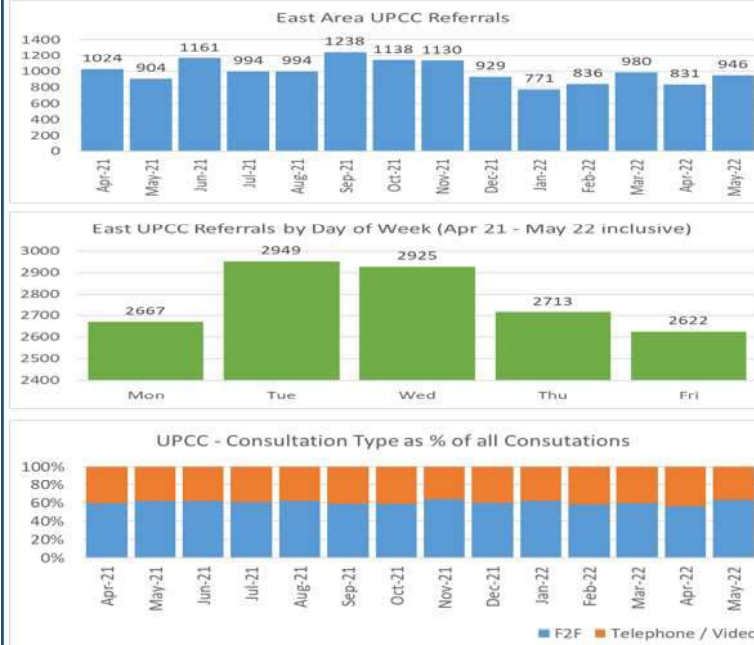
### Data for April 2021 to end May 2022 period

**13,876** Total Referrals

**991** Average Mthly Referrals

**46** Average Daily Referrals

| Outcome | 04/21 – 05/22 |
|---|---|
| Self Care Advice | 7470 |
| Medication & Self Care Advice | 4679 |
| Inappropriate Referral - Returned | 584 |
| UPCC Unable to accept (Operational Issues) | 313 |
| DNA / No response from Pt | 261 |
| Referral to a Specialty | 176 |
| Dealt with by OGP / Issue Resolved / declined contact | 173 |
| Referral to UPCC Physio | 105 |
| Directed to ED | 103 |
| Directed to Community Based Service | 7 |
| Directed to MIU | 5 |
| **Total** | **13,876** |

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Emergency Department (ED) Referrals into Urgent Primary Care Centers (UPCC)

| Row Labels | ED Referrals |
|---|---|
| Dec-20 | 6 |
| Jan-21 | 14 |
| Feb-21 | 42 |
| Mar-21 | 42 |
| Apr-21 | 57 |
| May-21 | 39 |
| Jun-21 | 26 |
| Jul-21 | 10 |
| Aug-21 | 37 |
| Sep-21 | 35 |
| Oct-21 | 20 |
| Nov-21 | 27 |
| Dec-21 | 35 |
| Jan-22 | 32 |
| Feb-22 | 25 |
| Mar-22 | 34 |
| **Grand Total** | **481** |



UPCC East - ED Referrals

Wxm UPCC started

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Rate of Pharmacy Enhanced Services accessed

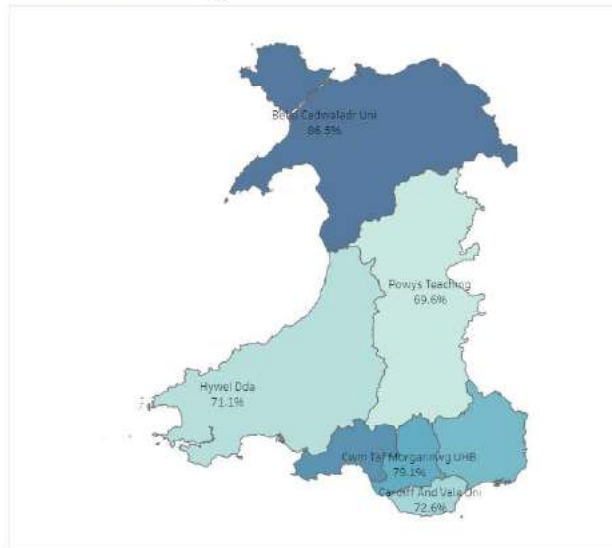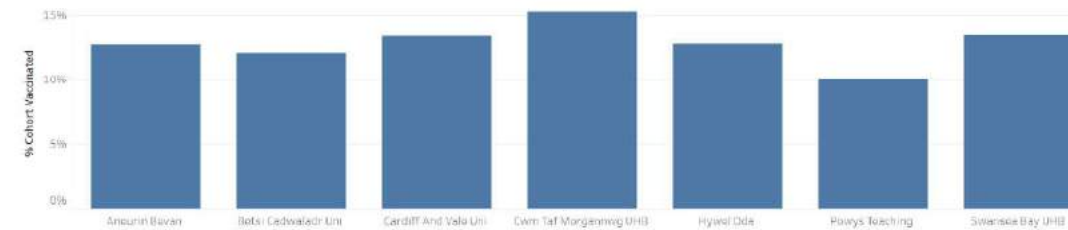| Common Ailment Scheme | Discharge Medicine Review | Emergency Contraction | Emergency Medicine Supply | Seasonal Flu Vaccinations | Smoking Cessation Level 3 |
|---|---|---|---|---|---|



**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Rate of Pharmacy Enhanced Services accessed

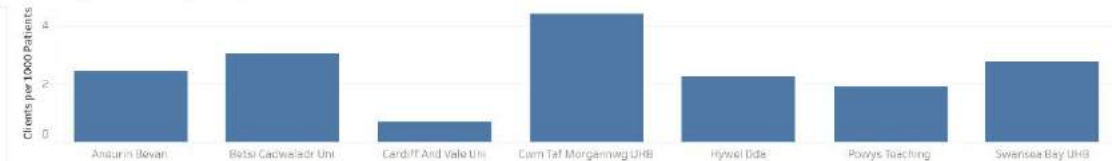| Common Ailment Scheme | Discharge Medicine Review | Emergency Contraction | Emergency Medicine Supply | Seasonal Flu Vaccinations | Smoking Cessation Level 3 |
|---|---|---|---|---|---|

## Smoking Cessation Level 3

Level: Health Board    Health Board: (All)

### % of Pharmacies Delivering Level 3 Service



Betsi Cadwaladr Uni 86.5%
Powys Teaching 69.8%
Hywel Dda 71.1%
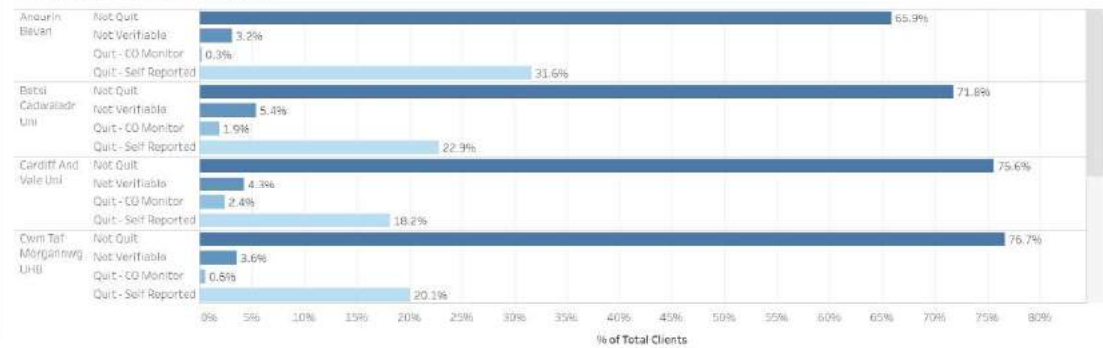Cwm Taf Morgannwg UHB 79.1%
Cardiff And Vale Uni 72.6%

Views based on claims for payment submitted to NHS Wales Shared Services Partnership in the last 24 months

### Clients per 1000 Registered Patients



### Client Quit Status at 4 Weeks



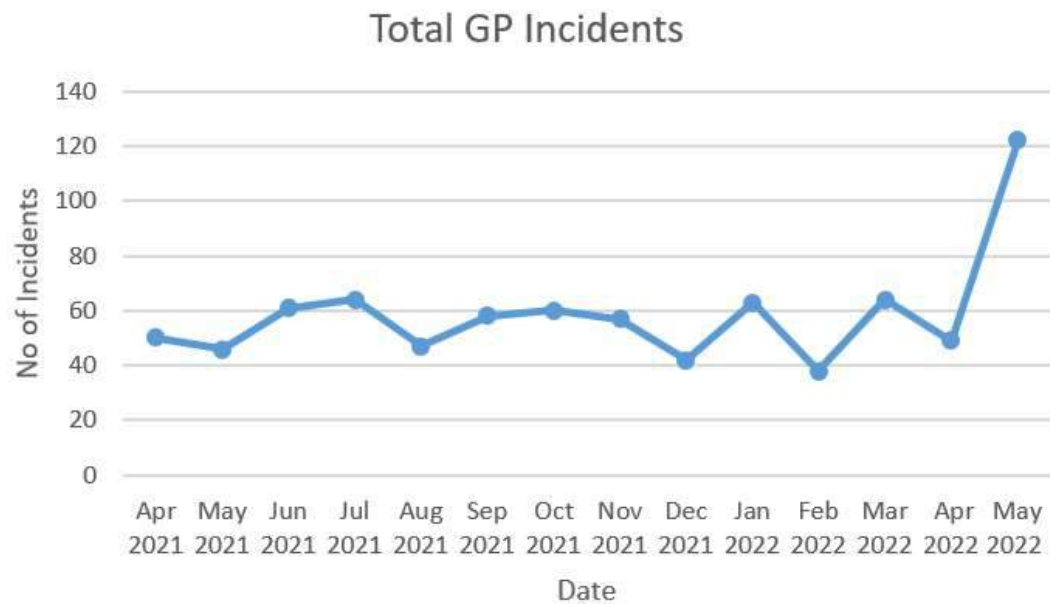Note: *Visualisation is a data snapshot of the current reporting month.*

# Rate of Pharmacy Enhanced Services accessed

| Common Ailment Scheme | Discharge Medicine Review | Emergency Contraction | Emergency Medicine Supply | Seasonal Flu Vaccinations | Smoking Cessation Level 3 |
|---|---|---|---|---|---|



**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Rate of Pharmacy Enhanced Services accessed

| Common Ailment Scheme | Discharge Medicine Review | Emergency Contraction | Emergency Medicine Supply | Seasonal Flu Vaccinations | Smoking Cessation Level 3 |

# Rate of Pharmacy Enhanced Services accessed

| Common Ailment Scheme | Discharge Medicine Review | Emergency Contraction | Emergency Medicine Supply | Seasonal Flu Vaccinations | Smoking Cessation Level 3 |
|---|---|---|---|---|---|



**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Rate of Pharmacy Enhanced Services accessed

| Common Ailment Scheme | Discharge Medicine Review | Emergency Contraction | Emergency Medicine Supply | Seasonal Flu Vaccinations | Smoking Cessation Level 3 |
|---|---|---|---|---|---|

## Smoking Cessation Level 3

Level: Health Board    Health Board: (All)



### % of Pharmacies Delivering Level 3 Service

Betsi Cadwaladr Uni 86.5%
Powys Teaching 69.6%
Hywel Dda 71.1%
Cwm Taf Morgannwg UHB 79.1%
Cardiff And Vale Uni 72.6%

Views based on claims for payment submitted to NHS Wales Shared Services Partnership in the last 24 months

### Clients per 1000 Registered Patients

### Client Quit Status at 4 Weeks

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Incidents Primary Care

| Total GP Incidents | GP Incident Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*
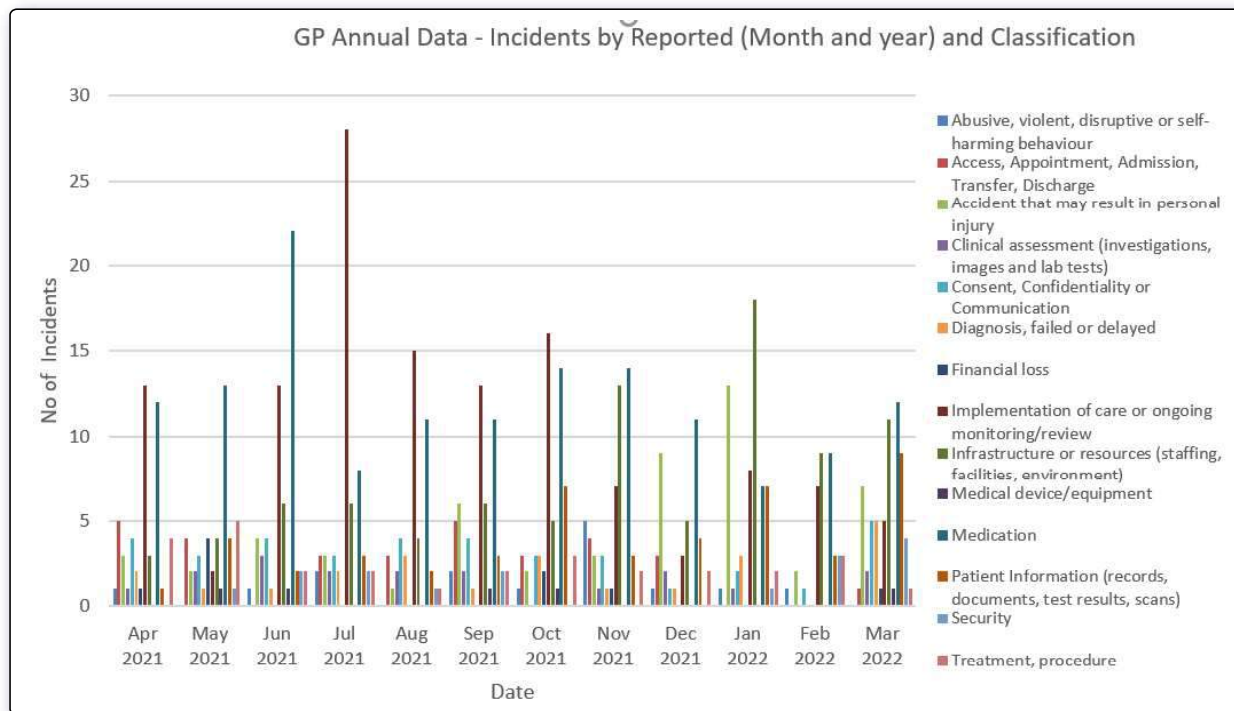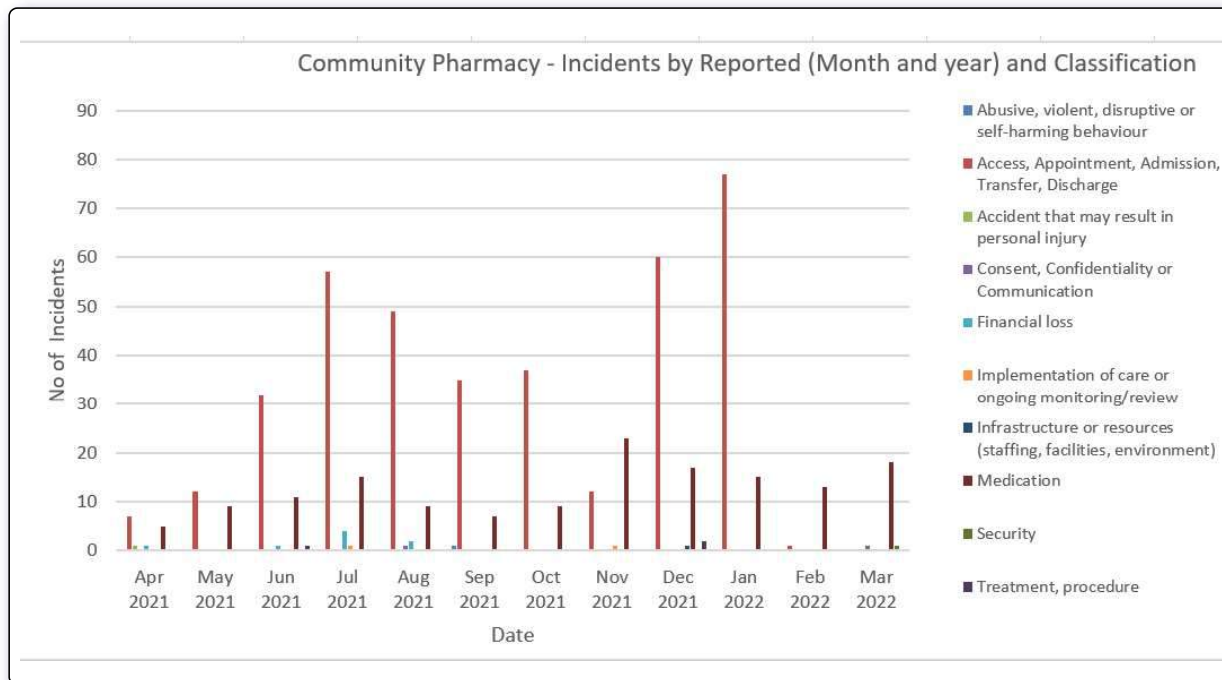
# Number of Incidents Primary Care

| Total GP Incidents | GP Incident Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*
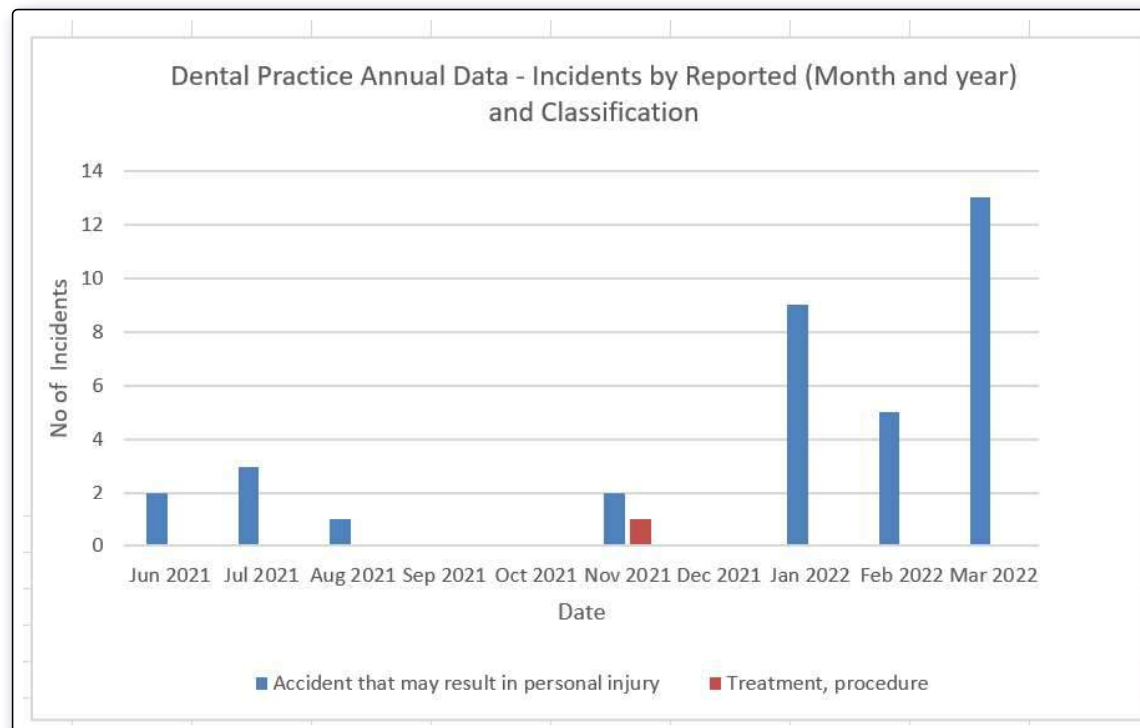
# Number of Incidents Primary Care

| Total GP Incidents | GP Incident Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*
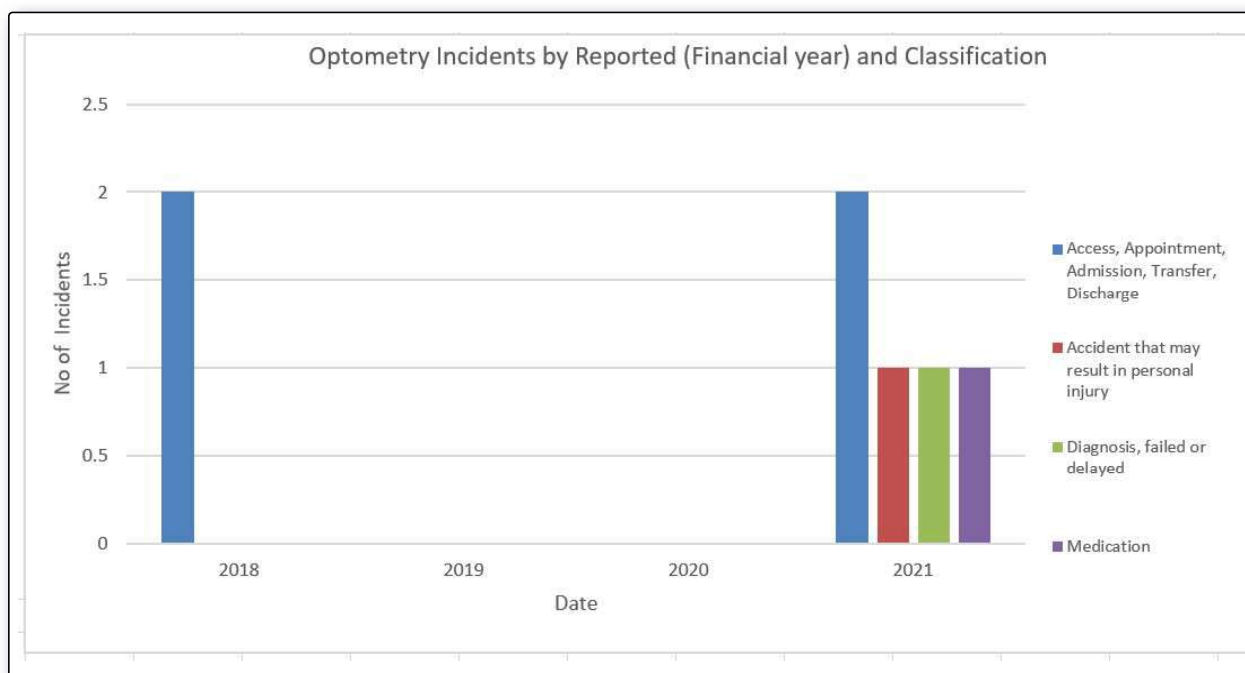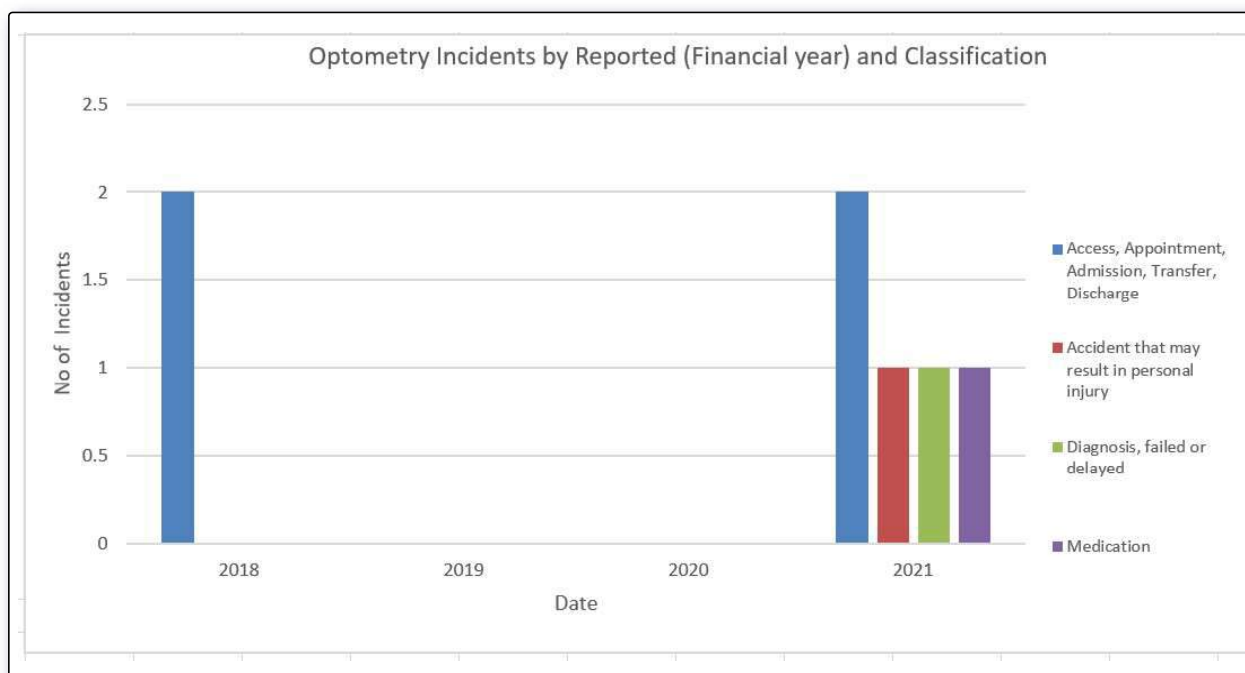
# Number of Incidents Primary Care

Total GP Incidents

GP Incident Details

Community Pharmacy Details

Dental Practice Details

Optometry Details



Community Pharmacy - Incidents by Reported (Month and year) and Classification

Legend:
- Abusive, violent, disruptive or self-harming behaviour
- Access, Appointment, Admission, Transfer, Discharge
- Accident that may result in personal injury
- Consent, Confidentiality or Communication
- Financial loss
- Implementation of care or ongoing monitoring/review
- Infrastructure or resources (staffing, facilities, environment)
- Medication
- Security
- Treatment, procedure

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Incidents Primary Care

| Total GP Incidents | GP Incident Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



Dental Practice Annual Data - Incidents by Reported (Month and year) and Classification

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Incidents Primary Care

Total GP Incidents

GP Incident Details

Community Pharmacy Details

Dental Practice Details

Optometry Details



Optometry Incidents by Reported (Financial year) and Classification

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Incidents Primary Care

| Total GP Incidents | GP Incident Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |
|---|---|---|---|---|



Optometry Incidents by Reported (Financial year) and Classification

Legend:
- Access, Appointment, Admission, Transfer, Discharge
- Accident that may result in personal injury
- Diagnosis, failed or delayed
- Medication

**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Complaints Primary Care

| Total GP Complaints | GP Complaints Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*
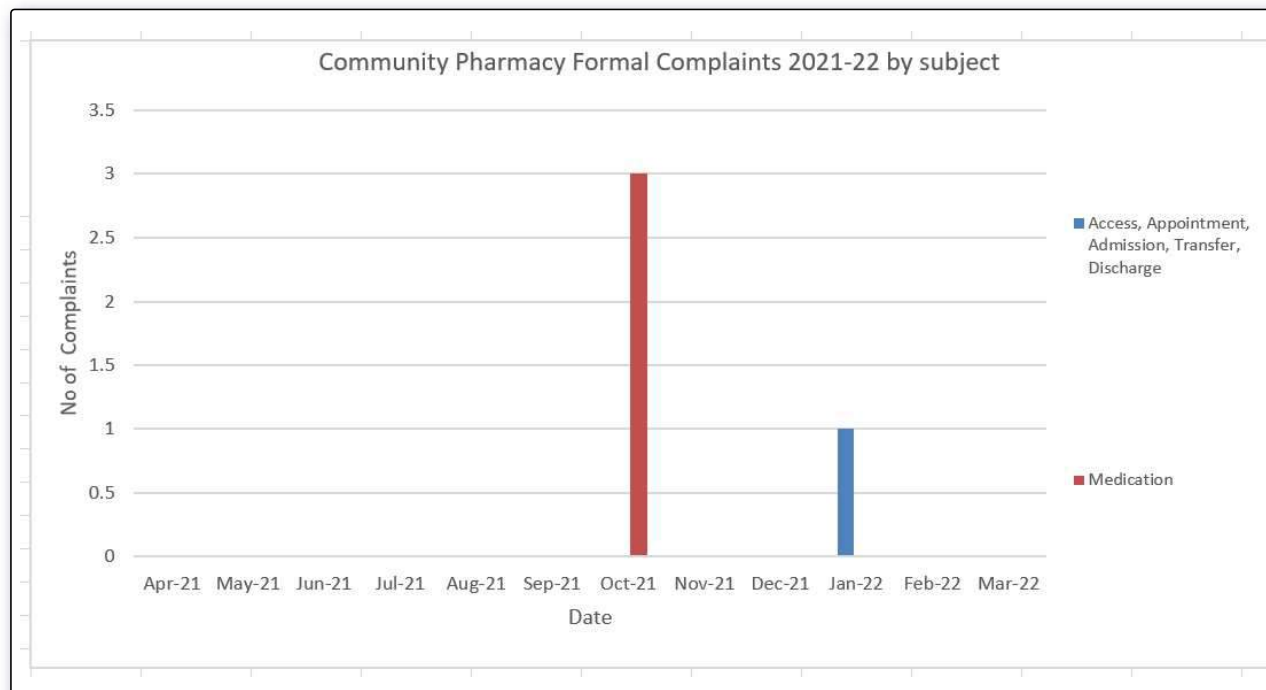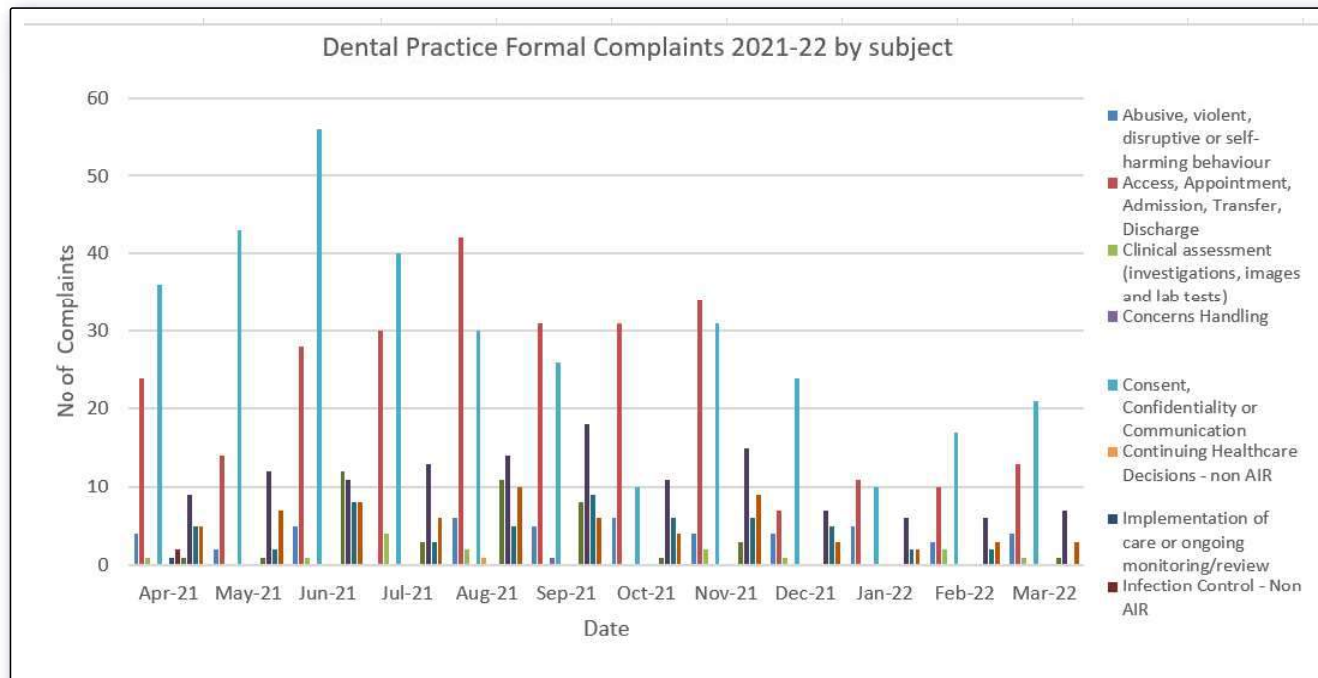
# Number of Complaints Primary Care

| Total GP Complaints | GP Complaints Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*
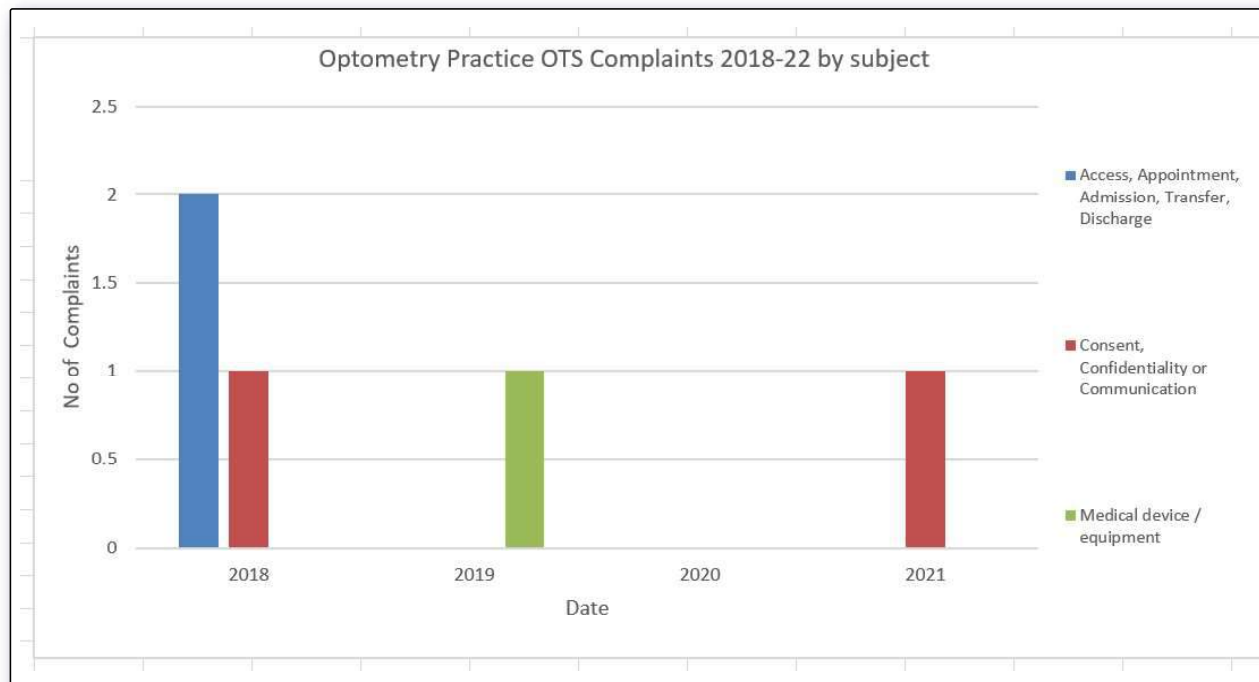
# Number of Complaints Primary Care

| Total GP Complaints | GP Complaints Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |

## Community Pharmacy Formal Complaints 2021-22 by subject



**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Complaints Primary Care

| Total GP Complaints | GP Complaints Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*

# Number of Complaints Primary Care

| Total GP Complaints | GP Complaints Details | Community Pharmacy Details | Dental Practice Details | Optometry Details |



**Note**: *Visualisation is a data snapshot of the current reporting month.*

| Cyfarfod a dyddiad:<br>Meeting and date: | **04.08.2022**<br>**Health Board** | | | | | |
|---|---|---|---|---|---|---|
| Cyhoeddus neu Breifat:<br>Public or Private: | Public | | | | | |
| Teitl yr Adroddiad<br>Report Title: | Annual Plan Monitoring Report 2022-23<br>Position as at 30.06.2022 | | | | | |
| Cyfarwyddwr Cyfrifol:<br>Responsible Director: | Sue Hill<br>Executive Director of Finance | | | | | |
| Awdur yr Adroddiad<br>Report Author: | Ed Williams<br>Deputy Director of Performance | | | | | |
| Craffu blaenorol:<br>Prior Scrutiny: | The data and information in this report has been reviewed by the Director of Performance. | | | | | |
| Atodiadau<br>Appendices: | Appendix 1 – Annual Plan programme action plan. | | | | | |
| **Argymhelliad / Recommendation:** | | | | | | |
| The Health Board is asked to scrutinise the report. | | | | | | |
| **Ticiwch fel bo'n briodol / Please tick as appropriate** | | | | | | |
| Ar gyfer<br>penderfyniad /cymeradwyaeth<br>For Decision/<br>Approval | | Ar gyfer<br>Trafodaeth<br>For<br>Discussion | | Ar gyfer<br>sicrwydd<br>For<br>Assurance | x | Er<br>gwybodaeth<br>For<br>Information | x |
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol**<br>**Y/N to indicate whether the Equality/SED duty is applicable** | | | | | N | |
| **Sefyllfa / Situation:** | | | | | | |

The Performance Team have worked with Independent Members, Executive Directors and the Planning Team in reviewing, strengthening and simplifying the monitoring process. This is the first, high-level iteration of the Annual Plan Monitoring Report. The report has been built using Microsoft Excel and provides an element of interaction (hyperlinks) to navigate between the sections.

The report contains a set of high-level programmes divided into chapters. Each chapter has a set of performance outcomes associated with it. At this stage, each chapter is a single page.

We will continue to develop and improve the report throughout 2022-23. Moving forward, the report will be built using Microsoft Office 365 tools including PowerBI (akin to the IQPR) which will support 'drill down' into more detailed levels of the plan, in order to provide further assurances and ease of collaboration between stakeholders.

This report provides a self-assessment by the Programme and Executive Leads of the progress being made in delivering the key priority actions contained in the 2022/23 Annual Plan, see appendix 1, as at 30.06.2022.

**Cefndir / Background:**

Programme Leads review their assigned actions and RAG-rate (Red, Amber, Green) progress at the end of each quarter. Where an action has been completed this is RAG rated Gold. Red ratings apply to actions where delivery was not achieved, a short narrative is provided for each red rated action.

**Key:**

| | |
|---|---|
| <span style="background:#b89c6a">     </span> | Completed |
| <span style="background:#1a9641">     </span> | On track |
| <span style="background:#f2b200">     </span> | Off Track - Mitigated |
| <span style="background:#ff0000">     </span> | Off track - Not Mitigated |
| <span style="background:#bfbfbf">     </span> | Update not yet due |

A rating is then provided for each chapter as a whole.

## Asesu a Dadansoddi / Assessment & Analysis

### Goblygiadau Strategol / Strategy Implications
The programmes underpin delivery of the 2022/23 Health Board Annual Plan, which has been developed in line with agreed local and national strategies – 'Living Healthier Staying Well' and 'A Healthier Wales'.

### Opsiynau a ystyriwyd / Options considered
Not applicable

### Goblygiadau Ariannol / Financial Implications
The Health Board has agreed a budget for delivery of the Annual Plan with performance against the budget reported to Board and Committees via the finance report.

### Dadansoddiad Risk / Risk Analysis

The RAG-rating reflects the risk to delivery of key actions.

### Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
This version of the report will be available to the public in PDF format once published for the Health Board.

### Asesiad Effaith / Impact Assessment
The Annual Plan has been subject to an Equality Impact and Socio-economic Duty Assessment.

Underpinning schemes and business cases referenced in the plan will take into account any potential equality/Welsh Language/quality/data governance/digital/children's rights implications that may require an impact assessment to be carried out.

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

# Welcome to Betsi Cadwaladr University Health Board's Annual Plan 2022-23 Monitoring Report

# Reporting Period 1st April to 30th June 2022

Produced by the Performance Directorate in collaboration with Programme Leads

# Annual Plan 2022-23 Monitoring Report

## As at 30th June 2022

**Key:**
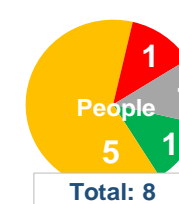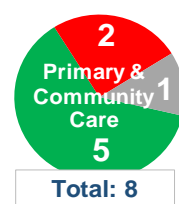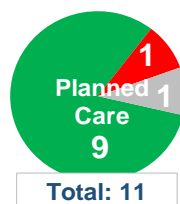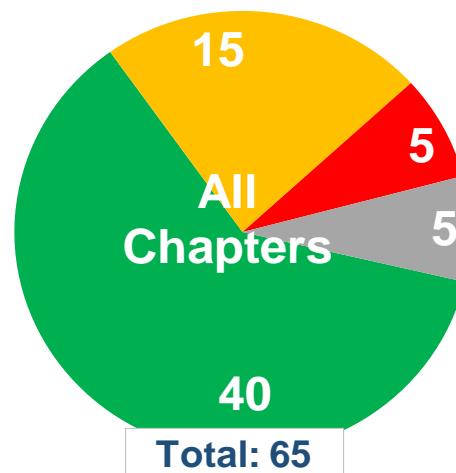
- Completed
- On track
- Off Track - Mitigated
- Off track - Not Mitigated
- Update not yet due



**All Chapters**
- 15
- 5
- 5
- 40

Total: 65

**Planned Care**
- 9
- 1

Total: 11

**Planned Care Recovery**
- 14
- 1

Total: 15

**Unscheduled Care**
- 2

Total: 2

**Primary & Community Care**
- 2
- 5
- 1

Total: 8

**Mental Health**
- 8
- 3

Total: 11

**Population Health**
- 2

Total: 2

**Transformation & Improvement**
- 1
- 1
- 2
- 4

Total: 8

**People**
- 1
- 1
- 5
- 1

Total: 8

Home
Summary
**Planned Care**
Planned Care Recovery
Unscheduled Care
Primary & Community Care
Mental Health
Population Health
Transformation & Improvement
People
About this Report
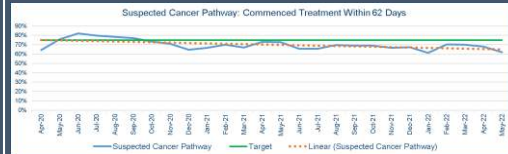Further Information

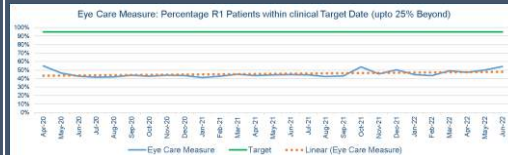| Planned Care | Status | 🟢 On Track | Executive Lead: Gill Harris | Last Updated on: | **29th July 2022** |
|---|---|---|---|---|---|

## Our Outcomes

### Suspected Cancer Pathway Performance: 62%


Suspected Cancer Pathway: Commenced Treatment Within 62 Days

### Eye Care Measure Performance: 54%


Eye Care Measure: Percentage R1 Patients within clinical Target Date (upto 25% Beyond)

### Diagnostic Waits Performance: 8,848 (over 8 weeks)


Diagnostic Waits: Number of Patients Waiting Over 8 Weeks

Produced by the Performance Directorate in collaboration with Planned Care Leads

## Our Programmes

Legend: 🟤 Completed   🟢 On Track   🟡 Off Track - Mitigated   🔴 Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| a.2022.36 | Suspected cancer pathway improvement | 🟢 | | | x |
| a.2022.6 | Eye Care | 🟢 | x | | |
| a.2022.30 | Radiology sustainable plan | 🟢 | x | x | x |
| a.2022.31 | Regional Treatment Centres | 🟢 | x | | |
| a.2022.38 | Urology - Robot Assisted Surgery | 🟢 | x | x | x |
| a.2022.12 | Long Covid | 🟢 | | | |
| a.2022.13 | Lymphoedema | 🟢 | | | |
| a.2022.10 | Implementation of Audiology pathway | 🟢 | x | | x |
| a.2022.39 | Vascular | 🟤 | x | x | |
| b.2022.8 | Diabetic Foot pathway | 🔴 | x | | |
| a.2022.11 | Improving minimal access surgery in gynaecology and north Wales specialist endometriosis care | 🟢 | x | | |
| a.2022.9 | Home First Bureaus ON HOLD | 🟤 | Update not received yet | | |

## Narrative

b.2022.8 Diabetic foot pathway - no progress has been made since January as the programme requires release of funding which has not yet occurred. Slippage is identified in the business cases being sent to scrutiny group w/c 18th July and then on to Executives f or review.

**Planned Care Recovery**

| | |
|---|---|
| Home | |
| Summary | |
| Planned Care | |
| **Planned Care Recovery** | |
| Unscheduled Care | |
| Primary & Community Care | |
| Mental Health | |
| Population Health | |
| Transformation & Improvement | |
| People | |
| About this Report | |
| Further Information | |

**Planned Care Recovery**   Status ● On Track   **Executive Lead: Gill Harris**

**Last Updated on:** **29th July 2022**

**Our Outcomes**

To be Confirmed

**Our Programmes**   Legend: ● Completed  ● On Track  ● Off Track - Mitigated  ● Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| Capacity – core and additional | Outsourcing | ● | | | |
| | Insourcing | ● | | | |
| | Partnerships | ● | | | |
| Lean, value-focused support infrastucture - clinical | Radiology sustainability - scheme a.2022.30 in Consolidated schemes plan | ● | | | |
| | Oncology capacity | ● | | | |
| | Pathology | ● | | | |
| Lean, value-focused support infrastucture - administrative | Validation programme | ● | | | |
| | BetsiPathways e.g. Audiology - scheme a.2022.10 referenced in Consolidated schemes plan | ● | | | |
| | GIRFT / National Programme in 5 specialities | ● | | | |
| | Patient Initiated Follow-up (PIFU) , See on Symptoms (SOS) , Advice & Guidance (A&G) | ● | | | |
| | Pre-habilitation | ● | | | |
| | 'Attend Anywhere' | ● | | | |
| Modernisation | Urology Robot | ● | | | |
| Building for the future | RTC project - a.2022.31 referenced in Consolidated schemes plan | ● | | | |
| Communication | Launch a Communication Strategy | ● | | | |
| a.2022.40 | Video consultations | ● | | x | x |

**Narrative**

Narrative only required for Programmes rated as Red - Off Track not Mitigated.

Produced by the Performance Directorate in collaboration with Planned Care Leads

| Unscheduled Care | Status | ● On Track | Executive Lead: Gill Harris | Last Updated on: | **29th July 2022** |
|---|---|---|---|---|---|

## Our Outcomes

### Ambulance Handover Over 1 Hr Performance: 1,932


BCU Level - Ambulance Handovers: Number of Patients Waiting Over 1 Hour

### ED&MIU Under 4 Hour Performance: 61.77%


BCU Level - Combined Emergency Department & Minor Injuries Units: Patients seen within 4 Hours
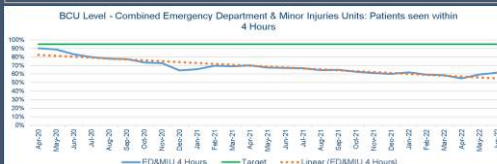
### Stroke Under 4 Hour Performance: 27.20%


Stroke Care: Admitted to Stroke Unit within 4 Hours

Produced by the Performance Directorate in collaboration with Unscheduled Care Leads

## Our Programmes

Legend: ● Completed ● On Track ● Off Track - Mitigated ● Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| a.2022.34 | Strengthening emergency department (ED) & SDEC workforce to improve patient flow. | ● | | x | |
| a.2022.35 | Stroke services | ● | x | x | x |

## Narrative

Narrative is only required when a programme has ben rated as Red = Off Track Not Mitigated.

**Primary & Community Care** | **Status** | 🟢 On Track | **Executive Lead: Gill Harris** | **Last Updated on:** | **29th July 2022**

## Our Outcomes

UPCC Referrals

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 614 | 513 | 600 | 518 | 540 | 785 | 696 | 650 | 533 | 418 | 500 | 566 |
| Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |

2021 - 2022

## Our Programmes

Legend: 🟤 Completed  🟢 On Track  🟡 Off Track - Mitigated  🔴 Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|
| a.2022.7 | Further development of the Academy | 🟢 | x | x | x |
| a.2022.37 | Urgent Primary Care Centres | 🟢 | x | | x |
| a.2022.44 | Widening of Primary Care workforce | ⚪ | Update due at Q3 | | |
| b.2022.14 | Recovery of Primary Care chronic disease monitoring | 🔴 | | x | x |
| b.2022.2 | Accelerated Cluster Development | 🟢 | x | x | x |
| a.2022.2 | Colwyn Bay Integrated services facility | 🔴 | | | |
| a.2022.1 | Care Home support | 🟢 | x | x | x |
| a.2022.3 | Continuing Healthcare infrastructure | 🟢 | x | x | x |

## Narrative

a.2022.14 - significant difficulties staffing additional sessions means that making a positive impact on the planned care backlog is a challenge. Senior Cluster Co-ordinators to work with Cluster leads to understand / measure backlog and develop additional measures to support reduction

a.2022.2 - although there has been some engagement undertaken on the service model a decision was taken by the project board not to start the broader public engagement at the moment as the sale / transfer of the site from WG to CCBC has been delayed and not yet f inalised.

Produced by the Performance Directorate in collaboration with Primary & Community Care Leads

**Mental Health** | **Status** | Off Track Mitigated | **Executive Lead: Teresa Owen & Gill Harris** | **Last Updated on:** | **29th July 2022**

## Our Outcomes

### Neurodevelopment Performance: 43.02%


Neurodevelopment - Referral to Treatment within 26 Weeks

### CAMHS Assessment Performance: 25.0%


CAMHS Assessments within 28 Days
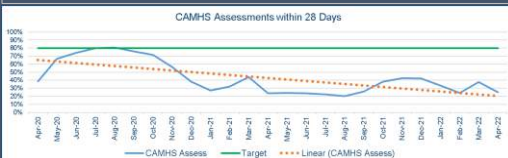
### Adult Psychotherapy Performance: 69.57%


Adult Psychotherapy - Referral to Treatment within 26 Weeks

Produced by the Performance Directorate in collaboration with Mental Health & Learning Disabilities Leads

## Our Programmes

Legend: ● Completed  ● On Track  ● Off Track - Mitigated  ● Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|-----|-----------|----|----|----|----|
| a.2022.14 | AISB Joint Commissioning | 🟡 | x | | |
| a.2022.15 | CAMHS Training and Recruitment | 🟢 | x | | |
| a.2022.16 | CAMHS Transition and Joint working | 🟢 | x | | |
| a.2022.17 | Early Intervention in Psychosis | 🟡 | x | | x |
| a.2022.18 | Eating Disorders Service development | 🟡 | x | x | x |
| a.2022.19 | ICAN Primary Care | 🟡 | x | x | x |
| a.2022.20 | Medicines Management support | 🟡 | x | x | x |
| a.2022.21 | Neurodevelopment recovery | 🟢 | x | | |
| a.2022.22 | Occupational Therapy | Not being progressed at this time | | | |
| a.2022.23 | Older Persons Crisis Care | 🟡 | x | | x |
| a.2022.24 | Perinatal Mental Health Services | 🟡 | | x | x |
| a.2022.25 | Psychiatric Liaison Services | 🟡 | | x | x |

## Narrative

Narrative only required for Programmes rated as Red - Off Track not Mitigated.

a2022.22 Occupational Therapy has been stood down from the plan pending decision to progress

Home
Summary
Planned Care
Planned Care Recovery
Unscheduled Care
Primary & Community Care
Mental Health
**Population Health**
Transformation & Improvement
People
About this Report
Further Information

**Population Health** | Status | ⬤ On Track | Executive Lead: Teresa Owen | Last Updated on: | **29th July 2022**

### Our Outcomes

**COVID-19 Vaccinations Given**

| Total Doses Given 1,669,708 | Moderna 150,347 |
| Pfizer Biontech 949,752 | Third/Booster Doses 460,842 |
| Astrazeneca 561,123 | Spring Booster 80,428 |

### Our Programmes

Legend: ⬤ Completed  ⬤ On Track  ⬤ Off Track - Mitigated  ⬤ Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|-----|-----------|----|----|----|----|
| a.2022.4 | COVID-19 vaccination and Test, Trace and Protect (TTP) | ⬤ | | | |
| b.2022.5 | Building a Healthier Wales (BAHW) | ⬤ | x | x | |

### Narrative

Narrative only required for Programmes rated as Red - Off Track not Mitigated

Produced by the Performance Directorate in collaboration with Population Health Leads

Home

Summary

Planned Care

Planned Care Recovery

Unscheduled Care

Primary & Community Care

Mental Health

Population Health

**Transformation & Improvement**

People

About this Report

Further Information

| | Transformation & Improvement | Status | ● | On Track | Executive Leads: Gill Harris, Chris Stockport & Teresa Owen | | Last Updated on: | **29th July 2022** |

**Our Outcomes**

**Our Programmes**

Legend: ● Completed   ● On Track   ● Off Track - Mitigated   ● Off Track - Not Mitigated

Outcomes will be included in the next report

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|-----|-----------|----|----|----|----|
| b.2022.11 | Implementing the Quality Act | ● | x | x | x |
| b.2022.1 | 3rd sector strategy | ● | x | | x |
| b.2022.3 | Atlas of Variation | ● | x | x | |
| b.2022.4 | BCUPathways | ● | x | x | x |
| b.2022.6 | Commissioning unit | ● | x | | |
| b.2022.10 | Golden Value Metrics | ● | | x | |
| b.2022.12 | Inverse Care Law work | ● | x | x | x |
| b.2022.13 | LEAN Healthcare system | ● | x | | x |

**Narrative**

Narrative only required for Programmes rated as Red - Off Track not Mitigated.

Produced by the Performance Directorate in collaboration with the relevant leads

## People

**Status** 🟢 On Track

**Executive Leads:** Sue Green, Teresa Owen , Nick Lyons

**Last Updated on:** **29th July 2022**

### Our Outcomes

Outcomes will be included in the next report

### Our Programmes

Legend: 🔘 Completed  🟢 On Track  🟡 Off Track - Mitigated  🔴 Off Track - Not Mitigated

| Ref | Programme | Q1 | Q2 | Q3 | Q4 |
|-----|-----------|----|----|----|----|
| a.2022.42 | Welsh Language | 🟢 | x | x | x |
| a.2022.28 | Operating Model | 🟡 | | x | x |
| a.2022.29 | People & OD Strategy – Stronger Together | 🟡 | x | x | |
| a.2022.32 | Speak Out Safely | 🟡 | x | x | |
| a.2022.33 | Staff Support and Wellbeing | 🟡 | x | x | |
| a.2022.45 | Workforce Operating Model – (inc. recruitment etc.) | 🟡 | x | x | |
| a.2022.8 | Health & Safety Statutory Compliance | 🔘 | | x | x |
| a.2022.27 | North Wales Medical & Health Sciences School | 🔴 Timeline moved to January 2023 | | | |

### Narrative

a.2022.27 North Wales Medical & Health Sciences School: The timeline for the strategic outline case to go to Board is now January 2023. This is to take into account work by Welsh Government taking place from April 2022 through to September 2022 and capital feasibility work that has been commissioned that is also ongoing to be completed September / October 2022.

Produced by the Performance Directorate in collaboration with Workforce Leads

**Navigation**

Navigate the report by using the content bar on each page.

The chosen header will highlight which page you are on.

Summary

Planned Care

Planned Care Recovery

Unscheduled Care

Primary & Community Care

Mental Health

**Home**

Summary

**Planned Care**

On the summary page, you can click through the pie charts to access the same information.

Planned Care 7
Total: 10

Planned Care Recover 14
Total: 1
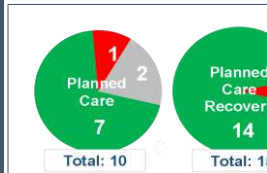
**Background and Content**

This report has been produced by the Performance Directorate in collaboration with programme leads.

The report is based upon a selection of programmes from the Annual Plan for 2022-23.

This report presents the status of the programmes deemed the highest priority for the Health Board (at the time of reporting) and covers the first quarter of 2022-23 (April to June).

This is the first iteration of this report and is presented for approval of content and format at Health Board on 4th August 2022.

Development and improvement of the report will continue throughout 2022-23 and more detailed layers will be added together with analysis of risk and assurance.

Each RAG rating and any associated narrative has been provided by the lead for that programme.

This Report was last updated on : **29th July 2022**

Produced by the Performance Directorate in collaboration with the Planning Department

| Cyfarfod a dyddiad:<br>Meeting and date: | Health Board 04.08.2022 |
|---|---|
| Cyhoeddus neu Breifat:<br>Public or Private: | Public |
| Teitl yr Adroddiad<br>Report Title: | Finance Report Month 3 2022/23 |
| Cyfarwyddwr Cyfrifol:<br>Responsible Director: | Sue Hill, Executive Director of Finance |
| Awdur yr Adroddiad<br>Report Author: | Tim Woodhead, Operational Finance Director |
| Craffu blaenorol:<br>Prior Scrutiny: | Executive Director of Finance |
| Atodiadau<br>Appendices: | Appendix 1: Finance Report Pack |
| **Argymhelliad / Recommendation:** | |
| It is asked that the report is noted. | |

| **Ticiwch fel bo'n briodol / Please tick as appropriate** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Ar gyfer penderfyniad/cymeradwyaeth<br>For Decision/ Approval | | Ar gyfer Trafodaeth<br>For Discussion | | Ar gyfer sicrwydd<br>For Assurance | ✓ | Ergwybodaeth<br>For Information | |
| **Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol**<br>**Y/N to indicate whether the Equality/SED duty is applicable** | | | | | | **N** | |
| Equality Impact (EqIA) and a socio-economic (SED) impact assessments are not applicable. | | | | | | | |

| **Sefyllfa / Situation:** |
|---|
| The purpose of this report is to provide a briefing on the draft unaudited financial performance of the Health Board for the three months from 1 April 2022 to 30 June 2022.<br><br>With regards to the financial statements for the financial year from 1 April 2021 to 31 March 2022:<br><br>• Whilst the audit is ongoing, the Auditor General, Audit Wales intends issuing a qualified true and fair opinion as he has been unable to obtain sufficient audit evidence that accruals, payables and related expenditure have been properly accounted for in the correct accounting period.<br>• Audit Wales continue to work to reduce any residual uncertainty with the balances.<br>• We have had to defer the AGM in lieu of this, and breached our standing orders<br>• An Audit Wales QA check is arranged which will allow the Health Board to finalise the audit, approve the accounts and hold the AGM |

| **Cefndir / Background:** |
|---|
| The plan is in line with the three year Integrated Medium Term Plan agreed by the Board in March 2022.<br><br>The Health Board's plans for 2022/23 include the £82m strategic support funding notified by Welsh Government last year (£40m to cover the deficit, £30m performance support and £12m transformation |

funding support) and £38.4m for Planned and Unplanned Care Sustainability. Together, these funds will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

For 2022/23 the Health Board can claim COVID-19 costs for PPE, Cleaning Standards, Mass Vaccination, Test & Trace, Long COVID and Extended Flu as per previous year. However, no expenditure can be claimed for Field Hospitals due to these being decommissioned. In addition, UPCC will not be funded from COVID and no allocation has yet been agreed for Winter Pressures or English Providers of elective recovery work.

An additional £20.5m of Surge Funding has been agreed to support the ongoing COVID-19 response to include additional costs because of increased bed capacity, prescribing charges, increased workforce and discharge support directly related to COVID-19.

However, the expectation is that COVID-19 costs will decrease over future months as we enter a transition period of de-escalation of COVID measures, to enable transformation and modernisation of planned and elective care.

| Asesiad / Assessment: |
|---|
| **Goblygiadau Strategol / Strategy Implications**<br>This paper aligns to the strategic goal of attaining financial balance and is linked to the well-being objective of targeting our resources to those with the greatest need. |
| **Opsiynau a ystyriwyd / Options considered**<br>Not applicable – report is for assurance only |

**Goblygiadau Ariannol / Financial Implications**

|  | Month 3 YTD £m | Annual Forecast £m |
|---|---|---|
| Actual Position | (2.3) | 0.0 |
| Planned Position | 0 | 0 |
| Variance | (2.3) | 0.0 |

The in-month and cumulative position is a £2.3m deficit against plan, (0.49% of allocation), which is forecast to be recovered by month 9. The position for month 3 was a breakeven against plan and therefore the position has not deteriorated from that reported in month 2.

The key reasons for the deficit are additional variable pay costs, particularly relating to Medical and Nursing Agency as well as higher than expected costs within CHC, due to both complexity of cases and increased prices.

Savings delivered in the 3 months to June 2022 was £3.38m against a plan of £4.44m, a shortfall of £1.06m. Non-recurrent savings delivered are £0.63m. The savings forecast is £13.7m, which is £21.3m behind the target of £35m for the year. There were no transformation savings planned to be delivered in the first quarter of the year.

The strategic support funding of £82m for the year is forecast to be fully utilised.

**Dadansoddiad Risk / Risk Analysis**

Current risks and mitigations are shown in Appendix 1, slide 12. £53m worth of risks relate to areas where Welsh Government have indicated that funding will be provided, however they have also advised that this funding should be classified as high risk, indicating that funding for these issues is not certain. Further mitigations to the risks continue to be identified to ensure that Health Board achieves its statutory financial duty.

**Cyfreithiol a Chydymffurfiaeth / Legal and Compliance**
Not applicable.

**Asesiad Effaith / Impact Assessment**
Not applicable.

# Executive Summary

**Objective**

To provide assurance on financial performance and delivery against Health Board financial plans and objectives and give early warning on potential performance issues. To make recommendations for action to continuously improve the financial position of the organisation, focusing on specific issues where financial performance is showing deterioration or there are areas of concern.

**Positives & Key Assurances**

✓ Current Month is reporting a balanced position and cumulative deficit of £2.3m.

✓ Forecast is to deliver a break even position based on a savings delivery target of £35m and that Welsh Government will fully fund the additional costs of COVID-19.

✓ The Health Board achieved the PSPP target to pay 95% of valid invoices within 30 days of receipt in three of the four measures of compliance during Quarter 1 2022-23 with only NHS invoices by number remaining below target at 83.4%.

**Issues & Actions**

➤ To achieve a break-even position, the Health Board is required to deliver a savings plan of £35m and is subject to inflationary risk.

➤ The Health Board has set a savings target of £35m for 2022/23 to be driven equally by both transaction and transformation led plans and programmes of work. As at Month 3, Saving Schemes identified as Green and Amber total full year forecast is £11.1m against a plan of £35m. Including red schemes, for which assurance reviews must be completed, the forecast totals £13.7m including income generation.

**Key Messages**

❖ The June position is reporting an in-month balanced position and year to date deficit of £2.3m. The forecast is to break-even for 2022/23.

❖ The Health Board's financial plan for 2022/23 is to deliver a balanced position which includes the £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition the Health Board has received £38M in relation to Planned and Unscheduled Care Sustainability Funding. Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.

❖ Productivity improvement estimates to be delivered by the Divisions have increased from £0.5m to £0.8m in addition to £3.1m in year savings identified by Transformation. With regards to further savings, the pace of progress has been impacted due to the challenging operational environment. The plan and approach to closing the gap to target is currently being reassessed.

# Summary of Key Numbers

| Month 3 Position | Forecast | Divisional Performance Month 3 |
|---|---|---|
| £152.4m against plan of £152.4m.<br>**Balanced**<br><br>YTD £459.1m against plan of £456.9m<br>**£2.3m adverse** | Projected Position but this is subject to inflationary risk.<br><br>**Balanced** | Area Teams — £0.2m favourable<br>Secondary Care — £6.3m adverse<br>Mental Health — £0.9m adverse<br>Corporate and Other — £4.8m favourable |

| Savings | Savings Forecast | COVID-19 Impact |
|---|---|---|
| In-month: £1.4m against target of £1.5m<br>**£0.1m adverse**<br><br>YTD: £3.4m against target of £4.4m<br>**£1.0m adverse** | £13.7m, including pipeline savings, against plan of £35.0m<br><br>**£21.3m adverse** | £13.2m cost YTD<br><br>£47.2m forecast cost.<br>Funded by Welsh Government (with risk)<br>**£NIL impact** |

| Income | Pay | Non-Pay |
|---|---|---|
| £33.5m against budget of £34.4m<br><br>**£0.9m adverse** | £225.4m against budget of £223.7m<br><br>**£1.8m adverse** | £267.2m against budget of £267.6m<br><br>**£0.4m favourable** |

# Revenue Position

| | Actual M1 £'000 | Actual M2 £'000 | Actual M3 £'000 | 2022/23 Cumulative | | | | Forecast Actual £'000 |
|---|---|---|---|---|---|---|---|---|
| | | | | Budget £'000 | Actual £'000 | Variance £'000 | Variance % | |
| Revenue Resource Limit | (152,882) | (151,609) | (152,384) | (456,875) | (456,875) | 0 | 0.0% | (1,847,919) |
| Miscellaneous Income | (11,293) | (10,787) | (11,435) | (34,420) | (33,515) | (905) | 2.6% | (133,644) |
| Health Board Pay Expenditure | 76,620 | 73,442 | 75,384 | 223,662 | 225,446 | (1,784) | (0.8)% | 912,362 |
| Non-Pay Expenditure | 88,898 | 89,855 | 88,452 | 267,633 | 267,205 | 428 | 0.2% | 1,069,201 |
| Total | 1,343 | 901 | 17 | 0 | 2,261 | (2,261) | | 0 |

- The Health Board's financial plan for 2022/23 is to deliver a balanced position which includes the £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition £38m funding has also been received for Planned and unscheduled Care Sustainability.

- Together, these will be used to improve performance, reduce waiting lists and drive a programme of transformation linked to a sustainable clinical model for North Wales.



Financial Performance & Forecast
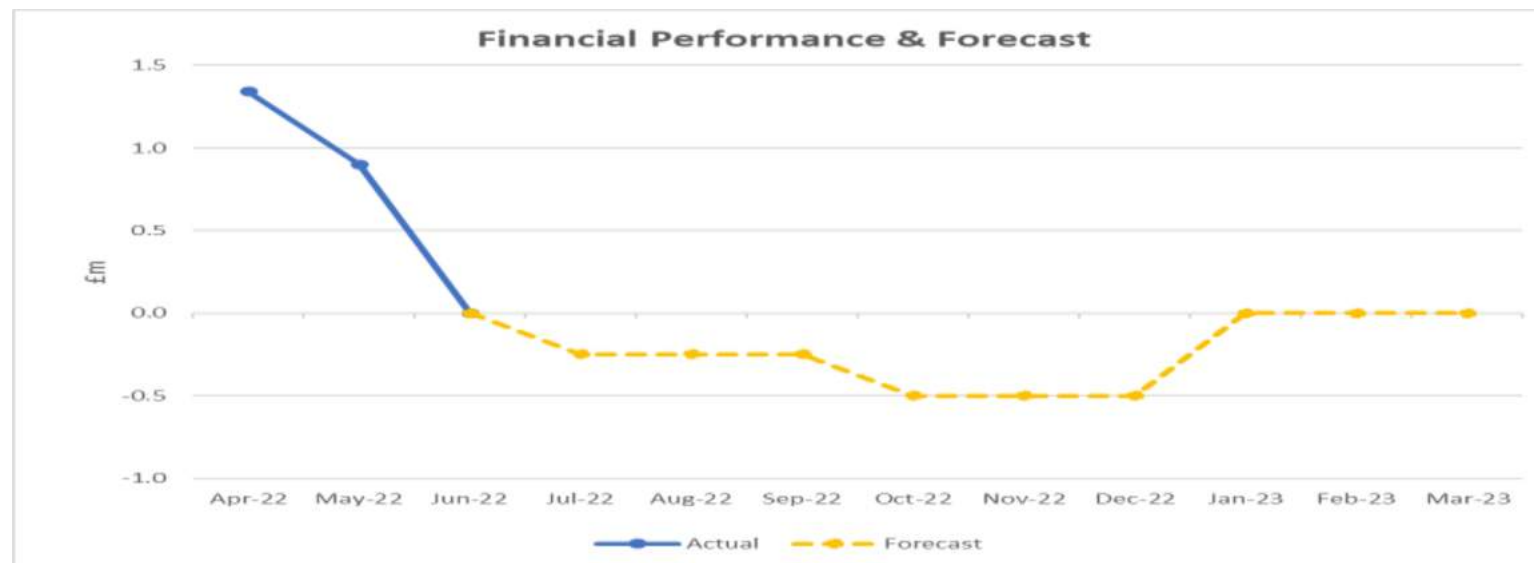
- Current Month is reporting a balanced position and cumulative position to end of June is reporting a deficit of £2.3m.

- The total cost of COVID-19 in June is £3.6m (£13.2m year to date), a reduction of £1.0m from May expenditure. Total year forecast cost of COVID-19 is £47.2m for which Welsh Government income has been anticipated to fully cover these costs, giving a nil impact on the financial position.

- The forecast to deliver a balanced position is based on a savings delivery target of £35.0m.

- The delivery of a balanced position is also dependant on Welsh Government fully funding the costs of COVID-19 and the exceptional costs outlined in our anticipated income.

# Divisional Positions

| | In Month | | | Cumulative | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance to Plan | Budget | Actual | Variance to Plan |
| | £000 | £000 | £000 | £000 | £000 | £000 |
| WG RESOURCE ALLOCATION | (152,384) | (152,384) | 0 | (456,875) | (456,875) | 0 |
| AREA TEAMS | | | | | | |
| West Area | 13,907 | 13,876 | 30 | 41,725 | 42,138 | (413) |
| Central Area | 18,241 | 17,879 | 362 | 54,656 | 54,021 | 635 |
| East Area | 20,636 | 20,643 | (7) | 61,978 | 62,178 | (200) |
| Other North Wales | 5,930 | 5,793 | 137 | 15,502 | 15,639 | (137) |
| Field Hospitals | 0 | 0 | 0 | 0 | 0 | 0 |
| Track,Trace,Protect & Vaccination | 1,849 | 1,849 | (0) | 6,012 | 6,012 | 0 |
| Commissioner Contracts | 20,469 | 19,881 | 587 | 61,384 | 61,100 | 283 |
| Provider Income | (1,765) | (1,772) | 7 | (5,295) | (5,315) | 20 |
| Total Area Teams | 79,266 | 78,150 | 1,116 | 235,962 | 235,773 | 189 |
| SECONDARY CARE | | | | | | |
| Ysbyty Gwynedd | 9,235 | 9,768 | (533) | 27,691 | 29,297 | (1,606) |
| Ysbyty Glan Clwyd | 11,110 | 12,429 | (1,319) | 34,088 | 36,594 | (2,506) |
| Ysbyty Maelor Wrexham | 9,885 | 10,297 | (413) | 29,971 | 31,100 | (1,130) |
| North Wales Hospital Services | 9,943 | 10,156 | (213) | 29,814 | 30,847 | (1,033) |
| Womens | 3,461 | 3,480 | (19) | 10,473 | 10,538 | (64) |
| Total Secondary Care | 43,634 | 46,131 | (2,497) | 132,037 | 138,376 | (6,339) |
| Total Mental Health & LDS | 11,641 | 11,499 | 142 | 34,925 | 35,832 | (907) |
| Total Corporate and Other | 17,843 | 16,623 | 1,221 | 53,951 | 49,155 | 4,796 |
| TOTAL | 0 | 18 | (18) | 0 | 2,261 | (2,261) |



Divisional Positions at Month 3
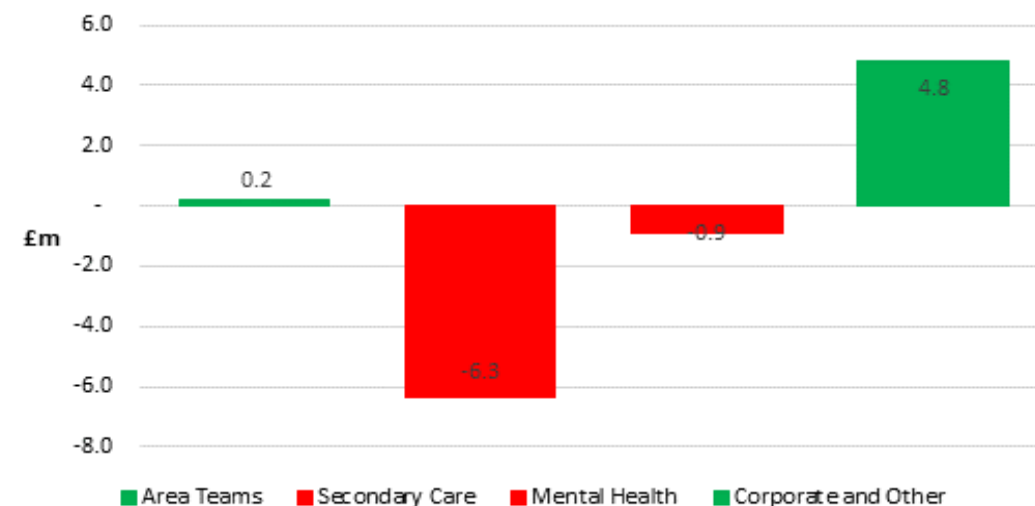
- Key impacts affecting divisional positions include additional costs in Secondary Care due to Medical and Nursing Agency premium covering vacancies and sickness. Variable Pay, including Bank, Agency, Locum, Overtime.

- Pressures continue within Mental Health due to Continuing Healthcare packages requiring more complex packages, driving an increase in costs.

- Other Budgets & Reserves includes Performance, Transformation and Sustainability schemes funding, for which some costs have been reported within the Divisions, but have yet to have funding released from reserves. The reserves profile has been adjusted to account for these costs, which is resulting in an underspend in other budgets.

| Description | £m |
|---|---|
| Allocations Received | 1762.8 |
| **Total Allocations Received** | **1,762.8** |

| Description | £m |
|---|---|
| **Allocations anticipated** | |
| Capital | 1.6 |
| COVID-19 | 42.0 |
| Energy (Price Increase) | 12.2 |
| Employers NI Increase (1.25%) | 7.4 |
| Real Living Wage | 2.5 |
| Substance Misuse | 6.0 |
| IM&T Refresh Prorgamme | 1.9 |
| Prevention & Early Years Funding | 1.3 |
| Urgent Primary Care Centres | 1.0 |
| MSK Orthopaedic Services | 1.2 |
| Obesity Pathways | 0.6 |
| SDEC | 1.6 |
| PACU | 0.9 |
| WPAS | 0.8 |
| Annual Leave Overtime (Flowers Case) | 3.6 |
| Dementia Assessment Services - part of RIF funding | 2.2 |
| WRP Risk Share 22/23 for M1 MMR | -4.8 |
| Repayment of invest to save | -0.5 |
| British Red Cross - Wellbeing and home service | 0.5 |
| Memory Assessement Services - part of RIF Funding | 0.7 |
| All Wales Robotics Partnership | 0.5 |
| Real Living Wage B1 & B2 - from April 22 | 0.6 |
| Other | 1.3 |
| | |
| **Total Allocations Anticipated** | **85.1** |

| | £m |
|---|---|
| Total Allocations Received | 1,762.8 |
| Total Allocations Anticipated | 85.1 |
| **Total Welsh Government Income** | **1,847.9** |

- The Health Board is funded in the main from the Welsh Government allocation via the Revenue Resource Limit (RRL). The RRL is currently £1,847.9m for the year, of which £456.9m has been profiled into the cumulative position which is £5.1m less than 3/12ths of the allocation.

- The RRL includes confirmed allocations to date of £1,762.8m, with further anticipated allocations in year of £85.1m.

- The anticipated allocations includes £42.0m for COVID-19 income, as £5.2m of COVID-19 funding has now been received within the allocation. £13.2m of this income has been profiled into the cumulative position to match expenditure.

- Also, within the allocations received includes £82.0m strategic support funding from Welsh Government (£30.0m Performance Fund, £12m Transformation Fund and £40.0m Strategic support). In addition, £38M has also been received for Planned and Unscheduled Care Sustainability Fund.

| COVID -19 Funding | £m |
|---|---|
| Total COVID-19 costs in 2022/23 | 47.2 |
| **Total Covid -19 funding** | **47.2** |

| | |
|---|---|
| Received | 5.2 |
| Anticipated | 42.0 |

| Pay Costs | M10 £m | M11 £m | M12 £m | M1 £m | M2 £m | M3 £m | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Forecast £m |
|---|---|---|---|---|---|---|---|---|---|---|
| Administrative & Clerical | 10.8 | 10.9 | 17.3 | 11.4 | 10.0 | 11.0 | 32.4 | 32.4 | (0.1) | 133.1 |
| Medical & Dental | 17.0 | 17.1 | 26.8 | 17.6 | 17.3 | 17.9 | 50.1 | 52.8 | (2.7) | 218.7 |
| Nursing & Midwifery Registered | 24.1 | 23.6 | 36.7 | 23.7 | 22.9 | 23.4 | 72.9 | 70.1 | 2.8 | 279.7 |
| Additional Clinical Services | 11.9 | 11.0 | 17.5 | 11.2 | 10.6 | 10.7 | 29.4 | 32.4 | (3.0) | 36.2 |
| Add Prof Scientific & Technical | 3.3 | 3.2 | 5.0 | 2.9 | 2.9 | 2.9 | 9.7 | 8.8 | 1.0 | 128.3 |
| Allied Health Professionals | 4.7 | 4.6 | 7.1 | 5.0 | 4.7 | 4.7 | 14.3 | 14.5 | (0.2) | 58.4 |
| Healthcare Scientists | 1.2 | 1.3 | 2.1 | 1.3 | 1.2 | 1.3 | 4.0 | 3.8 | 0.2 | 14.9 |
| Estates & Ancillary | 3.6 | 3.4 | 5.3 | 3.5 | 3.7 | 3.5 | 10.8 | 10.6 | 0.2 | 42.2 |
| Students | 0.1 | 0.1 | 0.2 | 0.1 | 0.1 | 0.1 | 0.2 | 0.2 | (0.1) | 0.9 |
| **Health Board Total** | **76.7** | **75.3** | **118.1** | **76.6** | **73.4** | **75.5** | **223.7** | **225.5** | **(1.9)** | **912.4** |
| Other Services (Incl. Primary Care) | 2.0 | 2.4 | 2.5 | 2.0 | 2.4 | 2.2 | 5.6 | 6.6 | (1.0) | 26.6 |
| **Total Pay** | **78.6** | **77.7** | **120.7** | **78.7** | **75.8** | **77.6** | **229.3** | **232.1** | **(2.8)** | **939.0** |

| Non-Pay Costs | 2021-22 M10 £m | M11 £m | M12 £m | 2022-23 M1 £m | M2 £m | M3 £m | YTD Budget £m | YTD Actual £m | YTD Variance £m | Full Year Forecast £m |
|---|---|---|---|---|---|---|---|---|---|---|
| Primary Care Contractors | 20.3 | 18.4 | 18.8 | 18.1 | 17.9 | 16.5 | 54.6 | 52.5 | 2.0 | 218.7 |
| Primary Care Drugs | 9.3 | 8.9 | 9.9 | 8.7 | 8.8 | 9.9 | 26.1 | 27.4 | (1.3) | 112.8 |
| Secondary Care Drugs | 7.2 | 6.4 | 7.1 | 7.0 | 7.3 | 5.4 | 19.0 | 19.6 | (0.6) | 83.7 |
| Clinical Supplies | 7.4 | 7.7 | 14.5 | 6.1 | 6.8 | 6.7 | 17.3 | 19.6 | (2.3) | 70.2 |
| General Supplies | 5.5 | 6.1 | 10.5 | 4.2 | 3.9 | 4.7 | 12.2 | 12.8 | (0.6) | 46.0 |
| HC Services Provided by Other NHS | 27.3 | 24.1 | 28.0 | 25.1 | 25.7 | 24.7 | 76.3 | 75.5 | 0.7 | 310.3 |
| Continuing Care and FNC | 8.7 | 7.6 | 9.4 | 9.4 | 9.4 | 9.4 | 25.5 | 28.2 | (2.7) | 112.0 |
| Other | 12.5 | 15.9 | 11.6 | 7.8 | 7.7 | 8.8 | 29.2 | 24.3 | 4.9 | 85.6 |
| **Non-pay costs** | **98.3** | **94.9** | **109.8** | **86.4** | **87.5** | **86.0** | **260.1** | **260.0** | **0.1** | **1,039.2** |
| Cost of Capital | 3.1 | 3.1 | (0.5) | 2.5 | 2.5 | 2.5 | 7.5 | 7.5 | 0.0 | 30.0 |
| **Total non-pay** | **101.5** | **98.1** | **109.3** | **88.9** | **90.0** | **88.5** | **267.6** | **267.5** | **0.1** | **1,069.2** |

| Variable Pay | 2021-22 M10 £m | M11 £m | M12 £m | 2022-23 M1 £m | M2 £m | M3 £m | Total £m |
|---|---|---|---|---|---|---|---|
| Agency | 4.5 | 4.9 | 5.4 | 4.6 | 5.0 | 5.5 | 15.1 |
| Overtime | 2.7 | 2.1 | 2.4 | 1.8 | 1.8 | 0.9 | 4.5 |
| Locum | 1.7 | 1.8 | 3.0 | 1.7 | 2.1 | 1.8 | 5.6 |
| WLIs | 0.2 | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 1.1 |
| Bank | 3.1 | 2.8 | 4.8 | 2.8 | 2.5 | 2.3 | 7.6 |
| Other Non Core | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | 0.0 | 0.2 |
| Additional Hours | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.4 | 1.0 |
| **Total** | **12.5** | **12.2** | **16.3** | **11.7** | **12.2** | **11.2** | **35.1** |

- Total Pay costs in June are £77.6m. Provided Services Pay costs are £75.5m, which is £2.1m higher than May costs. However, Month 2 Pay costs were understated due to the estimates for the impact of the backdated pay award being reversed in Month 2 as instructed by WG.

- Variable Pay, including Bank, Agency, Locum, Overtime, WLI's has decreased by £1.0m from May. This is mainly due to a reduction in Overtime costs in June due to the Enhanced COVID overtime rate being withdrawn.

- A total of £2.4m pay costs were directly related to COVID-19 in June, a reduction of £0.3m from May.

- Total Non Pay expenditure in June is £88.6m, a reduction of £1.4m from May. Year to date Non Pay is reporting an adverse variance of £0.1m.

# Pay Costs

- Pay costs have increased in Month 3 due to the estimates for the impact of the pay award being reversed in Month 2 . Overtime has also reduced due to enhanced COVID overtime rate being withdrawn.
- The below graphs summarises monthly Pay costs and WTE trend, including WTE Vacancies.



- Total Agency costs for June were £5.5m, representing 7.1% of total pay costs. Agency expenditure is £0.5m higher than May Agency costs and £1.4m above the average monthly expenditure in 2021/22. Of the £5.5m, the 3 hospital sites accounted for £2.6m of the costs.

- Medical agency costs are £2.6m, an increase of £0.7m compared to May and is £0.9m more than the monthly average in 2021-22.

- Agency nursing spend is £1.9m in June which is line with previous month.
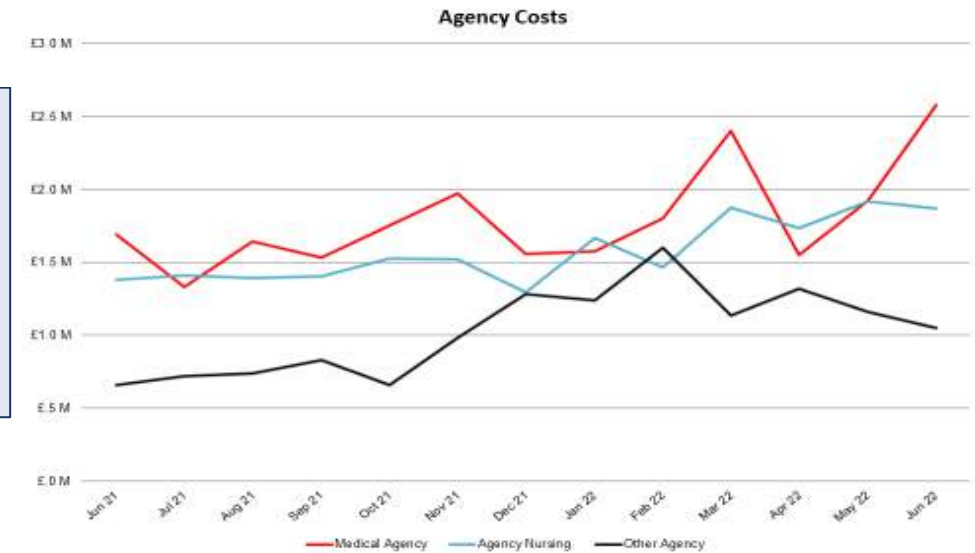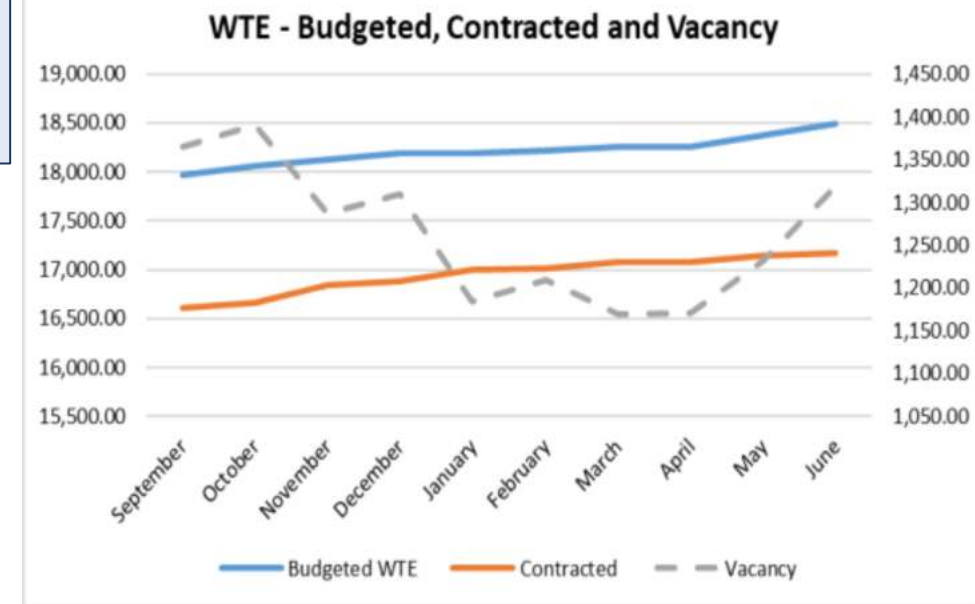
## Non Pay Expenditure (Excluding Capital Costs)



Legend:
- Primary Care Contractors
- Primary Care Drugs
- Secondary Care Drugs
- Clinical Supplies
- General Supplies
- HC Services Provided by Other NHS
- Continuing Care and FNC
- Other
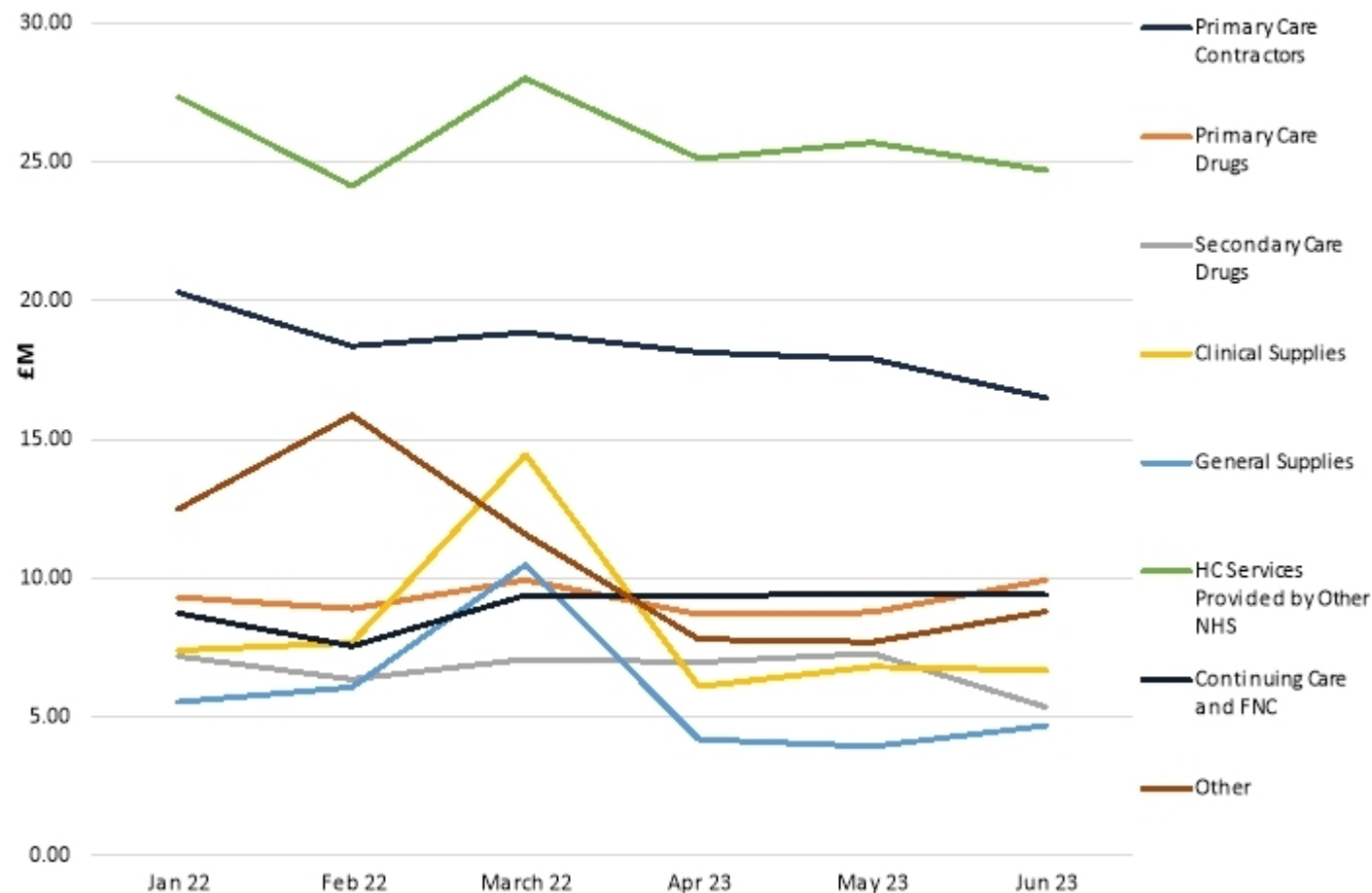
**Non-Pay Expenditure:** June spend is £86.1m excluding capital charges, which is £1.4m lower than May.

**Primary Care Drugs:** June costs are £1.2m higher than May spend due to costs being understated in April and May. April actual prescribing data used for estimating June costs also showed an increase in activity. The overall number of items prescribed per prescribing day has increased by 8.2%; April had 74,268 items prescribed compared to 68,671 in March.

**Healthcare Services provided by Other NHS Bodies:** June expenditure is £24.7m, an reduction of £1.0m from May due to the reduction in WHSCC Commissioner Contract spend. Tariffs have increased for both English providers and WHSCC.

**Continuing Health Care (CHC) and Funded Nursing Care (FNC):** Expenditure in June is £9.4m which is in line with May costs. Pressures continue within Mental Health Continuing Healthcare packages requiring more complex packages driving an increase in costs.

**Forecast expenditure:** The forecast includes £42m Performance Fund and Transformation fund expenditure, 1.25% increase in NI costs and additional impact of the full year cost of the Real Living Wage for Band 1 and 2.

# Impact of COVID-19

| | Actual M01 £m | Actual M02 £m | Actual M03 £m | Total YTD 2022/23 £m | Forecast 2022/23 £m |
|---|---|---|---|---|---|
| Testing | 0.3 | 0.3 | 0.2 | 0.7 | 4.6 |
| Tracing | 1.0 | 0.9 | 0.9 | 2.8 | 5.3 |
| Mass COVID-19 Vaccinations | 0.7 | 1.1 | 0.8 | 2.6 | 12.6 |
| Extended Flu Vaccinations | 0.0 | 0.0 | 0.1 | 0.1 | 1.8 |
| Cleaning Standards | 0.1 | 0.1 | 0.2 | 0.4 | 2.2 |
| Other Costs | 2.9 | 2.3 | 1.4 | 6.6 | 20.7 |
| **Total COVID-19 expenditure** | **5.0** | **4.7** | **3.6** | **13.2** | **47.2** |
| Welsh Gov COVID-19 income | (5.0) | (4.7) | (3.6) | (13.2) | (47.2) |
| **Impact of COVID-19 on Position** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |



2022/23 Forecast COVID-19 Costs
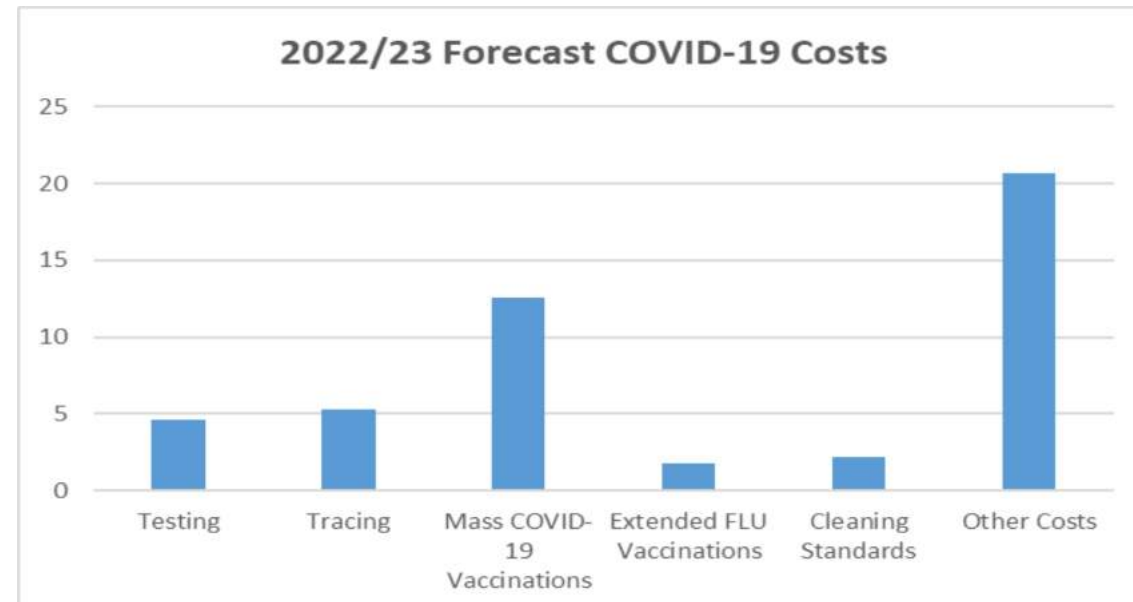
- COVID-19 expenditure in June is £3.6m, a reduction of £1.1m from May. Total forecast cost of COVID-19 is currently £47.2m. The forecast is based on the assumption that COVID-19 costs will continue to have an impact for the whole year, however costs are expected to reduce over future months. Welsh Government income has been anticipated to fully cover this cost, however £21.2m of this funding is a risk as outlined in the Risks Table. COVID-19 forecast is regularly reviewed, revised and updated monthly.

- COVID-19 Other Costs is £1.4m for June which includes costs for Long COVID, additional staffing and PPE due to COVID Surge, Investigation and learning from Nosocomial Case and Patient Charge Income Target (Loss of Dental income).



2022/23 COVID-19 Cost Distribution

- Testing
- Tracing
- Mass COVID-19 Vaccinations
- Extended FLU Vaccinations
- Cleaning Standards
- Other Costs
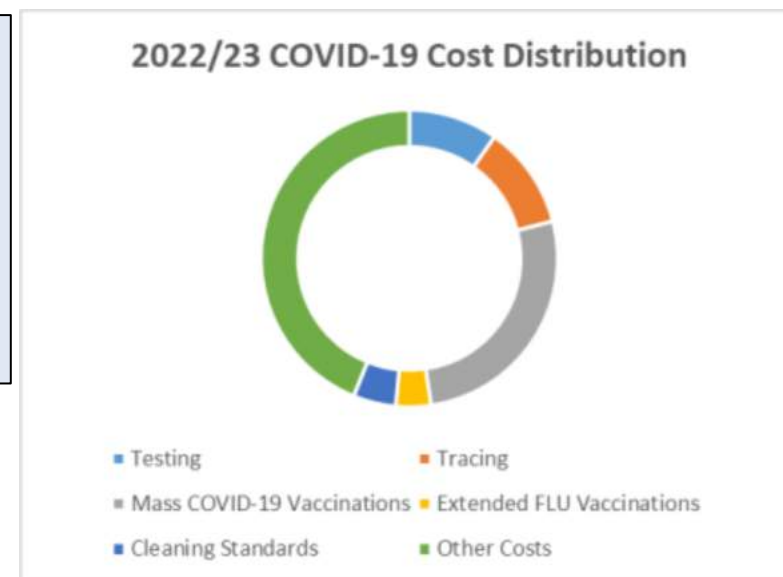
# Savings

| | Savings Target £000 | SCHEMES IN DELIVERY | | | | | | | | | PIPELINE SCHEMES | | | | TOTAL PROGRAMME | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Savings Target £000 | Year to Date Recurring Savings Delivered £000 | Variance in Recurring Savings £000 | Non-Recurring Savings £000 | Recurring Forecast £000 | Variance £000 | Forecast Non-Recurring Forecast £000 | Total Forecast £000 | Forecast FYE £000 | Recurring Plan £000 | Non-Recurring Plan £000 | Total Plan £000 | Plan FYE £000 | Total Forecast £000 | Variance £000 |
| Ysbyty Gwynedd | 3,124 | 391 | 23 | (367) | 0 | 569 | (2,555) | 0 | 569 | 1,108 | 142 | 53 | 195 | 203 | 764 | (2,360) |
| Ysbyty Glan Clwyd | 3,951 | 494 | 0 | (494) | 51 | 0 | (3,951) | 465 | 465 | 0 | 226 | 61 | 287 | 322 | 752 | (3,199) |
| Ysbyty Wrexham Maelor | 3,171 | 396 | 129 | (268) | 0 | 804 | (2,367) | 0 | 804 | 1,049 | 213 | 58 | 270 | 257 | 1,074 | (2,097) |
| **Total of hospitals** | **10,246** | **1,281** | **152** | **(1,129)** | **51** | **1,373** | **(8,873)** | **465** | **1,838** | **2,157** | **581** | **171** | **752** | **783** | **2,590** | **(7,656)** |
| North Wales Managed Services | 89 | 448 | 282 | (166) | 0 | 927 | (2,659) | 0 | 927 | 961 | 87 | 54 | 141 | 89 | 1,068 | (2,518) |
| Womens Services | 1,375 | 238 | 78 | (160) | 169 | 177 | (1,198) | 342 | 519 | 257 | 7 | 5 | 12 | 7 | 530 | (845) |
| **Secondary Care** | **15,207** | **1,967** | **512** | **(1,455)** | **220** | **2,477** | **(12,730)** | **807** | **3,283** | **3,376** | **675** | **230** | **905** | **878** | **4,188** | **(11,019)** |
| Area - West | 2,940 | 368 | 403 | 35 | 113 | 1,295 | (1,645) | 685 | 1,979 | 1,295 | 27 | 16 | 43 | 29 | 2,022 | (918) |
| Area - Centre | 4,942 | 618 | 686 | 69 | 0 | 2,459 | (2,483) | 0 | 2,459 | 2,479 | 67 | 30 | 97 | 70 | 2,556 | (2,386) |
| Area - East | 5,080 | 635 | 796 | 161 | 193 | 1,378 | (3,702) | 900 | 2,278 | 1,378 | 70 | 36 | 106 | 75 | 2,384 | (2,696) |
| Area - Other | 235 | 29 | 0 | (29) | 0 | 0 | (235) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (235) |
| Contracts | 1,804 | 226 | 0 | (226) | 0 | 0 | (1,804) | 0 | 0 | 0 | 100 | 0 | 100 | 100 | 100 | (1,704) |
| **Area Teams** | **15,001** | **1,875** | **1,886** | **11** | **306** | **5,132** | **(9,869)** | **1,585** | **6,717** | **5,152** | **264** | **82** | **346** | **274** | **7,063** | **(7,939)** |
| MHLD | 613 | 77 | 351 | 275 | 0 | 1,000 | 387 | 0 | 1,000 | 1,000 | 16 | 10 | 26 | 16 | 1,026 | 413 |
| Corporate | 4,179 | 522 | 10 | (513) | 100 | 39 | (4,140) | 104 | 143 | 39 | 551 | 741 | 1,293 | 586 | 1,436 | (2,743) |
| **Divisional Total** | **35,000** | **4,441** | **2,758** | **(1,682)** | **626** | **8,648** | **(26,352)** | **2,495** | **11,143** | **9,567** | **1,507** | **1,063** | **2,569** | **1,755** | **13,712** | **(21,288)** |
| **Total Programme** | **35,000** | **4,441** | **2,758** | **(1,682)** | **626** | **8,648** | **(26,352)** | **2,495** | **11,143** | **9,567** | **1,507** | **1,063** | **2,569** | **1,755** | **13,712** | **(21,288)** |

- The Health Board has set a savings target of £35m for 2022/23 to be driven equally by both transactional and transformational led plans. Savings delivered in June was £1.4m against a target of £1.5m, resulting in an adverse variance of £0.1m.

- The Transactional savings Target is £17.5m. We started the year with savings identified and plans developed in the transactional area, which totalled £12.6m including red schemes. As at Month 3, Savings Schemes identified as Green and Amber total full year forecast is £11.1m. Including red schemes, for which assurance reviews must be completed, the forecast totals £13.7m including income generation.

- The proportion of identified recurring savings are £10.1m including red schemes and income generation, with Green and Amber recurring savings being reporting as £8.6m in the monitoring return. Further potential cash releasing gains relating to supplies increases the total transactional savings forecast by £0.5m from £13.7m to £14.1m.



Savings Achieved and Forecast v. Target
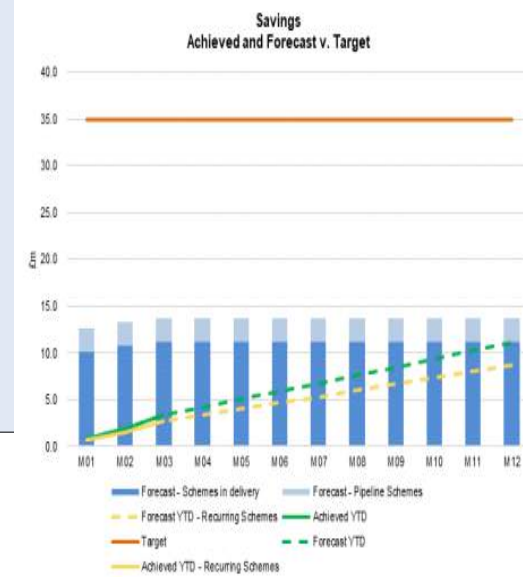
# Risks and Opportunities (not included in position)

| | RISKS | £m | Level | Explanation |
|---|---|---|---|---|
| 1 | Continuing Healthcare | £1.0m | High | There is a risk that Nursing Home prices will be higher than the 3% allowed for due to energy costs and general inflation. |
| 2 | Higher than anticipated general inflationary costs | £1.5m | High | CPI is currently at 9% |
| 3 | Increase in Agency costs due to recruitment difficulties | £0.5m | High | Difficulty in recruiting may lead to higher costs due to agency usage covering vacancies. |
| 4 | Not identifying all the required savings | £11.9m | High | Risk that 50% of Savings will not be delivered as planned. |
| 5 | COVID-19 Testing Costs | £1.5m | High | Testing costs forecast to be above indicative £3.1m funding |
| 6 | Non programmable COVID costs | £19.6m | High | Risk of Non Programmable COVID costs not being funded. |
| 7 | Anticipated Income for Exceptional costs | £22.1m | High | Anticipated income for Exceptional costs not being funded. |
| 8 | Increase in Energy Prices | £9.8m | High | Latest Energy forecast from Shared Services Partnership |
| | **Total Risks** | **£67.9m** | | |

| | OPPORTUNITIES | £m | Level | Explanation |
|---|---|---|---|---|
| 1 | Delay internally funded developments | £13.9m | Medium | Slippage due to delay in internally funded developments. |
| 2 | Recruitment in post leads to reduced Agency premium | £1.0m | Medium | Recruitment will lead to reduction in Agency costs. |
| | **Total Opportunities** | **£14.9m** | | |

| Report title: | Capital Programme Report | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 6.2 |
| Executive Summary: | The purpose of this report is to brief the Board on the capital programme and the on-going challenges with respect to current and future capital funding. | | |
| Recommendations: | The Board is asked to receive and note the contents this report. | | |
| Executive Lead: | Sue Hill, Executive Director of Finance | | |
| Report Author: | Neil Bradshaw – Assistant Director – Capital | | |

| Purpose of report: | For Noting ☒ | For Decision ☐ | For Assurance ☐ |
|---|---|---|---|

| Assurance level: | Significant ☒ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |
|---|---|---|---|---|

**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):** | The capital programme is in aligned with the Integrated Medium Term Plan (IMTP), Living Healthier; Staying Well and the emerging clinical strategy. |
| **Regulatory and legal implications** | The planned projects and discretionary programme assist the Health Board in meeting its statutory and mandatory responsibilities. |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | The demand upon capital investment significantly exceeds the resources available requiring the Health Board to prioritise investment to address the highest risks. |
| **Financial implications as a result of implementing the recommendations** | |
| **Workforce implications as a result of implementing the recommendations** | |
| **Feedback, response, and follow up summary following consultation** | |
| **Links to BAF risks:** (or links to the Corporate Risk Register) | See attached report |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |
| **Next Steps:** | |
| **List of Appendices:** None | |

**Capital Programme Report**

**Health Board meeting 4 August 2022**

1. **Introduction**

   In accordance with the Standing Financial Instructions the Health Board is required to approve an annual capital plan prior to the commencement of the financial year. The purpose of this report is to brief the Board on the capital programme agreed in March and the on-going challenges with respect to current and future capital funding.

2. **Background**

   Capital expenditure is defined as investment in fixed assets, for the Health Board this includes our estate; equipment and medical devices; and informatics systems and infrastructure.

   The Health Board has access to a number of potential capital funding sources:

   - All Wales Capital Programme, generally for larger value projects >£5m, subject to approval of strategic, outline and full business cases. Typically project specific expenditure is approved over more than one year but the funding is allocated on an annual basis.
   - Discretionary capital, an annual funding allocation provided by Welsh Government (WG). Expenditure is at the "discretion" of the Health Board but must be utilised to address estates issues and support medical devices and informatics development and replacement.
   - Grant funding, funding from government to support specific topics/issues again subject to business case approval.
   - Sale receipts, the Health Board may retain the first £0.5m from the sale of any fixed asset; the remainder must be returned to the WG. A case may be made to retain a greater proportion but is subject to the agreement of the WG.
   - Charitable funding, donated monies that the Health Board may invest at our "discretion" subject to charitable rules.

   However, our Establishment Order places a number of legal obligations upon us that restrict our flexibility and access to funds including:

   1. Our annual capital allocation from all sources is defined within our Capital Resource Limit. The Health Board must deliver the agreed CRL (+/- £0.5m) each year or our accounts would be "qualified". An initial CRL is confirmed by April and is reviewed and "frozen" in October.
   2. The Health Board may not transfer monies from one year to the next and there is no opportunity to carry forward un-spent allocations.
   3. The Health Board may not borrow or lend capital and cannot invest capital in assets that are not wholly owned by the Health Board (where these assets are developed by a third party).

   IFRS 16 places new obligations on the Health Board in that the cost of any asset leased by the Health Board must now be accounted for as capital rather than revenue.

   Experience to date has been that in most years, additional funding is made available to the Health Board in the third and fourth quarters as a consequence of slippage within the overall

All Wales capital programme. Whilst this funding is welcomed it is limited in its potential application due to the need for it to be spent by year end.

3. **Capital funding**

Welsh Government (WG) have confirmed BCU's discretionary capital allocation for 2022/23 as £10.971m. This is a 24% reduction from previous years and reflects the overall reduction in the NHW Wales capital allocation of circa £100m per year for the next three years.

This allocation is approximately 0.6% of our revenue allocation and, as indicated above, is expected to address backlog maintenance and risk within our estate, equipment and medical devices replacement, informatics system and hardware replacement and upgrade **and** support service development as defined within the IMTP.

Additional funding of £4.25m for 2022/23 has been confirmed by WG in support of agreed Imaging and radiotherapy priorities and a number of business cases have been submitted to the All Wales capital fund, further details of which are provided later in this report.

The Capital Investment Group have considered the capital investment required over the next 10 years to ensure our assets are compliant and developed to support our vision as described within Living Healthier; Staying Well and the clinical strategy. This has indicated a total requirement of circa £1.6bn at today's prices.

4. **The capital programme**

The Health Board approved the five year capital programme in March 2022. The programme builds upon the Estate Strategy (approved by the Board in 2019) as amended by the IMTP and evolving clinical strategy and the approved digital strategy.

The programme seeks to maximise the resources potentially available to the Health Board by:
- Submitting business cases for All Wales and grant funding in support of defined strategic priorities.
- Seeking alternative procurement routes either in partnership with others, including local authorities, RSLs etc., or through revenue models e.g. the Regional Treatment Centres.
- The discretionary capital programme (together with sale receipts and charitable funds) is planned over 5 years and overcommitted on an annual basis to allow for slippage and to accommodate any additional funding that may be made available in year by WG. It should be noted that the programme is monitored on a monthly basis to ensure that this initial over-commitment is managed and that the year-end expenditure aligns with the funding available.

The programme is managed by the Capital Investment Group (CIG) which is chaired by the Executive Director of Finance and comprises membership from all integrated health communities, regional services and business support functions. The CIG reports to the Performance, Finance and Information Governance sub-committee.

5. **Discretionary capital programme**

The programme seeks to be a balance of compliance/replacement and support for service transformation/development priorities as the IMTP. In developing the programme the CIG required all schemes to demonstrate that they will:

- Address the major risks
- Improves the quality of care/health outcomes (supports service transformation)
- Ensure capital assets are sustainable
- Ensures capital asset are affordable

Schemes were reviewed and scored against the following criteria and ranked in priority order:

| Criteria | Objective | Definition | Scoring criteria | Score |
|---|---|---|---|---|
| Address major risk | Reduces risk | Meets identified corporate or division/department risk (as identified in relevant Risk Register). | Related to assessment of risk and urgency: does not reduce risk or risk rated as low, medium or high | 0,2,4 or 6 |
| Improves the quality of care/health outcomes (supports service transformation) | | Describe outcomes and benefits | Ability to meet national or local targets as defined within the operational plan | 0 to 6 |
| Ensure the estate is sustainable | Meets KPIs (as attached) | Supports the delivery of the estate KPIs | No or yes | 0 or 6 |
| | Supports service continuity | Describe outcomes and benefits | Ability to meet national or local targets as defined within the operational plan | 0 to 6 |
| Ensures the estate is affordable (delivers financial recovery) | Cost avoidance or cash releasing | | Ability to avoid/reduce cost or release cash | 0, 3 or 6 |

The approved annual programme for 2022/23 may be summarised as follows:

| Discretionary and national programmes | £million |
|---|---|
| Estates | |
| - Health & safety, risk and compliance | 4.087 |
| - Service recovery including Covid-19 response, planned and unscheduled care and patient experience | 5.130 |
| - Mental Health | 0.829 |
| - Sustainability including Decarbonisation | 1.230 |
| Medical Devices replacement programme | 1.379 |
| Imaging and radiotherapy national Programmes | 4.250 |
| Informatics | 2.213 |

The programme seeks to mitigate/reduce the following top risks:

- Board Assurance Framework

- Strategic Priority 1

    -BAF 21-14 Pandemic exposure

- Strategic Priority 2

    - BAF 21-09, Infection prevention and control

- BAF 21-12, Security services
- BAF 21-13, Health and safety

- Strategic Priority 3

    - BAF 21-03, Primary care sustainable health services

- Strategic Priority 4

    -BAF 21-04, Timely access to planned care

- Strategic Priority 5

    -BAF 21-01, Safe and effective management of unscheduled care

- Strategic Priority 6

    -BAF 21-06, Safe and effective mental health service delivery

- Aligned to Key Enabler

    - BAF 21-16, Digital estate and assets
    - BAF 21-17, Estates and assets development
    - BAF 21-20, Development of IMTP
    - BAF 21-21, Estates and assets

- Corporate Risk Register:

    - 20-01, Asbestos management and control
    - 20-03, Legionella management and control
    - 20-04, Non-compliance of fire safety systems
    - 20-06, Informatics – patient records pan BCU
    - 20-07, Informatics – capacity, resource and demand
    - 20-11, Informatics – cyber security

The programme also seeks to address tier 2 and 3 risks and the programme proposes investment to increase capacity and reduce risks with respect to safe sustainable services, timely access to planned care and mental health & learning disabilities services.

6. **All Wales capital funding**

The following business case have been submitted to Welsh Government:

| Scheme | Stage | Value (£m) | Comment |
|---|---|---|---|
| Royal Alexandra Hospital Redevelopment | FBC | 71 | Full Business Case (FBC) submitted March 2021, all scrutiny comments responded to by September 2021. On-going discussions with respect to affordability. |
| Adult and Older Persons Mental Health Unit (redevelopment of Ablett Unit) | OBC | 67 | Outline Business Case (OBC) submitted September 2021. All scrutiny comments responded to and presentation provided to WG Infrastructure Investment Board (IIB) in |

| | | | January 2022. All further questions have been answered. |
|---|---|---|---|
| Wrexham Continuity Phase 1 | PBC | 43 | The Programme Business Case (PBC) has been supported by WG who have agreed that we may "fast track" the immediate risks and provided funding to progress the FBC. |
| Ysbyty Gwynedd Compliance Programme | PBC | 250+ | The PBC was submitted in May 21 with scrutiny comments received in July 21 and further comments in Nov 21. All questions and comments responded to and presentation provided to WG IIB in January 2022. Discussions are on-going to agree support to progress to OBC. |
| Nuclear Medicine | SOC | 11 | Strategic Outline Case (SOC) submitted Oct 21 proposing centralisation of nuclear medicine (gamma camera) and introduction of PET CT supported by All Wales PET business case. WG has supported SOC (May 22) and provided fees to progress OBC/FBC. |
| Conwy/Llandudno Junction Primary Care Development | SOC | 17 | SOC submitted Nov 21. Support provided from RPB as pilot project (through the Integration and Rebalancing Fund) to progress to OBC. We have responded to WG scrutiny comments and are awaiting their response. |

Capital business cases are also being developed for Wrexham Redevelopment (£300m+), School of Medicine and Health Sciences (£30m) and Radiotherapy Programme (£14m).

7. **Alternative procurement**

The Health Board is progressing the development of Regional Treatment Centres with a view to engaging a partner to design, build and finance new facilities to support the segregation of planned ambulatory care through a mutual investment model.

There are also number of community schemes that are being taken forward in partnership including:

Deeside "gateway"
Cefyn Mawr
Dinerth Road development
Denbigh integrated reablement unit
Penygroes / Dyffryn Nantlle Health & Wellbeing Hub
Bangor - Community Paeds CDC / Talarfon Replacement
Bangor Wellbeing Hub
Pwllheli - former Penrhos Polish Home

These schemes are seeking support from the Regional Partnership Board and potentially accessing the WG Integration and Rebalancing fund. Finally, the Health Board is seeking an

appropriate partner to progress the development and management of our residential accommodation.

8. **Estate Strategy**

**T**he Health Board's current Estate Strategy was approved in 2019 and was due to be updated by March 2022. This is a significant task and, following consultation with Welsh Government and NWSSP we have sought external support.  The overall aim of the work is to test the current strategy to ensure that our estate enables the delivery of BCUs strategic vision, clinical strategy and operational plan and supports and compliments BCU's workforce, digital and finance strategies.

There are three elements to the work:  Firstly, to review the current estate strategy within the context of BCU's service and enabling strategies and operating plans to review and further develop the strategic vision for the estate. Secondly, to evaluate how the existing estate measures up to this vision, identify the gaps and how the estate must change. Finally, develop solutions and the required investment pipeline and through engagement prioritise the investment profile.

The outputs will be:

**A refreshed Estates Strategy** that provides a vision of the future estate and a roadmap of how to get there.

**A prioritised Capital Investment Plan** – this will present a 10 Year Capital Investment Programme detailing the project pipeline. The plan will be prioritised and ranked based upon agreed criteria developed by BCU and external stakeholders. The prioritisation and ranking of projects will be developed and agreed through engagement with key stakeholders.

**An estate rationalisation programme** – detailing the properties/land to be surplus to requirement and a programme of disposals with potential value.

It is expected that the draft outputs will be produced in Q3 22/23.

| Report title: | Annual Equality Report 2021/22 | | |
|---|---|---|---|
| Report to: | The Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 6.3 |
| Executive Summary: | The Annual Equality Report 2021/22 provides an overview of progress towards fulfilling the Health Boards equality objectives and delivery of the Equality Act 2010.There is a range of activity taking place across BCUHB, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations. The Health Board has continued to work with the valued and knowledgeable Equality Stakeholder Group this year to help ensure that equality and human rights considerations are embedded into key programmes of work. Staff network peer support groups for people who share protected characteristics have also been further developed, providing an additional staff engagement vehicle. This report outlines a number of key achievements over the past year. | | |
| Recommendations: | The Board is asked to note the report | | |
| Executive Lead: | Sue Green, Executive Director of Workforce and Organisational Development | | |
| Report Author: | The Corporate Equality Team | | |
| Purpose of report: | For Noting ☐ | For Decision ☐ | For Assurance ☒ |
| Assurance level: | Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |

**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): | The Strategic Equality Plan is aligned to the Living Healthier Staying Well Strategy and seeks to mainstream equality considerations across all Health Board functions. |

| | |
|---|---|
| **Regulatory and legal implications** | Compliance with the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011.<br>Compliance with the Equality Act (Authorities subject to the Socio-economic Inequality Duty) (Wales) Regulations 2021.<br><br>This report provides an overview of how the Health Board is delivering the Welsh Specific Equality Duties and embedding the "A More Equal Wales" goal of the Wellbeing of Future Generations Act. On 31st March 2021, the Socio-economic Duty was also introduced in Wales, requiring the Health Board to ensure that any strategic decisions are informed by Socio-economic Impact Assessment. |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | The Welsh Specific Equality Duties aim to ensure that listed bodies when carrying out public functions consider how to positively contribute to a fairer society in day-to-day activities. The report outlines the positive steps the Health Board is taking to advance equality and how equality impact assessment continues to be embedded in governance processes. |
| **Financial implications as a result of implementing the recommendations** | There are no financial implications attached to this report. |
| **Workforce implications as a result of implementing the recommendations** | There are no workforce implications as a result of this report, rather this report identifies areas of progress and informs future priorities. |
| **Feedback, response, and follow up summary following consultation** | This Annual Equality Report 21/22 has undergone consultation with, and been approved by the Equality and Human Rights Strategic Forum. The Report was presented to PPPH 20.05.22 and the Local Partnership Forum 19.07.22. |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | **Corporate risk register tier 2**:<br>**1971**: Risk of failure to comply with Statutory Duties under the Equality Act (Statutory Duties) (Wales) Regulations 2011<br>Risk score 12 |

| | 3111:Risk of Failure to comply with The Socio-economic Duty under The Equality Act 2010<br>Risk score 12 |
|---|---|
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |
| **Next Steps:**<br>**Implementation of recommendations** | |
| **List of Appendices:**<br>    None | |

# Annual Equality Report 2021-2022

**Sustaining our Commitment to Advancing Equality**

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

Celebrating our wonderful diversity in BCUHB!

**This report and any supporting documents are available in Welsh, and can be made available in other languages and formats on request.**

**For other formats, please contact:**

Patient Advice and Liaison Service
Tel 03000 851234
BCU.PALS@wales.nhs.uk

To contact the Equality Team at BCUHB email:
BCU.Equality@wales.nhs.uk

# Contents

# Foreword

Welcome to Betsi Cadwaladr University Health Board's (BCUHB) Annual Equality Report covering the period April 2021 – March 2022. This report summarises the actions we have taken to sustain our commitment to advancing equality and human rights as we have planned and delivered health care during the second year of the COVID-19 pandemic. Our Strategic Equality Plan (SEP) for the period 2020-2024 was agreed and published in March 2020 with an intention to embed and strengthen equalities and human rights across all functions of the Health Board to ensure delivery of our SEP.

We have invested in our Corporate Equality Team, recruiting two additional managers. This has supported an increased focus on key aspects of equality, and will enable more support and advice to operational and corporate teams across the Health Board.

On 31st March 2021, the Socio-economic Duty was introduced in Wales, requiring the Health Board to ensure that any strategic decisions are informed by a Socio-economic Impact Assessment (SEIA). In line with this, SEIA work has informed our refresh of our long-term Strategy, Living Healthier Staying Well, the development of our Integrated Medium Term Plan, our Vaccination Programme, and our Stroke Services Improvement Programme together with other key strategic developments. We have provided training for our Board members and other senior leaders on their responsibilities to ensure due regard to the Socio-economic Duty and continue to work with services to ensure the duty is embedded in all strategic decision-making.

We have continued to work with our valued and knowledgeable Equality Stakeholder Group to ensure that equality and human rights are

embedded into key programmes of work, and continue to work towards developing a co-productive approach.

We have taken the step this year of developing an Equality Accountability Framework to be introduced in 2022-23. This will enable us to better evidence our compliance with the Public Sector Equality Duty and Socio-economic Duty.

We have further developed our staff networks for people who share protected characteristics. These are important peer support groups for our staff and also key groups with whom we engage as we develop our services and plans for the future. As we move into 2022-23, we remain as committed as ever to advancing equality and human rights to achieve our goal of minimising health inequality in North Wales.

We hope this report provides evidence of this commitment and the progress made during the last 12 months as we also look forward to sustaining our commitment to advancing equality during 2022 and into 2023.

Sue Green - Executive Director People and Organisational Development

Jacqueline Hughes - Independent Member and Equality Champion

# 1. Background and Context

**The Equality Act 2010:**

The Equality Act 2010 protects people and groups from unfavourable treatment and makes it unlawful to discriminate, harass or victimise people because of a reason related to their protected characteristics.

**The Public Sector Equality Duty:**

Section 149 of the Equality Act 2010 requires us to demonstrate compliance with the Public Sector Equality Duty (PSED) which places a statutory duty on the Health Board to:

- Eliminate unlawful discrimination, harassment, and victimisation;
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not;
- Foster good relations between those who share a relevant protected characteristic and those who do not.

Our Health Board also has a specific duty under the PSED to undertake the following actions:

- Publish information to demonstrate  compliance with the Equality Duties, at least annually
- Set equality objectives, at least every 4 years.

**The Socio-economic Duty:**

The Socio-economic Duty is a new duty introduced by the Welsh Government on 31st March 2021, implementing a previously dormant section of the Equality Act (2010).  Its aim is to deliver better outcomes for those who experience socio-economic disadvantage. It further enhances current equality legislation and the Well-being of Future Generations (Wales) Act 2015 and Social Services and Well-being (Wales) Act 2014.

The Socio-economic Duty places a requirement on the Health Board that when taking strategic decisions, the Health Board has due regard for the need to reduce inequalities of outcome that result from socio-economic disadvantage.

During 2021, we have established new processes to ensure Socio-economic Impact Assessments (SEIAs) are undertaken for decisions of a strategic nature, with a new impact assessment process introduced and training provided to Board members and other senior leaders.  A specific Advisory Group with a focus on embedding the Socio-economic Duty across the organisation has been established and continues to evolve based on feedback and learning to help advance socio-economic equality in a more integrated way.

**The Human Rights Act 1998:**

The Human Rights Act 1998 set out universal standards to ensure that a person's basic needs are recognised and met.  Public Bodies have a mandated duty to ensure they have arrangements in place to comply with the Human Rights Act 1998.  It is unlawful for a healthcare organisation to act in any way that is incompatible with the Human Rights Act 1998.  In practice, this means we must treat individuals with Fairness, Respect, Equality, Dignity and Autonomy. These are known as the FREDA principles.

**Our Health Board's Vision, Values and Purpose**

**Our Health Board Vision**

- We will improve the health of the population, with particular focus upon the most vulnerable in our society.
- We will do this by developing an integrated health service which provides excellent care delivered in partnership with the public and other statutory and third sector organisations.
- We will develop our workforce so that it has the right skills and operates in a research-rich learning culture.

**Our Health Board Values**

- Put patients first.
- Work together.
- Value and respect each other.
- Learn and innovate.
- Communicate openly and honestly.

**Our Purpose as a Health Board**

- To improve health and deliver excellent care.

**The Health Board's Strategic goals**

As well as making sure we are working together to fulfil A Healthier Wales, the Health Board's strategic goals described in Living Healthier, Staying Well are:

- Improve physical, emotional and mental health and well-being for all
- Target our resources to people who have the greatest needs and reduce inequalities
- Support children to have the best start in life

- Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being
- Improve the safety and quality of all services
- Respect people and their dignity
- Listen to people and learn from their experiences
- Use what we have wisely, explore new ideas and learn from research
- Support, train and develop our staff

For more information visit: <u>About the Health Board.</u>

# 2. Key Equality Achievements in 2021-22

We have:

- Advanced equality through the delivery of the second year of our Strategic Equality Plan (SEP).
- Strengthened equality and human rights scrutiny in governance and decision making structures through partnership working.
- Implemented processes for the new Socio-economic Duty.
- Developed an equality duty accountability framework, designed to ensure consistency of approach in applying equality considerations across the organisation.
- Continued to build on the response to COVID-19 delivering the vaccination programme in line with Welsh Government guidance, this being informed by an EqIA.
- Taken action to understand the ongoing impacts of COVID-19 on people who share protected characteristics and supported teams to promote inclusive decision making.
- Established a Race Equality Action Group, comprising colleagues from our BCUnity Ethnic Minority and Overseas Staff Network and senior leaders.

- Delivered targeted Equality Impact Assessment training virtually to over 200 managers.
- Achieved 87.78% mandatory equality training compliance.
- Grown our staff support networks for individuals who share protected characteristics, with the addition of a Gender Equality Network.
- Improved the collection of staff equality monitoring data.
- Gained national recognition for our development of a ground-breaking gender identity pathway service which has been adopted nationally.

# 3. Delivering the Socio-economic Duty

The Socio-economic Duty was implemented by Welsh Government on 31st March 2021. The duty aims to deliver better outcomes for those who experience socio-economic disadvantage, and reduce inequalities of outcome.

**Key work achieved during 2021-22 includes:**

A Task and Finish Group was established to oversee an implementation plan and review Welsh Government guidance ready for 31st March 2021 go live date.

Socio-economic Impact Assessments (SEIA) procedures have been established (including development of a policy and SEIA template).

A training plan to raise awareness and understanding of the responsibilities of senior leaders to deliver the Socio-economic Duty was developed, with a workshop delivered to our Board in April 2021.

A range of supporting documentation and guidance has been published, to ensure colleagues understand their responsibilities to the Equality Duty and Socio-economic Duty through specific guidance distributed

through the BCUHB Equality Briefing and the equality intranet (BetsiNet) site.

**Next Steps for 2022-23:**

Work is ongoing to mainstream the Socio-economic Duty across the organisation, and the Socio-economic Duty Advisory Group will continue to oversee this and provide assurance.

# 4.    Delivering the Public Sector Equality Duty

The Equality Objectives we set out to deliver in our 4 year Strategic Equality Plan take account of all the Health Board's work and activities, including being a very large employer, planning and delivering healthcare and policy development. Our Equality Objectives are also informed by gathering and analysing information from national and local sources, evidence, and from impact assessments undertaken as well as from ongoing engagement with staff and service users.

In this section of our Annual Report, we outline in further detail our key progress during 2021-22.

## Engagement

We have continued to strengthen our engagement with people who share protected characteristics and an overview of progress is provided in section 7.

## Equality Impact Assessments

When we make decisions that potentially impact on communities, patients and our workforce, we have a statutory duty to assess the impact of our decisions on people who share protected characteristics.

Our Health Board has developed a comprehensive Equality Impact Assessment tool (EqIA). EqIAs are required for a wide range of decision making across the Health Board, including developing strategies or policies, or developing and reviewing services. The process of assessing the impact of a project or decision on equality is embedded within the Health Board's governance arrangements and ensures that decisions have taken account of the needs of those who share protected characteristics.

Our impact assessment process encourages decision makers to consider intersectional impact, the interconnected and overlapping disadvantage and potential discrimination faced by people who share more than one protected characteristic. The assessment tool also supports consideration of cumulative impact, in which the effects of a decision on people may add to or interact with the impacts of other decisions being made.

We have continued to strengthen our scrutiny processes of Equality Impact Assessments during 2021 into 2022, and have also provided further training, guidance and support for staff undertaking EqIAs. Our Equality Scrutiny Group has played a key role in the scrutiny of EqIAs undertaken for significant programmes of work such as the COVID-19 Vaccination Programme.

During 2021 into 2022, we commenced an EqIA training programme aimed at senior managers, seeking to build consistency of the use of EqIA across the organisation and increasing insights and awareness of issues affecting people who share protected characteristics. This training programme has been delivered virtually to over 200 managers and we will continue to drive this training programme during 2022 and into 2023.
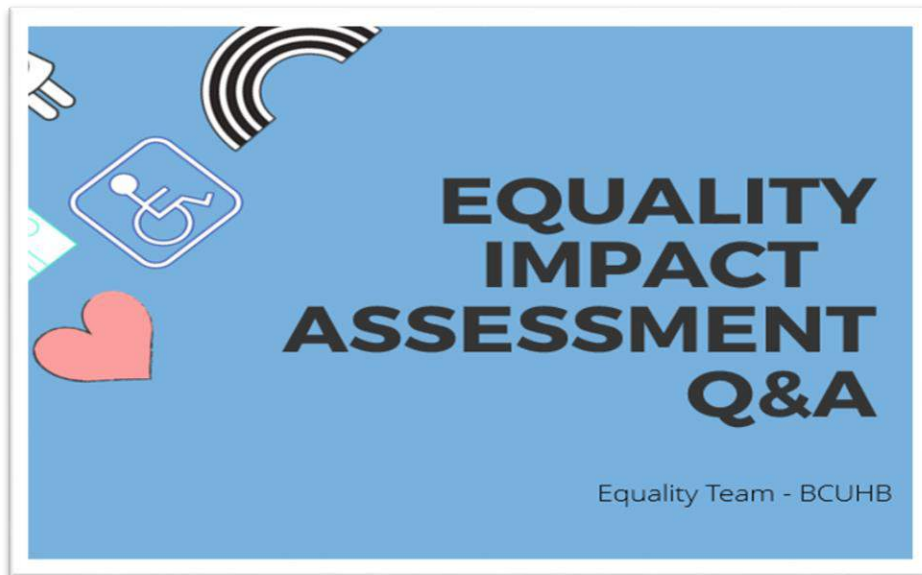
## Equality Information

### Patient Experience

Our Patient and Carer Experience Team provide comprehensive support to gather patient experience for the organisation to use to inform service planning and delivery. We are working to strengthen evidence gathering with regards to equality information. Every day, we collect the views of our service users so that we can really understand what matters to them, especially when people are at their most vulnerable. With permission, we then share the feedback with the relevant managers via the Patient Safety and Experience Team in order to both learn, and identify areas where we need to improve. During 2020, improvements to recording and monitoring patient and carer feedback for those who share protected characteristics was identified. During 2021, this led to the development of the 'Civica Real-Time Patient Feedback System' which will be fully implemented in 2022 and into 2023.

Our Patient and Carer Experience Team

For more information on our Patient and Carer Experience Team: About the Patient and Carer Experience Team - Betsi Cadwaladr University Health Board (nhs.wales)

Our Patient Advice and Liaison Service, commonly referred to as PALS, are also available to listen to concerns and liaise with relevant staff to resolve concerns or problems that our patients and carers raise.

Information on our PALS service is available in bilingual formats.

Whilst the majority of people are happy with the health care that they receive from us,  sometimes things might not go as well as expected. When that happens, we want to find out what went wrong to make things better. Our complaints procedure called Putting Things Right, provides information on how patients and carers can make a formal complaint. This information is also available in video format for people using British Sign Language.

The Health Board publishes an annual report on Patient Experience. The most recent report is available here: Patient Experience Annual Reporting 2019-2020.

## Our Workforce

We have published our statutory employment reports on our BCUHB website. These include our Gender Pay Gap report and Annual Employment reports.

Information relating to the equality characteristics of our workforce is held in our electronic payroll system, the Electronic Staff Record (ESR). Information on job applicants is gathered as part of the recruitment process via a national system known as NHS Jobs and this enables us to understand the profile of people applying to work for us, those who were shortlisted for interview, and those who were successful. During 2021, we improved the rate of completion for our workforce equality monitoring data, and we will continue to emphasise throughout the organisation the importance of gathering equality workforce data. This enables us to improve the visibility of our workforce who share protected characteristics and also importantly informs our workforce planning and helps identify key themes and areas for action across all stages of the employment journey.

Our Gender Pay Gap report for 2021 shows that for the first time since reporting this information in 2017, our gender pay gap has narrowed. This report is published on our Equality and Human Rights reports page, and a copy is also included in Appendix 1. During 2022 and into 2023, we will continue to identify opportunities to address our pay gap.

An NHS staff survey was not conducted in 2021 due to the COVID-19 pandemic, but we expect a national NHS staff survey to be carried out during 2022. We are committed to promoting the survey and to using the results to gain valuable insights into the experiences of our staff who share protected characteristics, which will shape our work going forward.

During the latter part of 2021, we established a Race Equality Action Group. The group takes a co-productive approach with its membership comprising representatives of our Ethnic Minority, Black and Asian staff as well as senior leaders. This work will be further developed upon publication of the anticipated Welsh Government Race Action Plan.

In addition, during 2021-22 we continued to grow our staff networks, and we now have four networks, which include a new Gender Equality Network. We are committed to further developing and supporting our staff networks to enable ongoing engagement with our staff to help us better understand lived experience and ensure this informs our priorities for action.

## Staff training

Promoting knowledge and understanding of the Public Sector Equality Duty and the specific responsibilities it places on our staff remained a priority during 2021. We are pleased to have achieved 87.78% mandatory equality training compliance by February 2022. This is an improvement against the 85% completion rate achieved in 2020-21. We continue to analyse results and target key staff groups.

## Strategic Equality Plan

Our Strategic Equality Plan (SEP) for the period 2020-2024 was agreed by Board in December 2019 and published in March 2020.

## Procurement

We have initiated a review of our contracting, procurement and commissioning frameworks in regards to the Equality Duties. We have set up a working group to review these frameworks aligned to best practice.

# 5. Context of COVID-19

It is well recognised that COVID-19 has further magnified and amplified inequalities for many people who share protected characteristics and those who are socio-economically disadvantaged. For some individuals, these inequalities may be further exacerbated by barriers to accessing healthcare, marginalisation from society or discrimination.

Whilst COVID-19 significantly impacted all areas of work throughout the Health Board, evidence continues to emerge that certain groups within our communities and workforce are disproportionately impacted.

The Education Programme for Patients (EPP) team have continued to provide courses throughout the pandemic, and have adapted their courses to support patients with Long COVID as knowledge of this new condition grows.

BCUHB delivered 1.5 million vaccines between April 2021 and early February 2022.  Our vaccine delivery programme is informed by a robust, live EqIA process.

Day to day changes have impacted on the way we work and deliver care and we continue to engage with our workforce to understand the impacts. We have developed an integrated Staff Wellbeing Support Service (SWSS), providing a range of services to meet the differing emotional and psychological needs of our staff and this will continue to develop in 2022 and into 2023.

# 6. Delivering Our Strategic Equality Objectives

This section of our report outlines our progress in year two of our Strategic Equality Plan. During 2020 we added two additional equality objectives in light of learning from the COVID-19 pandemic. Progress is reported every quarter to our Equality and Human Rights Strategic Forum to provide assurance.

## BCUHB Equality Objective 1:

**We will prioritise action to help identify and mitigate the impact of poverty for recipients of healthcare at risk of or actually living in low income households in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 1.  We:

- Established processes to ensure compliance with the Socio-economic Duty (SED). We have an approved procedure with specific support, guidance and intelligence base available to enable effective assessment of impacts.
- Ensured the COVID-19 response for our vaccination programme is informed by a live and robust Equality Impact Assessment.
- Provided support, including enhanced arrangements, for staff absent from work due to sickness associated with the effects of COVID-19 illness, with these enhanced arrangements being in place regardless to length of service.
- Continued with the Well North Wales Programme partnerships to ensure a continued focus on addressing health inequalities. Many of these partnerships involve public sector, third sector and housing providers.
- Supported staff experiencing in-work poverty and financial hardship through establishing a dedicated intranet page with helplines and access to a range of support organisations.

**Focus on… The Well North Wales Programme**

This multi-agency programme led by Public Health Wales delivers a number of projects, including:

- Bwyd Da Mon

This project addresses food poverty in partnership with supermarkets across North Wales.

- Denbighshire Community Supermarket Project

This is a work in progress through a multi-agency initiative which will focus on South Denbighshire in the first instance. This aims to provide affordable fresh produce to disadvantaged communities.

- Plas Madoc Food Initiative

A successful project involving local community groups focussing on nutrition, the availability of fresh produce and educational activities using social media for engagement and support.

- Social Prescribing

There are seven projects on-going across North Wales. A common dataset has been created to compare outcomes, which will inform future decisions around commissioning.

**Focus on… Well North Wales**

- Bwyd Da Bangor

This is a recently opened training café providing employment opportunities to individuals coming through drug and alcohol rehabilitation and individuals from homeless hostels. [Bwyd Da Bangor - Home | Facebook.](#)

- Rhyl Homelessness Lifestyle Programme

This offers opportunities for homeless individuals to participate in lifestyle programmes, aiming to improve health and wellbeing outcomes, and to facilitate increased confidence to engage in the wider community.

- Flintshire Wellbeing Service

This is a recently-established service, linked to the Community Support Hub, offering alternatives to Primary Care, and works with individuals to provide social and community focused support.

**Further work to take forward Equality Objective 1 in 2022-23 will include:**

- Working in partnership to understand and mitigate the impact of poverty for recipients of healthcare.
- Continuing to raise awareness of socio-economic disadvantage within the Health Board to inform strategic decisions taken and ensure socio-economic disadvantage is addressed.
- Continuing to mainstream the Socio-economic Duty.
- Continuing to provide support for staff experiencing socio-economic disadvantage.

## BCUHB Equality Objective 2:

**We will prioritise action to reduce health inequalities and increase the accessibility of healthcare for people sharing different protected characteristics in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 2.  We:

- Strengthened the Equality Team capacity through the recruitment of two additional full time Equality, Diversity and Inclusion managers.
- Ensured equality and human rights requirements were reflected in the review of the governance framework across the Health Board.
- Implemented the Socio-economic Duty for strategic decision making and associated guidance and resources.
- Ensured that the refresh of the Health Board's Ten Year Strategy, Living Healthier Staying Well, was subject to rigorous Equality Impact and Socio-economic Impact Assessments, and aligned with  key national strategies including the Anti-racist Wales; Race Equality Action Plan, the LGBTQ+ Action Plan, as well the Code of Practice for Delivery of Autism Services.
- Ensured that Equality Impact and Socio-economic impact assessments have been undertaken to inform the Health Board's Integrated Medium Term Plan.
- Continued to provide EqIA training for managers across the organisation.
- Commissioned research to identify barriers to accessing effective healthcare for ethnic minority people living in Rhyl, which will inform the work of the newly formed Race Equality Action Group.
- Adapted the provision of Spiritual and Pastoral 24-hour support to our patients during the second year of the COVID-19 pandemic.
- Revised the equality profiles for the six local authority areas which was undertaken by Public Health. The profiles include demographic

data for North Wales and the latest available data relating to the Protected Characteristics under the Equality Act 2010. These informed service planning and delivery decisions during 2021, and will continue to do so during 2022.

- Strengthened the guidance for and scrutiny of accessible patient information.
- Embedded guidance on the Rights of Children and Young Persons (Wales) Measure 2011 in the EqIA process and guidance.

**Focus on: Supporting Information: Interpretation and Translation Services**

Requests for English to Welsh and Welsh to English translations are referred to our internal Welsh Language Team.

In order to meet the communication needs of patients, staff have access to a range of translation services. These are provided by Language Line and The Wales Interpretation and Translation Service (WITS).

These services are available 24-hour, 365 days a year and include:
- Telephone and face to face;
- Interpretation for deaf people or hearing-impaired people;
- Document translation services.

Guidance is available to staff for arranging translation services, and includes checking if the correct dialect is spoken, and cultural considerations for same sex interpreters which may be required for religious observance.

During the calendar year 2021, a total of 3191 requests for translation support were made across the Health Board.

The top languages requested include:

- Polish

- British Sign Language – BSL

- Arabic

- Bulgarian

- Turkish

- Romanian
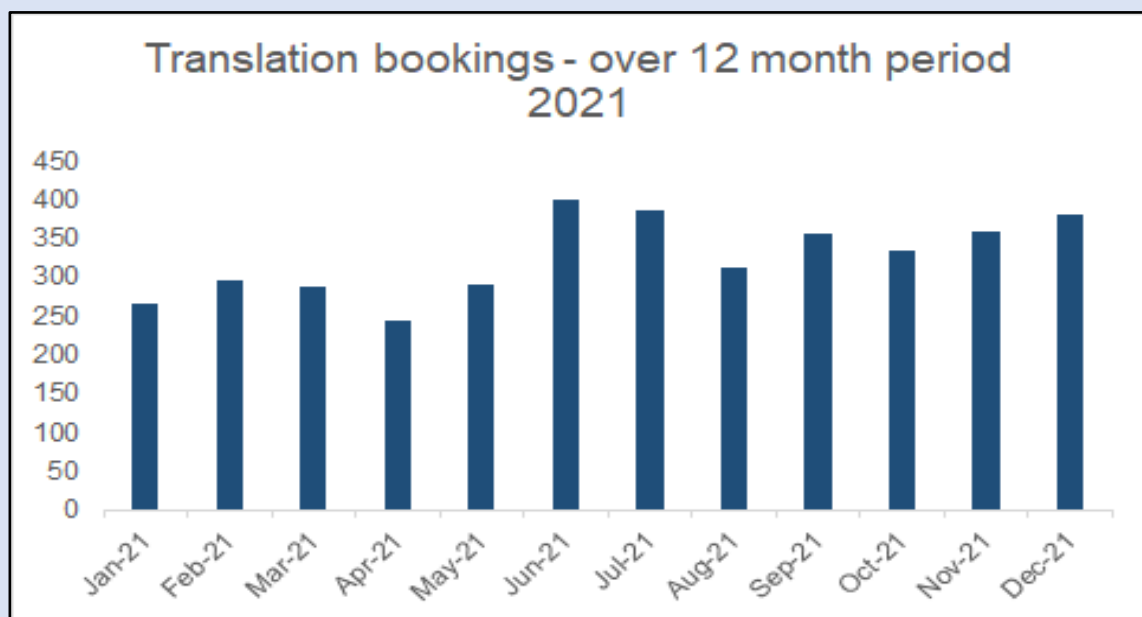


Source: WITS 2022

**Focus on:  Spiritual and Pastoral Support 2021-2022**

We continued to provide 24-hour urgent pastoral care to our patients upon request.  We adapted our approach to providing spiritual and pastoral support to any patients, visitors and staff of all beliefs during 2021. Examples of our work include:

- Supporting the last rites for patients, working with clinical teams and our pastoral support, including virtual services being provided.

- Reverend Wynne Roberts now has a weekly Broadcast on Radio Ysbyty Gwynedd. Christmas services and concerts were recorded and broadcast with online  contributions from Board Members. Reverend Roberts is currently the North Wales member of the Interfaith Council for Wales and sits on the third sector advisory panel for the Welsh Minister as a representative of the Inter Faith Council and Faith Community.

- A Children's Memorial and Organ Donation Service were held at Bangor and St Asaph Cathedrals.  Remembrance Day Services were also held outside the three District General Hospitals. This year we introduced a wider spiritual perspective by inviting leaders from other faith groups to participate, for example, a Druid Priest took part in the Organ Donation Service.



Photograph showing Reverend Wynne Roberts.

**Focus on…  Men's Mental Health**

Around 1 in 8 men have a common mental health problem.

BCUHB Mental Health Services designed and provided bite size panel sessions to support any staff wishing to access help and support.

**Focus on… New online support launched for people in North Wales with mental health problems**



Published BCUHB website News Page 21.04.2021

An online support service has been launched to help reduce the loneliness and isolation experienced by people with mental health problems and their Carers across North Wales.

The online peer support community offers a safe space for people to talk about their mental health in a supportive environment, connect with others in similar situations, and receive useful information on services in all six counties of North Wales.

Online mutual support communities like Clic play an important role in helping to reduce the loneliness and isolation that many people with mental health problems can experience.

For further information on mental health support available in North Wales, visit the Mental Health Hub on the BCUHB website: https://bcuhb.nhs.wales/health-advice/mental-health-hub/

To access North Wales Space, visit: https://northwales.clic-uk.org/

**Focus on… COVID-19 Vaccine Equity Programme**

The Health Board has continued to mainstream equality considerations in its Vaccine Programme throughout the year with the Strategic Vaccine Equity Group advising and guiding the operational delivery. During the year, the group produced and distributed a self-assessment checklist for all Vaccine Centres. This incorporated issues of physical access, and support for Neuro-divergent people attending centres, adequate signage, arrangements for people with sensory loss and arrangements for translation and interpretation services. The programme has translated key advisory materials into numerous spoken languages in North Wales, and the Vaccine Teams have achieved one of the highest Treat Me Fairly mandatory training compliance rates across the Health Board - a phenomenal achievement!

In August 2021, the Health Board held two virtual Question & Answer sessions on COVID-19 vaccinations for pregnant and breastfeeding people living in Flintshire and Wrexham. One session was delivered in partnership with the Association of Voluntary Organisations in Wrexham (AVOW). Stacey Jones, Matron of the COVID-19 Vaccination Programme for Flintshire and Wrexham, was available to discuss the latest information for people who are pregnant or breastfeeding on the COVID-19 vaccinations. Matron Stacey said:

"We were keen to speak to any expecting mums to join our Q&A sessions to discuss their concerns, help answer questions and dispel any fears".

**Further work to take forward Equality Objective 2 during 2022-23 will include:**

- Advancing Equality through the Health Board's long term strategy for the future 'Living Healthier Staying Well'.
- Driving strategic alignment and operational consistency of Equality Impact Assessment, ensuring that they are routine practice.
- Supporting the development of inclusive and responsive services with the aim of contributing towards closing the gap in life expectancy between people living in the most and least deprived areas of North Wales.
- Ensuring governance frameworks are robust and consistent in applying the Public Sector Equality Duty and Socio-economic Duty.
- Strengthening the collection, monitoring and analysis of data, including improving the quality of data for people who share protected characteristics.
- Identifying and addressing barriers to accessing culturally appropriate and effective services.

## BCUHB Equality Objective 3:

**We will prioritise action to respond to key policy and legal developments in healthcare for people sharing different protected characteristics in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 3.  We:

- Implemented processes that pay due regard to the Socio-economic Duty in strategic decision-making.
- Promoted the Social Model of Disability as part of the programme of equality briefings across the organisation.

- Promoted numerous equality campaigns and marked Equalities Week in May 2021 (see "Focus on").
- Supported the implementation of the Code of Practice for Delivery of Autism Services, working with stakeholders to adopt a co-productive approach.

**Focus on: Equality Campaigns of 2021-22**

- International Day Against Homophobia, Transphobia & Biphobia – led by Celtic Pride staff network.

- National Deaf Awareness Week, including promotion of the BCUHB Sensory Loss Toolkit was promoted to staff. An information film was promoted across the Health Board.

- Windrush Day, marking the anniversary of the arrival of the Windrush generation.

- UK Pride Month.

- UK Black History Month.

- Mental Health Awareness Week.

- International Women's Day.

- International Non-Binary Day.

- Sensory Loss Awareness Month.

- World AIDs Day.

- International Day of Persons with Disabilities.

- Human Rights Day.

- Hate Crime Week.

**Focus on… Equality Week 2021**



During Equality Week we worked in partnership with all Wales colleagues to facilitate a range of interactive workshops. Daily events took place to promote and highlight equality issues related to the workplace and service delivery. These included keynote speakers who delivered sessions on Race Equality, A Little Bit of Banter – impacts of harassment, Autism, Collective Voices of people with protected characteristics, and a session called Autism and Me focussing on the experiences of two Autistic residents of North Wales in engaging with the Health Board.



Photo of our Race Equality event.

**Further work to take forward Equality Objective 3 during 2022-23 will include:**

- Coordinating equality campaigns with other Health Boards across Wales. This will be organised through the NHS Wales Equality Leadership Group, the membership of which comprises Equality Teams from NHS organisations across Wales.
- Implementing new national policy drivers such as the Welsh Government Race Equality Action Plan, LGBTQ+ national plan, and Human Rights Act review.

## BCUHB Equality Objective 4:

**We will prioritise action to advance gender equality in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 4.  We:

- Published our Gender Pay Gap report – see Appendix 1.
- Launched our Gender Equality Staff Network in early March 2022.
- Worked in partnership with the Gender Equality organisation, Chwarae Teg, to raise awareness of Welsh Government's Gender Equality Review: Chwarae Teg's reports and 'Deeds not Words' report.
- Held our first Gender Panel discussion led by the Chief Executive Officer, the Executive Director of People and Organisational Development and the Executive Director of Nursing on 25th October. The aim of this event was to engage with the workforce to start to identify gender issues across the Health Board, including support for women in leadership, childcare and caring responsibilities, and providing support for menopause.

- Celebrated International Women's Day on 8th March 2022 with a programme of events and the "#BreakTheBias" campaign.

**Focus on… Gender Pay**

We have continued to monitor and report our Gender Pay Gap. The latest report shows that the gender pay gap has narrowed. The average pay gap has dropped from 27.97% to 25.99% and Median pay gap from 11.36% to 7.99%. Further, our average bonus gap of 16.65% is based on actual bonuses and so it does not take into account part-time working. This gap has reduced from the previous year figure of 20.96%.

The pay gap has reduced this year which is positive, however the results are indicative that further improvements are needed. These potentially link to the availability of flexible working options and development opportunities at senior levels of the organisation.

As well as our new Gender Equality Staff Network, we also plan to establish a gender pay action group to develop strategies to address the gender imbalance in senior roles and to improve opportunities for women to be properly represented in all senior roles.
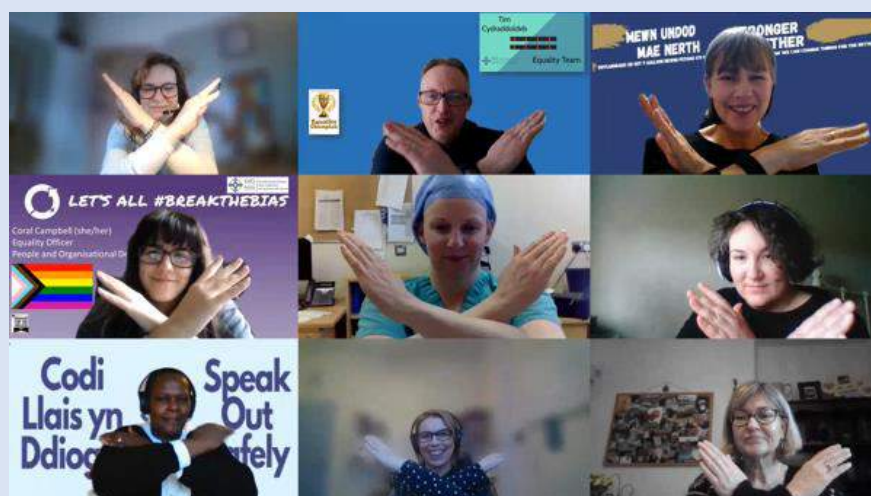


Photo showing our Gender Equality Network #BreakTheBias

**Ysbyty Gwynedd doctor inspiring the next generation of female surgeons**
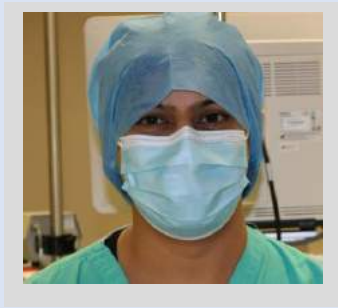



A doctor at Ysbyty Gwynedd is inspiring young women to become the next generation of surgeons. Mrs Faiza Ali, who is an Ear Nose & Throat (ENT) Speciality Doctor at Ysbyty Gwynedd, has been visiting schools in the region to encourage students to consider a career within surgery. Mrs Ali joined Ysbyty Gwynedd's ENT department in 2015 as a Junior Doctor and became a Speciality Doctor in 2018.

"I think at every step of my journey I was told by different people everywhere that I should choose a lighter job being a mother and wife and that surgery would be too much for me. Only recently I went to see a patient just before her operation and I was asked when the surgeon would arrive, to which I replied that I was the surgeon".

"This came as a surprise to this patient, I believe people still have a perception that the majority of surgeons are men. This is something I want to change and I'm very passionate about promoting positive female role models in the field and also encouraging other younger women to pursue this career. My message to the young women is that if you have a dream to pursue a career in surgery then just go for it and never give up. You should always believe in yourself and nothing should stop you, failures may come your way at some point but learn from them and start again."

**Focus on… Women in Leadership Panel Event**

On the 25th October 2021, the Equality Team hosted a live panel event involving our most senior leaders, and a keynote presentation by Cerys Furlong, CEO of Chwarae Teg, a leading gender equality charity in Wales, who regularly work with Welsh Government.

The aims of the session were to:

- Provide insight into the career journeys of some of the organisation's senior leaders.
- Recognise the impacts of the pandemic on women.
- Underline the current and continuing issues surrounding gender inequality through the lens of healthcare.
- Provide useful information for women in our organisation.
- Highlight our work and support systems for women.

Our CEO Jo Whitehead opened the session by recounting her professional journey, and sharing her support for gender equality. Cerys Furlong's keynote followed, and then questions submitted by BCUHB colleagues were put to the panel. Some fascinating aspects of the panel's lives were conveyed, and personal insights and experiences were shared.
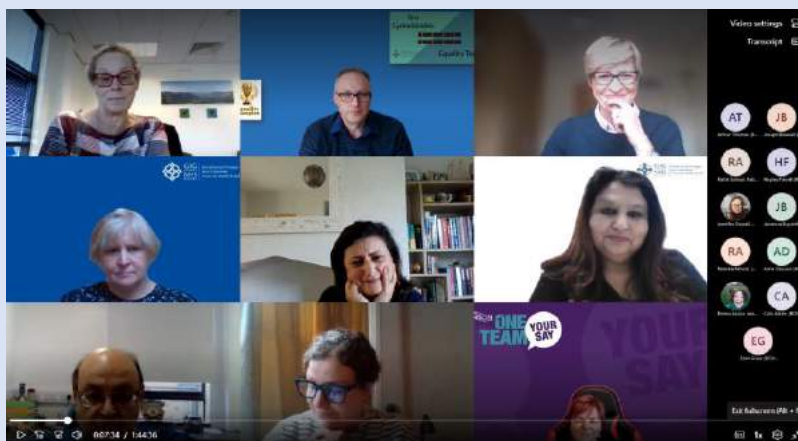


Photo of Women in Leadership Panel Event

**Further work to take forward Equality Objective 4 during 2022-23 will include:**

- Continuing to publish our gender pay gap and implementing improvements.
- Establishing the work of the gender action group to deliver actions to advance gender equality.
- Developing the gender equality network and supporting mechanisms, and advancing its programme of work.
- Improving awareness of and access to work life balance opportunities.
- Taking action to support pregnant staff, those returning to work following maternity leave and new parents.

## BCUHB Equality Objective 5:

**We will prioritise action to address personal security for people sharing different protected characteristics accessing health services in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 5.  We:

- Ensured the safe delivery of the COVID-19 Vaccination Programme, including measures to ensure the safety of our staff and facilities.
- Worked in partnership with North Wales Police to raise awareness of hate crime initiatives, including the promotion of Hate Crime Awareness Week 2021.
- Launched the new Speak Out Safely service, a way for staff to anonymously raise concerns and have these responded to fairly

and efficiently, contributing to creating a culture of psychological safely, openness and transparency within the Health Board.

- Raised awareness of the new Respect and Resolutions NHS Wales Policy and EHRC guidance on sexual harassment and harassment in the workplace.

- Worked in partnership with Victim Support to signpost people to the support available for them as well as supporting pathways for members of staff who may be victims of hate crime and domestic abuse incidents.

- Recorded and reviewed risks where hate crime is reported as a factor, and establishing base line information to identify trends through on-going monitoring.

- Embedded considerations of security and feeling safe as part of the application of the Socio-economic Duty. Our Socio-economic Impact Assessment (SEIA) includes factors of feeling safe, domestic violence and hate crime.

**Focus on… Hate Crime**



Hate hurts Wales

Our Equality Team attend quarterly meetings with North Wales Police to maintain awareness of current issues. These meetings help to ensure that organisations across North Wales share information and best practice. The meetings are also a good opportunity to give scrutiny to current and ongoing work to tackle hate crime. Data on hate crime in North Wales is routinely shared between North Wales Police and the Health Board and is also shared with the North Wales Public Sector Equality Network.

**Focus on… Codi Llais Yn Ddiogel - Speak Out Safely**



Codi Llais Yn Ddiogel - Speak Out Safely is BCUHB's approach to supporting staff to raise concerns when going through formal routes to raise their concern may not be an option for the staff member concerned. The approach offers an independent and anonymous web-based platform called 'Work in Confidence', which supports anonymous two-way conversation between staff and one of the Speak Out Safely Team. This can be in person, virtually, by phone or by e-mail.

Speak Out Safely has been introduced to ensure that all staff, students, contractors and volunteers working within the Health Board have opportunities to have their concerns heard and taken seriously. As part of the launch process, targeted engagement was undertaken to ensure that the staff networks were made aware of the process, and that the design of promotional materials was inclusive and accessible.

There are a number of ways to raise concerns, which helps support staff who may otherwise experience barriers to speaking up, and those who may not have access to digital technology.

**Further work to take forward Equality Objective 5 during 2022-23 will include:**

- Promoting All Wales Respect and Resolution policy.
- Working with partners to improve the identification, reporting and support for victims of incidents and hate crime across those who

share protected characteristics with a particular focus on LGBT+ and people from ethnic minority backgrounds.

- Encouraging the reporting of hate crime and incidents across all protected characteristics, reporting and analysing through the online Datix reporting system.

- Built equality considerations into the design of a significant staff engagement exercise which aimed to engage with 10% of our staff – known as Discovery – and undertook targeted engagement, including with our staff networks as well as monitored the engagement and involvement of staff with protected characteristics.

## BCUHB Equality Objective 6:

**We will increase engagement with individuals and groups sharing different protected characteristics in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 6. We:

- Engaged with organisations across North Wales to inform the review of Living Healthier, Staying Well, the Health Board's ten year strategy.

- Appointed an Engagement Officer, dedicated to working with ethnic minority communities to improve engagement with these communities.

- Built equality considerations into the design of staff engagement work and undertaken targeted engagement and monitored involvement of staff sharing protected characteristics.

- Grew the Health Board's staff networks and provided on-going facilitation and support to these networks to ensure strong staff engagement.

**Focus on…  Maintaining Partnerships and Networks**

The Health Board has continued to work closely with a number of partners and networks to support and embed the delivery of the equality objectives in the Strategic Equality Plan.

**Equality Stakeholder Group**

The Equality Stakeholder Group's purpose is to advise the Health Board's Equality and Human Rights Strategic Forum. The group helps formulate solutions through co-production to overcome barriers faced by groups and people who share protected characteristics whilst engaging  and involving as wide a representation of people and organisations as possible. Membership of the Stakeholder Group has continued to grow during 2021-22 and continues to provide valuable insight to inform the work of the Strategic Forum.



Photo of our Equality Stakeholder Group meeting.

**Engagement Practitioners Forum**

We have used virtual platforms during 2021-22 to maintain engagement through this Forum. The Health Board's Engagement Team has held several Engagement Practitioners Forums via Skype and Zoom and also supported a wide range of joint network events. This has helped the Health Board to maintain continuous engagement during the COVID-19 pandemic.

**Focus on…** **Maintaining Partnerships and Networks**

**Community Cohesion Forums**

There has been ongoing engagement with the North Wales Community Cohesion Forums and good links have also been maintained with the Chinese in Wales Association and the Chinese Women's Association based in Flint.



**Advancing Equality through Engagement**

Engagement has enabled us to understand and remove barriers people may face in fully accessing and engaging with health care services. During 2021-22, this has included producing information materials in several languages, enabling increased engagement with programmes such the Digital Strategy and engaging with communities to listen to their views about the refresh of the Health Board's long term strategy, Living Heathier, Staying Well.

**Focus on… BCUHB Staff Networks**

Our staff networks provide a pathway of support to staff in the workplace and facilitate a forum for discussion and escalation of issues relevant to individuals who share protected characteristics. During 2021-22, the networks have focussed on increasing awareness of their existence, increasing membership and identifying priorities for action.



Celtic Pride is our long-established Lesbian, Gay, Bisexual and Transgender (LGBT+) Staff Network that supports staff at Betsi Cadwaladr University Health Board, the Welsh Ambulance Services NHS Trust, and NHS Wales Shared Services Partnership in their working lives and promotes awareness of LGBT+ issues within organisations. During 2021, the Celtic Pride Network has continued to grow, with new starters to the organisation getting in contact and joining the network. Communication with Network members is being maintained as are the network's links with North Wales Police. During 2021-22, Pride events were  marked differently, innovative ways of holding Prides on-line were undertaken.  In August, the Health Board took part in a week of NHS Wales Pride events.  We have continued to work with Stonewall as Diversity Champions and also work with other organisations, such as Unique.

**Focus on: BCUHB Staff Networks**

Our BCUnity Ethnic Minority and Overseas Staff Network has been engaged in developing our response to the Welsh Race Equality Action Plan and some members of the Network are now members of our newly formed Race Equality Action Group. The BCUnity Ethnic Minority and Overseas Staff Network continues to work to provide support to newly appointed staff from overseas. The network has worked with colleagues working in recruitment and the overseas nursing support team to ensure new recruits from overseas have access to local information and are supported from their first day of working in BCUHB.

During 2021-22, our RespectAbility Staff Network has developed a newsletter to raise awareness and understanding amongst staff of a wide range of issues related to disability.

We established a new Gender Equality Staff Network in early March 2022 which will continue to grow during 2022.

**Focus on… Engagement with Black Asian and Minority Ethnic communities**

The Public Engagement Team held online COVID-19 Vaccination Question and Answer (Q&A) sessions for members of the public. The events were a collaboration between the Health Board, North East and West Community Cohesion Forums - who chaired the events, and the Black Association of Women Step Out, (BAWSO) who hosted the sessions on their Zoom platform.

These events provided reassurance about the vaccine, and proactively offered an opportunity for the public to ask questions and address concerns related to having the vaccine.  A panel of experts attended, including members of Muslim Doctors Cymru, and the Chair of the BCUnity Ethnic Minority and Overseas Staff Network.

Throughout 2021-22 we have continued to build engagement with Black, Asian and ethnic minority communities and stakeholder groups that provide services and support communities, including events focused on Breast Health, supported by the North Wales African Society (NWAS):



Another event promoting Men's Health was held alongside a celebration event for Black History Month. Further events have included engaging with Black, Asian and ethnic minority groups on the Health Board's End of Life and Palliative Care Strategy.

**Further work to take forward Equality Objective 6 during 2022-23 will include:**

- Supporting the organisation to adopt an inclusive approach to all engagement activity.
- Facilitating the delivery of patient stories at senior management forums to contextualise lived experience.
- Increasing engagement across all protected characteristics and Socio-economic disadvantage through our Equality Stakeholder Group.

## BCUHB Equality Objective 7:

**We will prioritise action to increase participation for people sharing different protected characteristics in health services across North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 7. We:

- Developed and published Our Digital Future Strategy which is published here: Digital Strategy - Betsi Cadwaladr University Health Board (nhs.wales)
- Widely promoted the importance of inclusive communications, increasing access and reducing cultural and language barriers.
- Mobilised volunteers to support activities across the Health Board, including with the Vaccination Programme.
- Continued our Robin Volunteer scheme with 330 Robin Volunteers from all walks of life supporting our hospital sites and over 700 registered Public Volunteers supporting our COVID-19 Vaccination Programme as helpers.
- Continued our employability schemes during 2021-22.

**Focus on… Digital First – leaving no-one behind**

In May 2021, we published our strategy – <u>Our Digital Future, Digital Roadmap for Health in North Wales 2021-2024</u>. This is an ambitious strategy with a primary focus in improving the experiences of our patients, carers and staff.

We aim to ensure that patients and carers have easy access to the information they need to support them to self-manage their care and also that our staff can access the right information in the right place at the right time to be able to provide safe, positive patient experiences and improved outcomes. The core approach is "Digital First – leaving no-one behind". This is crucial as some of our patients and their carers may be digitally excluded and this strategy aims to ensure that everyone's needs are included to ensure there is no negative impact on people's health.

Public consultation informed the strategy with over 4,000 comments received. This consultation highlighted concerns with digital exclusion as a barrier. An Equality Impact Assessment and Socio-economic Impact Assessment were undertaken to inform the approach taken to developing digital services. The Health Board will continue to provide and support people to access our services non-digitally, including providing a range of communication options through contacting patients by letter, the use of an interactive voice messaging service to the patients landline, text message reminders and an app for ordering repeat prescriptions. We continue to provide face to face appointments to ensure no-one is excluded. This will help us continue to address existing health inequalities, and to engage patients and carers who are facing digital poverty.

**Focus on: Employability Programmes:**

The Health Board operate a number of employment schemes which provide opportunities to gain experience, skills and confidence.

Our Employability Programmes are delivered in partnership with:

- Communities First Projects and Job Centres.

- Agoriad, Scope, Remploy, Sight and Sound, Gisda.

- North Wales Regional Equalities Network (NWREN).

- Educational settings.

- 'Go Wales' University Students.

The opportunities included:

- Apprenticeships in partnership with Further and Higher Education.

- Apprenticeships promoted to disabled people through Disability action plan for apprenticeships | GOV.WALES.

- Step into Work Adult Volunteer Work Placement Programme, providing support for a range of people including those at risk of long term unemployment.

- Project SEARCH, a unique pre-employment programme helping young people with cognitive impairments and who are neuro divergent to gain the skills to enter employment.

- The Kick-start Scheme is funded by the Department of Work and Pensions to create new job placements and support for 16 to 24 year olds on Universal Credit who are at risk of long term unemployment.

The Health Board carry out a range of other work to promote employability across North Wales. This includes attendance at careers fairs and visits to colleges and schools including mock interview sessions.

**Focus on: A Step into Work**



We work in partnership with social enterprises to deliver our 'Step into Work' programme.

This provides opportunities through placements for people including workless households and the long-term unemployed. The programme is delivered in partnership with communities for work project, In Work Poverty, Agoriad, Remploy, Mon Communities Forward, North Wales Regional Equalities Network (NWREN), Not in Education, Employment or Training, Go Wales, Higher Education Students and Further Education Students.

Since 2017, our 'Step into Work' programme has helped over 250 participants secure a role in the Health Board including as Health Care Assistants, Domestics, Porters and others working in catering, administration and laboratories.

**Further work to take forward Equality Objective 7 in 2022-23, includes:**

- To increase staff awareness, we will develop and publish a set of co-production principles for colleagues on the Health Board's intranet system "BetsiNet".
- Ensure examples of best practice are published on the Betsi Net and will include the Code of Practice for Delivery of Autism Services,

Gender Inclusion, and work with Military Veterans, Asylum Seekers and Refugees.

- Increase our understanding and potential of a co-productive approach.

## BCUHB Equality Objective 8:

**We will prioritise action to develop an inclusive culture where leaders routinely demonstrate their commitment to promoting equality within BCUHB and beyond and enable a fair and inclusive workforce**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 8.  We:

- Implemented Socio-economic Duty governance and assessment procedures through the SEIAs.
- Continued to embed equality and human rights considerations to ensure compliance with the Public Sector Equality Duty through a focus on EqIA procedures and support.
- Developed an Equality Accountability Framework and Balanced Scorecard with roll out planned for 2022-23.
- Took account of the Compassionate Leadership Principles launched by Health Education and Improvement Wales (HEIW).
- Took account of the All Wales 10-year workforce strategy, 'A Healthier Wales: Our Workforce Strategy for Health and Social Care' when advising on the development of BCUHB strategies.
- Developed equality language best practice resources for colleagues through the equality team BetsiNet pages.
- Continued to increase the percentage of staff disclosing equality information on Electronic Staff Record.

- Improved the support given to staff recruited to the Health Board from overseas which includes the provision of welcome and guidance packs to help our overseas staff adjust to life in North Wales.

- Continued to gather staff and patient stories to increase understanding of lived experiences of people who share protected characteristics.

- Continued to work with Health Education Improvement Wales (HEIW) to implement the mandatory Equality Training - 'Treat Me Fairly'.

- Applied EqIA and SEIA principles to inform the development of the People Strategy and Plan.

**Further work to take forward Equality Objective 8 in 2022-23 includes:**

- To agree a suite of key performance indicators for those who share protected characteristics to support the implementation of the Equality Accountability Framework.

- To continue to provide EqIA training for all senior managers.

- To provide SEIA training for all project managers and senior managers responsible for strategic projects.

## BCUHB Equality Objective 9:

**We will prioritise action to advance race equality in North Wales**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 9.  We:

- Established a Race Equality Action Group to take forward the workforce race equality plan and plan for the publication of the Welsh Government Race Equality Action Plan.

- Gained a better understanding of the experience of local populations, patients and carers from a Black, Asian and ethnic minority background with a report for those living in Rhyl commissioned by the

North Wales Regional Equality Network. This work will both inform the tasks of our Race Equality Action Group and also Year 3 of our Strategic Equality plan for 2022.

- Sustained and supported the BCUnity Ethnic Minority and Overseas Staff Network to better understand lived experience and provide our staff with the opportunity to engage in influencing service planning and delivery.

- Celebrated Black History Month across the Health Board.

- Developed resources to support cultural competency with the commissioning of the Cultural Competency programme from 'Diverse Cymru' to provide Cultural Competency training to key staff, with this continuing into 2022-23.

- Launched staff development grants to fund the provision of training and development opportunities for Black, Asian and ethnic minority staff.

- Developed an inclusive calendar of multicultural festivals and celebrations and used it to improve awareness amongst our staff.

**Mehreen Rafique, Acting Chair of the BCUnity Ethnic Minority and Overseas Staff Network said:**

"The past year has been yet another challenging year for the Health Board, as we find ourselves affected by numerous issues directly and indirectly resulting from the ongoing pandemic. Now, more than ever, it is vital that we pull together in understanding and value the contribution that everyone makes to our society. In our place of work, it is also crucial that we value and respect each and every staff member regardless of ethnic background. This way, we will have an engaged and productive workforce in what is often a challenging environment. Events like Black History Month and recognising festivals and celebrations from different faiths and cultures are part of making everyone feel included. Our Race Equality Action Group is an important group that will ensure that we measure and improve our performance when it comes to racial equality in BCUHB."

Photograph of Mehreen Rafique.

**Focus on: Promoting collaborative working with organisations working to support Black and Minority Ethnic individuals**

It is widely recognised that whilst the coronavirus pandemic has impacted on the lives and livelihoods of all communities in Wales, the impacts on Black and Minority Ethnic individuals have been especially profound. A key focus of the Health Board's work this year has been to maintain awareness of this evidence as it has emerged, work with our stakeholders and staff to address immediate issues and identify actions to take forward in 2022 and beyond.

We have worked closely with the North Wales Regional Equality Network (NWREN) for many years and have welcomed their continued engagement, support and advice in this challenging year.



During 2021, we worked in partnership with NWREN to undertake a study in Rhyl to map the agencies engaged with Black and ethnic minorities individuals, and to identify themes within the experiences of local Black and ethnic minority individuals in accessing healthcare. This report and the lived experience evidence it gathered will inform the work of the newly formed Race Equality Action Group.

**Focus on: Grant Scheme for staff from ethnic minority backgrounds**

Following work undertaken by our BCUnity Ethnic Minority and Overseas Staff Network, Awyr Las, our local NHS charity, launched a small grants scheme specifically for BCUHB staff from ethnic minority groups, with grants awarded to support supplementary development activity related to additional continuous personal development and extra accredited training.

**Norah Musyoki explains what the grant scheme means to her:**

"Most times many of us walk around with a basketful of ideas and dreams that we have no clue how to bring them to pass...this is an even more resounding truth when in a new environment where you barely have an idea of what is right to say or not, when and where exactly to find help...

Providing career development for our ethnic minority staff is not only about providing information about opportunities and how to access them but also to ensure that staff are supported to take advantage of them. The grant scheme provided through Awyr Las seeks to remove barriers and make sure all staff, irrespective of background, have fair and equal opportunities to opportunities for personal and professional development.

I realise that for me to remain relevant in my field within the UK and beyond, I need to be well equipped with all the knowledge I can get. For the longest time I have known I have to go back to school and upgrade my qualifications to the UK equivalent. With this grant, I will have obtained support to fund part of the fees for my BSc (Hons) Nursing studies top up degree at the University of Derby. I'm optimistic that this is the door I need to step onto the career development ladder".



Photo showing Norah Musyoki

**Case study: Black History Month**

In October 2021, we celebrated Black History Month. This was promoted widely through our Equality Briefings and by our BCUnity Ethnic Minority and Overseas Staff Network. Together, we coordinated a campaign to celebrate our amazing diversity across the Health Board. The theme this year was "Proud to be...".

**Further work to take forward Equality Objective 9 in 2022-23 includes:**

- Continuing to develop and strengthen our Race Equality Action Group and implement our workforce race equality plan.
- Implementing the actions arising from the Wales Race Equality Action Plan when published.
- Strengthening engagement and the role of the BCUnity Staff Network.
- Reviewing membership of our Equality Stakeholder Group, and promoting participation from underrepresented groups.

## BCUHB Equality Objective 10:

**We will prioritise action to deliver the Public Sector Equality Duty**

During 2021-22 the Health Board achieved a number of milestones to support Equality Objective 10. We:

- Mandated Equality reporting completed and published on the Health Board website in Welsh and English.
- Provided a quarterly progress report on the delivery of the Year two of the Strategic Equality Plan to the Equality and Human Rights Strategic Forum.
- Engaged and involved people to join the Equality Stakeholder Group who are representative of one or more of the protected groups and who have an interest in how the Health Board carries out its equality duties.
- Developing and implementing an EqIA Training Plan for all senior managers. This has involved facilitating twice weekly EqIA training sessions during 2021-22.
- Included a requirement to collect Equality Monitoring information as a standard is included in the Health Board's draft Quality Strategy.

- Continued to celebrate Equality, Diversity and Inclusion with a week of virtual events across the Health Board during May 2021 to mark Equality Week 2021.
- Strengthened the Public Sector Equality Duty in the Health Board's procurement processes.

**Further work to take forward Equality Objective 10 during 2022 includes:**

- Increasing the proportion of managers across the Health Board who have undertaken EqIA training.
- Reviewing and analysing employment information held on the electronic staff record (ESR) and identified themes to inform delivery of our Year three Strategic Equality Plan.
- Publishing our Annual Employment Report.
- Continuing to provide quarterly updates on progress with delivery of Year three of our Strategic Equality Plan to the  Equality and Human Rights Strategic Forum.
- Implementing the Equality Accountability Framework.

# 7. Conclusion

BCUHB remains committed to advancing equality, promoting human rights and reducing health inequalities. This annual report highlights our key achievements during 2021/22 to ensure that our services reflect and respond to the needs of our people and that we comply with our statutory equality and socio-economic duties. This annual report aims to show how we continue to work to ensure that equality, diversity and inclusion are mainstreamed and fully embedded in the planning and delivery of our services both now and to meet the future needs of the population and our workforce across North Wales.

COVID-19 has been ever present in all our work across the Health Board in the last year, and awareness and understanding of health inequalities has been brought into sharper focus with the differential impact COVID-19 has had on the people we serve who share protected characteristics and those who experience socio-economic disadvantage. Our equality objectives have been further revised to reflect this developing evidence and we will continue to drive and monitor implementation during year three and four of our Strategic Equality Plan.

Responding to and acting upon the introduction of the Socio-economic Duty in 2021 has provided a further platform for the Health Board to ensure our strategic decisions take account of the potential socio-economic impact of our decisions and deliver better outcomes for those who experience socio-economic disadvantage. This year we have strengthened the governance of this work, a key achievement has been the wide promotion of a range of resources to raise awareness of the Duty and implementation of a process and framework to help ensure that robust socio-economic impact assessment informs our strategic decision making across the Health Board.

During 2021/22 we have further developed and strengthened our Staff Networks and continued to work with our Equality Stakeholder Group. This ongoing engagement is invaluable in helping us maintain an understanding of the barriers experienced by some groups and by working together to identify improvements. We know that the ongoing Covid-19 pandemic will continue to highlight and may exacerbate existing health inequalities. As such it is important as ever to plan and deliver our services from the founding principle of equality, human rights and inclusion.

We look forward to delivering the third year of our Strategic Equality Plan in 2022-23. Finally, we conclude this report by acknowledging the significant challenges everyone has faced during 2021-22 and sincerely thank and note our appreciation for all our stakeholders, staff and partners who have continued to support and help BCUHB deliver the second year of our Strategic Equality Plan.

# Appendix 1 – Gender Pay Gap report

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

Gender Pay Gap Report 2021

Introduction

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 set out the requirements for organisations with more than 250 employees to calculate and publish their gender pay gap information. Greater transparency in pay gap reporting is designed to help organisations better understand the issues that give rise to, and sustain gaps in average pay between men and women, and to encourage organisations to take steps to tackle them.

We have therefore, decided to go beyond the specific legal requirements contained in the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 and to voluntarily publish this pay gap report based upon the 2017 Regulations.

This is our third Gender Pay Gap Report. All figures are based upon data taken from the NHS ESR (Electronic Staff Record) payroll systems as at the latest snapshot date (31st March 2020).

This report contains the following:

Average & Median Hourly Rates and Pay Gaps

Average and Median Bonus and Pay Gaps

Proportion of staff receiving a bonus

Number and percentage of males and females divided into four groups (Pay Quartile) ordered from lowest to highest pay.

Table 1. Average & Median Hourly Rates and Pay Gaps

| Gender | Average Hourly Rate (£p per hour) | Median Hourly Rate (£p per hour) |
|---|---|---|
| Male | 22.18 | 16.20 |
| Female | 15.97 | 14.36 |
| Difference | 6.21 | 1.84 |
| Pay Gap % | 27.97% | 11.36% |

The gender pay gap is defined as the gap in median pay that male and female employees receive.

The mean pay gap is the difference between average hourly earnings of men and women. The median pay gap is the difference between the midpoints in the ranges of hourly earnings of men and women. It takes all salaries in the sample, lines them up in order from lowest to highest, and picks the middle salary.

The figures above highlight a gap between the average hourly pay for men and women in the organisation. Further research has been undertaken to better understand why these gaps exist, and the early indications are that this could be attributable to the high numbers of women in some of the lower grades, as well as a high proportion of men in senior grades, where staff numbers are not so great. This is borne out by the numbers shown in Table 4 and the accompanying graph.

Gender pay reporting is different to equal pay- equal pay deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. We are confident that men and women are paid equally for doing equivalent jobs across BCUHB. More than 93% of BCUHB staff are paid in accordance with NHS Agenda for Change Terms and Conditions – these are the national agreements on pay and conditions of service for NHS staff other than very senior managers and medical staff.

Table 2. Average and Median Bonus and Pay Gaps**

| Gender | Average Bonus (£) | Median Bonus (£) |
|---|---|---|
| Male | 11,474.79 | 10,003.02 |
| Female | 9,069.67 | 8,057.67 |
| Difference | 2,405.12 | 1,945.35 |
| Pay Gap % | 20.96% | 19.45% |

In line with the reporting requirements, our mean bonus gap of 20.96% is based on actual bonuses and so it does not take into account part-time working.

Table 3. Proportion of staff receiving a bonus**

| Gender | Employees Paid Bonus | Total Relevant Employees | % |
|---|---|---|---|
| Male | 297 | 4,405 | 6.74% |
| Female | 104 | 17,091 | 0.6% |

** Bonus payments comprise Clinical Excellence and Commitment Awards paid to medical staff.

Table 4. Number and percentage of Employees by Pay Quartile

| Pay Quartile | Female | Female % | Male | Male % |
|---|---|---|---|---|
| 1 (Lowest) | 4012 | 84.66 | 727 | 15.34 |
| 2 | 3917 | 82.64 | 823 | 17.36 |
| 3 | 3978 | 85.77 | 660 | 14.23 |
| 4 (Highest) | 3426 | 70.77 | 1415 | 29.23 |

**Percentage and Number of Employees by Pay Quartile**
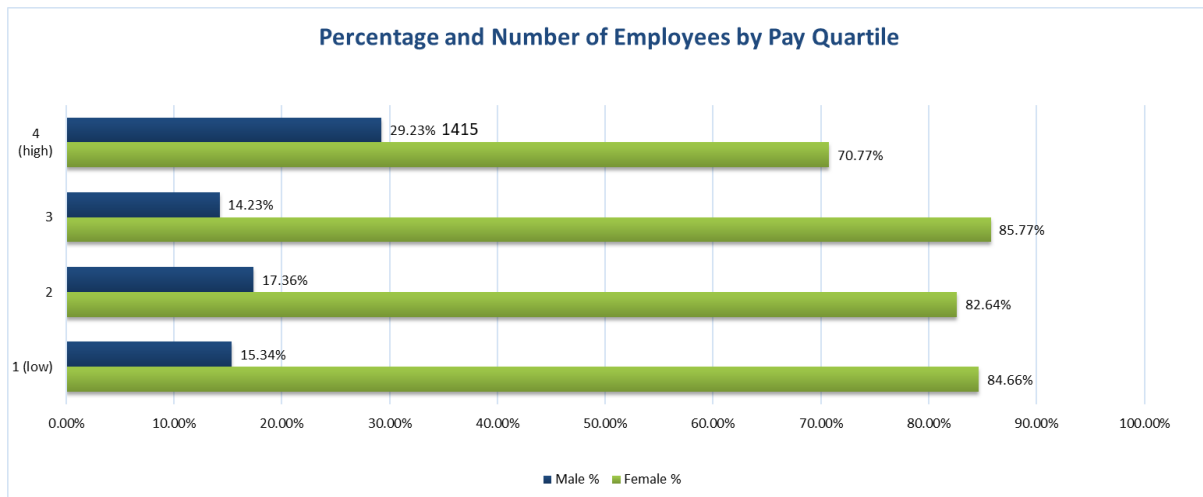


The table and graph demonstrate how the proportions of women and men change from lowest to highest pay quartiles, meaning that fewer women are employed in senior roles than men. The spread of Male and Female across the pay quartiles has changed very little since 2018.

Conclusions and Next Steps

The Health Board's workforce is predominantly female; this is similar to most NHS organisations. Whilst national pay scales, supported by local starting salary and pay progression processes are designed to support equity and fairness, we have identified a gender pay gap across the workforce. We are working to better understand these issues. A number of themes have emerged which will be aligned to the BCUHB Workforce Strategy and Key Priorities: -

**Work-life balance**

**Networks and Support Mechanisms**

**Organisational Development and Training**

**Recruitment, Retention and Progression**

Statement by our Executive Director Workforce and Organisational Development

"We recognise the disproportionate impact of the Covid-19 pandemic on some groups, our organisation employs over 18,000 people, the majority of whom are members of communities across North Wales. Pay gap reporting is a vital tool in helping us understand and tackle gender inequality at work. Creating a culture of inclusion, fairness and equity

across our workforce is at the heart of our Workforce Strategy. This is reflective of the Health Boards' strategic equality objectives, and is supported by an increasing body of evidence, which correlates inclusion, wellbeing and the engagement of the workforce with the quality of health and care experienced by the people we serve. The Covid-19 pandemic continues to shape our strategy and the operations of our organisation, we recognise the disproportionate impact the pandemic has had on some women, working mothers balancing childcare and homeschooling and those with caring responsibilities. Our move this year to agile and more flexible working will provide valuable insight going forward. Maintaining a clear picture of both the pay gap, staff experience and strengthening our BCUnity staff networks will help us take the right steps as we progress."

| | Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board |
|---|---|

| Report title: | Quality and Patient Safety Report: April 2022 – May 2022 | | |
|---|---|---|---|
| Report to: | Health Board | | |
| Date of Meeting: | Thursday, 04 August 2022 | Agenda Item number: | 7.1 |
| Executive Summary: | This report provides the Health Board with information and analysis on significant quality and patient safety issues arising during the prior two month period, alongside longer-term trend data, and information on the improvements underway. | | |
| Recommendations: | The Health Board is asked to receive this report. | | |
| Executive Lead: | Gaynor Thomason, Interim Executive Director of Nursing and Midwifery<br>Dr Nick Lyons, Executive Medical Director | | |
| Report Author: | Matthew Joyes, Associate Director of Quality<br>Dr Kath Clarke, Head of Patient Safety<br>Sarah Musgrave, Patient Safety Lead Manager | | |

| Purpose of report: | For Noting ☐ | For Decision ☐ | For Assurance ☒ |
|---|---|---|---|

| Assurance level: | Significant ☐ | Acceptable ☐ | Partial ☒ | No Assurance ☐ |
|---|---|---|---|---|
| | 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 | No confidence/evidence in delivery |

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

There is confidence in the data provided in the report however, the strength of learning and improvement remains an areas of concern and is a key focus of work. This is being addressed through a range of measures including the actions aligned to the BAF risk (BAF21-10), the Patient Safety Improvement Programme and the Quality Strategy currently being finalised.

| Link to Strategic Objective(s): | Quality |
|---|---|
| Regulatory and legal implications | Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards or safety legislation. |
| Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR) | BAF21-10 - Listening and Learning |
| Financial implications as a result of implementing the recommendations | N/A |
| Workforce implications as a result of implementing the recommendations | N/A |
| Feedback, response, and follow up summary following consultation | N/A |
| Links to BAF risks:<br>(or links to the Corporate Risk Register) | BAF21-10 - Listening and Learning |
| Reason for submission of report to confidential board (where relevant) | N/A |

**Next Steps:** N/A

**List of Appendices:** Quality and Patient Safety Report

# Quality and Patient Safety Report to the Health Board

## April 2022 - May 2022

## INTRODUCTION

Within the NHS in Wales, quality is defined in statute as having three dimensions: patient safety, clinical effectiveness and patient (and carer) experience.

This report provides the Health Board with a summary of key quality related information from the months of April and May 2022. The aim of this new report is to provide the Health Board with key quality highlights at each meeting.

Detailed information relating to trends, themes, learning and improvement is provided to the Quality, Safety and Experience Committee in the bi-monthly Patient Safety Report and triannual Patient and Carer Experience Report.

There are two sections of this report that may include incidents that affect employees and members of the public, as well as patients; these are nationally reportable incidents and liability claims. As the Quality Directorate manage these matters, they are included in this report to provide an overall view of these areas.

## NATIONALLY REPORTABLE INCIDENTS (NRI)

In October 2020, the NHS Wales Delivery Unit (DU) took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Quality Directorate has regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

As of 14 June 2021, NHS Wales' responsible bodies were required to implement Phase 1 of the Welsh Government's National Incident Reporting Policy. The most obvious change in policy direction is a change in terminology with the removal of the word "serious" from the term serious incident. The intention here in removing the word "serious" is to support a more just and learning culture where reporting incidents does not feel punitive.

From 14 June 2021, the following definition of a nationally reportable patient safety incident applies:

*"A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare."*

The timescale for reporting such incidents has increased from 24 hours to within seven working days.

The Delivery Unit lifted any reporting restrictions that were put in place because of Covid-19 as of the 14 of June 2021.

Never Events are defined as "*patient safety incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.*" The Welsh Government issues a list of incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.

During April and May 2022, 20 nationally reportable incidents were reported, down from 42 in February and March 2022.
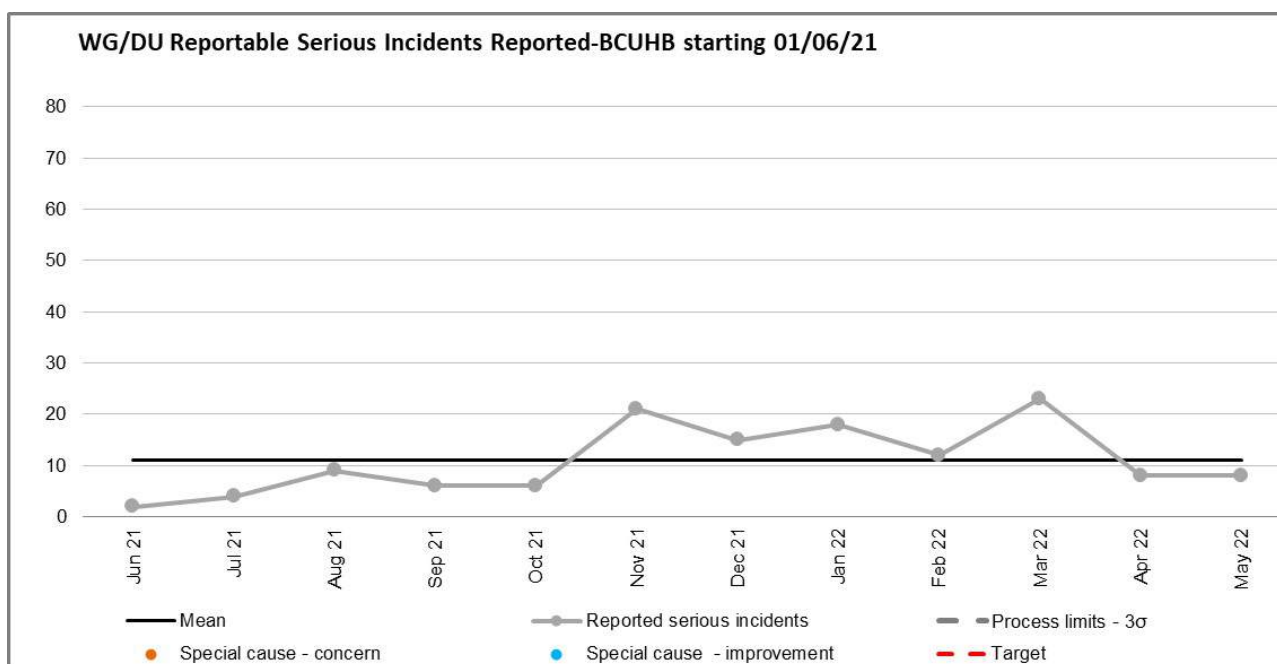


The table below shows the Health Board position in terms of reportable incidents per 100,000 population in relation to the All-Wales position per 100,000 population.

| Time period | BCUHB incidents/100,000 population | All wales incidents/100,000 population |
|---|---|---|
| Jun/July 2021 | 1.0 | 1.8 |
| Aug/Sept 2021 | 1.8 | 2.3 |
| Oct/Nov 2021 | 3.8 | 3.0 |
| Dec /Jan 2022 | 4.3 | 3.2 |
| Feb/March 2022 | 6.2 | 3.8 |
| April /May 2022 | 2.9 | 2.9 |
| **AVERAGE** | **3.3** | **2.8** |

Given the small numbers involved, and the particular reporting requirements for certain incidents which can fluctuate, the average should be considered a more useful comparison than an individual two-month period.

In line with the All Wales position there was a reduction of the number of incidents reported per 100,000 population. The numbers reported across the Health Board have fallen

significantly. Last period, the Health Board reported a particularly high number of falls, and numbers in this period have returned to a more usual level.

In addition to the above mentioned nationally reportable incidents, there were eight Early Warning Notifications (EWN) reported, two of which were Procedural Response to the Unexpected Death in Childhood (PRUDiC) related. These notifications are not investigations but rather alerts of potential stakeholder interest. The other notifications relate to incidents that may attract media attention.

At the time of writing, the total number of Nationally Reportable Incidents open is 69 of which 32 are overdue. The total number of open incidents has increased from 68 from the previous time period; the number that are overdue has significantly increased from 16.

Overall closure rate within timeframe was 60% in April, falling to 30.8% in May. This is disappointing considering the improved position over previous months. The impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment continued to impact on the ability of services to respond in a timelier manner to incident investigations. In addition, staffing issues within the Patient Safety Team and the introduction of the new RLDatix Cymru system in April 2022 has meant a reduction in efficiency with regards to management of the process.

The Patient Safety Team are committed to returning to performance levels seen in the previous period and is working closely with services to resolve issues that have contributed to this less favourable position.

In the immediate term, recognising the delays to full investigations, the Patient Safety Team are placing particular focus on ensuring Make it Safe Rapid Reviews are completed so that early learning to improve safety is identified and implemented.

The NRIs recorded during this period can be broken down as follows

- Fall with severe harm (n=6)
- Grade 3 or above healthcare associated pressure ulcer develops (n=3)
- Delay or failure to monitor patient (n=3)
- Delay in diagnosis (n=3)
- Failure/delay to act on adverse symptoms (n=2)
- Unexpected death of patient not known to mental health services (n=2)
- Ambulance delays resulting in harm/death to patient (n=1)

All NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel and a proportionate investigation. The learning and actions from each are recorded on the Datix safety management system.

Rapid Learning Panels (RLP) take place between the senior service team and clinical executives as soon as practicable following a Never Event and/or when an adverse incident where significant harm or death of a patient has occurred. The role of these meetings is to review immediate learning and actions being taken (including any cross-Health Board immediate learning), identify key risks and provide support where required. These compliment the Make it Safe (MIS) Rapid Review completed within 72 hours and the

investigation completed within a specific proportionate timeframe (30, 60 or 90 working days). During April and May 2022, 12 RLP meetings took place into the most serious incidents.

The Incident Learning Panel (ILP) was introduced as part of the new Incident Management Process in April 2021. The role of the panel is to moderate and ensure that we are constantly improving the quality of investigations and reports. All investigations into serious incidents that have occurred since April 2021 have been reviewed at the ILP. There has been an initial focus on the quality of reports by the panel and services have taken on feedback provided with a subsequent marked improvement noted. During the months of April and May 2022, 58 investigation reports were presented to the ILP. This includes those investigations commissioned that do not meet the national reporting threshold. 21 reports were approved by the panel, 37 were deferred and needed further work for reasons such as the quality of the report writing or weak action plans.

The sharing of learning from incidents (beyond the immediate service) is achieved through clinical governance/quality meetings and networks, and through safety alerts where appropriate.

The system sharing and embedding of learning remains a risk for the organisation (and is contained on the Board Assurance Framework). Plans are in place to strengthen the extracting, sharing and embedding of learning to include:

- Learning on a page to replace the "lessons learned "template re-named Insight
- Monthly ILP Bulletin serving as a compendium of all the Insight reports
- A central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Events (using the Oxford Model Event concept) following each completed investigation
- Updating the Safety Alerts Policy and process

**Themes identified from Nationally Reported Incidents**

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities (recognising full investigations are underway). At this time, the following are the identified themes:

- Recognition and escalation of deteriorating patient
- Falls
- Healthcare acquired pressure ulcers (HAPU)
- Surgical safety

These four theme areas are underpinned by a recurring issues of record keeping, that whilst not directly causal to an incident occurring, is contributory to the circumstances that create unsafe conditions.

These five areas form the priority projects to be taken forward as part of the Patient Safety Programme which is detailed below. The charts below show the spread of where the incidents occurred per division.

The following section provides a summary of some of the themes and the actions underway.

Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis (n=8)

There have been eight incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. Six of the incidents occurred in Ysbyty Glan Clwyd and two in Wrexham Maelor.

Over the last year, the following related incidents were reported as NRIs:
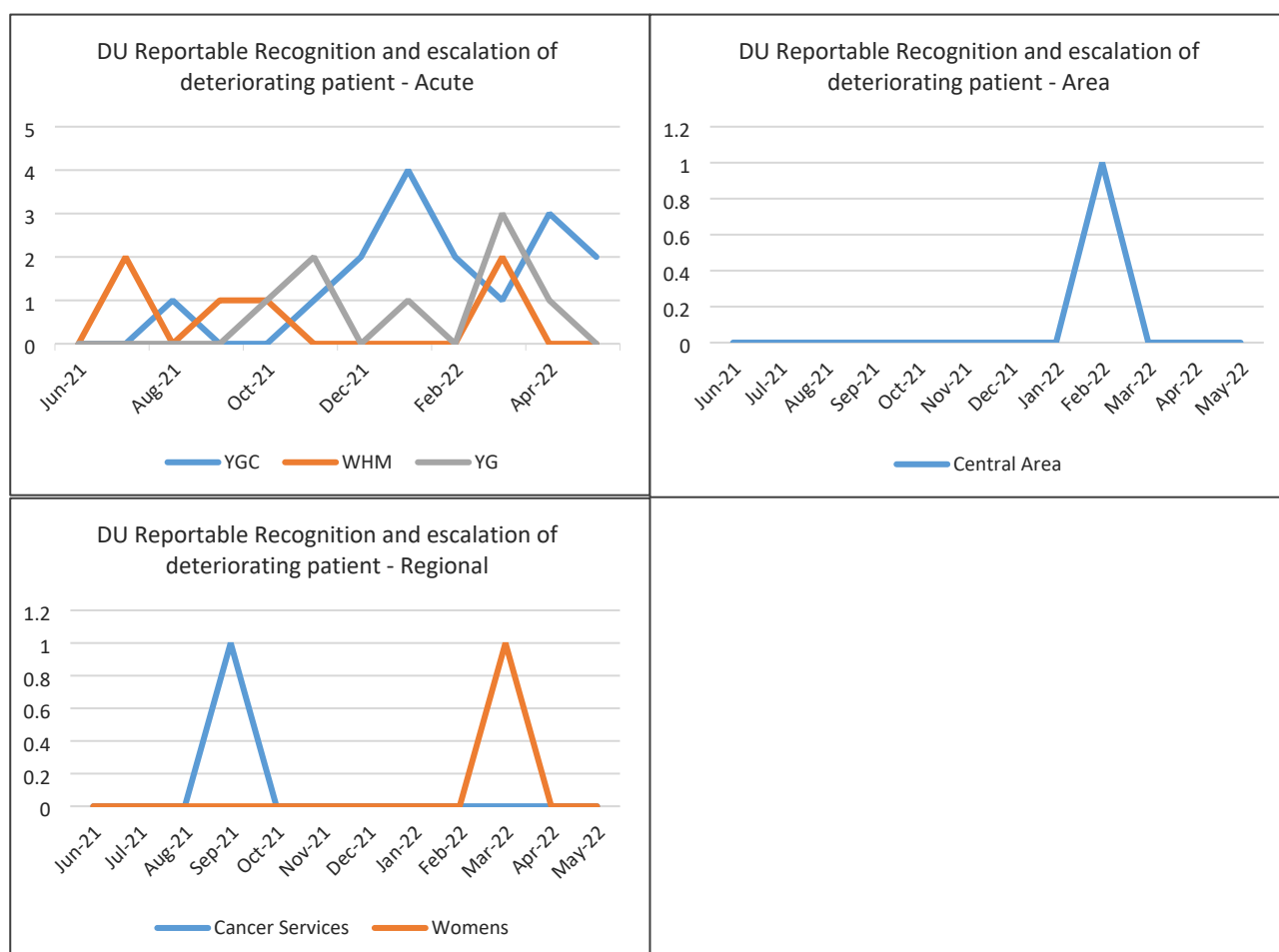


In respect of improvement, work, this will be further refined as part of the new Patient Safety Programme. Work already underway includes an audit of medical emergency team (MET) calls, being led by one of the acute site Hospital Medical Directors. In respect of immediate actions from the Rapid Learning Panels and Make it Safe Rapid Reviews:

- A MET call report has been introduced to make clear reporting easier and faster for the MET teams and not introduce difficult logistic steps. The form can be used by anyone to flag a case for audit if a particular case requires review. The data is collected on the BCU SharePoint site and is secure.
- The data is being used to show where MET calls happen, when they happen and to some degree why they happen. Most MET calls are out of hours, in patients without definitive plans and on frail patients.

- Cases will be selected randomly on a monthly basis to do more in depth reviews on what lead to the MET call and if it could have been prevented.
- A ward based "care actions on deterioration" document is being introduced designed to help clinical teams to delineate what actions might or might not be appropriate for their patients. It is only for patients who have DNACPRs but are still for active treatment. When complete it will be filed at the front of the notes with the DNACPR. This will be completed by the end of July 2022.

In addition, the Health Board has re-formed an improvement group to look at one aspect of this area. The Sepsis Trigger, Escalation and Antibiotic Stewardship Review (STEAR) Group met for the second time in May 2022 where they reviewed and further discussed the following

- Recommendations on how the Health Board look at sepsis triggers
- Who is performing the assessments
- How we currently escalate
- How to provide good first rate care for sepsis across the Health Board
- How to provide education to meet the goals
- Compare outcomes nationwide.

These discussions are forming an improvement plan which will be monitored by the group.

Falls (n=6)

Within the reporting period there were a total of 6 patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is broken down as follows:

East Acute (1), West Acute (4), West Area (1)

This is a significant reduction from the previous period where the number of falls was 17.

Over the last year, the following rates of falls were reported as NRIs:

**DU Reportable Falls - Specialist**
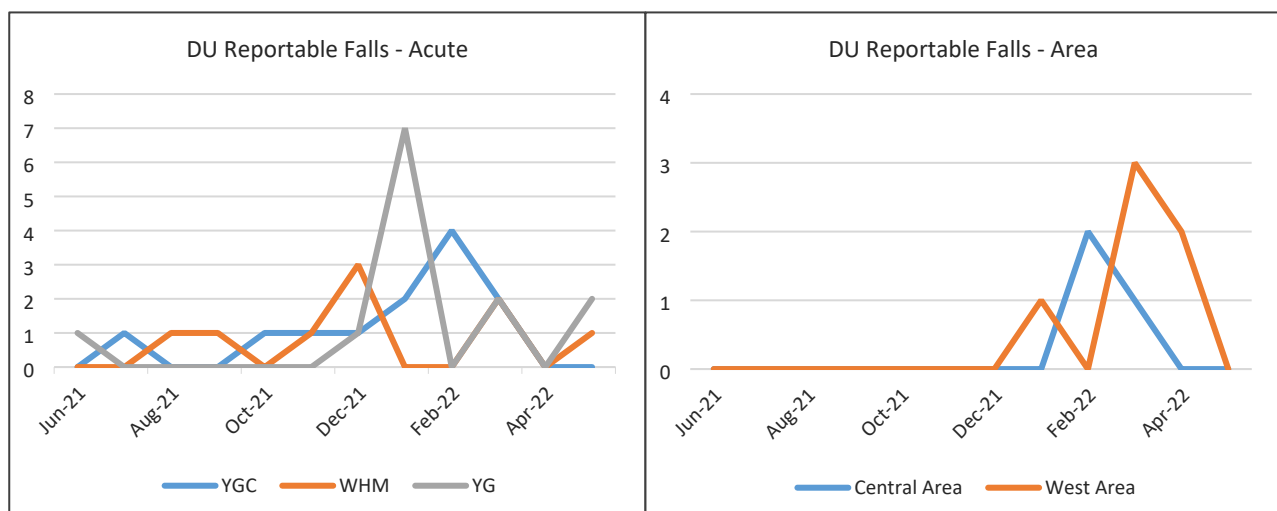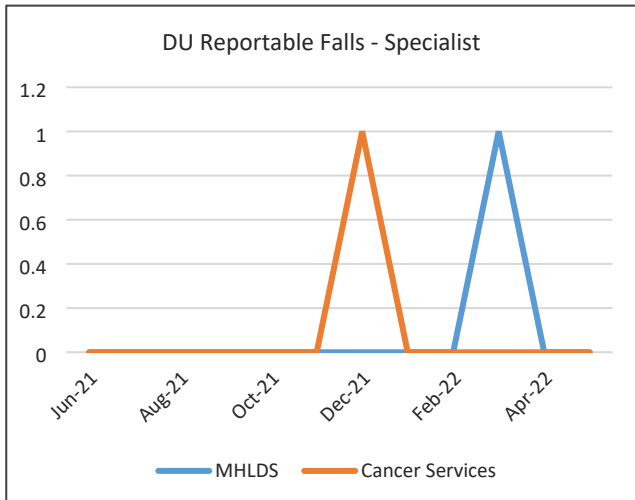
On review of initial learning from these incidents, there are ongoing themes that can be identified that contribute to these falls:

- Staff shortages
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Lack of use of call bells
- Reliance on alarm equipment
- No lying and standing BP taken

Immediate actions include localised training and the increasing of awareness through sharing incidents details. The impact of this awareness and training is then monitored and measured through the ward accreditation process.

There were 6 investigation reports relating to falls during this period that were approved following a review at the Incident Learning Panel.

A specific paper was provided to the QSE Committee in March 2022 on performance and the improvement work being done. This included re-commencing the improvement collaborative model, new e-learning and updating the policy. The early indications of the pre-COVID Falls Collaborative were extremely positive. Building on this, a proposal paper is with the Executive Director of Nursing and Midwifery to establish a falls project, aligned to the Patient Safety Programme, and operating within the Health Board's quality improvement methodology. This work will be overseen by a reformed Strategic Falls Improvement Group underpinned by health community working groups. Locality workshops are being arranged to take this forward. The application of the collaborative approach by each health community (as opposed to stand alone improvement teams) is envisaged will support rapid improvement across the complexities of each health economy whilst providing opportunity for local quality improvement to develop with the common language, skill and tools. Project plans will be developed with clear measures.

A number of specific improvement actions have been implemented:

- The Multi-Disciplinary Team (MDT) Model of upskilling staff 'bedside learning', with risk assessment completion and accurate intervention will be implemented with pace across inpatient areas and has been received positively by the HSE.

- E-learning modules continue to increase in percentage of completion across HB currently: module 1a is at 70% mandatory for all staff in BCU, module and 1b at 71% for all Patient facing clinical staff on Adult inpatient wards. To note: ward teams are mostly above the Health Board standard of 85%.
- The self-assessment tool developed to assess where wards, departments and divisions are against the approved Falls Policy (NU06) for each health economy has had a first test completed. The tool has been refined and tested in a further area this will be the mechanism for reporting and focusing on the basic evidence-based areas first for improvement in the new heath economies. Feedback received so far is that the tool has given clear focus on areas for improvement in terms of policy and deliverables·

Datix data is currently not pulling through into Health Board data warehouse. This is a national issue with no fixed timeline available. A short-term fix is being explored with the Datix Team to build a report that wards can easily access to retrieve their data which almost replicates the information on the Nursing Information Portal.

Grade 3 or above healthcare associated pressure ulcer (n=3)

Within the reporting period there were a total of 3 grade 3, grade 4 or ungradable healthcare associated pressure ulcers.

Over the last year, the following rates of HAPUs were reported as NRIs:
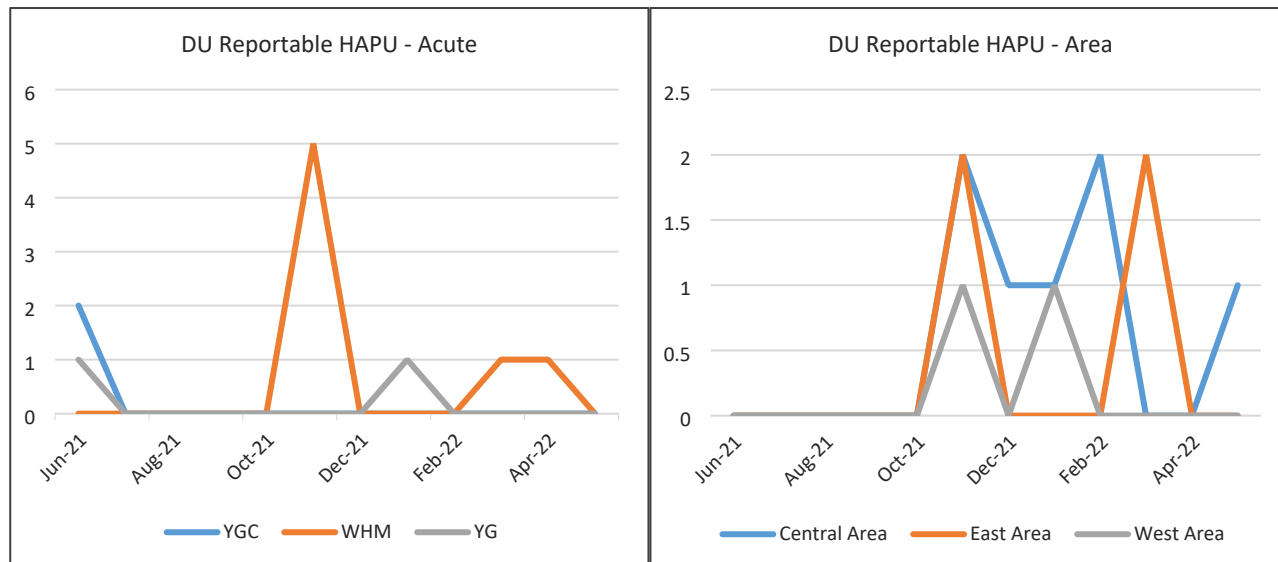


The recurring themes are:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation

All investigations from pressure ulcer investigations are reviewed weekly at local harms' meetings. In addition, the sharing of findings at local level is reflected through the raising of awareness at safety briefs. The impact of the increased awareness is then monitored and measured through the ward accreditation process.

There were 4 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers during this period. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when needed
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

A specific paper was provided to the QSE Committee in March 2022 on performance and the improvement work being done. This included re-commencing the improvement collaborative model which were suspended during the pandemic. As with falls, this will consist of health community improvement work feeding into an organisation wide strategic group using the Health Board's quality improvement methodology. Project plans will be developed, with measures, at both health community and organisation level. This work will form part of the overarching Patient Safety Programme which is detailed later in this report. Locality workshops are being arranged to take this forward.

A paper has recently been shared with the Interim Executive Director of Nursing and Midwifery that proposes a collaborative approach to harms and prioritises HAPUs. A draft improvement plan has also been shared and once approved, a workshop in each of the three Health Economies will be set up, with the over-arching aim to be agreed. A HAPU Strategic Group will supervise local HAPU improvement work.

Surgical safety

Within the reporting period, zero incidents were nationally reported related to surgical safety.

Over the last year, the following rates of surgical safety incidents were reported as NRIs (excluding never events which are detailed in the specific section later in the report):
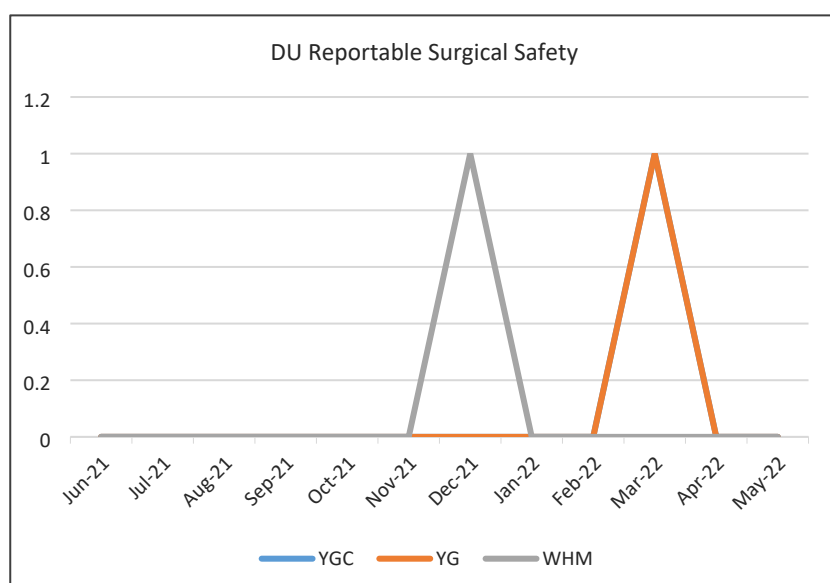


In response to the number of surgical safety incidents (including Never Events), and the learning identified, the Health Board recognised the role of human factors in the prevention

and mitigation of systemic failure on patients, families and clinical staff. The Health Board aims to mainstream human factors knowledge, understanding and practice in order to ensure the consistent, sustainable delivery of safer care for patients, whilst supporting our staff in that delivery: *making it easy for them to do the right thing.*

To do this, the Health Board has (1) commissioned an external company with human factors expertise, AQuA, to build capacity and capability in human factors and its application to healthcare and training for cohort 1 (of 3) has commenced, (2) commenced the development of an organisational wide faculty dedicated to human factors, and (3) commenced a targeted programme into the surgical safety checklist.

To support (3) the Transformation and Improvement Directorate has recruited a Quality Improvement Fellow (which is a substantive member of the Patient Safety Team now on secondment). To date the QI Fellow has facilitated initial introductions and team engagement session, establishing the rationale, aims and timescales of the programme
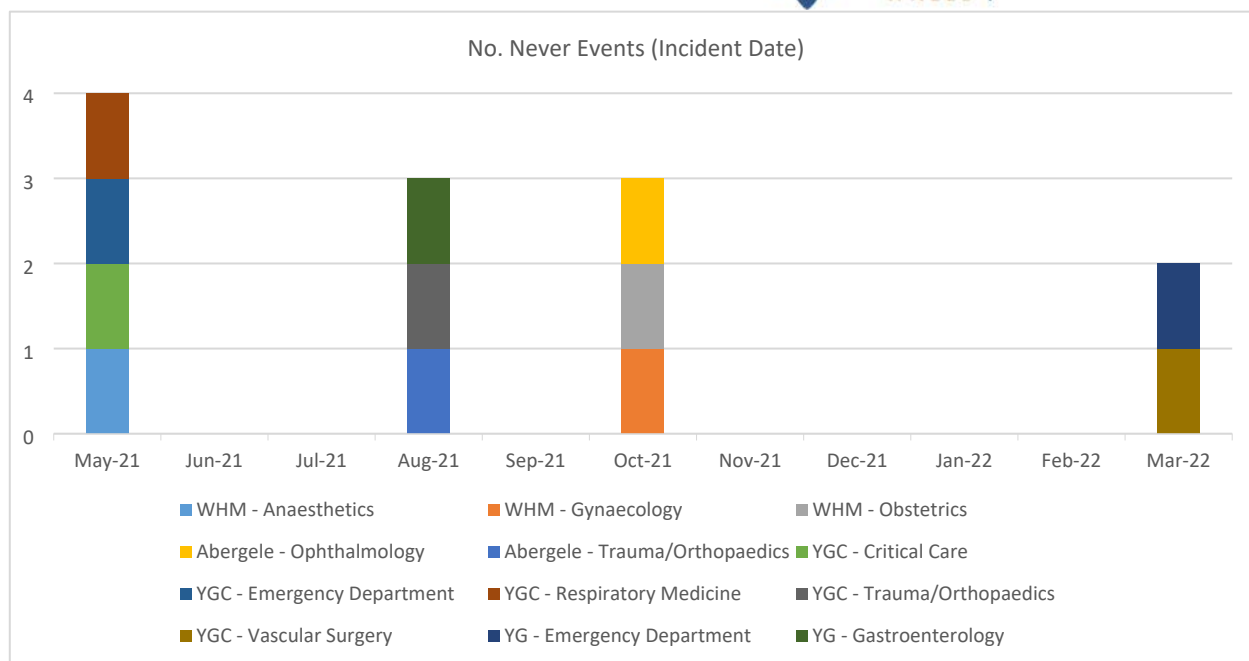
A process mapping session was held, the goals of which were to:

- Visualise the '5 Steps to Safer Surgery' journey and pinch point bottlenecks and constraints to the 'Perfect' Checklist process and identify areas witnessing reduced engagement.
- PDSA cycle and brainstorming sessions undertaken, where low risk, quick win ideas were suggested for trial within the team Benchmarking of pan BCUHB and NHS England WHO Checklists'.
- Discuss around potential simulation and education sessions for clinical governance days.
- Review of proposed LocSSIP 69 '5 Steps to Safer Surgery – The WHO Checklist'.
- Creation of observation tool for the project team to collate data across all theatre specialties.

As well as focussing on service improvements, the application of human factors can also enhance and supplement traditional investigation techniques. The human factors programme supported by AQuA will develop our staff in the use of human factors at both an expert and practitioner level, and it is planned that staff who attend will also contribute to patient safety incident investigation teams.

## NEVER EVENTS

In total, twelve Never Events have been reported in 2021/22 (compared to five in 2020/21 and six in the full year of 2019/20). Action relating to the primary theme (11 of 12 incidents) is surgical safety, which is detailed above.

No. Never Events (Incident Date)

Legend:
- WHM - Anaesthetics
- WHM - Gynaecology
- WHM - Obstetrics
- Abergele - Ophthalmology
- Abergele - Trauma/Orthopaedics
- YGC - Critical Care
- YGC - Emergency Department
- YGC - Respiratory Medicine
- YGC - Trauma/Orthopaedics
- YGC - Vascular Surgery
- YG - Emergency Department
- YG - Gastroenterology

## New Never Events

There were no new Never Events reported during April and May 2022.

## Open Never Event Investigations

The following Never Event investigations remain underway.

| Incident date | Incident Description | Current status |
|---|---|---|
| Retrospective incident 10/05/2021 | Retention of a foreign object – a surgical swab found within the patient's throat following a theatre visit. | The investigation is in the final stages of investigation. |
| 20/08/2021 | Ascetic drain inserted inappropriately. Consent taken from patient as intended to relieve respiratory symptoms. | Rejected at ILP – more robust action plan required. |
| 22/08/2021 | Patient underwent surgery to fix left proximal humerus fracture, during surgery the small guide for philos plate used was left in situ. The day after surgery, a check x-ray revealed the issue after being also alerted by HSDU to the absence of the small block. | The investigation is in the final stages of investigation. |
| 13/10/2021 | During laparoscopy for ectopic pregnancy, healthy tube removed prior to visualisation of rupture tube containing pregnancy. | Investigation completed – awaiting action plan. |

| 06/03/2022 | Wrong site surgery – patient taken to theatre for a femoral - popliteal bypass but received a femoral - femoral bypass only. | Investigation ongoing. |
|---|---|---|
| 18/03/2022 | Wrong site surgery – Patient taken to theatre for laparotomy and litigation of right iliac artery. Further exploratory laparotomy undertaken where the surgeon removed vicryl tie around left common iliac artery. | Investigation ongoing. |

## INDEPENDENT INVESTIGATIONS

There is currently one independent external investigation ongoing as commissioned by the Health Board:

| Location | Incident | Update |
|---|---|---|
| **CMHT (East) MHLD** | Patient known to Community mental health team arrested on suspicion of murder | The draft report has been received for an accuracy check. Child and Adolescent Mental Health Service (CAMHS) have requested further clarity and accuracy changes. The final report is expected to be received by mid July 22 |

## PATIENT SAFETY IMPROVEMENT PROGRAMME

The Quality Directorate are currently working closely with the Transformation and Improvement Directorate to develop a **Patient Safety Improvement Programme**. A workshop was held on 07 February 2022 led by the Associate Director of Quality. All medical, therapy and nursing directors were invited, and the aim of the workshop was to work through priorities for the projects (approximately 4/5 per year) focused on preventing or reducing harm. The recommendations were presented at a meeting with the Executive Clinical Directors and a paper on the programme structure is being drafted for submission to the Executive Team.

These five priority projects proposed, linked to the themes that are highlighted in this report, are:

- Deteriorating patient
- Falls
- Healthcare Acquired Pressure Ulcers (HAPUs)
- Surgical Safety
- Clinical documentation

## PATIENT SAFETY ALERTS AND NOTICES

The Welsh Government (WG), supported by the NHS Wales Delivery Unit, leads on the vital role in identifying significant national safety risks and concerns that would require a Patient Safety Solution at a national level for issue to the NHS in Wales. There are two types of solutions issued:

- ALERT (PSA): This requires prompt action with a specified implementation date to address high risks/significant safety problems.
- NOTICE (PSN): This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas and take immediate action. This stage 'warns' organisations of emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action.

Organisations are required to confirm that they have achieved compliance by the date stated.

## Open Alerts

| Reference | Title | Applicable To? | Type | Date action underway | Deadline | Notes |
|-----------|-------|----------------|------|---------------------|----------|-------|
| PSN057 | Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children | BCU-wide | Patient Safety Solution - Notice | 27/05/2021 | 31/12/2021 | SOP developed with specialty consultant and medical director - to be approved through governance structure by Mid July. |
| PSN058 | Urgent assessment/ treatment following ingestion of super strong' magnets | BCU-wide | Patient Safety Solution - Notice | 13/07/2021 | 05/10/2021 | Closure due end June – evidence being evaluated. |

## Closed Alerts

No PSA/PSN were closed in this time period.

**LITIGATION**

During this bi-monthly period of April and May 2022, 54 claims or potential claims were received against the Health Board. Of these, 44 related to clinical negligence and 10 related to personal injury.

Whilst the numbers have fluctuated a little throughout the bi-monthly periods, it is anticipated by Legal and Risk Services (the Health Board's solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic. The number of new claims received has fluctuated over the last two months, which has been as expected and it is believed this figure will continue to rise as the Health Board begins to deal with the effects of cancelled procedures and appointments.



Clinical Negligence-BCUHB starting 01/06/21



Personal Injury Claims-BCUHB starting 01/06/21
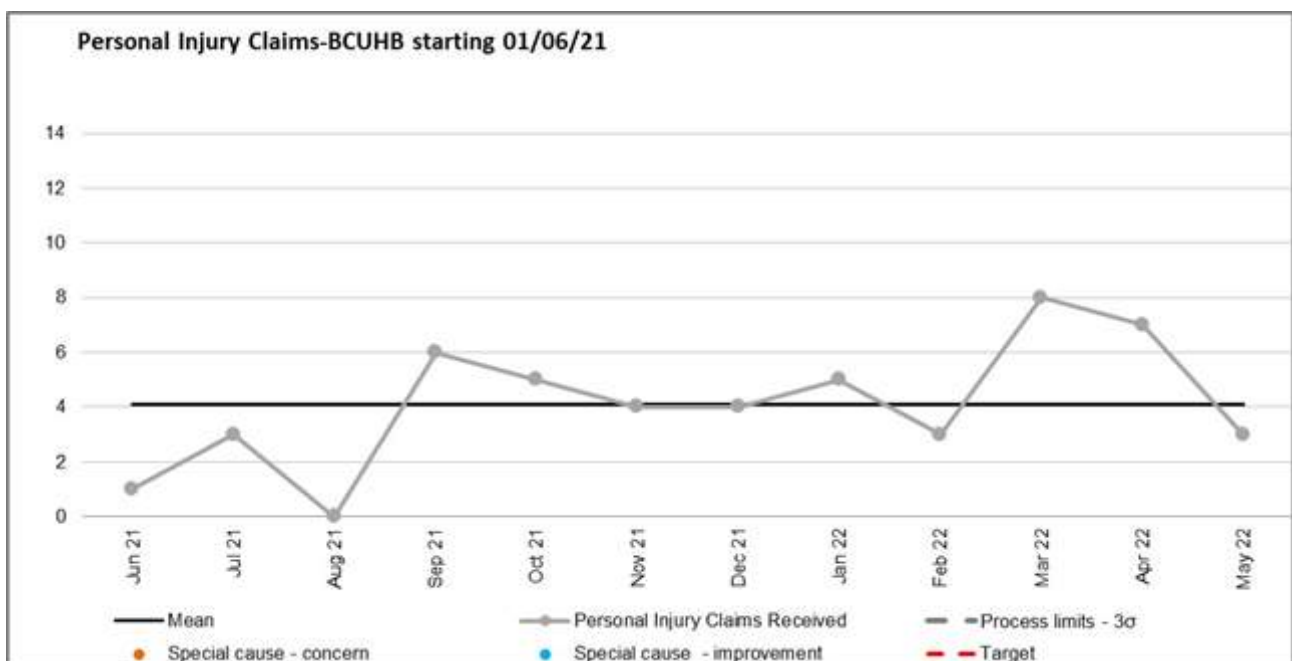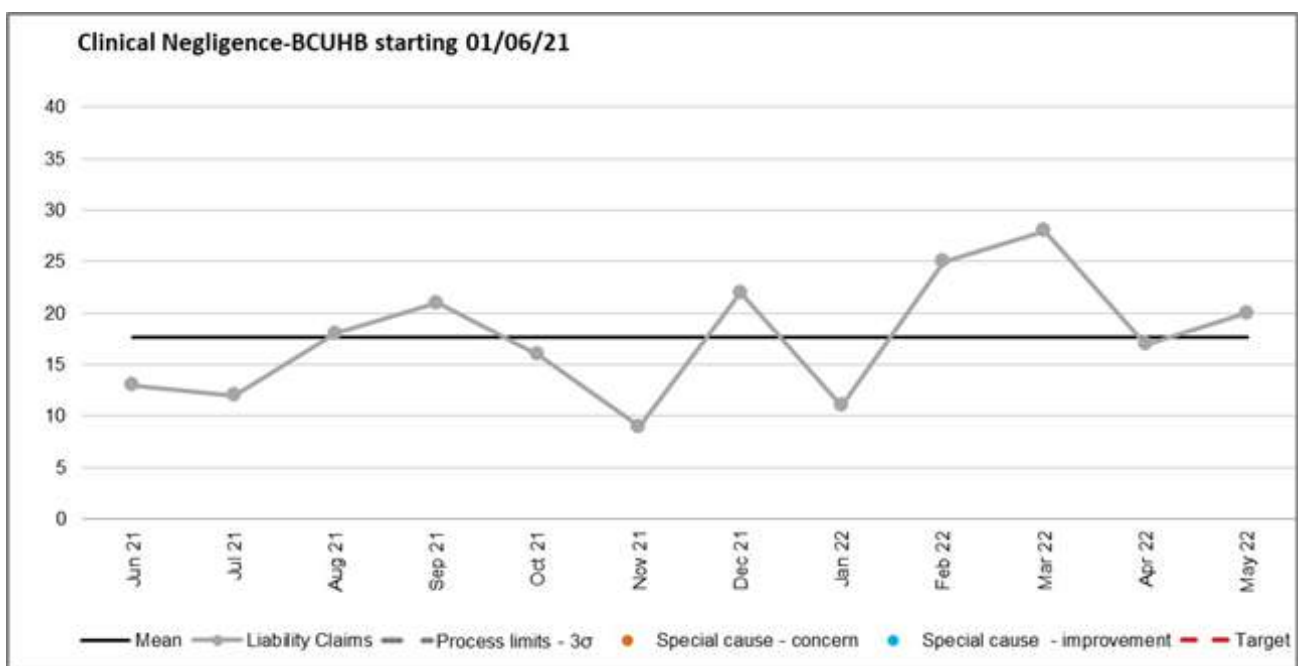
During the bi-monthly period, 92 claims were closed. Of these, 85 related to clinical negligence and 7 related to personal injury. This figure is higher than previous months as the team have been reviewing claims prior to migration to RL Datix and closing those that were limitation barred and dormant over 12 months. The total costs for these overall closed claims amounted to £2,233,625.33 before reimbursement from the Welsh Risk Pool.

## INQUESTS

*"An inquest is an inquiry into the circumstances surrounding a death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died and to provide the details needed for their death to be registered. It is not a trial."* (Gov.UK)

HM Coroner notifies the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board. The Health Board's Healthcare Law Team within the Quality Directorate facilitate this process and offer support to any witness by way of training and one to one support.

During the relevant time period, April and May 2022, 65 new inquests or requests for information from the Coroner were received from the Coroners in North Wales.

54 inquests were concluded between during April and May 2022.

**Regulation 28 (PFD)**

In the period of this report, 3 new Regulation 28 (PFD) reports were received by the Health Board,

1 **NF: Medication reviews by ANP in community** (Inquest heard in February 2022 but Reg 28 report not received from HMC until April 2022)

**Coroner's Concerns**:
1. Despite discussion between the Advance Nurse Practitioners and Care Home staff, Levothyroixine was not restarted – and despite the deceased being seen on a further six occasions – there was no routine medication review to identify this omission.
2. Time constraints restricting ANP access of medication charts
3. The absence of proper consideration of patients' medication during each visit presents a risk to life as errors are not identified

**Response:** Response issued by Health Board on 10 June 2022 include the following actions:

- Review of best practice guidance for ANPs – for completion by 30 September 2022
- Rolling training programme facilitated by Medicines Management for all nursing and residential homes
- Introduction of local policy for documentation of medication review at each ANP visit to homes
- All district nursing teams will develop, review or adapt their SOP/checklist to meet the needs of their service and provide assurance of medication reviews
- Review of Medicines Policy (MM01) – for clarity in community settings – complete by 30 September 2022

- Business case for investment into Medication Administration Training for all residential and nursing home settings
- Audit of the existing rolling training programme to be developed – to identify homes where training is incomplete or out of date, to include a compliance matrix
- Welsh Government pilot project has been developed (for future implementation) with a view to community pharmacy carrying out medication reviews of patients in care homes.

2  **TR:  Theme – delay providing evidence of completed actions post investigation / change in working practices**

**Coroner's Concerns:**

1. Despite earlier identification that existing working practices within Oncology (placement of report on clinician's desk) resulted in failure to treat in a timely manner, the Health Board did not fully implement a new SOP until December 2021.
2. Formal acknowledgement of new SOP by Oncology and Haematology secretaries not completed until 22 February 2022
3. Failure to have completed an audit process to assure changes were operational and effective.
4. The length of time taken to implement changes and ensure introduction and adoption of new, safe working practices presents a risk to life.

Response due with HM Coroner by 01 July 2022.

3  **RG:  Theme – Ambulance delays**

**Coroner's Concerns:**

1. First cause of ambulance delay – all other resources already allocated
2. Delay in handover from WAST to BCUHB across all sites
3. Concern that future deaths will occur either with patients awaiting transfer into hospital from ambulance, or by ambulances not being available to meet community need.
4. These matters of concern are longstanding and despite proposed future action the concerns remain.

**Regulation 28 PFD issued jointly to BCUHB and to WAST**

Response due with HM Coroner by 20 July 2022.

Regulation 28 PFD reports received in the last year were summarised in the previous report.

**HEALTHCARE INSPECTORATE WALES (HIW)**

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. HIW reviews and inspects NHS services in Wales, and regulates healthcare providers against a range of standards, policies and regulations to ensure they comply with regulations and meet the healthcare standards, highlighting areas of improvement.

HIW monitor the use of the Mental Health Act and review mental health services to ensure that vulnerable people receive good quality of care in mental health services.

HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

The Health Board manages correspondence and inspections from HIW via an internal standard operating procedure.

All correspondence from HIW is received into the Health Board via the Chief Executive's Office or direct to the Quality Directorate (to a dedicated inbox) depending on the request i.e. inspection, request for information, raising of concerns. All correspondence to HIW follows a review and approval process from the service through to the appropriate executive sign off, prior to submission. Monthly engagement meetings are held between the Health Board (the Associate Director of Quality) and an assigned relationship manager/team from HIW.

The Quality Directorate continues to capture and monitor HIW activity via the DatixWeb patient safety system, whereby action plans developed in response to HIW inspections and enquiries are inputted and assigned to responsible officers. Actions are followed up to completion, with the support of the Quality Assurance Team, and evidence supporting progress is uploaded. This enables an efficient and auditable process for regulatory activity and Health Board response, as well as an opportunity to provide regular reports.

The cloud based DatixCymru system that has been implemented as of the 1st April 2022 does not support HIW activity capture and management; discussions have been held with the national Once for Wales Management System (OFWCMS) to address this deficit, but will not be realised within this financial year.

In the interim, the Quality Team are testing the AMaT system. The system was created with NHS clinical audit teams to give healthcare trusts more control over audit activity and to provide real-time insight and reporting for clinicians, wards, audit departments and trusts. The inspection module within AMaT has been built to capture inspections and will therefore ensure that Healthcare Inspectorate Wales activity is recorded, tracked and will assist with future reporting and providing assurance.

In May 2022, HIW activity covered the following areas:

**Service Requiring Significant Improvement:**
**Emergency Department, Ysbyty Glan Clwyd, May 2022**

On the back of the Quality Check in March, HIW undertook an unannounced inspection of the Emergency Department at Ysbyty Glan Clwyd between 03 - 05 May 2022. During the quality check HIW found immediate assurance improvements were required around timely access, record keeping, managing risk, medicine management and governance and leadership. An Immediate Assurance Improvement Plan was submitted to HIW for assurance.

Consequently HIW considered their findings and evidence following a No Surprise Notification in January along with the inspection in March and May 2022.  HIW has

determined that the Health Board has not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care.

The Emergency Department at Ysbyty Glan Clwyd was considered and consequently identified as a Service Requiring Significant Improvement.

The service remain under this status until such time that HIW de-escalate the service from this status. The Health Board await further details from HIW in terms of their planned approach to this.

The inspection report from March was published by HIW on 18 May 2022.

Jo Whitehead, Chief Executive, issued a statement to the media and public in response to the notice of Service Requiring Significant Improvement.

The Quality Team have scheduled regular quality reviews with members of the Hospital Management Team (HMT). Since the week commencing 6 June 2022, these reviews have been conducted daily as more focus is required to ensure that significant progress is made and assurance provided to the Board, HIW and Welsh Government.

The Quality Team plan the following by the end of June;

1. The Corporate Nursing Assurance Team will visit the Emergency Department to assist with audits for collating evidence where there are gaps identified.
2. A further ward accreditation visit will be scheduled. This will help to determine if the changes made so far, have made the required improvements.
3. The Quality Team will support the appointed HMT work stream lead (Director of Operations) for the improvement work to ensure that an improvement plan is in place, and a collaborative approach is taken with key colleagues, to include Transformation and Improvement.
4. The Quality Team will schedule further quality reviews with the lead and key colleagues to ensure support and continuous review of the improvement work and collation of evidence.

Strengthening the improvement work is a Patient and Carer Experience Engagement Plan which aims to improve Patient and Carer Experience at Ysbyty Glan Clwyd Emergency Department with the following key objectives;

- To work with Emergency Department staff at Ysbyty Glan Clwyd to increase patient and carer feedback.

- Implement learning and service improvement from Patient and Carer experiences.

- Identify training needs and implement appropriate awareness sessions to help improve patient and carer experience.

- Engagement weeks - undertake patient experience improvement actions identified by the Emergency Department and data gathered throughout this time.

- Evaluate data gathered in collaboration with Emergency Department staff, share learning and good practice.

The feedback is collated in many difference ways and includes a regular presence from the Patient and Carer Experience Team in the Emergency Department. Improvements have already been suggested by the team and work is underway to implement the improvements with the HMT.

## Complaints

During April and May 2022, 417 complaints were received and 298 early resolutions were actioned. There has been a notable increase in the number of complaints received.

The 75% target for a 30-day response rate was not achieved by the Health Board (actual performance was an average of 36.21%). This has led to an increase in the number of overdue complaints during this period. The position deteriorated over the winter period and is slowly recovering. At the end of May 2022, 395 complaints were overdue from the 660 open complaints. Significant focus is in place to support services recover their position and a recovery plan is in place. The Patient and Carer Experience Team are moving as much resource as possible to focus on improving this position.

The common themes within complaints were consent, confidentiality and communication, as well as access to appointments, admission, transfer and discharge. This information is shared with services to support local improvement.

## Public Services Ombudsman for Wales (PSOW)

There are no specific matters for exception reporting to the Board at this time.

There have been no Public Interest Reports issued by the Ombudsman during April and May 2022.

Detailed information on key cases investigated by the Ombudsman is included in the Patient and Carer Experience Report to the QSE Committee.

## Patient Feedback

Patient feedback and listening to the voices of patients, carers and service users, is key to effective service improvement. The CIVICA real-time patient feedback system is currently being embedded across the Health Board, with implementation started in summer of 2021, and is a mechanism to support real time patient and carer feedback. The online patient feedback system supports the development and deployment of multiple surveys across multiple channels, along with standard reporting, alerting and enhanced text analytics. It signals an important milestone in providing every patient and carer with an opportunity to have their voices heard and acted upon.

In April and May, 1,537 patient feedback responses were received. Of these:

- The average experience rating was 9.35 out of 10;
- 43.19% of respondents reported they could speak Welsh to staff if they wanted to;
- 86.31% of respondents reported staff took time to understand what matters to them;
- 82.75% of respondents reported they were given all the information they needed;

- 91.28% of respondents reported they received assistance when needed.

The Patient and Carer Experience Team is using Pansensic™ Hybrid Text Analysis of qualitative data to provide key information from the narrative provided by patients in addition to the scoring provided by patients.

The main positive keywords are compassion, friendliness, professional and polite. The main negative keywords are waiting, facilities, comfort and food.

A breakdown of this information is provided to services by means of a live dashboard and a monthly report. Services are encouraged to look at their feedback and take action to improve.

A new Patient and Carer Feedback Framework is in development to establish a strengthened approach to listening and acting upon feedback.

The Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Detailed information is contained in the Patient and Carer Experience Report to the QSE Committee.

## CONCLUSION

This report provides the Health Board with information and analysis on quality and patient safety matters including Nationally Reportable incidents, Never Events and HIW activity occurring in the last two months.

The Health Board is asked to note the report.

| Teitl adroddiad:<br>*Report title:* | North Wales Vascular Service Update | | | |
|---|---|---|---|---|
| Adrodd i:<br>*Report to:* | Public Board | | | |
| Dyddiad y Cyfarfod:<br>*Date of Meeting:* | Thursday, 04 August 2022 | | | |
| Crynodeb Gweithredol:<br><br>*Executive Summary:* | This report updates the Board on progress in delivery of the Vascular Improvement Plan and ongoing work to ensure safe delivery of vasular servivces through the "hub and spoke" model that was implemented in April 2019. The paper also summarises current operational pressures in the service | | | |
| Argymhellion:<br><br>*Recommendations:* | The Board is asked to note the report | | | |
| Arweinydd Gweithredol:<br><br>*Executive Lead:* | Dr Nick Lyons, Executive Medical Director | | | |
| Awdur yr Adroddiad:<br><br>*Report Author:* | Dr Nick Lyons, Executive Medical Director | | | |
| Pwrpas yr adroddiad:<br>*Purpose of report:* | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |

| Lefel sicrwydd:<br><br>*Assurance level:* | Arwyddocaol<br>*Significant*<br>☐<br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>*Link to Strategic Objective(s):* | |
|---|---|
| **Goblygiadau rheoleiddio a lleol:** | |

| | |
|---|---|
| *Regulatory and legal implications:* | The vascular service is a Service Requiring Significant Improvement and close work continues with partners and regulators. |
| **Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>*In accordance with WP7 has an EqIA been identified as necessary and undertaken?* | No |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>*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)**<br><br>*Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)* | The CRR and operational risk registers are currently being updated to reflect the fragility of the service |
| **Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith**<br><br>*Financial implications as a result of implementing the recommendations* | None |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>*Workforce implications as a result of implementing the recommendations* | Availability of workforce remains a key issue for the service and recruitment currently |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>*Feedback, response, and follow up summary following consultation* | The paper summarises information that was presented to the Vascular Steering Group on 26th July 2022 and reports received at Quality, Safety and Patient Experience Commitee (QSE) |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>*Links to BAF risks:*<br>*(or links to the Corporate Risk Register)* | |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>*Reason for submission of report to confidential board (where relevant)* | Amherthnasol<br><br>Not applicable |
| **Camau Nesaf:**<br>**Gweithredu argymhellion**<br><br>*Next Steps:*<br>*Implementation of recommendations*<br><br>The improvement work for the network will continue | |

**Rhestr o Atodiadau:**
   Dim

*List of Appendices:*
*None*

**CYFARFOD CYHOEDDUS BWRDD Y CYFARWYDDWYR**

*BOARD OF DIRECTORS MEETING IN PUBLIC*

**4 August 2022**
**North Wales Vascular Service Update**

**1. Introduction/Background**

The Health Board implemented a hub and spoke model for delivery of vascular services in north Wales in April 2019 with some services being provided by providers in England, thereby implementing a model for service delivery that was endorsed by external review. An Invited Service Review by the Royal College of Surgeons (RCS) was commissioned by the Board in 2020 to review the quality of the new service, the first report from this review being received by the Health Board in March 2021 and the second report being received in February 2022.

In response to the first report a group was established to develop and oversee an improvement plan. This group has participation from the Community Health Council (CHC) and lay representation. In November 2021 the Terms of Reference for the group were revised and the group became the Vascular Steering Group which now meets monthly and is chaired by the Executive Medical Director (EMD). Quality, Safety and Patient Experience (QSE) Committee receive regular updates on progress with the Vascular Improvement Plan and the Board retains close oversight. The second report from the RCS related to a case note review of 50 sets of notes. The College was able to review 47 sets of notes and raised concerns about the care received by patients and the quality of documentation.

The Board therefore convened a Vascular Quality Panel (VQP) with an external chair and an external medical lead to review those notes and to make recommendations about the care of individual patients and any service improvements that could be made. That panel first met in April 2022 and reports to QSE, with weekly escalation reports to the EMD, which then inform the Vascular Improvement Plan.

Two Never Events in the service and other concerns relating to safety and sustainability resulted in Health Inspectorate Wales (HIW) designating the vascular network a Service requiring Significant Improvement in March 2022.

In response to these safety concerns a series of additional measures were introduced on 7th March 2022 to ensure safe delivery of care to patients. These measures were reviewed regularly and two requirements (including dual consultant operating) were removed on May 23rd 2022 after a detailed risk assessment, supported by external vascular advice.

The work on the Vascular Improvement plan continues and is currently being updated to ensure that there is a consistent approach to improvement methodology with other work in the Health Board.

The Board has significantly supported investment in the vascular workforce through the IMTP process to address issues within the vascular consultant workforce, the staffing of diabetic foot teams in both hub and spoke sites and the recruitment of nursing staff to Ward 3 (the vascular ward in YGC).

**1. Body of report**

On 8 July 2022 the Chair of the VQP raised safety concerns in relation to the management of aortic patients following the completion of a review of 11 patients' notes. The EMD received 3 recommendations for immediate implementation. These were:

1. Reintroduction of dual consultant operating (for aortic patients only)

2. Involvement of a specialist centre in the Multidisciplinary Team (MDT) meetings for all aortic cases
3. The recruitment of a vascular surgeon with aortic experience.

The first and second recommendations were implemented that day and remain in force. The MDT is supported by Liverpool University Hospital Foundation Trust (LUHFT).

The Health Board to consider contingency plans should the service not be able to be delivered due to staff absence as currently configured and these plans remain under close review.

LUHFT have supported these plans to date and have supported out of hours provision for emergency surgery for one on-call period (due to consultant sickness and leave pressures) although no patients required treatment during this period.

These arrangements have resulted in cancellation of some outpatient activity and non-urgent elective surgery.

2. *Budgetary / Financial Implications*

There are not direct budgetary implications at this time, but any further development or utilisation of the contingency plans may change the current position.

3. **Risk Management**

The risk register is currently being updated and reviewed in the light of feedback from the Vascular Quality Panel.

4. *Equality and Diversity Implications*

None at this time

| Report title: | Partnerships, Engagement and Communication Update | | |
|---|---|---|---|
| **Report to:** | Betsi Cadwaladr University Health Board | | |
| **Date of Meeting:** | Thursday, 04 August 2022 | Agenda Item number: | 8.1 |
| **Executive Summary:** | This paper provides an update to the Health Board on activity related to partnerships, engagement and communication over the last three months (April to June 2022). It includes a triangulation of engagement activity across functions (ie not just the public engagement function) to show the breadth of work taking place across BCU. | | |
| **Recommendations:** | The Board is asked to note the update and feedback comments on its content and suggestions for improvement for future updates. | | |
| **Executive Lead:** | Jo Whitehead, Chief Executive | | |
| **Report Author:** | Helen Stevens Jones, Director of Partnerships, Engagement and Communication | | |

| Purpose of report: | For Noting ☒ | For Decision ☐ | For Assurance ☒ |
|---|---|---|---|
| **Assurance level:** | Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives | Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives | Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives | No Assurance ☐ No confidence/evidence in delivery |

**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:**

Good mechanisms and embedded objectives are in place to ensure ongoing delivery of activities within the Partnerships, Engagement and Communication Team.

| | |
|---|---|
| **Link to Strategic Objective(s):** | The work of the PEC team relates to all BCUHB strategic objectives |
| **Regulatory and legal implications** | All public services in Wales have a duty to engage and consult with citizens. The Partnerships, Engagement and Communication Team works closely with Health Board colleagues to ensure we are meeting the duties. |
| **In accordance with WP7 has an EqIA been identified as necessary and undertaken?** | No, not for this update  The impact of EqIAs carried out as part of service plans, service reviews, capital investments etc are factored into/form a basis of the work of the |

| | Partnerships, Engagement and Communication Team. |
|---|---|
| **In accordance with WP68 has an SEIA identified as necessary been undertaken?** | No, not for this update<br><br>The impact of SEIAs carried out as part of service plans, service reviews, capital investments etc are factored into/form a basis of the work of the Partnerships, Engagement and Communication Team. |
| **Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)** | There are no specific risks associated with this paper but the work of the Partnerships, Engagement and Communication Team is closely linked to reputation risk management.<br><br>Related risks include: BAF 21-10 (Listening and Learning). |
| **Financial implications as a result of implementing the recommendations** | There are no direct financial implications. |
| **Workforce implications as a result of implementing the recommendations** | There are no direct workforce implications. |
| **Feedback, response, and follow up summary following consultation** | This paper is a Board update only |
| **Links to BAF risks:**<br>(or links to the Corporate Risk Register) | BAF 21-10 (Listening and Learning) |
| **Reason for submission of report to confidential board (where relevant)** | Not applicable |
| **Next Steps:**<br><br>The Board is asked to note the update and to feedback suggestions for improvement | |
| **List of Appendices:**<br>    None | |

**BOARD OF DIRECTORS MEETING IN PUBLIC**

**4th August 2022**

**PARTNERSHIPS, ENGAGEMENT AND COMMUNICATION UPDATE**

**1.     Introduction/Background**

The attached slide set provides an update to the Health Board on activity related to Partnerships, Engagement and Communication over the last three months (April to June 2022).

The slides include a triangulation of engagement activity across functions (ie not just the public engagement function) to show the breadth of work taking place across BCU.

**2.     Budgetary / Financial Implications**

2.1    There are no budgetary implications associated with this paper.

**3.     Risk Management**

3.1    There are no direct risk issues that relate to the report. The work of the Partnerships, Engagement and Communication Team is closely related to reputation risk management.

**4.     Equality and Diversity Implications**

4.1    There are no direct Equality and Diversity implications in the report. The work of the Partnerships, Engagement and Communication Team is closely related to equality and diversity work across the organisation.

# Partnerships, Engagement and Communication Update

April – June 2022

# Public affairs and partnerships

- More than 30 meetings and discussions have been held with the majority of the North Wales Members of the Senedd and MPs over the last four months. These have been face-to-face, via Zoom or on the telephone. Of these, 19 have been held in their constituency offices.

- We are building a positive relationship with MSs, MPs and their staff. As a result of the face to face meetings they contact members of the team by telephone or email on a daily basis with a variety of queries, most of which are answered within a few days.

- Further meetings with all MS and MPs are scheduled on a regular cycle throughout the year. We are also arranging visits for them to Health Board premises to highlight new initiatives and the positive work of our staff.

- A Bulletin is circulated weekly to every MS and MP in North Wales as well as their support staff. It is also sent to the political leaders and Chief Executives of all local authorities, as well as representatives of other organisations including the CHC, Welsh Government and the Welsh Ambulance Services NHS Trust. Some politicians have used positive health news contained in the Bulletin to publish their own press releases.

- MS/MP correspondence increased during the pandemic and built up a backlog of overdue cases. We are making good progress to clear this backlog, with 104 cases overdue in June compared with almost 150 in February. We have made it a priority to tackle this backlog so that all questions are answered within the agreed timescale, whenever possible. We are on track to have made significant progress by the end of 2022.

# Engagement

- We supported engagement for the Clinical Services Strategy. We designed and promoted an online survey with 557 responses and targeted discussions with partners including North Wales local authorities, third sector partners, Community Health Council, BCUHB senior clinical leaders and the Stakeholder Reference Group.

- We are working with Third Sector partners to co-design a revised framework for commissioning and strategic approach.

- Through capturing patient stories we are seeing changes being made, such as support for parents accessing maternity services and bereavement support, improvements in food and nutrition standards and improvements in people's dementia experience.

- We have had BCUHB stalls at/booked to go to: Armed Forces Day, North Wales Pride, Men's Mental Health Week, Anglesey Show, Denbigh and Flint Show. On average, events like these provide opportunities to reach in excess of 1,000 people.

- We have established a new Regional Engagement Network in collaboration with the Co-production Network for Wales to create a "community of interest" in engagement.

- Good progress against the Targeted Intervention engagement measures, including embedding a culture of engagement through creation of toolkits and a review of engagement activity across services to inform our strategy.

- Routine meetings with communities who are from the nine protected characteristic groups to understand their health priorities and barriers and feedback to services. We also engage with our staff networks to understand their concerns.

# Print and broadcast communications

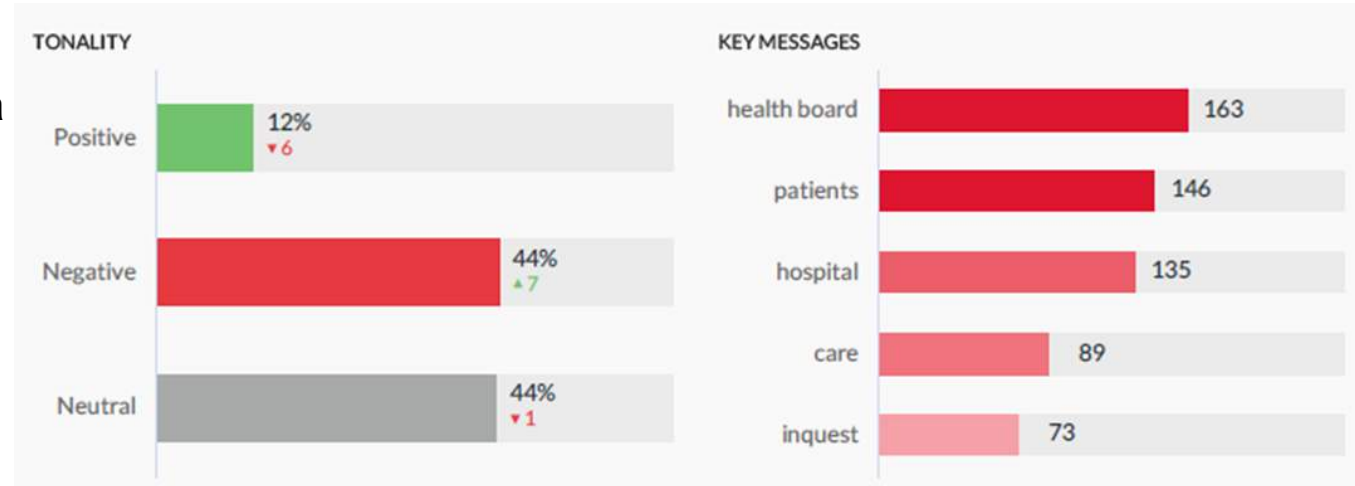During the first quarter of 2022/23, we issued:

- 30 proactive press releases, and
- responded to 146 media enquiries

Overall, BCU was mentioned in 564 articles. There was a significant increase in negative coverage this quarter.
Key issues included:

- Vascular services
- Welsh Government announcements around Targeted Intervention
- HIW inspection reports (YGC Emergency Department)

A highlight was the BBC Wales Investigates programme that aired in June.

**TONALITY**

| | |
|---|---|
| Positive | 12% ▼6 |
| Negative | 44% ▲7 |
| Neutral | 44% ▼1 |

**KEY MESSAGES**

| | |
|---|---|
| health board | 163 |
| patients | 146 |
| hospital | 135 |
| care | 89 |
| inquest | 73 |

Full list of stories published:

Health-board-news - Betsi Cadwaladr University Health Board (nhs.wales)

# Digital communications



**EXECUTIVE SUMMARY**

HIGHLIGHTS FROM THE QUARTER

- Social mentions decreased 19%
- Potential reach decreased 17%
- BCUHB's net tonality trended upward and was overall positive

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

≡ **Social Mentions** 5.7k
The number of mentions in social posts

mSCORE **68**
Apr 1, 2022 - Jun 30, 2022

↗ **Potential Reach** 17.3M
Approximate number of social posts views you appeared in

❝ **Net Tonality Score** +31
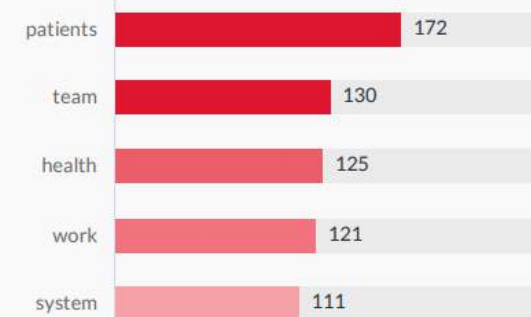The net change (up or down) in sentiment over the time period

**TONALITY**

| | | |
|---|---|---|
| Positive | 49% ▲ 20 | |
| Negative | 19% ▲ 3 | |
| Neutral | 32% ▼ 23 | |

**KEY MESSAGES**

| | |
|---|---|
| patients | 172 |
| team | 130 |
| health | 125 |
| work | 121 |
| system | 111 |
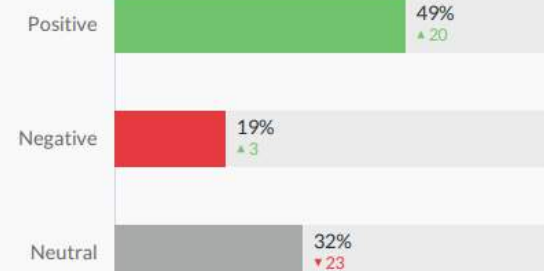
- Our social channels saw greater positive tonality than print and broadcast.
- Patients top the chart for mentions on social (it is the Health Board in print and broadcast).

**What is the m-Score?**

The m-Score is a measurement developed by the monitoring system. It is a simple way to understand the health of perception over time. *It gives equal weight to volume, reach, and tonality.* Each score relative to the competitors is provided and the average for each metric is 50 out of 100. Anything above 50 is above average for our set, and anything below 50 is below average.
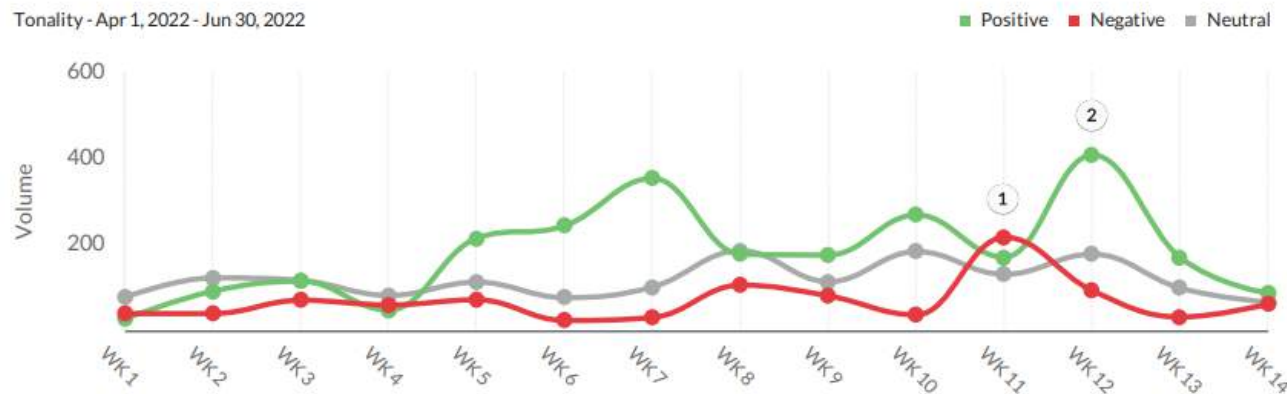
# TONALITY

## HIGHLIGHTS FROM THE QUARTER

- ① Week 11 had the highest volume of 217 negative posts, rising 486%
- ② Week 12 had the highest volume of 408 positive posts, rising 139%

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

## BCUHB's net tonality increased 16 points

Tonality - Apr 1, 2022 - Jun 30, 2022

■ Positive ■ Negative ■ Neutral



### POSTS WITH MOST IMPACT

**Twitter | juin 22**

@BETSICADWALADR Today is Reserves Day and we wanted to reach out to say a big thank you to Betsi Cadwaladr UHB for your ongoing support of HM Armed Forces and the Armed Forces Covenant. #ReservesDay #...

Reach 633k ● Positive

**Twitter | juin 8**

RT @WalesPolitics: Conservatives say Betsi Cadwaladr health board should go back into 'reformed' special measures after a string of recent failures https://t.co/9w2GPJpTJt

Reach 157k ● Negative

- The reach of the positive tweets discussing Armed Forces Day is four times higher (633) than the reach of the HIW/TI announcements (157)

Key proactive stories across all channels (broadcast, print and social) included:

- New rapid diagnostic clinics
- New urgent primary care centres
- New executive nurse announced
- Armed Forces pledge
- Dementia patients support scheme
- New gamma camera at the Maelor
- Recognition for bereavement midwives
- Cardiovascular nurse of the year
- Dietitian shortlisted for national award
- Celebrating International Nurses Day
- New endometriosis nurses
- Expansion for specialist mental health services for new and expectant mums

# Coming up

- We are supporting the new Operating Model with targeted communications and engagement with staff and partners.

- We are supporting the YGC targeted improvement work with internal communications, this includes a drive to raise greater awareness of our values with patients and staff.

- We are launching the IMTP and People Strategy.

- We are developing a strengthened approach to patient and public engagement, which includes developing a forum of people who want to be involved in planning, service improvements or simply general updates.

- We are starting phase two of our public affairs work - Chief Executives and Leaders of all six North Wales local authorities are being approached for meetings over the next few months, as well as other stakeholders.

- We will be attending health and social care committees as observers to identify any issues that may have an impact on Health Board responsibilities.

- We will work with the new Integrated Health Communities to further develop links with local authorities and elected members in their areas and build on our communications and engagement offer to them.

- The weekly Partners Bulletin is being developed into a more attractive newsletter-style design, making it easier for politicians to share with their constituents.

| | |
|---|---|
| **Teitl adroddiad:**<br><br>*Report title:* | Summary of Private Board Business |
| **Adrodd i:**<br><br>*Report to:* | Health Board - Public |
| **Dyddiad y Cyfarfod:**<br><br>*Date of Meeting:* | Thursday, 04 August 2022 |
| **Crynodeb Gweithredol:**<br><br>*Executive Summary:* | Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings. |
| **Argymhellion:**<br><br>*Recommendations:* | The Board is asked to note the report |
| **Arweinydd Gweithredol:**<br><br>*Executive Lead:* | Molly Marcu – Board Secretary |
| **Awdur yr Adroddiad:**<br><br>*Report Author:* | Philippa Peake-Jones – Head of Corporate Affairs |

| **Pwrpas yr adroddiad:**<br>*Purpose of report:* | I'w Nodi<br>*For Noting*<br>☒ | I Benderfynu arno<br>*For Decision*<br>☐ | Am sicrwydd<br>*For Assurance*<br>☒ | |
|---|---|---|---|---|

| **Lefel sicrwydd:**<br><br>*Assurance level:* | Arwyddocaol<br>*Significant*<br>☐<br><br>Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*High level of confidence/evidence in delivery of existing mechanisms/objectives* | Derbyniol<br>*Acceptable*<br>☒<br><br>Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*General confidence / evidence in delivery of existing mechanisms / objectives* | Rhannol<br>*Partial*<br>☐<br><br>Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol<br><br>*Some confidence / evidence in delivery of existing mechanisms / objectives* | Dim Sicrwydd<br>*No Assurance*<br>☐<br><br>Dim hyder/tystiolaeth o ran y ddarpariaeth<br><br>*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:**<br><br>*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:**<br><br>*Link to Strategic Objective(s):* | No - N/A/ |
| **Goblygiadau rheoleiddio a lleol:**<br><br>*Regulatory and legal implications:* | No - N/A/ |

| | |
|---|---|
| **Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>*In accordance with WP7 has an EqIA been identified as necessary and undertaken?* | No - N/A/ |
| **Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?**<br><br>*In accordance with WP68, has an SEIA identified as necessary ben undertaken?* | No - 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)**<br><br>*Details of risks associated with the subject and scope of this paper, including new risks( cross reference to the BAF and CRR)* | No - N/A/ |
| **Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith**<br><br>*Financial implications as a result of implementing the recommendations* | None |
| **Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith**<br><br>*Workforce implications as a result of implementing the recommendations* | None |
| **Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori**<br><br>*Feedback, response, and follow up summary following consultation* | Not applicable |
| **Cysylltiadau â risgiau BAF:**<br>(neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)<br><br>*Links to BAF risks:*<br>(or links to the Corporate Risk Register) | Not applicable |
| **Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol)**<br><br>*Reason for submission of report to confidential board (where relevant)* | Not applicable |

**Camau Nesaf:**
**Gweithredu argymhellion**

*Next Steps:*
*Implementation of recommendations*

The Health Board considered the following matters in private session on 26 May 2022:

- Bangor Health and well-being Strategic Outline Case (SOC)

- Microsoft Enterprise Agreement

**Rhestr o Atodiadau:**
   Dim

*List of Appendices:*
*None*